PERCEPTIONS CONCERNING THE EFFECTIVENESS OF AFTERCARE PROGRAMMES FOR FEMALE RECOVERING DRUG USERS

BY

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2015

As the candidate's supervisors, I agree to the submission of this thesis

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ABSTRACT

PERCEPTIONS CONCERNING THE EFFECTIVENESS OF AFTERCARE PROGRAMMES FOR FEMALE RECOVERING DRUG USERS

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2015

Drug addiction is a chronic disease and it needs effective long term treatment for one to overcome the habit. The road to recovery is a strenuous effort. This is because biological, psychological, social and spiritual dynamics all contribute to the complete recovery of a drug addict. It is important that aftercare programmes take cognizance of these factors in assisting female recovering drug users to reintegrate well into society following a period of treatment. Very few studies have been conducted in South Africa to explore the effectiveness of aftercare programmes for female recovering drug users, thus there is a gap in knowledge in that area. This study therefore aimed to add to the body of knowledge in the area through investigating the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.

The study focused on the biological, psychological, social and spiritual aspects of female recovering drug users' recovery and provides insight on the perceptions concerning the effectiveness of aftercare programmes. The study utilized a qualitative research methodology and the biopsychosocial-spiritual model was used to understand addiction and recovery better. Data collection was conducted at a well-established treatment centre in Gauteng through individual interviews with six female recovering drug users and a focus group discussion with five social workers.

Results of the study show that both female recovering drug users and social workers who participated in the study perceived aftercare programmes as effective and helpful. Aftercare assisted the female recovering drug users in biological, psychological, social and spiritual aspects of their lives leading to a different lifestyle from the one during addiction. There were however some challenges faced during aftercare and participants also suggested some improvements needed for aftercare.

Key words: aftercare, recovery, drug user.

DECLARATION ON PLAGIARISM

I, **TALENT HAZVINEYI MHANGWA**, hereby declare that this thesis for the Master of Social Work degree at the University of KwaZulu-Natal, hereby submitted by me has not previously been submitted for a degree at this or other institution, and that it is my own work in design and execution. All reference materials contained therein have been duly acknowledged.

SIGNATURE…………………………… **DATE………………………**

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DEDICATION

This thesis is dedicated to my late mother Mrs. Josephine Mhangwa for sending me to good schools and grooming such a wonderful young man. The thesis is also dedicated to my siblings, their spouses and children.

CHAPTER ONE
INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 INTRODUCTION

The study was aimed at gaining insight concerning the effectiveness of aftercare programmes for female recovering drug users. This chapter provides an introduction to the study by focusing on the background and motivation of the study, significance of the study, aims and objectives of the study, theoretical framework, location of the study, definition of major concepts and structure of the report. The aim of this chapter is to introduce the research study and highlight aspects pertinent to the study such as background and significance of the study, an outline of the study and structure of the research report.

1.2 BACKGROUND AND MOTIVATION OF THE STUDY

Stein, Ellis, Meintjes and Thomas (2012) argue that men have traditionally been believed to have a high prevalence of substance abuse while women had high mood and anxiety disorders. They further argue that, this traditional belief was being overturned as women were now more empowered in social structures leading to substance abuse among them becoming more common. Morojele, Rich, Flisher and Myers (2012) also argue that there has been an increase in the range and availability of illegal drugs in South Africa since 1994. Looking at the data provided by both these authors, it seemed that substance abuse among women was on the increase and the availability of illegal drugs in South Africa was also increasing. Faced with both these problems effective substance abuse treatment is needed in South Africa and this was the basis of my study as I wanted to understand whether aftercare programmes were perceived as providing effective services specifically in relation to female drug users.

People use drugs due to several reasons and Dykes (2010) propounded that the environment people live in could affect them negatively or positively. Drug use was seen as being a result of negative influences from the environment due to conditions such as discrimination and oppression. Dykes (2010) further states that an unresponsive environment, the “dop” system, powerlessness, poverty, stresses and life events may result in substance abuse. The “dop” system however, was mainly related to alcohol abuse in South Africa. Peer group relationships, gang

membership, family experiences and genetic factors such as people being affected by ADHD may also contribute to substance use (Dykes 2010). Zastrow and Kirst-Ashman (2004) argue that the media through popular songs and movies could also glamorize substance abuse. In addition, Gray (2010) alludes to the fact that the characteristics of substance users may be linked to poor, marginal, oppressed and minority populations. With all these factors being prevalent in South Africa, it can be seen that substance use is a social problem that needs discrete attention and treatment. The abovementioned factors that may contribute to substance use will be discussed in further detail in Chapter 2.

Miller, Forcehimes and Zweben (2011) state that there is a need to treat addictions due to the prevalence and extent of problems that addictions cause. Working at a rehabilitation centre in Gauteng also made me gain broader perspective on the effects of addiction to the substance users and the community at large. My tenure working in the substance abuse field motivated me to conduct the study as most of the recovering drug users leaving long term institutional treatment, appeared motivated and focused about not using drugs again. However, after a short period of time there would be reports that the same former residents had relapsed. This made me ask the question: what is really happening in aftercare and do recovering drug users benefit from programmes offered in aftercare? These concerns form the basis of this study.

According to a study conducted by Maehira, Chowdhury, Reza, Drahozal, Gayen, Masud, Afrin, Takamura and Azim (2013) in Bangladesh, relapse was more common among females than males after a three-month drug detoxification rehabilitation programme. The study could not establish reasons why these females relapsed more than males. The findings of this study made me eager to get more information on perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. Anecdotes from service providers in the study in Bangladesh working at the Dhaka drug treatment clinics stated that females who sold sex after treatment had a higher possibility of relapse. With females being at risk of relapse into drug use, and aftercare programmes being responsible for relapse prevention, I decided to tackle the effectiveness of aftercare programmes with regard specifically to women to understand perceptions of effectiveness of aftercare programmes better.

A study conducted by Gossop, Stewart and Marsden (2007) in England found that clients who attended Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) meetings after

residential treatment for drug dependence were more likely than non-attenders to be abstinent from opiates at follow up. The results of this study in particular motivated me to conduct a study to get information on how female recovering drug users perceived the effectiveness of aftercare programmes. Frequency of NA and AA attendance was seen to have a great impact on abstinence from alcohol and drugs. However, it should be noted that I only managed to access limited information on the effectiveness of aftercare programmes in South Africa and more particularly on female recovering drug users.

The National Drug Master Plan (NDMP) 2013 – 2017, asserts that reports from the South African Revenue Service (SARS) state that the known direct cost of drug use in 2005 was estimated to be R101 000 million. There are also emotional, social and financial implications arising from drug abuse that affect the immediate family of substance abusers discussed in the NDMP 2013 - 2017. Zastrow and Kirst-Ashman (2004:420) state that drug abuse may lead to "deterioration in health, relationship problems, automobile accidents, child abuse and spouse abuse, loss of job, low self-esteem, loss of social status, financial disaster, divorce, and arrests and convictions." Thus it can be seen that drug abuse does not only affect one aspect of a person's life but also affects the biological, psychological and social aspects with more recent theory also suggesting that substance abuse also affects the spiritual dimension of a person's life. Van Wormer and Davis (2008:3) argue that "where there is assault, incest, rape, child neglect, or attempted suicide, more often than not some form of substance misuse is involved." Due to all these social ills caused by substance abuse, as a social worker I wanted to understand the perceptions concerning the effectiveness of what was being done to stop substance abuse with particular attention being on aftercare programmes for female recovering drug users.

A Rapid Participatory Assessment (RPA) conducted in 2012 by the Central Drug Authority (CDA) in South Africa discovered that 65% of the respondents reported they had a substance user or abuser in their home (NDMP 2013 – 2017). With such a high rate of substance use and abuse in South Africa, there was definitely a need to get information on the treatment and aftercare programmes being offered in the country. Due to the aforementioned statistics, it is clear that substance abuse is a major social problem in South Africa and sustainable treatment is needed. Treatment can only be effective if both the service providers and the service users perceive this treatment as helpful and beneficial. In my study I was interested in both the

perceptions of the service providers and the service users concerning the effectiveness of aftercare programmes for female recovering drug users.

1.3 SIGNIFICANCE OF THE STUDY

I conducted a study that should be of significance to the society, for substance abuse treatment policy, for the social work profession and for future research. My study was intended to benefit stakeholders in understanding better the perceptions concerning the effectiveness of aftercare programmes. The study is anticipated to be of great value as I interviewed both the service providers and service users of aftercare programmes. Through interviewing both the service providers and the service users I had a more holistic and vivid view on perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. Having perceptions from both service users and service providers also assisted in deducing a concrete view from different perspectives on the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.

My study should assist in understanding better the plight of female recovering drug users attending aftercare programmes. As will be discussed in Chapter 2, women experience a different path in terms of addiction and recovery from men. Investigating the perceptions of female recovering drug users attending aftercare was of great value to South African substance abuse treatment as from my investigation, limited detailed information concerning women and aftercare was available in the South African context. The study is considered vital for future researchers and policy makers as it provides a description of what both service users and service providers perceive concerning the effectiveness of aftercare programmes. The research may enlighten policy makers and future researchers on the shortfalls and strengths of the aftercare programme being offered to female recovering drug users. An understanding of the perceptions concerning effectiveness of aftercare also assists in improving the current aftercare programme.

My study is considered valuable as it aimed at understanding female recovering drug users from a holistic perspective that is, in terms of biological, psychological, social and spiritual aspects and this assisted as service providers can explore areas they need to expand on be it the biological, psychological, social or spiritual aspects of recovery to improve the quality of aftercare programmes they offer.

1.4 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to gain insight on the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.

The following objectives and questions were directed at both female recovering drug users and social workers involved in their aftercare.

Table 1.1

Objectives and Questions of the Study

OBJECTIVES OF THE STUDY	**QUESTIONS TO BE ASKED**
To gain insight on the effects of aftercare to female recovering drug users' lives.	How does aftercare affect the lives of female recovering drug users?
To understand the challenges female recovering drug users might face during aftercare.	How do the challenges female recovering drug users face during aftercare affect their recovery?
To understand how environmental factors affect female recovering drug users during aftercare.	How do environmental factors affect female recovering drug users during aftercare?
To explore biopsychosocial and spiritual factors that affect female recovering drug users during aftercare programmes.	What biopsychosocial and spiritual factors affect female recovering drug users during aftercare?
To ascertain recommendations for improvement to aftercare programmes from social workers and female recovering drug users.	What do social workers and female recovering drug users think needs to be done to improve aftercare?

1.5 THEORETICAL FRAMEWORK

The theoretical framework applied was the biopsychosocial-spiritual model. The model entails looking at the biological, psychological, social and spiritual dimensions that have an impact on the drug user. Miller *et al.* (2011) state that addiction treatment is holistic and therapists need to take consideration of the whole person that is the biological, psychological, social and spiritual. They further state that addiction treatment is not effective if it does not cater for all the four dimensions of a person. According to Hatala (2013:270) "future health intervention programs

and research should focus on the holistic interaction between these four domains rather than separate aspects of the individual or environment." Thus as Hatala (2013) and Miller *et al.* (2011) indicate, for both substance abuse intervention and research to be effective one has to consider the four dimensions of a person; since I aimed to conduct valuable research, I considered all four dimensions. The four dimensions which are biological, psychological, social and spiritual assisted me in understanding the effectiveness of aftercare programmes with all the dimensions being offered some attention in my study.

Social work and other counselling professions consider drug addiction holistically, paying particular attention to the biological, psychological, social and more recently spiritual causes and consequences of drug addiction. Zastrow and Kirst-Ashman (2004) emphasize that social workers should not focus on a problem only in one system, but holistically in terms of biological, psychological and social factors linked to the problem. According to Zittell, Lawrence and Wodarski (2008:30) social work interventions need to "be tailored to integrating cognitive, social and spiritual strengths when facing health problems." I referred to drug addiction as a health problem as Stanbrook (2012:155) argues that "addiction is a chronic relapsing disease that we must treat as we do other such diseases." In my study drug addiction was viewed as a disease. The arguments by Zastrow and Kirst-Ashman (2004), and also Zittell *et al.* (2008) show that health problems need to be understood holistically thus I used the biopsychosocial-spiritual model to describe better the perceptions concerning aftercare programmes for female recovering drug users.

The biology part of the biopsychosocial-spiritual model in relation to substance abuse entails looking at the hereditary effects of drug addiction and the physiological problems that may arise from addiction due to prolonged drug use (Van Wormer & Davis 2008). In my study I also looked at the biological aspects of addiction as addiction was viewed as a disease in the study. Gray (2010) states that the biological component of the biopsychosocial-spiritual perspective on drug addiction focuses on the genetic causes of addiction and medical solutions. In my study I focused on the genetic effects of drug addiction but due to the nature of my study, less focus was afforded to the medical treatment of drug addiction.

The psychological component of the biopsychosocial-spiritual model entails the thinking and mental processes that lead to drug addiction (Van Wormer & Davis 2008). Irrational thinking

may be related to depression or anxiety and may encourage drug use in order to escape from psychological ills the person is facing. Gray (2010) states that psychological aspects of the biopsychosocial-spiritual model entails the mental processes related to drug addiction and the therapeutic and social approaches in treating drug addiction. My study provided some attention to the psychological aspects of the female recovering drug users since in social work there is a huge focus on psychosocial aspects of a person's life.

The social aspect of the biopsychosocial-spiritual model in addiction relates to the place where drug use is being conducted. Friends and family may be involved directly or indirectly in a person's drug use. Gray (2010) states that social aspects of the biopsychosocial-spiritual model entails environmental and structural factors that lead to drug use. By environmental factors, this study seeks to understand the drug users' immediate environment. Here, attention is paid on participants' interests, hobbies and things that they do for entertainment. Risk factors around the participants' social environments are also explored. In exploring the structural factors that influence or impact on addiction, this study seeks to understand the role played by things such as gender, poverty, being from a marginalised group and the political status of women in women's addiction and recovery.

The spiritual aspect of the model talks to the belief of the substance user in relation to a supreme power. Van Wormer and Davis (2008) state that the spiritual aspect of drug addiction is important as it is associated with a person's meaning and interconnectedness in life. Treatment approaches like the 12-step programme pay particular attention to the spiritual realm and emphasize that a person is powerless to overcome addiction without assistance from a higher power.

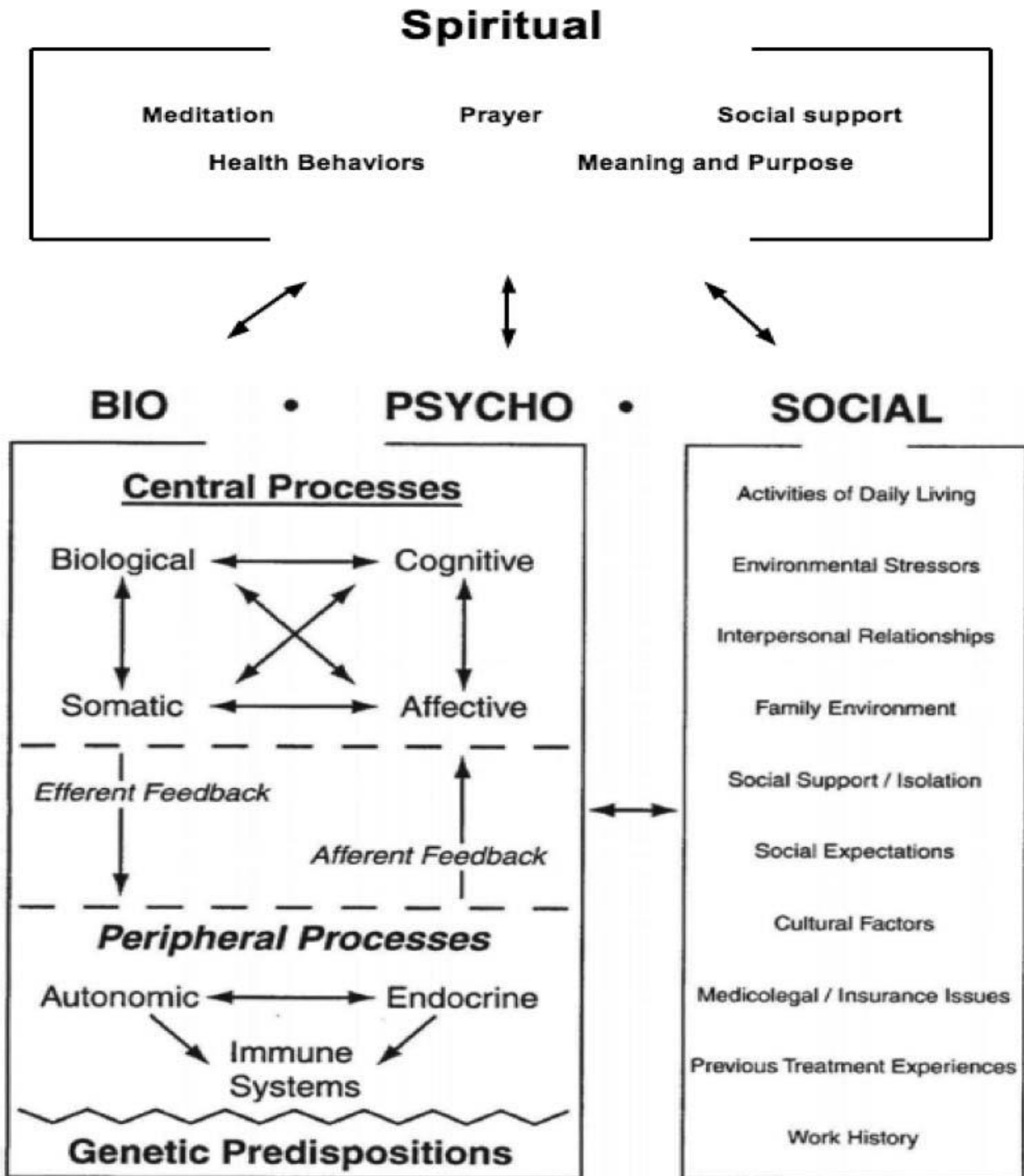
Van Wormer and Davis (2008) state that a key component of the biopsychosocial-spiritual model of addiction is the element of interactiveness. Body, mind, society, and spirituality are all braided in the cycle of addiction. Zastrow and Kirst-Ashman (2004) provide an example of an alcohol addicted adult. Her drinking affects her biological, psychological, and social systems. Biologically she loses weight and has frequent physical problems such as severe hangover headaches. Her physical health affects her psychological health as she becomes frequently disgusted with herself. Her psychological condition will affect her interactions with those close to her, and they begin to avoid her. Hence, her social system is affected. Social isolation, in turn,

enhances her psychological desire to drink and escape, and her physical condition continues to deteriorate. Gray (2010) notes that with the influence of the systems theory, these biological, psychological, social and spiritual aspects of a human's life have been integrated into the biopsychosocial-spiritual model. Social workers assess the functioning of various biopsychosocial-spiritual systems within the context of professional values and ethics.

Hatala (2013:269) devised the diagram on Fig 1.1 in order to clearly explain the biopsychosocial-spiritual model. Though Hatala (2013) propounded this biopsychosocial-spiritual model in relation to health psychology, it can be seen that the diagram can be related to social work and substance abuse also. Hatala (2013: 256) terms the biopsychosocial-spiritual model the "holistic" perspective. The biopsychosocial-spiritual model can be seen as a holistic model as it covers the major aspects of a human's life as the model talks to the biological, psychological, social and spiritual elements of an individual's life. Traditionally behavioural scientists in particular focused on the biopsychosocial model propounded by George Engel and Hatala (2013) was emphasising the importance of inclusion of the spiritual aspect.

In Fig. 1.1 on the next page, it can be seen that Hatala (2013) describes spiritual aspects as meditation, prayer, meaning and purpose. In my study I also sought to explore how these components of spiritual life evolve during recovery for female recovering drug users. Hatala (2013) describes biological elements as involving immune systems and genetic predispositions. In my study, as mentioned earlier I also explored biological aspects that affected the female recovering drug users. Psychological factors include cognitive processes and social factors that include environmental stressors, family environment, social expectations; elements that were afforded some attention in my study. Thus as Hatala (2013) terms it, in my study I was also studying the "holistic" aspects of female recovering drug users. The diagram on the next page enhances the understanding of the biopsychosocial-spiritual model in my study as it provides a summary of the model.

Fig. 1.1
Summary of the biopsychosocial-spiritual model



A Biopsychosocial-Spiritual Interactive Processes Involved in Health and Illness Reproduced from Hatala (2013:269).

1.5 LOCATION OF THE STUDY

The study was conducted at a well-established treatment centre in Gauteng. The treatment centre has assisted a lot of people with drug related problems. Peltzer, Ramlagan, Johnson and Phaswana-Mafuya (2010) argue that urbanisation contributes to drug abuse due to the lack of "traditional values" in urban areas. They further argue that Gauteng and the Western Cape have the highest rates of substance abuse in South Africa and correspondingly they were the most urbanised provinces in South Africa. This motivated me to conduct my study in Gauteng due to its relative proximity to KwaZulu Natal compared to the Western Cape. Further, globalization was seen as contributing to increased drug use in South Africa due to more effective transport routes (Peltzer *et al.* 2010). With Gauteng having the largest international airport in the country, this influenced my selection of the research site. Henk Strydom the senior prosecutor at the Boksburg Magistrate Court at a lecture at Freedom Recovery Centre stated his opinion that there were many drug related cases in Ekurhuleni for instance due to its proximity to the airport. This too warrants my study location being in Gauteng.

According to the results of Census 2011, Gauteng had the largest number of people in a South African province (Provincial Profile: Gauteng 2014). Furthermore, 21% of this population were females between the ages of 15 and 34. With urbanisation being discussed as a contributor of substance abuse and Gauteng having the highest rates of urbanization in South Africa, there was a need to establish whether the substance abuse treatment programmes offered in the province were effective. Temmingh and Myers (2012) also argued that the highest number of treatment centres in South Africa were located in Gauteng and Western Cape. This further motivated my decision to conduct my study in Gauteng as it was the area where more treatment centres were located thus contributing to a higher chance of gaining access to conduct the study at a well-established research site.

I secured gatekeeper permission from the director at the research site to conduct the study at the centre when submitting the proposal of the study to the University, under whose auspices this was conducted in order to expedite securing ethical clearance for the study. Ethical clearance for the study was subsequently secured.

1.6 DEFINITION OF THE MAJOR CONCEPTS

1.6.1Addiction

"A progressive, chronic, primary, relapsing disorder that involves features such as compulsion to use a chemical, loss of control over the use of a substance, and continued use of a drug in spite of adverse consequences caused by its use" (Doweiko 2006:3).

1.6.2 Aftercare

" 'Aftercare' means the 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 social functioning" (Prevention of and Treatment for Substance Abuse Act 70 of 2008).

1.6.3 Drug

"Refers to psychoactive or dependence-producing substances and often, more specifically, to those that are illicit" (NDMP 2013 – 2017: 17).

1.6.4 Drug Abuse

"The use of a drug in such a manner or in situations such that the drug use causes problems or greatly increases the chance of problems occurring" (Ray & Ksir 2004).

1.6.5 Recovery

"all the positive benefits to physical, mental, and social health that can happen when alcohol- and other drug-dependent individuals get the help they need" (The Betty Ford Institute Consensus Panel 2007: 225).

1.6.6 Substance Abuse

"The misuse and abuse of legal or illicit substances such as nicotine, alcohol, over-the-counter and prescription medication, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illegal or illicit substances" (NDMP 2013 – 2017: 19).

1.6.7 Treatment

"A process aimed at promoting the quality of life of the drug dependant and his/her system (husband/wife, family members and other significant persons in his/her life) with the help of a multi-professional team" (NDMP 2013 – 2017: 19).

1.7 STRUCTURE OF REPORT

Chapter 1: Introduction and Background of the Study

This chapter contains an introduction, background and motivation of the study. The chapter also discusses the significance of the study, aims and objectives of the study and the theoretical framework used in the study. The last sections of the chapter are on the location of the study, definition of the major concepts and structure of the report.

Chapter 2: Literature Review. Substance Abuse and Aftercare Programmes

This chapter focuses on the literature concerning substance abuse and aftercare programmes. The chapter includes information on addiction, effects of drug use, substance abuse treatment in South Africa, substance abuse recovery, aftercare programmes, policies for substance abuse treatment in South Africa, a summary of biological, psychological, social and spiritual factors affecting recovery and life after substance abuse treatment. The chapter looks at what authors and research findings say concerning substance abuse and aftercare programmes with emphasis being on female drug users.

Chapter 3: Research Methodology

The chapter focuses on the research methodology used in the study. The chapter discusses the research approach, research design, sampling and sampling method, method of data collection, data analysis, trustworthiness, reflexivity, ethical considerations and limitations of the study. This is the chapter that provides a description of how the research was executed. The chapter provides adequate rationale based on literature for choosing the selected methodology.

Chapter 4: Presentation and Discussion of the Results

In Chapter 4 there was the use of systematic methods and the technical presentation of the data collected in my study. There is relationship and correspondence with issues in the research instruments. The chapter discusses the data provided by the participants in relation to existing literature on the specific topics.

Chapter 5: Summary of Study Findings and Recommendations

This is the last chapter of my report and consists of concise interpretation of the findings. It also contains the researcher's interpretation of the findings and linkages with reviewed literature. The chapter also provides presentations of recommendations and implications of the findings on the

perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.

1.9 CHAPTER SUMMARY

Chapter one provided an overview on the background and motivation of the study, significance of the study, aim and objectives of the study, theoretical framework, location of the study, definition of the major concepts and structure of the report. This chapter acted as an introductory chapter to what the study was about.

CHAPTER TWO

LITERATURE REVIEW: SUBSTANCE ABUSE AND AFTERCARE PROGRAMMES

2.1. INTRODUCTION

This chapter discusses substance abuse and aftercare programmes as they were the core of this study. The chapter is divided into several sections focusing on understanding addiction, effects of drug use, substance abuse treatment in South Africa, substance abuse recovery, aftercare programmes, policies for substance abuse treatment in South Africa as well as a summary of biological, psychological, social and spiritual factors affecting recovery and life after substance abuse treatment. These areas are consistent with the choice of theory framing the study, namely the biopsychosocial-spiritual model which provides for the systematic ordering of the chapter with the focus being on the biological, psychological, social and spiritual elements in relation to drug addiction.

2.2. UNDERSTANDING ADDICTION

Zastrow and Kirst-Ashman (2004:420) define drug addiction as "an intense craving for a drug that develops after a period of heavy use". Drug addiction therefore does not result from one incident of drug use with SANCA Vaal (2015) clarifying that drug addiction is a gradual process. Drug addiction develops as a result of progression from experimental drug use. During experimental use, a person uses drugs for the first time. SANCA Vaal (2015) argues that experimental use develop into social use whereby a person starts using drugs occasionally because they enjoyed the experience the first time. Later, there is harmful use whereby abuse of drugs leads to problems such as absenteeism from work and not fulfilling duties at home. Finally, addiction occurs when there are permanent changes to the way the brain functions and the only option left for recovery is total abstinence (SANCA Vaal 2015). This understanding of drug addiction as a process clearly highlights that drug use takes a period of time before one is regarded as addicted.

Miller *et al.* (2011:10) argue that "something becomes an addiction when it increasingly dominates a person's life and, as a result, harms or detracts from other aspects of life". Drug

addicted individuals may neglect several aspects of their biological, psychological, social and spiritual areas of life. Authors have different criteria they use to deduce when someone is addicted to drugs. SANCA Vaal (2015) argues that the central feature highlighting addictive disorders is a progressive loss of control over drug abuse, and the continued use of drugs despite increasingly devastating consequences. Due to addiction, substance abusers need to continue the drug taking as they can no longer live without the drug though there are negative consequences due to the drug use. The criterion used by Miller *et al.* (2011) and SANCA Vaal (2015) to describe addiction as discussed above may seem diverse but for both descriptions, I have identified major common elements for a person to be regarded as addicted to drugs. Drug addiction brings forth problems be they biological, psychological, social or spiritual. Continued use of drugs is evident in drug addiction in spite of some devastating consequences of the drug abuse. Substance use becomes a central part of the person's life and he/she may not function well without abusing the substance, leading to the person neglecting other aspects of life.

Characteristics of addiction involve loss of control, need and compulsion and continued use in spite of negative consequences (SANCA Vaal 2015). Loss of control entails not being able to turn down an offer of drugs, not being able to control drug use and wanting to stop drug use but failing. A person therefore is in addiction when they cannot willingly control when to use the drug and to stop using the drug. Need and compulsion involves feeling distressed without drug use. It also involves being triggered to use drugs after seeing, smelling and even the mention of drugs and the drug addict being preoccupied with drug use. This may be the reason why some people who are addicted to drugs spend most of their time trying to get the next spell of drugs. Continued use despite negative consequences entails experiencing social, psychological, occupational and biological problems but still continuing with drug use, and also having a tendency to minimize or deny the drug problem (SANCA Vaal 2015). In addiction therefore, due to the desire of getting the next 'fix' a person will continue using the drugs after a devastating demise for example loss of a job. This therefore, justifies the need for effective substance abuse treatment to combat the negative effects of drug use thus the relevance of my study.

Miller *et al.* (2011) further argue that, to understand addiction is not simple and one has to combine different perspectives in order to fully comprehend it. Dimensions that can be used to diagnose whether someone is addicted include drug use, problems, physical adaptation,

behavioural dependence, cognitive impairment, medical harm and motivation to change; these being explained herewith (Miller *et al.*2011). When a person is addicted to drugs; he/she may face problems at work, school, relationships, finances and in other areas of life. Addiction also comes in the form of physical adaptation when the body adapts to the use of drugs and needs the drug to function 'normally' (Miller *et al.* 2011). Behavioural dependence in addiction entails that substance use plays an important role in the life of the addicted person that he/she may not give enough attention to other areas of life. The behaviour of the person changes in order to suit the drug use and the addicted person may start isolating him/herself from family and friends for example. Cognitive impairment takes place when mental functioning and intelligence are affected due to substance use.

From the above discussion it can be noted that drug addiction is a complex process that involves several criteria to determine whether someone is addicted to drugs. It can be seen from the discussion that drug addiction affect different aspects of the biological, psychological, social and spiritual aspects of people's lives meriting the selection of the biopsychosocial-spiritual model as my theory frame.

2.3 EFFECTS OF DRUG USE

Van Wormer and Davis (2008:3) state that "the effects of addiction are everywhere and nowhere – everywhere because they are in the family and workplace, nowhere because so much of the behavior is hidden from public view." Different systems of the society are affected by drug abuse ranging from the individual, family to the community at large. However, though there may be negative effects of substance abuse, the family usually tends to cover up the behaviour for outsiders not to recognize the substance abuse problems. Thus the above assertion highlights that the effects of drug addiction is hidden from the public eye. Though the effects of addiction might be somewhat hidden, there are different biological, psychological, social and spiritual effects of drug use that I will discuss hereunder.

2.3.1 Tolerance

Tolerance refers to a phenomenon experienced by many drug users in which continuous exposure to the same dose of drug results in a lesser effect (Ray & Ksir 2004: 45). As the substance user experiences less of the desired effect, it is often possible to overcome the tolerance by increasing the dose of the drug. Miller *et al.* (2011) state that it is believed that

many heroin addicts become addicts as they will be 'chasing' the first rush they experienced after their first experience of the drug. Some regular drug users might eventually build up to taking much more of the drug than it would take to kill a non-tolerant individual (Ray & Ksir 2004). Thus using the abovementioned information, it can be deduced that tolerance leads to the use of increased amounts of drugs in order to attain the desired effects of intoxication. Tolerance has been proposed by some authors as a key element in determining addiction. Because tolerance results in an increased dosage, a person may develop dependence to a substance which I will discuss hereunder.

2.3.2 Dependence

One of the long term effects of drug use is dependence. Dependence according to Doweiko (2006: 498) is "a state in which the body requires the regular use of a compound to continue functioning." Thus the dependent body is used to the presence of the toxic substances and adjusts accordingly. With prolonged use of drugs a person may become dependent on the drug, that is, a person's life is centred on attaining the drug, using, and recovering from the effects of the drug. Drug dependence may therefore be the reason why a drug addict continues using drugs even though there are serious negative consequences of using the drug in his or her life.

Ray and Ksir (2004) divide dependence into physical and psychological dependence. Physical dependence entails that the person continuously takes high doses of drugs over a long period of time and the body gets used to the presence of drugs in the system. With some drugs for example heroin, once the level of drugs decreases in the body, there may be symptoms that appear for example running nose, fever or diarrhea (Van Wormer & Davis 2008). This is a condition popularly known as withdrawal symptoms. The withdrawal symptoms vary for different types of drugs. Due to the painful nature of some withdrawal symptoms, drug addicts may commit crime or do absurd things to get money for drugs. Psychological dependence also known as behavioural dependence entails the frequency of using a drug or the amount of time the drug addict consume in drug-seeking behaviour (Ray & Ksir 2004). When a person is in advanced stages of drug addiction, they spend most of their time in drug seeking behaviour.

2.3.3 Health Consequences

Drugs have harmful effects on body parts such as the brain, liver, lungs, heart and the gastrointestinal system (Van Wormer & Davis 2008). These are important parts of a human's

body as they are responsible for different tasks in the functioning of a person. There is also high risk of heart disease associated with drug abuse (Van Wormer & Davis 2003). Many people in the world are suspected to have died of cardiac arrest linked to drug abuse or overdose. Cocaine is closely associated with heart problems and heart attacks as cocaine related deaths may occur on first use due to cardiac arrest or seizures followed by respiratory arrest (Miller *et al.* 2011). This shows the high toxicity of drugs. According to the United Nations Office on Drugs and Crime (UNODC) (2014) the most extreme effect of drug use is drug-related death. The UNODC (2014) estimate there were 183 000 drug related deaths in the world in 2012. Drug overdose was the major contributor of the drug related deaths. This is a negative impact of drug abuse as it deprives the world of people who could have made the world a better place. Loss of life on account of drug addiction is costly and yet avoidable.

Substance abusers may experience health problems due to poor hygiene or nutrition. Poor nutrition may be as a result of a person depriving self time to eat a well balanced meal due to the drug-taking behaviour. During drug addiction, a person may also neglect their hygiene leading to dental problems, skin diseases and other health problems (Ray & Ksir 2004**.** Some authors state that poor health hygiene may act as an indicator to drug abuse. There is also some form of sexual dysfunction associated with chronic substance abuse (Van Wormer & Davis 2008). This can be a contributor to why people addicted to drugs struggle with intimate relationships.

Substance abuse is also linked to HIV/AIDS. Drug addicts may contract HIV/AIDS due to the promiscuous behaviour that can arise when people are high and unable to control themselves or because of injection of needles (Ray & Ksir 2004; Zule, Myers, Carney, Novak, McCormick & Wechsberg 2014). With South Africa having a high rate of both HIV/AIDS prevalence and substance abuse, it is of great concern that substance abuse may lead to infection with HIV/AIDS as this puts many South African drug users at risk of infection. Substance abuse also affects the adherence of people who are on Anti-Retroviral Treatment (ART) to medication negatively, as they are preoccupied with substance use and may neglect regular ART intake (UNODC 2014). Thus drug addiction has got negative health impacts on people infected with HIV/AIDS and also puts HIV negative drug addicts who unsafely inject needles at risk of acquiring the disease. Unsafe injection of needles does not only result in HIV/AIDS infection but also infection with other blood-borne diseases like Hepatitis B and C (UNODC 2014). The discussion above

indicates that drug use has a lot of negative health consequences; therefore effective treatment of substance abuse is mandatory.

2.3.4 Psychological Consequences

Long term effects of drug use may also result from short term drug use. Psychoactive drugs may impair one's ability to detect what is safe or acceptable to do when under the influence of drugs. During the period of intoxication a person may drown, commit suicide, or get involved in accidents (Miller *et al.* 2011). Being high on drugs impairs a person's judgement and concentration span thus resulting in a lot of accidents. It is alleged that a lot of road accidents are linked to drug addiction (Van Wormer & Davis 2008). This therefore, is a devastating consequence of drug use as road accidents claim lives of many innocent people and it is something that can be avoided should people minimize drug use. Use of drugs is also linked with paranoia and psychosis (Miller *et al.* 2011). Due to this paranoia and psychosis, drug addicts can tarnish their relationship with loved ones leading to negative social consequences in addition to the psychological consequences of drug use.

Drug use may lead to increasing negative emotions such as loneliness, depression and anxiety (Van Wormer & Davis 2008). Loneliness, depression and anxiety may also be as a result of the psychosis and paranoia affecting the drug abuser. Due to psychosis and paranoia loved ones may desert the drug user resulting in loneliness and depression. Paranoia during drug addiction may also result in the person's anxiety thus there are a lot of interrelated psychological disorders that affect a person addicted to drugs (Van Wormer & Davis 2008). During aftercare therefore, the recovering drug user must be monitored as he/she is no longer using drugs and has to deal with these negative emotions while sober (Miller *et al.* 2011). This is an aspect I afforded some attention in my study.

2.3.5 Social Consequences

During the period of severe drug use, ties with family, friends and intimate partners usually suffer as the person will be affording more time to the drug use habit (Centre for Substance Abuse Treatment 2004). This may result in different social problems as drug use becomes the drug user's preoccupation as time will now be spent attempting to acquire and use the drug. This leaves loved ones excluded from the social life of the substance abusing person thereby resulting

in broken relationships (Miller *et al.* 2011). The broken relationships lead to the substance user feeling isolated and lonely resulting in increased drug use, thereby causing addiction.

Addiction according to the Centre for Substance Abuse Treatment (2004) is usually associated with divorce, isolation and loss of child custody. As this research was being conducted in the field of social work, social relationships were important and this aspect was given particular attention. A person using drugs may have continued absenteeism from work leading to expulsion. This puts a strain on relationships and the person using drugs could end up homeless and without support from family or friends. Due to the strained relationships, there may be need for therapeutic sessions with significant others of the recovering drug user during recovery.

2.3.6 Financial consequences

Drug addiction has financial implications on the individual, family, community and the whole nation as mentioned earlier in Chapter 1. The economic cost of drug addiction is difficult to calculate as it is broad and at times difficult to account. Billions of dollars are spent worldwide in trying to curb addiction and also in arresting perpetrators involved in drug related crimes (Van Wormer & Davis 2008). In South Africa also, substance abuse has both direct and indirect financial consequences. According to Geldenhuys (2015) substance abuse in the workplace is a serious problem in South Africa and it leads to low productivity in the workplace, absenteeism, failure to meet deadlines, poor work performances and errors, wasting of materials, criminal activities such as fraud, and disputes with managers and superiors. This therefore affects the Gross Domestic Product (GDP) of South Africa as a whole and impact negatively on the development of the economy. During the drug taking behaviour, financial consequences as a direct result of drug use for example borrowing loans and using the money to buy drugs may occur.

2.3.7 Crime and violence

There are numerous cases of killings attributed to belligerent gangs of drug dealers (Ray and Ksir 2004: 36). This shows the nature of violence and crime that is associated with substance abuse. Many studies on aftercare focused on this aspect of recovery as several studies were conducted with participants who had been released from prison. Prisons have a huge number of people convicted for drug-related crimes. A study conducted in Gauteng on female offenders found that most women in prison were using alcohol and drugs and a large percentage of the

females believed that substance abuse contributed to their criminal act (Prinsloo & Hesselink 2015). This was an important revelation for my study since my study was also conducted in Gauteng with female recovering drug users. Likewise, a study on recovering substance users who were once in prison in Israel by Chen (2006), concluded that substance use was a contributing factor to crime. I afforded some attention to the impact of aftercare on crime in my study.

Ray and Ksir (2004) however argue that the fact that drug addicts are involved in robberies or that car thieves are likely to also use drugs does not say anything about causality of crime. They go further to argue that both criminal activity and drug use could well be caused by other factors, producing both types of deviant behaviour in the same individual. I am of the opinion that though other factors cause drug addicts to be involved in crime, there is no doubt that the use of drugs is directly related to crime be it to attain more money to buy drugs or drugs provide people with courage to commit crime. Violence caused by substance abuse may be seen in relationships, as substance abusers tend to be both physically and verbally violent (Van Wormer & Davis 2008). They further state that drugs like cocaine are well known for making people aggressive. This aggressiveness caused by drug use therefore results in the negative consequence of crime and violence. Aftercare programmes can also assist recovering drug users be less aggressive and violent to attain its goal of aiding successful reintegration into society.

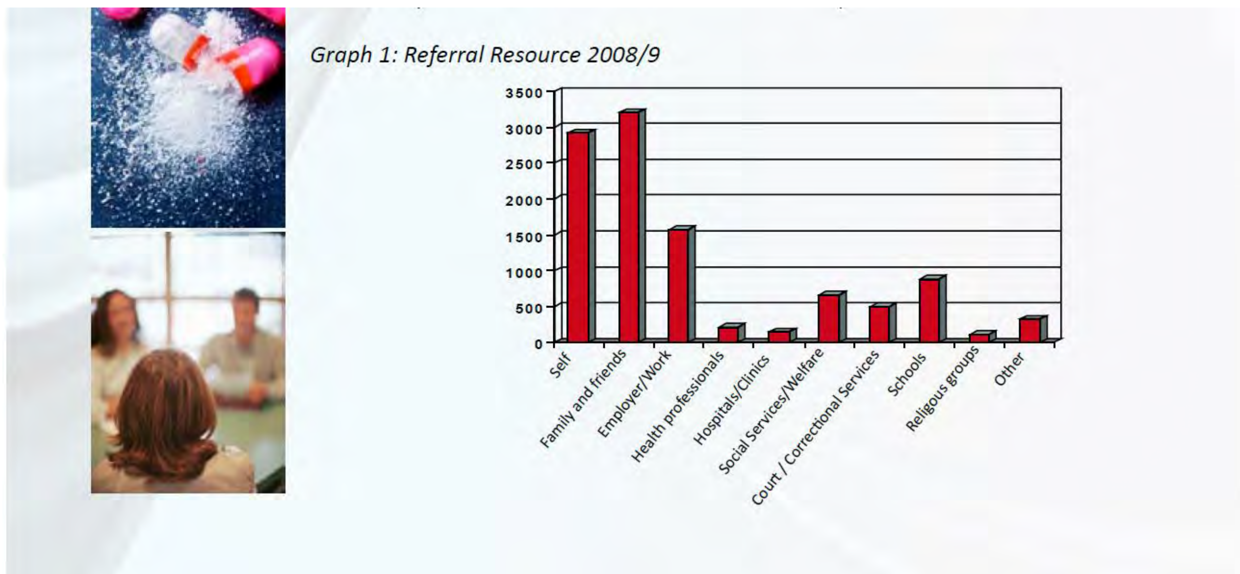
2.4 SUBSTANCE ABUSE TREATMENT IN SOUTH AFRICA

According to Temmingh and Myers (2012:329) “substance abuse treatment refers to the provision of specialized medical, psychiatric and psycho-social services to individuals with substance abuse and dependence disorders.” The Prevention of and Treatment for Substance Abuse Act 70 of 2008 define substance abuse treatment as “the provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse with a view to addressing the social and health consequences associated therewith.” In both definitions it can be seen that the biological, psychological and social elements of substance abuse treatment were included in describing substance abuse treatment. However, the spiritual aspects of substance abuse treatment were neglected in both definitions of substance abuse treatment. These definitions highlight that the focus of substance abuse treatment in South Africa is on the biopsychosocial elements of recovery only.

In South Africa, substance abusers seek treatment due to various motivators with most people seeking treatment due to persuasion from family and friends, work-related absenteeism, via legal and financial resources for example non-payment of bills, by the medical route for example referral from general practitioners and also as some seek treatment through self-referrals (Temmingh & Myers 2012). This concurs with the statistics on referrals to treatment at SANCA. According to the SANCA National Profile of Clients in Treatment Fourth Report: April 2008 – March 2009 (2009) as indicated in Fig 2.1 on the next page, most referrals of clients to SANCA treatment in the year 2008 to 2009 were from self-referrals and referrals from family and friends. There were a number of self-referrals as the substance abusers could have become tired of the drug use and they discerned that they needed professional assistance to quit drugs. Family and friends led the chart on referrals as they are the people closest to the drug abuser and this suggests that they may see the negative consequences of the drug addiction before anyone else. Notable referrals were also from work and school as these are the institutions people spend most of their time at and also negative impacts of drug abuse may be evident at these institutions. There were limited referrals from health professionals, hospitals or clinics and religious groups. I speculate that this could be as a result of drug addicts not attending religious activities during the period of drug use.

Fig 2.1

Referral Sources



Fourth Report: April 2008 – March 2009. Reproduced from SANCA National Profile of Clients in Treatment.

According to Temmingh and Myers (2012), before 1994 treatment of substance abuse disorders in South Africa was limited. Socio-political factors hampered access to treatment for South Africans. They further state that substance abuse treatment services were inadequate and poorly distributed. Temmingh and Myers (2012) attribute this poor distribution of substance abuse treatment facilities to the lack of coordination between different stakeholders responsible for substance abuse treatment at that time. Provision of treatment services was a divided effort between the Department of Social Development (DSD) and the Department of Health (DoH). The DSD was responsible for partial treatment while the DoH only catered for medical and mental problems (Temmingh & Myers 2012). This could have been as a result of the disjuncture and the poor service distribution during the apartheid regime resulting in poor equality of service distribution of substance abuse treatment facilities. The provision of partial treatment by government departments may also have led to poor substance abuse treatment programs due to lack of coordination. Substance abuse treatment needs a well jointed multidisciplinary approach in order to provide effective treatment.

Since South Africa's transition to democracy, the DSD has been assigned responsibility for the provision of holistic substance abuse treatment (Temmingh & Myers 2012). Though Temmingh and Myers (2012) state that provision of substance abuse treatment has improved post 1994, I believe the period should not be over glorified as there are still some substance abuse treatment challenges up to date. The study conducted by Wechsberg, Wu, Zule, Parry, Browne, Luseno, Kline and Gentry (2009) in Pretoria found that some women involved in commercial sex work and substance abuse did not have knowledge of existing substance abuse treatment services. This may only be one of the several cases of people who are in need of substance abuse treatment but cannot access the services.

According to Ray and Ksir (2004), treatment programs can be divided into two major categories which are residential and outpatient programmes. In South Africa, these programmes are usually termed as inpatient and outpatient programmes. Inpatient settings are settings wherein the clients stay at the centre in a controlled drug-free environment for a period of the programme duration. Outpatient programmes on the other hand provide non-residential programmes and they allow

clients to return to their usual living environment after each session.There are many different substance abuse treatment centres in South Africa with most of the centresas highlighted in Chapter 1, located in Gauteng and the Western Cape and fewer facilities being available in rural areas (Temmingh & Myers 2012). Gauteng province is geographically the smallest province in South Africa (Provincial Profile: Gauteng 2014). However, in 2009; 40% of SANCA inpatient treatment centres for instance, were in Gauteng and 60% of the organization's outpatient centres were also in Gauteng (SANCA National Profile of Clients in Treatment Fourth Report: April 2008 – March 2009 (2009)). This might represent an unequal distribution of substance abuse treatment facilities in South Africa with the treatment facilities being located mainly in the wealthy provinces of the country. I decided to conduct my study in Gauteng due to the availability of well-established treatment centres in the province, this being key to choice of locale.

Stein *et al.* (2012) argue that there is the lack of effective substance abuse treatment both in South Africa and the rest of the world. They attribute this to limited resources for example infrastructure and personnel and also the attitudes of the substance abusers. This may be the reason why there are continued arguments on the effectiveness of substance abuse treatment as it is a complex field that needs adequate resources in order to accomplish the treatment goals. Lack of resources is as a result of lack of funding for substance abuse treatment (Stein *et al.* 2012). Funding for substance abuse treatment might be challenging to attain as the DSD might be faced with a lot of social ills to tackle for instance unemployment, HIV/AIDS, early child development, social security to mention but a few areas. Funding for substance abuse treatment may also be challenging as there are still people in society who instill stigma on substance abusers and believe drug addiction is a choice and there is no need to assist the person.

South Africa tend to have a number of barriers to effective substance abuse treatment. Van Wyk (2011) argues that international research has criticized service delivery for substance abuse treatment in low and medium income countries including South Africa. He also states that South Africa's treatment is costly and time consuming as it usually provides long term institutional treatment for example three month programmes leading to absenteeism from family and work. This means that a person has to put everything on hold to go for substance abuse treatment and it is challenging for breadwinners to do so. Most treatment facilities in South Africa are private and

many people cannot afford the services (Temmingh & Myers 2012). Some of the state owned treatment centres that offered free treatment have closed down (Temmingh & Myers 2012). This makes it more difficult for poor people to access treatment as they cannot afford the money needed at private institutions. According to Pasche, Kleintjes, Wilson, Stein and Myers (2015), South Africa does not have sufficient health professionals who are well-trained and competent in substance abuse treatment. The researcher agrees with this as there is also a lack of certified courses for addiction counselors in South Africa which may in turn result in the effectiveness of the treatment programme being questioned. Recently, a postgraduate addiction treatment programme was introduced at the University of Cape Town but this only accommodates a few individuals (Pasche *et al.* 2015).These barriers to effective substance abuse treatment need to be addressed should South Africa aim to succeed against substance abuse.

2.5 SUBSTANCE ABUSE RECOVERY

In Section 2.2 I discussed the effects of addiction. Van Wormer and Davis (2008) argue that the only way to avoid the progression of these negative effects of addiction is through "recovery". According to The Betty Ford Institute Consensus Panel (2007:225) as mentioned in Chapter 1, recovery may be "the best word to summarize all the benefits to physical, mental and social health that can happen when alcohol- and other drug-dependant individuals get the help they need." White (2007:36) proposes that recovery be defined as "the experience through which individuals, families, and communities impacted by severe alcohol and other drug problems utilize internal and external resources to voluntarily resolve these problems, actively manage their continued vulnerability to these problems, and develop a healthy, productive, and meaningful life." The definitions show that recovery is the effort to combat effects of addiction. The definitions also highlight that recovery is an experience a substance abuser has to go through to attain a better life holistically. There is a gap however in the definitions of recovery as they do not include spiritual aspects of recovery something which the recovering substance users may develop during the course of recovery. The focus of my study was the biopsychosocial-spiritual elements of recovery as they provide a more holistic view of recovery.

In the definition discussed above, White (2007) states that recovery is an experience. Recovery is an experience as it is deeply personal and filtered through the dimensions of age, gender, ethnicity, sexual orientation, cultural affiliation, degree of religiosity, and particular life-shaping

experiences (White 2007). Since recovery is an experience, it shows that the individual and family are upfront in the process and not the helping professionals. Thus all the efforts by the health professionals should be aimed at empowering the substance abuser and should be conducted in the best interests of the substance abuser and not the health professional. This is the reason why in my study, I also involved the female recovering drug users as they were the ones who experienced the recovery and who utilized the aftercare programmes.

In discussing recovery, acknowledging that recovery is a process entails that recovery is not just a one day decision to stop using drugs but is a long-term process that requires effort. Recovery is a sustained status as it alters a person's identity and engenders meaning from having survived a potentially life-threatening condition which is addiction (White 2007). She further argues that full recovery from severe drug problems cannot be declared until a point of durability has been reached in which the risk for future lifetime relapse has been dramatically reduced. Recovery includes individuals, families and communities. Thus in my study it was also important to look at the effectiveness of the influence of the family and the community in aftercare programmes. This was a fundamental part of my study as it assisted me in acknowledging the role of social support in aftercare an element that has been seen as reinforcing recovery in previous studies.

Though I discussed the positive effects of recovery above, health professionals and lay people in the community tend to have negative attitudes towards recovering substance users. According to Stanbrook (2012), health professionals too, often think and behave negatively toward addicts and addiction. In this way health professionals share the attitudes of society which discriminates addicts. However, Stanbrook (2012) argues that health professionals need to behave better since addiction is a disease. In my study also, I viewed addiction from the lenses of it being a disease. Stanbrook (2012) further argues that there is usually some compassion and understanding towards heart failure patients but little compassion is shown towards recovering substance abusers. It might take a lot of effort and time to change the attitudes of the community, but health professionals, and social workers in particular, should be non-judgemental in their work with recovering substance abusers, this being part of the ethics of the profession.

2.5.1 Women and Recovery

Traditionally women were seen to be having more mood and anxiety disorders as opposed to substance abuse disorders (Stein *et al.* 2012). More recently however, substance abuse among

women has been more common and this may have come to effect due to women being more empowered in social structures (Van Wormer and Davis 2008; Stein *et al.* 2012). In the past, women who were identified as drug addicts were seen as deviant and promiscuous (Van Wormer and Davis 2008). The globalization of the world and empowerment of women could have resulted in women being freer to conduct behaviours that were traditionally viewed as for men. Due to globalization, conduct that has been predominantly Western is also now transferred to Africa and there are also networks to transport drugs to different parts of the world, evident in several drug "busts" that take place at airports all over the world. However, as will be discussed in the next paragraph, one should realize that changing community values do not necessarily spare substance abusing women from stigma and prejudice

A study conducted by Myers, Fakier and Louw (2009) in South Africa on stigma, treatment beliefs and substance abuse treatment use in historically disadvantaged communities concluded women with substance use disorders as more negatively perceived than males. They propounded that this might be due to female substance abuse being linked to sexual availability and inability to fulfil traditional gender roles. Concurring with the findings, a study conducted in Spain by Jimenez, Molina and Garcia-Palma (2014) on gender bias in addictions and their treatment, found that in rural areas drug use by women was seen as sharply judged as women were expected to strictly comply with social norms. Since both these studies were conducted in areas that may be termed as disadvantaged, they point to a need to attain data on attitudes towards female substance abuse in more modern and developed cities.

Female commercial sex workers are seen to be more prone to substance abuse than non-sex workers. This has been linked to drugs making women feel more confident during their commercial sex work (Wechsberg *et al.* 2009). The female sex workers in the study by Wechsberg *et al.* (2009) in Pretoria portrayed female commercial sex workers as having a history of physical and sexual abuse. Due to these findings, it makes it complicated to understand whether the substance use was a result of the history of abuse or it was merely to assist them in their sex work. Another notion could be that, drug use may be related to overcoming the negative emotions resulting from physical and sexual abuse, leading to the females conducting commercial sex work to feed their substance use habit. However, whatever the case may be, the

stakeholders involved in substance abuse treatment in South Africa need to assist the commercial sex workers in attaining treatment.

A study conducted in Cape Town by Wechsberg, Myers, Kline, Carney, Browne and Novak (2012) found that women who were involved in polydrug abuse were more likely to engage in sex behaviours that put them at risk of HIV/AIDS than women who used less different types of substances. Polydrug abuse according to Doweiko (2006:501) means "the abuse of more than one substance at once." Different substances in context of the study meant different drugs. Using fewer substances was seen in the study as safeguarding women from having unprotected sex. The study also focused on behaviours of women from different racial backgrounds. Coloured women using substances were seen likely to engage in unprotected sex more so than black women. This has been linked with black people having more loved ones who were HIV positive and they may have been aware of the dangers of the disease. HIV/AIDS is already a serious social problem in South Africa, thus assisting women with substance abuse treatment could protect the nation from many different social ills, a powerful rationale used in identifying the topic of my study.

Women trying to attain recovery may be affected by lack of money and resources, lack of support from partner and family, and lack of treatment facilities available for women with children (Van Wormer & Davis 2008). This may also be the case in South Africa and Gauteng in particular as there is a high rate of unemployment among women; and some women who need treatment may not afford the fees leading to the people in treatment not being a true reflection of the people who actually need substance abuse treatment services. A study conducted by Maehira *et al.* (2013) in Bangladesh, found as discussed in Chapter 1 that relapse was more common in females and service providers suggested that females who sell sex seek treatment repeatedly as their ability to attract clients for commercial sex deteriorates with prolonged drug use. These findings show that recovery in females is a complex experience due to the values of society and that warrants further research.

Ramlagan, Peltzer and Matseke (2010) in their study on the epidemiology of drug abuse treatment in South Africa found that the number of females in treatment was lower than females who needed treatment. Similarly, Myers *et al.* (2009) in their study conducted in Cape Town on stigma, treatment beliefs and substance abuse treatment suggest that due to negative perceptions

towards women substance abuse, the women tend not to seek treatment due to fear of being labelled, their children being taken away from them or treatment providers being judgemental. The study conducted by Wechsberg *et al.* (2009) in Pretoria correspondingly found that very few women entered substance abuse treatment as they had little knowledge of programmes offering substance abuse treatment. As discussed earlier, they suggested that women should learn about treatment programs and there must be treatment programs designed specifically for women and their needs for instance addressing issues like physical and sexual abuse. These three studies conducted on substance treatment and recovery for women in South Africa portray a worrying picture as they highlight the ineptitude of the substance abuse treatment programme currently being implemented in the country. All these barriers to effective treatment of women in South Africa should be taken care of should there be sustainable substance abuse treatment for women in the country.

2.6 AFTERCARE PROGRAMMES

Continuing care is a term that can be used interchangeably with the term aftercare (Miller *et al.* 2011). In my study I used the term aftercare as it is the term mainly used in legislation and programmes in South Africa. Blodgett, Maisel, Fuh, Wilbourne and Finney (2014:87) state that aftercare, "a period of less intensive treatment following a more intensive initial treatment episode, has been utilized in an effort to extend and reinforce an initial period of recovery." Correspondingly Ray and Ksir (2004) state that aftercare is the "follow-up or maintenance support that follows a more intense period of treatment." Both the abovementioned definitions of aftercare highlight that aftercare is a less intensive episode of support that follows a more intensive treatment programme.

When discussing aftercare Perkinson (2008:269) states that "this is where the rubber hits the road and it's where most addiction programs fall short." If the assertion is true then my study could have assisted in understanding the perceptions concerning the effectiveness of aftercare programmes. He further argues that most treatment programmes advice clients to attend twelve step programmes for their aftercare but clients only attend a few sessions and drop out. Poor attendance to aftercare is a common phenomenon that authors discuss. Knowledge on the perceptions of fellow recovering drug users on aftercare could assist in understanding why many recovering substance users do not attend aftercare. SANCA Vaal (2015) argues that only 2% of

recovering substance users attends aftercare programmes. Perkinson (2008) further argues that dropping out of aftercare programmes is the reason why most recovering substance abusers relapse in the first year after treatment.

Perkinson (2008) argues that ideally aftercare programmes should be for a period as long as necessary. All recovering substance users coming from a treatment program need to follow through with their aftercare plan which other organizations term as the relapse prevention plan. Studies show that therapists in treatment should make a follow up on their clients for a period up to 5 years. According to Perkinson (2008) aftercare programmes entail the following:

- Submitting a maximum of three random drug tests a week for the first year after treatment.
- Sending in evidence of attendance of mutual help groups.
- Having a sponsor who will assist the recovering substance abuser once a week.
- Attending diverse forms of therapy for example anger management, marriage, counseling as agreed upon during treatment.
- Taking all medication as prescribed.
- Following consequences agreed upon should the recovering substance abuser slip back to drugs.

The abovementioned characteristics of aftercare programmes by Perkinson (2008) are a clear summary that stipulates programmes offered during aftercare. Miller *et al.* (2011) suggest that helping professionals after treatment should neither tell clients that treatment is finished nor tell them they are likely to relapse. They suggest that a reasonable middle ground must be kept inviting clients to come back for counseling sessions when they see the need as clients are good judges of where they are in their recovery. Miller *et al.* (2011) argue that most people revert to drug use three to six months after rehabilitation. This is the basis of their argument that aftercare follow up counseling may be offered two months after treatment and again after four months. However, I am not in concord with Miller *et al.'s* (2011) suggestion that the social worker must not tell a client when to come back for follow-up counseling but a client must decide for him or herself. The reason for this argument is that there is much evidence of poor attendance for aftercare programmes and not persuading clients to come for aftercare sessions may result in

relapse. A study conducted by Duffy and Baldwin (2013) in England, also found that treatment agencies usually did not refer their clients for aftercare and the clients that attended aftercare were mostly informed by peers of availability of aftercare services. This may suggest that agencies do not have confidence in the effectiveness of aftercare programmes being offered.

A study conducted by Grella and Rodriguez (2011) in California on the motivation for women offenders to participate in aftercare, found that women involved in child welfare programmes were more likely to participate in aftercare programmes. This may be as a result of the desire for reunion with their children. This finding shows that family reunification was important to women offenders as they were willing to attempt to get their children back. However, helping professionals should ensure that the women are attending the programme so as to genuinely quit drugs and not just to get their children back. The study conducted by Grella and Greenwell (2007) on completion of community based aftercare by women offenders in the USA found that women with mental health problems usually were less likely to finish aftercare programmes as they had greater treatment needs. This may seem logical as the women were having mental problems and those mental problems could have been more serious than their substance abuse problems. Thus they needed mental treatment before substance abuse treatment.

During aftercare, the client must be assisted in dealing with problems they had before treatment and also problems arising after treatment. Some clients resorted to using drugs due to the problems they were facing in their lives, so during aftercare because the recovering drug users are no longer using drugs to suppress their feelings, they may have to face the challenges again (Miller *et al.* 2011). Aftercare programmes therefore should assist recovering drug users to be able to cope with life while being sober. As discussed earlier, should a client slip back to substance use, the helping professional should assist the recovering substance user to identify the triggers that led him/her back to drugs (Van Wyk 2011). Resumed use should not be discouraging to the helping professional but should assist the professional to determine the risk factors for the recovering substance user and work on them.

Braig, Beutel, Toepler and Peter (2008) in their study in Germany found that recovering substance abusers were satisfied with the services provided at treatment centres. However, they suggested that there should be aftercare services to consolidate the gains of treatment. They

further argue that there should be aftercare treatment as research show that there is positive outcome linked to aftercare attendance. This study conducted in Germany highlights the importance of aftercare treatment; this is also important in South Africa as there are currently only a few centres providing aftercare services. Arbour, Hambley and Ho (2011) conducted a study in Canada on the outcome of aftercare treatment. They state that there was increasing research demonstrating an overall positive correlation between aftercare attendance and improved substance use outcome. The results of their study reveal that the number of days the participants spent in residential treatment was associated with a greater likelihood of attending twelve step and individual counseling aftercare. Results of the study revealed that for each additional day the participants spent in inpatient treatment, they were 2% more likely to attend twelve step and individual aftercare sessions. These results also assisted me in understanding better recovering drug users in relation to treatment they went through. The length of treatment recovering substance users underwent had an impact on aftercare attendance. This could have made my study to have participants who were more positive about aftercare as they had been in treatment for long thus producing some bias towards aftercare, a consideration to be noted in interpreting results.

Tuten, Jones, Lertch and Stitzer (2007) in their study in Baltimore, USA on plans of patients for aftercare found that virtually all the participants interviewed had some plans of aftercare after their inpatient treatment. However, they state that previous research shows that not all people who had plans for aftercare attended aftercare programmes. This appears to be a common phenomenon as clients may tell the researchers that they will attend aftercare as they think that is what the researchers want to hear, or because just like during the period of addiction, the recovering substance users fail to stick to their goals leading them to abandoning aftercare. The study suggests that among the reasons why clients might fail to follow through with aftercare arrangements is due to available services not meeting needs or expectations. Access to individual counseling therefore may increase aftercare attendance.

Majority of the participants in the study conducted by Tuten *et al.* (2007) mentioned their desire to be assisted to find a job during aftercare. Similar findings were also attained in the study by Duffy and Baldwin (2013) in Northern England. However, in the study by Duffy and Baldwin participants indicated they wanted to work in the substance abuse field. In Gauteng province

where I conducted my study, unemployment is more common in women than in men (Provincial Profile: Gauteng 2014). As the studies above were conducted in USA and Northern England, employment opportunities may be more accessible for clients, but in South Africa with the current economic climate, finding employment for clients is challenging.

Access to stable and drug free housing during aftercare was also seen as important in both the studies by Tuten *et al.* (2007) and Duffy and Baldwin (2013) as going back to their old neighbourhoods would trigger relapse upon the recovering substance users. The environment the recovering substance abusers stay at is important in recovery. Helping recovering substance abusers with education was also seen as important during aftercare as it improves their employment chances (Tuten *et al.* 2007).In my opinion, these findings will be difficult to implement in South Africa which is still a developing country and providing recovering substance users with employment and housing may need resources that are not readily available in the country.

Wu, Ling, Burchett, Blazer, Shostak and Woody (2010) on quality of life in opioid detoxification in the USA also found that during detoxification patients intended to attend aftercare programmes and were expecting employment services, self-help meetings, transportation, housing, individual or group counseling, education, medical treatment, social services, vocational training, relationship counseling or legal assistance. These findings are somehow similar to the findings of the study conducted by Tuten *et al.* (2012) discussed above. However, many patients received treatment only, and repeated phases of treatment without attending aftercare. They further state that, research shows women experience greater drug-related problems than men. Their study indicated that women usually had more psychiatric and family or social relationships problems. These results may apply in South Africa as generally women are traditionally believed to be the more caring and emotional people. Wu *et al.* (2010) also suggest that women need specific gender related intervention focusing on relationship and mental health problems and childcare services for example.

Blodgett *et al.* (2014:87) states that although it may be common to assume that aftercare is effective; however, there have been mixed results on studies on the effectiveness of aftercare. In their study, they found that aftercare had positive, although limited impact on the outcomes of substance abuse treatment. They state that aftercare "can provide at least modest benefit after

initial treatment." This was an interesting finding for my study as I was also willing to elaborate the perceptions concerning the effectiveness of aftercare programmes. My study differs from the one of Blodgett *et al.* (2014) however, as I focused on female recovering drug users only.

2.6.1 Aftercare Services in South Africa

According to SANCA Vaal (2015:16) "aftercare provides services which will make transitioning into a new life with new habits and new ways of thinking more successful with less risk of relapse." They further state that aftercare assists in keeping the patient motivated to continue with recovery and also provides support when recovery gets challenging for the patient. During aftercare, clients learn life skills and coping strategies. According to the Gauteng DSD (2015) aftercare is a central component of the continuum of intervention and support. Aftercare assists people who have undergone treatment for substance abuse problems to follow a lifestyle of abstinence from drugs. As these definitions come from major substance abuse treatment organizations in South Africa, this can be seen as the understanding of aftercare in South Africa. The definitions are inline with the earlier definitions of aftercare provided in this chapter. SANCA offers aftercare in the form of individual counseling, group therapy, family therapy and extensive utilization of self-help groups (SANCA National 2015). These services are consistent with international aftercare services discussed earlier.

According to the CDA Annual Report 2007 – 2008 (2008), aftercare and reintegration which are both therapeutic and non-therapeutic maintenance of recovering dependents and associated co-dependents over an extended period of time is needed together with support for their reintegration into society. This summarizes the provision of aftercare services in South Africa as the Central Drug Authority is responsible for the implementation of policies on substance abuse in the country. The CDA stipulates clearly that aftercare provides both therapeutic and non-therapeutic care. This is because aftercare programmes are involved with reintegration into the community thus they focus on assisting recovering drug addicts in different spheres of life and not just through therapy.

According to Temmingh and Myers (2012) the commonly offered aftercare services in South Africa include:

- Provision of lower-intensity counseling to clients who have completed treatment

- Twelve step oriented halfway houses and sober living establishments that provide low-intensity support to recovering substance users
- Mutual-help support groups that consist of recovering substance users in different stages of recovery. In South Africa the twelve step support groups are the most common mutual help groups available.

These aftercare services discussed above are specifically the ones provided in South Africa unlike the ones discussed earlier by Perkinson (2008) which were mainly based on aftercare services in the USA. Mutual-help groups, counseling and family therapy all assist in the recovery of the substance user as individual counselling assists the client overcome his or her challenges by focusing on self. Mutual help groups will assist clients to learn from other recovering substance users and they may help the recovering drug user to understand how others overcame similar problems they are currently facing. Family therapy helps in reintegration as during substance abuse there is a lot of hurt between family members and healing and forgiveness is needed.

2.7 POLICIES FOR SUBSTANCE ABUSE TREATMENT IN SOUTH AFRICA

According to Van Wyk (2011) the national registry of substance abuse treatment facilities in South Africa had 65 treatment facilities and only 2 were state owned and operated. Of the 63 identified private treatment facilities nationwide, 35 were receiving funding from the DSD. The government offered funding in order to improve treatment and rehabilitation turn-over in the country. However it should be noted that in spite of all the government efforts, there are still substance abuse treatment challenges in South Africa as demand is higher than supply. Van Wyk (2011) states that 29 institutions offered out-patient treatment of which 17 were run by SANCA. Currently on the list of substance abuse treatment centres in the Western Cape for example, there are 27 centres of which 3 are state owned and 4 are subsidized in-patient centres (Western Cape DSD 2015).This shows the government needs to take part more in establishing and funding substance abuse treatment centres in South Africa.

The government is the major player in the treatment of substance abuse in South Africa and it develops the policies and legislation to be adhered to. Two of the main legislations and policies that talk to substance abuse treatment are discussed below. I will firstly discuss the National Drug Master Plan 2013 to 2017 hereunder.

2.7.1 National Drug Master Plan 2013 – 2017

The NDMP (2013 – 2017) approved by the cabinet on 26 June 2013, was instigated with immediate effect by the CDA. The CDA was established as an advisory body in terms of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 and is mandated to assist in the fight against substance abuse in South Africa (DSD 2015). According to the National Drug Master Plan (NDMP) 2013 – 2017, a Drug Master Plan is "a single document, adopted by government, outlining all national concerns regarding drug control." The NDMP 2013 – 2017 requires national and provincial government departments to devise methods and implement action to combat substance abuse problems as part of their planning and budget.

The overall objective of the NDMP is to ensure coordination of efforts to reduce the demand, supply and harm caused by substances that are abused. A further objective is to ensure effective and efficient services for combating substances of abuse through the elimination of drug trafficking and related crimes. In achieving this objective, different departments of the government need to work together. The NDMP 2013 – 2017 has clustered various government departments into groups namely economic sectors and employment; human development; social protection and community development; justice, crime prevention and security and international co-ordination and security. This may assist female recovering drug users attending aftercare as the collective action of different departments may "sweep drugs off the streets" resulting in less triggers for relapse Another objective of the NMDP 2013 - 2017 is to strengthen mechanisms for implementing cost-effective interventions to empower vulnerable groups. This may assist recovering drug users since, as discussed earlier many treatment centres are privately owned and they may be too expensive for the average drug abuser. An objective of the NDMP 2013 – 2017 is to provide a framework for the commissioning of relevant research. Another objective is to provide an outline for monitoring and evaluation of substance abuse programmes. All these objectives could assist female recovering drug users attending aftercare as the NMDP 2013 – 2014 aims at reducing demand, supply and harm caused by drug use.

The NDMP 2013 –2017 aims at promoting national, regional and international cooperation to reduce the supply of drugs and other substances of abuse. One of the desired impacts of the NMDP 2013 – 2017 is to develop "a strategic approach to substance abuse that involves prevention, treatment, aftercare and re-integration with society as a means of enabling the

population to deal with the problem.” The problem of substance abuse is a huge problem in South Africa and the CDA needs to work tirelessly to combat substance abuse. The fact that the NDMP 2013 – 2017 focuses on different levels of intervention from prevention to aftercare makes it an important policy to deal with substance abuse in South Africa. As a policy the NDMP 2013 – 2017 is a concrete document on substance abuse. In my opinion, emphasis should be put on implementing the policy in practice as the NMDP 2013 – 2017 covers the holistic treatment model from prevention of drug abuse to aftercare and reintegration services.

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

The preamble of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 encompasses aftercare programmes as reintegration services. The preamble of the Act partially states that

> *“The Act provides for a comprehensive national response for the combating of substance abuse; to provide for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and reintegration programmes”*

Like the NDMP 2013 – 2017, the Act focuses on prevention, treatment and aftercare programmes. The preamble of the Act goes further to discuss the establishment of treatment centres and halfway houses. Halfway houses also assist during aftercare as they are houses provided to recovering substance users after treatment.

The Act provides for substance abuse intervention from the prevention of substance abuse to early intervention, treatment of substance abuse and aftercare and reintegration services. The Act also offers different services through the establishment of treatment centres and halfway houses, committal of certain persons to detention, treatment and training centres which is more of holistic intervention to the substance abusing persons. Aftercare and reintegration services focus on reintegrating the substance user back into the community after a period of substance abuse treatment. This is the aspect of recovery that my study was focusing on. The establishment of halfway houses in South Africa can be seen as still lacking and this could be due to lack of resources in the country.

Chapter 7 of the Act is entirely on “Aftercare and reintegration services.” The chapter talks to the establishment of aftercare and reintegration services and also support groups. The Act stipulates that aftercare services must allow interaction between substance users, their families and communities; promote relapse prevention and enable services for the person to stay clean from substance abuse, promote group cohesion and allow users to share long-term sobriety experiences. In the context of aftercare and reintegration services the Act provides for support groups and halfway houses. It can be said that the government, through the act, provides strategic guidelines of rendering aftercare programmes and in my study I wanted to understand the perceptions concerning the effectiveness of these aftercare services. In summation the Act stipulates that aftercare and reintegration services should “prescribe integrated aftercare and reintegrated services aimed at the successful reintegration of a service user into society, the workforce, and family and community life.” This assertion shows the importance of aftercare and reintegration services in assisting a person to attain development in different spheres of life. With such a good focus of aftercare services in South Africa based on policy, my aim was to gain insight on whether this ideal is perceived as effective by the service users and service providers.

2.8 SUMMARY OF BIOPSYCHOSOCIAL-SPIRITUAL FACTORS AFFECTING RECOVERY

An analysis on the impacts of genes on addiction and recovery is important to consider when working with drug addicts (Van Wormer & Davis 2008; Miller *et al.* 2011; SANCA Vaal 2015). Some people are genetically predisposed and more vulnerable to addiction that others (SANCA Vaal 2015). Due to this genetic predisposition, it is believed that addiction may affect some families more. Withdrawal symptoms for example exhaustion and diarrhea are perceived as contributing to continued drug use (Pienaar 2012). These physical symptoms are at times seen as unbearable leading to drug addicts using drugs again. Van Wormer and Davis (2008) argue that an addicted brain is different from a normally functioning brain as the sight, smell or sounds associated with drug use might trigger cravings. Initial drug taking is perceived as voluntary though continued drug used during addiction is seen as uncontrollable (Van Wormer & Davis 2008; Stanbrook 2012). These biological factors make addiction treatment challenging.

Victimization of girls may lead them to drug use. Girls may run away from home due to victimization and later engage in drug use (Van Wormer and Davis 2003, Van Wormer and Davis 2008). Substance use therefore, may be a way to escape from the negative emotions resulting from victimization. Bello, Robles, Sarmiento, Tuliao, and Reyes (2011) in their study conducted in the Philippines discovered that cognitive factors such as stress and anxiety acted as determinants to relapse. Marlatt and Witkiewitz (2005) also argue that recovering substance abusers are confronted with urges, cues and automatic thoughts regarding maladaptive behaviours they want to change and this is a challenge in maintaining abstinence. Therefore, cognitive factors are an important factor during recovery. According to a study conducted by Ducray, Darker and Smyth (2012) in Ireland, low mood was an important factor contributing to relapse as most participants reported their mood was worse than usual at the moment of relapse.

The study conducted by Maehira *et al.* (2011) in Bangladesh found that where the recovering substance abusers lived before treatment and who they lived with before admission for treatment both correlated with relapse. Unstable living conditions for women before treatment predicted a relapse. A family environment that is toxic can contribute to relapse (Van Wormer & Davis 2008). This warrants the importance of family therapy during aftercare. Morojele, Parry and Brook (2009) argue that when parents are abusing drugs, children may also use drugs due to modelling. Families however were seen as not participating in recovery and this was attested to lack of trust between the family and the recovering drug users (Duffy & Baldwin 2013; Huscroft-D'Angelo, Trout, Epstein, Duppong-Hurley & Thompson 2013). A study conducted by Lewandowski and Hill (2009) showed that social support had a positive impact on recovery. Friends and partners were also seen as important during recovery.

Spirituality according to Miller *et al.* (2011:334), refers to "the individual's subjective experience of that which lies beyond the material world, be it of God, a Higher Power, a realm of spirit, meaning of life, or ultimate reality that transcends human existence." Various studies found that spirituality enhanced the quality of life of recovering drug users during recovery (Laudet, Morgen & White 2006; Zemore 2007). According to Galanter, Dermatis, Bunt, Williams, Trujillo and Steinke (2007) spirituality is important in substance abuse recovery as it facilitates recovering substance users' openness to change. Kasiram and Sartori (2015) in their study on near death experience and life threatening illness found that people who had faced a

near death experience or crippling ailments sought peace in an "inner strength" that is, they believed in a higher power in whom they will find solace and comfort. This may apply to female recovering drug users as well. As my study was focused on the biopsychosocial-spiritual model, it should therefore be of great value if helping professionals could assist recovering drug users with spiritual aspects of their lives.

2.9 LIFE AFTER SUBSTANCE ABUSE TREATMENT

After treatment a lot of changes are expected in one's life. The recovering drug user needs to create a new lifestyle that does not remind him or her of old drug using days. SANCA Vaal (2015) suggests there must be new ways of relaxing and having fun. Living a life that does not remind a person of the past however may be challenging as there are different cues that always take people down the memory lane. A recovering substance user is encouraged to exercise daily as this combats stress and helps the individual feel good about self. A recovering substance user should also eat a healthy diet as the brain and nervous system needs healthy nutrients to keep moods stable and to recover (SANCA Vaal 2015). The recovering person must also be involved in spiritual practices to feel connected to the world and feel they have a meaning in life (SANCA Vaal 2015). This is important as there is evidence that eating healthy food, exercising, and being involved in spiritual practices may lead a person to a better life without using drugs. These activities also assist in occupying one's time thereby there will be less free time to contemplate drug use.

Therapy or support in recovery from sponsors and significant others is important after substance abuse treatment. Moreover, a person should maintain a balance between relationships, work, social life and sport, spiritual and financial life. One must not over exercise for example or spend too much time with friends but all aspects of life must be balanced. Clients must keep daily records of their lives especially during the period just after treatment (Miller *et al.* 2011). These daily records will assist clients to rate their own recovery. When a client realizes there are negative changes for example in mood swings, the client should contact the helping professionals for a counseling session (Miller *et al.* 2011; SANCA Vaal 2015). In my study I enquired on the activities that female recovering drug users take part in to exercise and also for spiritual growth. Duffy and Baldwin (2013) state that during treatment recovering substance users are assisted on physical and mental health and also financial management. They stated that the most important

aspect after treatment was having a strong social support network consisting of family and friends also securing accommodation. These aspects assist the recovering substance user as support during abstinence.

Reasons why a recovering substance user may decide to use or not to use substances at different stages of the recovery process are complex and they may vary depending on a person's motivation, thoughts, emotions, circumstances, lifestyle and physical neurocognitive status at that time. Some of the major challenges that a recovering substance abuser may face involves triggers, thoughts, cravings and relapse (SANCA Vaal 2015). They further state that triggers may lead to thoughts, and thoughts may lead to cravings, finally cravings may lead to relapse. Triggers involve people such as dealers, places such as bars, things such as music, times such as weekends, situations such as social functions and emotions such as being angry (SANCA Vaal 2015). Thoughts involve thinking about using and there are many thought stopping techniques such as yelling "stop" or self-talk about the benefits and consequences of using. Self-talk assists in overcoming cravings (SANCA Vaal 2015). Cravings are intense desires to use and they last for 4 to 21 minutes (Pienaar 2012). Witkiewitz, Bowen, Douglas and Hsu (2013:1564) define craving as "the subjective experience of an urge or desire to use substances." In my study I focused also on the triggers, thoughts and cravings that the female recovering drug users may experience.

A study conducted by Dennis, Foss and Scott (2007) found that as the years post treatment increased, the use of coping skills reduced among recovering substance users. Mental health problems were seen on the rise first three years after treatment and they suggested that ongoing mental health treatment is necessary after recovery. Physical health also, was not seen to improve with more years in recovery. There was a huge decrease in the number of illegal activities conducted and the recovering substance users' families were living a modest life. Increased number of sober friends, social support, spiritual support and self-efficacy increased with more years in recovery. Women improved their chances of complete abstinence faster than men and women were seen to be more likely to enter and stay in recovery. This shows that recovery is not a smooth road as there are challenges and benefits of recovery. The recovering substance users therefore should be disciplined and dedicated to their recovery. Factors on physical and mental health, coping skills and illegal activities were also explored in my study.

A study by Satre, Blow, Chi and Weisner (2007) on the outcome of treatment for older adults found that women had better abstinence outcomes than men and they stayed longer in treatment. However, the study found that the length of stay in treatment is more important than gender in predicting the outcome of treatment. Underutilization of mutual aid groups was seen as more common in older adults. I explored in my study how often the female recovering drug users attend mutual aid groups. A study conducted by Ducray *et al.* (2012) found that the majority of lapses occurred during the first week after leaving treatment. SANCA Vaal (2015) on the other hand states that relapse happens when one fails to deal with her cravings and 50% of patients will relapse. During treatment therefore, recovering substance users should be encouraged to stay for longer periods. These high and early relapse rates highlight the need for effective treatment followed by viable aftercare and clients should be encouraged to attend the aftercare.

Since relapse is a possibility, recovering substance users should be equipped with skills to deal with a lapse though they must stay positive that complete abstinence is attainable. Khan, Cloete, Harvey, and Weich (2014) in a study on outcomes on heroin treatment in South Africa found that 55% of the participants in their study were abstinent from drugs 4 years after treatment. They are of the opinion that the lack of social grants for substance abusers in South Africa may have resulted in the substance abusers not having money for drugs leading to the high rate of abstinence. I would like to differ from this opinion however as if a recovering heroin user was desperate to use again, money may not be an issue as they might try several means to acquire money for example from begging to stealing.

2.10 CHAPTER SUMMARY

This chapter was aimed at taking the reader on a journey exploring what is drug addiction through identifying the many facets of addiction to life after substance abuse treatment. The chapter was guided by examining aftercare programmmes and used the biopsychosocial-spiritual theoretical model. The literature was aimed at enhancing knowledge of drug addiction, addiction treatment and aftercare programmes in order to understand better the perceptions about the effectiveness of aftercare for female recovering drug users. The literature should also assist the reader to understand substance abuse and aftercare better leading to the understanding of the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter is a discussion on how I executed my research. The chapter consists of my research approach, research design, sampling and sampling method, method of data collection, data analysis, trustworthiness pertaining to the study, ethical considerations and limitations of the study. The chapter is integration between research methodology theory and the practical implementation of my study. The chapter provides the reader with a clear picture of the research methodology used and the justification for the utilization of the particular research methodology.

3.2 RESEARCH APPROACH

The research approach used was the qualitative approach to get in depth information about the perceptions concerning the effectiveness of aftercare programmes in relation to female recovering drug users. According to Carey (2009) qualitative research is important to social work students and practitioners as it helps better understand the context under which they practice and also offers a broader and more detailed understanding of social problems, needs and the impact of social work interventions. This study was aimed at aftercare programmes where social workers work and also to get in depth information on the perceptions of aftercare service users, so the researcher selected the qualitative research approach.

Durrheim (2006:47) states that "qualitative methods allow the researcher to study selected issues in depth, openness, and detail as they identify and attempt to understand the categories of information that emerge from the data." Rubin and Babbie (2013: 40) also state that "qualitative research methods are more likely to tap the deeper meanings of particular human experiences, and generate theoretically richer observations that are not easily reduced to numbers." Both these descriptions of qualitative research show that qualitative research is interested in studying data in depth, and in my study I wanted to obtain in depth understanding of the perceptions concerning the effectiveness of aftercare programmes. I wanted in depth information in order to have a thick description that assist the reader to understand the perceptions related to the effectiveness of aftercare programmes better.

Welman, Kruger and Mitchell (2005) allude to the fact that in qualitative research the researcher intends to give meaning to the importance that the participants give to their environments. In this study I sought to understand the significance that the participants gave in response to their experiences of aftercare programmes. Qualitative research involves the use of words and descriptions that are usually not in numerical form. The words cannot be easily reduced into numbers but they have rich depth in understanding the information qualitatively (Higson-Smith & Kagee 2006; Rubin & Babbie 2011; Schutt 2012; Rubin & Babbie 2013). In my study the data I collected was in form of words as I intended to qualitatively describe perceptions concerning the effectiveness of aftercare programmes.

3.3 RESEARCH DESIGN

My research design was the descriptive research design. Kumar (2011:10) states that a study is classified as descriptive when it attempts to "describe systematically a situation, problem, phenomenon, service or programme, or provides information about say, the living conditions of a community, or describes attitudes towards an issue." In my study I describe systematically a programme or service, which is the aftercare programme that was being offered to female recovering drug users. My study describes perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. The study was aimed at describing the effectiveness of aftercare programmes for female recovering drug users in a qualitative way through providing dense descriptions of the narratives provided during data collection. Babbie (2010: 121) describes descriptive research as "the precise measurement and reporting of the characteristics of some population or phenomenon under study." In my study, I sought to be precise both in the way that I executed my study and also in the way I produced my research report. I intended to produce an in depth report that assist the reader to understand the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.

De Vaus (2001:1) states that good descriptive research is "fundamental to the research enterprise and it has added immeasurably to our knowledge of the shape and nature of our society." My research will assist service providers, future researchers and the community at large to understand better perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. The study is important as both service users and service providers were

involved. Schutt (2012:12) states that "good descriptive research can also stimulate more ambitious deductive and inductive research." The outcome of my research may stimulate other researchers to explore further on aftercare programmes or can provide the zeal to conduct similar research in a different setting. I provided a good description of my study that will assist other researchers to understand the context to which the research was conducted and the results of the research.

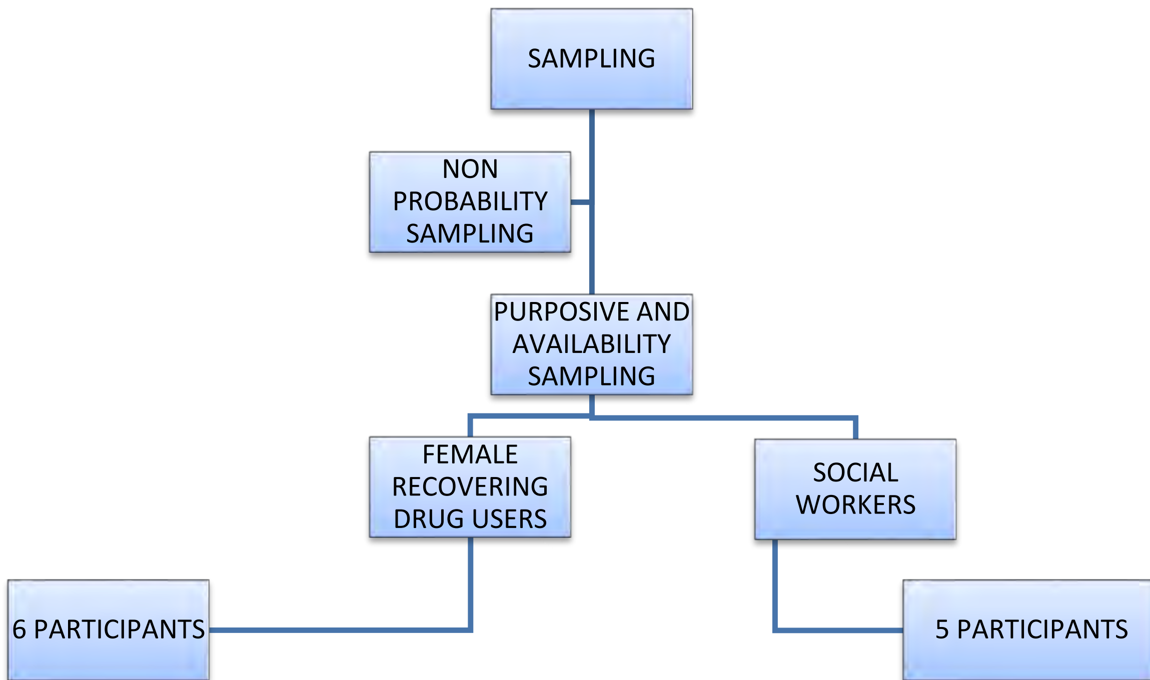
Many social work researchers conduct descriptive studies as they intend to describe phenomena they observed within deeper meanings (Rubin & Babbie 2011; Rubin & Babbie 2013). In my study I also sought to provide deeper meaning on the way participants perceived aftercare programmes. Rubin and Babbie (2011: 211) allude that "qualitative descriptions tend to be more concerned with conveying a sense of what it's like to walk in the shoes of the people being described – providing rich details about their environments, interactions, meanings, and everyday lives – than with generalizing with precision to a larger population." I wanted to understand the way female recovering drug users and social workers perceived aftercare and to describe their perceptions in a detailed report. It should be noted that though the perceptions may apply to other female recovering drug users attending aftercare programmes in different settings, the aim of my study was mainly to understand the perceptions of the participants in my study than to generalize the findings to all females attending aftercare.

3.4 SAMPLING AND SAMPLING METHOD

I used two samples in my study. The sampling method can be summarized in the diagram on the next page.

Fig. 3.1

Summary of sampling and sampling method



For both samples, I used the non-probability sampling method and my sampling type was purposive sampling and availability sampling. Davies (2007:62) states that purposive and availability samples are non-probability samples because "you have no assurance that the results obtained can be related, in terms of probability levels, to the population from which they were drawn." In my study I am not guaranteed that the information I got from the participants can be generalized to all female recovering drug users attending aftercare.

Purposive sampling according to Nieuwenhuis (2007:79) means "selecting participants according to preselected criteria relevant to a particular research question." In my study I used purposive sampling since I had a specific group of participants that I needed, in order to achieve the desired research output. I also used availability sampling. Rubin and Babbie (2010) state that availability sampling select participants due to their ready availability and convenience. Rubin and Babbie (2010:146) state that availability sampling is frequently used in social work as "it is usually less expensive than other methods and because other methods may not be feasible for a particular type of study or population." In my study I used availability sampling as gaining

access to female recovering drug users attending aftercare was difficult and cost extensive and had to settle for participants who were readily available at the research site.

Sarantakos (2005) states that purposive sampling can be used to select participants that are relevant to the subject and the selection process is based on the judgement of the researcher. Schutt (2012: 157) states that "in purposive sampling, each sample element is selected for a purpose, usually because of the unique position of the sample elements." In both Sarantakos (2005) and Schutt's (2012) discussion about purposive sampling, it can be noted that purposive sampling puts emphasis on the unique characteristics of the participants that make them relevant for the study and in my study I intended to have a sample of female recovering drug users and social workers that I selected because of their experience in aftercare programmes. The participants were selected as they had experience of the topic and were perceived to have adequate knowledge about the chosen topic.

Denscombe (2007:17) argues that in purposive sampling, participants are 'hand-picked' for the study. In my study, though there were many different female recovering drug users and social workers involved in aftercare, I carefully chose specific participants who had characteristics that I will discuss below. In purposive sampling, the participants are chosen with prior knowledge about the knowledge and expertise of the population and the purpose of the intended study (Sarantakos 2005; Denscombe 2007; Babbie 2010). I had knowledge about the existence of aftercare services at the research site and it was an organization that was usually highly recommended in the media and by other professionals.

To supplement on purposive sampling, I also used availability sampling in my study. Bless, Higson-Smith and Kagee (2006) state that availability sampling entails selecting all cases that are at reach of the researcher until the researcher attains the required sampling size. In my research I intended to have 8 to 10 female recovering drug users and also 5 social workers at the research site that I selected according to their availability and willingness to participate in my study. As attaining female recovering drug users attending aftercare programmes was a mammoth task, I used the participants that were available and were willing to participate. However, only six female recovering drug users attending aftercare were available for my study. Rubin and Babbie (2011) argue that availability sampling is usually used in social work due to the method being less expensive and also because social work research at times deals with a

particular type of population that can only be best selected using availability sampling, both of which applied to my study. Schutt (2012) argues that in availability sampling participants are selected due to convenience because they are available or easier to find. I used participants from the research site partly due to their convenience as I managed to attain permission to conduct my study at the centre.

Sampling procedure

The study was conducted at a well-established treatment centre in Gauteng, South Africa. I first conducted thorough research about the organization then I sent them a request asking to conduct research at the centre. I sent my research proposal and I later secured written consent from the director at the organization to conduct my study at the centre. For the purpose of triangulation and to get information from different perspectives I used two samples. The first sample was of female recovering drug users and the second sample was of social workers. I will discuss the sampling procedure of the two samples separately hereunder.

Female recovering drug users

In my study I aimed to secure a sample of 8 to 10 female recovering drug users attending aftercare at the research site. I intended to get 8 to 10 participants, this number being dependent on data saturation. However, I managed to attain data saturation after collecting data from six female recovering drug users, this number was also due to the availability of participants. Data saturation is achieved when no new data are emerging or the data you are getting from interviews is now negligible (Corbin & Strauss 2008; Kumar 2011; Schutt 2012). Corbin and Strauss (2008: 145) state that saturation is "the point in the research when all the concepts are well defined and explained." I intended to fully exhaust all the desired areas of my research using the sample and I managed to attain data saturation after collecting data from 6 participants. I had six participants as Davies (2007) states that having a small sample allow interviewees to talk at length suggesting that the information obtained will be closer to reality of the interviewee's life. This helped me get perceptions from female recovering drug users that were closer to their views of aftercare programmes.

To get the participants I asked the director at the centre to refer the female recovering drug users to me. The director informed the female recovering drug users that participation in the study was voluntary. The criteria for participating in the study were:

- Female recovering drug users between the ages of 18 and 35 as this is the age group for youth in South Africa. Stein *et al.* (2012:2) argue that "South Africa's youth are particularly important population to consider when thinking about substance use." This shows the seriousness of the substance abuse problem among the young thus the need to evaluate youth's perceptions on the effectiveness of treatment programmes. Thus the rationale for me choosing to conduct my study with the youth.

- They should have attended institutional treatment first for a period of not less than 4 weeks before being involved in aftercare because I was interested in aftercare programmes after long term institutional treatment. "Aftercare" in the study was considered to range from 0-2 years, as this was the period I expected to secure a sample but also in this time, participants will remember their experiences from the beginning of aftercare fairly easily. The first year of recovery is one of transition. During this stage, individuals who have completed addiction treatment are beginning to implement lifestyle changes through developing coping strategies, new healthy behaviours, ending unhealthy social relationships, and so on (Arbour *et al.* 2011). This justifies my selection.

- The female recovering drug users were supposed to be able to communicate in English as I can only communicate in English and I was not willing to use an interpreter as this would have contaminated my data as addiction is a sensitive topic.

<u>Social workers</u>

I employed a sample of 5 social workers from the research site in Gauteng. The social workers were supposed to have worked at the organization for a period not less than three months. The director at the research site gave me permission to conduct the study at the organisation. The sampling category for the focus group was purposive sampling and availability sampling. Kelly (2006:304) states that in focus groups sampling is often purposive in that one is looking for "particular types of participant, according to what one already knows about the field, so as to include a range of perspectives." I selected social workers who had knowledge of aftercare services. I also used availability sampling as the participants were social workers that were available and willing to participate in my study.

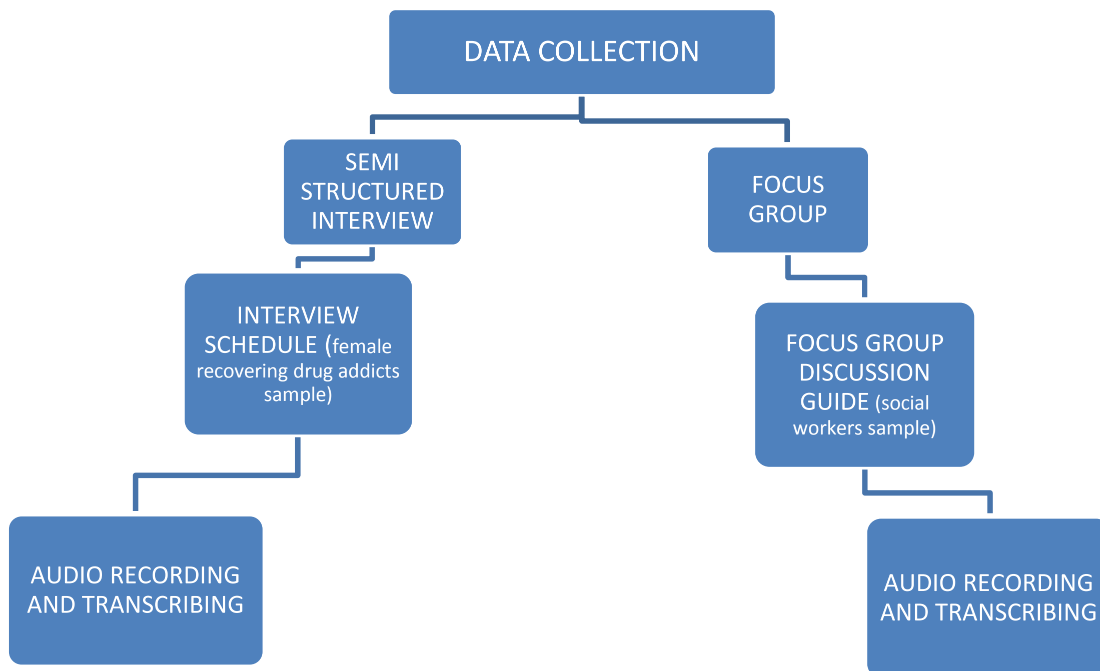
I used the sample of social workers for the purpose of triangulation. Kelly (2006) alludes to the fact that triangulation entails collecting research data from different sources that can provide diverse information. In my study I employed triangulation through the use of two different samples, one consisting of female recovering drug users and the other consisting of social workers. Kelly (2006) and Denscombe (2007) argue that triangulation assists in making the researcher understand better the phenomenon being studied. In my study, triangulation helped me understand better the perceptions concerning the effectiveness of aftercare from both service users and service providers thereby getting a view from different perspectives. According to Denscombe (2007: 138) triangulation "focuses on producing complementary data that enhances the completeness of the findings" which was important in researching the biopsychosocial-spiritual aspects of addiction in my study.

3.5 METHOD OF DATA COLLECTION

Due to the two samples I used in my study, I employed two different data collection methods as summarized in the diagram below.

Fig. 3.2

Summary of data collection methods



Schutt (2012:17) states that qualitative approach are “methods such as participant observation, intensive interviewing, and focus groups that are designed to capture social life as participants experience it rather than in categories predetermined by the researcher.” As I used qualitative research for my study, I employed intensive interviewing and focus groups to facilitate discussions with the participants on their perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. I collected data on the perceptions of the female recovering drug users and social workers concerning the effectiveness of aftercare programmes based on their experiences within the programme, I chose data collection methods that made the participants talk and give a lot of valuable information as they were the ‘experts’ on the subject.

In my study I collected data using semi-structured interviews for the female recovering drug users sample and a focus group discussion for the social workers sample. I will discuss the two data collection methods separately below.

3.5.1 Semi-Structured Interview

I used semi-structured interviews with six female recovering drug users. An interview schedule was used during the interviewing process (please find as appendix). Schutt (2012) states that in depth interviewing is ideal in qualitative research when investigating about people’s experiences, thoughts and feelings. In my study I was interested in the experiences and thoughts of the female recovering drug users concerning aftercare programmes. I used semi-structured interviews in particular; and May (2011: 135) states that semi-structured interviews are data collection methods that help to gain “an understanding of how interviewees generate and deploy meaning in social life.” In my study, the semi-structured interviews helped me understand how female recovering drug users perceived the effectiveness of aftercare programmes in their lives. Greef (2011: 351) describes semi-structured interviews as used “in order to gain a detailed picture of a participant’s beliefs about, or perceptions or accounts of, a particular topic”, this too being covered in my study.

Sarantakos (2005) is of the notion that the degree to which an interview is structured depends on the research and the type of information the researcher intend to acquire. Sarantakos (2005) further asserts that the decision to use an unstructured, semi-structured or structured interview is also seen to depend on the resources that the researcher has available. In my study I wanted to obtain in depth information on the perceptions of female recovering drug users about the

effectiveness of aftercare programmes. Semi-structured interviews were used due to the time resource that I had. Since the recovering drug users were the knowledgeable people on their subjective experiences of aftercare, I used open ended questions to get in depth information.

Greef (2011:352) asserts that "with semi-structured interviews the researcher will have a set of predetermined questions on an interview schedule, but the interview will be guided rather than dictated by the schedule." The interview schedule I used guided my interview as participants brought up new issues of interest that I explored further during the interview. Sarantakos (2005: 433) states that semi-structured interviews are "interviews with a given structure but with relative freedom to formulate the questions and to determine their order and presentation." In semi-structured interviews, the researcher has an interview schedule with specified questions in order to have a certain standard in the interviews but will also have room to probe (May 2011). The guide that I had assisted me in data analysis as I had specific themes derived mainly from the structured questions asked in the interviews. The set questions also assisted me in the direction of my interviews as I knew the areas I wanted to cover and get information on in my study. Standardized questions in the semi-structured interviews also assisted me in comparing the data provided by different participants as they responded to similar questions.

In addition to the standardized questions on the interview schedule, the researcher had relative freedom to ask unplanned questions during semi-structured interviews. Denscombe (2007) asserts that the order in which questions are asked in semi-structured interviews is flexible and questions are asked in line with the responses that interviewees are providing. This assisted me in my study as the participants were the ones more knowledgeable about the topic and they were discussing their subjective experiences. Niuwenhuis (2007) is of the view that semi-structured interviews work well in social work research as the unplanned questions give room to query issues that are raised by the participants. Nieuwenhuis (2007:113) further adds that the unplanned questions in semi-structured interviews help in "allowing the interviewer some discretion to create new questions in response to participant's answers." Since addiction treatment and aftercare programmes are complex processes, the unplanned questions assisted me in clarifying and elaborating the participants' responses.

Denscombe (2007) states that semi-structured interviews are good in providing in depth information as there is room for probing. Sarantakos (2005) suggests that probes also assist in

making it easier for participants to answer questions as probes promote continuity of the discussion. Welman *et al.* (2005) complement probing as they state that it assists in clearing up vague answers and in expanding incomplete answers. In my study, probes were used when the researcher did not easily understand the response given by the participant or when more information was needed. Since I was interested in providing a clear descriptive report on perceptions concerning aftercare programmes, I needed to clearly understand the responses provided by the participants and probing assisted me attain this goal. The semi-structured interviews were audio recorded after getting written permission from the participants.

I conducted my interviews in an office at the research site, this providing a private space with limited interruptions. Denscombe (2007: 190) states that "the researcher needs to try get a location for the interview which will not be disturbed, which offers privacy, which has fairly good acoustics and which is reasonably quiet." The office at the centre offered all the mentioned qualities. I used the office as I wanted the participant to remain focused on the interview with limited disturbances.

3.5.2 Focus Group Discussion

I conducted a focus group discussion with five social workers providing aftercare services at the research site. I had a sample size of five social workers since that is the number of social workers available at the centre. Sarantakos (2005: 427) defines a focus group as "a group of people used as a research unit, constructed for the purpose of studying a particular issue." In my study it was a group of social workers constructed to study perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. Greef (2011) asserts that a focus group discussion is assembled for the purpose of understanding better how people feel or think about an issue or service. In my study I wanted to understand how social workers perceived the aftercare programme that was being offered to female recovering drug users. Cronin (2008) is of the notion that focus group discussions assist in exploring views and experiences on a certain area in depth. Since aftercare programmes are a complex phenomenon and their effectiveness for female recovering drug users is an area that might be challenging to determine; a focus group discussion with the social workers assisted me in this regard. I went through literature to understand aftercare programmes before drawing up questions for my interview guide as suggested by Bless *et al.* (2006).

Cronin (2008: 228) states that “a focus group is not a replacement for the individual interview; the type of data generated through focus groups is very different from that generated through individual interviews.” As mentioned above, collecting data from social workers will assist with triangulation. The data from the focus group discussion provided me with a different perspective on the effectiveness of aftercare programmes for female recovering drug users. According to Welman *et al.* (2005: 201) the aim of a focus group discussion is “to gather information that can perhaps not be collected easily by means of individual interviews.” The information I attained in the focus group assisted me as I got data that I would not have attained in individual interviews as a discussion promotes the development of ideas that may not have come up should it have been an individual interview. Bless *et al.* (2006) asserts that during a focus group discussion one idea may lead to many different ideas for other participants. This assisted me to get rich data as the social workers deliberated on different interesting topics.

According to Denscombe (2007) a focus group discussion has a particular focus as the facilitator would like to get information on the experiences of the participants who might be having a similar occupation or disease. In my study, the focus group discussion with social workers shared their experiences in working with female recovering drug users attending aftercare. I conducted the focus group discussion at the boardroom at the research site as Cronin (2008: 235) asserts that “if possible, choose a venue which is familiar to the members of the focus group, thus aiding attendance and participation.” The boardroom at the centre was convenient as the social workers did not have to travel long distances to participate in the research thus promoting the availability of the participants. In agreement, Nieuwenhuis (2007) states that social workers are usually not prepared to travel for long distances to participate in a research project.

Participants for a focus group discussion are selected due to the characteristics they have in common as they provide responses to similar topics (Greef 2011). In my focus groups the social workers were discussing aftercare programmes which they all offered at the research site. Greef (2011: 360) further asserts that focus groups “are fundamentally a way of listening to people and learning from them, and creating lines of communication.” As the social workers were experienced in working with female recovering drug users during aftercare programmes, I learnt from them and produced a report that may also assist others to understand aftercare programmes. Bowling (2009: 424) states that focus group discussions “have the advantage of making use of

group dynamics to stimulate discussion, gain insights and generate ideas in order to pursue a topic in greater depth" which I was able to do as a social worker with the requisite skills.

Focus groups should consist of small number of participants that are gathered to discuss their views on a certain topic (Welman *et al.* 2005; Soley & Smith 2008). Soley and Smith (2008:189) state that "all research is a trade-off, and focus group researchers are willing to trade sample size for quality and depth of answers." Due to the small number of participants, I was able to get extensive information about the views of the social workers concerning the effectiveness of aftercare programmes. Sarantakos (2005) asserts that focus group discussions should have enough people to promote a discussion but not too many to make interaction difficult and he suggests a group of between five and ten people. Soley and Smith (2008) suggest that focus groups should have a smaller sample as they take long to administer the responses provided are usually not predetermined and easily summarized. Bless *et al.* (2006) also suggest a sample of four to eight participants and in my study I had a focus group consisting of five social workers as it was a manageable size. The focus group discussion would lasted about 90 minutes and this is the ideal time (Denscombe 2007; Cronin 2008).

Welman*et al.* (2005) state that one of the disadvantages of focus group discussions is that participants may not express their perceptions and emotions freely as they are intimidated by the presence of other participants. To aid participants to feel comfortable in the study, at the introduction of the focus group discussion I elaborated on the need for confidentiality among the group members and I also promised to keep the information they provided confidential. Cronin (2008:238) in tandem states that the aim of ensuring confidentiality in focus group discussions is to "provide a friendly and welcoming atmosphere in which participants will feel sufficiently comfortable and relaxed to talk." The principle of confidentiality was also discussed in the informed consent form that the participants signed stating that they will adhere to confidentiality during the study.

Bless *et al.* (2006:122) asserts that from focus group discussions "a careful record of the debate between participants can give the researcher much deeper insight into a topic than would have been gained from interviewing all the participants individually." I ensured that I had an audio recording in order to have a careful record of the focus group discussion. Denscombe (2007: 195) states that "audio recordings offer a permanent record and one that is fairly complete in

terms of speech that occurs." In my study I used audio recordings as I did not want to miss the information provided by participants. Denscombe (2007) however is of the notion that audio recordings have the disadvantage that they do not capture the non-verbal communication in the focus group discussion. To overcome this, I made some brief field notes during the focus group discussion. The field notes reminded me of the group dynamics that occurred during the discussion. The field notes were brief however, so as not to disturb the flow of the discussion.

3.6 DATA ANALYSIS

After data collection I transcribed the individual interviews and focus group discussion. Kelly (2006:302) asserts that "it is easier to refer back and forth to different parts of an interview if we have it on paper in front of us than it is to find our way around an audio cassette." Concurring with Kelly (2006), Denscombe (2007:196) states that transcribing "provides the researcher with a form of data that is far easier to analyse than the audio recording in its original state." Transcribing assisted me in analyzing my data better as it was much easier to refer back to previous excerpts thus helping me in coding and developing themes. When transcribing, I also took note of the filler words used in interviews. Welman *et al.* (2005: 211) state that "it is important that the 'uhs', 'ers', pauses, word emphases, mispronunciations, and incomplete sentences are taken into consideration in the write-ups." I took note of the filler words during analysis as they assisted me in understanding better the expression of the participants.

In used the thematic data analysis process. According to Carey (2009) thematic data analysis is a common type of data analysis used in social work qualitative research. Thematic data analysis works well with small samples and themes need to be meticulously explored (Carey 2009). I also intended to rigorously explore the themes in my study as I had a small sample. I analyzed my data using the thematic data analysis process by Whittaker (2012) consisting of six phases where I became familiar with the data, created initial codes, searched for themes, reviewed themes, defined and named themes then I produced the report. I used the thematic data analysis process as the data collected was qualitative data and I wanted to break the data into themes so as to understand and describe the data better.

In the first phase of data analysis I immersed myself by reading the data collected so as to be familiar with the data. I took time repeatedly going through the data in order to be conversant with the data. In the second phase of data analysis I created codes by breaking the data into parts

before rebuilding it into themes. Welman *et al.* (2005:211) states that codes are tags or labels that "are used to retrieve and organize chunks of text in order to categorize it according to particular themes." I used these tags or labels to categorize the data better as in the next phase of data analysis I put data into themes. According to Corbin and Strauss (2008:159) coding is "extracting concepts from raw data and developing them in terms of their properties and dimensions." Coding assisted me in facilitating data analysis as I selected and differentiated information; the coding was the actual process that assisted me in creating the codes I have discussed above. Welman *et al.* (2005:211) states that "the purpose of coding is therefore to understand material that is unclear by putting names to events, incidents, behaviours, attitudes and so on." Coding assisted me categorize and understand the bulk of information I obtained into labels or tags that I understood.

In the third phase I grouped the codes into themes. Welman *et al.* (2005:211) state that "themes can be described as 'umbrella' constructs which are usually identified by the researcher before, after, and during the data collection." I developed themes that were emerging from the data I collected being guided by my theory frame. Themes assisted me in report writing as they guided me when writing my thesis. In the fourth phase of my data analysis I reviewed the themes by reading all the extracts from the transcripts and also examining the data extracts from each theme. After having developed a suitable thematic map I then defined and refined the themes and tried to identify names that capture the core of what the theme was about. Lastly I then produced the report in my thesis aiming to be coherent and convincing, giving an interesting account of the story the data told (Whittaker 2012).

3.7 TRUSTWORTHINESS

To ensure I conducted a valuable study I considered the four dimensions of trustworthiness that I will discuss hereunder.

3.7.1 Credibility

Denscombe (2007:297) states that credibility entails "the extent to which qualitative researchers can demonstrate that their data are accurate and appropriate." To ensure credibility in my study, I spent time with my participants before the actual interview so as to build some level of trust. I also emphasized to the participants that information they provided will not affect their relationship with the organization. The focus group discussion with the social workers also

assisted in attaining credibility as it assisted on attaining triangulation of data sources. Denscombe (2007) asserts that to attain credibility triangulation can be used in the study. I used triangulation to attain more accurate and appropriate information as interviewing both the service users and service providers helped me better understand the position from which the participants derived their perceptions concerning aftercare programmes.

3.7.2 Transferability/ Generalizability

The terms generalizability and transferability can be used interchangeably in qualitative research. Sarantakos (2005: 98) asserts that generalizability "refers to the capacity of a study to extrapolate the relevance of its findings beyond the boundaries of the sample." In my study this might imply the degree to which perceptions concerning the effectiveness of aftercare programmes may be generalized to other female recovering drug users and social workers involved in aftercare. Kumar (2011) mentions that though it is difficult for qualitative studies to achieve transferability, transferability can be achieved to some extent if a researcher extensively and thoroughly describes the process they used for other researchers to follow and replicate. In my study I provided a thick description that explains the research process followed, time and context of data collection so that other researchers may understand how I got the findings that I found in my research. Just as Davies (2007) states that when employing transferability in qualitative research, one has to do this with great caution; I will apply great caution in the transferability of my study as I only used a small sample. Overgeneralization which Schutt (2012: 7) describes as "when we unjustifiably conclude that what is true for some cases is true for all cases" should be avoided with my study mainly due to the small sample I used.

Sarantakos (2005:98) uses the term fittingness to refer to "the degree of fit between the case studied and the case to which researchers want to generalize the findings." Should other researchers want to generalize my findings they should consider the process that I used to conduct my research and also bear in mind that the research was only conducted at one organization. Qualitative research entails using small samples and the generalizability of the findings to the population of the study is challenging (Shenton 2004; Denscombe 2007). It should be noted that to a larger extent, the results of this study were relevant to the participants of the study and can only be used as reference by other researchers.

3.7.3 Dependability

Dependability according to Denscombe (2007) assesses whether similar research results will be obtained should the research be conducted in similar settings by a different researcher. Qualitative research gives room to flexibility and the researcher has a great impact in developing the research instruments (Denscombe 2007; Kumar 2011). Due to the impact of the researcher on the study dependability of the study in qualitative research is challenging. Schutt (2012) suggests that scientific methods should be used in qualitative research to ensure dependability rather than just relying on the researcher's personal sentiments. In my study, clear, well defined and rationalized scientific methods were selected based on literature to ensure the dependability of my study.

Shenton (2004), Denscombe (2007) and Kumar (2011) suggest that to ensure dependability the researcher should provide a thick description of the research process followed. Sarantakos (2005: 434) states that thick descriptions are "descriptions pertaining to settings, people and interaction that are rich, natural, accurate and vivid enough to bring the reader close to the natural life of the study object."To ensure dependability, my study has a dense description of the settings and interactions that I had with the participants that should be clear enough for the reader to understand the research process. My report also provides a clear step by step process of the study and the rationale for selecting each step. This will assist other researchers should they find a need to replicate my study. Shenton (2004) asserts that a thick description of the research process will also assist the reader gauge the extent to which effective research methods were implemented.

3.7.4 Confirmability

Shenton (2004: 72) states that to attain confirmability, "steps must be taken to help ensure as far as possible that the work's findings are the result of the experiences and ideas of the informants, rather than the characteristics and preferences of the researcher." As will be discussed in the next section on reflexivity, I intended to be as value-free as possible when conducting my study. The report I produced was intended to be based on solely the information that I attained from the participants and not my own perceptions. Shenton (2004) asserts that confirmability may be attained through triangulation as it reduces the effect of the researcher's bias. In my study I utilized triangulation also as this provided me with different perspectives and I got a better understanding of the data thus reducing my bias in the study. To ensure confirmability also, my

research will be examined by the University of KwaZulu-Natal. The University will assess to what extent my research results and report conforms to scientific research methods. In my bid to ensure confirmability, I was recording my research processes in a journal and not relying on human memory therefore important data was not lost.

3.8 REFLEXIVITY

Sarantakos (2005: 45) states that "qualitative research is reflexive – it values the reflexivity – the self awareness – of the researcher." In my study I assessed my values and perceptions about aftercare programmes and attempted to separate them from the research process and report. Ali and Kelly (2012) assert that reflexivity entails assessing the impact of the research process, how the participants viewed the researcher and the processes that took place between the researcher, the research process and the research participants. In my study I assessed the different research processes available and selected the best research process for my study that assisted me in getting supposedly the best possible understanding of the perceptions towards the effectiveness of aftercare programmes for female recovering drug users. I also portrayed the image of a researcher to the participants and enlightened them on how their honest perceptions will assist in the goals of the research and assist in the understanding of aftercare programmes.

Lietz, Langer and Furman (2006) emphasize that during data analysis a researcher should avoid bias and should analyze the data from the perspective of the participants and not his own perspective. In my study I applied the principle of being value-free in order to produce research that is beneficial in understanding the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. In addition, Sarantakos (2005: 92) states that "social scientists should be value free; they should rule out value judgements, subjective views, personal bias and personal convictions." To accomplish a comprehensive study valuable for the future, I conducted a study free from judgements, bias and subjective views that will distort the data provided by the participants. Denscombe (2007: 300) states that

> *"The researcher's identity, values and beliefs play a role in the production and analysis of qualitative data and therefore researchers should be on their guard to distance themselves from their normal, everyday beliefs and to suspend judgements on social issues for the duration of their research."*

I ensured reflexivity by distancing my beliefs and judgements from my research especially during data analysis. I also ensure I had sufficient control of my perceptions so as to have valuable research not clouded by my own prejudices. I consulted my supervisors and received guidance on how best to minimize personal biases and beliefs from contaminating data.

However, Sarantakos (2005) and Denscombe (2007) argue that objectivity can never be fully attained in qualitative research. Qualitative reports are a result of interpretation by the researcher thus the researcher has a huge impact on the research (Denscombe 2007).Though total objectivity may be difficult to attain in qualitative research, I strived to ensure I produce quality work as Sarantakos (2005: 94) alludes to the fact that not having objectivity in qualitative research "does not mean that qualitative researchers abandon the academic requirement to be responsible, truthful and transparent in their work." As discussed above in my study I intended to achieve trustworthiness and this assist me in producing supposedly high quality work. Since as a qualitative researcher I was highly involved in my work, attaining objectivity was challenging but I strived to adhere to the abovementioned principle of value-neutrality in order to produce research results that might assist the community at large.

3.9 ETHICAL CONSIDERATIONS

3.9.1 Honesty and Integrity

According to Hugman (2009) honesty and integrity implies the truthfulness of research that is both as a process and as product. I ensured the truthfulness of my research product through triangulation as the interviewing of social workers helped me in getting a clearer view of the perceptions of female recovering drug users as I would have got knowledge from professionals as well who deal with the female recovering drug users regularly. In order to ensure honesty and integrity I recorded my interviews with the consent of my participants and should my supervisor want proof of honesty and integrity of my research I would have provided the recorded interviews.

Schutt (2012) asserts that to attain integrity and quality a researcher should ponder carefully whether the study is being conducted in a way that adheres to ethics in research and at the same time producing quality results. I ensured integrity in my study by sticking to the ethical principles upheld in qualitative research. I also upheld the ethical principle of honesty and integrity by presenting myself to the participants as a researcher and not deceiving them in any

way. Rubin and Babbie (2010) concur with the notion of presenting yourself as a researcher and notifying the participants the real reason for research. Since the study was being conducted in the discipline of social work, honesty and integrity is also important as it is one of the ethical principles of the discipline.

3.9.2 Beneficence

Wassennaar (2006:67) states that ethical studies should consider the "relative risk of a proposed study against and benefits that the study may directly bring to participants or to society through knowledge gained." The potential risk of my study was that female recovering drug users could have discussed some sensitive issues they were not comfortable discussing during the interview. However, the benefit of my research is that it may lead to a more effective aftercare programme that might assist many female recovering drug addicts in aftercare. My study can assist service providers to understand what female recovering drug users perceive concerning aftercare programmes. This may also assist service providers to improve their programme. The input from social workers could also assist other social workers to learn more about aftercare programmes. Not only service providers may benefit but also other recovering drug users might learn more about aftercare programmes from the participants of my study.

Schutt (2012: 67) suggests that to attain beneficence, researchers should be "minimizing possible harms and maximizing benefits." In my study I assessed the harm that the data gathering techniques could impose on the research participants and weighed the potential harm to the benefits that the study will bring about. Using female recovering drug users attending aftercare was necessary as they received the aftercare services at first hand and they had experience of the programmes. Their experience was invaluable and difficult to attain from any other person. Thus the choice to select female recovering drug users for the interviews. To ensure that my study benefits the service providers and the participants, I will provide the research site copies of my thesis; participants of my study together with service providers can refer to the thesis to access the results of the study. I also wish to disseminate the results via a workshop to service users and to publish the findings in an academically acclaimed journal.

3.9.3 Utility and Futility

Utility and futility entails using the relevant and most appropriate methodology to get the desired results (Hugman 2009). For the sake of utility and futility I carefully chose relevant research

methodology based on literature that is carefully and thoroughly discerned based on practicability. My research supervisors also guided in the selection of research methodology. Proper rationale has been provided for each research methodology chosen. Since my research involved disclosing of personal information, I ensured I used the most appropriate research methodology in conducting research on substance abuse. When considering utility and futility researchers should select ethically valid methodology that produces scientifically valuable research at the same time without causing harm to the participants (Rubin & Babbie 2010; Rubin & Babbie 2011). While considering the earlier discussed ethical principle of beneficence I carefully selected my research methodology based on relevant literature that made my study valuable.

3.9.4 Nonmaleficence

In line with the ethical principles discussed above of beneficence and utility and futility is the ethical principle of nonmaleficence in my study. According to Wassennaar (2006: 67) nonmaleficence requires the researcher to "ensure that no harm befalls research participants as a direct or indirect consequence of the research." In my study I ensured no harm to participants by emphasizing to them that they may withdraw from participating from the research if they feel they cannot continue and there will be no penalty. Rubin and Babbie (2010) state that research in social work has no right to harm the participants even when the participants have volunteered to participate in the study. In my study I ensured that no deliberate harm was imposed upon the participants. As a social worker myself, I also had knowledge of when to refer a person for ongoing services should I detect traces of harm being induced on the participants.

Bless *et al.* (2006) are of the view that harm in research may be inflicted upon participants either intentionally or unintentionally. In my study I ensured I did not intentionally impose harm upon the participants by adhering to the code of ethics expected in research. I attempted to avoid unintentional harm upon participants in by informing them before the interviews and focus group discussion that should they feel uncomfortable to continue the study in any way, they should inform me and I will stop the interview. Harm to participants may be in the form of mental, physical or even legal harm. Sarantakos (2005: 19) states that mental harm "entails cases where subjects are subjected, directly and/ or indirectly, to procedures that cause discomfort, stress of some kind, anxiety, loss of self-esteem, or embarrassment." Thus to avoid unintentional harm to

the participants, I informed them before the interview and focus group discussion that should they feel I am causing any of the abovementioned conditions they should inform me and I will stop the interviewing.

I avoided asking participants questions in a demeaning form and being disrespectful as this causes mental harm (Sarantakos 2005). Rubin and Babbie (2010) state that in social work research the interviewer must be careful not to ask participants questions that will make them give responses that embarrass the participants or put the participants in danger be it at work or in social life. During data collection I was careful when asking questions as I only asked questions that led me to attaining information on perceptions concerning the effectiveness of aftercare for female recovering drug users and avoided asking personal questions that did not add any value to my study.

According to Schutt (2012: 313) "researchers should try to identify negative feelings and help distressed subjects cope with their feelings through debriefing or referrals for professional help." Since I am a social worker, I used my social work skills to assess how the participants felt and where I saw signs of discomfort, I offered on-site assistance and/or referred the participants to the social workers at the centre for further assistance. The ethical principle of nonmaleficence goes together with the ethical principle on the right to know versus the right to withdraw information. Since my research participants were human beings, they had the right to withhold information they felt they did not want to share in the research. Due to this ethical consideration, I did not force research participants to divulge information they were not comfortable talking about. In as much as I wanted to gain knowledge for my research, I valued the worth and dignity of the participants more so as a social worker (Hugman 2009).

3.9.5 Informed consent

The aforementioned ethical consideration of the nonmaleficenceis directly linked with the ethical consideration of informed consent. May (2011) states that informed consent entails people participating voluntarily and knowingly in research. Hugman (2009) is of the view that informed consent entails participants being notified they can withdraw from the research anytime and participants should be informed about the nature, purposes and procedures of the research. Informed consent is directly linked to nonmaleficence as I informed potential participants of the possible harm that participating in the study could have caused. Participants must participate

voluntarily in a study with full knowledge of the risks of participating and what they must do should they feel they no longer want to continue (Babbie 2010). The participants were also informed that if the decided they no longer wanted to continue with the research, the information they had provided would be deleted. However, no participant withdrew from the study.

According to Wassennaar (2006: 72) informed consent “means that researchers must provide potential participants with clear, detailed, and factual information about the study, its methods, its risks and benefits, along with assurances of the voluntary nature of participation, and the freedom to refuse or withdraw without penalties.” This proclamation summarizes the informed consent process in my study as I sufficiently informed the potential participants about the study beforehand. I also attained consent from the participants to conduct audio recording during interviews and focus group discussions. Denscombe (2007: 173) states that an interview “is not done by secret recording of discussions”, I ensured that potential participants knew of my intent to record the interviews and I made them sign consent forms after allowing me to record the interviews.

In determining the capacity of the potential participants to provide consent, I enquired from the director at the research site whether there were participants that were mentally challenged and not eligible to make informed choices. Kumar (2011: 244) states that there are people who are not competent to give consent to participate in research “for example, some very old people, those suffering from conditions that exclude them from making informed decisions, people in crisis, people who cannot speak the language in which the research is being carried out, people who are dependent upon you for a service and children.” In my study I did not have participants that were not eligible to provide consent for the study and having the characteristics mentioned. It should be noted however, as Ray and Ksir (2004) state, that aftercare is a period of less intensive treatment that is a follow up to more intense institutional treatment and is aimed at reintegrating recovering substance users into the society. It is therefore usually a period where former substance users have recovered and all the participants were competent to provide consent for my study.

In social research, participants should voluntarily participate in a study and not be forced into participating or be deceived (Bulmer 2008). In my study no participant was forced to participate against their will. I upheld ethical principles of research and treated the participants with respect.

Potential participants were made aware of their rights before they were to participate in the study. Ali and Kelly (2012) add that gaining informed consent in research upholds the value of autonomy and serves to protect participants as they knowledgeably participate in a study. In my study I attained informed consent from the participants as I value the worth and dignity of participants and acknowledge the right of a person to decide whether to participate or not in my study.

In research, participants should know that they are being research and they should provide for the consent to be researched and they should be well informed about the research (Welman *et al.* 2005; Bulmer 2008). Schutt (2012) adds that the language in the consent form should be easy for the potential participants to grasp. In my study I used English phrases that were common and easy to understand for the majority of people in order for the potential participants to give consent while satisfactorily informed about the study. Sarantakos (2005) asserts that a common practice in research is making the participants sign an informed consent form that has information about the study to be conducted. In my study participants signed consent forms showing that they were participating voluntarily and they were also notified of the nature, purpose and procedure of the research.

3.10 LIMITATIONS OF THE STUDY

Some of the problems and limitations were:

During the Fourth Annual Postgraduate Conference where I presented tentative results of my study, one peer researcher highlighted that due to female recovering drug users having been through different life experiences, the fact that I was a male researcher could have affected the results of my study. This also needed consideration as the therapists for the female recovering drug users were all female social workers. However, the researcher being a qualified social worker built rapport before the interview and I also fostered trust and comfort among the participants as seen in some of the sensitive issues they shared.

I collected my data from one organisation using a small sample, hence the transferability of the study will be limited. Bless *et al.* (2006) states that when using purposive sampling, usually the sample is chosen with the discretion of the researcher and is not a representative sample. The results of my findings were specifically linked to the participants of my study though other

researchers can refer to the results to have an idea of the perceptions concerning the effectiveness of aftercare for female recovering drug users.

In my study, there was difficulty securing the sample. This occurred due to the small number of female recovering drug users regularly attending aftercare at the research site. To address this I made sound preparatory arrangements and I made more than one trip to the research site. I also decided on using only six female recovering drug users due to availability, and especially because there was evidence of data saturation.

3.11 CHAPTER SUMMARY

This chapter aimed at vividly explaining the research methodology used in the study and the rationale for selecting that methodology. It is a mixture of literature and the practical aspects of the research. The chapter aimed at moving with the reader through the research process followed in a clear and informative manner. This chapter provides the reader with a journey from the research approach to sampling and data collection up until the limitations of the study. Though the study had some few limitations, it should be noted that the research methodology was appropriate for the study and the study was conducted smoothly.

CHAPTER FOUR
PRESENTATION AND DISCUSSION OF THE RESULTS

4.1. INTRODUCTION

This chapter focuses on data presentation, analysis, interpretation and discussion of the findings. The reader is further reminded of the objectives of the study which were:

- To gain insight on the effects of aftercare to female recovering drug users' lives.
- To understand the challenges female recovering drug users might face during aftercare.
- To understand how environmental factors affect female recovering drug users during aftercare.
- To explore biopsychosocial and spiritual factors that affect female recovering drug users during aftercare programmes.
- To ascertain recommendations for improvement to aftercare programmes from social workers and female recovering drug users.

The data presented in this chapter emerged from the individual interviews conducted with six female recovering drug users and a focus group discussion conducted with five social workers involved in aftercare at a well-established rehabilitation centre in Gauteng.

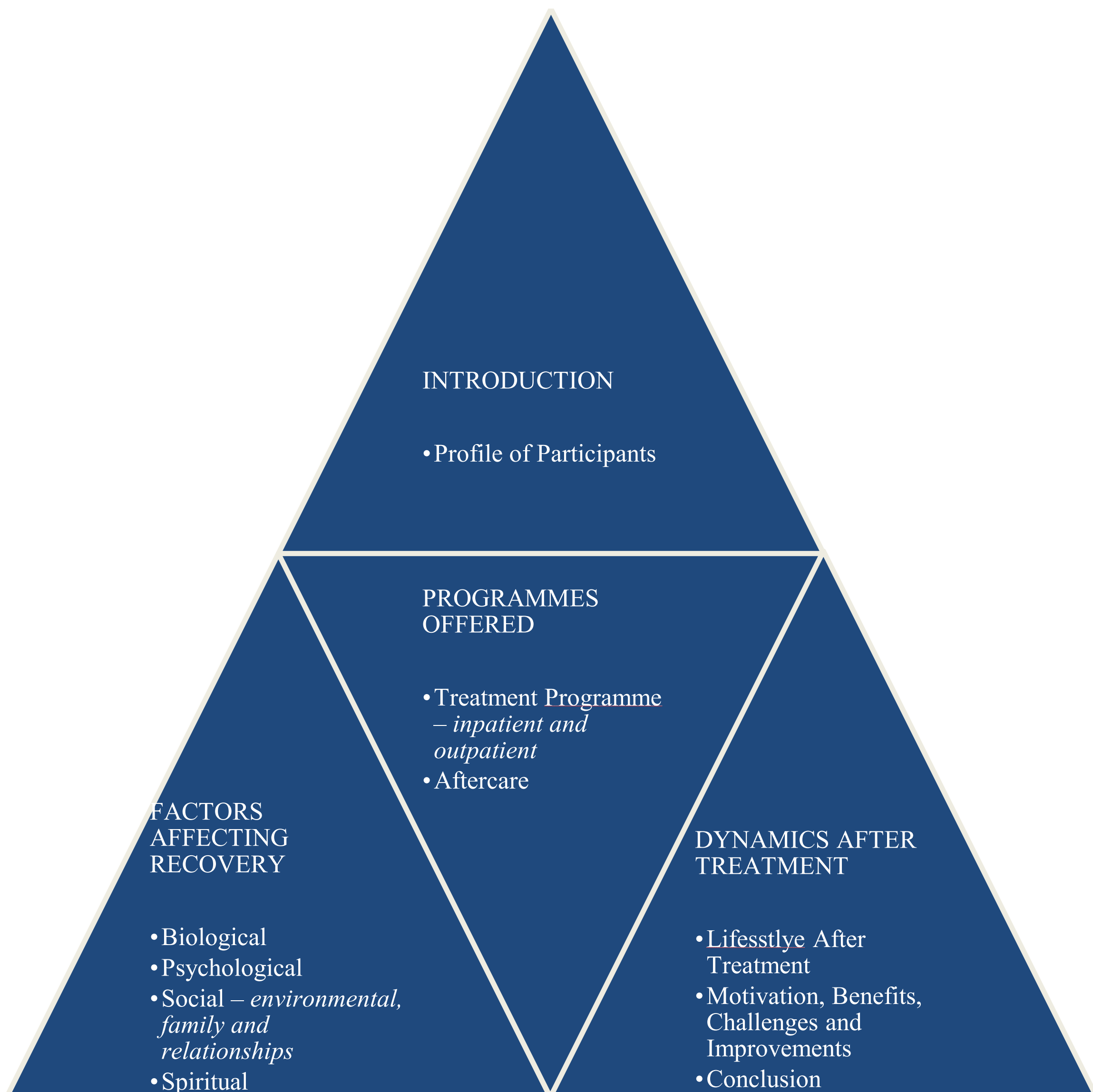
Both the data presented by the social workers and the female recovering drug users were thematically analyzed and are presented here concurrently. This concurrent presentation of data will enable one to grasp the findings holistically rather than in a piecemeal fashion. However, where I deem it necessary to identify and separate findings of the two sample groups, I shall do so. For the purposes of this chapter and due to ethical reasons, pseudo names are used for both social workers and recovering drug users when presenting the findings of the study.

This chapter can be broken down into four parts which are the introduction, programmes offered, factors affecting recovery and dynamics after treatment. I will include a visual impression of how the chapter will be divided through a pyramid in Fig 4.1 hereunder. It is important to note that the distribution of tiers in this pyramid is not in any way indicating the

differences in size, importance or priority of any of the themes presented but it should be taken merely as a visual presentation of the themes of this chapter.

Fig 4.1

Outline of Chapter 4



4.2. PROFILE OF PARTICIPANTS

Table 4.1.

Profile of Social Workers in the Study

NAME	REGISTEREDSOCIAL WORKER	WORKING AT RESEARCH SITE	YEARS AT ORGANISATION			
			3 Months to 1 Year	1 Year to 1½Years	1½ Years to 2 Years	4 Years Plus
Lindsay	✓	✓				✓
Ashley	✓	✓	✓			
Laurencia	✓	✓		✓		
Kayla	✓	✓		✓		
Portia	✓	✓			✓	

Table 4.1 highlights that focus group participants were all registered social workers who had worked at the research site for more than 3 months. Though Ashley had been at the organization for only 3 months, she had prior experience working at another treatment centre. A collaboration of all these factors clearly highlights that the social workers participating in my study were experts in the field who provided valuable information for my research.

Table 4.2.

Profile of Female Recovering Drug Users in the Study

NAME	AGE	DRUG OF CHOICE	YEARS OF USING	AT LEAST 4 WEEKS IN TREATMENT	DURATION IN AFTERCARE
Emily	34	Cocaine, heroin, ecstasy, acid and dagga	10 years+	✓	2 months
Michelle	29	Methcathinone (CAT) and dagga	7 years	✓	1½ years
Hazel	25	Heroin	8 years	✓	2 months
Natasha	25	CAT	10 years	✓	8 months
Gladys	32	CAT and alcohol	12 years	✓	8 months
Cynthia	22	Crystal methamphetamine	4 years	✓	5 months

The female recovering drug users were youth who had been using different drugs for four or more years. They all had attended substance abuse treatment for a period of four or more weeks and they had been attending aftercare for a period between zero and two years. These factors clearly highlight the use of purposive sampling in meeting the determined criteria for sample inclusion and in attaining the objectives of the study.

4.3. PROGRAMMES BEING OFFERED

4.3.1 Treatment Programmes Being Offered

Social workers participating in the study were asked about the treatment programme offered at the centre. This helped the researcher establish a background of the treatment programme and the period prior to aftercare.

The discussion about the inpatient and outpatient programmes that are offered at the research site was held with social work participants. With the inpatient programme it is for 21 days for alcoholics and 28 days for the recovering drug users. The outpatient programme is a 9 weeks

programme. There is the provision of psychosocial and medical services during the treatment programme. The treatment programme is seen by the social workers as more intensive than the aftercare programme. The social workers also highlighted that before determining whether a client should be enrolled for an inpatient or outpatient programme, they had to assess the severity of the client's addiction. They argued that:

> *"Before the aftercare programme, we start with the treatment programme where we deal with them intensely" (Laurencia).*

> *"You will have to relook to see if that person will be able to stay clean and sober on an outpatient treatment program. If somebody is using heroin for example on a daily basis we would never recommend an outpatient programme we would only recommend outpatient program for someone who perhaps is using on weekends or recreational use because somebody who is using on a daily basis we know would never cope on an outpatient program due to the constant triggers, not having enough skills yet to be able to deal with the addiction…" (Portia).*

From what was asserted by the social workers, it can be seen that the treatment programme was more intensive than the aftercare programme that was provided later on during recovery. This clearly shows that the aftercare programme therefore, is there to consolidate the gains attained during the more intensive treatment programme. This is consistent with the view that treatment programmes are more intensive than the aftercare programmes (Ray & Ksir 2004; Blodgett *et al* 2014). I will discuss the aftercare programme in more detail in the next section. The inpatient programme is the more intensive treatment programme offered at the centre and it assists people who are deep into addiction. Consistent with what the social workers argued that there were a lot of triggers when someone was staying at home during treatment, Maehira *et al.* (2011) in their study in Bangladesh also found that the surroundings where someone lived can act as a trigger for relapse.

Social workers in my study were more content with the inpatient programme. The female recovering drug users in my study also favoured the inpatient programme. They shared their views and experiences in the following excerpts:

"Outpatients are normally not as motivated because they haven't experienced the rock-bottom. Inpatients have already experienced devastating life experiences so they are focused on their recovery" (Kayla) – social worker.

"I went to (name of organization) for two weeks. At that time I was on heroin, I just went for the detoxing, because if you detox, then everything is out of your system. And then your first dip then it takes you high again. So I was there, I was only clean for one month. But here in inpatient the programme was different and helpful" (Emily) – female recovering drug user.

Stein *et al.* (2012) argue that in South Africa and the rest of the world, substance abuse treatment may not be satisfactory due to the lack of resources and infrastructure. In the case of Emily, she could have relapsed as detoxification only focused on the biological aspects of recovery and neglected all the other dimensions. The recovering drug user was using heroin for several years, and was only in treatment for two weeks. The patient also did not attend any aftercare following this treatment programme. This therefore, suggests that substance abuse treatment that only focuses on the biological aspects of recovery may not be successful, thus stressing the importance of focusing on the biological, psychological, social and spiritual aspects of recovery as a whole.

4.3.2 Aftercare Programmes Being Offered

The focus of the study was on the effectiveness of aftercare programmes offered at the centre and this section highlights on the programme itself. The discussion below is also in line with what literature says about aftercare programmes.

During aftercare there were individual and group sessions offered for recovering drug users. These sessions are only for clients who had attended treatment at the centre. According to the social workers, individual sessions were aimed at assessing how recovering drug users were doing and the group sessions were to educate and empower them. In addition there were also family support groups. Notable, the aftercare programmes that were offered at the research site are in line with the aftercare programmes discussed by Perkinson (2008). Perkinson (2008) discussed a variety of forms of therapy that are being used in aftercare. The aftercare programme

at the research site included random drug tests on the recovering drug users. In this regard, a social worker in the study stated that:

> "*Normally with the aftercare because they get tested randomly, if they test positive they need to schedule a session with the individual therapist and they won't be allowed to attend the aftercare until they are ok" (Portia).*

Perkinson (2008) also supports the use of random drug tests during aftercare. The social workers mentioned that they assessed the recovering drug user on the triggers for relapse. This was important as Islam, Hashizume, Yamamoto, Alam and Rabbani (2012) state that relapse may be as a result of different reasons so the assessment by the social workers will also assist them find the cause of addiction. Miller *et al.* (2011) also argue that the therapist must not give up on the client when they relapse showing that the social workers in question were doing a good job. Though the organization may suspend a client who has tested positive in order to protect the rest of the group from being influenced negatively by the client who has relapsed, it can be noted that the client needs more help to overcome the relapse. It may be suggested therefore that instead of suspending a client who has relapsed, it would be advisable to provide the client with more care and attention after relapse.

Aftercare programmes provided at the research site highlighted that aftercare was a team effort and a multidisciplinary approach was used to cater for the needs of the recovering substance users. In this regard, social workers mentioned it during the focus group discussion and female recovering drug users also concurred during the individual interviews.

> *"During the aftercare programme if we see that there is a need for them to continue seeing the psychiatrist and the psychologist, we are able to refer them" (Kayla) – social worker.*

> *"I currently see a social worker, Ashley here at* (name of organization) *and I am seeing a psychiatrist on the outside" (Emily) – female recovering drug user.*

The assertion by the social workers and the recovering drug users helped highlight the provision of services by a multidisciplinary team. The use of the multidisciplinary team is important as it assists in catering for the different dimensions of recovery, which are the biological,

psychological, social and spiritual; and is consistent with what is discussed by Perkinson (2008). Interestingly, it should be noted that the involvement of the clergy was not mentioned in the focus group discussion and interviews. Involving the clergy would assist in providing for the spiritual needs of the recovering drug users.

During the individual interviews the female recovering drug users highlighted satisfaction with the aftercare group sessions. There were however some areas that female recovering drug users suggested needed some improvements that I will discuss later in this chapter. One of the recovering drug users stated that:

> *"They ask you how was your week since last week Wednesday. Did you have any obstacles that you had, were there tribulations? …In the group there were people maybe 6 to 8 months clean so they would assist you on your challenges. So it's really helping a lot" (Cynthia).*

According to the social workers, asking clients how they had been over the past week assisted the therapists to have an idea of where the client was in her recovery. The presence of other recovering drug users also assisted the recovering drug user where they were struggling, as Cynthia mentioned that there were some people who were in their later stages of recovery and they gave advice on how they overcame similar situations.

Female recovering drug users were generally satisfied with the availability of their therapists when they were in need of counselling sessions. Social workers (therapists) on frequency of sessions with female recovering drug users highlighted that they were available when the clients felt they needed a session. This was consistent with what Miller *et al.* (2011) argue regarding clients having self determination to decide on when they need sessions with the social worker. However, because aftercare services are provided when the recovering drug addicts are staying at home, I am of the opinion that there will be many triggers for relapse and constant assessments by the social worker are needed. The following excerpts from the transcripts attest to this:

> *"If I need Lindsay* (the therapist) *I phone her and I tell her, listen I can't cope this is the problem. She tells me to come in… I got anxiety attacks one day out of the blue and it was a Friday morning, I phoned her* (therapist) *I said to her I can't cope, I am thinking*

of using. She said come to me, I came immediately and they helped and I talked to her and they gave me some of their tablets" (Emily) – female recovering drug user.

"I think it depends on the patient themselves (when they need sessions). *We give them the option. Obviously before they come for the first aftercare group session they need to see you for a session first. So in that first session you determine what they have been struggling with, and would they need to see you on a weekly basis or you know, can you see them now and after a month's time again" (Laurencia) – social worker.*

The assertion above shows that the social workers were available to assist the clients when they were in need, which can help make the aftercare programme effective. Perkinson (2008) argues that in aftercare, this is where substance abuse recovery faces challenges, and seeing that the social workers at the research site were available for their clients when needed, makes their programme to be perceived as beneficial.

However, it should be noted that not all participants were satisfied with the availability of their therapist during aftercare. There was one patient who was dissatisfied and stated:

"I haven't seen my therapist, I think I saw my therapist once since I have been out of here. I don't know when I am going to see her again. I don't ever see her here. I would like to see her more often" (Hazel).

It was difficult to determine the reasons why the participant in the study was meeting the therapist less frequently as this aspect was not part of the focus of my study. However, it should be noted that for most of the participants, appeared to be satisfied with the frequency of the individual sessions. The recovering drug users argued that they had more frequent individual sessions during the early stages of their aftercare programmes, but the frequency would deteriorate as the programme progressed due to the needs of the recovering drug user. The study was not just focused on availability of therapists but on the provision of all types of aftercare services. However, with the study being conducted in the discipline of social work, there was bias towards the provision of social work services.

Concerning the number of females who attended aftercare, the social workers stated that only a small percentage of females attended in relation to men. They clarified that poor attendance of

females start during in or outpatient treatment though most women who attended treatment also attended aftercare.

> *"Only about 10 to 20% of the people who attend aftercare programmes are female. This is similar to the representation of the percentages when they are still in or outpatients. However, we can say that almost 90% of the females that attend in and outpatient programmes also attend our aftercare programmes" (Laurencia).*

> *"Even when we are doing the assessment, we already then start speaking about the aftercare programme and it's something we reinforce throughout the treatment programme" (Ashley).*

Ramlagan *et al.* (2010) and Myers *et al.* (2009) similarly found that the number of females seeking treatment in South Africa was lower than the actual number needing treatment. The fact that a higher percentage of females in treatment attended aftercare, differed from the assertion by SANCA Vaal (2015) that only 2% of people who needed aftercare attended aftercare. So though there may be a low number of females during treatment, a lot of them appear to be attending aftercare, on the insistence of social workers. The finding contrasts with the study by Duffy and Baldwin (2013) in England that found that social workers did not motivate the clients to attend aftercare.

Another matter that kept on being discussed was that all the recovering drug users mentioned they attended NA meetings. This was a common finding and both the social workers and the recovering drug users differentiated the NA meetings from what they termed "aftercare". When the participants in my study were talking of aftercare they were only referring to the individual, group and family sessions provided by the social workers. Participants in the study stated that NA made them accountable as members of society. The following excerpts attest to this:

> *"NA is a non-profit organization. Basically, it is for recovering addicts by recovering addicts. Right up to your big boikkies that organize the literature, it's called ASC uhm, Area Service Committee. You don't get paid for it, it's your time that you are giving back because you are becoming a responsible, productive member of society" (Michelle).*

"It's (aftercare) *important because you need to connect with people that used the same substance, because like my fiancé doesn't understand. When I am craving, he doesn't understand nothing. But when you go to a meeting and you open up and you speak to people then you connect with people that used the same drugs, so they know exactly how you feel" (Cynthia).*

With this in mind, the attendance of the female recovering drug users for aftercare and NA meetings demonstrated their motivation in recovery and the fact that they viewed the programmes as effective, since if they were not benefiting they were not going to continue attending. Similarly, a study conducted by Gossop *et al.* (2007) in England showed that attendance to NA meetings provided positive results in recovery.

4.4. BIOLOGICAL FACTORS AFFECTING RECOVERY

Inline with the biopsychosocial-spiritual model, during data collection I focused on biological aspects affecting recovery during aftercare. The participants had different views concerning these biological factors.

A policy and view at the research site was perceiving addiction as a disease. Social workers during the focus group discussion elaborated on addiction being viewed as a disease. They argued that:

"With the disease we say it is lifelong, there is no cure. And it is progressive. With someone with a high rate of relapse, the first time they go to rehab, maybe it's an outpatient because they're using on weekends. But as you see them as they progress, the addiction progresses, the tolerance becomes higher, they use more and more" (Portia).

"Addiction is a disease, the reason why it is given the terminology is if you link it to something like diabetes, diabetes you have it for life. ...And the same with addiction, there isn't a cure, there is no magical pill or injection that we give anybody that makes her stop wanting to use drugs" (Lindsay).

"Addiction qualifies to be a disease because under the World Health Organization, they normally say for a disease to qualify to be a disease it is because it has the causes, it has the symptoms as well as the cure part of it meaning the treatment. So with

addiction, we realize that there are contributing factors. ..And then the symptoms, we have seen the symptoms of the disease where you find that even in terms of behaviour it affects the behaviour and also affects their life. On the treatment side, where we say that yes for this disease, because it is chronic, it doesn't have any treatment" (Laurencia).

The social workers all supported the view that addiction was a disease, with Stanbrook (2012) viewing it as a chronic relapsing disease. Since addiction is a disease, it cannot be treated only using psychosocial or spiritual methods without using biological methods. Addiction being a chronic disease also entails that there is need for long term treatment thus the need for aftercare programmes.

During the discussion on addiction being a disease, social workers alluded to the fact that genetic factors contributed to drug addiction. Further it could be noted that the female recovering drug users in my study also related addiction to genetic attributes as they stated they had other close family members who were also abusing substances. Stanbrook (2012) also suggests that genes play a role in addiction, and addiction was not a choice but a result of biological components in the body. The following excerpts from the transcripts attest to this:

"We can get for example a patient who at one point we treated the father, we have treated the brother, and we treated the uncle... So theoretically, if you have a family member who has an addiction problem, you have a higher chance of developing an addiction problem yourself. What would happen is, with the right or wrong psychosocial stresses, the gene is then activated, so it's not to say that all children of addicts or alcoholics will become addicts or alcoholics themselves" (Ashley) – social worker.

"My brother and sister were also using drugs. My sister introduced me to CAT when I was about 20 years old. My father is an alcoholic… His father and all his six brothers and sisters all drank at some point in time in their lives. Their father had cirrhosis of the liver. My mother takes still pain codeine tablets, I am sure she takes 12 to 16 of them a day" (Michelle) – female recovering drug user.

Although the suggestion above is that addiction is genetic, it is also likely that social learning may contribute to addiction being learned in families and across generations. Social workers discussed that the trauma, coping and non-coping skills of a person in addition to genetic factors contribute to drug addiction. Ray and Ksir (2004) argue that genetic differences in personality make some people more susceptible to addiction. This was an important discussion in my study as Zastrow and Kirst-Ashman (2004) argue that usually social workers tend to neglect the biological aspects of recovery. However, with the data I collected in my study only, I cannot conclude that biological aspects cause addiction. This warrants further research.

Concerning the biological aspects of recovery I asked the female recovering drug users about their experience of cravings and there were different responses. One of the female recovering drug users stated that she was experiencing severe cravings. However, generally the female recovering drug users perceived cravings as being more severe during the early stages of recovery than the period they were during data collection. They stated that:

> *"Now the last week was very hectic for me. I experienced a lot of cravings because of the triggers in my life. It's bad, I am trying, they say that the craving only last for 5 seconds and then it goes away but it's you that ring the bell the whole time that you think about it, how your life was when you were using and how your life is now. So, and, I am very depressed at this walk of life* (giggles)*" (Emily).*

> *"I no longer experience so much cravings anymore. Next week I will be 9 months clean so I am kind of past that stage of craving, I don't even find myself thinking about it* (drugs) *that much" (Natasha).*

I will discuss triggers for drug use in more detail when I discuss the psychological factors affecting recovery in the next section of this chapter. From the findings of my study, though there was no uniform trend on cravings, the recovering drug users who had been in recovery longer did not complain of cravings as much as did the ones in early stages of recovery. However, this area of cravings still need further research as various authors agree that there is no concrete knowledge yet about cravings. According to Van Wormer and Davis (2008), it is these cravings that make a recovering drug user relapse. They further argue that full understanding of the processes that take place in the mind will assist in discovering more about cravings.

The aftercare programme offered at the research site was not just for group work and individual sessions. As discussed earlier, they also offered medical and biological assistance. The female recovering drug users in my study made positive remarks towards the medical intervention.

> "*…yes I am definitely benefiting from aftercare because they also give you your vitamins. If they don't give you a pill, then they will give you an injection" (Emily).*

> *"I am reducing on my medication but it really helped me. It always made me feel better" (Natasha).*

> *"The matron helped me a lot. Actually all the nurses have been there for me when I needed them" (Gladys).*

> *"The medicine they give is so helpful and it is not addictive. They are actually helping us" (Cynthia).*

The excerpts above clearly indicate participants' satisfaction with the medical assistance offered at the organization. It can therefore be deduced that when there are biological complications during addiction, biological solutions are needed.

There were some physical ailments that were at times linked to drug addiction. During the interview, I asked the female recovering drug users if there were physical and biological challenges they experienced as a result of drug use. Participants in the study mentioned the following:

> *"I have problems with my lungs, I am on asthma pumps now, due to the drugs. My bones, aren't as strong as they used to be. I have a problem with my right knee which gets dislocated every now and then from using drugs. And my eyesight, I have got very bad eyesight due to that" (Hazel).*

> *"I don't have a gall bladder, my gall bladder was removed December 2013. It's more than likely due to drug abuse because I didn't have stones, it's just my gall bladder was sick" (Cynthia).*

Van Wormer and Davis (2008) argue that drug addiction affect different body parts as suggested by the female recovering drug users in my study. Different female recovering drug users mentioned that they suffered from various medical problems due to drugs, so it may be concluded that as a result of drug use some people may have physiological problems. This therefore calls for effective biological treatment during aftercare.

4.5. PSYCHOLOGICAL FACTORS AFFECTING RECOVERY

Psychological aspects affecting recovery were also explored during data collection. According to the social workers, female recovering drug users may experience trauma due to different activities that took place in their lives. When asked about the common traumatic events that the female recovering drug users faced, one of the social workers mentioned the following:

> *"The patients that I have assessed experienced a lot of childhood trauma, in terms of abuse at home and then marrying into an abusive relationship, then going on to be raped at the end of the day, with all of that and having a miscarriage" (Portia).*

Van Wormer and Davis (2008) discuss this trauma, stating that girls usually go into drug use due to victimization that took place when they were still young. This could be the reason why the clients in aftercare had a history of trauma. They could have used drugs to avoid facing their emotions post the traumatic experience.

During the individual interviews, an issue that also arose was that of attempted suicide. Three participants in my study stated that they once attempted suicide during their recovery. They discussed that:

> *"I tried suicide 3 times in my life and it didn't happen. Well the first time I took 86 sleeping tablets and anti-depressants and I was in a comma for three days… Two times after that I slit my wrists and just it didn't happen. God didn't take me so obviously He's got a plan for me" (Emily).*

> *"…I climbed in the car, I don't know which field I popped in, but I started swallowing pills" (Michelle).*

"….I was so stressed that I wanted to hang myself. However, I did not have the guts to do it and I did not continue" (Natasha).

The above excerpts emphasize the need for substance abuse treatment and aftercare services to assist recovering drug users realize their sense of worth and their purpose in life. Clearly, female recovering drug users go through many life challenges and stressful situations during their recovery. Affirming and helping them to cope were mentioned as important and beneficial services for recovery. Weaver, Turner and O'Dell (2000) also discuss stress and ineffective coping as requiring monitoring during recovery.

During aftercare female recovering drug users reported going through different emotional and psychological experiences. Some of the negative emotional experiences mentioned were the following:

"I am going through a very bad depression. But I will get out of it" (Emily).

"I struggle with my moods, today I am in a good mood and tomorrow I am not. Maybe it's because of having to face reality now. With drugs I was always high but now I have to face my challenges while sober" (Cynthia).

"What triggered a relapse is that going to my doctor, any woman has a problem with weight gain. So we went to my doctor and I asked him to prescribe me some sort of diet pills needless to say these diet pills had ephedrine in them. My body tested it and it wasn't even a month later I was using again" (Michelle).

Throughout the interview, Emily showed resilience towards her life challenges. Whenever she mentioned challenges in her life, she always appeared determined about overcoming them. This is something that could have been learnt during aftercare. The fact that during group sessions there were other recovering drug users who had been clean for a long time could have assisted participants in maintaining a positive attitude. This is because they could see that there were other people who overcame similar challenges. Being sober was something that was a distant memory and this could be the reason why they struggled to control their emotions and moods as drugs would usually do this for them. With regard to Michelle, here self-image and sense of worth had to be improved as discussed by Bello *et al.* (2011) in relation to cognitive factors in

relapse. This further elaborates the need to build on self-esteem and assertiveness in female recovering drug users during aftercare.

Female recovering drug users' thoughts were seen as important during recovery as they had an impact on triggers and relapse. Certain situations like being alone in the house were perceived by the female recovering drug users as triggering relapse. Another common phenomenon mentioned by the participants was having dreams of drug use. They said the following:

> *"I think it's situations like the daily situations that you go through, if you get up in the morning, and if it's (drugs) the first thing that comes up to mind, think of something else. Don't entertain that thought because if you keep on entertaining that thought, it reminds me of drug use" (Cynthia).*
>
> *"If I'm sitting alone in my room just for example and the tv is on and somebody in that movie is using, then that thought of a memory will like kick back on what I used and who I was using with and then it gives me, it's like a bad feeling on the inside" (Hazel).*
>
> *"I have, I won't call it a nightmare but I do have dreams of using, and with that I take it into a positive note that with my dreams, it just gives me a reminder of what my life used to be like and I won't turn to that life again" (Natasha).*

From the excerpts, it can be seen that triggers were common in the lives of the female recovering drug users. This therefore indicates the need for females recovering to be mentally equipped during aftercare to be able to resist the triggers to drug use. I will discuss activities to address triggers later in this chapter when discussing lifestyle after treatment. The female recovering drug users had to be kept motivated in their recovery as Bello *et al.* 2011 in their study in the Philippines found regarding the role of motivation during relapse.

4.6. SOCIAL FACTORS AFFECTING RECOVERY

I will divide this theme into environmental factors affecting recovery and family and relationship factors affecting recovery.

4.6.1 Environmental Factors Affecting Recovery

Female recovering drug users had mixed opinions on how the community reacted to the fact that they were recovering drug users. Some participants in my study stated that the community was mean to them while others highlighted support. These were presented through the following statements:

> *"You know, some of them* (community members) *don't react the way I want them to, they still label you as a substance abuser or whatever you used, they don't have faith in you, they say she went through rehab and all of that and she will fall back again" (Emily).*

> *"At church they know that I am a recovering addict and they support me. Other members of the community however still judge me" (Cynthia).*

> *"They* (colleagues at work) *were aware when I came into treatment so they were very supportive of that. They only know that I am a recovering alcoholic. They have not at all sort of discriminated in any way. You know, they were supportive of the treatment" (Gladys).*

The above statements suggest that community members react differently towards the rehabilitation programmes. In communities like Emily's community; drug addiction seems to be stigmatized. Myers *et al.* (2009) also noted that in disadvantaged communities in South Africa, stigma regarding drug use was worse towards women than men. This makes it challenging for female recovering drug users going back to the community to reintegrate well into society.The results of my study therefore may be an important resource for communities to gain insight on the world of recovering drug users and the effectiveness of aftercare programmes. It is important to note that not all communities are unsupportive towards the recovering drug users. Church and co-workers were mentioned as supportive towards the recovering drug users.

There were a lot of triggers in the community that prompted relapse, friends being one of them. Due to the recovering drug users staying in the community where they were using drugs, they also knew where to easily access drugs. Thus the presence of friends who they were using with

and drug dealers were a huge trigger for female recovering drug users. Participants in my study stated that:

> *"There is plenty friends that live around me that come driving past that I used to use with so when they drive past it also gives me that thought of using so I try and stay inside or I am not in the area" (Hazel).*

> *"Well no I erased it* (numbers of the dealer) *when I got out of (name of research site) but it was so strange because the second week I was craving so much, I am still staying where I used to stay when I was using, but we changed a lot inside the house, I was walking and I saw him* (the drug dealer) *coming on the other side and I was craving so badly, and I am thinking by myself, you know, maybe I must just ask him, nobody will know" (Cynthia).*

I found that living in the same surroundings one was staying before abstaining from drugs made it challenging for clients who were in recovery (Maehira *et al.* 2011).Seeing the person who was selling drugs to you is devastating and it needs a sound mental strength to overcome it. Cynthia however managed to overcome the temptation as she thought of the past and where drugs had taken her.

One of the participants of the study mentioned that at NA meetings they were taught to be responsible, productive members of the society. When asked about this, participants generally declared that they were better members of the society than during addiction. Some participants declared that:

> *"I am a productive, responsible member of society. I got arrested in 2013. I was speeding* (giggles). *Stone cold sober on my way to work in the morning, they arrested me for speeding. So yes, I now try not to go too fast in my car, not as fast as I was then and I haven't been arrested since so yes I am a responsible productive member of society" (Michelle).*

> *"Currently I am a volunteer at a humanitarian organization since I do not have a job yet. I do this in order to keep busy and not think about drugs, and also so as to help other people" (Cynthia).*

Fortunately, during recovery the participants in the study had vowed to be better members of society and stick to the rules of society. Chen (2006) in her study in Israel found that drug use contributed to crime, so it is positive when recovering drug users commit to sticking to the law. This highlights that the female recovering drug users wanted to make amends with the community/law and stay positive and productive during recovery, with another participant also volunteering at a humanitarian organization. Participating in community activities and giving back may also assist recovering drug users to overcome boredom. This shows that aftercare can have some positive effects for the society as well.

4.6.2 Family and Relationship Factors Affecting Recovery

The social workers during the focus group discussion emphasized the value of family in the recovery process. They argued that not involving the family may contribute to relapse.

> *"During every assessment it is compulsory that they have to bring somebody with them to the assessment because we know that the drug or alcohol users may not always give us a full interior account of what is happening… also we know that having a support system as part of their treatment program is vital for their recovery if they want to do it their own, their chances of relapse is much higher so we always have some significant other in the assessment process" (Portia).*

The social worker's statement that drug or alcohol users may not always say the truth highlights a judgemental attitude, something which is against the ethics of the social work profession as clients should be viewed as unique and be treated with dignity. However, the social worker might have adopted this attitude due to several experiences she had working with different recovering addicts.

When asked who constituted the support system of the female recovering drug users, the social workers stated that the support system encompassed people who were close to the recovering drug user and it was not just the family members. According to the social workers:

> *"… often it would be someone who is always living in the household with them so if they are living with their wife they will bring their wife, if they are living alone they will bring whoever maybe a brother or a friend, if they are still living with their parents they*

will bring their parents. They will bring someone who they feel they still have a relationship with and they trust enough to be part of the process" (Ashley).

"It depends, sometimes it (support system) *can be an employer, it can be a religious institution, it can be a church, it can be the family" (Laurencia).*

Having someone they still had a relationship with as part of the support system is important as the person may be patient enough to travel the road of recovery with the recovering drug user. The support system is not always about blood ties as in recovery family may be seen as anyone who supports the recovering drug user in their life (Centre for Substance Abuse Treatment 2004).

During the interviews, the female recovering drug users highlighted they were receiving support from their family. They however, discussed in detail that their mothers were assisting them in their recovery. Only two participants mentioned receiving support from their fathers. The following excerpts from the transcripts attest to this:

"When I finished my programme (treatment programme) *my mother came here to pick me up. The look on her face, she was proud of me, because I made it through my 28 days" (Cynthia).*

"My parents support me in my recovery. I do speak to my mum; I let her know when something is wrong so that she can take my mind off a bit. My mum likes to take me out of the house during the day, she makes me take her to shopping just to get my mind out of the bad thoughts (smiles)*" (Hazel).*

"I phoned my mum, I still remember shame, I said to her, "mum I have been using again," she said "Oh God, Michelle why again? I thought we were over this." You know she had heard this so often, I could hear the disappointment in her voice. That's when she brought me for rehab" (Michelle).

From the extracts it can be seen that female recovering drug users cherished the support they received from their mothers. As highlighted above, female recovering drug users only discussed about support from their fathers in little detail. This could be an interesting avenue for research

to find why female recovering drug users rarely referred to their fathers supporting them. Michelle and other female recovering drug users said their family had referred them for treatment. This is in line with literature that states that in South Africa family and friends mainly referred people for treatment (SANCA National Profile of Clients in Treatment Fourth Report: April 2008 – 2009 (2009); Temmingh & Myers 2012).

Participants stated that before treatment they usually had strained or no relations with their families. During aftercare however, recovering drug users also started to see how loving and supportive their families were. Now that recovering drug users were sober, they had time at home to see the positive side of their families. Only Emily stated that she did not have a good relationship with her family during aftercare. Selected participants stated that:

> *"I don't think they* (my family) *could live with me and my drug using anymore, I think it was getting a bit too much for them to handle me disappearing for a few days at a time, not taking care of my daughter properly, not pulling my weight enough. Well because it was almost like a you get clean or we write you off story" (Natasha).*

> *"I currently have a good relationship with my family but it was not always like this. In addiction I was really a bad girl and we were always fighting" (Cynthia).*

> *"My support system is my daughter. She is very mature for her age. And my fiancé. And, not my mum and my sister and them, I haven't even seen them since I came out (of treatment) because I was labeled as a black sheep of the family so they don't really care about me up until today but I don't mind because I got my children and I got (name of fiancé) and then Ashley* (social worker) *here at* (name of research site) *and I've got a couple of friends I made here, when I was here" (Emily).*

This clearly shows that substance abuse recovery is a process and it is not just a one day accomplishment as most female recovering drug users alluded they had tense relations with their families during addiction but the relations were good during aftercare. Relations between family and recovering drug users might improve during aftercare as the female recovering drug users were now sober and spending more time with family.

The female recovering drug users stated that their relationships with their partners were good and the partners supported them in their recovery. In some instances, even their in-laws were supportive towards their recovery.

> *"My relationship with my fiancé is good, he is very supportive. He also used* (drugs) *but he is 6 years clean now. He used before I met him. My fiancé also comes to family meetings" (Emily).*

> *"My husband's family are very big (in supporting her). They were both at my year (celebration of being clean for a year), my husband's mum, my brother in law, and my sister in law were all also there at my one year" (Michelle).*

The fact that Emily's fiancé had been sober for the past 6 years could have motivated her in recovery. The fiancé's support could be due to him understanding how the road to recovery is. All the participants in the study stated that their partners assisted them positively in their recovery. Some of the participants however still had relationships that had lasted only for a short while. Michelle could have been supported by the family of her husband as there was also a history of substance abuse in that family. The support could have assisted Michelle in her recovery as recovering drug users need a lot of support during recovery.

However, it should be noted that with relationships it is not always positive when it comes to recovery. One of the participants in the study mentioned that when she relapsed, her husband was furious.

> *"My husband said to me the first time that they came to visit me here* (during treatment), *they were both in the parking and he was fighting with my mother. He said "she is not my problem, why do you keep making her my problem?" (Michelle).*

This could have been because the husband did not use drugs and had a bad history when it came to drugs as his father also used drugs and was abusive towards him and his mother. Michelle stated that she attempted suicide after seeing how her husband reacted after the relapse. This shows that partners are vital in the recovery of female recovering drug users.

Friends may also affect a person during recovery. They may influence female recovering drug users to relapse. One of the participants explained her relapse as being influenced by "bad friends". Participants in the study also highlighted that they were no longer friends with their old friends because they were no longer using.

> *"Bad friends. It was actually one of the girls that I was actually in treatment with. And a couple of guys that made part of the meetings as well and we decided to go to* (name of pub)*... So we ordered vodka, because we were still gonna go to the meeting and then they are not gonna smell it" (Michelle).*

> *"My old friends that I used to use with, they don't speak to me anymore, they think that now I'm an outsider, but the families, the people that didn't use, they do see a difference in me, that I have picked up weight, I look different, I' m more friendly" (Hazel).*

> *"I sat across the table from this man that was my best friend for like almost 10 years and I did not recognize him..... I had said to him before that I am clean and sober now.... He said to me you can have something to drink* (alcohol)*... And he pulled out a bag with white powder in it and he put it on the table. I looked at him and I said to him, 'please put that away you are making me feel uncomfortable'" (Natasha).*

This highlighted that at times friends in recovery can also influence negatively female recovering drug users. So what is needed in aftercare is the mental strength to be able to resist such temptation.

Hazel declared that she met some friends in recovery and they helped her positively in her recovery. She argued that:

> *"I met these four friends inside of here* (research site)*, we stay in contact. We actually go to NA meetings together every Tuesday night, every Thursday night and every Friday night and we attend aftercare every Wednesday" (Hazel).*

Michelle had a relapse on alcohol while with friends that she was attending aftercare with. This then should make us wary as Hazel was still in the early stages of her recovery and the positive impact of having friends who were also in recovery cannot be hastily concluded. Female

recovering drug users therefore need to have a strong mental strength to overcome temptations from friends.

4.7 SPIRITUAL FACTORS AFFECTING RECOVERY

To conclude the biopsychosocial-spiritual frame supporting my study, I will conclude by discussing spiritual factors affecting recovery. During the focus group discussion, one of the social workers stated that they provided spiritual programmes through the twelve step program. The female recovering drug users also confirmed that they were benefiting spiritually from the aftercare groups. It should be noted however that only one participant did not perceive the twelve step programme offered at the centre as spiritual. Selected excerpts in this regard state that:

> *"We support the 12 step program which is Narcotics Anonymous and Alcoholics Anonymous and part of their program is talking about a higher power which means that part of them attending the twelve step program is they have to start working on building a relationship with a higher power. We also support that because we treat patients holistically, their physical, mental, social, spiritual and all of that. ...We would support any religion that they choose except Rastafarianism and Satanism" (Portia) – social worker.*

> *"Yes I am a spiritual person, I was not before. But through my recovery, I think the spiritual aspect is very much a part of Narcotics Anonymous. I wouldn't say I'm very spiritual but a lot more than I was before and I keep working on that spirituality because that does help me" (Gladys) – female recovering drug user.*

> *"No no* (it's not spiritual), *the twelve steps, they tell you the first three steps is surrendering… I take it that you need to apply it daily. But for me that's (12 steps) just the guideline, but for me it's only God that can help you" (Emily) – female recovering drug user.*

During the focus group discussion, the social workers were not comfortable discussing spirituality. There was a moment of silence when I asked them about their spiritual involvement. The researcher had to ask the question for the second time. Portia was the one who broke the ice. As mentioned by the social worker, the provision of the spiritual programmes was important and

it aligned the programme of the organization with the biopsychosocial-spiritual model which was the theoretical frame I was using in my study. Miller *et al.* (2011) refer to the twelve step programme as being based on spiritual principles and a higher power. The extract from Gladys endorsed the importance of the twelve step programme in fostering aftercare, as at NA they were using the twelve step programme. Emily however, perceived the twelve step programme as not being spiritual and this could be due to her conception of spirituality. She declined that the twelve step programme was spiritual though she alluded that during the first step you are surrendering to the notion that you cannot overcome your addiction alone. You need a higher power. From the discussion above, one can safely argue that the social workers could have been against Rastafarianism due to its supposed link to drug use.

A common finding of my study was that female recovering drug users mentioned that since they started recovery, they were more spiritual and attending church frequently. Participants perceived spirituality as being beneficial in their recovery. They stated the following:

> *"I do attend church every Sunday since rehab. I go to church with my family. From childhood I was going to church regularly with my parents, I only stopped church when I started doing drugs" (Cynthia).*

> *"It* (going to church) *does give me a spiritual uplifting for my week ahead. It helps me believe in my higher power and knowing that I can speak to Him with any problem that I am facing, maybe if I can't speak to a relative about it, I know that He is there with me and for me" (Hazel).*

> *"It's* (spirituality) *helped in that when I do have those stressful periods I remember that drugs will help me feel better. The spiritual side sort of also reminds me that whatever I am feeling right now is only temporary" (Natasha).*

As discussed earlier, recovering drug users usually reach a difficult experience before considering quitting drugs, which may lead them to seek strength from spirituality as discussed by Kasiram and Sartori (2015). All the participants in my study stated that they became more spiritual during recovery. Laudet *et al.* (2006) as discussed as discussed earlier, in their study found that spirituality helps reduce the level of stress. It can be concluded that participants in my

study, both social workers and recovering drug users perceived spirituality as a positive aspect of recovery.

4.8 LIFE AFTER SUBSTANCE ABUSE TREATMENT

After long term substance abuse treatment, inpatients had to go back home and start living life in an environment almost similar to the one where they were using drugs. Outpatients on the other hand continue staying at home so it can be assumed that during aftercare they would have adapted better to staying at home. Social workers perceived boredom as a big trigger for relapse during the time after substance abuse treatment. A female recovering drug user also stated that after treatment money was a big trigger for her. They stated that

> *"Boredom is a very big trigger for craving, so we know that they need to keep as busy as they possibly can for each day. Depending on where they staying and what their circumstances are, they must do activities unique to their interests and to their situation. They can't be socializing 24hrs a day, they also need to have self-reflective time, spiritual time, recovering time which then it would be attending aftercare meetings. So we would help guide them on a tailor made plan for them" (Ashley) – social worker.*

> *"Money was one of my big triggers so what we did in the beginning, is that my husband would keep my bank card and I was not allowed any cash on me. If I did take cash to go and buy a loaf of bread or milk I would bring the change plus the slip back and it would all be calculated" (Michelle) – female recovering drug user.*

> *"I started to read again, I started to pray again. The more I read God's word, the more I renew my mind" – female recovering drug user.*

Recovering drug users need to always have something to occupy their mind especially when they are not in company of others. Boredom may lead them to start thinking of different cues that may lead them to relapse. The social workers asserted that the recovering drug users needed to learn new habits as well as revert to healthy old activities they conducted prior to drug use. SANCA Vaal (2015) suggests that recovering drug users needed to get new ways of relaxing and having fun as they would have dropped the drug using behaviour. As will be discussed later in this

section, it can be seen that participants in my study reported having different activities they conducted throughout the day as a means to keep occupied and prevent themselves thinking about drugs. With Michelle being triggered by money, it was important that the significant others were strict with her when it came to money. Having a support system that is stern is positive for recovery as addicts are viewed as manipulative. The strict measures could be the reason why Michelle had been sober for so long.

The female recovering drug users deliberated on different lifestyle changes made during recovery. The participants discussed reading the Bible and different books, they cooked more often, no longer listened to certain types of music and watched movies. Two participants also highlighted they were studying for their degrees. The following excerpts present some of the coping strategies they use to deal with recovering challenges:

> *"I struggle to sleep but I don't want to take medication. I am trying to drink hot milk before I go to sleep or tea or something, I don't watch horror movies anymore because it works on your conscience. In treatment they had an activity which you do for relaxation, your breathing, you do your breathing exercise to relax yourself. So I am trying to do that before I go to sleep at night" (Emily).*

> *"I get up and I make coffee in the morning and I have breakfast, I didn't do that. I only had something to eat like 11 o'clock in the morning. Now I'm starting to have breakfast, I go to bed at 10 o'clock, where sometimes I didn't sleep for 4 days during drug use, so my body was so used to that… I go to the gym as well so it's good" (Cynthia).*

> *"I am not listening to the music I used to listen anymore. I was listening to trance music, and r n b, and you know, getting into the mood music* (laughs). *You know listening to the radio is fine but not constantly listening to that" (Natasha).*

> *"I am currently studying towards a business degree and I get big reward out of doing those things. Doing things for myself and feeling that I am adding value to people around me" (Gladys).*

From the extracts it can be seen that the participants were conducting activities that would occupy their time and this might have been positive to avoid boredom discussed earlier by the

social workers as a trigger for relapse. Participants engaged in physiological exercises at the gym, and reading might have helped in their mental strength; socially they changed their type of music and movies, and lastly spiritually they were now praying and reading the Bible more. This shows that the female recovering drug users intended to improve their lives holistically in terms of the biopsychosocial-spiritual aspects of recovery. A study conducted by Dennis *et al.* (2007) found that a long period in recovery assists the recovering drug user learn coping skills. The different activities conducted by the female recovering drug users might be coping mechanisms that strengthened them in their recovery. Listening to the music they used to and movies could trigger recovering drug users into thinking of the period of drug use thus the participants in my study were doing a positive thing in relapse prevention by changing their lifestyles.

Overlapping with the section on social factors affecting recovery that I discussed earlier in this chapter, many participants stated they had to let go some of their old friends. Participants had to let go their old friends who were using and the period after substance abuse treatment entailed that it was a period to make new friends. The participants attested that

> *"I had to let go of a lot of friends which I don't speak to anymore, I am off the social networking, I had to change my number, I had to get two restraining orders against my ex-boyfriend" (Hazel).*

> *"I met my boyfriend after I got clean, and we've been together for about 3 months so I've been making friends with his friend's girlfriends for example. So it's like just people that I know through him because I know he doesn't smoke anything, he doesn't even smoke cigarettes, he doesn't drink, so I know his friends are obviously not gonna pull me back down into the drug world again" (Natasha).*

This could have been a challenging part of recovery as the female recovering drug users had to stop befriending people they had been close to for many years. This was a positive step towards recovery however, as friends that were using could pull them back into drug use.

4.9 MOTIVATION, BENEFITS, CHALLENGES AND IMPROVEMENTS FOR AFTERCARE

4.9.1 Motivation to Remain Sober

The recovering drug users when asked why they were motivated to stay clean highlighted that it made them happier and more positive in life. Being clean for the sake of their children was also a popular response during the interview. Participants said:

> *"I don't ever want to feel as bad as I felt when I was at the end of my using. I saw no purpose for my life, I felt, I was depressed, I felt unhappy, I don't know when last I felt happy in my life when I was using" (Gladys).*

> *"I am more happier without drugs than what I am in the drug life and I have a 4 year old boy that needs mummy, there is my biggest reason, is my son" (Cynthia).*

> *"One day I would like to be a mother and I don't want to be a mother that's using drugs. That's one of the reasons that keep me going" (Michelle).*

Social workers stated that during drug abuse, drug addicts are usually "selfish" and they neglect their children. The reason why female recovering drug users wanted to stay clean could be to make up for the time they did not spend with their child. According to a study conducted by Grella and Rodriguez (2011) in California, women involved in child welfare services were more motivated in aftercare. Children were the reason why females were motivated to participate in aftercare as four of the participants in my study mentioned children as their motivation to stay clean. Thus it can be deduced that the happiness female recovery drug users experienced during recovery and their children were huge motivators for recovery. Having flashbacks of life they used to have while still addicts was a constant motivator as the participants in my study frequently mentioned its importance in their recovery.

One of the participants in the study had a cousin who had been clean for three years. She stated that seeing the achievements made by her cousin made her motivated in recovery. She said

> *"I have my days when I feel like I am going nowhere slowly… And then I think, look how far she* (her cousin) *has come in the 3 years she has been clean so if she can do it what's stopping me" (Natasha).*

The cousin was the role model of the participant to stay clean. They appeared to be close to the cousin and they may have used together before. Thus the cousin may be a souvenir to show the participant that staying clean for long is possible.

4.9.2 Benefits of Attending Aftercare

During the focus group discussion, one of the social workers mentioned that aftercare was important as it provided continuous care for the recovering drug users who had used drugs for a long time, thus also in need of long term treatment. Aftercare also assisted the female recovering drug users in staying clean as there were random drug tests so they wanted to remain clean to have negative drug tests. Extracts from the transcripts state that

> *"…they come to treatment for a month, we start the process of change but they may not have in those 4 weeks been able to deal with all the traumas, to deal with all the self-esteem issues, to deal with all of their thought processes, how they handle emotions so they are ready enough to go face the world but it's an ongoing process of dealing with things that happened in the past" (Lindsay) – social worker.*

> *"It's* (attending aftercare) *helping me by staying clean because I know I get tested here regularly. Listening to the classes that the social workers are giving us every Wednesday does help give a reminder on staying positive and keeping clean for today" (Hazel) – female recovering drug user.*

This further affirms that recovery is an ongoing process, therefore highlighting that aftercare is important for the continuation of the gains of treatment. The social workers also alluded to the fact that aftercare helped in making the participants *'keep on their toes'*. The random drug tests therefore would appear to be a constant measuring stick of progress in recovery. According to Perkinson (2008) dropping out of aftercare is the reason why many recovering drug users relapse during the first year following substance abuse treatment. Thus it can be noted that both the social workers and recovering drug users perceived aftercare as important in helping the recovering drug user stay on the path of recovery.

Concerning the benefits of aftercare, participants in the study stated that aftercare helped them talk about things that happened in their lives, which could be an important part of therapy. They stated that

> *"Aftercare, will give you a chance to talk about things, a lot of the therapy has been not so much about the drugs, it's been about other things in my life, and that has helped as well to deal with those other issues" (Cynthia).*

> *"When I am feeling down I can pick up the phone and call the therapist or the matron. The door is always open" (Natasha).*

This helped in recovery as recovering drug users may not have had people to confide in during recovery and being able to talk to other recovering drug users and staff members assisted them positively on their recovery. Several times the participants of the study mentioned they also involved the medical staff when they wanted someone to talk to, referring to the medical staff as "caring and nurturing." This shows that the level of work ethics and motivation to serve at the organization was high as staff members were always willing to assist recovering drug users thus aiding to the aftercare. This made aftercare to be perceived as beneficial.

Participants of the study mentioned they were benefiting from the classes provided during aftercare. When asked about this one participant stated that

> *"Well, I think it's* (aftercare) *quite effective because the therapists that hold the meetings rotate and there is always a different topic of discussion and what they also do is they will ask us is there any sort of topic that we want to discuss so that they can prepare for it for the next week for example" (Natasha).*

The fact that therapists rotated for aftercare could have provided the recovering drug users with lessons from therapists who had different strengths and perspectives. This could also have helped in keeping the recovering drug users keen to participate as having lectures from the same facilitator every week may become monotonous and cause drop out.

During the focus group discussion, a social worker in addition to what was stated by the female recovering drug users stated the benefits or improvements their clients acquired during aftercare.

She mentioned different areas of improvement including dealing with emotions and also finances. She said

> *"Improvements might be maintaining sobriety, balancing their lifestyle because we can see improvement with them when it comes to that as well. And then mental clarity where they know how to deal with their emotions. So with improvement I can say even financial stability, because now they are not drugging, so their finances its being budgeted in a good way, improving with their relationships as well at home with the loved ones, with the family members where they now spend quality time with them unlike before, so those would be some improvements that we see the most with our female aftercare patients" (Kayla).*

This was a summary of the benefits of aftercare from Kayla and it was important as it highlighted the perceptions concerning the effectiveness of aftercare programmes, the core of my study. These were several benefits of aftercare that the recovering drug users desired to acquire. The above assertion by the social worker mainly covers the psychosocial aspects of recovery however, as the biological and spiritual aspects were not included.

4.9.3 Challenges Faced During Aftercare

Female recovering drug users face many different challenges including none attendance. The social workers during the focus group discussion also argued that some female recovering drug users stayed far from the treatment centre and could not attend aftercare. Transport was a challenge the female recovering drug users faced as asserted by the social workers. A female recovering drug user also argued that she did not attend aftercare as much as she would have loved to due to different responsibilities she had. Below are some of the statements mentioned by social workers and female recovering drug users as contributing to their challenges:

> *"It is not always possible for each person who finishes the programme* (treatment programme) *to attend. We sometimes get patients who come from a different province which makes aftercare impossible for them to attend. Sometimes they do get a new job and they move somewhere else so if they do decide after 3 months to stop attending because the circumstances have changed or they just decide to stop attending because they are 'cured' we can't forcibly request them to attend" (Ashley) – social worker.*

> *"Our aftercare group sessions are in the evening, we run it in the evening 6 to 7* (pm) *so sometimes lack of transport contribute to low attendance" (Portia)- social worker.*

> *"…Their children have also been affected and I think especially with the aftercare in the evening if they have little children or they are single parents that is also difficult for them to attend sessions. Now having to be a parent and the guilt feelings of many years they weren't being a very good parent" (Kayla) – social worker.*

> *"I attend aftercare not as much as I should be, I see Lindsay* (therapist) *more than I do NA meetings. This is because of my studies, unfortunately life is too demanding with everything that I have got going to attend aftercare" (Michelle) – female recovering drug user.*

The social workers however stated that when someone stopped attending aftercare, they organized a session with the person to establish the reasons the recovering drug user stopped attending. Distance could genuinely had been a reason someone stopped attending aftercare as aftercare was in the evening and people could have had different responsibilities to attend to. As the female recovering drug users will be back in society for long now, they might have had many responsibilities to take care of for instance raising their children. Lack of transport was also a challenge as female recovering drug users would need a private car to attend aftercare due to the location of the centre. Though the time for aftercare was not conducive for some female recovering drug users, aftercare groups had to be done in the evening as most of the clients were at work during the day and also, social workers were working with inpatient and outpatient clients during the day.

The social workers also mentioned challenges with regard to work and family. One of the social workers stated that:

> *"Maybe they* (female recovering drug users) *are unemployed and looking for work or they are not adapting in their current job and they have to face the environment as a sober person and worried about other people's perceptions of them. There is also family issues were it's often their relationships have been strained from the drug use so it's about repairing those relationships" (Lindsay).*

Some of these challenges have been discussed earlier. Because the female recovering drug users were now staying in the community they faced many challenges while they were sober hence the need for aftercare.

Challenges also noted by the social workers included challenges with relationships and children. Female recovering drug users also confirmed this. Participants in my study, both social workers and female recovering drug users alluded to this.

> *"…if they are single they often want to find a partner, if they have a partner that they had while they were using, there are often a lot of trust issues and a lot of challenges" (Lindsay) – social worker.*

> *"It was difficult to say goodbye to my ex-boyfriend after 4 year relationship" (Hazel) – female recovering drug user.*

During drug abuse, relationships may be strained due to different problems brought about by addiction. Leaving a partner one was having during addiction was also a challenge as the female recovering drug users were used to their partners. However, female recovering drug users had to leave their partners in order to avoid relapse. This highlighted the commitment female recovering drug users had to their recovery.

Due to the fact that female recovering drug users had to go back and stay with their families, social workers saw this as a challenge as female recovering drug users could access drugs. One of the social workers stated that:

> *"Remember they are now aftercare and they are already outside back to their families so obviously they are still staying in the same location, the same community where they can access the drugs from" (Laurencia).*

This was a challenge as the recovering drug users would know exactly where to find drugs should they not withstand the longing to use again. This has been discussed earlier.

Other challenges that were mentioned by the social workers in evaluating the effectiveness of aftercare programmes were the psychological beliefs recovering drug users had. They stated that recovering drug users wanted immediate gratification and also after treatment they had the

perception that they were "cured", perspectives that could hinder progress during aftercare. Social workers stated that:

> *"My perception is that it is not specifically the aftercare that is the problematic factor, the problematic factor is that we are working with addicts. Part of the addicts is they want immediate gratification. They don't want to work for things. So in terms of aftercare the ones that will continue to attend will be the ones who are motivated, who genuinely want to make the life change and are willing to put in the work that it takes" (Lindsay).*

> *"I think the reason why there would be poor attendance in aftercare, or relapse in aftercare is unfortunately because addicts often think I'm feeling fantastic, I have done my month time, I will be fine now, and what happens is they start losing self-awareness, they think that they can do it on their own" (Lindsay).*

The assertions above may then give the picture that since the participants in my study were long into their aftercare programme, they were the motivated group and they viewed aftercare positively as those less motivated could have dropped out of aftercare already. It is however an intuition, that was not possible to investigate considering the scope of this study. In my study I only had female recovering drug users already long into the aftercare programme and this may hint that they might not have been after immediate gratification as they already stayed long into the aftercare programme, making it difficult to conclude on the perception of the social workers. The affirmation by Lindsay however, shows social workers had positive belief towards the aftercare programme they were offering.

Finance was one of the challenges cited:

> *"I am worried, still finances, work, my health. Finances are always the big thing, I mean it's like that in any household. I'm worried about my dad as well, my dad had a stroke about 2 months ago, then he has got emphysema" (Gladys) – female recovering drug user.*

"Financial aspects always feature, with the recession or whatever the case may be in terms of them budgeting because they often have a lot of debt and they have got a lot of loans that they have to pay" (Portia) – social worker.

Finances as a challenge may have been related to recovering substance users having debts before going for treatment. Financial problems may result in many other challenges for example physical problems due to stress, social problems due to fights with significant others and so on. Gladys had stopped using drugs and had time for family, this could have been the reason why she was worried about her family as that attachment to family became strong again.

Trust issues were also cited as another challenge:

"In the beginning you can't just open up because I don't trust anybody that I see, I used to but not anymore, because people stab you in the back. And the more they know about your past, it's like they've got something against you" (Emily).

"I don't have very many close friends. I do have some friends, and there are a number of people that I have met through narcotics anonymous that I see socially, I think I don't trust people very easily, and so I find it difficult to make close friendships" (Gladys).

Opening up in the early stages of aftercare may have been difficult for the recovering drug users as they needed to bond with the group first. This could have been as a result of the aftercare groups having some people who were already long into their recovery so the females still in the early stages of recovery could have felt intimidated to join and just start opening up especially to people they had not been in treatment with. Trust issues may also have been a struggle due to the different life experiences female recovering drug users went through during addiction. Female recovering drug users could also have had challenges forming new friendships as the community was perceived as having stigma towards them.

To add on to the previous discussion, Gladys when asked about her challenges during aftercare stated that stigma was one of her challenges. She said "*I still think there is a stigma about addiction, and I do have certainly still some feeling of shame about the way I behaved" (Gladys).*This hindered Gladys from freely associating with other people that were not in

recovery. This aspect of recovery has been discussed earlier but I included it in this section as well as it is a challenge worth noting. It can be noted that there were different challenges that could be evident during aftercare. The social workers and female recovering drug addicts both perceived varying types of challenges during aftercare.

4.9.4 Improvements for Aftercare

When it came to improvements needed for aftercare programmes to be more effective, one of the social workers discussed that the family needed to be more involved in the course of recovery of the female recovering drug users, a concern expressed earlier in the study. She stated that:

> *"Maybe if families can be involved throughout the programme (aftercare), because what I realized, they get tired along the way to continue supporting them* (recovering drug users) *and coming with them for family sessions because they* (female recovering drug users) *like it especially when we have individual sessions where we also involve them to come, they like that our female patients" (Lindsay).*

Duffy and Baldwin (2013) also asserted that families are not usually active in attending therapy because either they do not want to participate or the recovering drug user does not want to involve the family. This was a challenge as recovery should not just be for the individual but the family as a whole.

After asking female recovering drug users what they thought could be improved in aftercare programmes, one participant replied that sometimes topics in the group were irrelevant. This may also had been a challenge for aftercare programmes but I decided to discuss it under this section as it could be an aspect that needed improvement.

There was also a concern about mingling recovering drug users with recovering alcoholics during aftercare. Participants stated that:

> *"Sometimes the actual group attendances here go a lot off topic. You gonna keep in mind that you've got a group of mixed addicts, and I call them that because each of our drugs of choices are different. And it's not to isolate a certain person but, you know, your alcohol and your drug patients are joint together in an aftercare" (Michelle).*

"I attend NA meetings because there its only people who were using drugs. With aftercare, there are also alcoholics and they might not understand what we (recovering drug users) *went through" (Emily).*

Michelle went on to give an example of an argument that took place between an alcoholic and a drug addict. Mixing with alcoholics during aftercare was a concern among several of my participants and this may also be because the participants were also used to attending NA meetings where there were just people who used the same substance as them thus they saw the advantage of being separate. Informing the facilitators that they were not happy that the groups at times went off topic could have been a challenge for female recovering drug users as they could have been scared of offending their therapists.

Michelle also mentioned a challenge female recovering drug users faced when it came to aftercare as being mixed with men during aftercare. She suggested that to overcome the challenge, males and females should be separated. She mentioned that:

"When it comes to coming into aftercare, I think a lot of women are too scared to speak up properly because they are worried about how men are gonna look at them. I do remember one particular session that we had here when I was here (during treatment), that was a women's only session. It was a very emotional session, that was something I feel that every women needs. So maybe a separate, on the side women's aftercare might actually be a good idea" (Michelle).

At the research site, aftercare was mixed for males and females. Michelle perceived that females were scared to cry in front of males for instance. This could have been a valid suggestion considering that some of the aftercare participants were dating each other. Separate aftercare may also provide females a chance to discuss female related matters. However, this may then translate that even facilitators (social workers) will have to be female also.

Another participant of my study also mentioned that she had some problems with times for aftercare. She suggested that they needed more time for aftercare. She stated that:

"We need more time with the social workers because an hour isn't enough with the people... Sometimes we don't get to actually do the activity that we come here for

because the social worker will ask "how are you" and "how are you" and "how are you" and by the time she finishes, there is no time for class. So we need more time. Even if it's half an hour more it will help because a lot of people get lost in how are you then they tell them the whole life story in that hour, it's not enough for us" (Cynthia).

She also added that aftercare should start at 7:00pm instead of 6:00pm as people were still at work at 6:00pm and some people worked far from the treatment centre. She gave an example of NA meetings that started at 7:00pm and she said there were always many people there. This may be a valid suggestion also as another participant also stated that one hour per week was not sufficient. Due to the challenges that female recovering drug users face in recovery, they may need a longer aftercare programme.

4.10 CHAPTER SUMMARY

This was a comprehensive chapter that looked at the different facets of the perceptions concerning the effectiveness of aftercare programmes. I discussed the contents of aftercare programmes being guided by the objectives of my study and the theoretical frame which was the biopsychosocial-spiritual model. The results of the study varied due to the different perceptions of the six female recovering drug users and the five social workers who participated in my study. From the discussion above however, it can be concluded that the general consensus among social workers and female recovering drug users was that aftercare programmes were effective. However, though aftercare programmes could have been effective in terms of different biological, psychological, social and spiritual factors; it could be seen that aftercare programmes had some challenges and some areas where improvements were needed.

CHAPTER FIVE
SUMMARY OF STUDY FINDINGS AND RECOMMENDATIONS

5.1 INTRODUCTION

This final chapter aims at summarizing the study findings and providing recommendations deduced from the collected data. The findings are discussed in relation to the objectives of the study. This chapter suggests recommendations for aftercare programmes for the society, policy, the social work profession (education and training) and for future research. The recommendations in this study are a combination of the knowledge derived from literature, data from the interviews and the focus group discussion that I conducted. Recommendations have been, in part, co-constructed with the findings from participants as the main objective of the study was to understand the effectiveness of aftercare programmes as perceived by the participants.

The chapter is divided into biological, psychological, social and spiritual factors affecting recovery consistent with the topic of the study. There are also sections on lifestyle during aftercare and the motivation, benefits, challenges and improvements needed to improve aftercare programmes. These categories have been informed by data received concerning perceptions on effectiveness of aftercare programmes for female recovering drugs users, the theoretical frame used in the study and the objectives of the study. There is also a final section on recommendations for future research as there were some emerging findings in my study that need further exploration.

5.2 BIOLOGICAL FACTORS AFFECTING RECOVERY

The researcher wanted to understand how social workers and female recovering drug users perceived biological aspects in relation to aftercare programmes. From the discussion with the social workers, it was found that the organization had a general consensus that addiction is a disease and is included in the mission statement of the organization. Moreover, the social workers provided varying and convincing reasons that addiction is a disease and they fully understood why it is referred to as such. This was important as, as discussed in Chapter 2, Van Wormer and Davis (2008) state that helping professionals should understand the biological

implications of addiction in order to assist recovering drug users. Therefore, with addiction now being accepted as a disease globally, it is encouraged that the social work curriculum in South Africa also starts acknowledging this and adjusting curricula accordingly.

In the study, genetic factors were perceived to contribute to addiction. This was evident as social workers participating in the study mentioned that they had provided treatment services to different members of the female recovering drug users' families. This perception was consistent with responses from the female recovering drug users as they too stated that addiction was a family problem as they had several family members who had a similar problem. This is consistent with literature discussed earlier about genetic factors contributing to addiction. Moreover, the social workers in the study were of the view that other biological, social and psychological factors also contributed to a person being addicted to drugs in addition to the genetic factors. Therefore, prevention measures may be necessary, specifically to family members of drug addicts, raising consciousness on the effects of addiction and the genetic impacts of drug use.

With regard to cravings, there were different perceptions from the participants with some participants highlighting they no longer experienced cravings, and the others stating they still experienced cravings. However, it should be noted that there was a general consensus among the participants that cravings were more severe during the early stages of recovery and declined in severity as time in recovery progressed. Since cravings lasted for a short time, aftercare programmes should focus on assisting female recovering drug users by teaching them techniques to overcome cravings especially in the early stages of recovery.

During aftercare, there was also the provision of medical services to the female recovering drug users. The participants highlighted that they had good relations with the medical staff whom they described as caring and nurturing. This was in contrast with what was argued by Stanbrook (2012) that health professionals tended to behave negatively towards recovering drug users. This was an important finding as provision of aftercare services which involved a multidisciplinary approach promotes the adoption of biopsychosocial-spiritual interventions. The finding contrasts with what was discussed earlier in Chapter 2 that previously in South Africa biological treatment services were provided separately from psychosocial treatment (Temmingh & Myers 2012). This holistic provision of treatment services, as was seen in affection participants had for staff,

suggest that staff should emanate from multiple disciplines. It is thus recommended that the DSD should include in the norms and standards for aftercare that treatment centres provide multidisciplinary intervention for aftercare.

There were also some health challenges that female recovering drug users stated they were experiencing as effects of drug use. Social workers during the focus group discussion however, did not mention these health challenges that female recovering drug users face. The female recovering drug users discussed many different physical challenges they experienced ranging from gall bladder problems, problems with joints and asthma. Though I may not have concrete scientific evidence that there was a direct link between abuse of drugs and the ailments female recovering drug users alluded to, it could be noted that the participants perceived the ailments as caused by drug use as before drug use they did not experience such health problems. Literature confirms that drugs cause physical damage to certain organs of the body and poor nutrition and hygiene during addiction may also cause health problems (Van Wormer & Davis 2008; Miller *et al.* 2011). It may therefore be fundamental for social work education to focus on biological aspects of recovery as the social workers appeared to have insufficient knowledge on the topic. There may also be a need for regular workshops to update practitioners in the substance abuse field on recent developments in addiction.

In summation, biological effects of drug addiction also call for biological interventions. From the focus group discussion conducted with social workers, it could be concluded that social workers tended to unconsciously neglect biological aspects of drug addiction as they rarely mentioned the biological aspects of addiction. This may be due to social workers traditionally focusing on the psychosocial aspects of social problems. Zastrow and Kirst-Ashman (2004) also highlight that social workers tend to neglect the biological aspects of addiction.

5.3 PSYCHOLOGICAL FACTORS AFFECTING RECOVERY

Social workers during the focus group discussion, argued that female recovering drugs users usually had experienced some form of trauma before commencement of drug use. The trauma was perceived to be ranging from childhood trauma, being raped, being married into an abusive relationship, miscarriages and abortion. This was consistent with the findings of Wechsberg *et al.* (2009) in Pretoria which found that female commercial sex workers who were using drugs had a history of physical and sexual abuse. This may be as a result of high levels of violence in South

Africa. Due to these different forms of trauma, the female recovering drug users were in need of therapeutic services to overcome these challenges. Social workers perceived that the female recovering drug users needed long term treatment, hence the need for aftercare programmes. Moreover, because partly the trauma may be caused by family members and during aftercare the recovering drug users stayed with their families, it made it more complicated for the female recovering drug user to overcome the post-traumatic stress problems. This therefore calls for social workers working in treatment centres to have expertise in trauma and family counselling. Also there is need for employee assistance programmes for the social workers as they deal with intensive cases that may lead to early burn out.

There were also a lot of cases of attempted suicide that were reported by the female recovering drug users. Some participants in the study stated that they had attempted suicide several times using means such as drug overdose and self-mutilation as per literature (Miller *et al.* 2011). However, it should be noted that in my study the participants were already in recovery when they attempted suicide.

During aftercare the female recovering drug users perceived themselves as stronger mentally and they were more positive about life. The recovering drug users also perceived themselves as having more self-worth and had found purpose in life. They had acquired resilience skills and were optimistic they would overcome the challenges they faced. This may be a positive outcome of aftercare treatment. Due to assertiveness and other psychological techniques taught to the female recovering drug users during recovery, they seemed to have realized their self-worth, thus no longer attempting suicide. It is important therefore during treatment for social workers to emphasize to female recovering drug users on their worth and purpose in life as during addiction addicts may perceive themselves as worthless, hence the thought of suicide.

The female recovering drug users reported negative psychological experiences for example depression and having a negative perception of self. Some female recovering drug users reported experiencing depression during aftercare while there was a participant that reported once relapsing due to insecurities about gaining weight. This too highlights the need for social workers to foster assertiveness and a sense of self-worth among the female recovering drug users. The female recovering drug users in the study complained of experiencing depression, suggesting the need for therapeutic interventions like the cognitive behavioural therapy.

Activities like relaxation techniques and hobbies that could lift their spirits and keep them busy can be very beneficial to them.

From the data it could be deduced that thought processes were perceived as playing a huge role in relapse. The female recovering drug users discussed that there were different situations and activities that would trigger the thought of drug use and re-use consistent with findings of Marlatt and Witkiewitz (2005) that during recovery, drug users may experience cues, urges and unconscious thoughts regarding the drug using behaviour they want to change. Dreaming about drugs and seeing people using drugs in movies were also seen as triggers for drug use. Though the female recovering drug users had dreams while using drugs, they stated that in the morning when they realized they had not used drugs, they felt relieved and happy. This shows that the female recovering drug users were determined not to use drugs again. It is recommended therefore that social workers help recovering drug users with relaxation techniques that they may do before going to sleep in order to have a fresh mind before sleeping. The support system should also be assisted with how to support the female recovering drug users after they had drug dreams.

5.4 SOCIAL FACTORS AFFECTING RECOVERY

The social factors impacting on recovery is divided into three subsections. The first one being the environmental factors affecting recovery, the second being family factors affecting recovery and lastly relationship factors affecting recovery.

5.4.1 Environmental Factors Affecting Recovery

There were mixed reactions about how the community reacted to the fact that the participants of the study were recovering drug users. However, most of the participants stated that there was a lot of stigma associated with being a recovering drug user. Discussions with some participants also suggested that the community may be more tolerant towards alcohol addicts than drug addicts. This was evident as one of the participants only notified her work colleagues that she was a recovering alcoholic though she was also addicted to drugs, and colleagues supported her well. The community members also may be portrayed as having doubts towards the effectiveness of substance abuse treatment as a participant in my study mentioned that it felt like the community was waiting for her to relapse. This warrants the need for society to be educated on

addiction and what it means to be in recovery. This may be important as people in recovery need support as suggested by Stanbrook (2012).

Since after treatment recovering drug users go back to their communities where drugs are still accessible, it was noted that there were a lot of triggers in their surrounding areas. Seeing old friends they were using drugs with in the neighbourhood was seen as a trigger for relapse and participants stated that they had to do their best to avoid their old friends. Being in the surroundings where they were using also meant that they knew where the drugs could be obtained. This is consistent with the findings of Maehira *et al.* (2011). The challenge for the participants was to avoid places close to where the drug dealer stayed and they also had to delete all contact details of the dealer. It is recommended that the government, treatment facilities or other stakeholders build more halfway houses for aftercare treatment. Clients may stay there until a point is reached when the social workers deemed it fit for the recovering drug users to go back home. It should be noted however, that there are a few registered halfway houses in South Africa, a step in the right direction in recovery.

Participants in the study stated that during NA meetings they were taught to be responsible and productive members of society with participants also discussing their intention in this regard as well. The Prevention of and Treatment for Substance Abuse Act 70 of 2008 as discussed in Chapter 2 states that aftercare should aim to assist recovering substance users with successful reintegration into the society, work, family and the community. Thus, it was the duty of the organization to assist the participants to adapt well into the community. According to the participants, they were settling well into the community because of aftercare. Society should be taught to cherish these positive steps that the female recovering drug users were taking to be responsible members of the society, and support them.

5.4.2 Family Factors Affecting Recovery

Addiction starts in the social context and ends in the social context and emphasis during treatment should be given to treating the social network (Van Wormer & Davis 2003; Van Wormer & Davis 2008). This shows the importance of involving family members in aftercare programmes. At the research site, there are family support groups weekly. Social workers elaborated that participation by the family was vital for recovery especially for female recovering drug users as they valued family involvement in aftercare. The involvement of families however

did not only start during aftercare as the family was involved from the early stages of treatment. However, the support system for female recovering drug users did not only include the family but also people from work or church for instance. Thus the involvement of different people who had a relationship with the recovering drug user would help the recovering drug user as involving the church could assist the recovering drug user on the spiritual aspects of recovery for instance. Social work education should therefore equip future social workers with relevant skills to involve different stakeholders in substance abuse recovery and also family counselling techniques and re-connecting with a support network.

A common trend in my study was that the female recovering drug users usually mentioned their mothers and their daughters as the main people supporting them in their recovery, fathers were rarely mentioned. It was evident that the female recovering drug users cherished the support they were receiving from their families and this could have been due to recovering drug users having more time to bond with family during abstinence. Men are generally believed to find it challenging to show their support, love and affection. Educating the society about substance abuse recovery and the need to support the recovering drug users may assist fathers to be more involved in recovery.

All participants in the study mentioned they had tense relations with their families during addiction but at the time of data collection, during aftercare, they all mentioned having good relations with their families save for one participant. This was consistent with was discussed by Miller *et al.* (2011). This further merits the importance of family aftercare groups so as to deal with the emotional challenges they all experienced during the addiction of the recovering drug user. Family counselling is also important in this regard as recovering drug users can apologize and relations can be mended.

5.4.3 Relationship Factors Affecting Recovery

In this section I will be looking at both romantic relationships and friendships that affect recovery. Participants in my study usually mentioned that relationships they had with their partners were positive for recovery. Some partners also attended aftercare family support groups. Social workers should have regular couples counselling sessions as one of the participants stated that she once attempted suicide after fighting with her husband. Because partners will be supporting female recovering drug users, if they fight, this could be challenging for the female

recovering drug user to deal with as they would have lost a pillar of strength. Having a partner who had a history of addiction was seen as positive as the partner would have an idea of what the road to recovery entails and would accordingly support the recovering drug user. However, it should be noted that a partner who is still in his early stages of recovery is usually not recommended. Though partners may support females during their recovery, it was found that they did not take relapse well. One of the participants attempted suicide after the partner was furious when he heard about her relapse. It can therefore be recommended that, social workers not only assess the female recovering drug users but also their relationships, the partner and the emotional state of the partner and how it could affect recovery.

Friends were also seen as affecting recovery both positively and negatively. During aftercare the participants in the study mainly referred to their friendship with other recovering drug users as positive as they motivated each other to attend aftercare and NA meetings together. However, on a negative note, one of the participants in the study also stated that she once relapsed after friends she had met during aftercare had influenced her to drink alcohol together. In conclusion, it may not have been the friends themselves that made a recovering drug user relapse but the mental strength and stage of recovery that the female recovering drug user was at. It is recommended therefore, that female recovering drug users get friends from the society who do not use drugs and though there may be acquaintances with other recovering drug users, they must always have a non-user when they are out together.

During aftercare, participants mentioned that old friends they used drugs with secluded them due to the fact that they were no longer using drugs. The relations became hostile as the recovering drug users were no longer using. However though the relations were bad, most of the recovering drug users reported that after inpatient treatment they stopped communicating with the old friends. It is therefore recommended that during aftercare female recovering drug users do not associate with the old friends they were using drugs with as usually the friendship was just based on drug use.

5.5 SPIRITUAL FACTORS AFFECTING RECOVERY

Social workers participating in the study mentioned that during aftercare the female recovering drug users benefited spiritually through the 12 steps programme offered at NA, something which the female recovering drug users confirmed. Female recovering drug users mentioned that since

they started their recovery, their spiritual levels had been increasing and were attending church or in the process of looking for a church to attend. It was perceived that when facing challenges during aftercare, the female recovering drug users would talk to a higher power as per literature to this effect (Laudet *et al.* 2006; Zemore 2007). As spiritual programmes were perceived to be beneficial in recovery, there could be need to nurture spirituality from treatment right through to aftercare. The society due to the perceived stigma they portray towards recovering drug users, may make the recovering drugs users not feel comfortable to join their religious organisations. Thus members of the society must be welcoming, loving and non judgemental as most religious doctrines teach.

The participants also perceived that spirituality was helpful in recovery regarding change in their personality and relinquishing negative attitudes such as selfishness and pride as discussed by Galanter *et al.* (2007). Selfishness is a common attribute during addiction and makes drug addicts self-centered and neglect their children for instance. SANCA Vaal (2015) also argues that spirituality helps recovering drug users to connect more meaningfully with the world. This may also be the reason why female recovering drug users mentioned they were no longer anticipating suicide.

Spiritual factors tended not to be afforded much attention by the social workers during aftercare. This may be an area that social workers have not been comfortable dealing with in recovery. This is an aspect that needs some attention as culture sensitive practice emphasize a holistic approach that recognizes that humans are also spiritual beings. Thus substance abuse treatment policies in South Africa need to be amended to involve spiritual aspects as spirituality is perceived to be beneficial in recovery.

5.6 LIFE AFTER SUBSTANCE ABUSE TREATMENT

The social workers perceived boredom as a big trigger for recovering drug users during aftercare (Ray & Ksir 2004). This could be because during treatment the recovering drug users were used to having a programme where they were always occupied and now at home they got bored. To overcome boredom social workers suggested that the female recovering drug users conduct different activities to occupy their time. They also suggested that the female recovering drug users should strike a balance with activities so as not to be extremist in the behaviour, devoting all attention to one or two activities only. Female recovering drug users should therefore have a

diary where they can log every night to see how they spent their day and the free much time they had. The diary may act as a pointer to when the female recovery drug users had too much free time or lack of variation in activities.

Female recovering drug users made several lifestyle changes after treatment. They stated that they were involved in praying, reading the Bible and other books, studying for their degrees, cooking, going to gym, and they changed the type of movies and music they were listening to. These activities could be important in helping them occupy their time and taking their minds off drugs. The activities assisted the female recovering drug users physically, psychologically, socially and spiritually thus helping the female recovering drug users holistically. Changing their type of music and movies shows how serious the female recovering drug users were with their recovery. Family members should support the female recovering drug users on their choices/activities and help them stay motivated regarding their new lifestyles. After treatment, the recovering drug users also had to let go of their old friends, some struggling to make new friends and this may be attributed to the society having some negative attitude towards female recovering drug users. Therefore, they had to settle for friends also in recovery, old friends that did not use drugs and making new friends with friends of their lovers they met during recovery.

5.7 MOTIVATION, BENEFITS, CHALLENGES AND IMPROVEMENTS FOR AFTERCARE

This section is divided into four sub-sections. These are motivation to remain sober, benefits of attending aftercare, challenges faced during aftercare and improvements for aftercare hereunder.

5.7.1 Motivation to Remain Sober

On what motivates them to remain sober, participants in my study mentioned that being clean and sober made them happier in life, something which they did not experience in the many years they were using drugs. According to Van Wormer and Davis (2008) as discussed in Chapter 2, during addiction drug addicts struggle with loneliness, anxiety and depression. This may be the reason why female recovering drug users appreciated the happiness they experienced during aftercare. Seeing other people who had been clean for long also acted as a motivating factor. An additional common perception in my study was participants wanted to remain sober for their children and become good mothers. Social workers could thus empower female recovering drug users with parenting skills and also help them deal with the feelings of guilt. This therefore can

justify the establishment of an aftercare programme for females only that may assist them with such skills as parenting.

5.7.2 Benefits of Attending Aftercare

The participants of my study, both social workers and female recovering drug users perceived aftercare as beneficial in recovery. The social workers were of the view that inpatient and outpatient treatment programmes were too short to deal with all the issues female recovering drug users had as they would have used drugs for a long time. Also they perceived that since addiction was a chronic disease, it needed long term treatment. So aftercare was perceived as beneficial as it was a continuation of the inpatient and outpatient treatmentprogramme. This could be a valid argument why the organization did not take clients from other rehabilitation centres for aftercare as aftercare may be viewed as a continuation on the gains of treatment as discussed by Miller *et al.* (2011). It is recommended therefore, that since aftercare is continuation of the treatment programmes there must be persuasion so that all participants participate in aftercare. Policy makers may also need to consider making all treatment centres provide aftercare as only a few treatment centres provide aftercare services in South Africa. Should a person not be able to continue attending aftercare at the organization, referral letters should be provided with progress reports so that the recovering substance may attend aftercare at another treatment facility.

Aftercare was perceived as beneficial by both the female recovering drug users and social workers as it assisted the female recovering drug users to stay focused on their recovery. Due to female recovering drug users attending aftercare weekly, it could be seen as constant reminder for the clients that they were drug addicts and had to stick to their recovery plan. Random drug tests also motivated the female recovering drug users as they served to test progress in recovery. It can be assumed therefore that having a negative drug test result may motivate the recovering drug users as they may feel they have passed their test on recovery.

Aftercare assisted female recovering drug users share their challenges. Due to the many challenges faced during aftercare that I will discuss in the next subsection, it was important that the female recovering drug users had people available to them, to discuss their challenges. Social workers on the benefits of aftercare concluded that aftercare helped recovering drug users maintain sobriety, having a balanced lifestyle, dealing with emotions better, having financial

stability and having improved family relations, also discussed by Duffy and Baldwin (2013). This could be the reason why the female recovering drug users improved financially during aftercare.

The female recovering drug users perceived aftercare as beneficial as they were benefiting from the classes they attended. Female recovering drug users perceived aftercare classes as effective as different topics were discussed during their sessions. This made the aftercare to cover different aspects of recovery which is important as recovery should be holistic covering the biological, psychological, social and spiritual dimensions of an individual's life. This is consistent with the study conducted by Arbour *et al.* (2011) in Canada that showed aftercare attendance as having positive benefits for recovery. Due to these positive benefits of aftercare, policy makers must devise certain incentives that will attract female recovering drug users to attend aftercare.

5.7.3 Challenges Faced During Aftercare

There were female recovering drug users who stayed far from the treatment centre making it difficult for them to attend aftercare. Transport was a key challenge as aftercare programmes were conducted in the evening and there was need for private transport for the female recovering drug users to attend aftercare. Treatment centres can thus organize public transport were female recovering drug users. Participants in the study also highlighted having a lot of responsibilities that made it challenging for them to attend aftercare. This could be due to female recovering drug users being in the community and having to attend duties such as parenting and studying. Another challenge with regard to attendance was discontinuing aftercare as they believed they were "cured" and did not need aftercare services anymore. This was seen as a challenge by the social workers as people who usually stopped or did not attend aftercare relapsed, earlier discussed by Bello *et al.* (2011) as contributing to relapse. Social workers should constantly notify female recovering drug users of their progress in aftercare and what they need to do to stay sober.

A challenge experienced during aftercare as stated by the social workers was the issue of unemployment. Due to drug use it may be assumed that the recovering drug users could have lost their jobs as discussed by Geldenhuys (2015). Addiction may cause drug users to be involved in absenteeism, low productivity, errors at work, fraud and disputes with seniors at work. Thus

during inpatient treatment for example the clients will not be going to work thus during aftercare they need a new job. Studies conducted in USA and Northern England showed that participants attending aftercare wanted aftercare programmes to assist them with finding a job (Tuten *et al.* 2007; Duffy and Baldwin 2013). When they got new jobs, social workers also stated that female recovering drug users also struggled adjusting into their new work environments. During aftercare therefore, female recovering users may also need to be taught life skills such as how to construct a good curriculum vitae and ways to adapt well into a new work environment.

The social workers reported that during aftercare the female recovering drug users faced the challenge of fixing their relations with their families. This was seen as being due to the different stresses during and prior to addiction. For example there may be history of abuse that took place while the recovering drug user was still young. However, it should be noted that the participants in my study reported having good relations with their families during aftercare. Attending aftercare for female recovering drug users with children was also challenge. Being parents was seen as a challenge by social workers due to guilt feelings that the female recovering drug users may experience due to neglecting children when they were still using drugs. Due to the challenges in family relations, there is need for family counselling sessions. Policy makers also need to establish children's services during aftercare so that children could be taken care of while the mothers will be attending aftercare.

Continuing with relationships female recovering drug users had during addiction was seen as challenging due to trust issues. Having to break up with boyfriends they were using drugs with was also perceived as a challenge by participants in my study. With the society being seen as having stigma towards female recovering drug users, it can be seen that finding a partner was a challenge. However, by the time of data collection, participants in my study were having partners. This could be due to the participants being in aftercare for a relatively long period. Social workers should help female recovering drug users understand that it is normal to face this challenge during aftercare. This may assist the female recovering drug users not to put pressure on themselves and rush into harmful relationships.

Another challenge female recovering drug users frequently mentioned was financial issues. However, it should be noted that social workers perceived female recovering drug users as financially better during aftercare than at the time of addiction and has been discussed earlier.

Recovering drug users and social workers also mentioned that during aftercare participants will be staying in the community and they knew where to access drugs also discussed earlier. This was seen as a challenge as it would make it easier for the female recovering drug users to relapse should they feel like using drugs again. The issue of establishing halfway houses has already been discussed.

5.7.4 Improvements for Aftercare

One of the social workers believed that family attendance for aftercare sessions needed to improve. The social workers went further to state that female recovering drug users specifically loved family counselling sessions. This was important as the study by Lewandowski and Hill (2009) showed social support was important in recovery, even more than financial assistance. Family members should thus be informed of the importance of attending family aftercare sessions as not attending was seen as demotivating the female recovering drug user in her recovery. Participants in the study also mentioned the time for aftercare as not being adequate as some sessions would end before the intended discussion. To overcome this challenge aftercare groups can be divided into smaller groups and proper social work group work can be conducted. Participants mentioned they were more than 20 people during an aftercare session and this could be a challenge in meeting everyone's needs in an hour with such a large group.

Some participants discussed that some aftercare sessions went off topic. There was also a general consensus among the female recovering drug users who believed that alcohol patients were supposed to be separated from drug related patients. A participant in the study also suggested a separate aftercare programme between males and females and she felt females may be scared to express their emotions while males were present. This could be an important suggestion for aftercare as females may need to discuss female related matters for example parenting that may not necessarily affect males to the same extent as females. Since these are suggestions by the service users, they need to be taken into consideration. A separate aftercare programme may also be important as one of the participants in my study was also dating someone attending aftercare which could jeopardize her recovery. Separating alcoholics from drug users may also be of necessity as these people face different challenges with alcohol being available in restaurants for instance something that may be a genuine concern for an alcoholic but not for a drug addict. With the topics going "off topic", it shows that there must be platforms to evaluate aftercare

programmes where female recovering drug users may be given a chance to air their views on aftercare programme content.

5.8 RECOMMENDATIONS FOR FUTURE RESEARCH

A conclusive, maybe scientific study from the natural sciences may be needed to confirm the biological effects of addiction more especially in relation to genes as the participants in my study highlighted they had close family members who also had a history of abusing substances. It should be noted however, that other factors could have played a role for instance social learning.

There may also be a need for further scientific studies on cravings as the findings of my study were not conclusive. Should future researchers get to understand cravings, this may be an avenue the world needs to tackle the drug addiction problem.

Female recovering drug users rarely mentioned the involvement of their fathers in their recovery. This could be an interesting avenue for further research to investigate the role fathers play in supporting recovery of their daughters and it may also enlighten parents on social support. Further research is warranted on whether family members benefit from attending aftercare sessions and the reasons why family members stop attending family aftercare. My study also hinted that female recovering drug addicts during aftercare may receive more stigma than female recovering alcoholics. This may be an interesting avenue for social research to find whether this hypothesis may be true and what causes the variation.

5.9 CONCLUSION

In conclusion, from my study it can be seen that both social workers and female recovering drug users all perceived aftercare programmes as beneficial in recovery. From the above mentioned discussion it can be seen that the social workers in my study perceived addiction as a disease and female recovering drug users perceived they were experiencing different ailments as a result of drug use. Aftercare programmes were perceived as fostering a positive attitude and provided a sense of self to the female recovering drug users. Social support during recovery from family, partners and friends was seen as cherished by the female recovering drug users. From the discussion it can also be seen that female recovering drug users perceived their spirituality as having increased during aftercare. The improvement in spirituality was also perceived as positively influencing them to stay sober in their recovery. Though aftercare was perceived to be

beneficial, there were some challenges and areas of improvement that were suggested. Therefore, from the discussion in this chapter one can safely state that the objectives of this study were met and my quench for knowledge on perceptions concerning the effectiveness of aftercare programmes for female recovering drug users was served.

Aftercare consolidates the gains of treatment and female recovering drug users need to continue attending. This may be important as it is believed that:

> *"We cannot, in a moment, get rid of habits of a lifetime" – Mahatma Gandhi*

> *"Great works are performed not by strength, but perseverance" – Samuel Johnson*

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APPENDIX 1: ETHICAL CLEARANCE LETTER

16 September 2015

Mr TH Mhangwa 215076191
School of Applied Human Sciences – Social Work
Howard College Campus

Dear Mr Mhangwa

Protocol reference number : HSS/0858/015M
Project title: Perceptions concerning the effectiveness of aftercare programmes following long term institutional treatment for female recovering drug users.

Full Approval- Full Committee Reviewed

In response to your application dated 07 July 2015, the above mentioned project was discussed at the HSSREC Meeting held on 29 July 2015. It has been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

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Professor Urmilla Bob
University Dean of Research
On behalf of Dr S Singh (Chair)

/px

cc Supervisor: Professor M Kasiram
cc Academic Leader Research: Dr J Steyn
cc School Administrator: Ms A Ntuli

Humanities & Social Sciences Research Ethics Committee
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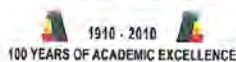

APPENDIX 2: GATEKEEPER CONSENT LETTER

9 May 2015

RE: PERMISSION TO CONDUCT RESEARCH AT OUR CENTRE

This letter serves to confirm that grants permission to Talent Hazvineyi Mhangwa to conduct research at our Centre. We acknowledge that he is going to conduct research on "Perceptions concerning the effectiveness of aftercare programmes following long term institutional treatment for female drug users." He should stick to the code of ethics in research and his research should not implicate negatively on our Centre. After completing his research we would be interested in knowing the major findings of his study.

will support Talent in his study. We wish him well in his studies.

I trust you find this in order

Yours truly,

DIRECTOR

APPENDIX 3: INFORMED CONSENT FORM

School of Applied Human Sciences

College of Humanities,

University of KwaZulu-Natal,

Howard College Campus.

Dear Participant

INFORMED CONSENT LETTER

My name is Talent Hazvineyi Mhangwa I am a Master of Social Work student studying at the University of KwaZulu-Natal, Howard College campus, South Africa.

I am interested in learning about the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users. I intend to employ participants from the organization you are attending aftercare. To gather information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will **not** be penalized for taking such an action.
- The research aims at gaining insight on the perceptions concerning the effectiveness of aftercare programmes for female recovering drug users.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing

Audio equipment		
Photographic equipment		
Video equipment		

I can be contacted at:

Email: tahmhangwa@gmail.com

Cell: 078 446 8837

My supervisor is Professor M. Kasiram (PhD in Social Work) from the Department of Social Work at the University of KwaZulu-Natal. She can be contacted on 031 260 7443.

You may also contact the Research Office through:

P. Mohun

HSSREC Research Office,

Tel: 031 260 4557 E-mail: mohunp@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I………………………………………………………………………… (full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT DATE

………………………………………… …………………………………………

APPENDIX 4: INTERVIEW SCHEDULE

TALENT HAZVINEYI MHANGWA

215076191

INTERVIEW SCHEDULE

PERCEPTIONS CONCERNING THE EFFECTIVENESS OF AFTERCARE PROGRAMMES FOR FEMALE RECOVERING DRUG USERS

SECTION A: IDENTIFYING PARTICULARS

- Age

SECTION B: CONFIRMATION QUESTIONS

- How long was your treatment programme?

SECTION C: EFFECTIVENESS OF AFTERCARE

- How often do you attend aftercare programmes?
- How is attending aftercare programmes assisting you in your recovery?

SECTION D: SOCIAL FACTORS AND RECOVERY

- How has the support you have been given by your family affected your recovery during aftercare?
- How has the support you have been given by your friends affected your recovery during aftercare?
- How has the support you have been given by your partner affected your recovery during aftercare?
- How does the community you live in affect your recovery?
- How do people react to the fact that you are a female recovering drug user?

SECTION E: PSYCHOLOGICAL FACTORS AND RECOVERY

- What are your concerns and stresses during aftercare?
- What motivates you not to use drugs again?
- What usually makes you think of using drugs again?

SECTION F: BIOLOGICAL FACTORS AND RECOVERY

- How does aftercare assist you in dealing with cravings?

- What other physical symptoms do you suffer from now in recovery?

SECTION G: SPIRITUAL FACTORS AND RECOVERY

- How has your spirituality served you during aftercare?
- Has spirituality changed in any way to assist you in your recovery?

SECTION H: IMPROVEMENTS

- What do you think needs to be improved in aftercare programmes?

APPENDIX 5: FOCUS GROUP DISCUSSION GUIDE

TALENT HAZVINEYI MHANGWA

215076191

FOCUS GROUP DISCUSSION TOPICS

PERCEPTIONS CONCERNING THE EFFECTIVENESS OF AFTERCARE PROGRAMMES FOR FEMALE RECOVERING DRUG USERS

SECTION A: PROGRAMME OUTLINE

- Briefly describe the aftercare programme you are offering
- How do you rate aftercare attendance by female recovering drug users?
- What usually motivates female recovering drug users to attend aftercare and stay sober?

SECTION B: EFFECTIVENESS OF AFTERCARE

- How do you think female recovering drug users benefit from aftercare?
- Which areas do you mainly focus on during aftercare when assisting female recovering drug users?

SECTION C: CHALLENGES DURING AFTERCARE

- Which major challenges do female recovering drug users experience during aftercare?

SECTION D: SOCIAL FACTORS AND AFTERCARE

- How is the support that female recovering drug users are receiving from their families?
- How does the support affect the female recovering drug users in their progress in recovery?

SECTION E: IMPROVEMENTS

- What improvements need to be done to increase the treatment outcome in aftercare?