AN INTEGRATED MODEL OF AFTERCARE FOR SUBSTANCE USE DISORDER CLIENTS IN KWAZULU-NATAL

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01 DECEMBER 2023

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As the supervisors, we hereby approve this thesis for submission.

Supervisor: ……... Date: …….
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Co-Supervisor: ……... Date…….
Prof A Voce

DEDICATION

This study is dedicated to all persons with substance use disorders, their families and the resilient service providers who constantly endeavour to provide their best service despite rural challenges.

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ABSTRACT

Background: There is currently a high global burden of substance use, which is burdensome to the public health and welfare system. Adequate treatment, including aftercare services, tends to be limited worldwide. In South Africa (SA), substance abuse contributes considerably to morbidity and mortality and treatment services are not only limited but also fragmented among stakeholders. These problems are compounded by a number of factors, including the absence of aftercare policies, treatment models, a lack of resources, and an absence of norms and standards for aftercare services. Consequently, most persons with Substance Use Disorders (SUDs) do not receive aftercare. Furthermore, there is high relapse and many re-admissions of persons with SUDs, which exacerbates the burden on the health care and welfare systems. The situation appears to be worse in rural districts. South African policies have called for the development of an aftercare model of care for persons with SUDs, which has not been realised to date.

Aim: The aim of the study was to propose an integrated model of aftercare for persons with SU post-inpatient treatment phase in a public facility in KwaZulu-Natal.

Methodology: A qualitative study in two phases. The first phase: policy analysis, and the second phase had two stages: Stage one was semi-structured and focus group interviews with forty-six participants who represented all five levels of the Beer's Viable System Model (VSM) from governmental and non-governmental organisations (NGOs). Stage two semi-structured interviews with five persons with SUDs and their family members (n=5). Data was analysed thematically using the Braun and Clarke approach.

Results: Findings indicated that South African policies did not provide clear guidelines on aftercare. Aftercare was found to be lacking, fragmented, poorly coordinated among service providers and not well integrated into the substance use treatment system. The needs of service users demonstrated the extent and nature of aftercare required.

Conclusion: The extent and nature of aftercare services warranted aftercare services that are integrated into SUD treatment systems, lifelong orientated, and responsive to the needs of persons with SUDs and their families. An integrated recovery management model of care is proposed together with relapse management strategies.

Keywords*:* Aftercare, Substance Use Disorder, Systems-thinking Approach, Recovery Management

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ABBREVIATIONS AND ACRONYMS

AA:	Alcoholics Anonymous
AAPA:	Anti-substance Abuse Plan of Action
CDA:	Central Drug Authority
DoH:	Department of Health
DoSD:	Department of Social Development
DOH-MDMP:	Mini National Drug Master Plan – Department of Health
ICASA:	Inter-ministerial Committee on Alcohol and Substance Abuse
IRMMC:	Integrated Recovery Management Model of Care
ITC:	Inpatient Treatment Centre
KZN:	KwaZulu-Natal
HPSR	Health Policy and Systems Research
M&E:	Monitoring and Evaluation
NA:	Narcotics Anonymous
NDMP:	National Drug Master Plan of South Africa
NGO:	Non-Governmental Organisations
PWSUD:	Person with Substance Use Disorder
RMNMNS:	Recovery Management National Minimal Norms and Standards
SA:	South Africa
SACENDU:	South African Community Epidemiology Network on Drug Use
SANCA:	South African National Council on Alcoholism and Drug Dependence
SP:	Service Provider
SU:	Service User
SUD:	Substance Use Disorder
UNODC:	United Nations Office on Drugs and Crime
VSM:	Viable Systems Model
WHO:	World Health Organisation

DEFINITION OF TERMS

Aftercare: 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 enhance self-reliance and proper social functioning (The Prevention and Treatment of Substance Abuse Act 70 of 2008)

Fieldworkers: People or professionals who are working at institutional level, such as hospitals, clinics, NGOs, Department of Social Development and at community level or first level of substance abuse services, particularly being in touch with those who are abusing substances

Mental health team: A psychiatrist or registered medical practitioner or a nurse, occupational therapist, psychologist or social worker trained to provide psycho-social, mental health care, treatment and rehabilitation services (The Prevention and Treatment of Substance Abuse Act 70 of 2008)

Revolving door syndrome: The tendency of a service user to recover for a certain period of time and then relapse and return to the Treatment Centre

Substance Use Disorders (SUDs): Mental and behavioural disorders resulting from psychoactive substance use (DoH, 2011)

Substance abuse: Also known as drug abuse, the sustained or sporadic excessive use of substances and includes any use of illicit substances and the unlawful use of substances (The Prevention and Treatment of Substance Abuse Act 70 of 2008)

Substance abuse service provider: An employed person or a professional who provides certain services (prevention, promotion, rehabilitation and remedial) in relation to substance abuse

Service user: An individual who is using or has used a service

A person with Substance Use Disorder: An individual with a substance use disorder

PEER REVIEWED PUBLICATIONS

Published Manuscript

Mpanza, D. M., Govender, P., & Voce, A. (2021). Aftercare services to people with substance use disorders: analysis of South African policy. *Drugs: Education, Prevention and Policy*, *28*(2), 138-155.

Published Manuscript

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Manuscript in Review

Aftercare Needs Post Inpatient Treatment in a South African Rural Context: Perspectives of Persons with Substance Use Disorders and Their Families

Authors: DM Mpanza, A Voce and P Govender

ORAL CONFERENCE PRESENTATIONS

INTERNATIONAL

Topic: *Aftercare and Reintegration Services in a Rural Context of South Africa.*
Convenors: Occupational Therapy African Region Group
Venue: Kigali Hotel, Rwanda
Date: 27 August 2019

Topic: *Perspectives of Service Providers on Aftercare Service Provision for Persons with Substance Use Disorders in a Rural District in South Africa. 2023*
Convenors: Occupational Therapy African Region Group
Venue: Windhoek, Namibia
Date: 24 August 2023

NATIONAL

Topic: *Aftercare Journey of Persons with SUDs Post Discharge from a Public Inpatient Treatment Centre in a Rural Context of South Africa.*
Convenors: South African Community Epidemiology Network on Drug Use (SACENDU)
Venue: Durban, South African Medical Research Council
Date: October 2018

Topic: *Perspectives of Service Providers on Aftercare Service Provision for Persons with Substance Use Disorders at a Rural District in South Africa. 2021*
Convenors: Public Health Association of South Africa
Venue: Durban, South Africa, Elangeni Hotel
Date: 11–14 September 2022

Topic: *Perspectives of Service Providers on Aftercare Service Provision for Persons with Substance Use Disorders at a Rural District in South Africa. 2021*
Convenors: South African Community Epidemiology Network on Drug Use (SACENDU)
Venue: Zoom online
Date: 02 November 2022

CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

Globally, substance use disorders (SUDs) are prevalent and complex problems (1) which heavily burden public health systems (2, 3). There is also a high treatment demand for SUDs, comprising psychosocial, rehabilitative, aftercare and pharmacological interventions, however, the availability of these interventions remains limited and inadequate (4, 5). According to the World Drug Report 2019, thirty-five million people worldwide suffer from substance use disorders whereas only one in seven people receive treatment each year (1). In 2021, the number had increased to 36.3 million people, or 13% of the total number of persons who use substances, suffer from substance use disorders (6). However, access to treatment is determined by regional differences that continue to prevail (6). In low-and middle-income countries (LMICs), especially in Sub-Saharan Africa, one out of eighteen persons whilst the Western and Central Europe is one in five had access to treatment in 2015 (6). In particular, psychosocial interventions such as counselling and social assistance services are more readily available and accessible than other interventions in the African region (6).

In most countries, there is an overall lack of aftercare provision, even though SUDs require comprehensive intervention, including planned aftercare for better treatment outcomes (5). Several studies (7-13) have indicated a major positive influence of aftercare in the process of recovery and relapse prevention. However, aftercare service provision in most countries is known to have several inadequacies, including a lack of research (5). Most international studies have not adequately addressed the significant clinical and policy question of how best to provide ongoing aftercare services to individuals with SUDs to sustain long-term recovery (7). Furthermore, there are inconsistencies in the conceptualisation and terminology of aftercare i.e. follow-up, follow up care, continuous/continuing care, aftercare, sustained recovery management, and recovery management. The United Nations Office on Drugs and Crime (UNODC) and the World

Health Organisation (WHO) promulgated a terminology of aftercare to be called recovery management, also known as recovery-oriented "aftercare", "continuing care" or social support which describes a long-term process of increasing patients' health and wellness, as well as supporting them in recovery from drug use disorders (5).

In a South African context, the overall policy, the National Drug Master Plan (NDMP) 2019-2024 regards the recovery management as an approach then define aftercare as "ongoing professional support to a service user after a formal treatment episode has ended to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning."(14) However, this term 'aftercare' is mostly used together with a term 'reintegration' and sometimes appear to be used synonymously. NDMP 2019-2024, defines reintegration as an ongoing professional support to a service user after a formal treatment episode ended, aimed at successful reintegration of the service user into society, workforce, family and community life (14). Beside the lack of clarity with aftercare terminology necessitating a study, the global lack of aftercare is similar to the South African context where aftercare is limited and inadequate (4, 15-17) necessitated research on how best to provide aftercare services in a South African context.

1.2 BACKGROUND AND CONTEXT

The South African context has a complex treatment system consisting of two separate systems for Substance use disorder (SUD) service provision, namely the public and private sectors (18). In the public sector, services are free or offered at low cost. In the private sector, services are expensive and most persons with SUDs rely on their medical aid funds (18, 19). In a South African context, the medical aid funds refer to the insurance that is paid by individuals to pay for their medical expenses, mostly used in private health care. The public sector, the tax-funded health care system provided by the Department of Health (DoH) and Social Development services provided by the Department of Social Development (DoSD), previously known as Social Welfare, is intended to serve most of the population (approximately 86 per cent), gratis to those who are needy or for a fee-for-service calculated on an income-based scale (18). In the private sector, which serves about 16 per cent of the population, services are expensive and most people utilise their medical aid funds (18) to pay for services. In addition, non-governmental organisations (NGOs)

also offer treatment services. The South African treatment services include inpatient/residential which refers to admission to care facility, community based which include outpatient care services, and aftercare services. Aftercare interventions may include, but are not limited to, group counselling, individual therapy, telephone counselling, brief check-ups, self-help group meetings, relapse prevention, and reintegration services (14).

All SUD treatment service provision in South Africa are regulated by these two State entities i.e., the DoH and DoSD (14) who are primary sources of referrals that are provider initiated. Only a few are self-referrals and court mandated. In essence, multiple stakeholders provide treatment services. Subsequently, the SUD treatment service provision is characterised by several complexities compounded by the two separate service provision systems (19) and multiple stakeholders. Public sector services are largely limited and inaccessible to the majority of South Africans, in particular to rural populations (15). Essentially, the origins of these unmet treatment needs can be ascribed to the general inequitable spread and limited availability of SUD treatment service South Africa (15), one of the most unequal countries in the world (20). Disadvantaged and marginalised communities continue to experience high levels of unmet treatment needs including aftercare, which impacts the health and welfare system of South Africa (2). For instance, the KwaZulu-Natal (KZN) Province, the second largest province in South Africa where this study was conducted, has only two public sector Inpatient Treatment Centres (ITCs) located in urban areas, with a lengthy waiting list for admission (16). In contrast, there has been an increase in the establishment of private-sector treatment services (both licenced and unlicensed) in SA, with at least one facility in each city (15). However, 40 per cent of the entire South African population resides in rural areas, and in KZN, 55 per cent of the population resides in rural areas (21). As a result, most people with SUD continue to have no access to SUD services.

Paradoxically, the legislative framework such as the Substance Abuse Act No. 70 of 2008 (22), mandates service providers to provide aftercare and reintegration services that should successfully reintegrate persons with SUDs into society, the workforce, family and community life. In addition, the National Drug Master Plan (NDMP) 2019-2024, an

overall policy on SUDs, promotes community-based service provision to all persons within their areas of residence (14). However, over the past years, treatment services for persons with SUDs have remained fragmented and poorly coordinated among the stakeholders, with inadequate aftercare services (4, 15-17, 23, 24). Most persons with SUDs are discharged from inpatient/residential facilities with no referrals, and to communities where there is no adequate support and follow-up care (16, 24). This situation is worse in rural areas. This lack of care has resulted in a high relapse rate, and persons with SUDs often fall into a 'revolving door' pattern of care (24). Revolving door pattern refers to cyclical patterns of readmissions to the health care facility. The inadequacies of aftercare, including poor coordination occur despite the existence of the National Norms and Standard as set out by the DoSD, which prescribe the responsibilities of rehabilitation facilities in terms of aftercare.

In addition, the Substance Abuse Act No. 70 of 2008 (22) mandated the DoSD to lead all government departments and other stakeholders in SUD service provision. Furthermore, the Substance Abuse Act No. 70 of 2008 mandated the Central Drug Authority (CDA) as the lead agency to oversee and monitor the implementation of the NDMP, including the coordination of SUD stakeholders. Nonetheless, policymakers and the CDA are aware of the policy implementation gap. As a result, attempts have been made in past years to improve SUD services i.e., three out of thirty-four resolutions of the 2nd Biannual Anti-Substance Abuse Summit 2011 and Action Plan focused on accelerating the improvement of aftercare services, including the collaboration of stakeholders. Subsequently, two policies, namely the NDMP 2013–2017 and the Anti-substance Abuse Plan of Action (AAPA) 2011 recommended developing an aftercare and reintegration model to guide service provision. However, despite these plans, no known aftercare model is currently in use or developed. Even today, the gap between policy, NDMP and implementation remains problematic and progress is minimal. Therefore, an authoritative aftercare model of care is required to be developed. Given the context of SUD treatment services provided by various stakeholders and fragmented, an integrated aftercare model is needed so that aftercare can be provided collaboratively by multiple sectors, with distinct roles for each stakeholder within the legislative framework in consideration of the rural population.

1.3 PROBLEM STATEMENT

The population in rural districts must travel to access ITCs before being discharged into their community for aftercare services, which are mostly unavailable or inadequate and likewise in the rural district in which this study was located. Previous research in this district appraising SUD service provision revealed that treatment services, particularly aftercare, were largely lacking and, where available, were fragmented with no monitoring and evaluation (M&E) (24, 25). As a result, stakeholders such as DoH, DoSD, NGOs, the South African Policy Service (SAPS), Education and so on worked independently in SUD treatment service provision (24, 25) which resulted in multiple referrals. However, these stakeholders worked collaboratively in substance use prevention services in this district. Furthermore, it was found that poor communication also existed between the ITCs and aftercare service providers in this district. For instance, persons with SUDs were discharged from the inpatient facility to the district without a report/referral for aftercare at the community level, contrary to what is stipulated by the National Minimum Norms and Standard for in- and outpatient services (26). However, persons with SUDs who were untraceable in the system post-inpatient intervention later returned for re-admission or intervention, thus sustaining a cycle of dysfunctionality. Furthermore, demonstrating the disintegration of aftercare to the existing SUD treatment system.

As a consequence of fragmented treatment interventions as a whole, including aftercare in this particular district, there is high relapse and wastage of limited resources. This is evident from the increased number of re-admissions, entrapping persons with SUDs in a 'revolving door' pattern of care with minimal success. This reduces effectiveness and cost-effectiveness in service provision. The absence of an aftercare model, M&E and a tracking system for relapse compounds these factors. In addition, stakeholders working in silos and an unclear legislative framework for aftercare also compound the problem. Due to these consequences and implications of fragmented aftercare at this district, there is a dire need for integrated aftercare services responsive to the rural context and legislative framework.

1.3 PURPOSE

The purpose of the study is to develop an integrated aftercare model for aftercare service provision for persons with SUDs within a rural South African context.

1.4 AIM AND OBJECTIVES

1.6.1 Overall aim of the study

To propose an integrated model of aftercare for persons with substance use disorders post the inpatient treatment phase at public facilities in rural KwaZulu-Natal.

1.6.2 Objectives

1. To describe national policies governing SUD aftercare service provision in South Africa.
2. To describe SUD aftercare implemented at the district level in rural areas.
3. To explore barriers and enablers of SUD aftercare at the district level in rural areas.
4. To describe monitoring and evaluation strategies of SUD aftercare service provision at the district level.
5. To propose a model of aftercare for persons with SUDs in a South African rural context.

1.7 SIGNIFICANCE OF THE STUDY

This study contributes to the limited knowledge of aftercare in the SUD field (27). From the researcher's present knowledge, there are very a few studies on substance use aftercare (28-32), and none within a rural SOUTH AFRICA context. These include two early studies (29, 30); a study by van der Westhuizen (30), who developed aftercare practice guidelines for chemically addicted adolescents from a social work perspective. However, this study excluded contextual issues and only explored perspectives of one stakeholder group, that of social workers. The work resulted in recommended general guidelines for aftercare specifically for social workers (29, 30). The study by Mahlangu and Geyer (28)

explored the aftercare needs of nyaope (a heroin-based substance also known as whoonga) users in a township. The study concluded with implications for aftercare and reintegration services for said substance use. None of these studies explore intersecting contextual issues, such as rural contexts and service settings requiring collaboration among multiple stakeholders. In addition, since these two studies, no known studies have been conducted on aftercare South Africa. The current study, therefore, responds to both a research, policy and practice gap. Moreover, the research gap appears to also exist at an international level as the researcher could not access any other studies of exploring both rural context and multiple stakeholders service provision. The study therefore emphasises the need to explore intersecting contextual issues, such as rural contexts and collaboration among multiple stakeholders, minimise fragmentation or disintegration of aftercare services. Thus, the current study explores what would be an integrated model for aftercare service provision in a rural context, incorporating perspectives of various essential stakeholders.

The NDMP 2013-2017, 2nd Biannual Anti-Substance Abuse Summit in 2011, resolutions and Substance Abuse Programme of Action 2011-2016 recommended developing an aftercare model of care, which has not occurred to date. This study could potentially inform policy reformation and respond to the recommendations of the NDMP 2013-2017. In addition, it affords a review of current strategies/approaches and focuses on the needs of service users and providers. Therefore, this study contributes to a body of knowledge that could potentially benefit researchers, policymakers may use the research to inform policy reform, service providers may improve their current practices, and service users and their families may receive better support and care., service providers, and service users and their families. Furthermore, this study may contribute to improving the current SUD aftercare service provision in South Africa and how it can be integrated to existing systems. Moreover, the results from the study could be extended to other contexts and may also facilitate future research, such as implementing the integrated aftercare model of care and evaluating the impact thereof.

1.8 OUTLINE OF THE THESIS

The outline of the study complies with the PhD thesis formatting guidelines of the University of KZN College of Health Sciences 'Thesis by Manuscripts'. Some adjustments have been made to the guidelines to ensure the nature of the study is well-presented. The researcher is the author of three papers emanating from this study, with two published and one in review. These papers form the framework for the integrated aftercare model proposed in the concluding chapter. This study consists of seven chapters outlined as follows:

Chapter 1 provides the introduction and background to the study, which offers insight into service provision for persons with SUDs in the South African context, particularly regarding aftercare service provision. The chapter includes the research problem, research questions, aim and objectives of the study and concludes with the significance of the study.

Chapter 2 outlines the literature reviewed pertaining to aftercare service provision in South Africa and globally. The literature review exposes the research and policy gap in aftercare service provision. In addition, it includes the context of the South African health system in which aftercare is provided and demonstrates the literature gap in aftercare. South African literature emphasises the need for the development of an aftercare model.

Chapter 3 discourses on the methodology and the theoretical framework, the philosophical assumptions for the study and the study design. The study location and two phases are detailed with an overview of how the integrated aftercare model was developed. However, specific methodology details are also contained in various manuscripts (Chapters 3, 4, and 5). This chapter provides a comprehensive account of the overall research design, data collection instruments, data collection processes, data management and the trustworthiness of the study.

Chapter 4 addresses objective one, and is related to manuscript I entitled *Aftercare Services to Persons with Substance Use Disorders: Analysis of South African Policy*. Eight policy documents relevant to aftercare service provision were analysed, providing

an in-depth understanding of the policy and legislative background of SUD treatment and aftercare service provision in South Africa and consideration of a global context.

Chapter 5 addresses objective two, three, four and five viewed from the perspectives of service providers, presented in Manuscript 2, entitled *Perspectives of Service Providers in Aftercare Service Provision for Persons with Substance Use Disorders at a Rural District, South Africa.* This chapter examines the delivery of aftercare services in rural areas, focusing on the viewpoints of service providers at both the policy and implementation levels. The chapter is concluded by presenting recommendations for developing a comprehensive aftercare model.

Chapter 6 addresses objectives two, three and five from the perspectives of service users. These perspectives are presented in Manuscript 3, entitled *Aftercare Needs Post Inpatient Treatment in South Africa: Perspectives of Persons with Substance Use Disorders and Their Families.* Using iterative data collection in a qualitative multiple-case study design, the individual and collective needs of persons with SUDs and family members were analysed. This chapter informed the development of a model that is responsive to the needs and preferences of service users.

Chapter 7 synthesises all the findings and culminates in a proposed SUD aftercare service provision model. Study limitations, conclusions and recommendations are also included in this chapter.

1.9 CONCLUSION

The provision of aftercare services in South Africa is faced with many challenges, including a lack of empirical research and policy guidelines. The proposed aftercare model intends to provide guidelines on the aftercare service provision. The chapter has presented the background, problem statement, aim, the purpose of the study and significance of the study. This chapter has positioned the study within the context of existing evidence in aftercare and identified the lacunae the study intends to address. The outline of all the chapters is included to provide a broad overview of the thesis. The

following chapter presents the literature review to locate the study within the existing evidence in the field of SUDs and aftercare service provision, locally and globally.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter reviews the literature regarding aftercare service provision for persons with SUDs. The review commences with a discussion on the importance of aftercare in the treatment management cycle of persons with SUDs. This is followed by aftercare intervention reforms globally and nationally including a brief discussion on the state of aftercare service provision globally and nationally. The chapter concludes with a review of aftercare service provision within the South African policy context and aftercare within a care system.

2.2 IMPORTANCE OF AFTERCARE IN THE TREATMENT MANAGEMENT CYCLE OF PERSONS WITH SUDs

A strategically planned aftercare, is associated with improved and sustained treatment outcomes among persons with SUDs (3, 5). Aftercare is an essential part of the SUD treatment management cycle and associated with relapse prevention. Several international studies (7-12) and local studies (28-32) demonstrated a positive correlation between aftercare participation and relapse prevention. The findings indicate that persons with SUDs who engage in aftercare have improved treatment outcomes, compared to those who only receive once-off treatment without further support. The Department of Health National Mini Drug Master Plan (DoH-NMDMP) of 2011 and NDMP of 2013-2017 and 2019-2024 align with these findings, and emphasise the importance of community-based interventions and self-help support groups as essential components of aftercare for persons with SUDs (23). Therefore, aftercare forms an integral role in the treatment management cycle and contributes to relapse prevention. It is important to acknowledge that relapse is likely to occur given the high relapse rates and the chronic nature of an SUD condition (5, 14) , associated with SUDs. Predictors of relapse include peer and social pressures for adolescents, while adults commonly relapse due to internal

psychological difficulties or interpersonal issues (33). Other factors influencing relapse include the type of treatment received; the nature of aftercare provided; the individual's motivation level and their level of participation (34, 35). Hence, enhancing aftercare service provision is crucial in reducing relapse rates and improving treatment outcomes for persons with SUDs. However, several factors need to be considered in the South African context where the provision of aftercare services for persons with SUDs, particularly in rural areas, is inadequate (15). Challenges such as unclear policies and limited resources further compound the issue (15, 24). Nonetheless, efforts have been initiated to reform aftercare, as the following section will discuss.

2.3 AFTERCARE INTERVENTION REFORMS GLOBALLY AND NATIONALLY

Internationally, the treatment including aftercare approaches for SUDs have undergone significant evolution. In 2009, the UNODC and the WHO promulgated a Joint Programme on drug dependence treatment and care, recognising SUDs as chronic diseases (5) with various parameters. This Joint Programme aims to provide effective and humane treatment for all persons with SUDs, comparable to the care provided for other chronic conditions (5). In 2015, the UNODC acknowledged that SUDs are complex, multifaceted and are relapsing chronic conditions requiring stable and effective aftercare (36). This is in contrast to the acute care model, which expects persons with SUDs to fully recovered upon discharge (36). In 2017 the UNODC and WHO jointly published the International Standards for the Treatment of Drug Use Disorders (5). These Standards emphasise long-term and chronic-care oriented approaches, with aftercare being referred to as 'recovery management' and may take as long as is needed by the person with SUDs, not limited to a specific duration. The changes by critical international bodies such as the WHO and UNODC aim to reduce the health and social burden caused by SUDs, promote evidence-based treatment and aftercare/recovery management strategies and advocate for a public health and human rights approach (5).

Nationally, South Africa has experienced a dynamic political transition from apartheid to democracy in 1994, followed by the adoption of a constitution based on a human rights approach. This transition has resulted in various changes in social and health services,

(37), prompting an ongoing evaluation of the policy landscape. Efforts have been made at the governance level, to enhance SUD services. The NDMP complements the work of the Inter-Ministerial Committee on Alcohol and Drug Abuse, guiding and monitoring government departments, whilst fostering collaboration among stakeholders and community participation. In 2006, the NDMP of 2006-2011 specified the establishment and support of provincial forums and local drug action committees to facilitate inter-sectoral and enabling community participation (38, 39). However these forums have had minimal impact and have primarily focused on prevention (24, 25), and failing to create inter-sectoral collaboration and develop specific plans as stipulated by the NDMP 2006-2011(39). Additionally, the Prevention and Treatment of Drug Dependency Act No. 20 of 1992, was amended to the Prevention and Treatment of Substance Abuse Act No. 70 of 2008. The amended Act No 20 of 2008, including Chapter 7, introduced reforms dedicated to aftercare and reintegration services, mandating collaboration among sectors and stakeholders in aftercare service provision. Despite these reforms, the lack of inter-sectoral and stakeholder collaboration in aftercare services have continued unabated over the past years (4, 16, 17, 24, 25, 27) demonstrating the ongoing gap between policy directives and implementation.

It is noteworthy that South African policy reforms have made efforts to address the policy implementation gap. Out of the 34 resolutions of the 2nd Biannual Anti-Substance Abuse Summit 2011, three resolutions specifically focused on expediting the improvement of aftercare services. These resolutions were No. 25: Strengthening aftercare services; No. 30: Increasing the provision of rehabilitation and aftercare, and No.23: Implementation of a continuum of care and a public health approach that provided for prevention, early detection, treatment, rehabilitation and aftercare services (18). As a result, the NDMP of 2012-2016 was revised to cover 2013-2017 incorporating all the resolutions. Additionally, the Anti-substance Abuse Programme of Action (AAPA) 2011-2016 was collaboratively formulated by stakeholders and included specific targets and indicators (18) These targets encompassed the establishment monitoring of an aftercare model by 2014; an increase in the percentage of aftercare facilities, protocols, policies and facilities applying an integrated multi-modal approach to substance abuse treatment, an increased in the number of successful patients; a 10 per cent increase in the number of treatment

facilities, and the application of an integrated approach to substance abuse treatment (18) However, despite this detailed planning, it is worth noting that no known aftercare model has been utilised or developed to date, and no aftercare facility was established during the specified period. Given these circumstances, it becomes crucial to assess national policies in order to understand how they have responded to these directives and policy changes aimed at enhancing aftercare services.

2.4 THE STATE OF AFTERCARE SERVICES GLOBALLY AND NATIONALLY

Globally, relapse is a common problem (40), with 60 per cent of persons with SUDs relapsing due to limited availability, accessibility, and inadequate treatment services including poor aftercare service provision (5, 36). Where treatment is available, it is often not evidence-based and is ineffective (5) in most countries. Consequentially, post discharge, relapse and re-admission rates remain consistently high at 60 per cent with only an estimated 40 per cent rate of sustained recovery (36). Globally, aftercare service provision is limited (5, 36) due to several prevailing barriers. Although some studies (7-13) have indicated the benefit of aftercare in a treatment cycle for persons with SUDs, there is a limited scientific evidence on aftercare and long-term recovery management, as the efficacy of interventions has not been assessed in most countries (5). The WHO and the UNODC promulgated treatment guidelines published in 2020 which include aftercare. However, these guidelines have only been scientifically tested in ten countries thus far (5) as contextual barriers are confronting every country in the aftercare service provision.

In South Africa there appears to be a lack of distinctive policy directives on aftercare service provision. The overall guiding policy, the National Drug Master Plan 2013-2017 (27) and 2019-2024 (14), only provides superficial guidelines on aftercare services provision. Consequently, in SA, similar to that which has been observed globally, that is, poor treatment outcomes for persons with SUDs, including high relapse rates, the 'revolving door' syndrome and poor reintegration of persons with SUDs into society are associated with limited treatment services (2) and inadequate aftercare service provision (17, 28, 30). The limited availability and inadequacy of aftercare services persist despite the consistent finding from South African studies, that a critical need for persons with

SUDs is that of adequate aftercare and reintegration following a treatment intervention (28). In addition, two policies, namely the National Drug Master Plan (NDMP) 2013–2017 and the Anti-substance Abuse Plan of Action (AAPA) 2011 (27) endorsed the development of an aftercare model to guide service provision, but to date no model has been developed.

The absence of an aftercare model appears to have contributed to a number of inadequacies within aftercare service provision which include: poorly coordinated interventions, persons with SUDs discharged without referral to aftercare, stakeholders working in silos, and high rate of readmissions and relapse (4, 17, 30). This study intends to minimise this gap by proposing an integrated aftercare model.

2.5 AFTERCARE SERVICES WITHIN THE SOUTH AFRICAN POLICY CONTEXT

The South African policy context took a noticeable turn at the inception of democracy as signalled during the first democratic parliament opening address (1994) by the first democratic president, Dr Nelson Mandela. He emphasised that urgent attention was critical in attending to alcohol and drug abuse as social pathologies (27). In addition to the internal legislative/political will to respond to substance abuse issues, South Africa, being part of the global community, has been responding to its obligation to the United Nations conventions and the conventions of other relevant international bodies such as the UNODC and WHO through formulating policies and practices pertinent to South Africa as a country (27). South Africa is a signatory to the United Nations (UN) Conventions. These conventions, including the United Nations Single Convention on Narcotic Drugs of 1961 as amended in 1972, the UN convention on Psychotropic Substances of 1971, and the UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances of 1988, serve as the bedrock of international substance abuse policies (41-43). Since then, there has been progress at a legislative and policy level. Most South African substance use policies and legislation jointly recognise the lack of aftercare service provision and their significant role in a treatment management cycle, hence the emphasis on the need to improve.

At legislative level, SUD services in South Africa are governed by the amended Prevention of and Treatment for Substance Abuse Act No 70 of 2008 (22). The Act (No. 70 of 2008) is administered by the DoSD, which leads the Inter-ministerial Committee on Alcohol and Substance Abuse (ICASA) (22). The Act legislates aftercare service provision in section 30, subsection 1 as follows: Establishment of aftercare and reintegration services stipulates that,

> the Minister (DoSD) must, in consultation with the ministers … and Organs of State referred to in section 8 prescribe integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and family and community life" (Chapter 7 page 38 of Substance Abuse Act No: 70 of 2008) (22).

In addition, the Act mandated the CDA with the oversight duty of the formulation and implementation of the NDMP by a national strategic policy document. Both ICASA and CDA report directly to Parliament and are responsible for the compliance to the Acts, implementation of policies and the coordination of substances abuse services.

At policy level, CDA in partnership with DoSD and other stakeholders formulated the first NDMP in 1999 and was revised every five years, i.e., NDMP 1999-2004, 2006-2011, 2012-2016, 2013- 2017 and 2019-2024. Although, the NDMP is a five-year plan that aims to ensure that the country meets both the requirements stipulated by international bodies and the specific needs of South African communities (27). The term 2019-2024 is almost expired and not much has been achieved regarding aftercare services and policies. The NDMP prescribes the role and contribution of various government departments at national and provincial levels and recognises the contributions of other stakeholders in combatting the scourge of substance abuse (27). For instance, the NDMP 2019-2024 mandates both DoSD and the DoH to provide treatment services, including aftercare, collaboratively with other SUD stakeholders (14). DoSD oversees and regulates the entire treatment services and the DoH regulates detoxification and provides other treatment services. Currently, the NDMP of 2019-2024, National Minimum Norms and Standard for Inpatient and Outpatient Services and the DoH-NMDMP 2011-2014 prescribe and detail the expected standards of aftercare although the content is superficial. This prescription includes that every service user must be discharged with a referral letter to a

community-based social worker and self-help groups like Alcoholics Anonymous (AA). However, at policy implementation and service provision level, aftercare services continue to be limited, inadequate and poorly coordinated among stakeholders (4, 17, 23, 24, 30) despite the relevant policies. Service users are discharged without a follow-up plan or a referral letter (16). South African policies do not seem to translate into available, accessible, adequate and coordinated aftercare services for its diverse population. The factors influencing the policy implementation gap are not well documented and the gap between policy and implementation remains an abyss. Therefore, this study intends to illuminate and, where possible, eliminate some challenges to improve aftercare service provision, hence a policy analysis was conducted.

2.6 AFTERCARE AS A SUB-SYSTEM WITHIN A SUD SERVICE PROVISION SYSTEM

The South African policy context demonstrate the intricate complexities of aftercare service provision, which is a sub-system embedded within a SUD service provision system. The aftercare service provision system comprises multiple components and interactions inextricably linked within the South African health care system and welfare/social development system (14, 22). The fact that aftercare belongs to two ministries/departments, DoH and DoSD, mandated to collaborate with other stakeholders in the provision of SUD services complicates the aftercare service provision system. Furthermore, the CDA, another key role player, has a huge role to play from service provision at grassroot level up to the policy and legislative level (22). Notably there are many role players involved in the aftercare system which can be both advantageous and disadvantageous. Inevitably, aftercare invariably interacts with and within a number of supportive systems of human services including health care, welfare/social development, NGOs and others. In addition, the KwaZulu-Natal Province has a supporting

structure/forum called Operation Sukuma Sakhe[1] and war room[2] within a municipal ward level, which facilitates collaboration of all stakeholders in government service delivery. Furthermore, the NDMP of 2019–2024, the overall SUD policy promotes systems-approach and cross-sector collaborations in aftercare service provision (3). Therefore, systems-thinking, also known as systems approach, offers a most suitable perspective in comprehensively understanding the intricacies of the aftercare service provision system. Systems-thinking helps to manage complex situations more effectively (44). Besides aftercare service provision being complex, SUD is a complex and multifaceted condition (5). Systems-thinking focuses on the whole and the interactions/relationships of its parts/subsystems (45) , as opposed to understanding its parts without studying the whole. Jackson (45) states that it is the whole (holism) that gives meaning to the parts and their interactions. Systems-thinking assumes that everything is connected to everything else within a context and thus cannot be studied separately or in isolation (44-47). Changing one part or component may effect changes to the entire system. Studying relationships would enable an understanding of how a system works when interacting with its surroundings (44). Essential systems-thinking would give an understanding of how the aftercare service provision system works as a sub-system to SUD service provision and interactions with other systems.

Ultimately the systems-approach focus is on improving real-world problem situations (45, 46), as will be shown in this study in terms of aftercare service provision. However, there are various types/paradigms of system approaches, namely, functionalist, interpretive, emancipatory and postmodern (45). Therefore, it is essential to distinguish and identify the paradigm that is more suitable to improve aftercare service provision. These paradigms have the following differences according to Jackson (45 p308):

Functionalist:

[1]is a provincial programme that was founded on the premises of taking government to the people in a coordinated manner where all ggovernment departments work together with non-governmental entities to solve an identified problem or meet a particular need.

[2] A meeting of all government departments and non-governmental entities at a municipal ward level to solve a ward related problem.

"an assumption is made that the real-world is systemic, and analysis of the problem situation is conducted in systems terms";

Interpretive:

"there is no assumption that the real world is systemic; analysis of the problem situation is designed to be creative and may not be conducted in systems terms";

Emancipatory:

"an assumption is made that the real world can be systemic in a manner alienating to individuals and/or oppressive to particular social groups; analysis of the problem situation must take into account who is disadvantaged by current systemic arrangements";

Postmodern:

"Postmodern systems practice is a way of thinking and acting, with an attachment to the postmodern theoretical rationale, and is focused on improving real-world problem situations."

Aftercare service provision would be better understood through an emancipatory paradigm because in this paradigm problems are analysed to take into account who is disadvantaged by current systemic arrangements and helps us to know how best to improve (45). Coherently, this study aims to develop an aftercare model of care, which is responsive to the needs of the people with SUDs in rural areas and it is a system contribution addressing the inequalities in the South African context.

2.7 CONCLUSION

This chapter has provided a synopsis of the literature review pertaining to aftercare, which demonstrated the need for exploring how best to provide aftercare services in a South African context. Chapter 3 details the methodology followed in conducting the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter briefly describes the methodology for the study. The philosophical underpinnings and theoretical framework guiding the study are outlined. The study design and an overview of how the aims and objectives were met is schematically presented to summarise the entire study. The chapter concludes with the approaches to ensure trustworthiness of the findings and ethical considerations.

3.2 PHILOSOPHICAL ASSUMPTIONS OF THE STUDY

My philosophical assumptions and beliefs are shaped by my research exposure, clinical experience and continued involvement with SUDs. I therefore describe my paradigmatic orientation in terms of ontology, epistemology, methodology and axiology, which underpins the interpretive paradigm espoused in this study.

3.2.1 Ontology

Ontology (the nature of reality) concerns researchers' assumptions about the nature of the world and reality (48) and is largely concerned with the nature of the existence of a phenomenon (49). My ontological position is that there are multiple realities in aftercare service provision which includes utilisation of services by persons with SUDs and provision of aftercare services by service providers.

3.2.2 Epistemology

Epistemology is the assumptions about knowledge and refers to what constitutes acceptable and legitimate knowledge (48). Epistemology is about how reality is being known or uncovered by the researcher (49). The study was within the boundaries of the health policy and systems research (HPSR) which is an emerging area of health research that focuses on health policies and health systems, and explores strategies to improve policy (50). HPSR is defined as research that "…*seeks to understand and improve how*

societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. By nature, it is interdisciplinary, a blend of economics, sociology, anthropology, political science, public health and epidemiology that together draw a comprehensive picture of how health systems respond and adapt to health policies, and how health policies can shape − and be shaped by − health systems and the broader determinants of health."(50 p21). The HPSR accommodates a number of paradigms depending on the problem being addressed rather than by any particular disciplinary underpinnings (50). As a result, in this study, phase 1 is policy analysis embracing systems thinking and phase 2 is qualitative interviews with service providers and service users embracing an epistemological position of social constructivism. Social constructivism is a worldview that seeks to understand the world through the perspectives and meanings of the participants' lives or work experiences (48). Constructivism holds that knowledge and truth are created and not discovered, and humans are continually constructing the meaning of what they experience (51). In this study, these meanings are multiple, complex, varied and contradictory, but are equally valid accounts of the experiences (51) of aftercare services, thus important for the construction of knowledge. Constructivism is a theoretical perspective linked to interpretivism (51). Therefore, the interpretivism paradigm guides the study as I seek to understand the complex phenomenon of providing or using aftercare services from the subjective experiences (48) of service providers and persons with SUDs and their families as reflected in the multiple realities of their world.

3.2.3 Methodological Approach

Methodology refers to the nature of knowledge production (48). The methodological approach employed in this study was within the HPSR which has the ultimate goal of generating knowledge that will enable societies to strengthen health systems and achieve health goals (50). Furthermore, HPSR brings together health policy and health systems work into one research field (50), with an intention to understand the system level factors and forces within a health policy and systems. Although the HPSR is regarded as a developing field of research (52) it has a number of advantages such as being multidisciplinary and responds to the characteristics of the problem studies (50), thus my

methodological approach embraces the interpretive paradigm of the study to respond to the nature of the problem studied. An interpretive study seeks to explore people's subjective experiences and their perspectives of these experiences (51). Interpretivists study meanings to create new, richer understandings of realities (48). In this study, I sought to understand the meaningful experiences and perspectives of aftercare service providers and service users (persons with SUDs and their families). Interpretive studies are mainly associated with qualitative approaches to data gathering and analysis (51). Qualitative research intends to specifically understand a phenomenon based on those experiencing it but with less generalisation (53). Furthermore, qualitative research generates rich narrative textual data that represents the subjective experiences of respondents (54). This study therefore, adopts the qualitative approach to provide an in-depth understanding of multiple meanings and interpretations of aftercare services and co-create solutions to inform the development of an aftercare model for a rural context. Hence multiple stakeholders (policy, service providers and service users) and multiple sectors (government and private) participated in the study, including those who used the service, i.e., persons with SUDs and their families.

3.2.4 Axiological Beliefs

Axiology refers to the role of values and ethics within the research process (48). Therefore, it is essential to consider the values of a researcher and the participants. As an interpretivist researcher, I am aware that my values and beliefs play a critical role in the research process. My beliefs are shaped by my experiences, experiential knowledge and previous exposure. I worked as a clinician for four years in a rural environment. Providing SUD services was a challenge, in particular aftercare services. I was frustrated that persons with SUDs were discharged from ITC, lost track of in the system and then reappeared when they relapsed. As a clinician, I could do very little to alter or improve the situation. As a researcher and student, I completed my Masters on the experiences of service providers in the provision of SUD services in a rural context (25), which resulted in this study and I intend to provide a viable solution to improve aftercare services. In addition, I support the notion of a top-down and bottom-up approaches, meaning that solutions should not be derived from only one source. Thus, I believe we need to find solutions from the bottom-up (from service provision level to the policy level) and vice

versa. I understand that I have the potential to distort the meanings of my participants, therefore, my goal is to enter the social world of my research participants and understand it from their point of view with no or minimal distortion. I therefore used reflexivity to state my beliefs clearly upfront and throughout the study, i.e., conceptualisation, data collection and interpretation processes.

3.3 THEORETICAL FRAMEWORK

Aftercare service provision is a sub-system of the SUD service provision system, mainly treatment services; it therefore comprises multiple components and interactions, with the associated complexity of human services systems. Thus, systems-thinking, also known as a systems-approach, is best suited as a theoretical approach to developing an aftercare model for persons with SUD. Systems-thinking focuses on the whole and the interactions/relationships of its parts/subsystems (45, 47) instead of comprehending the part without studying the whole. Changing one part may affect changes to the entire system because everything is connected. In this study systems-thinking enables studying the aftercare system in the context of relationships with other systems such as SUD service provision system, DoH, and DoSD services rather than in isolation. In addition, systems-thinking emphasises the need for cross-sector collaboration and community partnerships (45, 47) of which the Substance Abuse Act No. 70 of 2008 (22) mandates the collaboration of all relevant sectors in substance use service provision. Consistently, the NDMP of 2019–2024, the overall SUD policy direct, support the systems-approach and cross-sector collaborations in preventing relapse during aftercare and service provision as a whole (14). Collaborating sectors include DoH, DoSD, NGOs, the South African Policy Service (SAPS), Education and so on. However, SUD treatment services including aftercare continues to be delivered in silos among sectors (4, 15-17, 23-25) especially at service provision level. There appears to be no mechanisms/channels of communication among sectors at service provision (implementation) level while at policy and national level (Central Drug Authority and inter-ministerial committee) there are mechanisms and platforms of communication which indicate the weaknesses of a system that is expected to enable collaborations at all levels. The quest to gain an in-depth understanding of the intricacies of the SUD system warranted a systems-thinking approach (47) to be adopted for the study. Furthermore, systems-thinking explore the

collaboration of various sectors in SUD services which is essential to inform the development of an integrated aftercare model.

There are numerous methods and approaches within systems-thinking. This study adopts Beer's Viable Systems Model (VSM) (46)which espouses a functionalist systems-approach (45-47). Beer's VSM assists in defining the structured features of a model of aftercare, with the functions to be fulfilled by each part of the system for the system's overall effective functioning (46). Beer's VSM has five key functions in a system: implementation, coordination, control, development/intelligence and policy within an environment. Beer's VSM is advantageous in deepening the understanding of the key functions of the system; however, it is limited in identifying the key role players within a system. Thus, the Policy Analysis Triangle Framework (55) assists in identifying policy actors within a system and the power and influence the actors exert during policy formulation and implementation. The Policy Analysis Triangle Framework as an analytical framework extends beyond identify the actors but also analyse actors who may be individuals or members of interest groups or professional associations influenced by the context they live in or work at macro-governmental and micro-institutional level (55). Furthermore, the context itself is influenced by various intersecting factors, mainly the political regime, war, and culture. These actors directly impact on policymaking processes; hence, their expectations, values and position of power reach beyond deciding on which policy is formulated but also influence the content of the policy. As a result, the policy content reflects the interplay of these dimensions (actors, context and process). Walt and Gilson (55) maintain that using the Policy Analysis Triangle Framework assists researchers and policymakers to understand policy formulation and planning for effective implementation. Thus, Policy Analysis Triangle Framework can be applied retrospectively or prospectively (55). In this study, the Policy Analysis Triangle Framework is applied retrospectively in policy analysis, which exposes the weaknesses and strengths in the policy formulation and implementation within the aftercare system. Furthermore, it reveals policy content, the role players, processes and context affecting policy development and implementation, including the interaction among these factors (55). Merging the two approaches (Beer's VSM and Policy Analysis Triangle Framework) is valuable and informative for the development of an aftercare model and

identifies key role players in the aftercare system. In this study, the key role players (service providers) and users of aftercare services (family and persons with SUDs) are interviewed to solicit their experiences and perceptions to construct an aftercare model that is relevant to the entire aftercare system. Thus, the study participants are representative of the five key functions identified by Beer's VSM in a system (Refer to Table 3.2 on p 35). Furthermore, the study is situated within a social constructivist paradigm aiming to understand the world through the perspectives and constructed meanings (often complex and varied) of the participants' experiences of their lived realities (51). The study sought to develop an integrated aftercare model for persons with SUDs in rural KZN, a system-level contribution. Aftercare is a sub-system of the service provision system; however, the integrated aftercare model for persons with SUDs represents a system of care in and of itself.

3.4 STUDY DESIGN

This study was underpinned by systems-thinking approach to understanding a system related problem, that is, of providing aftercare services in a rural context and to provide a solution i.e. to develop a suitable model of care. Within a systems-thinking approach, multi-methods (qualitative) were used to meet the study aim and objectives. Cresswell and Clark (56) describe 'multi-method studies' as studies that employ multiple types of qualitative or quantitative data collection. In this study qualitative multiple approaches were used for data generation and analysis, depending on the research objective. Policy analysis was used to understand the policy context of aftercare services and how the current systems functions. Thereafter, the aftercare service provision was described and explored using qualitative techniques from multiple perspectives of multiple stakeholders, i.e., policymakers, service providers (at M&E, implementation), and service users which included persons with SUDs and their families. Using multiple methods, meanings and accurate experiences of service providers and users of aftercare services were understood from within their own environment. This elicited experiences of how the current systems functions and demonstrated the unmet treatment needs of service users which assisted with the development of a proposed integrated aftercare model. Refer to Table 3.1 for a summary of the study phases with associated methods per objective, and to Figure 3.1 (p 28) for the methodology overview.

Table 3.1: Summary of the Study Phases with Associated Methods Per Objective

Objective	Method	Sampling Strategy	Sources of Data	Data Collection Tools	Data Analysis	Phases
1. To describe policies governing SUD aftercare service provision in South Africa.	Policy analysis	Purposive Sampling of Substance Abuse Policies and Programme Guidelines in South Africa	Key policies	Data Extraction Check-list	Thematic Analysis using the Policy Analysis Triangle Framework and VSM	Phase One
2. To describe SUD aftercare implemented at the district level.	Key informant Interviews	Purposive Sampling of service providers and service users.	Service providers and service users.	Interview Guide and Focus Group Discussion Guide	Thematic Analysis	Phase Two
3. To explore barriers and enablers of SUD aftercare services at the district level in rural areas.	Key informant Interviews	Purposive Sampling of service providers and service users.	Service providers and service users	Interview Guide and Focus Group Discussion Guide	Thematic Analysis	
4. To describe monitoring and evaluation strategies of SUD aftercare services at a district level.	Key informant Interviews	Purposive Sampling of service providers	Service providers	Interview Guide and Focus Group Discussion Guide	Thematic Analysis	

5. To propose an integrated model of aftercare for persons with SUDs at district level	Synthesis of findings	Synthesis of findings from objective 1 to 5	Findings from Objectives 1 to 5			

3.4.1 *Phase One*

This phase included identifying relevant policies and analysing nine specific policies pertinent to SUDs treatment services. Further details of this phase are provided in 3.6 below.

3.4.2 *Phase Two*

The phase two comprised two stages to meet four objectives of the study.
Stage 1: interviews and focus group interviews with service providers. Which focused on achieving objective 2,3,4, and 5.
Stage 2: interviews with service users and their family members which achieved objective 2,3, and 5.

The findings from these two phases informed the development of a model of aftercare service provision, for example, the key features of the VSM were identified in the phase 1 policy analysis and also in phase 2 with the participants. The features are essential for the model and system understanding. See further details of phase 2 provided in 3.7 (p37).

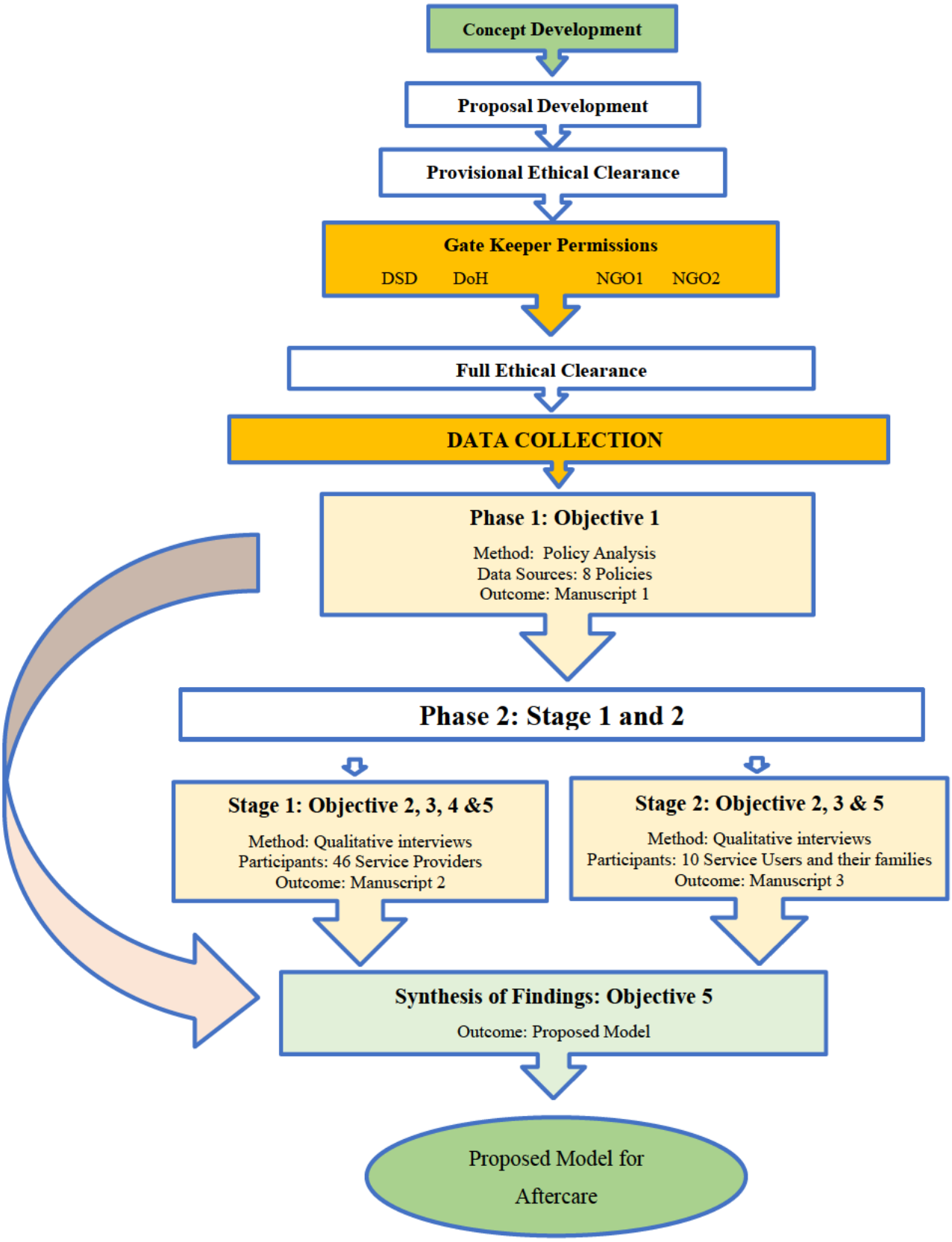

Figure 3.1: Methodology Overview

3.5 RESEARCH SETTING

The study was conducted in a rural district, which is one of eleven districts in the KwaZulu-Natal (KZN) province of South Africa. As the second largest province in the country, KZN has a total population of 11,3 million people, which equates to approximately 19,2 per cent of the South African population (21). As one of the most rural provinces, more than 55 per cent of the population in KZN reside in rural areas (57). In SA, of the 57% of the population living below the poverty line, 25% are in KZN (21). The province faces a triple burden of high poverty levels and a high prevalence of HIV and tuberculosis (TB) (57), which complicates service provision.

The district in which the study was located has a particularly challenging situation. between 82 – 95 per cent of households live below the poverty line, with 70 per cent of this population living on less than 800 South African Rands (ZAR) (44.07$ on 05th of March 2023) per month (58). No Inpatient Treatment Centres (ITCs) are located in this district; therefore, persons with SUDs are referred to one of two urban public sector ITCs. The resources in this district are limited, and the with a poor infrastructure is poor with (predominantly gravel roads), reflecting the common conditions in similar to most rural areas of SA. There are five district public hospitals that provide health care services to persons with SUDs. There is also two NGOs. The one NGO offers outpatient mental health treatment services, including services for SUDs, among other programmes. The other NGO provides outpatient services for persons with SUDs and referrals to inpatient treatment centres, in the public or private sectors, according to affordability. Social development services, including outpatient services also serve the population in the district. Consistently, the treatment centre admissions in KZN indicate that the most common substance of abuse, being cannabis, accounted for 37 per cent of admissions, followed by heroin (including nyaope/whoonga) at 27 per cent and alcohol at 14 per cent (59). Several *shebeens*[3] and the consumption of homebrewed substances and cannabis (both mainly brewed and cultivated at home) are commonly used in this district (25).

[3] Shebeen: illicit taverns

3.6 PHASE ONE OF THE STUDY

Phase one comprised of policy analysis which intended to respond to objective one of the study, i.e. to describe national policies governing SUD aftercare service provision in South Africa. The Policy Analysis Triangle Framework conceptualized by Walt and Gilson (55) was used to analyse eight SUD policies retrospectively (analysing the already developed policies); however this analysis has the potential also to inform future policy formulation. Findings from this phase achieved objective 1 of the study, detailed in Chapter 4, Manuscript 1. This analytical framework focuses on the policy content and the role players, processes and context affecting policy development and implementation and the interaction among these factors (55). Refer to Figure 3.2 below.

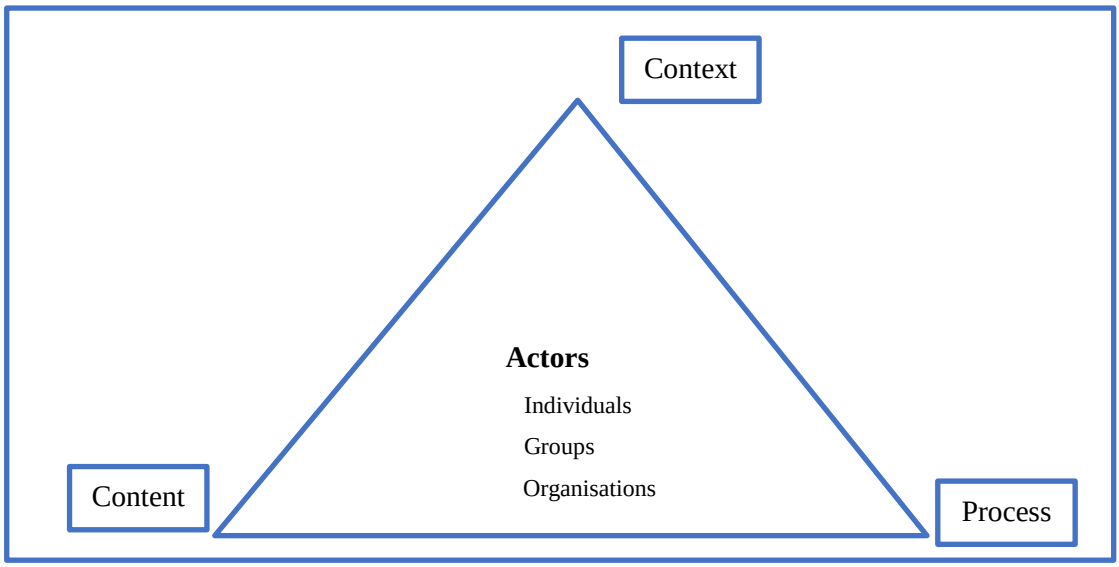

Figure 3.2: A Model for Health Policy Analysis (Van der Walt & Gilson, p. 55)

The analysis of actors refers to the influence wrought on policy development and implementation by individuals or interest groups, or professional associations as shaped by their context or work at the macro-governmental and micro-institutional level (46). Furthermore, the policy context itself is influenced by various intersecting factors, mainly the political regime, conflict, and culture. These actors directly impact policymaking processes; thus, their expectations, values, and position of power go beyond deciding on which policy is formulated and impact the content of the policy. As a result, the policy

content reflects the interplay of these dimensions (role players or service providers, context and process).

The advantage of using this analytical framework is that it does not only focus on policy content. It interrogates the power of role players or service providers and processes within the context of a policy formulation and implementation. However, in in the analysis of SUD policies, the Policy Analysis Triangle Framework was limited in that it did not deepen the exploration of the intricacies of the SUD system i.e., interactions of the components of the aftercare service provision system. Thus, Beer's VSM was used to facilitate an in-depth exploration of the interactions and roles fulfilled by each component for the effective functioning (46) of the SUD system. The Beer's VSM five components, namely, implementation (institution where Persons with SUD are serviced), coordination (district and institution), control (district level), development/intelligence (provincial) and policy (provincial and national) were analysed for each policy. Refer to Figure 3.3

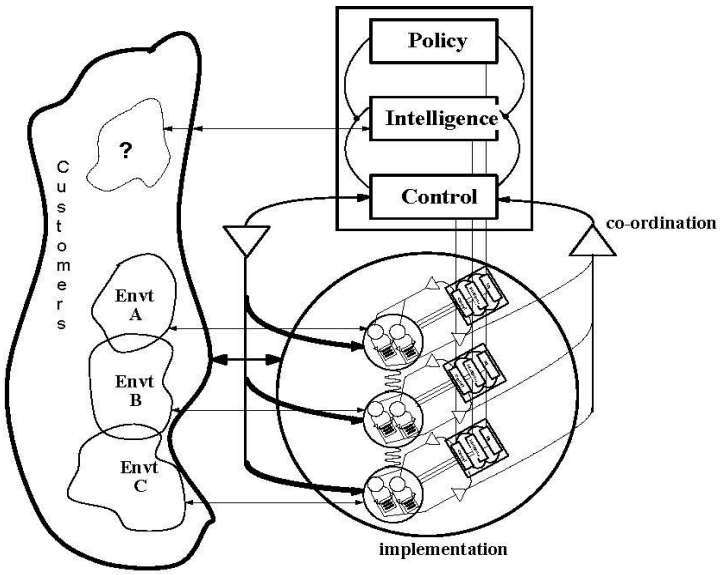

Figure 3.3: The Viable Systems Model (Van der Walt & Gilson, p. 60)

VSM was essential given that aftercare service provision occurs within a system of care, the Beer's VSM was essential and was used to deepen the analysis. The advantage of the VSM is that it explains how viable is the system i.e. ability to exist independently (60).

As a result, the policy analysis provided a detailed exploration of how these five components relate to the aftercare service provision system in a South African context and how viable is the aftercare service provision system. Sixteen documents (11 policies and three acts) were identified as substance use policies at a national level. Three strategies were used to identify all substance use policies: (i) an online internet search of the national DoH and DSD web sites; (ii) direct requests for circulating policies from key stakeholders. Eight policy documents were included and eight excluded, based on the inclusion criteria namely: (a) it had to be a South African policy; (b) the policy had to include content guiding aftercare and reintegration service provision in relation to substance use; and (c) if there were several versions/editions, the latest or most recent version of the document needed to be included. In addition, a meeting with a representative of the Provincial Substance Abuse Sub-Directorate of the DSD was held to confirm the selection. Findings from phase 1 contributed to the development of an aftercare model sensitive to local and international policy prescripts. Furthermore, it provided a framework for phase two data generation, beginning with the identification of key role players including service providers and their functions within the SUD system. Refer to chapter 4 for further details.

3.7 PHASE TWO OF THE STUDY

Phase two focused on data generation with 56 respondents within the aftercare service provision system. Forty-six respondents were service providers, five were service users-persons with SUDS and five were family members of persons with SUDs. Refer to Table 3.2 for the alignment of responses with VSM. Phase two comprised two stages, stage one: being interviews and focus group interviews with service providers, stage two: interviews with service users and their family members.

3.7.1 Stage 1 in phase 2: Interviews and focus groups with service providers

Interviews and focus group discussions with service providers generated data against objective 2 (to describe SUD aftercare implemented at a district level), objective 3 (to explore barriers and enablers of SUD aftercare at the district level in rural areas), objective 4 (to describe monitoring and evaluation strategies of SUD aftercare services,

and objective 5 (to propose a model of aftercare for persons with SUD). Further details are described in Chapter 5, Manuscript 2. The interview and focus groups explored the broad topic, i.e., experiences and perspectives of service providers in the provision of aftercare services within a SUD service provision system. Hence, this stage embraced systems-thinking theory and was additionally framed using the Beer's Viable Systems Model (VSM), which facilitated in-depth exploration of the interactions and functions fulfilled by each component for the system's effective functioning (46, 51) of the aftercare service provision system. Service providers at implementation level participated in focus groups discussion and interviews for service providers at the other levels. This was to minimise power dynamics such as influence of those in power to participants at implementation level who are generally their subordinates. Using a social constructivist paradigm (51), an understanding of the aftercare system was developed through the perspectives and constructed meanings of the service providers. This offered varied and complex experiences in the aftercare service provision.

3.7.1.1 Sampling strategy and sampling size

A non-probability purposive maximum variation sampling strategy was employed to select and recruit forty-six participants representing all role players from all sectors placed in all five functions of the Beer's VSM (46, 47) and sectors within the SUD service provision system. The majority of participants were from Implementation (Service Provision) (61 per cent), 22 per cent from Policy and Intelligence (Development), and 17 per cent from Coordination and Control (Monitoring and Evaluation) functions. The VSM does not include sectors. Refer to Table 3.2 for a further description of participants.

Table 3.2: Study Participants of Stage 1 of Phase 2 (N=46)

Level of Function	Role players or Service Provider's Designation	Discipline	ITC (DoSD)	DoSD	DoH	NGO1	NGO2	Total
(Policy and Intelligence-development) **Total number of participants: 10**	Executive Director	Social Worker				1		1
	Director	Project Management					1	1
	Substance Abuse Services Director	Social Worker		1				1
	Deputy District Manager/ Programs Manager	Social Worker		3				3
	Substance Abuse District Coordinator	Social Worker		1				1
	Clinical and Programs Manager	Nursing			1			1
	Facility Manager	Social Worker	2					2
(Coordination and control-monitoring and evaluation) **Total number of participants: 8**	Substance Abuse Facility Coordinator	Social worker		3				3
	Mental Health and Rehabilitation Coordinator	Occupational Therapist			1			1
	Social Work Supervisor	Social Worker	1					1
	Head of Social Services	Social Worker			1			1
	Medical Manager	Medical Officer			1			1
	Head of Occupational Therapy Department	Occupational Therapist			1			1
(Implementation-service provision level) **Total number of participants: 28**	Counselling Psychology Service Provider	Counselling Psychologist					1	1
	Social Auxiliary Service Provider	Social Auxiliary		1				1
	Occupational Therapy Service Provider	Occupational Therapist	1		2			3
	Occupational Therapy Technician Service Provider	Occupational Therapy Technician			1		1	2
	Social Work Service Provider	Social Worker	2	1	5	3	2	13
	Mental Health Care Nurse Service Provider	Nursing			4		1	5

	Counselling Service Provider	Lay counsellor					1	1
	Nursing Services	Nursing	2					2
Grand Total			8	10	17	4	7	46

However, in each system in the VSM for aftercare for persons with SUDs, multiple sectors would need to be involved as prescribed by the Substance Abuse Act No. 70 of 2008 (22), adding to the complexity of the system. Likewise, in this study sectors which are stakeholders in SUD treatment services (which include aftercare) were adequately represented, the leading departments (22), i.e. 39 per cent of participants were from DoSD, 37 per cent from DoH and 24 per cent from NGOs. In addition, participants also represented multiple disciplines: a majority were from social services (57 per cent), nursing (17 per cent), occupational therapy (15 per cent) and others (9 per cent). Note: Some participants had a dual level of function, but only the critical function is indicated in the table. Participants were recruited via their workplace (further details in Chapter 5). Refer to Figure 3.4 for the diagram illustrating data generation and sampling.

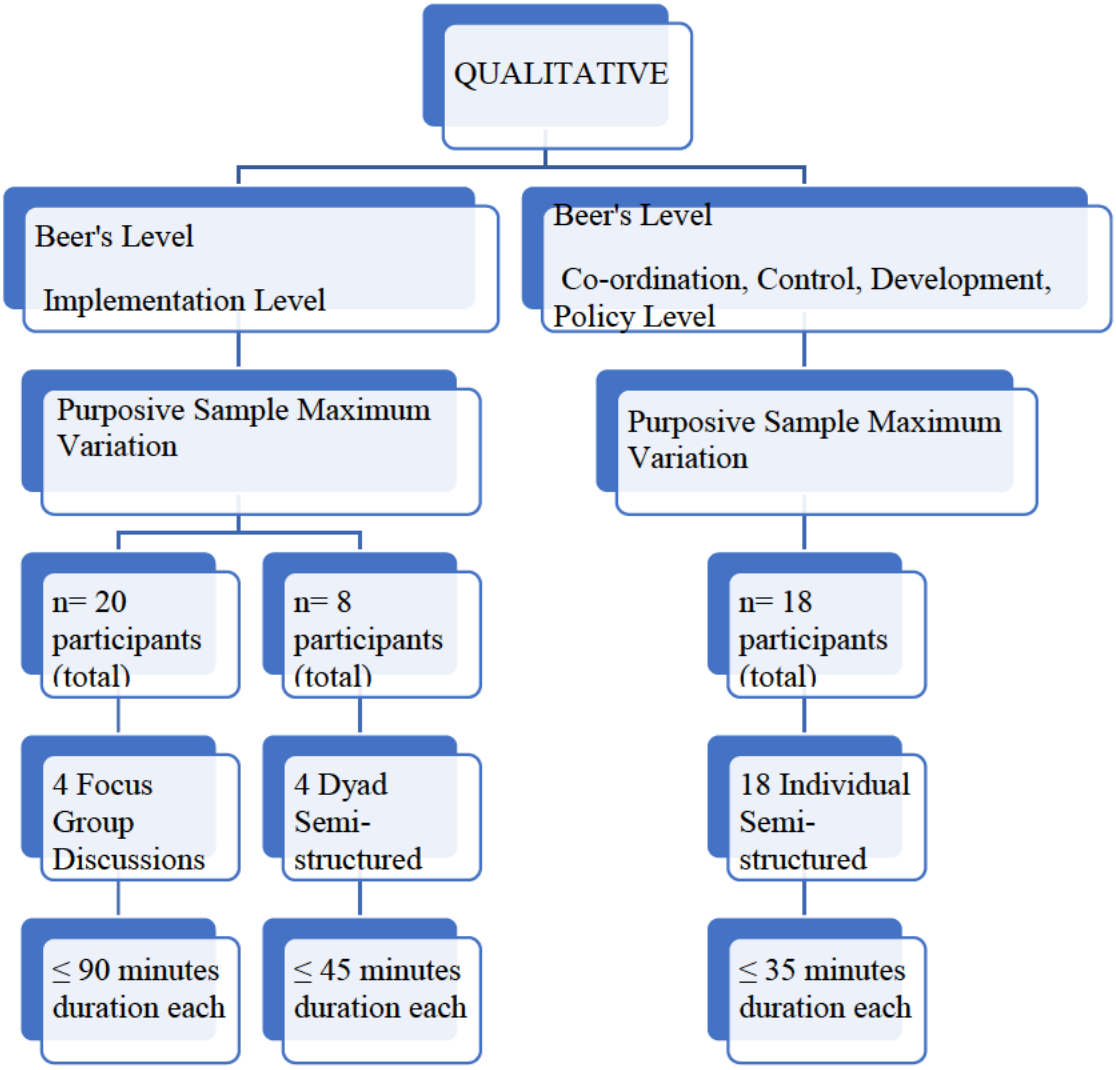

Figure 3.4: Diagram Illustrating Data Generation and Sampling

3.7.1.2 Data collection technique and instrument

Data were generated concurrently through focus groups discussions and face-to-face individual/dyad semi-structured interviews. A focus group discussion is an interactive discussion about a particular topic of interest by a small group (61). The advantage of a focus group is its ability to provide in-depth insight into a topic efficiently and timely (61). Four focus group discussions (n=20) for not more than ninety minutes were conducted with participants at the implementation level. Owing to the availability and convenience of participants at the implementation level (not constituting a focus group),

four dyad face-to-face semi-structured interviews (n=8) for not more than forty-five minutes were conducted. Semi-structured interviews are a common qualitative data collection technique involving a number of predetermined open-ended questions based on a study topic (62). The advantage of semi-structured interviews includes predetermined, open-ended questions. Furthermore, open-ended questions allow flexibility for the participants to express themselves freely. Mainly, semi-structured interviewing maintains rigour while allowing the researcher to collect meaningful and rich data (62). In this study, open-ended questions included a discussion on aftercare services provided in the district (refer to annexures 12-15 for question guide). Face-to-face individual semi-structured interviews (n=18) were conducted for not more than thirty-five minutes with participants at the coordination, control, development/intelligence and policy level function (based on Beer's VSM) to avoid any influence on the focus groups where the majority of service providers were at the implementation functional level.

3.7.1.3 Stage 1 in Phase 2: Data analysis

The audio recordings of interviews and focus groups were transcribed verbatim by an independent transcriber to produce a written transcript. Field notes aided the transcription. The researcher read the transcript whilst listening to the recordings and thereafter verified and edited the transcripts to ensure accurate verbatim transcriptions. Listening to audio recordings during data analysis forms the basis for trustworthiness (63). This was part of immersing oneself into the data prior to the analysis, as recommended by Braun and Clarke (53). Data were analysed thematically (64) using a deductive approach. Codes were predetermined from the questions, aims and objectives of the study using Beer's VSM (46). Thematic analysis is well aligned with a social constructionist epistemology (64), embraced in this study, where patterns are identified as socially produced and constructed by respondents. NVivo Pro 12 qualitative data analysis software (65) guided the organisation and further analysis of the data. The findings informed the development of an aftercare model that was informed by service providers and service users and their family members from all levels of service provision.

3.7.2 Stage 2 in phase 2

A total of 10 respondents participated in stage 2 of phase 2. The focus was on achieving objective 2 (describe SUD aftercare implemented at the district level in rural areas), objective- 3 (to explore barriers and enablers to SUD aftercare), and objective 5 (to propose a model of aftercare for persons with SUD), from the perspective of service users and their family members. Refer to Chapter 5, Manuscript 2.

3.7.2.1 Stage 2 in phase 2: Interviews with service users and their family members

Semi-structured interviews were conducted with persons with SUDs and their family members. Refer to annexure 14 and 15. Data were generated through individual face-to-face semi-structured interviews, guided by an interview schedule, conducted in isiZulu with each participant in their home; lasting not more than ninety minutes. Interviews were undertaken first with the persons with SUDs, followed by separate interviews with the family member/s to encourage free expression. Stage 2 was framed within social constructivism (51), which focused on understanding the unique and shared perspectives of aftercare needs in a rural context for persons with SUDs and their family members. Hence, a qualitative case study design (66) was followed, which yielded a rich description of everyday life (66, 67) in aftercare services utilisation post discharge from an ITC. A collective case study design allows studying multiple cases at single or multiple sites to better understand a phenomenon (66, 68).

3.7.2.2 Sampling strategy and sampling size

A non-probability purposive sampling strategy was employed to select and recruit participants from a single site (setting), i.e., a rural district described in 3.5. Using iterative data collection in a collective case study design, the individual and collective needs of five persons with SUDs (n=5) and five family members (n=5) were recorded. Refer to Table 3.3 for more details of the persons with SUDs. .

Table 3.3: Key Background Characteristics of Persons with SUDs (N=5)

Name	Age	Sex	Race	Education status	Employment status	Substance Used	Period of substance use	Referred to the Inpatient Treatment Centre by	Recovery Status	Recovery Period	The period since discharge at the time of the interview	Aftercare received
PWSUD1	29	Female	African	Grade 12 – (Technical Matriculation)	Unemployed	cannabis, alcohol	16 years	DoSD	Relapsed	1 year 7 months	2 years	Yes Social worker and Registered Counsellor
PWSUD2	38	Female	African	Grade 9	Community Health Worker	alcohol	Cannot recall	DoSD	Relapsed	1 day	2 years	No
PWSUD3	24	Male	African	Grade 10	Unemployed	Primary Substance- cannabis, alcohol, whoonga, poly-substance use	8 years	NGO	No relapse, but substitution addiction	Till to date	1 year	No
PWSUD4	22	Male	African	Grade 8	Unemployed	Primary Substance- cannabis, alcohol,	6 years	NGO	Relapsed	1 month	4 months	No
PWSUD5	27	Male	African	Grade 12	Unemployed	Primary Substance- cannabis, alcohol whoonga, poly-substance use	5 years	NGO	Relapsed	1 month	1 year	No

Table 3.4 presents the key features of the participating family members.

Table 3.4: Key features of the family members of persons with SUDs (n=5)

Participant ID	Relationship with the person with the SUD	Employment status	Prepared for discharge	Aftercare received	Family counselling	Intervention with ITC	Letter of apology received
FP1	Grandmother: PWSUD1	Pensioner	No	No	No	No	Yes
FP2	Father: PWSUD3	Unemployed	No	No	No	No	Yes
FP3	Stepfather: PWSUD4	Employed	No	No	No	No	No
FP4	Mother: PWSUD4	Unemployed	No	No	No	No	No
FP5	Mother: PWSUD5	Unemployed	No	No	No	No	No

Stage 2 phase 2 findings contributed to the development of an aftercare model (Chapter 7) that is responsive to the needs of service users and of their family members. For instance, interventions received by persons with SUDs revealed divergences within the SUD system which represents the diversities of navigating the SUD System during their quest for treatment intervention. Among the five participants, only one person with SUDs received aftercare. Inconsistences are demonstrated in the system. the real world/real context and real-life stories of respondents is reported which informed the in developing an aftercare model.

3.7.2.2 Data analysis of stage 2 phase 2

The audio recordings of interviews were transcribed verbatim into isiZulu, translated into English by an independent translator to produce a written transcript and revised for accuracy and quality. A three-step analysis recommended by Harling (68), was followed: a detailed case description was developed for each case, followed by a within-case analysis, and concluded with a cross-case analysis. Within-case and cross-case analyses were performed via a thematic analysis. A hybrid approach (69) to the thematic analysis was implemented: Codes were predetermined deductively from the study question, aims and objectives to align with study purpose i.e. recommendations for aftercare model, content of aftercare. New codes were derived inductively from the data. Codes were collated into thematic categories and further refined into sub-themes and named (64)

3.8 ACADEMIC RIGOUR AND TRUSTWORTHINESS

The study was wholly qualitative; thus, the trustworthiness of the findings was ensured by applying four criteria: credibility, confirmability, dependability and transferability (70, 71) through the implementation of the following strategies. Extensive details are outlined in each manuscript.

Theoretical triangulation (70) was achieved, by the following :

- The three theoretical perspectives to analyse the data, i.e., in phase 1 and 2,
- The policy analysis framework, namely the Policy Analysis Triangle Framework (55) and the systems-thinking model, i.e., the VSM (46) and thematic analysis (64).
- The thematic approach developed the analysis and allowed new themes to emerge from the policy documents and transcripts (64).

To ensure a truthful representation and credible interpretation of the analysis, identified themes were supported with extracts of verbatim narratives of the respondents and excerpts from policies (72) which minimised the threat of researcher influence on data analysis. In addition, the threat of researcher influence was managed through regular peer debriefing and reflexivity (73), which also enhanced confirmability (74). The researcher kept a written, reflexive journal (70), throughout the study process. The reflexive journal was used for self-reflection to critique and expose own views with the intention to minimise the influence on the interpretation of the findings. Peer debriefing was done with colleagues and supervisors through discussions of findings and interpretations the researcher had. In phase 2, stage 2, face-to-face member checking occurred to affirm and clarify the preliminary analysis and further collect data from respondents (service users and family members). Furthermore, the findings of this study were examined in relation to previous studies (73) which were commonly congruent with those of earlier studies, except for some components of the aftercare content.

A rich description, including a detailed methodological description which was employed in all study phases (73, 74), was included using diagrams to further augment the descriptions. Furthermore, the shortcomings of the methodology were exposed (73) for readers to determine the extent to which findings could be accepted and methods confirmed (73, 74). Additionally, to promote transferability, a thick description of the context and study respondents was provided.

3.9 ETHICAL CONSIDERATIONS

3.9.1 Ethical clearance and permission to conduct the study

Ethical approval was granted by the Biomedical Research Ethics Committee, University of KwaZulu-Natal, reference number BE274/17. (Please refer to Annexures 2 and 3).
Gatekeeper permissions were sought from all relevant stakeholders comprising the sample cohort, namely DoH, DoSD and two NGOs. (Please refer to Annexures 8 to 11 for Gatekeeper permission letters).

3.9.2 Ethical Principles

The ethical principles were adhered to according to the guidelines of the Declaration of Helsinki (75, 76) and the four principles of the Singapore Statement on Research Integrity (77, 78). These were applied as follows:

3.9.2.1 Justice and Inclusiveness

Justice refers to fairness and equity for all participants (76) in the research process. In this study, attempts were made to ensure that all relevant stakeholders were offered an opportunity to participate with equitable time allocation and treated with the utmost respect, with no discrimination and ensured that no sector was prioritised over another.

3.9.2.2 Minimising Harm (Non-maleficence)

Non-maleficence refers to the duty to avoid, prevent or minimise harm to others (76). This study was non-invasive as there was no physical contact procedure required. Thus harm/risk was minimal except possible mental and emotional distress that could happen, this was not observed however all participants were given information for referral, should they feel distressed.

3.9.2.3 Maximising Benefits (Beneficence)

The principle of beneficence enacts a duty to benefit others (76). The researcher maximised possible benefits and minimised potential harm; this entailed ensuring that the study would contribute to a model of aftercare that would directly benefit the SUD community. In addition, all pertinent service providers who were included contributed to the model's development and could enhance its utility. Publications in accredited peer-reviewed journals are ensured for broader usage and application for the academic community.

3.9.2.4 Autonomy, Free and Informed Consent

Informed consent entails ensuring study participants that they are fully informed about the study to make an informed decision whether to participate or not (76, 77). This process was undertaken without coercion but rather, with a clear description of the nature of the research and process involved; as a result, participants provided their consent. An information document explaining the details of the study, including their right to autonomy and withdrawal at any time, supplemented their understanding. It offered clarity on the contact details of the researcher, supervisors, the research office and ethics committee (Please refer to Annexure 6).

Autonomy recognises the right of an individual to make their own decisions and judgments to determine their action. Regarding the study participant's autonomy, the researcher apprised them of their right to withdraw from the study at any given point without incurring any consequences. Thereafter, those participants willing to participate signed the consent form. (Please refer to Annexure 7).

3.9.3 Privacy and Confidentiality

Protection of Personal Information Act (POPI Act) – POPIA of 2013 prescripts were followed to ensure protection of information of participants. Privacy and confidentiality ensure that all study participants are protected in terms of their personal/sensitive information and privacy/dignity (77, 78). This was ensured throughout the study process in terms of data collection, storage, and dissemination. All participants were assigned codes to protect their identity throughout the study.

3.9.4 Conflict of interest

The researcher declares no conflicts of interest. The researcher has two sponsors, namely the Department of Higher Education and Training (New Generation of Academics Programme, University Capacity Development Programme) and the National Research Foundation (via the Thuthuka Grant). The mandate of both is to offer financial support to facilitate the completion of the PhD study.

3.10 DATA MANAGEMENT AND STORAGE

All data were organised and categorised electronically. Hard copies of the data were managed as per the University of KwaZulu-Natal policies on the management of research data, as follows:

3.10.1 Electronic Data

During data collection and analysis, the recorded audiotapes of interviews and electronically filed notes were stored in the researcher's password-protected computer using codes for security purposes and then duplicated to an external drive as a backup.

3.10.2 Hard copies

Transcription scripts, fieldwork notes and informed consent forms signed by research participants were stored in lockable storage.

3.10.3 Disposing of data

Upon completion of the study and publication of results, data will be kept for five years. Thereafter it will be disposed of through the shredding of documents.

3.11 CONCLUSION

This chapter provided an overview of the methodology of the study, including the theoretical framework and philosophical underpinnings. Some pertinent details of the methodology are detailed in each manuscript in subsequent chapters. This chapter coherently demonstrated how each objective was achieved. In addition, the chapter outlined the academic rigour of the study and ethical considerations.

CHAPTER 4

PHASE 1: THE ANALYSIS OF SOUTH AFRICAN POLICIES FOR PERSONS WITH SUDs

4.1 INTRODUCTION

South Africa has developed a number of substance use policies and Acts. However, the policy directives and their comprehensiveness and relevance in guiding aftercare service provision for persons with substance use disorders (SUDs) have not been examined. Consequently, it is essential and timely to analyse the policies related to aftercare service provision in South Africa (37, 41). Within such a policy analysis, the focus on content should be evaluated against the national and international context (41). Therefore, this chapter aims to achieve the first objective of the study, which was to describe national policies governing SUD aftercare service provision in South Africa. The chapter establishes the aftercare content in South African policies and explores how these local policies respond to the national and international context.

4.2 AFTERCARE SERVICES TO PERSONS WITH SUBSTANCE USE DISORDERS: ANALYSIS OF SOUTH AFRICAN POLICY

The paper entitled "Aftercare Services to Persons with Substance Use Disorders: Analysis of South African Policy" and reporting on national policies governing SUD aftercare service provision in South Africa was published in the *Drugs: Education, Prevention and Policy Journal*. This journal provides a forum for researchers, policy makers and practitioners to engage in pertinent issues pertaining to substance use. This paper contributes to the current debate and the South African lacuna in policy-related research. The journal *"publishes multi-disciplinary research papers, reviews and commentaries on policy, treatment, prevention and harm reduction issues regarding both the use and misuse of alcohol, tobacco and other drugs."* Note the link to the journal: https://www.tandfonline.com/action/journalInformation?journalCode=idep20. The journal has six issues per year and a 43 per cent acceptance rate. The journal is indexed in Alcohol and Alcohol Problems Science Database (ETOH), Alcohol, Drugs and Traffic Safety, ASSIA (Applied Social Science Index and Abstracts), British Education Index, and Cambridge

Scientific Abstracts (CSA), to mention a few. Please refer to Table 4.1 for publication details of the article.

Table 4.1: Publication Details

ITEM	DETAILS
Article Title:	Aftercare services to persons with substance use disorders: analysis of South African policy.
Authors:	December Mandlenkosi Mpanza, Pragashnie Govender & Anna Voce
Journal:	Drugs: Education, Prevention and Policy
Journal Details	Peer-reviewed (double-blinded). Accredited with Department of Higher Education and Training (DoHET) in South Africa
Impact Factor:	1.710 (2020)
Quartile	2nd
Submission history:	Submitted: 15 September 2019 Accepted: 10 March 2020 Published: 13th April 2020
Publication Status:	Published online
DOI:	https://doi.org/10.1080/09687637.2020.1742661

4.3 AUTHOR CONTRIBUTION

The PhD candidate conceptualised the policy analysis, analysed policies and drafted the manuscript with guidance from supervisors (co-authors), Prof Anna Voce and Prof Pragashnie Govender, who also provided critical review throughout.

4.4 OVERVIEW OF THE PAPER

This is the first paper of the overall study. Pasted below is a PDF copy of the paper. Please refer to the online link: https://doi.org/10.1080/09687637.2020.1742661

THE MANUSCRIPT

TITLE: AFTERCARE SERVICES TO PERSONS WITH SUBSTANCE USE DISORDERS: ANALYSIS OF SOUTH AFRICAN POLICY.

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ARTICLE

Aftercare services to people with substance use disorders: analysis of South African policy

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ABSTRACT

People with substance use disorders require comprehensive treatment, including planned aftercare, for improved treatment outcomes. However, access to treatment and aftercare is limited globally, as in South Africa, under-girded by a paucity of empirical research on substance use aftercare and reintegration policies. When examining South African substance use aftercare and reintegration policies, the complex local and international contexts require scrutiny. The aim of this paper is to establish the aftercare content in South African policies and to explore how these local policies respond to the national and international context. The Policy Analysis Triangle proposed by Walt and Gilson, Beer's Viable Systems Model and Thematic Analysis guided the analysis of eight selected policies. The analysis demonstrated that South African policies have undergone changes over the past years: from having no aftercare content to a minimal allowance for aftercare in policies. Policies embrace an acute treatment approach similar to the healthcare delivery in South Africa. Therefore, an Integrated Recovery Management Model for recovery (aftercare) service provision is recommended which should be aligned to local policies and context with due cognizance of the United Nations Office on Drugs and Crimes (UNODC), and World Health Organization (WHO) chronic treatment approach.

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Introduction

People with substance use disorders (SUDs) require comprehensive treatment and planned aftercare, also known as recovery management, for improved treatment outcomes, especially towards relapse prevention (United Nations Office on Drugs and Crimes [UNODC] & World Health Organization [WHO], 2017). Global SUD relapse rates are high, with an estimated 60% of people with SUDs relapsing due to limited and inadequate treatment services, and poor provision of aftercare services (UNODC & WHO, 2017). South Africa has not had a reliable system of data collection for substance abuse (Peltzer et al., 2010). Relapse rates have been estimated to be 50% for cannabis, 33% for alcohol and 65% for other drugs such as cocaine and heroin (Ramlagan et al., 2010). A mere 3% success rate was estimated for clients attending treatment centers in South Africa (Van Wyk, 2011). The South African Community Epidemiology Network on Drug Use (SACENDU) (2019) statistics indicated that there has been very little changes in repeat of admissions into treatment centers and relapse rates from 2014 to 2018. Repeat of admissions in Gauteng Province were 15% in 2014 and 18% in 2018; Northern Region 8% in 2014 and 9% in 2018; Eastern Cape 32% in 2014 and 13% in 2018; Western Cape 29% in 2014 and 25% in 2018; and in KwaZulu-Natal 7% in 2014 and 14% in 2018 (SACENDU, 2019). Albeit the relapse rates statistics inconsistences, high relapse rates and repeat of admissions in South Africa are a cause for a concern in treatment services.

In SA, similar to what has been observed globally, poor treatment outcomes for people with SUDs, including high relapse rates, revolving door syndrome and poor reintegration of people with SUD into society are associated with limited treatment services (Myers et al., 2010) and inadequate aftercare services (Department of Social Development [DSD], 2013a; Ramlagan et al., 2010; Swanepoel et al., 2016; Van der Westhuizen, 2007).

Globally, one out of seven people who requires treatment has access to treatment programmes (UNODC, 2019). In Latin America only one out of 11 has access to treatment; and in low- and middle-income countries (LMICs), such as in many African countries, including SA, one out of 18 (UNODC & WHO, 2017). In addition, where treatment is available, it is frequently ineffective and not evidence-based (UNODC & WHO, 2017). As a result, post-discharge relapse and re-admission is high, with up to only 40% of people with SUDs achieving sustained recovery (UNODC & WHO, 2017).

In SA, Act No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, legally mandates the Department of Social Development (DSD) to administer treatment services to people with SUDs, with assistance from the Department of

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Health (DoH) for providing detoxification services. However, a limited number of people with SUDs have access treatment services (Burnhams et al., 2012; Lund et al., 2012; Mpanza & Govender, 2017; Myers et al., 2010). Treatment services for SUDs are grouped into three categories, namely, in-patient, outpatient and community based treatment. SA has a limited number of public sector inpatient treatment centers. For instance, the KwaZulu-Natal Province, the second largest province, serving a total population of 11,3 million people, 19,2% of the South African population (Stats SA, 2018), has two public sector in-patient treatment centers, both located in cities. As a result these public facilities have long waiting lists (Lund et al., 2012). In post-apartheid SA, there has been a drastic increase in the establishment of private sector treatment services (both licensed and unlicensed) (Burnhams et al., 2012). In contrast to public sector treatment facilities, privately owned treatment centers are generally available, with at least one facility in each city. However, the facilities are mostly inaccessible to the majority of the population, particularly to poorer communities in rural areas, due to high costs of care and no medical aid cover (Burnhams et al., 2012).

Globally, aftercare service provision is limited (UNODC, 2015; UNODC & WHO, 2017; WHO, 2016; 2018). The UNODC and WHO (2017) have also recognized that aftercare and long-term recovery management have not been addressed scientifically, nor has the efficacy of interventions been assessed in most countries. In the South African context, recovery management and relapse prevention fall within the scope of aftercare and reintegration services. Aftercare and reintegration services occur within outpatient and community based programmes, within the public and private sectors, comprising two separate systems of care. In the public sector, services are free, or at a low cost for those who can indeed afford to pay. In the private sector, services are expensive, majority of people use medical aid insurances. Both private and public sector, available aftercare and reintegration services may involve self-help, 12-step and mutual support groups, home visits, as well as individual and family interventions. However, studies exploring the needs of people with SUDs have reported the limited availability and inadequacy of aftercare and reintegration services (Department of Health [DoH], 2011; DSD, 2013a; Lund et al., 2012; Parry, 2005; Plüddemann et al., 2013; Van Der Westhuizen & de Jager, 2009; Wang et al., 2007). The limited availability and inadequacy of aftercare and reintegration services persists despite the consistent finding, from South African studies, that a major need for people with SUDs is adequate aftercare and reintegration following a treatment intervention (Mahlangu & Geyer, 2018; Van der Westhuizen et al., 2013). In an attempt to improve aftercare and reintegration services, two policies, namely, the National Drug Master Plan (NDMP) 2013–2017 and the Anti-substance Abuse Plan of Action (AAPA) 2011 endorsed the development of an aftercare and reintegration model to guide service provision. Such a model has not been developed to date.

Internationally, SUD treatment approaches have undergone changes over the years. In 2009, the UNODC and WHO promulgated a joint programme on drug dependence treatment and care, recognizing SUDs as chronic diseases (UNODC & WHO, 2017). The Joint Programme promotes effective and humane treatment for all people with SUDs, where similar care would be given for people with SUDs as for people with any other chronic condition (UNODC & WHO, 2017). In 2015, the UNODC issued a statement that SUDs had recently been understood as complex, multifaceted and relapsing chronic conditions requiring strong aftercare. This in contrast to the acute care model, where people with SUDs are expected to be fully recovered by discharge (UNODC, 2015). In 2017, the UNODC and WHO jointly published the International Standards for the Treatment of Drug Use Disorders. These Standards are long-term and chronic care orientated, with aftercare being referred to as 'recovery management' taking as long as is needed, rather than being limited to a particular period.

The changes introduced by key international bodies such as the WHO and UNODC aim to reduce the health and social burden caused by SUDs, to promote evidence-based treatment and aftercare/recovery management strategies and policies, that are grounded in a public health and human rights approach (UNODC & WHO, 2017). The changes are expected to influence national policy developments, making it pertinent to examine national policies to understand how they have responded to these directives and policy changes.

In SA, with the dynamic political transition from apartheid to democracy, and the adoption of a Constitution based on a human rights approach, several concomitant policy changes in the provision of social and health services have ensued (Pienaar & Savic, 2016). The approach to the provision of services pre-democracy was characterized by racial segregation and inequality (Ramlagan et al., 2010). Policy reforms, including the declaration of the White Paper for the Reconstruction and Development Programme (ANC) (1994) and the White Paper for Social Welfare (RSA) (1997), espoused a transformation from a social welfare state to a developmental state and a developmental approach to the provision of social welfare services. The developmental approach aims to overcome a history of injustice and of human rights violations and promotes social transformation, human emancipation and reconstruction, social inclusion, socio-economic development and poverty alleviation (Republic of South Africa (RSA)), 1997; DSD, 2013b). The developmental approach to the provision of social welfare services adopts a strategy with a preferential focus on the poor and disadvantaged, with the intention to promote the development of human capacity and self-reliance within a caring and enabling socio-economic environment (Ntjana, 2014).

SUD policy reforms in 1999 resulted in the formation of the first NDMP 1999-2004, a national policy on service provision for substance abuse in SA. Also in 1999, the Central Drug Authority (CDA) was established, which is a regulatory body for SUD services. In 2008 the Prevention and Treatment of Drug Dependency Act No. 20 of 1992 was repealed and replaced by Act No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, hereafter referred to as PTSA Act No. 70 of 2008 (Government Gazette, 2009). This act describes aftercare as an 'on-going professional support to a service user after a formal treatment episode has ended, in order to enable him or her to maintain sobriety or abstinence, personal growth, and to enhance self-reliance and proper social functioning' (Government Gazette, 2009, Chapter 1, p. 11). The Act no. 70 of 2008 further states that

the main goal of aftercare and reintegration services includes successful reintegration of people with SUDs into society, the workforce, family, and community life (Government Gazette, 2009, Chapter 7, sub-section 30.1, p. 38).

Although SA has developed a number of substance use policies and acts, namely: NDMP 2013–2017, AAPA 2011, the National Minimum Norms and Standard for Inpatient Treatment Centres (NMNSITC) (n.d), the National Health Mini Drug Master Plan (NHMDMP) 2011–2014, National Development Plan (2011) and PTSA Act No. 70 of 2008, there is a paucity of empirical research on the application of these policies (Pienaar & Savic, 2016). The directives contained within South African policy documents, and their comprehensiveness and relevance in guiding SUD aftercare and reintegration service provision in SA, have not been examined. These developments make an analysis of SA's substance use policy context timely (Pienaar & Savic, 2016; Scheibe et al., 2017). Within such a policy analysis, the focus on content should be evaluated against the national and international context (Scheibe et al., 2017). In addition, the NDMP 2013-2017 emphasize the need to develop policies that are aligned with the regulations of international bodies but responsive to local needs and contextual problems. Thus there is need to analyze policies against prescripts of the WHO and UNODC as well as the Sustainable Development Goals (United Nations Department of Economic and Social Affairs [UN DESA], 2015). In particular goal number one, 'End poverty in all its forms everywhere'; three, 'Ensure healthy lives and promote well-being for all at all ages'; and 10, 'Reduce inequality within and among countries' (UN DESA, 2015, p.14). Therefore, the aim of this paper is to establish the aftercare content in South African policies and to explore how these local policies respond to the national and international context.

Methods

Theoretical framework

The Walt and Gilson (1994) Policy Analysis Triangle for Health Policy Analysis was used to guide the aftercare and reintegration policy analysis and examine the content, actors (local and international), process, and context (local and international) (Walt & Gilson, 1994). This policy analysis approach may be applied both to the policy formulation process and the implementation thereof, either prospectively or retrospectively. In this study it was applied retrospectively.

The Policy Analysis Triangle (Walt & Gilson, 1994) assists to identify policy actors but the limitation is that it does not deepen the understanding of their key functions and roles within a system. It instead focuses on the power and influence the actors exert during policy formulation and implementation. Given that SUD aftercare and reintegration service provision occurs within a system of care, the Beer's Viable System Model (VSM) (Jackson, 2000; Leonard & Beer, 1994) was used to deepen the analysis. The Beer's VSM therefore assisted in identifying the five key functions in a system, namely: implementation, coordination, control, development, and policy (Jackson, 2000; Leonard & Beer, 1994). Figure 1 depicts how approaches were merged in the study.

Research process

The study has focused on an analysis of the existing policies in relation to SUD aftercare and reintegration service provision in SA. The procedure entailed: (1) identifying substance use policies; (2) selecting policies relevant to SUD aftercare and reintegration; and (3) data extraction for the detailed analysis.

Identifying substance use policies

In this study, a policy document was described as a document with a broad statement of goals, objectives and content that serves as a blueprint to guide activity (Haglund, 2010). Three strategies were used to identify all substance use policies at a national level, these being: (i) an online internet search of the national DoH and DSD web sites; (ii) direct requests for circulating policies from key stakeholders, i.e. the National DoH, the Substance Abuse sub-Directorate

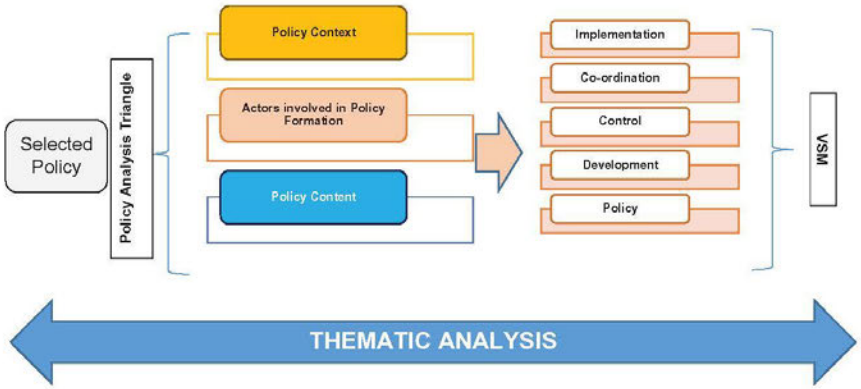

Figure 1. Depicting methodology approaches used in the policy analysis.

Table 1. Chronology of policies including selection criteria for the study.

YEAR	AUTHOR	POLICY	DECISION	CRITERIA
1992	SA Parliament (Government gazette)	Prevention and Treatment of Drug Dependency (PTDP) Act No. 20 of 1992	Excluded	Outdated and was replaced by the Prevention of and Treatment for Substance Abuse Act no 70 of 2008.
1992	SA Parliament (Government gazette)	Drug and Drug Trafficking (DDT) Act No. 140 of 1992	Excluded	Legal framework for drug control and drug trafficking. No attention given to service provision and aftercare for drug use and misuse.
1996	SA Parliament (Government gazette)	Liquor Act of 1996	Excluded	Focus on liquor regulation. No attention given to service provision and aftercare for alcohol use and misuse.
1997	Department of Welfare, now known as Department of Social Development.	White Paper for Social Welfare 1997 (WPSW)	Included	Included because it is a national policy framework and strategy for Social Development, informs the restructuring of services which includes substance abuse services.
1999	National Department of Social Development	National Drug Master Plan 1999–2004	Excluded	Outdated and no longer in use. Replaced by the current NDMP 2006–2011.
2002	SA Parliament (Government gazette)	Mental Health Care Act of 2002	Excluded	Deals primarily with the legal rights of people with mental health conditions. No attention given specifically to service provision for SUDs.
2006	Central Drug Authority	National Drug Master Plan 2006–2011	Excluded	Outdated and no longer in use. Replaced by the current NDMP 2013–2017.
Unknown date	National Department of Social Development	National Minimum Norms and Standards for Inpatient Treatment Centres (NMNSITC)	Included	Included on the basis of its focus on aftercare and prescription of minimum norms and standards of services to be provided. Furthermore, it was confirmed by DSD as a policy still in use.
Unknown date	National Department of Social Development	National Department of Social Development Minimum Norms and Standards for Out-Patient Treatment Centres	Excluded	Excluded because focused on Out-Patient Treatment Centres. The policy analysis focused on SUD clients discharged from inpatient treatment centres.
2009	SA Parliament (Government gazette)	Prevention of and Treatment for Substance Abuse Act no 70 of 2008	Included	Included because it is a legal framework for prevention of and treatment for substance abuse. In addition it has one chapter dedicated to aftercare and it has been used to develop policies in the field.
2011	National Planning Commission	National Development Plan Vision for 2030 (NPD)	Included	Included because it is an overall country's development plan. In addition, it has a chapter on promoting health and social protection which include a developmental approach to social welfare services.
2011	National Department of Health	National Health Mini Drug Master Plan (NHMDMP) of 2011/12–2013/14	Included	Included because it is a national policy for the Department of Health, has aftercare content, guiding the provision of SUD services and confirmed by both DSD and DoH as a national policy.
2011	National Department of Social Development	Anti-Substance Abuse Programme of Action 2011–2016	Included	Included on the basis that it was formulated to guide the implementation of the Second Biannual Anti-Substance Abuse Summit Resolutions, and has content of aftercare at a national level. Also affirmed by DSD as a national policy.
2013	Central Drug Authority	National Drug Master Plan 2013–2017	Included	Included on the basis that it is an overarching policy and a blue-print for service provision and has aftercare content. In addition, it was confirmed by DSD as an overarching drug policy.
2013	Department of Social Development	Framework for Social Welfare Services 2013 (FSWS)	Included	Included because it is a framework that guides the provision of social development services. In addition, it has a section on aftercare and reintegration.
2015	SA Government-The Presidency and National Youth Development Agency	National Youth Policy 2015–2020	Excluded	Excluded because it has no aftercare content nor does it guide treatment services. It is a generic policy for youth issues in SA.

within the DSD, and the secretariat of the CDA; and (iii) identifying policies within publications on substance use policy analysis. Sixteen documents were retrieved, of which eleven were national policies and three were acts.

Selecting policies relevant to SUD aftercare and reintegration

All identified policies related to substance use were reviewed for relevance to SUD aftercare and reintegration, with the most recently published versions being included for analysis. A meeting with a representative of the Provincial Substance Abuse Sub-Directorate of the DSD took place to confirm the selection. Eight policy documents were included and eight excluded, based on the inclusion criteria namely: (a) it had to be a South African policy; (b) the policy had to include content guiding aftercare and reintegration service provision in relation to substance use; and (c) if there were several versions/editions, the latest or most recent version of the document needed to be included. Refer Table 1 for more details

and explanation on how each policy met the inclusion criteria.

Data extraction from selected policies

A data extraction framework using four domains of the Policy Analysis Triangle (Walt & Gilson, 1994) was designed in a Microsoft Excel spreadsheet. These were the actors involved in the policy formulation; the context within which the policy was located; the process of policy formulation; and the policy content. The five key functions of Beer's VSM (Jackson, 2000; Leonard & Beer, 1994), namely, implementation, coordination, control, development, and policy were thereafter used to categorize the roles of policy actors. The eight selected policies were read twice, and texts pertaining to each domain in the Policy Analysis Triangle (Walt & Gilson, 1994) were displayed for comparison on the spreadsheet.

Data Analysis

Data analysis occurred at two levels: descriptive and interpretive, with the former outcome leading to a synthesized summary of each policy document. The summary consisted of a brief overview of the policy and its intended purpose, the international and local actors involved in its formulation, the international and local political and historical context of the policy, and the process followed in the formulation and its content. The outcome of the interpretive analysis was underpinned by a six-staged thematic approach described by Braun and Clarke (2006) to further analyze the policy content, which was a representation of the aftercare and reintegration continuum of care (Figure 2). Some themes were generated from both the policy analysis triangle and the VSM. Whilst some emerged from the analysis. NVivo qualitative data analysis software (2015) was used to store, organize and analyze the data. To ensure trustworthiness in this study, strategies to ensure confirmability and credibility were implemented (Lincoln & Guba, 1986; Patton, 2002).

Credibility was achieved through five strategies, namely triangulation (Lietz & Zayas, 2010; Lincoln & Guba, 1986; Patton, 2002; Shenton, 2004), managing the risk of researcher bias (Lietz & Zayas, 2010), reflexivity (Lietz & Zayas, 2010; Patton, 2002; Shenton, 2004), debriefing (Shenton, 2004), and examination of findings in relation to previous research findings (Shenton, 2004). Analyst triangulation (Patton, 2002) was applied through multiple analysts, where two authors reviewed the findings and further analyzed policies, which helped to illuminate blind spots in the analysis process. Theoretical triangulation (Patton, 2002), was achieved with the use of multiple theoretical perspectives to analyze the data. In this study, two policy analysis frameworks were used, namely, policy analysis triangle and the VSM. These two frameworks have some limitations, such as predetermined themes, which may have resulted in omission of some important contents in policies. To mitigate such limitations and ultimately enhance creditability, thematic analysis (Braun & Clarke, 2006) was further employed. This thematic approach deepened the analysis and allowed new themes to emerge from policy documents (Braun & Clarke, 2006; Figure 2). To ensure a truthful representation, the interpretation of the analysis was supported by the extracts from policies (Slevin & Sines, 2000; Table 2 and Figure 2). In addition, the threat of researcher bias was managed through regular peer debriefing (Lietz & Zayas, 2010; Lincoln & Guba, 1986;

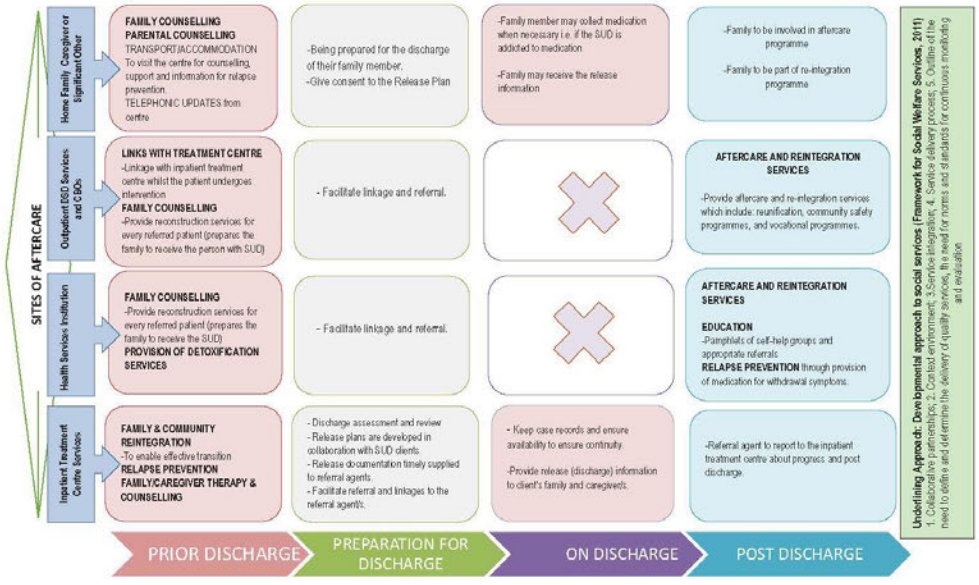

Figure 2. Consolidated Summary of Aftercare Content from eight analyzed policies.

Table 2. Policy Formulation, Content and Context of South African Policies related to SUDs.

Policy		White Paper for Social Welfare 1997 (WPSW)	Prevention of and Treatment for Substance Abuse Act 70 of 2008 (PTSA)	National Development Plan Vision for 2030 (NPD)	Framework for Social Welfare Services 2013 (FSWS)	National Drug Master Plan 2013–2017 (NDMP)	National Health Mini Drug Master Plan of 2011–2014 (NHMDMP)	National Minimum Norms and Standards for Inpatient Treatment Centres (NMNSITC)	Anti-Substance Abuse Programme of Action 2011–2016 (AAPA)
Policy Description and Formulation	Current Edition	1997	2008	2011	2013	2013	2011	Undated	2011
	First edition	1997	1992	2011	2013	1999	2011	Unknown	2011
	Evaluations	Not specified	Not specified	Continuously	Not specified	Not specified	Not specified	Not specified	Not specified
	Updates/Revisions	Not specified	Not specified	Every five years	Not specified	Every five years	Not specified	Not specified	Not specified
	Content Focus	A document to 'inform the restructuring of services and social welfare programmes in both the public and the private sectors' in to using Social development approaches. White Paper for Social Welfare 1997 (WPSW) Preamble point no 5.	An act that governs prevention of and treatment for substance abuse.	The country's development blueprint for vision 2030, which is to eliminate poverty and reduce inequality by 2030.	The focus is demonstrated by this goal: 'The Framework seeks to facilitate/guide the implementation of a comprehensive, integrated, rights-based, well-resourced and quality developmental social welfare service'	A single document defining priorities and allocating responsibility for drug control efforts.	The overall guide for the health sector for substance use interventions in South Africa.	Standards of care designed to prescribe an acceptable quality of care for substance-dependent persons at inpatient treatment centres.	A programme of action for the implementation of BASA Summit 2011. Emphasises the need for a multi-modal approach to care and aftercare model development.
	Purpose	Re-orientate social welfare services to social developmental approaches in service provision. Demonstrated in these extracts: 'The Ministry for Welfare and Population Development is committed to the continuity of existing services whilst at the same time re-orientating such services towards developmental approaches.' White Paper for Social Welfare 1997 (WPSW) Preamble point no 5.	To provide for: a comprehensive national response for the combating of substance abuse; mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes; the registration and establishment of treatment centres and halfway houses; the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres; the establishment of a central drug authority; and to provide for matter connected herewith. (Direct Extract from the Act no 70 of 2008)	The plan aims to provide South Africa with a policy directive and a vision for 2030. The plan focuses on reindustrialising the economy, eliminating poverty, reducing inequality and improving access to quality education by 2030.	The purpose is clearly demonstrated in this extract: To give effect to the developmental approach espoused in the White Paper for Welfare. Framework for Social Welfare Services 2013, p5	Overarching policy that guides the service provision for SUDs in SA which is framed within the legal provisions of the Prevention and Treatment of Drug Dependency Act No. 20 of 1992 repealed by the Prevention of and Treatment of Substance Abuse Act No. 70 of 2008.	Policy that aims to guide the health sector in implementing interventions (applicable to all levels of healthcare) essential to achieve goals set in the overall inter-sectoral National Drug Master Plan.	Policy that aims to provide standards of care including minimum requirements and quality assurance for service providers to ensure that the rights of chemical dependents (and families) are protected and that young people at risk (and their families) receive a high quality service.	A programme that is based on five key objectives, namely: to develop policy; review and align liquor registration; educate and create awareness on substance use; promote equal access to resources across the country; respond to policies and legislation on drugs and organised crime; and to review institutional mechanisms to prevent and manage alcohol and drug use in the country.
	Process of Policy Formulation	Formulated through the leadership of Ministers of Department of Social Development with other stakeholders in the welfare field. Demonstrated in these extracts: 'The Ministry for Welfare and Population Development is committed to the continuity of existing services whilst at the same time re-orientating such services towards developmental	The Drugs and Drug Trafficking Act No. 140 of 1992 was repealed and replaced by the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008. It was adopted by parliament and assented by the President on 1st April 2009.	The National Planning Commission led the formulation of the plan over a period of 18 months with inputs and perspectives of 'thousands of people'. It was adopted by Parliament in 2012. Demonstrated in this extract: 'The Commission consulted widely	Formulated through the leadership of the Department of Social Development. Consultative sessions were conducted nationally and provincially with national departments and other stakeholders with co-responsibility for the delivery of social welfare services. The consultations included the national reference team and working teams and the First National	Formulated through the headship of the Central Drug Authority (CDA). The process involved a review of the 2006 – 2011 edition in a series of workshops: attendance at national and international conferences by the CDA to determine the implications for SA; feedback reports from the provincial substance abuse desktop review of the burden of substance use in the	Formulated following the BASA Summit 2011, in which presidential support for inter-sectoral collaboration and attention from government was provided. Formulated in response to the mandate within the Prevention and Treatment of Drug Dependency Act No. 20 of 1992 (as amended), the PTSA Act No. 70 of 2008 and the NDMP (2013 – 2017).	No date of formulation nor release specified. Refers to a time period of publication ten years after the inception of democracy in 1994, and is signed by the DSD National Minister that was in office between 1999 and 2009. Derive its legal mandate from the Prevention and Treatment of Drug Dependency Act No. 20 of 1992. A number of consultative meetings	Process of formulation is not indicated in the document except for an indication that 'the programme of action was developed based on resolutions taken during the BASA Summit in 2011' (AAPA, 2011, p2).

(*continued*)

Table 2. Continued.

Policy		White Paper for Social Welfare 1997 (WPSW)	Prevention of and Treatment for Substance Abuse Act 70 of 2008 (PTSA)	National Development Plan Vision for 2030 (NPD)	Framework for Social Welfare Services 2013 (FSWS)	National Drug Master Plan 2013–2017 (NDMP)	National Health Mini Drug Master Plan of 2011–2014 (NHMDMP)	National Minimum Norms and Standards for Inpatient Treatment Centres (NMNSITC)	Anti-Substance Abuse Programme of Action 2011–2016 (AAPA)
		approaches …' Paper for Social Welfare 1997 (WPSW) Preamble section no 3. However no mention of a particular stakeholder: 'This White Paper has been drawn up with the full participation of the stakeholders in the welfare field.' White Paper for Social Welfare 1997 (WPSW) Preamble section no 5.		on the draft plan. Our public forums drew in thousands of people; we met with parliament, the judiciary, national departments, provincial governments, development finance institutions, state-owned entities and local government formations; and we held talks with unions, business, religious leaders and non-profit organisations.'	Indaba on Social Welfare Services held in February 2010.The formulation process reviewed the progress made since the inception of the White Paper for Social Development: 'Thirteen years since the inception of the White Paper, the sector reflected on the progress made with the implementation of the principles and guidelines …' Framework for Social Welfare Services 2013, p8	country; community consultations (although not specified in detail) in the form of national rapid participatory assessments and door-to-door anti-substance use campaigns.		were held over a period of 6 months. The NMNSITC was approved by cabinet, but no approval date is recorded and no review date is indicated. The policy as a strong legal mandate, the policy has been in place for more than 12 years and is still in use by inpatient treatment centres.	
Context	International Context	This white paper was influenced by the United Nations, demonstrated in this extract: 'The proposed direction of the White Paper is in line with the approach advocated by the United Nations World Summit for Social Development, held on 6 to 12 March 1995.' White Paper for Social Welfare 1997 (WPSW) Preamble section, point no 5.	Although not specified in any document, presumable this Act was formulated in cognisance of SA being a signatory to the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances (1971), Convention on the Law of the Sea (1982) and Convention against illicit Traffic in Narcotic Drugs and Psychotropic Drugs (1988).	Was developed in cognisance of sustainable development goals, such as eliminating poverty and reducing inequality. In addition, recognition of global influence noted in this extract: 'International and regional developments affect South Africa in complex ways. Our view is that on balance, global trends can have positive implication for South Africa's development, notwithstanding several notable risks. Understanding and responding appropriately to complex global challenges is the first task of planning.	No international influence recorded. However the FSWS was developed in line with the white Paper for Social Welfare 1997 which had a international influence demonstrated in this extract: 'The proposed direction of the White Paper is in line with the approach advocated by the United Nations World Summit for Social Development, held on 6 to 12 March 1995.' White Paper for Social Welfare 1997 (WPSW) Preamble section, point no 5.	SA is a signatory to the Single Convention on Narcotic Drugs of 1961, the Convention on Psychotropic Substances (1971), Convention on the Law of the Sea (1982) and Convention against illicit Traffic in Narcotic Drugs and Psychotropic Drugs (1988). NDMP was revised to include the shift from supply reduction strategies to primary prevention strategies, as advocated by UNODC and WHO (NDMP 2013 – 2017, p27). Revision of the NDMP prior version was influenced by the international debates around decriminalising or criminalising of substances and users or abusers (NDMP 2013 – 2017, p4).	Emphasises compliance with international evidence-based principles for the effective treatment of drug addiction, such as the treatment guidelines for drug addiction published by the National Institute of Drug Abuse (NIH Publication 00-4180 in the NHMDMP, 2011 – 14). Acknowledges and emphasises the need to adapt internationally developed treatment models to meet specific needs in the SA context.	Financial assistance and guidance was provided by the UNODC towards the formulation of the NMNSITC.	None recorded

(continued)

Table 2. Continued.

Policy		White Paper for Social Welfare 1997 (WPSW)	Prevention of and Treatment for Substance Abuse Act 70 of 2008 (PTSA)	National Development Plan Vision for 2030 (NPD)	Framework for Social Welfare Services 2013 (FSWS)	National Drug Master Plan 2013–2017 (NDMP)	National Health Mini Drug Master Plan of 2011–2014 (NHMDMP)	National Minimum Norms and Standards for Inpatient Treatment Centres (NMNSITC)	Anti-Substance Abuse Programme of Action 2011–2016 (AAPA)
	National (Local) Context	The socioeconomic and political situation had undergone changes, apartheid to democracy, thus policies had to align with new changes. This White Paper was influenced by the White Paper for the Reconstruction and Development Programme (RDP) 1994 which was released with a transformation agenda after inception of democracy. Demonstrated in this extract: 'The Ministry for Welfare and Population Development is committed to The Ministry for Welfare and Population Development is committed to the continuity of existing services whilst at the same time re-orientating such services towards developmental approaches. The Ministry will strive to achieve the above social goals in a collaborative partnership with individuals, organisations in civil society and the private sector in keeping with the values, goals and priorities of the Reconstruction and Development Programme.' White Paper for Social Welfare 1997 (WPSW) Preamble section no 3.	This Act was formulated in the post-apartheid era and the South African constitution in use. Thus influenced by the values of democracy and the constitution which include equality, inclusivity, human rights based.	Post-apartheid context demonstrated in this extract: South Africa's transition from apartheid to a democratic state has been a success. In the past 18 years, we have built democratic institutions, transformed the public service, extended basic services, stabilised the economy and taken our rightful place in the family of nations. Despite these successes, too many people are trapped in poverty and we remain a highly unequal society. Too few South Africans work, the quality of school education for the majority is of poor quality and our state lacks capacity in critical areas. Despite significant progress, our country remains divided, with opportunity still shaped by the legacy of apartheid. In particular, young people and women are denied the opportunities to lead the lives that they desire. Our Constitution obliges all of us to tackle these challenges. (NDP 2011, p1)	The Framework was guided by the change in socio-economic and political situation of the country, White Paper on Reconstruction and Development (1994) and the progress made since the adoption of the White Paper for Social Welfare (1997). Demonstrated in this extract: 'The environment within which social welfare services are rendered has changed during the last fifteen years. This has been largely influenced by changes in the socio-economic and political situation of the country, which necessitated legislative and policy reviews to make social welfare programmes and services responsive and equitable to the needs of the poorest of the poor, marginalised and vulnerable groups of our society. The White Paper for Social Welfare (here after referred to as White Paper) guided this transformation process.' Framework for Social Welfare Services 2013, p8.	Considered the resolutions taken at the BASA Summit 2011 (three of which addressed aftercare service provision) in response to the 2012 – 2016 edition of the NMDP. The NDMP emphasises the need for each government department to design its own mini-drug master plan, so that solutions and strategies would be devised from the bottom up rather than the top down.	Acknowledged the resolutions from the BASA Summit 2011, which was a situational factor in 2011. Emphasises the goals from the PTSA Act No 70 of 2008 and NDMP 2006 – 2011 which charge all key government departments to develop their own mini drug master plans, to guide their own core functions in the provision of substance use services.	NMNSITC used by the DSD to accredit inpatient treatment centres, based on an objective assessment and comparison with expected standards. Guided by the NMNSITC, inpatient treatment centres are regulated, supported, and developed within the legal and constitutional framework of South Africa, and within international standards of service delivery (NMNSITC, n.d). NMNSITC formulation was influenced by the prevailing human rights culture and constitutional framework of the new democratic South Africa, as demonstrated in this extract: 'They [the minimum norms and standards] will contribute positively towards the regulation of treatment centres as well as ensure that services rendered by these centres are sensitive to the prevailing human rights culture and are in line with the legal and constitutional framework of the country'. (NMNSITC, n.d, p3)	Draws its legal mandate from the Prevention of and Treatment for Substance Abuse Act No 70 of 2008.

Shenton, 2004) and reflexivity (Lietz & Zayas, 2010; Patton, 2002; Shenton, 2004). Debriefing with colleagues was conducted to ensure the analysis was based on policy content rather than the primary author's own views. The primary author kept a written reflexive journal throughout the study process (Lietz & Zayas, 2010; Patton, 2002; Shenton, 2004). The journal increased the awareness of potential researcher bias and facilitated in-depth discussion among the three authors. Furthermore, findings of this study were examined in relation to previous studies (Shenton, 2004) of policy analysis in South Africa. The findings were commonly congruent with those of previous studies except for the content on aftercare, which was not comparable due to the absence of previous policy analysis studies on aftercare.

Confirmability refers to extent to which findings of the study could be confirmed or corroborated by others (Lincoln & Guba, 1986; Shenton, 2004). In this study, similar steps that were undertaken to achieve credibility, namely, reflexivity and debriefing were also applied to enhance confirmability (Lietz & Zayas, 2010). In addition, thick descriptions including detailed methodological description was employed (Lietz & Zayas, 2010; Shenton, 2004). Details of the methodology and procedures followed in this study and its shortcomings were exposed (Shenton, 2004), refer Figure 1 for a diagrammatic presentation of methods used. Possibly, the details are enough to allow readers to determine the extent to which findings can be accepted and confirm the research methods (Lietz & Zayas, 2010; Shenton, 2004). Notwithstanding, the steps carried out in this study, enhanced the confirmability of the findings.

Findings

Once the policies relevant to SUD aftercare and reintegration had been selected, the findings were presented under three broad headings of the Policy Analysis triangle, as follows: Policy context, Actors involved in Policy Formulation, and Policy content with a focus on aftercare and reintegration content. In addition, the actors were further analyzed using the five key functions of the Beer's VSM, namely: implementation, coordination, control, development, and policy.

Policy context

Table 2 provides a summary of the included policies, with an emphasis on the content focus, purpose, as well as the process of formulation and the context (international, national and situational factors).

Walt and Gilson (1994) highlight the importance of analyzing the international and national context to understand the interplay of context, process and actors. Buse et al. (2005) emphasize that situational factors within the context must also be noted. This necessitates a reference to two situational factors, namely, the democratization of South Africa in 1994 and the second National Biennial Anti-Substance Abuse Summit 2011, hereafter referred to as BASA Summit 2011. Post 1994 the country had a task to transform its policies and approaches to suit the new dawn of democracy, as demonstrated in Table 2. Policies were developed, namely, the White Paper for Social Welfare Services was formulated in 1997 'to re-orientate social welfare services to social developmental approaches in service provision' and align with the White Paper for Reconstruction and Development (1994) (RSA,1997). It is also important to note the international context influence such as the United Nations World Summit for Social Development, held on 6 to 12 March 1995. In 2008, the Prevention and Treatment of Drug Dependency Act No. 20 of 1992 was repealed and replaced by the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008. This act (Act No 70 of 2008) embraced a more humane approach and reflected the values of democracy and constitution of the country.

Thereafter, in 2011, the quest to review and reflect on progress since 1994 and on policy reforms, gave birth to two further polices, namely, the Framework for Social Welfare Services was formulated with a reflection of 'how developmental services have evolved since the adoption of the White Paper for Reconstruction and Development (1994) (hereafter referred to as RDP) and White Paper on Social Welfare (1997)' (DSD, 2013 b, p.3). Another situational factor for the Framework for Social Welfare Services was the First National Indaba on Social Welfare Services held in February 2010. In the same year, 2011 the National Development Plan (hereafter referred to as NDP) was released and adopted by parliament in 2012. The NDP set out to explore how far the country had progressed since 1994 and the adoption of the RDP then charted a vision for 2030. 'The Diagnostic Report of the National Planning Commission, released in June 2011, sets out, South Africa's achievements and its shortcomings since 1994.' (The Presidency, 2011, p.1). Also the international influence was noted especially the influence of the Sustainable Development Goals, namely, end poverty and reduce inequality (UN DESA, 2015).

As mentioned earlier, another situational factor in the context was the BASA Summit 2011, which provided the impetus for the formulation of the National Health Mini Drug Master Plan (hereafter referred to as NHMDMP) 2011–2014, Anti-substance Abuse Programme of Action (hereafter referred to as AAPA) 2011–2016, and revision of the overarching NDMP 2012–2016 prior to its term expiring to facilitate the NDMP 2013–2017.

Actors involved in Policy Formulation: Their roles, level of function, power, and influence

Table 3 provides an overview of the actors involved in formulating each of the included policies, with the VSM (Jackson, 2000; Leonard & Beer, 1994) enabling the actors' roles and levels of function to be categorized into implementation, coordination, control, development and policy. Table 2 however provides details of the formulation processes followed by the actors. The Policy Analysis Triangle places actors at the center of policy analysis and emphasizes the importance of being attentive to the power dynamics involved in policy formulation in order to understand the interplay of the policy analysis domains of context, content, actors and formulation process (Walt & Gilson, 1994). While international actors were absent in South African policy formulation processes, they had a strong influence on the focus

Table 3. Actors involved in the policy formulation for the eight selected policies.

LEVEL OF FUNCTION	ACTORS	NDMP	NHMDMP	NIMNSITC	AAPA	PTSA ACT	WHITE PAPER	FSWS	NDP
International bodies (Policy)	WHO								
	UNODC			X					
National (Policy)	Approved by SA Parliament (policy)	X		X		X	X		X
	Inter-Ministerial Committee on Alcohol and Substance Abuse				X				
	National Planning Commission								X
	Minister of DoH	X	X	X					
	Minister of DSD	X			X		X		
	National DoH	X	X		X				
	Central Drug Authority	X							
	National DSD	X			X				
	Institutions of Higher Learning							X	X
	National Government Departments (not specified)	X			X				X
	Interdepartmental Technical Team				X				
	Civil Society (Non-Governmental Organizations)	X			X				X
	Civil Society (Faith Based Organizations)	X							
	National Association of Child and Youth Care Workers							X	
	SANCA National Office	X		X					
	Non-governmental Organizations (not specified)							X	
Provincial Actor (Intelligence/development)	Central Drug Authority	X							
	Provincial DSD	X		X					
	Provincial DoH	X							
	Other Provincial Government Departments	X			X				X
	Provincial Substance Abuse Forums (PSAF)	X			X				
	Consultants: Bridges of Somerset West in the Cape			X					
	Consultants: Qondisa Development Facilitators from Johannesburg			X					
District Actor (Control/monitoring and evaluation)	District DSD	X							
	District DoH	X							
	Other District Government Departments								X
	Local government formations								X
	Local Drug Action Committee	X							
Institutional Actor (Implementation)	Inpatient Treatment Centre: Swartfontein Treatment Centre			X					X
	Civil Society (Non-Governmental Organizations)	X							
	Civil Society (Faith-Based Organizations)	X							
	Social Workers,							X	
	Community Development Practitioners							X	
	Child and Youth Care Workers							X	
	Public forums/consultation-SA Citizens								X

of some policies. The participation of local actors (SA) in the policy formulation processes was inconsistent, with the DSD and DoH being the most common and consistent participants. The following description of each policy illuminates the roles, levels of function (as per the VSM), power and influence (as per the policy analysis triangle) of the actors for each policy formulation.

White Paper for Social Welfare (1997)

The White Paper for Social Welfare (RSA) (1997) was formulated through the headship of the Ministry for Welfare and Population Development (now known as DSD; Tables 2 and 3). The role and level of functioning for the Minister was at a policy level, as political head, therefore his/her power and influence shaped the transformational agenda following democratization of SA and the promulgation of the White Paper on RDP 1994. As the socio-economic and political context demanded change in approach, social welfare transformed to using social development approaches. Since other stakeholders are not specified, their roles, and level of function within the system of service provision is unclear. At an international level, this White Paper for Social Welfare (RSA) (1997) was influenced by the United Nations, demonstrated in this extract: 'The proposed direction of the White Paper is in line with the approach advocated by the United Nations World Summit for Social Development, held on 6 to 12 March 1995.' (White Paper for Social Welfare 1997 (WPSW) Preamble Section, point no 5). This summit advocated for a people-centered social development (United Nations, 1996).

Prevention of and Treatment for Substance Abuse Act 70 of 2008

The Act No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008 replaced the Drugs and Drug Trafficking Act No. 140 of 1992 that was repealed. Actors involved in the formulation process are not mentioned except that it was adopted by parliament and assented by the President on 1st April 2009. Presumably, the formulation process followed the legal route of repealing an act which included public consultation and extensive debates. Nonetheless, the actors involved in this act were influenced by the transformational agenda of post-apartheid reforms, which was to align the acts with the constitution of SA and the values of democracy.

National Development Plan Vision for 2030 (NPD)

The NDP was formulated by the National Planning Commission (NPC) through extensive consultations, from parliament to SA citizens, over a period of 18 months. Refer Tables 2 and 3 for more details. The NPC had a mixture of roles, levels of function, power and influence as demonstrated in this extract: 'To establish a commission consisting largely of people from outside government and give them a mandate to be critical, objective and cross-cutting was always going to be risky. The Commission thanks [the] President … for his courage and ongoing support in guiding its work.' It would seem the mixture of actors produced a valuable outcome, as the document does not only praise the government but takes a critical role to review success and shortcomings. In addition, the formulation process had a representation of actors for all levels of the VSM, namely, implementation, coordination, control, development and policy as demonstrated in Table 3. Therefore, we can postulate that there may have been a balanced influence.

Framework for Social Welfare Services 2013 (FSWS)

The FSWS was formulated through the leadership of the DSD in consultation with a number of stakeholders from different levels of function, as demonstrated in Table 2 and 3. The process involved the reflection on the progress made in 13 years since the inception of the White Paper for Social Welfare Services. The actors were influenced by the change that had occurred in the socio-economic and political situation of the country, that is, the apartheid era to democracy. Subsequently, there was a need to design policies that are responsive and equitable to the needs of the poorest of the poor, and other marginalized and vulnerable groups in society (DSD, 2013 b). The FSWS emphasized the use of developmental approaches to social welfare services.

National Drug Master Plan (NDMP) 2013–2017

The NDMP 2013–2017 was formulated under the leadership of the Central Drug Authority (CDA), which is the overall custodian of the NDMP 2013-2017, mandated by the PTSA Act No. 70 of 2008 (DSD, 2013a). The CDA therefore embodies power and influence during policy formulation and reports to the parliament of the country, with consultations being reported to have been held to elicit community perceptions on drug prevention strategies. International bodies, such as the UNODC and WHO, were not recorded in the NDMP formulation, although the task of the CDA was to re-align the NDMP 2013–2017 with their changing strategies (DSD, 2013a). The power and influence of the international bodies did therefore prevail, despite not being acknowledged in the formulation. Additionally, the UNODC and WHO were involved in the BASA Summit 2011, which was a situational factor that contributed to the formulation of NDMP 2013-2017, and where an actor who had power and influence exercised this to influence policy decisions. A number of local policies also influenced the NHMDP 2011–2014 and AAPA 2011–2016.

National Health Mini Drug Master Plan (NHMDMP) 2011–2014

The leading actor in the development of the NHMDMP 2011–2014 was the National DoH, with no other actors being listed.

National Minimum Norms and Standards for Inpatient Treatment Centres (NMNSITC)

The NMNSITC was developed under the leadership of the DSD, with the UNODC as the international actor providing support and guidance (DSD, n.d.). A broad spectrum of local

actors was involved in the process of formulating the NMNSITC, including non-governmental entities and consultants (Table 3). However, the reason for the exclusion of the CDA and a number of government departments is unclear, and the SUD clients' involvement is also not recorded.

Anti-Substance Abuse Programme of Action (AAPA) 2011–2016

The development of the AAPA was coordinated by the DSD, with contributions from substance use stakeholders, including the Inter-Ministerial Committee on Combating Substance Abuse, and the Inter-departmental Technical Team on Combating Substance Abuse (DSD, 2011). The actors responsible for the overall monitoring and evaluation (M&E) of the AAPA were not specified (Table 3).

Policy content: a focus on aftercare and reintegration content

The eight policies were examined for content focusing on aftercare and reintegration service provision for SUD clients. The content was not organized into specific sections, but was dispersed and lacked details with exception of the Act no 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008 where chapter 7, p.38 is dedicated to aftercare and reintegration services. Therefore, it was difficult to understand from these documents, as indicated below, how the policies have guided SUD aftercare and reintegration service provision.

White Paper for Social Welfare (1997)

The White Paper for Social Welfare (1997), proposed that the approach to SUDs be comprehensive and inter-sectoral. Two guidelines for strategies related to aftercare and reintegration are proposed, firstly, 'Focus on holistic community-based treatment programmes with the aim of re-integrating the person into society and preventing the recurrence of abuse.' Secondly, 'Inter-professional treatment and after-care programmes will ensure the effective reintegration of the dependent into the community' (White Paper for Social Welfare (1997), section 4). These principles emphasize collaboration of stakeholders, relapse prevention, and reintegration of people with SUDs.

Prevention of and Treatment for Substance Abuse Act 70 of 2008

The Act No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008 dedicates chapter 7 to aftercare and reintegration services. The Act mandates the Minister of DSD to prescribe integrated aftercare and reintegration services, demonstrated in this extract: 'The Minister must, in consultation with the ministers and organs of state referred to in section 8(1), prescribe integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and family and community life.' No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008 chapter 7, subsection 30.1. Refer Figure 2 for more information.

National Development Plan Vision for 2030 (NPD)

The NDP does not have a section on aftercare and reintegration service. However, as an overall vision for the country for 2030, it gives directives for service provision to the DSD. The chapter on social protection covers the developmental social welfare services that DSD is expected to provide. 'The state should play a much larger role in the provision of social welfare services, including establishing effective partnerships with the private and community sectors.' (The Presidency, 2011, p.377). The NDP states, 'South Africa needs to confront the reality that social services are critical for improving social integration and human development. The current model of shifting the burden of care, treatment and rehabilitation to the non-governmental sector and the poorest communities is not working.' (The Presidency, 2011, p. 378). Instead, DSD should strengthen collaboration and partnerships with governmental and non-governmental social service providers. This implies that DSD should strengthen inter-sectoral collaboration in reintegration and aftercare and reintegration service provision.

Framework for Social Welfare Services 2013 (FSWS)

The FSWS as an overall framework does not include a particular section on SUD but has a small sub-section on aftercare and reintegration services and reintegration in general. In this section, the FSWS proposes family centered aftercare and reintegration services that are aimed at reintegrating and reunifying individuals and their families upon termination of treatment as demonstrated in this extract: 'Developmental social welfare services need to be family focused to strengthen the functioning of individuals within families. Reintegration services are aimed at reintegrating and reunifying individuals and their families once interventions outside the home environment have been completed and terminated. These services are applicable to individuals who have been discharged from residential care facilities, alternative care and correctional service facilities. The success of reintegration and aftercare services depends on the availability and willingness of families and communities to receive and support individuals who are being reintegrated.' (DSD, 2013 b, p. 35). In addition, four types of reintegration and aftercare services are listed, namely, reunification, community safety programmes, and vocational programmes. Refer Figure 2 for more information. The FSWS embraces a developmental approach to social welfare as described in this excerpt 'The developmental approach to social welfare services; The promotion and strengthening of collaborative partnerships; The practice context or environment; Developmental social welfare service integration; A description of the nature, level and scope of delivery of developmental social welfare services (developmental social welfare service delivery process); and An outline of the need to define and determine the delivery of quality services, the need for norms and standards, and the need for continuous

monitoring and evaluation' (DSD, 2013b, p. 9). Lastly the FSWS promotes collaboration at a grassroots level: 'On local level where direct services are provided, inter-sectoral collaboration helps integrate local integrated development plans and local social welfare service delivery planning.' (DSD, 2013b, p. 29).

National Drug Master Plan (NDMP) 2013–2017

The aftercare and reintegration content of the NDMP is limited and no section is dedicated to aftercare services instead is dispersed in various sections of the policy document. Aftercare and reintegration is recognized as an integral part of a treatment cycle, which is acknowledged as being limited in SA and hence requires improvement. Through the BASA Summit 2011 resolutions, the NDMP charged the DoH, DSD and registered treatment centers to strengthen aftercare and reintegration service provision in an integrated manner (DSD, 2013a). Moreover, a target of 10% increase in the number of aftercare and reintegration facilities was set.

National Health Mini Drug Master Plan (NHMDMP) 2011–2014

The NHMDMP revealed superficial information in a small section on aftercare and reintegration that dealt with the role of the DoH in the provision of these services. Despite this, the document indicates that the 'DoH [is] to develop protocols for a stepped down/tiered system of care, where allocation of service and intensity of service provided will be influenced by problem severity for substance abuse patients' (DoH, 2011, p. 13). Nonetheless, the NHMDMP outlines the role of health service institutions in the provision of aftercare and reintegration. Refer Figure 2 for details. Health service institutions refer to healthcare facilities such as clinics, primary health care centers and hospitals.

National Minimum Norms and Standards for Inpatient Treatment Centres (NMNSITC)

The NMNSITC had no stand-alone section dealing with aftercare and reintegration, which was embedded within other sections. The information was comprehensive and prescriptive in setting norms and standards to prepare and initiate aftercare and reintegration services prior to discharge.

Anti-Substance Abuse Programme of Action (AAPA) 2011–2016

The AAPA outlines two tasks and the associated stakeholders responsible for taking action for improved aftercare and reintegration. These tasks include the development and monitoring of an aftercare and reintegration model; and developing aftercare policies for establishing different levels of care, such as halfway houses, to which people can go (DSD, 2011).

Notwithstanding the limited information gained from these policies on aftercare and reintegration, an attempt was made to develop a consolidated summary from the available information (Figure 2). A continuum of care framework, from prior-discharge to post-discharge, by site of aftercare and reintegration, was used to organize the policy content, followed by the outline of the developmental approach to services which is promoted by the White Paper for Social Welfare (RSA) (1997), Framework for Social Welfare Services (DSD) (2013) and the The Presidency (2011).

As indicated in Figure 2, some aspects have limited information, which is indicative of the gaps in the analyzed policies. Ironically, the package of care, which has the most limited information, refers to post-discharge, where aftercare and reintegration is expected to actively occur. The packages of aftercare demand a strong collaboration between referral agents and inpatient treatment service providers. While the mechanisms of interactions are outlined, which include telephonic, face-to-face meetings and written reports (DSD, n.d.), no monitoring and evaluation is provided for.

Discussion

The aftercare policy content is discussed in relation to policy context, formulation process, and the actors, describing their roles and level of function at a local and international level, based on the eight policies analyzed. The discussion is structured into seven sub-headings; 1. Limitation of aftercare and reintegration content in South African policies is linked to the local and international context, formulation process and the actors involved; 2. Aftercare content available in most of South African policies is dispersed and disorganized; 3. South African policies often do not keep up to date with international trends. 4. Practical and specific aftercare policy content is limited in South African policies; 5. All eight policies recommend collaboration of stakeholders but do not propose a mechanism of interaction at implementation level. 6. Diverse sites of aftercare and reintegration service provision represent the collaborative and multi-stakeholder approach; and 7.Cursory monitoring and evaluation strategies of aftercare.

Limitation of aftercare and reintegration content in South African policies is linked to the local and international context, formulation process and the actors involved

This policy analysis established that aftercare and reintegration content in South African policies is limited, which affirms findings by Geyer and Lombard (2014) that the overarching policy, namely the NDMP (2013–2017) has limited aftercare content. This limited content can be attributed to the historical exclusion of aftercare content in policies due to a punitive and prohibitive paradigm approach of South African acts, such as Prevention and Treatment of Drug Dependency (PTDP) Act No. 20 of 1992, and Drug and Drug Trafficking (DDT) Act No.140 of 1992, and policies such as NDMP, 1999–2004 and NDMP, 2006–2011. It is unclear why the policies, namely, NDMP, 1999–2004 and NDMP, 2006–2011 that were developed after the White Paper for Social Welfare (RSA) (1997) continued to have limited content on aftercare and reintegration. Although the White Paper for Social Welfare (RSA) (1997) does not have a large amount of

aftercare and reintegration content it states that inter-professional treatment will ensure the effective reintegration of the dependent. In addition, it carries the transformational mandate and developmental approach to services. One would expect subsequent policies to have expanded on this but they do not. Notably none of the analyzed policies refer to the National Development Plan (2011) and White Paper for Social Welfare (1997) except the Framework for Social Welfare Services (DSD) (2013) which was formulated based on the developmental approach espoused in the White Paper for Social Welfare. This indicates a lack of coordination in policy development. It is also postulated that this limitation of aftercare and reintegration was caused by a transition of South African policies from purely demand and supply reduction strategies, which were punitive and prohibitive in nature, to the inclusion of harm reduction strategies. Markedly, South African substance use policies have been characterized by a punitive prohibitive stance and a declaration of a 'war on drugs' in order to achieve a drug free society (Parry & Myers, 2011; Pienaar & Savic, 2016; Van Wyk, 2011) . This stance seem to have emanated from the global focus of substance use policies, which included the three United Nations (a global actor) conventions on drugs; namely, the Single Convention on Narcotic Drugs (UN) (1961), the Convention on Psychotropic Substances (UN) (1971), and the Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances (UN) (1988) (Fellingham et al., 2012; Geyer & Lombard, 2014; Scheibe et al., 2017). All three conventions sanctioned imprisonment and regarded drug users as criminals who should receive very little assistance or restorative services (Parry & Myers, 2011; Pienaar & Savic, 2016). South Africa is a member of the UN and therefore complies with the UN's conventions on drugs, especially in the development of its policies. Consequently, SA's alignment with the global approach resulted in little attention being given to treatment interventions such as aftercare and reintegration. Notable, the limitation of aftercare policy content is not a South African phenomenon but a global one (Chi et al., 2011).

While SA seems to have always been influenced by international trends, this has not invariably culminated in the country following suit. In 2011, the Global Commission on Drug Policy (GCDP) published its report noting the failure of the approach of eradicating drugs and waging war on drugs, and therefore called for the decriminalization of drugs (Global Commission on Drugs, 2011). The NDMP 2013–2017 took a stance against the call. The policy makers of the NDMP 2013–2017 believed that a single approach would not solve the drug burden of the SA population but proposed that multifaceted strategies, which are inclusive of supply reduction, demand reduction and harm reduction were required (DSD, 2013a). Consequently, the NDMP 2013–2017 did not support decriminalization nor promote a single approach of criminalization of drug use. Despite South African policy commentators supporting this global move of decriminalization of drugs and criticizing the rhetoric of a drug free society in South African policies (Parry & Myers, 2011; Scheibe et al., 2017), policy makers remained adamant. This seems to have been influenced by the policy formulation process and the actors involved. The power of the actors involved in the policy formulation processes had a strong influence on the content of policies (Walt & Gilson, 1994). The presence of the former president of SA, Mr J.G. Zuma and his message at the BASA Summit 2011 (DSD, 2013a), is a noteworthy demonstration of the type and power of actors involved in policy formulation. Subsequently, the BASA Summit 2011 resolutions had a strong focus on an integrated, multifaceted and inter-sectorial approach to treatment service delivery for people with SUDs as indicated by the former president's message. Arguably, all policies formulated immediately after the BASA Summit 2011, namely, NDMP 2013–2017, NHMDMP 2011–2014 and AAPA 2011–2016 were aligned with the PTSA Act No. 70 of 2008. In addition recognized the lack of aftercare, and emphasized the need for improvement, compared to the previous policies. However, aftercare and reintegration continued to be limited at service delivery level (DoH, 2011; DSD, 2013a; Lund et al., 2012; Parry, 2005; Plüddemann et al., 2013; Van Der Westhuizen & de Jager, 2009; Wang et al., 2007). In SA, aftercare limitations can be linked to limited empirical research on SUD policies (Pienaar & Savic, 2016). However, this policy analysis demonstrates that aftercare and reintegration limitations can also be linked to a slow move of SA policies towards inclusion of aftercare policy content, which would be adequate and well organized to guide aftercare and reintegration service provision.

Aftercare and reintegration content available in most of South African policies is dispersed and disorganized

The nature of the available aftercare content in South African policies was found to be vague, dispersed and disorganized with exception to the Act no. 70 of 2008 where chapter 7 is dedicated to aftercare and reintegration services. Figure 2 synthesizes the nature of aftercare content in South African policies into packages of care, in a continuum from prior-discharge to post-discharge. Paradoxically, the package of care, which has the least information, is post-discharge where aftercare and reintegration is expected to actively occur. This paradox indicates how policies have not paid careful attention to aftercare and reintegration content, which requires that aftercare preparation be initiated early in admission and be facilitated at discharge with linking strategies back to the referring agents.

The aftercare and reintegration content includes relapse prevention, collaborative interventions, individualized or client-centered care, and family-centered care. These details are however in the initiation of aftercare services at the inpatient treatment centers and not post-discharge, highlighting a policy gap for aftercare and reintegration at this level. This policy gap could be one of the reasons why SUD clients are 'lost in the system' post-discharge with no aftercare services provided (Lund et al., 2012; Mpanza & Govender, 2017; Ramlagan et al., 2010). Where aftercare is provided, it is often uncoordinated and fragmented among stakeholders (Lund et al., 2012; Parry, 2005). Therefore, South African policies seem to be failing to provide a clear guide for aftercare and

reintegration service provision. In addition, consequences of policy gaps for aftercare are noticeable in the aftercare and reintegration needs raised by people with SUDs in South African studies (Mahlangu & Geyer, 2018; Van der Westhuizen et al., 2013), which include more available and adequate aftercare and reintegration services post discharge with family involvement.

South African policies sometimes does not keep up to date with international trends

Since 2009, both the esteemed international actors, UNODC and WHO advocated for SUD's recognition as a chronic but treatable multifactorial health disorder requiring a chronic approach (UNODC, 2009; and UNODC & WHO, 2017). However, the nature of aftercare and reintegration content in South African policies embraces an acute treatment approach (as opposed to a chronic treatment approach). In 2017, the UNODC and WHO jointly published the International Standards for the Treatment of Drug Use Disorders, which advocate a long-term and chronic orientated intervention, with aftercare being referred to as 'recovery management' (UNODC & WHO, 2017). Despite the power and influence of the UNODC and WHO, South African policies seem to have continued to promote acute treatment approaches. Understandably, SA does not always have to follow the international guidelines but has to check the relevance and applicability to the South African context, which is diverse and characterized by inequalities. This raises a question of what forms the basis of South African policy formulation and development as well as a question on whether the international standards are feasible in SA. Nonetheless, there is lack of empirical research for policy developments and formulation in SA (Groenewald & Bhana, 2018; Pienaar & Savic, 2016). Particularly, in this study, none of the analyzed policies used empirical research during the formulation and development processes. As a result policy formulation and development, seem to be influenced more by political moves than by evidence-based decisions. Having said that SA as a number of issues to consider before adopting an international standard, for instance, do the international policies take into account the dual implementation of African and Western Medicine?, and how should aftercare and reintegration services be structured for people living with a dual diagnosis/comorbidity?

Practical and specific aftercare and reintegration policy content is limited in South African policies

The content of aftercare lacks specific and practical steps for providing aftercare. For instance, the ultimate goal or outcome of aftercare and reintegration is described as having fully prepared clients to participate in aftercare programmes and fully reintegrating them back into their own communities, families and the work force (Act no.70 of 2008; and DSD, 2013a). However, a fully prepared client is neither described nor defined by these policies but such preparation is said to be achieved through provision of appropriate programmes and support, which would enable effective transition of a client from an inpatient treatment center to their families and communities. Appropriate programmes and effective transition are not described in any of the policies, which indicates policy inadequacies and vague statements that are subject to the readers' interpretation of South African policies.

All eight policies recommend collaboration of stakeholders but no mechanism of interaction at implementation level

All analyzed South African policies (White Paper on Social Welfare Services 1997, Act no.70 of 2008; NDP, 2011, Framework for Social Welfare (DSD), 2013; NDMP 2013–2017; NMNSITC, n.d; NHMDMP 2011–2014 & AAPA, 2011–2016) recommend the collaboration of stakeholders in service provision for people with SUDs but do not prescribe the mechanism of stakeholder interaction or engagement at a fieldwork/institutional (implementation) level where aftercare and reintegration services are provided. It is noteworthy that at a national (policy level), provincial (development) or district (coordination/monitoring and evaluation) level, there are platforms of stakeholder collaboration such as the CDA, provincial drug abuse forums, district forums and local drug action committees. The Beer's Viable System Model (VSM) with systems theory perspective emphasize that the entire system is more important than its part (Jackson, 2000; Leonard & Beer, 1994). This means that if one part in the system does not work, the entire system would fail. In this system of SUD aftercare and reintegration, one part has no policy mandate i.e. service providers at fieldwork level or institution (actors at implementation level). These platforms of collaboration at a higher level could be the reason why policies speak about collaboration, which does not translate to implementation at fieldwork or community level. As a result, stakeholders and service providers continue to work in silos in service provision (Lund et al., 2012; Mpanza & Govender, 2017; Parry, 2005). Conversely, in one policy, the NMNSITC, mechanisms of interaction between a referrer and the in-patient treatment center are outlined for the initiation of aftercare and reintegration but no collaboration strategies are mentioned for stakeholders at a fieldwork or community level. The said mechanisms of interactions include telephonic, face-to-face meetings and written reports but M&E strategies are not even mentioned.

Diverse sites of aftercare and reintegration service provision represent the collaborative and multi-stakeholder approach

Sites mentioned in policies where aftercare and reintegration services ought to be provided, include family or caregiver homes, health service institutions like community health centers, clinics, hospitals, public and private inpatient treatment centers, outpatient DSD services and community-based CBOs. These are outlined in Figure 2. It is noteworthy that these sites of services represent the collaborative and multi-

stakeholder approach advocated by South African policies. In particular, the White Paper for Social Welfare (RSA) (1997), Framework for Social Welfare Services (DSD) (2013) and the National Development Plan (2011) promotes developmental approach to services, which promotes collaboration and partnerships of stakeholders. However, the aftercare services lacks collaboration instead service providers are working in silos (Lund et al., 2012; Parry, 2005). Although sites such as the workplace, institutions of higher learning and schools are not mentioned in any of the policies, the NMNSIT emphasizes a client-centered approach as a principle to be adhered to and the NDMP 2013–2017 presents reintegration to community and work as an ultimate goal of treatment. Once more, policies are not specific, but inferences are made, which are subject to readers' interpretation.

Cursory monitoring and evaluation (M&E) strategies of aftercare and reintegration

Although M&E is mentioned by policies, the strategies specified are cursory and activity-based, as opposed to the outcomes-based M&E principles of which the focus is on prevention programmes. Hence, the NDMP 2013–2017 recognizes the need for ongoing monitoring, which will not only focus on prevention programmes but will also identify ways in which particular kinds of drug-related harm can be reduced and will determine the trends, patterns and types of drugs used by different communities. Although M&E gaps are recognized by policies, no prescriptions, guidelines or frameworks are provided on what and how M&E should be conducted. Myers et al. (2010) also noted that South Africa has not yet developed regional or national monitoring systems for SUD treatment services. Consistent with this, a study by Mpanza and Govender (2017) in a district of a province in South Africa, found that there were no M&E processes except recording activities of prevention campaigns. The study by Mpanza and Govender (2017) further highlighted that there were no records of statistics for treatment services, no patients' discharge records from inpatient treatment centers and no aftercare and reintegration records. As a result, SUD clients were lost, post-discharge from an inpatient treatment center then reappeared following a relapse. This lack of M&E has a negative impact on the policy formulation and developments. Hence, South African policies are said to lack empirical research (Groenewald & Bhana, 2018; Pienaar & Savic, 2016).

Limitations of the study

This desktop policy analysis excluded interaction with stakeholders, which may have deeply illuminated the role and level of function for the actors in policy formulation processes, policy context and content guiding aftercare and reintegration services. Some of the policies lacked information on policy formulation processes, which compromised the depth and understanding of the interplay between context, actors (roles and level of function), and content in these processes. In addition, the scope of the study was on policy formulation processes with an intention to portray policy developments. However, there is often a gap between the intentions of policy as represented in formal documents and the reality of the actions taken by people who are on the ground, within the system. Therefore further studies should explore policy implementation of aftercare and reintegration content in South African policies. Using the VSM's roles and level of function of actors (Jackson, 2000; Leonard & Beer, 1994) such as implementation, coordination, control, development and policy could generate a deeper understanding of why the status quo of aftercare and reintegration service remain the same over years, despite policy developments.

Conclusion

The policy analysis sought to establish the aftercare and reintegration content in SA policies and explore how South African policies respond to the national and international context. Five key issues have been noted in this paper. Firstly, the limitation of aftercare and reintegration content in South African policies is linked to the evolving national and international context, formulation processes and the actors involved. Policies seem to continue embracing a punitive stance and there seems to be no influence of empirical research in policy formulation and developments. Secondly, SA SUD policies emphasize the need for collaboration of stakeholders in service provision, in particular aftercare and reintegration services, but lack a mechanism or platform of interaction at implementation level i.e. fieldwork or institution. Thirdly, aftercare and reintegration policy content are not explicitly outlined in policies, and they lack practical steps which is indicative of the acute treatment approach that is embraced by South African policies and systems of care. Fourthly, some policies, namely the overarching policy NDMP 2013–2017 and AAPA 2011, recommend the development of an aftercare and reintegration model, which has not occurred to date. Fifthly, policies have cursory M&E strategies, which are activity-based as opposed to outcomes-based. These five issues indicate that, although SA follows international trends, it does not seem to keep abreast of changes. Understandably, SA does not have to always follow suit without exploring the relevance and applicability to a South African context. Therefore, the following recommendations are drawn from this policy analysis.

Recommendations

South African policies should embrace a more humane stance, which is sensitive to human rights and needs, as opposed to the punitive stance which is currently embraced. Moreover, policy formulation should involve people with SUDs as there appears to be inconsistency in the actors involved in policy formulation in SA, with the exclusion of people with SUDs from the process. As the NDP (2011), and Framework for Social Welfare Services (DSD) (2013) promotes active citizenry, their participation is essential in matters that concerns them.

To strengthen M&E strategies is pertinent and timely and should ensure that outcomes-based strategies are implemented, as opposed to activity-based ones. This could assist, inform and guide the collaboration plans of stakeholders in service provision, including aftercare, which is usually fragmented. In addition, empirical research should be part of policy formulation and development and should inform M&E strategies.

There is a need for the development of Recovery Management (aftercare and reintegration) National Minimal Norms and Standards (RMNMNS) for the M&E of aftercare services and for clearly outlining the expected standard of recovery management (also known as aftercare) services. This could benefit South Africa because the National Minimum Norms and Standards for Inpatient Treatment Centers (NMNSITC), which attempts to outline aftercare and reintegration principles and the expected standards, does not clearly outline the principles of recovery (aftercare) services and embraces an acute approach rather than a chronic one. The RMNMNS may serve as a blueprint for recovery management services and promulgate a chronic-orientated system of care, which is advocated by the UNODC and WHO. However, RMNMS should be adapted through local empirical research to suit the South African context.

A future direction would be to propose an Integrated Recovery Management Model for recovery (aftercare) service provision for people with SUDs that is explicitly expressed in and aligned to local policy documents with due cognizance of the UNODC and WHO chronic treatment approach. In addition, such a model should be responsive to the needs of the SUD clients, their families and should consider the resource constrained contexts of LMICs, such as that of South Africa. Furthermore, the model should embrace inter-sectoral collaboration and developmental approach to service provision as articulated in all analyzed policies.

Disclosure statement

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4.5 CONCLUSION

This chapter presented a paper that discusses the South African SUD policy context in relation to international bodies and regulations such as the WHO and UNODC. It identified eight policies pertinent to aftercare but noted that the content of these policies was vague and disorganised, with no coherent section dedicated to aftercare. Moreover, aftercare/recovery management service provision policies were undefined; mechanisms of service delivery areas were absent, and policies had no aftercare M&E, only cursory M&E strategies for prevention programmes. System-thinking together with the Walt and Gilson (55) Policy Analysis Triangle Framework for Health Policy Analysis exposed a number of policy strengths and limitations. It identified key role players (service providers) within the SUD system, which was essential for phase 2 of the study that will be more broadly addressed in Chapter 5.

CHAPTER 5

PHASE 2, STAGE 1: THE PERSPECTIVES OF SERVICE PROVIDERS

5.1 INTRODUCTION

In the South African context, the provision of aftercare services for persons with SUDs within rural contexts is typically met with various intersecting challenges, including unclear policy implications and lack of resources. Nonetheless, service providers are expected to provide aftercare services that should successfully reintegrate persons with SUDs into society, the workforce, family and community life as mandated by Substance Abuse Act No. 70 of 2008 (22). However, a paucity of evidence exists on the provision of aftercare services in South Africa, specifically within rural contexts. This chapter explores the perspectives of the providers in aftercare service provision for persons with SUDs in a rural district of KwaZulu-Natal, South Africa. Therefore, this chapter responds to the second objective, which was to describe SUD aftercare programmes implemented at the district level in rural areas; objective 3, to explore barriers and enablers within SUD aftercare; and objective 4, to describe monitoring and evaluation strategies of SUD aftercare services.

5.2 SUBSTANCE ABUSE TREATMENT, PREVENTION AND POLICY JOURNAL

The second paper, entitled "Perspectives of Service Providers on Aftercare Service Provision for Persons with Substance Use Disorders in a Rural District in South Africa", reporting on perspectives of service providers in aftercare service provision, was published online on 12 August 2022 in the Substance Abuse Treatment, Prevention, and Policy Journal. This journal provides a forum for engaging in harm caused by substance use. It encompasses several fields related to substance use such as medical treatment and screening; mental health services, research; and evaluation of substance use disorder programs. This manuscript also evaluated SUD programmes, including aftercare services and was deemed most suitable as a journal choice. The journal *"is an open access, peer-reviewed journal that encompasses research concerning substance abuse, with a focus on policy issues* (https://substanceabusepolicy.biomedcentral.com/submission-guidelines/aims-and-scope). Please refer to Table 5.1 for manuscript review details.

Table 5.1: Publication Details

ITEM	DETAILS
Article Title:	Perspectives of Service Providers on Aftercare Service Provision for Persons with Substance Use Disorders in a Rural District in South Africa.
Authors:	December Mandlenkosi Mpanza, Pragashnie Govender & Anna Voce
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5.3 AUTHOR CONTRIBUTION

The PhD candidate conceptualised the study, formulated a proposal, collected and analysed data, and drafted the manuscript with guidance from supervisors (co-authors), Prof Anna Voce and Prof Pragashnie Govender, provided critical review throughout all the stages of the research and the writing of the manuscript.

5.4 OVERVIEW OF THE PAPER

This is the second paper of the overall study. Pasted below is a PDF copy of the paper. Please refer to the online link: https://doi.org/10.1186/s13011-022-00471-5

THE MANUSCRIPT

TITLE: PERSPECTIVE OF SERVICE PROVIDERS ON AFTERCARE SERVICE PROVISION FOR PERSONS WITH SUBSTANCE USE DISORDERS IN A RURAL DISTRICT IN SOUTH AFRICA.

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Substance Abuse Treatment, Prevention, and Policy

RESEARCH Open Access

Perspectives of service providers on aftercare service provision for persons with substance use disorders at a Rural District in South Africa

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Abstract

Background: Provision of aftercare services for persons with substance use disorders (PWSUD) within a rural context is typically met with various intersecting challenges, including unclear policy implications and lack of resources. In the South African context, service providers are expected to provide aftercare services that should successfully reintegrate persons with PWSUD into society, the workforce, family and community life as mandated by Act No. 70 of 2008, despite population diversity. Little has been established on the provision of aftercare services in South Africa and specifically within a rural context. This article explores service providers' perspectives in aftercare service provision for PWSUD in a rural district.

Methods: A qualitative exploratory study design was conducted in a rural district in South Africa using semi-structured interviews and focus group discussions with forty-six service providers from governmental and non-governmental institutions, ranging from implementation to policy level of service provision. Data were analyzed thematically using a deductive approach. Codes were predetermined from the questions and the aims and objectives of the study used Beer's Viable Systems Model as a theoretical framework. NVivo Pro 12 qualitative data analysis software guided the organization and further analysis of the data.

Results: Four themes emanated from the data sets. Theme 1 on reflections of the interactional state of aftercare services and program content identified the successes and inadequacies of aftercare interventions including relevant recommendations for aftercare services. Themes 2, 3, and 4 demonstrate reflections of service provision from implementation to policy level, namely, identifying existing barriers to aftercare service provision, situating systemic enablers to aftercare service provision, and associated aftercare system recommendations.

Conclusions: The intersecting systemic complexities of providing aftercare services in a rural context in South Africa was evident. There existed minimal enablers for service provision in this rural district. Service providers are confronted with numerous systemic barriers at all levels of service provision. To strengthen the aftercare system, policies with enforcement of aftercare services are required. Moreover, a model of aftercare that is integrated into the existing services, family centered, sensitive to the rural context and one that encourages the collaboration of stakeholders could also strengthen and sustain the aftercare system and service provision.

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Keywords: Aftercare, Service provision, Persons with substance use disorders (PWSUD)

Background

Provision of aftercare services for persons with substance use disorders (PWSUD) within a rural context is typically met with various intersecting challenges, including unclear policy implications and scarcity of resources [1–3]. These challenges contribute to a decrease of recovery capital, of which aftercare is critical in increasing recovery capital for PWSUD [4]. However, a strategically planned aftercare program, also known as recovery management, is pertinent for improved and sustained treatment outcomes, particularly relapse prevention [5–7]. Globally, 60% of PWSUD relapse due to limited and inadequate treatment services and poor aftercare services [6] and one out of seven PWSUD have access to treatment [8]. In low-and middle-income countries (LMICs), especially in Sub-Saharan Africa, including South Africa (SA), one out of eighteen persons have access to treatment [6]. Notwithstanding this, where treatment is available, it is often not evidence-based and ineffective [6]. Consequentially, post-discharge relapse and re-admission rates remain consistently high, with an estimated 40% of PWSUD with sustained recovery [6]. Aftercare service provision is limited globally [6, 8, 9] due to several prevailing barriers. Predominantly, there is a lack of scientific evidence on aftercare and long-term recovery management, as the efficacy of interventions has not been assessed in most countries [6]. The World Health Organization (WHO) and the United Nations Office on Drugs and Crime (UNODC) have in fact, promulgated treatment guidelines, recently published in 2020, which included aftercare. Still, these guidelines have only been tested scientifically in ten countries thus far [7]. However, contextual barriers are confronting each country in aftercare service provision. In SA, there exists a lack of distinctive policy directives on aftercare services which may be attributed to a lack of empirical evidence within these policies [3]. The overall guiding policy, the National Drug Master Plan 2019–2024, only provides a superficial guide to aftercare services.

Aftercare service provision is a sub-system of the SUD treatment service provision system in SA [8], an overall treatment intervention system for people with SUD. The SUD treatment service provision is characterized by several complexities compounded by the two separate systems of service provision, namely, public and private healthcare systems [3]. In the public sector, the tax-funded healthcare system services are provided to the majority of the population (about 86%) at no cost, particularly for those who are indigent or on an income-based scale [10]. Services in the private sector, which serve about 16% of the population, are expensive, therefore the majority of PWSUD utilize their medical aids/personal medical insurance to pay for services [3, 10]. The public sector services are generally limited and inaccessible to the majority of South Africans, in particular the rural population [2]. For instance, the KwaZulu-Natal (KZN) Province, the second-largest province in SA where this study was conducted, has only two public sector in-patient treatment centers located in urban areas.

In contrast, there has been an increase in the establishment of private sector treatment services (both licensed and unlicensed) in SA, with at least one facility in each city [2]. In addition, policy reforms such as the White Paper for the Reconstruction and Development Program (1994) and the White Paper for Social Welfare (1997), were intended to hasten transformation from a social welfare state to a developmental state and a developmental approach to the provision of social welfare services [3], which has a preferential focus on those most vulnerable and disadvantaged [11]. The developmental approach is person- centered, promoting self-reliance and the capacity for growth and development through using own strengths, knowledge and maximizing human potential [11]. Furthermore, services are integrated, family-centered and community-based [11]. Also, the National Drug Master Plan (NDMP) 2019–2024, an overall policy on SUD, promotes community-based service provision to all people within their areas of residence [12]. Paradoxically, disadvantaged communities continue to experience high levels of unmet treatment needs, which is a burden to the health and welfare system of South Africa [13]. Largely, the origins of these unmet treatment needs can be traced to the general inequitable spread and limited availability of substance abuse treatment services in SA [2]. Coherently, the SA population remains the world's most unequal nation [14], with 40% of the SA population residing in rural areas [15]. Therefore, there may be additional complexities to the SUD treatment service provision system in SA that would require further exploration.

Little has been established on aftercare services provision in SA and specifically in rural contexts. Most SA studies [1, 2, 13, 16] have examined the treatment service provision for SUD with limited comments on aftercare. The few studies [17–20], that focused on aftercare were urban-based. Therefore, the extent to which the findings of these studies [17–20] apply to the rural context remains unknown. An extensive literature search revealed that no South African studies had examined

aftercare service provision in a rural context; it is, therefore, pertinent to extrapolate this study to the rural context of SA.

Problem statement

The province of KZN, which includes numerous rural areas [21], experiences various barriers in service provision. There are lengthy waiting lists for admission to the only two available public in-patient treatment centers (ITCs) [22], both located in urban areas. Therefore, the population in rural districts is required to travel to access ITCs before being discharged back into their community for aftercare services [23]. These ITCs are mostly unavailable or inadequate [16, 22, 23] and is a scenario applicable to the rural district in which this study was located. Aftercare services in this district are limited, inadequate and fragmented among stakeholders, with no monitoring and evaluation [1].

Consequently, some PWSUD are often lost in the system of care and re-emerge following a relapse [1]. A recent study by Mpanza et al., [24] on the same district revealed numerous inadequacies reported by PWSUD. These include the majority of PWSUD not accessing aftercare, and those who received aftercare experienced services that were terminated abruptly. The reasons for such inadequacies of aftercare and how service providers navigate such barriers are not well documented. Ultimately, service providers are expected to provide an aftercare service that should successfully reintegrate PWSUD into their society, the workforce, family and community life as mandated by Act No. 70 of 2008 [25]. In earlier work by Mpanza et al., an analysis of the policy context in SA was done [3], followed by an exploration of the aftercare service provision from the perspectives of PWSUD. In this current study, the service providers' perspectives in aftercare service provision for PWSUD were explored in this rural district. This exploration is underpinned by the justification that a comprehensive investigation into the state of aftercare services provision may assist in informing policy developments. It may also assist in improving service delivery strategies, thereby ultimately improving the aftercare service provision within the health system.

Methods

Theoretical framework

Aftercare services for PWSUD is an intrinsic sub-system in the component of the service provision system. However, the coordination of aftercare provision is perceived as a system endemic to the SUD service provision, comprising multiple components and interactions with the associated complexity of human services systems. With this understanding, systems thinking, also known as a systems approach, was utilized as the theoretical framework underpinning this study. Systems thinking focuses on the whole and the interactions/relationships of its parts/sub-systems [26–28] instead of understanding singular components that ignore the holistic interaction between systems. Moreover, systems thinking emphasizes cross-sector collaboration and community partnerships [29], and the NDMP of 2019–2024 supports the systems approach in preventing relapse during aftercare [12]. Hence, the systems approach was adopted in this study.

Within systems thinking, the study was additionally framed using the Beer's Viable Systems Model (VSM) which facilitated in-depth exploration of the interactions and roles fulfilled by each component for the effective functioning of the system [27, 28]. The Beer's VSM has five components, namely, implementation (institution where PWSUD are serviced), coordination (district and institution), control (district level), development/intelligence (provincial) and policy (provincial and national) within a given environment. In applying the VSM model, an exploration of how these five components relate to the aftercare service provision system is provided.

The study was situated within a social constructivist paradigm. It sought to understand the world through the perspectives and constructed meanings (often complex and varied) of the participants' experiences of their lived realities [30]. This article is a component of a larger study that seeks to inform a model for aftercare service provision, and preceded by a policy analysis within the SA context [3] and perspectives of PWSUD on aftercare needs [24].

Study design

A qualitative exploratory study design was adopted to gain a comprehensive understanding of the aftercare service provision from the perspectives of services providers for PWSUD. Such a design is appropriate where limited knowledge exists and facilitates a more in-depth exploration of the context to discover social meaning and its impact on individuals [31].

Location of the study

The study was conducted at a rural district, one of eleven districts in KZN with a total population of 11,3 million people, equating to approximately 19,2% of the South African population [15]. KZN has more than 55% of the population domiciled in rural areas [21], with 25% of disadvantaged South Africans (57% below the poverty line) residing in the province [15]. The province has the triple burden of high poverty levels, HIV and Tuberculosis (TB) [32], complicating service provision. This particular rural district has between 82 and 95% of

Table 1 Categories of Stakeholder groups represented within levels of function in Beer's VS

LEVEL OF FUNCTION	ACTOR'S DESIGNATION	DISCIPLINE	ITC (DSD)	DSD	DoH	NGO1	NGO2	TOTAL
Policy/Intelligence/ Development) $n=(10)$	Executive Director	Social Worker				1		1
	Director	Project Management					1	1
	Substance Abuse Services Director	Social Worker		1				1
	Deputy District Manager/Programs Manager	Social Worker		3				3
	Substance Abuse District Coordinator	Social Worker		1				1
	Clinical and Programs Manager	Nursing			1			1
	Facility Manager	Social Worker	2					2
Control/Monitoring and Evaluation) $(n=8)$	Substance Abuse Facility Coordinator	Social worker		3				3
	Mental Health and Rehabilitation Coordinator	Occupational Therapist			1			1
	Social Work Supervisor	Social Worker	1					1
	Head of Social Services	Social Worker			1			1
	Medical Manager	Medical Officer			1			1
	Head of Occupational Therapy Department	Occupational Therapist			1			1
Implementation/Service provision level $n=28$	Counseling Psychology Service Provider	Counseling Psychologist					1	1
	Social Auxiliary Service Provider	Social Auxiliary		1				1
	Occupational Therapy Service Provider	Occupational Therapist	1		2			3
	Occupational Therapy Technician Service Provider	Occupational Therapy Technician			1		1	2
	Social Work Service Provider	Social Worker	2	1	5	3	2	13
	Mental Healthcare Service Provider	Nursing			4		1	5
	Counselling Service Provider	Lay counsellor					1	1
	Nursing Services	Nursing	2					2
Grand Total			8	10	17	4	7	46

ITC Inpatient Treatment Centre, *DSD* Department of Social Development, *DoH* Department of Health, *NGO1 and NGO2* Non-Governmental Organizations

households who live below the poverty line, with 70% of this population living on less than 800 South African Rands (ZAR) (54$) per month [33]. No ITCs are located in this district; resources are limited with poor infrastructure (predominantly gravel roads) similar to most rural areas in SA. Hence PWSUD are referred to the two urban public ITCs. Located within this district, are public hospitals, one NGO providing outpatient mental healthcare treatment services (including services for SUD) among other programs, and an additional NGO providing outpatient services for SUD and referrals for in-patient intervention to public and private ITCs (to those who can afford the service). The district also has several social service centers providing social welfare services, including outpatient services. There are several shebeens providing illicit alcohol and other home-brewed substances and cannabis (mainly cultivated at home) commonly used in this district [1]. Consistently, the treatment center admissions in KZN indicate that cannabis, the most common substance of abuse, accounted for 37% of admissions, followed by heroin (including *Nyaope* / *Whoonga*) at 27% and alcohol at 14% [34].

Sampling strategy

Non-probability maximum variation purposive sampling was used to recruit and select participants ($n=45$) who represented all five levels of the Beer's VSM [26] and sectors within the SUD system of service provision (Table 1). The selection criteria included service providers who were employed for at least 1 year in SUD-related service provision at any level of the service provision system. The final sample size was achieved following data saturation, where the iterative collection and analysis of data presented no new information.

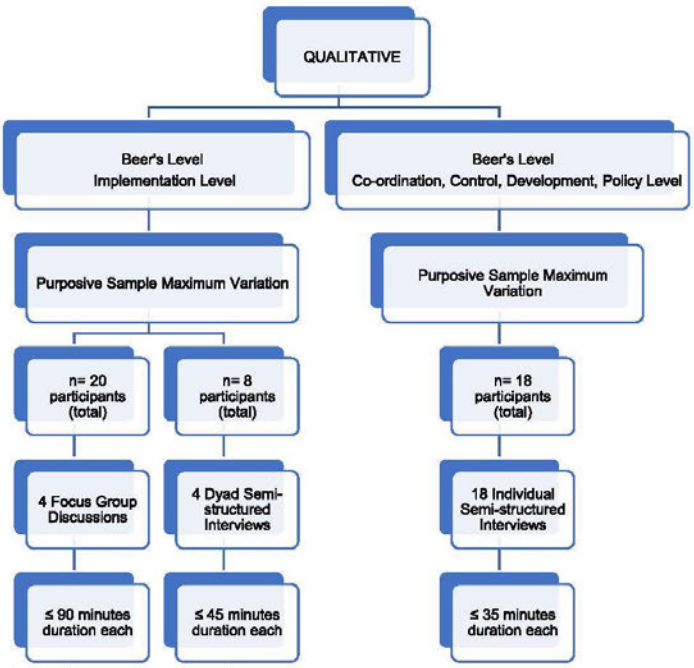

Fig. 1 A diagram illustrating data generation and sampling

Data generation

Data were generated concurrently through focus groups discussions and face-to-face individual/dyad semstructured interviews. Four focus group discussions ($n=20$) for not more than 90 min were conducted with participants at the implementation level. Owing to the availability and convenience for participants at the implementation level, four dyad face-to-face semi-structured interviews ($n=8$) for not more than 45 min were conducted. Face-to-face individual semi-structured interviews ($n=18$) were conducted for not more than 35 minwith participants at the coordination, control, development/intelligence and policy level function (based on Beer's VSM) to avoid their influence on the focus groups where the majority of service providers were at the implementation functional level. Refer to Fig. 1: Diagram illustrating data generation and sampling.

Data analysis

The audio recordings of the interviews and focus group discussions were transcribed verbatim to produce a written transcript by an independent transcriber prior to verification and editing by the first author for accuracy. Data were analyzed thematically [35] using a deductive approach. Codes were predetermined from the questions, aims and objectives of the study using Beer's VSM [27] and resulted in four themes. NVivo Pro 12 qualitative data analysis software [36] guided the organization and further analysis of the data. The verbatim narratives of the participants were italicized and indented.

Trustworthiness of the study

Four criteria were met to ensure the trustworthiness of findings, namely credibility, confirmability, dependability and transferability [26, 37]. This was achieved through the application of the following strategies, namely, to ensure a truthful representation and credible interpretation of the analysis, regular peer debriefing was carried out [26, 37–39]; identified themes were supported with extracts of verbatim narratives of the participants [40] which minimized the risk for bias; analyst triangulation was used [26] through two authors to identify possible shortcomings in the analysis process. Additionally, the study findings were examined against the existing

literature [39]. A rich description of the context and methodological processes was exposed, with details for readers to determine the extent to which findings could be accepted and methods confirmed [38, 39].

Ethical considerations

The study (Reference number BREC: BE274/17) was approved by the Biomedical Research Ethics Committee at the University of KwaZulu-Natal, South Africa. Due to the nature and sensitivity of information shared in this study, pseudonyms were used to maintain the confidentiality of service providers. Additionally, the participants' designation, profession and place of work were not revealed (Table 1).

Results

This study sought to explore service providers' perspectives in aftercare service provision for PWSUD in a rural district. Service providers reflected on the state of aftercare services, observed barriers, acknowledged existing enablers and contributed to recommendations for aftercare service provision. Four themes emanated from the data sets, namely, (i) reflections of the interactional state of aftercare services and program content, (ii) identifying existing barriers to aftercare service provision, (iii) situating systemic enablers to aftercare service provision, and (iv) associated aftercare system recommendations.

Theme 1: reflections on the interactional state of aftercare services and program content

Inadequacy of aftercare service provision

Service providers reflected on the inadequate state of aftercare in the district. In this rural district, the aftercare wasconsidered poor, executed within a fragile system, and if provided, lacked continuity and was deemed superficial at best, resulting in PWSUD being lost within the system.

> *I can say that there is this missing point of follow up or continuity of care. (Thandazile, Fieldwork and Implementation)*

> *There is still a lack of aftercare services to the people who have completed rehab, when they go out. Yes, they are still lacking aftercare so they find themselves coming back now and again in rehab because there is not much support for them ... Yes, however, even the DSD is supposed to run an aftercare program ... Ya they are supposed to because it is not happening but they have to (laughs). (Carol, Management, Coordination and Control)*

> *They get discharged from rehab but they get lost we do not see them then they show up when relapsed. (Jazzman, Fieldwork and Implementation)*

> *We can't even find her. They are still hunting for her. (Mngomezulu, Management, Control, Coordination and Implementation Control)*

Notable effective and successful aftercare intervention

Service providers reported limited successful aftercare intervention i.e. among 45 service providers, only three aftercare success life stories reported.

Story 1

> *But fortunately, I keep checking with the lady and she's drawing closer. But I'm doing a lot of aftercare for the teenager, and fortunately the teenager has gone back to school this year and apparently, he's doing well with the mother, though there are some elements of actually relapsing along the way. But with the care of the mother and also myself, we support. I also visit the school when I'm going to the clinic and stuff, just pass by the school just to check with the teachers. There's a lot of improvement. (Vika, Fieldwork and Implementation)*

Story 2

> *I think I visited the family because they knew that the patient had to stay for three months but I think he stayed for months. Then he had to explain at home why he came back earlier. So, I was the first one who was to talk to the family not to judge the patient because I knew that he had potential. He's the one who came to my office and said no I'm tired of using drugs, so I want to stop now. Then we tried to apply for rehab at Newlands. Then when he came back the family was disappointed, but I had to talk with the family, no he's okay provided we give him the support. Because he had potential, we were communicating now and again checking where he is, what he's doing, yeah. (Musa, Fieldwork and Implementation)*

Story 3

> *And I said to them no, it's a collective work for us as therapists and also the institutions. The person, I mean even now I saw him, he's functional and in the hospital where he is working. He is fully functional, I was actually doing some aftercare follow up with the supervisor in the ward that he is working and he's doing exceptionally well. Even in the training, where he was supposed to go. They were taken to further their training*

in nursing and he was doing well. Even passing with flying colours, even as tutors in this college. So, you can really see that how substance abuse can rob us of our potential. (Vika, Fieldwork and Implementation)

Validation of the types of aftercare services

There were inconsistencies in the provision of the limited aftercare services pertaining to home visits, family intervention, family reintegration services, school visits and individual counselling in this rural area.

Preparation for the environment, home visit to the family to strengthen support system. Counselling for family and the affected member. Then a CCG (Community Care Givers) because we cannot always be there then if the CCG identifies the problem they report to us. (Grace, Fieldwork and Implementation)

We do individual counselling, they come here at the center. (Joel, Fieldwork and Implementation)

Recommended aftercare program content

The essentiality of family centeredness

Service providers recommended that aftercare be centered on the family, and the family should know their essential role in aftercare.

As soon as they know that they have a more important role to play than the treatment center, they will then take part in a full way, in a fully pronounced way of the aftercare service. (Mngomezulu, Management, Control, Coordination and Control)

Because it's also very important to strengthen family support because they stay with the family they don't stay with us as health care workers. So, ours just ends here in the office, but I think we need to strengthen the family support. Even if we are not there. But the family will give support to the client. So that's very important. (Musa, Fieldwork and Implementation)

Family-centered aftercare should address broken relationships within the family.

There are broken relationships because the family is affected, the society is affected, the family does not want this person back home. The society does not want this person back. (Zinhle, Management and Control).

The pertinence of support groups in aftercare

Service providers reflected on the need for support groups during aftercare which were absent in their district. In addition, suggested that support groups should include family members because they also need support and a space to share their experiences.

I also thought of support groups where they can talk about their experiences. This must include family because you find that families are in denial and some rely on traditional healers. So, if they come to support groups they can also learn as a family. (Nickita, Fieldwork and Implementation)

Revisiting reintegration services in the system of care

Service providers maintained that reintegration services must endeavor to comprehensively reintegrate PWSUD within their context of family, workplace and community.

Yes, of course aftercare is good because we can even report to employment centers where the person was employed, that the person has the right recommendation, that they must take him back. Another thing that makes (cause) failure is the companies, the workplace that employed this person, the negative attitude of taking this person back because he could have done a lot of bad things before he was sent to that place. They say "no we cannot take him back" in spite of the person being more knowledgeable than the people who are now replacing him. (Mngomezulu, Management, Control, Coordination and Control)

However, reintegration is faced with a number of barriers, including stigmatization, therefore service providers should work with families and communities to facilitate reintegration.

The referral social worker needs to work with the family as well as the society. This person has been through help so please give him a chance, a second chance person but we will be working with him in the recovery process because the recovery is not a year or two, it is a process. (Zinhle, Management and Control)

Contextualizing the realities of vocational needs

Service providers admitted that most PWSUD have unmet vocational needs such as unemployment, job placement and skills development.

Sometimes there are just basic issues, unemployment. Which are the things that you cannot do easily but at the local offices they have other programs like program 5. Then we said link them. (Zinhle, Management and Control)

Table 2 Theme 1 with Subthemes and Categories

Theme 1: Reflections on the interactional state of aftercare services and program content	
Subthemes	**Categories**
Inadequacy of aftercare service provision	• Superficial aftercare services • PWSUD lost within the system
Notable effective and successful aftercare intervention	• Success story 1 • Success story 2 • Success story 3
Validation of the types of aftercare services	• Home visits • The essentiality of family centeredness • Family reintegration services • School visits • Individual counselling
Recommended aftercare program content	• Affirming family centeredness • The pertinence of support groups in aftercare • Reintegration services of PWSUD • Aftercare to address vocational needs • Relapse prevention • Chronic orientated aftercare

Service providers were of the view that the collaboration of departments in job placement could address unemployment needs.

> *Departments should be able to talk and say so and so has been discharged, can we find a placement? (Vika, Fieldwork and Implementation)*

Additionally, addressing vocational needs should include skills development.

> *I think maybe it's not only counselling that they need; they also need some skills, give them skills because they use drugs most of them and because they are staying at home, they are doing nothing. (Musa, Fieldwork, Implementation)*

> *In the aftercare program, if we can involve skills that we can do with them. That will create job opportunities for them. (Carol, Management, Coordination and Control)*

Sustaining relapse prevention

Relapse prevention was recommended through engaging in recreational activities, skills development and regular and consistent monitoring.

> *It becomes easy for them to relapse if there is nothing that they are doing that is keeping them busy. Even playing soccer or some activities, being involved in other activities, it takes their minds away from drugs. (Carol, Management, Coordination and Control)*

> *I think maybe if we do have a center, maybe a recreation center where they will come maybe once a week to have a support group there with them. (Thando, Fieldwork, Implementation and Coordination)*

Service providers also recommended aftercare that is chronic-orientated, which offers continual support or lifelong support for PWSUD.

> *Another thing aftercare should not have a specific duration we must not let go of our clients but live with them and support them until they die (Joel, Fieldwork and Implementation)*

> *They will always need intervention, regular follow-ups to prevent relapse. (Vela, Fieldwork and Implementation)*

Themes 2–4: identifying existing barriers and situating existing enablers to service provision and associated aftercare system recommendations (Tables 2 and 3)

To deliver the aforementioned aftercare content, a comprehensive understanding of all components of aftercare service provision should be assessed, bearing the stakeholders in mind. In this study, different levels of service provision, as per the Beer's VSM, namely implementation, coordination, control, intelligence/development and policy level, were explored [27]. Therefore, it is essential to classify these barriers and enablers at different levels to understand the contextual implications comprehensively.

Table 3 Themes 2, 3, & 4 according to VSM levels

Beer's VSM Levels	Theme 2 Identifying existing barriers to aftercare service provision	Theme 3 Situating systemic enablers to aftercare service provision	Theme 4 Associated aftercare systems recommendations
Implementation level	• Internal Motivation of PWSUD • Family denial • Family's limited knowledge of recovery process • Stigmatization of PWSUD • Poor community participation/partnerships in rehabilitation • Long waiting lists in ITCs • Unavailability of medication for withdrawal • Lack of education and training about SUD for service providers • Limited transport for service providers • Poor inter-sectoral collaboration • Lack of funding for aftercare services	• Team approach at hospitals and clinic level by DoH • High level of motivation of a PWSUD • Strong family support • Telephonic follow-ups from ITCs	Case manager or coordinator is required to coordinate aftercare services Teamwork in proving aftercare services • Teamwork should be facilitated through clinic card and CCG • Community partnerships facilitated through education cognizant of the cultural context.
Coordination level	Poor communication among stakeholders rendering services within the same community Limited awareness of each stakeholder's roles, responsibilities and scope of practice. Poor communication between ITC & referring service providers	The necessity of collaborating with community caregivers.	Encouraging inter-sectoral collaboration among various sectors Inter-sectoral collaboration should be facilitated through war-room
Control level	Evaluation of SUD Services: poorly managed and monitored	Maximizing on war-rooms Considering a Ward-based approach	Strengthen monitoring and evaluative mechanism for aftercare services.
Intelligence/ development level	Limited accountability and reporting of NGOs to local institutions Absence of aftercare statistics in Provincial reports	Negligible support for SUD programs	Accountability of NGOs should also be at institutional level i.e. DSD facilities or hospital. Encouraging comprehensive details of SUD in reports
Policy level	SUD programs not prioritized by DoH and DSD NGOs reporting renewal at policy level only Lack of standard of care Lack of policy awareness	Policies in place	Revisiting the accountability of NGOs

Implementation level

Service providers noted that some PWSUD lacked internal motivation towards recovery. Although service providers did not mention a highly motivated PWSUD as an enabler, the success stories for aftercare indicated that highly motivated PWSUD enabled service provision.

> *He's the one who came to my office and said no I'm tired of using drugs, so I want to stop now. (Musa, Fieldwork and Implementation)*

There were several barriers to the provision of aftercare to the family, namely family stigmatization, family denial and lack of knowledge regarding the recovery process.

> *The family understands that this is a long-term problem, it's not, we don't fix it at the hospital. You're admitted, you're here and it's expected that they will be fine, why are they not getting better? ... Yes. You know there's a, I find the families always come back, 'why are they not getting better?' 'Why are they not stopping?' And trying to make them understand the lifestyle change and it's for the rest of their life. They may have to deal with this and the dynamics of the family that has to change. (Dr K, Fieldwork, Implementation and Coordination)*

Service providers identified barriers at the community level, such as stigmatization of PWSUD and poor community participation/partnerships in rehabilitation.

> *I feel like not many people meet, so when you see a patient, they might come with psychosis, but they've only met their previous abuser so the stigma about being a substance abuser is still quite strong here, they are not open to talk about it. (Zakithi, Fieldwork and Implementation)*

Community partnerships were expressed as necessary in facilitating education that is culturally and contextually specific.

> *I believe there can be educational workshops ... You've got to equip them with knowledge and skills and how to deal with ... but it must be culturally based, whatever information you are giving it must be sensitive to culture, cultural norms and values of that group because each group has got different norms. It doesn't mean because you're a Zulu, your norms are the same ... Clan praises! (Laughs). (Mngomezulu, Management, Control, Coordination and Control)*

Service providers observed the lack of resources as a barrier in their respective sectors. These include staff shortages, a lack of ITCs in their district, lengthy waiting lists in ITCs situated in cities, unavailable medication for withdrawal symptoms, limited transport for home visits, and a lack of funding for aftercare services for NGOs.

> *There is no funding allocated to aftercare, so even if you want to do aftercare, there is no budget. (Palesa, Fieldwork and Implementation)*

> *From my department I felt we lack the constructive use of their time, and it will be very good to have groups. But due to a limited number of us, we don't have the human resources to carry through (Zakithi, Fieldwork and Implementation)*

Service providers also identified an urgent need for the training of social workers at the district level on SUD service provision in a South African context.

> *One of the challenges we have is that the support for continuity of care as well as training, education, regarding how we proceed with continuity of care particularly with substance abuse, we do find that the Department of Health doesn't really focus much on that. (Dr K, Fieldwork, Implementation and Coordination)*

Although service providers did not overtly express an interdisciplinary team approach as an enabler for service provision, service providers at some DoH institutions reported more comprehensive services at hospitals and clinics, using mental healthcare (MHC) teams. MHC teams enabled more robust communication and collaboration among disciplines within the same institution. The opinion of service providers is that poor communication among sectors could be minimized through promoting teamwork that can be facilitated through clinic cards and involvement of community caregivers (CCG).

CCGs are community-based and well acquainted with service users from the same community.

> *We have mental health teams so we are integrated into the hospital. (Nickita, Fieldwork and Implementation)*

> *Now it is better, we work with SORD (NGO), they are funded by DoH to provide mental health services. They do much treatment but focus on empowerment; they do follow up and support groups ... We write referral letters to them. (Grace, Fieldwork and Implementation)*

> *We also do lots of follow ups on the CCG's since they are the ones who actually do a lot of baseline visits to the families to check as to if there is any improvement. Though sometimes you'll find that the family will not give you all the information, but the CCG's you'll find they'll give you all the information as to what is happening, is there any improvement, any changes that are there. (Vika, Fieldwork and Implementation).*

> *Using the Clinic Card as a tool to communicate. Because everyone writes on this card even the CCG. Then we can all see what is written. Because when we do home visits we sometime go with the SW, OT and Psych nurse. I don't know how realistic is that because we do not know. (Thobile, Fieldwork and Implementation)*

Coordination level

Service providers expressed that there is poor coordination of services characterized by poor communication and lack of monitoring.

> *I am saying when they release a person from rehab sometimes, they do not tell us and that is a problem... We will only see a person when he is brought back when he has relapsed; this person, when was he released? That is another big problem... Uh ... the communication between the rehab center and the treatment center and the treatment organization and the NGOs is not well monitored. (Mngomezulu, Management, Control, Coordination and Control)*

There is also poor coordination within the same sector, which indicates poor cooperation and interaction of sub-systems. There is miscommunication between ITCs (sub-system) and service providers at community level (sub-system).

Even when they go to rehab they go there but when discharged, all the stakeholders I was telling are not aware. They go back home with no support. (Thobile, Fieldwork, Implementation and Coordination)

We still do not get any feedback unless a social worker from here is still liaising, client checking, that are you still okay; or maybe sometimes the client phones and "how are you doing"? "I am doing 1, 2, 3, 4,5 - giving the social workers feedback. (Carol, Management, Coordination and Control)

To achieve a well-coordinated system of care, service providers were of the view that a case manager is required to assist with coordinating the service and facilitate intersectoral collaboration. The service providers revealed that existing collaborative structures such as school health teams and local drug action committees enabled the collaboration of stakeholders in prevention programs, but not in any treatment interventions.

We work together with the school health team as well as with the local drug committee where we go to schools to do health education like awareness. (Thandazile, Fieldwork and Implementation)

Control level

Service providers acknowledged the inadequate monitoring of SUD services and the absence of statistics submission at the district level.

No M and E for aftercare, even SUD we report on how many admitted. (Nonhle, Coordination and Control)

We do it on a small scale. It is touch and go ... we group them in mental health stats, just reporting how many were SUD and how many were schizophrenic. (Thobile, Fieldwork, Implementation and Coordination)

No, we do not take any statistics of aftercare. Actually, nothing is reported about aftercare. (Sydney, Fieldwork and Implementation)

There should a very strong monitoring and an evaluation of SUD programs. More details for aftercare in the reports. (Bhekani, Management, Coordination, Control and Development)

The existing program of war rooms (a meeting of multiple stakeholders working in a ward/a a particular community) appears to be an enabling mechanism for collaboration in prevention strategies.

We use war rooms to communicate with other stakeholders where we identify cases together. (Nonhle, Management, Coordination and Control)

I believe we must also be using the war room groups. Yah. The war room groups because they are the ones that are going to report back to us. (Mngomezulu, Management, Control, Coordination and Control)

In addition, DSD recently implemented a ward-based approach (each or several social workers are allocated to a ward to render all services) to service delivery which was said to be a facilitator for stakeholder collaboration.

Ward-based approach is helping in a way although there are still challenges. (Joanne, Coordination, Control and Intelligence)

Intelligence level

Little support of SUD programs, characterized by inadequate provincial reporting tools, was noted as a barrier to service provision.

There is support for other programs from provincial but very little for SUD services. Aftercare is not even recorded in monthly stats. (Nonhle, Management, Coordination and Control)

The reporting tool does not include aftercare at all. It does include the number of people sent to rehab though. SUD is not a priority ... You find that we only report how many have been to rehab and it is not monitored. No statistics collecting it, so even when they have done it there is nowhere to report. (Thembeka, Coordination and Control)

Service providers maintained that the accountability of state-funded NGOs should also be at local institutions.

They run away from accountability, because these NGOs are funded by us ... They are funded by Health, they are funded by DSD. (Vika, Fieldwork and Implementation)

Additionally, service providers recommended that reports include SUD details such as aftercare and encompass the different/joint stakeholders instead of reporting in silos.

Then by doing that, when you come to Province and report, it's collective. (Vika, Fieldwork and Implementation)

Policy level

There was a noticeable lack of policy awareness on the service delivery (implementation) level, compared to

service providers at the management level. As a result, the implementation service providers were unaware of specific policies guiding aftercare.

> *No, we don't have a specific standard. I can't remember how I discharge them from or they discharge themselves, really. But I think once a month. (Musa, Fieldwork and Implementation)*

> *No aftercare program we follow, no, no, there is no specific program. (Jazzman, Fieldwork and Implementation)*

In addition, service providers expressed that the DoH and DSD do not prioritize SUD programs. Instead, service providers are under pressure to meet targets for other competing programs.

> *We have a lot of competing priorities. You see it has targets that are big very big, so social workers are chasing after them because they will report on them. So psychosocial services take a back seat because they will not report on them. (Joanne, Coordination, Control and Intelligence)*

Service providers at DSD expressed their frustrations about meeting targets of other programs, whilst for SUD, they were required to meet targets of prevention programs in the form of the number of people reached through awareness campaigns. In addition, the extensive reporting was time-consuming as opposed to rendering comprehensive services to their different client population. Notably, the targets they had to meet interfered with their duties.

> *Even the community knows us that we no longer work but we are pushing targets. It is hard because if you do not meet the target you have to explain why. So, SUD takes a backseat. (Joel, Fieldwork and Implementation)*

Discussion

Reflections on the interactional state of aftercare services

The inadequate state of aftercare in the district is consistent with South African literature [1, 2, 13, 18, 22]; aftercare services are limited and, where available, were insufficient. In this study, the inconsistencies in the provision of the limited aftercare services affirm the previous studies, treatment services in SA are limited and mainly non-existent for the rural population [2]. Similarly, in an earlier study, only one out of five PWSUD had aftercare services post-discharge from an ITC in the same district [24]. Likewise, among 45 service providers, only three aftercare success life stories were reported in this study. However, these narratives demonstrated efficient teamwork at hospitals within the existing mental healthcare teams, which aided in the collaboration of various disciplines.

Recommended aftercare program content

The essentiality of family centeredness

Service providers reiterated that aftercare should be centered on the family, a recurrent theme within available literature [17, 18, 41–43] and South African SUD policies [3, 23, 44, 45]. Social support from the family has been associated with positive outcomes in relapse [46, 47] and can assist with coping strategies for stress and dealing with triggers [47, 48]. Whilst the family is vital in aftercare, policy studies [3, 49] revealed that SA policies are ambiguous regarding family interventions. Nonetheless, service providers have expanded on family-centered aftercare intervention, which affords mending broken relationships for the reintegration of PWSUD and strengthening family support, creating a conducive environment for recovery and contributes to relapse prevention. This is consistent with findings from South African studies [17, 50] and international studies [51, 52]. Findings in this study suggest that to achieve a conducive environment, family education on SUD and the recovery process, especially building an understanding of the 'chronic partners' of SUD, is essential. Service providers indicated that family intervention should attend to family relationships, consistent with Groenewald & Bhana [49], who confirms that family relations are strained by the stress related to the user's substance abuse. Therefore, family-centered aftercare allows a conducive space to address existing dysfunctional issues, which a social worker could facilitate. The familial patterns of dysfunctionality that may hinder recovery can be adequately examined in such a professional space; however, this could be a complex process [53].

The pertinence of support groups in aftercare

Service providers are aware of a critical absence of support groups in their district, although support groups are needed for PWSUD. Evidence from the literature indicates that involvement in support groups such as self-help groups contributes positively to reducing relapse and is an essential component of aftercare and treatment [23, 25, 46, 54]. Previous studies [54, 55], suggest that PWSUD who attended support groups had improved treatment outcomes for a longer time compared to those who did not. Laudet, Savage & Daneyal [46] study identifies community support services and association with the 12-step program as critical in maintaining sobriety for almost 12 years [46]. Furthermore, support groups offer

several benefits, such as community reintegration [5], source of information and emotional support through peer support [56]. The peer support nature of the 12-step program provides information on health, employment, citizen restoration, a space for learning new skills and a conducive environment for establishing positive social relationships with others in drug and alcohol-free recovery environments [56].

In this study, service providers suggested that support groups include family members because they also need support and intervention. Generally, family members of a PWSUD mostly require to be equipped with coping strategies and knowledge on how best to be supportive [43], views which are also reinforced in support groups. In the previous study by Mpanza et al., [24], it was evident that family commitment to continued support group participation was a prerequisite for accepting a PWSUD [24]. Therefore, support groups such as mutual aid/self-help groups should be established in rural districts to benefit the family and PWSUD. Such groups can include both family and PWSUD and, in some sessions, be separated.

Revisiting reintegration services in the system of care

The Substance Abuse Act of 2008 emphasizes the importance of successful reintegration into home, family, workforce and community as an ultimate goal of aftercare intervention [25]. Similarly, service providers reiterated that aftercare program must endeavor to comprehensively reintegrate PWSUD within their context of family, workplace and community despite barriers such as stigmatization. Evidence from the literature indicates that reintegration is mainly hindered by stigmatization, a common phenomenon in SA [24]. However, community support services (CSS) play a vital role in reintegrating PWSUD into their community post-inpatient treatment [3, 54, 57] and may assist in mitigating barriers to successful reintegration.

Contextualizing the realities of vocational needs in aftercare

The opinion of service providers that PWSUD have unmet vocational needs to be addressed in aftercare is supported by SA literature [17, 18, 24, 42]. The various systems interact to produce an environment that is characterized by unemployment which has been linked to high relapse rates [42]. However, one must remain cognizant of the country's 32.5% unemployment rate [58] that inevitably impacts vocational needs. To address this need, service providers suggested that PWSUD should be linked to job placement programs such as Program Five of the DSD to facilitate job placement. Program Five is a community development program focusing on sustainable livelihoods and job placement for the indigent and vulnerable population [59]. In addition, the collaboration of stakeholders is required to achieve job placement. Studies demonstrate the need for a collaborative approach in assisting PWSUD in finding employment [4], which aligns with the South African overall policy on SUD [12]. Specifically, departments such as Economic Development and Municipalities should collaboratively consider addressing the vocational needs of PWSUD. This is supported by the prescripts of the NDMP (2019–2024), which reiterates that stakeholders should cooperate in rendering services to PWSUD, including skills, personal and economic development, and creating employment opportunities and support for Small Medium Micro Enterprises (SMMEs) [12].

Sustaining relapse prevention

Service providers recommended aftercare programs to include relapse prevention. Evidence from the literature [17, 18, 50, 60–62] supports aftercare to include relapse prevention strategies to achieve sustained recovery. However, relapse is inevitable for some PWSUD, given the chronic patterns of SUD [63], noting that in SA, the majority of PWSUD relapse post-inpatient treatment care [1, 23, 34, 54]. Therefore, interventions should focus on relapse prevention and prepare for relapse so that its impact is minimized and adequately managed and accepted as part of the recovery process. Notably, the NDMP 2019–2024, UNODC, and WHO 2020 acknowledge SUD as a chronic, relapsing disease but does not provide clear guidance on how to manage relapse and lapse, which form part of a chronic disease pattern; instead, they only focus on relapse prevention, and not managing relapse [7, 12]. Thus, an aftercare program that is chronic-orientated, which offers continual support or lifelong support for PWSUD, is essential.

Identifying existing barriers and situating existing enablers to service provision and associated aftercare system recommendations

Generally, in a rural context, various barriers exist and have been acknowledged in previous studies [2, 13]. Similarly, in this study, different levels of service provision, as per the Beer's VSM, namely implementation, coordination, control, intelligence/development and policy level, were explored [27], which gave a comprehensive understanding of barriers and enablers with contextual implications.

Implementation level

A lack of internal motivation was noted as one of the barriers towards service provision and recovery, consistent with a previous study [64]. Internal motivation and readiness to change is integral to the recovery process [64]. Although a lack of internal motivation is considered

a barrier to service provision, this should be noted with understanding that lack of motivation is part of the disorder that which the aftercare system should consider throughout the intervention. Therefore aftercare intervention should endeavour to continue motivate the PWSUD so that a lack of motivation is not a barrier/limitation to effective intervention.

Consistent with previous research [24, 43, 49, 53], SA policies [23, 44] and legislature [25], the study identified the family as an integral part of aftercare intervention. However, providing aftercare to the family is embedded with several barriers, namely family stigmatization, family denial and lack of knowledge regarding the recovery process. Such barriers affirm the notion that families of PWSUD require therapeutic intervention [65], which should address their specific needs and challenges. Moreover, to some families, substance use is a family legacy, with patterns that require examination within a therapeutic space for sustained change [65]. It was noted from the success stories that authentic and strong family support was integral in facilitating aftercare services. In this district, an earlier study by Mpanza et al., [24] also affirmed the necessity of strong family support for PWSUD.

At a community level, barriers such as stigmatization of PWSUD and poor community participation/partnerships in rehabilitation negatively impact service provision. Community stigmatization of PWSUD is common [18, 24, 66, 67] and typically influences community partnerships in rehabilitation. Thus, culturally appropriate community education would assist in eliciting community partnerships for the treatment of PWSUD [65] and should include efforts to minimize stigmatization [7].

Limited resources challenge service providers in rural areas within a largely non-conducive environment for recovery [65]. In this study, service providers reported a lack of resources as a barrier across all sectors. The majority of services are offered by the DSD, [2] thus, a needs assessment may provide direction as to how the mobilization of resources could be implemented. As noted in the literature [2], funding is generally an issue, particularly for NGOs; for instance, in this study, NGO service providers complained about the lack of funding and budget allocations, even though they were expected to render comprehensive services inclusive of home visits. Another concomitant aspect is essential staff shortages which hamper comprehensive care. In addition, ongoing staff development and training on SUD is critical. Consequently, a study by Burnhams et al. [2] also identifies an urgent need for the training of social workers at the district level on SUD service provision in a South African context. Similarly, the international standards for the treatment of SUD by UNODC and WHO also recognize the need for the training of service providers in SUD management [7].

Coordination level

Service providers' perspectives revealed that SUD treatment services are inadequately coordinated within and among respective sectors. Poor communication lends itself to inefficient coordination. Despite rendering services to the same community and engaging the same person, they remain unaware of each other's role. In SA, working in compartmentalized sectors is common within the treatment system of SUD [16, 68], despite Acts [25] and policies [7, 23, 44] promoting inter-sectoral collaboration. In some cases, poor coordination is within the same sector, despite policy guidelines available [44]. The cooperation and interaction of sub-systems of the overall treatment system influence the commitment to aftercare for PWSUD [69]. In addition, poor coordination between ITCs and service providers at the community level contributes to increased relapse rates [13]. Therefore, a coordinated, comprehensive system of care that contributes towards the prevention of relapse and complications aligned to treatment goals by UNDOC and WHO should be the desired goal [7]. In this study, a case manager was proposed as a solution to assist in achieving a well-coordinated system of care and facilitate inter-sectoral collaboration, which is in line with the national minimum norms and standards [44]. However, coordination of service remains an ongoing challenge.

Control level

The study identified the inadequate monitoring of SUD services at the district level as a barrier to service provision. Whilst aftercare is a sub-system of the SUD treatment system; it is also a sub-system in itself. A recent study by Mpanza et al. [3] revealed that SUD services' inadequate monitoring and evaluation may be linked to vague policy directives. In addition, no statistics nor reports for aftercare services are submitted at the provincial level. Inevitably, this lack of record keeping will negatively impact the aftercare system.

Although enablers were not easily identified in this study, the existing program such as war rooms and DSD ward-based approach to service delivery appeared to be an enabling mechanism for collaboration in prevention. Enhancing such programs to extend to treatment and aftercare could maximise available resources for rural communities [65].

Intelligence level

The study identified little support of SUD programs at a provincial level, characterized by inadequate provincial reporting tools, as a barrier to service provision. Service providers recommended that reports include SUD details such as aftercare and encompass the different/joint stakeholders instead of reporting in silos. This could foster collaborations and inter-sectoral service delivery

as expressed in the NDMP of 2019–2024 [12], Substance Use Act [25], and the UNODC and WHO International Standards for the Treatment of Drug Use Disorders [7]. In addition, service providers proposed that reporting and monitoring of NGOs rendering services at the community level should be extended to the local institutions such as hospitals and service centres as oppose to be monitored at the provincial level only. This skewed accountability hinders progress at an intelligence level.

Policy level

In this study, there was a lack of awareness of specific policies guiding aftercare at the implementation level. The lacunae in such policy awareness influence service delivery as services are aligned with policy directives. Policies such as the National Minimum Norms and Standards for Inpatient Treatment [44] should be familiar to service providers. In addition, SUD programs are not prioritized by the DoH and DSD, and the extensive reporting is time-consuming. Both targets and comprehensive reporting interfered with service providers duties. The heavy caseloads and excessive paperwork of service providers have reportedly interfered with their clients' quality of service [65], to the extent of neglect of other services, prioritizing other programs seem common in the public sector. Mpanza and Govender [1] also affirm that mental health and SUD programs were not prioritized in this district due to priority programs such as HIV and TB. Whilst prioritizing certain programs is understandable, for instance, this particular district has a high prevalence of TB and HIV, a balanced and equitable distribution of resources to all programs as per policy directives should be a guide. In addition, evidence-based practice should be promoted in service planning as indicated by UNODC and WHO 2020 [7].

Study limitations

The study explored the perspectives of service providers in aftercare service provision. The study was conducted in one outlying rural district away from cities where ITCs are located. Hence district/s closer to ITCs may be of the same rural context but vary in experience due to their proximity to towns compared to this district. Future studies should consider exploring more than one district to expand the comprehensive understanding of aftercare service provision in many districts.

Conclusions

The intersecting systemic complexities of providing aftercare services in a rural context in SA was evident in this study, irrefutably demonstrating the weaknesses and inadequacies within a fragile system. Aftercare services were at best superficial, such that PWSUD were lost within the system of aftercare. Where it was present, service provision followed an acute model instead of lifelong intervention as prescribed by overall policy. However, the limited success stories and effective teamwork at hospitals within the mental healthcare teams demonstrated the value and strength of integrating SUD services with the mental healthcare system. Minimal enablers exist for service provisions in this rural district, such as integrated SUD services to the mental healthcare system at the implementation level and existing multiple stakeholder collaborative programs such as war rooms and Operation *Sukuma Sakhe*[1] at the control and coordination level. These appeared to stimulate the collaboration of multiple stakeholders to a limited extent, therefore, it should be strengthened and extended to SUD treatment services at all levels of service provision. Service providers were continuously faced with numerous systemic barriers at all levels of service provision. Additional barriers were identified at the implementation and policy level. A key barrier was the low prioritization of SUD in government departments, where competing priority programs took precedence over SUD services. As a result, the various shortfalls of the SUD system were characterized by inadequacies in the aftercare system. To strengthen the aftercare system, policies with enforcement are required for aftercare services and outcome-based monitoring and evaluation linked with specific indicators. Moreover, a model of aftercare that is family-centered and sensitive to the rural context, encompassing both relapse management and prevention, is responsive to individual needs and evidence-based, integrated into the existing systems of service provision and one that encourages stakeholder collaborations, could also strengthen and sustain the aftercare system and service provision. To achieve a functional aftercare system, the perspectives, experiential knowledge and insight of service providers and PWSUD with their families as essential stakeholders should be considered for further policy developments, service delivery strategies and effective aftercare model development.

Abbreviations

CCG: Community Care Givers; DoH: Department of Health; DSD: Department of Social Development; ITCs: In-patient Treatment Centers; MHC: Mental Healthcare; NGO: Non-Governmental Organization; nGAP: New Generation of Academics Programme; PWSUD: Persons with Substance Use Disorder; KZN: KwaZulu-Natal; SA: South Africa; SUD: Substance Use Disorder; SMMEs: Small Medium Micro Enterprises; UNODC: United Nations Office on Drugs and Crime; VSM: Beer's Viable Systems Model; WHO: World Health Organization.

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[1] Operation Sukuma Sakhe (Stand up and build) refers to the integrated service delivery model bringing together all service delivery stakeholders to provide services in an integrated manner.

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Authors' contributions
DM zconceptualized and designed the study, conducted the interviews, wrote the first draft of the manuscript. Further additions and refining of the manuscript was done by all three authors. PG and AV provided consultation, critical reviewing of data analysis and guided the further analysis of results. All authors contributed to the interpretation of the results, revised and approved the final manuscript.

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Availability of data and materials
The data generated during the current study are not publicly available to protectof the confidentiality for participants. Data is available upon reasonable request from the first and corresponding author.

Declarations

Ethics approval and consent to participate
The study procedures were approved by the University of KwaZulu-Natal's Biomedical Research Ethics Committee (reference number BE274/17). The committee is registered with the South African National Health Research Ethics Council (REC-290408). Gatekeeper permissions were sought from all participating stakeholders, including the KwaZulu-Natal Provincial Health Research and Knowledge Management Directorate (reference no HRM255/17) and the KwaZulu-Natal Provincial Human Resource Management of the Department of Social Development (DSD). Informed consent was obtained from all participants.

Consent for publication
Not applicable.

Competing interests
The authors declare that they have no competing interests.

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Publisher's Note

5.5 CONCLUSION

Chapter 5 contributed to an understanding of the intricacies of delivering aftercare in a rural context as described from the perspective of service providers at the policy and implementation level of aftercare service delivery. Aftercare service provided at a district level was described to have included school visits, individual counselling, home visits, family intervention and reintegration services. However, aftercare services were generally poor and limited, and where provided, followed an acute model, thus terminated shortly after discharge. Some of the barriers and compounding factors for poor aftercare service provision were that services were not guided by policy nor programmes or specific packages due to lack of specific policies and policy awareness by service providers at the service delivery (implementation) level. However, good teamwork at hospitals within the mental health teams was an enabling factor and demonstrated the value and strength of integrating aftercare services for persons with SUDs in the mental health system. This chapter also illustrated synthesised recommendations for content towards developing an aftercare model of care. Chapter 6 below explores aftercare from the perspectives of service users.

CHAPTER 6

PHASE 2, STAGE 2: THE PERSPECTIVES OF SERVICE USERS

6.1 INTRODUCTION

Research on aftercare needs is limited and excludes the perspectives of persons with SUDs and their families. The South African studies commenting on the nature of aftercare services were not inclusive of persons with SUDs (16, 17). Studies that explored aftercare needs of persons with SUDs were urban-based and not in KZN (28, 30). Therefore, this chapter explored the aftercare needs post-discharge from Inpatient Treatment Centres (ITCs) for persons with SUDs in a rural district of KwaZulu-Natal South Africa. The chapter provides insight into aftercare needs essential for developing an aftercare model of care responsive to the needs of both families and persons with SUDs. The findings address Stage 2 of phase 2, of the study, which responds to objective 2, 3 and 5.

6.2 AFTERCARE NEEDS POST INPATIENT TREATMENT IN A SOUTH AFRICAN RURAL CONTEXT: PERSPECTIVES OF PERSONS WITH SUBSTANCE USE DISORDERS AND THEIR FAMILIES

The manuscript entitled "Aftercare Needs Post Inpatient Treatment in a South African Rural Context: Perspectives of Persons with Substance Use Disorders and Their Families," reporting on aftercare needs and experiences of persons with SUDs and their families, has been submitted to the South African Family Practice (SAFP). The SAFP provides a forum for primary care teams, researchers and others for scholarly engagement in the practice, training and learning of family medicine, primary care, primary health care, rural medicine, district health and other related fields. The journal was explicitly selected so that service providers in this field are exposed to the lived experiences of the service users in the context of SUD as an indelible component of health care in South Africa. The journal is an open-access journal and the

> *…official journal of the South African Academy of Family Physicians (SAAFP) and is aimed at all SAAFP members (including family physicians, registrars, associate members, students) working within primary care (both private and public health sectors, as well as urban and rural practice settings) within South Africa and the wider*

Southern African region. (https://safpj.co.za/index.php/safpj/pages/view/journal-information).

The SAFP has a publication frequency of once per year published online and then printed year-end. Please refer to Table 6.1 for Manuscript review details.

Table 6.1: Manuscript Review Details

ITEM	DETAILS
Article Title:	Aftercare needs post inpatient treatment in a South African rural context: Perspectives of persons with substance use disorders and their families.
Authors:	December Mandlenkosi Mpanza, Pragashnie Govender and Anna Voce
Journal:	South African Family Practice (SAFP).
Journal Details:	Peer-reviewed (double-blinded). Accredited with the Department of Higher Education & Training (DoHET) in South Africa
Impact Factor:	1.0 (based on CiteScore, based on SCOPUS, Elsevier 2021)
Quartile	3rd
Submission history:	
Publication Status:	Review in Progress

6.3 AUTHOR CONTRIBUTION

The PhD candidate conceptualised the study, formulated the research proposal, collected and analysed data and drafted the manuscript. Supervisors Prof Anna Voce and Prof Pragashnie Govender provided guidance and critical review throughout the study.

6.4. THE MANUSCRIPT

This is the third manuscript of the overall study. Included below is a copy of said manuscript.

MANUSCRIPT

AFTERCARE NEEDS POST INPATIENT TREATMENT IN A SOUTH AFRICAN RURAL CONTEXT: PERSPECTIVES OF PERSONS WITH SUBSTANCE USE DISORDERS AND THEIR FAMILIES

ABSTRACT

Background

Planned aftercare, also known as recovery management or continuing care following comprehensive inpatient treatment for persons with substance use disorders (SUDs), contributes to improved treatment outcomes. However, access to aftercare is limited, particularly in rural areas of South Africa. Programme development should be responsive to persons with SUDs and their families. Aftercare needs are, however, not well documented. This study explored the aftercare needs post-discharge from Inpatient Treatment Centres for persons with SUDs.

Methods

The study was conducted in a rural district in one of eleven districts in the KwaZulu-Natal Province of South Africa. Within a constructivist paradigm, qualitative data were generated through audio-recorded individual face-to-face semi-structured interviews with five persons with SUDs and their family members (n=5) at their homes. Data were analysed thematically.

Results

Experiences post-discharge highlighted inadequacies of current aftercare. Only one person with SUDs reported receiving aftercare, and none of the family members reported receiving family intervention. Participants identified aftercare needs, which included reintegration needs, the need for family interventions, and addressing vocational needs as a relapse prevention mechanism.

Conclusion

Persons with SUDs and their families shared similar perspectives of aftercare needs. Unmet aftercare needs are compounded by limited services within rural districts. It is therefore recommended that aftercare services be family-centred, promoting reintegration in families and communities, and community. The study had limitations such as the small number of participants and all participants with SUDs were unemployed of which the experiences of employed persons with SUDs is missing.

Contribution

The study demonstrates improvements required for the strengthening of aftercare services, which should be integrated into primary health care and be contextually responsive to the needs of persons with SUDs and their family members in South Africa.

Keywords: aftercare, persons with substance use disorders, family intervention, inpatient treatment care

INTRODUCTION

Planned aftercare, also known as recovery management or continuing care following inpatient treatment for persons with substance use disorders (SUDs), contributes to improved treatment outcomes.[1-8] Aftercare refers to "ongoing professional support to a service user after a formal treatment episode has ended to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning."[9] Aftercare interventions may include, but are not limited to, group counselling, individual therapy, telephone counselling, brief check-ups, self-help group meetings,[2] relapse prevention, and reintegration services.[10-13] Positive outcomes of effective aftercare include relapse prevention, sustained sobriety, and improved quality of life for persons with SUDs and their families.[2-5,8-12] Access to aftercare is the most influential factor in relapse prevention.[11,14-18] However, access to comprehensive aftercare is limited worldwide.[6,19,20] Generally, high relapse rates indicate limited availability of, and accessibility to, aftercare services and/or inadequate aftercare.

The global SUD relapse rate in 2017 was as high as 60 per cent.[7] Consistent with global trends, South Africa reports high relapse rates and repeat admissions for persons with SUDs associated with limited and inadequate aftercare. Repeat readmission to treatment centres for all SUDs ranged from 7 per cent in 2014 to 29 per cent in 2018.[21] Limitations in aftercare relate to the two-tiered nature of the health system in South Africa, that is, the public and private health sectors, limiting access to aftercare by a majority of the population who have no medical insurance coverage.[22,23] Significant disparities between the private and public sectors persist despite statutory requirements governing detoxification services in both sectors.[9,13]

Inadequacies in aftercare include unstructured programmes,[24] and fragmented and uncoordinated services among service providers,[10,25] lack of continuity of care exacerbated by the poor availability and accessibility of services, and the private/public and urban/rural

divides.[26] Limitations and inadequacies in aftercare provision are influenced by SUD policies that fail to provide a definitive guide to the essential nature and provision of aftercare in the South African context.[23] Current SUD policy formulation does not seem to have been influenced by empirical research and provides only cursory content on aftercare.[21] Furthermore, research on aftercare needs is limited and excludes the perspectives of persons with SUDs and their families. Three South African studies commenting on the nature of aftercare services were not inclusive of persons with SUDs.[25,27,28] Of the four studies which involved persons with SUDs,[14,18,24,29] only two explored the aftercare needs of persons with SUDs, but in an urban location and not in KZN.[14,29] Models for aftercare service provision, tailored for South African and KZN rural contexts, where approximately 40 per cent and 55 per cent of the population reside, are imperative.

A meta-analysis conducted by Lenaerts et al.[3] on recovery management (aftercare) concluded that individually customised recovery management is the most effective intervention. In addition, the family has been reported to be an integral part of aftercare.[10,11,29] The South African National Drug Master Plan calls for aftercare services to be responsive to the needs of persons with SUDs and their families.[9,10] Therefore, an understanding of aftercare needs in a rural context was necessary.

This study explored the aftercare experiences and needs post-discharge from Inpatient Treatment Centres (ITCs) for persons with SUDs in a rural district of the KwaZulu-Natal Province (KZN), South Africa (SA). The study had three objectives: to describe aftercare experiences post-discharge from an ITC, to describe the aftercare needs of persons with SUDs discharged from an ITC and to describe the aftercare needs of family members of persons with SUDs.

METHODOLOGY

Study orientation

The study was located within the constructivist paradigm.[30,31] Constructing a model for aftercare services needs to take cognisance of, and be responsive to, the multiple experiences, needs, and perspectives of those affected by SUDs. The unique and shared subjective experiences, needs and perspectives of persons with SUDs and their families were explored using qualitative data generation and analysis techniques.

Study setting

The study was conducted in a rural district, one of eleven districts in the KwaZulu-Natal Province, the second-most populous province in South Africa. Compared to the national average, the population in KZN province is most vulnerable to SUD and is confronted by unemployment and poverty [32,33,52] and a high incidence of HIV.[34] In KZN, of persons accessing treatment services, alcohol accounts for 33 per cent as the primary substance of use. In KZN, for persons younger than twenty years, cannabis is identified as the most common substance of use,[35,36] and reported as the primary substance used by 23 per cent of persons admitted to treatment sites in the year 2021.[36] Cocaine accounted for 26 per cent and heroin (which also includes nyaope/whoonga), accounted for 23 per cent.[36]

In the study rural district, resources for the management of SUDs are limited. There is no ITC; persons with SUDs are referred to public-sector ITCs located in urban areas at a distance of at least 360km away. Five public sector district hospitals provide acute management of substance-induced psychoses; one Non-Governmental Organisation (NGO) provides outpatient mental health treatment services, inclusive of SUDs; one other NGO focuses on outpatient SUD services and referrals to ITCs in the public or private sector, depending on user affordability; and several Department of Social Development (DoSD) service centres provide social welfare services, inclusive of SUD services. This district shares commonalities with and typifies most rural districts in South Africa.

Recruitment and Sampling

Participants were identified and recruited through the assistance of service providers from the local NGOs and the DoSD based on selection criteria that included being eighteen years and above, of any sex, residing in the study setting, with a history of using any substance, and had at least one-month post-discharge from a public sector ITC. Eligibility for the family included a significant family member who had lived with the person with the SUD before admission to the ITC and for at least one-month post-discharge. Seventeen names of participants were given for inclusion to the study, and they were approached telephonically to participate. Due to lack of availability or relapse, five persons with SUDs and five family members consented to participate.

Data generation

Data were generated through individual face-to-face semi-structured interviews, guided by an interview schedule, conducted in isiZulu with each participant in their home; lasting not more than ninety minutes. Interviews were undertaken first with the persons with SUDs, followed by separate interviews with the family member/s to encourage free expression. Broad topics addressed with persons with SUDs included the treatment experience in the ITC, the return journey from ITC to home, the aftercare experiences, challenges/barriers and enablers to aftercare services, and their aftercare needs. Recommendations for aftercare services were also elicited. With family members, the broad topics included their experience of the treatment journey with a relative with SUD, their experiences during aftercare of their family member, their perceived aftercare needs for the family member who has SUD, and recommendations for SUD aftercare services.

Data analysis

The audio recordings of interviews were transcribed verbatim into isiZulu, translated into English by an independent translator to produce a written transcript and reviewed by the first author for accuracy. As recommended by Harling,[37] a three-step analysis was followed: a detailed case description was developed for each case, followed by a within-case analysis, and concluded with a cross-case analysis. Within-case and cross-case analyses were performed via a thematic analysis. A hybrid approach[38] to the thematic analysis was implemented: Codes were predetermined deductively from the study question, aims and objectives; new codes were derived inductively from the data. Codes were collated into thematic categories and further refined into sub-themes and named.[39]

Ensuring trustworthiness

The trustworthiness of the findings, namely credibility, confirmability, dependability and transferability,[40,41] was ensured through the application of the following strategies: regular peer debriefing to ensure credible interpretation of the analysis;[40,42-44] and findings within themes were supported with extracts of verbatim narratives of the participants.[45] Additionally, the study findings were contrasted against the existing literature.[44] Methodological processes were described, and a detailed description of the context was presented with details to allow readers to determine the transferability of the findings.[43,44]

Ethical considerations

The Biomedical Research Ethics Committee at the University of KwaZulu-Natal, South Africa, provided ethical approval to conduct the study with reference number BE274/17. Gatekeeper permissions were sought from relevant NGOs and government departments. All participants provided signed informed consent to participate in the study and to be audio-recorded. Participants were assured of confidentiality and anonymity and were afforded the option to withdraw their participation at any time without incurring any negative consequences whatsoever.

RESULTS

The results are presented in three parts, namely a summary of study participants, reflecting key characteristics drawn from the case descriptions; a summary of pathways in the treatment journey of a person with SUD; and a summary of the data on the aftercare experiences and aftercare needs of persons with SUDs and their families.

Summary of study participants

Five persons with SUDs provided consent to participate in the study. They received treatment and were discharged from the same ITC. There were two females and three males, ranging between twenty-two to thirty-eight years of age. Each female participant had two biological children; the males had no children. Among the five participants, only PWSUD1 had received aftercare, from a social worker and a registered counsellor. However, her aftercare intervention was terminated six months post-discharge from the ITC. Table 1 provides the key background characteristics of each person with SUDs.

Table 1: Key background characteristics of each person with SUDs (n=5)

Participant ID	Age	Sex	Race	Education status	Employment status	Substance Used	Period of substance use	Referred to the Inpatient Treatment Centre by	Recovery Status	The recovery period sustained post discharge	The period since discharge at the time of interview	Aftercare received
PWSUD1	29	Female	African	Grade 12– (Technical Matriculation)	Unemployed	cannabis, alcohol	16 years	DoSD	Relapsed	1year 7 months	2 years	Yes Social worker and Registered Counsellor
PWSUD2	38	Female	African	Grade 9	Voluntary worker-Community Health Worker	alcohol	Cannot recall	DoSD	Relapsed	1 day	2 years	No
PWSUD3	24	Male	African	Grade 10	Unemployed	Primary Substance-cannabis, alcohol, whoonga, poly-substance use	8 years	NGO	No relapse but substitution addiction	Throughout 3 years of the study-then lost contact with the researcher	1 year	No
PWSUD4	22	Male	African	Grade 8	Unemployed	Primary Substance-cannabis, alcohol,	6 years	NGO	Relapsed	1 month	4 months	No
PWSUD5	27	Male	African	Grade 12	Unemployed	Primary Substance-cannabis, alcohol whoonga, poly-substance use	5 years	NGO	Relapsed	1 month	1 year	No

A total of five family members participated in the study; most were unemployed. None of the family members had received family counselling from the ITC or a referral agent or had received aftercare. As a result, none of the family members were prepared for the discharge of the person with SUDs. Only two families received letters of apology from the person with the SUD upon return to home. Table 2 presents the key features of the participating family members.

Table 2: **Key features of the family members of persons with SUDs (n=5)**

Participant ID	Relationship with the person with the SUD	Employment status	Prepared for discharge	Aftercare received	Family counselling	Intervention with ITC	Letter of apology received
FP1	Grandmother: PWSUD1	Pensioner	No	No	No	No	Yes
FP2	Father: PWSUD3	Unemployed	No	No	No	No	Yes
FP3	Stepfather: PWSUD4	Employed	No	No	No	No	No
FP4	Mother: PWSUD4	Unemployed	No	No	No	No	No
FP5	Mother: PWSUD5	Unemployed	No	No	No	No	No

Summary of the pathways to care for persons with SUDs

Interventions received by persons with SUDs revealed several diversities within the SUD system. Please refer to Figure 1, which represents the divergent pathways of participants navigating the SUD System during their quest for treatment intervention. Seeking care was initiated at home by the family members (family referrals) for three persons with SUDs (PWSUD 3 and 5), while for two persons with SUDs (PWSUD 1 and 2), seeking care was through self-referral. Among the five participants, only one person with SUDs received aftercare. Challenges are noted in the care system, including lengthy pre-admission waiting times and poor communication among most of stakeholders; some participants were transported to and from the ITCs, whilst others travelled independently. These issues demonstrate unmet needs during different stages of navigating the SUD care system, such as reintegration needs and lack of communication by the ITC with referral agents prior to discharge.

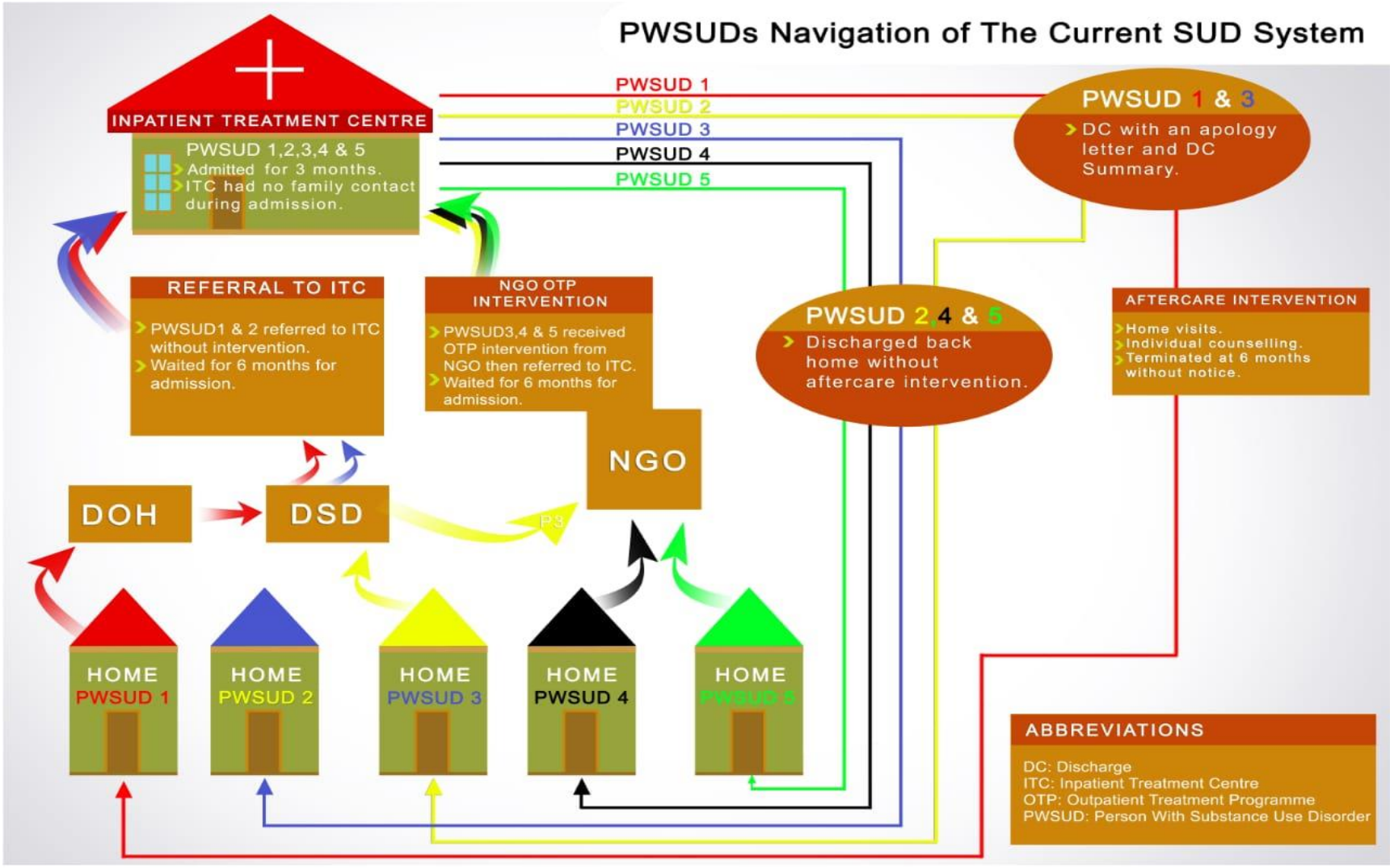

Figure 1: A Diagram Portraying Participants' pathways to the SUD System

Summary of experiences for person with SUDs who received aftercare

The summary of the experiences of care for the person with SUDs who did receive aftercare revealed both strengths and weaknesses in the SUD treatment system including aftercare (refer to Figure 2). At home, prior admission to ITC, no intervention occurred except for the Department of Health (DOH) Hospital referring the person to DoSD social workers who then referred the person to the ITC, leading to a waiting period of five months prior to admission. At the ITC, some strengths were noted, such as preparing the person with SUDs for discharge, and informing the referral agent of the imminent discharge. Post discharge, the person with SUDs received aftercare from the DoSD social workers which included individual follow up care at the DoSD centre and home visits at least once a month for six months. Fortuitously, during an awareness campaign event, the person with SUDs was linked to an NGO where she received psychological services. The person also received anti-depressants from a local hospital following a referral by a DoSD social worker. Yet there was no communication among the service providers, nor was there any provision of SUD services from the hospital, which indicated that service providers worked in silos, hence a lacuna in the integration of services preventing holistic case management. At the termination of aftercare in the sixth month post discharge, several flaws were noted, *inter alia*, the aftercare was terminated abruptly by a social worker which was later explained as a test for recovery. The person with SUDs was frustrated with the aftercare termination process for which she had not been informed or prepared. Others did not received aftercare because it was not offered to them.

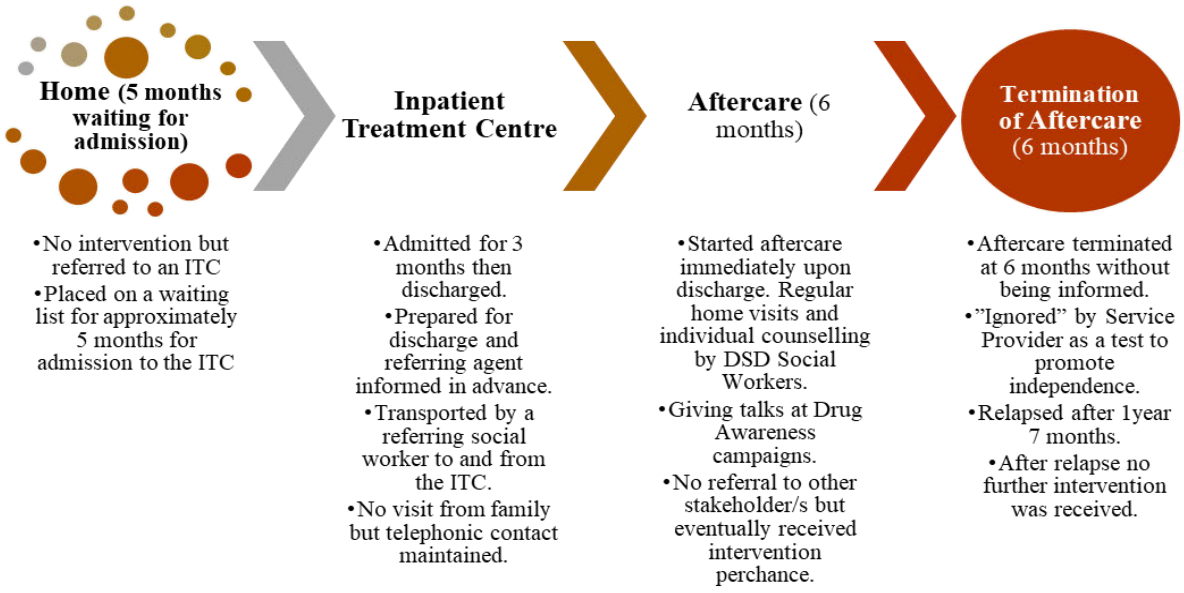

Figure 2: **Illustrative Case-study Constructed from the Experiences of the Person with SUDs Who Received Aftercare.**

AFTERCARE EXPERIENCES AND AFTERCARE NEEDS

Persons with SUDs and their family members expressed similar aftercare experiences and aftercare needs, summarised in Table 3.

Table 3: **Summary of the Aftercare Experiences and Aftercare Needs for Persons with SUDs and their Families.**

Themes	Sub-themes
EXPERIENCES IN RELATION TO AFTERCARE NEEDS	1.1 Availability, accessibility, and integration of care.
	1.2 Family and community reintegration
	1.3 Experiences of stigmatisation reiterated reintegration needs.
	1.4 Occupational engagement
AFTERCARE NEEDS	2.1 Family and community intervention needs
	2.2 Vocational needs as a preventive mechanism
	2.3 The types and nature of aftercare services needed.

THEME 1: EXPERIENCES IN RELATION TO AFTERCARE NEEDS

The experiences of the persons with SUDs and their families demonstrated needs that should be addressed in aftercare, which corroborate the aftercare needs expressed by the participants.

Sub-theme 1.1 Availability, accessibility, and integration of care.

The experiences of aftercare narrated by PWSUD1, the only person who received aftercare, demonstrated some strengths and a number of needs to be addressed in aftercare. She was referred by a social worker from DoSD to an ITC, she narrated how easily available and accessible was her social worker.

> *'… The social worker helped me especial when I had something troubling me, he was the person I could talk to…' 'I send a miscall, and sometimes I go to DoSD.'*
> PWSUD1, Female, Unemployed

The use of social media technology increased accessibility to the social worker:

> *'Yes, through WhatsApp even, we were able to communicate.'*
> PWSUD1, Female, Unemployed

PWSUD1 experience indicated a strength of an aftercare service provided i.e. an easily accessible social worker assisted her in relapse prevention. Remarkably, this was before she had relapsed and at the time of the first interview, when she was still receiving aftercare:

However, weaknesses/challenges of aftercare services such as uncoordinated service provision were demonstrated from the PWSUD1 aftercare experience through uncoordinated aftercare service among service providers which indicate the inherent benefits of coordinated collaboration of service providers in aftercare is demonstrated. PWSUD1 received aftercare from her referral agent, the social worker, but was subsequently not referred to other health care professionals. She coincidentally accessed a registered counsellor and there was no further interaction nor collaboration between her service providers (social worker and registered counsellor). She narrates as follows to explain her situation:

'It took long to see the psychologist (referring to a registered counsellor). I met her at the launch for substance abuse at Madlaka (Pseudonym municipality). Even there it was not a referral, but the social worker was asking for a job for me… they checked if I had a psychologist …, then we started sessions.'

PWSUD1, Female, Unemployed

In addition, the aftercare was not well structured indicating another weakness, PWSUD1 shared her experiences of how difficult it was when aftercare was abruptly terminated without notice and the time period was too short (six months).

'… aftercare is too short coz I remember I had challenges when I was neglected…'yaaaah (doubtingly), he (social worker) eventual came to check me but I saw that (six months) as a short time because I felt abandoned, I lost trust. I feel that they should extend time …'

PWSUD1, Female, Unemployed (the first interview).

Seven months later, at the follow-up interview, PWSUD1 had notably changed her perception and emphasised the need for lifelong aftercare without termination:

'We need aftercare nonstop so that when I need help, I can get it immediately. You see when I lost my aunt to cancer and being pregnant and eventual did termination of pregnancy because the boyfriend left me, it was just too much to deal with. Sadly, I had nobody to talk to.'

PWSUD1, Female, Unemployed

PWSUD1's grandmother validated this claim:

'They do not have to stop; they must not get tired because they no longer visit her now... they need to always check her.'

FP1, Grandmother of PWSUD1

Sub-theme 1.2 Family and community reintegration.

Family acceptance was not explicitly mentioned as a need but noted from the experiences of PWSUD3 and PWSUD1 and their families. PWSUD1 and PWSUD3, whilst at the ITC, wrote letters of apology to their family members. These letters have contributed positively to mending the family relations and acceptance by family.

'... but he came with a letter he wrote. When we read the letter, we realised that the letter was speaking to us as parents, promising that he is going to be OK and no drug use'

FP2, Father of PWSUD3

'...The issue is that before I went to rehab (ITC), I had messed up a lot, a serious trouble, even neglecting my child…So I had to build all those relationships...I don't know, but I have that credit (positive and hopeful) because I wrote the letter because it was hard to face them especially my child because she had seen all the wrongs I did, what kind of mother I had been.'

PWSUD1, Female, Unemployed

PWSUD3's and PWSUD1's parents were supportive and explored cultural options: PWSUD3 family in particular were hopeful that their son would maintain his sobriety because of the completion of the ancestral ritual.

'We consulted (sangoma) and found that some ancestral issues were contributing to this, therefore we fixed it'

FP2, Father of PWSUD3

PWSUD1 family believed that her relapse was attributed to being bewitched because of her progress and success.

'They (referring to witches) noticed that she was doing better and she is the one responsible, look she built that big house, now it's stopped, they bewitched her...'

FP1, Grandmother of PWSUD1

The promotion and maintenance of sound family support in preventing relapse. The narratives suggested that poor family support triggered relapse whilst nurturing family support positively impacted on the relapse prevention process. Notably, persons with SUDs who wrote a letter of apology to their families reported caring support.

Before PWSUD1 relapsed, she stated that she had reassuring family support; hence she remained sober:

'they (family) strengthen me a lot and they praise me whenever I do something good, and they support my opinion.'

PWSUD1, Female, Unemployed

Poor familial support was identified as a contributor to relapse. For PWSUD4 poor family support was reported to have contributed to relapse shortly after discharge.

'If family could support me and trust me … you find that people do not trust you even with money to buy bread thus you see that you are the only one who changed…so what's the point'

PWSUD4, Male, Unemployed

In addition, for PWSUD2 and PWSUD1 the complexities of intimate relationships were influential in their relapse. In particular, PWSUD2 had to contend with an abusive partner.

'… and very abusive (physically). So, I joined him (drinking alcohol) very quickly when I came back from rehab.'

PWSUD2, Female, Employed

Similarly, PWSUD1 relapsed after sustaining recovery for more than a year due to a change in family support and being involved with an abusive, alcoholic boyfriend. She attributed her relapse to an emotionally abusive relationship and the death of her supportive aunt. The emotionally abusive boyfriend convinced her to terminate her pregnancy but thereafter discontinued the relationship due to stress.

'When my aunt died and pregnancy, on top of that I did a TOP (TOP)-Termination of Pregnancy, convinced by her boyfriend and boyfriend dumped me. I was so stressed, I had nobody to talk to, no shoulder to cry on. Because even Mr M (pseudonym for social worker) had terminated aftercare…and did not respond promptly, he even ignored my call-backs (a free SMS sent to ask someone to call you) …but later he (Mr M) said it was a test to see if I can stand on my own.'

PWSUD1, Female, Unemployed

Sub-theme 1.3 Experiences of stigmatisation, reiterated reintegration needs

Reintegration endeavours were stymied by community stigmatisation experienced. Stigmatisation was exacerbated by the crimes they had committed previously. This emphasied the need for aftercare to address community stigmatisation to facilitate reintegration

'…others thought I was in prison…, some were happy to see me back, but some were saying, Weeeeh!! (lamenting) he is back, we are in trouble.' 'In the community, there are people we have hurt, so they look at us in that way.'

PWSUD3, Male, Unemployed

Families also experienced stigmatisation.

'…in the community, you will see that people look at you badly. As if you are promoting your child's behaviour.'

FP3, Stepfather of PWSUD4

'…because people look at you like that (meaning a negative view).'

FP2, Father of PWSUD3

Furthermore, a need for aftercare to address self-stigmatisation was demonstrated by PWSUD1 who experienced stigmatisation at church and then she developed self-stigmatisation which was compounded by her relapse.

'Nobody was interested...right now it is difficult even to go to church because I relapsed again.'

PWSUD1, Female, Unemployed

self-stigmatisation emanates from community stigmatisation.

'…what can I do (expressing loss of hope to change), people know that I drink a lot.'

PWSUD2, Female, Employed

Sub-theme 1.4 Occupational Engagement

Occupational engagement is essential during aftercare, the experiences of being unemployment re-emphasised employment needs. The intersecting realities of unemployment challenges that persist were further compounded by skills deficiencies, which PWSUD4 and PWSUD1 claim as being

'You get discharged, but you do not know where you are going'

PWSUD4, Male, Unemployed

'I wished to be independent, but I am unemployable due to a lack of skills.'

PWSUD1, Female, Unemployed

In addition, the intricacies of unemployment fuelled relapse. For PWSUD1, the intricacies of unemployment and abusive intimate partners were her contextual reality. Prior to her admission to the ITC, she sustained herself through financial support from her abusive boyfriends; two among three were abusive.

> *'Coz, in my past experience, I knew that if I have a boyfriend, I will do my hair and get cosmetics. But when you do not know what you gonna do to get by, it becomes difficult, if forces you to go for those boyfriends who will support you.'*
>
> PWSUD1, Female, Unemployed

After her relapse, she admitted using her child support grants money to purchase alcohol:

> *'...it's painful. I drank all the grant money for my kids.*'
>
> PWSUD1, Female, Unemployed

On the contrary, unemployment was a motivator for PWSUD3 to improve (self-development) his skills to increase his employment possibilities. Family support was also noteworthy. He narrated how successful he was post-discharge compared to when he was still using substances.

> *"When I retuned…, I had a clear mind of what I wanted to do. On the first week, on Monday I asked my dad for R500 for leaners licence. I learnt… on Thursday I passed…in 2 weeks I passed my driver's test. Everything went so smooth and I asked myself what was wrong before… I did security…mom to help me do the firearm certificate...'*
>
> PWSUD3, Male, Unemployed

Occupational engagement is essential in preventing boredom which is trigger to relapse**.** The experience of PWSUD4 demonstrated the necessity of occupational engagement during aftercare. He reported no occupational engagement; he relapsed one-month post discharge and attributed this to boredom as the trigger to his relapse.

> *'We get bored… I end up going to hang out with people I use to smoke with because I stay at home and get bored…'*
>
> PWSUD4, Male, Unemployed

A family member also identified same:

> *'You could see he is bored…'*

FP3, Stepfather of PWSUD4

PWSUD1 recounted how she addressed boredom by engaging in an occupation of her choice. Notable she sustained recovery with no relapse for a long time.

'I have also learnt to do a vegetable garden and look after the yard, I don't get bored at all. I enjoy telling people about substances and how bad they are.'

PWSUD1, Female, Unemployed

PWSUD3 also was purposefully proactive and sustained recovery for a long time through engaging in occupation and skills development. As narrated earlier, upon discharge he was immediately engaged in learners license training, security and firearm training and succeeded in all three ventures. Notably he sustained recovery for a long time (three years) until the researcher lost contact with him; he might even still be sober to date. (Refer to Table 1).

THEME 2: AFTERCARE NEEDS

Subtheme 2.2 Family and community intervention needs

Family members were not included in aftercare interventions, including PWSUD1's family, who is the only person who received aftercare. (Refer to Table 2). Family counselling intervention services are necessary prior to and post discharge, specifically focusing on mediating fragmented relationships. The following statements support the above sub-category:

'Whilst in rehab, I repeatedly told them (service providers) that my family is supposed to come so that I could speak to them so that they forgive me, or we speak the truth so that they trust me'

PWSUD4, Male, Unemployed

Family members were also in agreement:

'We had no communication with him (during admission); and his father could not forgive him, even when he was back'

FP5, Mother of PWSUD5

In addition, education was recognised as pivotal to the family and the person with SUDs.

'They (referring to family) must also be educated as to what kind of people we are…' PWSUD1, Female, Unemployed.

Family supported this.

'We also need to be educated about these people.'

FP3, Father of PWSUD4

The progress factor was emphasised, family should be educated to recognise progress made.

'They (family) must get an education and know how much I have changed…'

PWSUD4, Male, Unemployed.

Sub-theme 2.3 Reintegration needs

Participants expressed the necessity for reintegration needs to be met in aftercare service provision i.e. aftercare to assist with reintegration to home**.** PWSUD4 suggested an appropriate time to commence with aftercare to promote and facilitate an easy transition and reintegration to home.

'It would help if this (aftercare) would start before you are discharged, maybe two weeks...'

PWSUD4, Male, Unemployed

The family member supported the suggestion:

'…adjusting to home is difficult, they don't get used to being home again…they need help.'

FP3, Stepfather of PWSUD4

Furthermore, aftercare to assist with reintegration to community and family. there was also the need for the identification of a person to facilitate reconciliation in the community to aid reintegration.

'if there will be someone to go and ask for forgiveness and peace to people that you have hurt because we mess up before going to rehab…even at home'

PWSUD3, Male, Unemployed

Sub-themes 2.2 Vocational needs as a preventive mechanism

Participants indicated the significance of vocational needs as a preventive mechanism to ensure that relapse did not occur. Aftercare should address unemployment challenges as

they contribute to relapse. Unemployment triggered the relapse, and participants identified assistance towards securing employment as essential. The following statements support the above.

> *'At least they should check as to what skills do you have then place you in the relevant job.'*
>
> PWSUD1, Female, Unemployed
>
> *'...there should be a way to help find a job because when you are discharged and doing nothing, it is a problem.'*
>
> PWSUD3, Male, Unemployed

Family members reiterated such a necessity:

> *'If there could be ways for job placement after rehab, it will make a difference.'*
>
> FP3, Stepfather of PWSUD4
>
> *'Yah, job placement could help'*
>
> FP4, Mother of PWSUD4

Aftercare should include skills development as an intervention. Such skills development intervention should be individualised. Participants identified skills development as essential in increasing the prospects of employment. The following statements are in support of this:

> *'I wish to be independent but I have no skills... but they must show us how to bake bread. They mustn't give us, but show us how bake it (metaphorically speaking). And they must give us a way to start, like a kick start.' PWSUD1, Female, Unemployed*
>
> *'if I can do carpentry and plumbing.'*
>
> PWSUD4, Male, Unemployed

The family supported such an initiative:

> *'...they should be trained to use their hands'*
>
> FP3, Stepfather of PWSUD4

Furthermore, inclusion of business coaching and guidance is necessary during aftercare. Participants expressed a keen interest in establishing businesses, as follows:

> '...or maybe they can help you with starting a business...'

PWSUD1, Female, Unemployed

'There should be a way to be assisted to start.'

PWSUD4, Male, Unemployed

Sub-theme 2.3 Types and nature of aftercare needed

The state of aftercare is demonstrated in Tables 1 and 2, where no family members received aftercare and most persons with SUDs (4 out of 5) did not receive aftercare. Only one of the persons, PWSUD1 received several home visits and individual counselling from a registered counsellor and social worker. The experiences of PWSUD1 were characterised by dissatisfaction with the aftercare service she received. Participants raised that regular visits were essential to assist in the challenges they confronted. Therefore, regular check-ups are needed,

'*They should check us more often… what challenges we face.'*

PWSUD1, Female, Unemployed

However, those who did not receive aftercare advocated for more regular visits from the social workers:

'The social workers should check us more often...check what issues we have.'

PWSUD4, Male, Unemployed

Family members also reflected on such support:

'… he (the social worker) takes some time to visit but it has been long since he visited'

'there should be a strong follow-up care…'

FP5, Mother of PWSUD5

There exist no support groups in this rural area, although participants noted the benefits.

'You see razo, (slang for 'big brother') this thing of NA (Narcotics Anonymous) meetings, it's good, it can change a person.'

PWSUD4, Male, Unemployed

A person-centred aftercare was indicated by both the persons with SUDs and the family members.

'They must identify specifically each person's needs.'

FP2, Father of PWSUD3PWSUD3, Male, Unemployed

'... We are not the same and from different homes and backgrounds and some are from well-off families. They don't have those needs (referring to vocational needs).'

PWSUD1, Female, Unemployed

Participants identified specific service providers needed for their aftercare, which included the mayor, councillors, psychologists, social workers, and

'... councillor'

FP5, Mother of PWSUD5

'Pastors… mayor...'

PWSUD1, Female, Unemployed

'Municipality and skills people'

FP3, Stepfather of PWSUD4,

The expanded list of service providers indicates the participants' extended area of aftercare.

DISCUSSION

Aftercare experiences, needs and perspectives on service provision for persons with SUDs and their families are discussed in the following interrelated sections, *viz* family intervention needs to be addressed in aftercare, the necessity for vocational opportunities extending care, identification of the types of aftercare required and reiterating the reintegration needs to sustain care.

Ongoing family intervention is a critical component in aftercare.[9,11-14,24,29,46] Family intervention includes family counselling and education, with a goal to promote acceptance and effective family support for persons with SUDs. Many studies[14,24,29,46] and South African SUD policies[9,11-13] have highlighted the significance of family interventions in aftercare. However, it has been found that South African policies lack clear direction in terms of how family interventions can be implemented.[47] Despite reports of the benefits associated with involving family members in discharge preparation and aftercare, such as lower relapse rates,[48,49] the current study revealed that no family members received any intervention to prepare them for the discharge and aftercare of the

PWSUD or any family intervention services during aftercare period of their family member who has SUDs. This is surprising considering that the family is typically seen as an integral part of aftercare.[10,11,29] Additionally, the reconciliatory benefits also contribute to the strengthening of support.

Unemployment, poor or no occupational engagement and boredom were a challenge experienced post discharge and perceived as contributing factors to relapse. Swanepoel et al.[50] and Mahlangu and Geyer [29] consistently detailed a strong link between boredom and high relapse incidents. Occupational engagement contributes to sustained recovery by minimising boredom and engaging in creative, meaningful/purpose-filled and energising/life-giving activities.[46] Likewise in the current study, the vocational needs such as employment, skills development, business coaching and more were identified as pivotal to aftercare. Similar aftercare needs have been raised in previous South African studies.[14,29,50] The understandably high unemployment rate in South Africa stands at 27.6 per cent,[44] and employment opportunities are limited, particularly for those with minimal education.[51] Rurality and poverty exacerbate the prospect of employment in this particular rural district, where 82 to 95 per cent of households live below the poverty line, and with 70 per cent of the population living on less than 800 South African Rands (ZAR) (44.07$ on 05th of March 2023) per month.[52] Notably, the majority of participants were unemployed, including their family members. Unemployment has been linked to high relapse rates.[50] Mahlangu and Geyer[29] suggested that affording volunteer opportunities such as discussions about drugs help to regain trust from the community and assist with reintegration to the community. The current study affirmed these findings and added that voluntary seminars and discussions of occupational engagement, such as awareness campaigns, which contributed to relapse prevention. In addition, Act No. 70 of 2008 encourages the participation of persons with SUDs in awareness campaigns.[13]

Four out of five of the participants did not receive aftercare intervention, which is consistent with the well-documented state of aftercare provision in South Africa.[10,14,25,27,50,53] South African studies established that where aftercare is available, it is generally inadequate.[14,28,29,50] Similarly, the current study revealed inadequacies in the existing services and SUD system. The recognition for improvements such as regular

visits to the home, access to self-help/support groups, increased frequency of individual counselling, lifelong aftercare without termination, person-centred aftercare, flexible and easily accessible professional help (video, WhatsApp and telephone) to assist with relapse prevention was identified as necessary. On the contrary, a study by Elias [24] suggested that people attending aftercare services in Cape Town, Western Cape Province, were positive and were generally satisfied with their aftercare services. Diverse needs indicate the extent to which South Africa is characterised by inequalities concerning access to resources.[26] In this particular district, which is among the poorest rural districts in KZN and characterised by limited resources,[52] one participant who received aftercare reported a negative experience, whilst the others had not received any aftercare.

Participants emphasised the need for lifelong and comprehensive aftercare without termination. Such aftercare is coherent with the chronic approach to aftercare, known as recovery management and advocated by the World Health Organization (WHO), United Nations Office on Drugs and Crimes (UNODC) [7] and the National Institute on Drug Abuse (NIDA).[54] Several studies, [3-6,8] recognise the need for a chronic approach for SUDs because of the patterns of relapse, like other chronic diseases.[3-8,54]

In addition, treatment outcomes such as sustained recovery is strongly associated with regular, continuous participation in recovery management that focuses on long-term maintenance of recovery.[5,8] On the contrary, most treatment interventions continue to embrace acute approaches instead of chronic approaches,[55] with relapse prevention and sustained recovery remaining an ultimate goal.[7,10,13] The slow adoption of recovery management could be due to the lack of supporting empirical evidence.[7] Likewise, South African treatment continues to embrace an acute treatment approach. Mpanza et al.[23] attributed an acute treatment approach to South African policies that embody a punitive stance and lack scientific evidence. The findings of this current study are a typical example of an acute approach, where the majority of persons with SUDs did not receive the necessary aftercare services. The person with SUDs who received aftercare reflected that the limited duration and termination occurred without notification because service providers presumed she no longer required the service. There has been strong evidence supporting improved treatment outcomes for persons with SUDs who continue with

aftercare without restrictions placed on the duration and number of visits covered.[1,7,56] In this particular district, aftercare services are limited and inadequate, characterised by a paucity of compartmentalised service providers with no aftercare policies guiding them.[57]

The findings prioritised person-centred and flexible services. Most researchers support flexible aftercare, person-centred but evidence-based.[3-5,8] A meta-analysis conducted by Lenaerts et al.[3] on recovery management clinical trials concluded that the most effective recovery management is one that, among other strategies, includes customised activities for each person's unique preferences and needs with SUDs. Likewise, the World Health Report 2000 on Health Systems promotes a system of care that is responsive to the expectations and needs of the population.[58] In addition to person-centred aftercare, which would be more beneficial in a rural context by explicitly meeting individual needs, family members noted that cultural beliefs are essential considerations in aftercare services. The strategic intent of the overall substance policy in SA, the NDMP 2019-2024, emphasises the recognition of cultural beliefs when rendering services, to the extent that the development of the NDMP included the Traditional Healers Associations.[9] Similarly, cultural preferences should be well accommodated at the service provision level.

In the current study, easily accessible professional assistance was established as vital in relapse prevention. Other studies have supported and reported that maintaining contact with a person with SUDs and regular progress monitoring is critical in recovery management but should include standard treatment methods from professionals (service providers).[4,8,59] Studies have supported using technology to increase communication with persons with SUDs,[60] as maintaining contact with a service provider can be costly and time-consuming. However, a participant in the current study used available technology such as WhatsApp and video applications such as Zoom and telephone calls to contact the social worker. In the current study, professional assistance was limited, with only one person with SUDs consulting a social worker and a registered counsellor. Notably, the collaborative element amongst these professionals regarding their clients was non-existent. Service providers are known to work independently instead of collaboratively when providing aftercare services in South Africa,[10,25] despite the Substance Abuse Act No. 70 of 2008[13] and the NDMP [9,10] promoting the collaboration of stakeholders and

service providers. Collaboration of stakeholders in rural areas where resources are limited is essential and may minimise the impact of resource constraints.

The findings also suggest that reintegration into home and community is vital which can be facilitated through reconciliation in the community and family. However, several challenges, including self-stigmatisation and stigma from the community, become an influential factor in successfully reintegrating. Successful reintegration into home, family, workforce and community is the ultimate goal of aftercare intervention, as expressed in Substance Abuse Act, No. 70 of 2008.[13] In addition, the findings indicate that community stigmatisation is common, confirming a South African study finding by Mahlangu and Geyer,[29] that the majority (77 per cent) of persons with SUDs are stigmatised by community members even after they have received treatment, contributing to loneliness and, exclusion. In addition, stigmatisation from the community leads to self-stigmatisation[61] which was emphasised in the current study. Similar findings were reported by Swanepoel et al.[50] Overcoming stigma, although difficult, could be a motivating factor for recovery.[62] Thus, the need to address stigmatisation in aftercare is merited.

STUDY LIMITATIONS

Some limitations were noted in this study. First, the small number of participants was due to the limited number of persons with SUDS who accessed ITCs in this rural district, hence confining the overall sample. In addition, those who had accessed ITCs had relapsed and had not returned to their residential homes and could not be located. Second, none of the family members had received aftercare intervention among the available participants. As a result, none of the family members could reflect realistically on their in-depth experiences of aftercare. Hence, their narratives were based on their desired perceptions only. Third, only one person with SUDs had received aftercare, which limited the exploration of a comprehensive understanding of aftercare needs from their experiences. Fourth, none of the participants had formal employment. Therefore, work-related needs such as work reintegration were not explored. Fifth, all participants were discharged from the same ITC, whilst the province has two ITCs. One ITC was preferred due to transport logistics. Although there were challenges in locating persons with SUDs

who had received ITC intervention in this rural district, future studies should endeavour to increase the sample size and explore aftercare needs from multiple experiences.

RECOMMENDATIONS

The study explored the aftercare experiences and needs of persons with SUDs and their family members. Therefore, the following associated recommendations are offered at the policy, programme planning and service provision level, as well as the monitoring and evaluation:

Supplementing policy considerations:

- South African policies should consider including prescripts on aftercare requirements such as regular home visits and person-centred care without termination, as articulated in the WHO and UNODC.[7] This requires urgent consideration, with adaptations to suit the local context.

Contextualising programme planning within primary health care:

A context-specific aftercare model is required to guide aftercare services, which should be responsive to the individualised needs of persons with SUDs and family members. Therefore, the aftercare model should consider the following:

- Family intervention should achieve qualitative and sustained familial support and improve insights into SUD conditions and recovery processes.
- Person-centred intervention should be mindful of the cultural and ethnic beliefs of the service users, as also mentioned in the NDMP 2019-2024.
- Promote reintegration and realistic contextual occupational engagements that will assist the person with SUDs to avoid boredom and relapse.
- Include vocational rehabilitation in aftercare as part of relapse prevention strategies and promote reintegration into society.
- Embrace a chronic-orientated aftercare approach, also known as recovery management, where aftercare services are available for a lifetime. Furthermore, relapse management should essentially form part of the aftercare model.
- Adopt realistic and cost-effective strategies, including efficient use of technology such as WhatsApp and video applications such as Zoom, being cognisant of a resource-constrained environment.

Maximising service provisions

Aftercare needs have demonstrated existing gaps in the service provision processes. Hence, the following recommendations are suggested for ITCs, referring agents and other service providers:

For ITCs

- As expressed in South African policies such as National Minimum Norms and Standard for Inpatient Treatment Centre[12] and NDMP 2019-2024,[9] ITCs must ensure that family intervention occurs during admission and effective collaboration with referring agent/s is established so that inpatient intervention is in cognisance of the family dynamics.
- Facilitating linkages to the referring agents and other service providers for aftercare intervention.

For referring agents and other service providers at primary health care

- Maintain contact with their clients whilst at the ITC and provide intervention to the family as recommended by the relevant policies.[12]
- Assist the person with SUDs in developing a structured client-centred routine that will promote occupational engagement to avoid boredom and prevent relapse.
- Network to facilitate skills development and linkage with existing skill development programmes.
- Consider facilitating and establishing self-help support groups for persons with SUDs and their families.
- Extend the types of aftercare service providers to include, among others, pastors, municipal mayors, and ward councillors as needed or identified by each service user.
- There is a need for collaboration between allopathic and traditional health systems.

Strengthening monitoring and evaluation of aftercare

- The monitoring and evaluation mechanisms should evaluate the successful reintegration of the intersecting work, family and community environment.[13]
- Aftercare requirements related to relapse prevention should be monitored and evaluated with consideration of a chronic disease pattern of SUDs.[3-8,54] Therefore, there is a need to develop relapse management strategies.
- Regular needs analysis must be conducted in context to ensure the relevance of services rendered.

CONCLUSION

This study explored the aftercare experiences and needs of persons with SUDs and their family members in a rural context where primary healthcare services are the integral source of intervention. Predominantly, similar aftercare needs were identified by those with SUDs and their families. Four key conclusions emanated from the study; first, aftercare services are characterised by challenges compounded by limited services within this rural district. Where aftercare services are available, they are generally inadequate, unstructured, unmonitored, and uncoordinated among service providers, which affirms the status quo of aftercare services in South Africa. Second, aftercare needs are partially aligned with South African policies; these include family involvement, vocational needs and reintegration needs of a person with SUDs. Third, the types of aftercare required include regular visits at home, self-help groups and individual counselling. Fourth, the nature of aftercare needs includes a person-centred, culturally sensitive, lifelong without termination, the collaboration of service providers and flexible, easily accessible professional assistance to prevent and manage relapse. The findings necessitate the improvement and strengthening of aftercare services, which should be integrated with the primary healthcare system and be contextually responsive to the needs of persons with SUDs and their family members in South Africa.

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COMPETING INTERESTS

The authors declare no conflict of interest.

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CHAPTER SEVEN

SYNTHESIS

7.1 INTRODUCTION

To date, South Africa has not developed an aftercare model for service provision for persons with SUDs after discharge from an inpatient treatment centre (ITC). Hence, the purpose of the study was to develop a model of aftercare for persons with SUDs in KZN as a system-level contribution. This chapter synthesises the outcomes of all the phases and stages of the study in developing the aftercare model of care. An overview is presented of the study outcomes in response to the research aim, objectives with a tabulation of the findings and recommendations presented in each manuscript. Based on these findings and recommendations, a proposed aftercare model is presented in both narrative and illustrative form. In addition, specific recommendations are offered. The strengths and limitations of the study are detailed, with recommendations for further studies and conclusions of the entire study at the end of the chapter.

7.2 OVERVIEW OF STUDY OUTCOMES

The quest to develop an integrated aftercare model for persons with SUDs after discharge from an ITC was initiated through the lens of systems thinking (46, 47, 51). Systems thinking focuses on the whole and on the interactions/relationships between the parts that comprise the whole (46, 47, 51). This study focused on the aftercare sub-system within a SUD system of care in one rural district of KwaZulu-Natal, South Africa. The overall aim of the study was to propose an integrated aftercare model for persons with SUDs post the inpatient treatment phase at a public facility in KwaZulu-Natal. The study aim was fulfilled by accomplishing five research objectives, as reflected in Table 7.1 below.

Table 7.1: Overview of the Study Objectives and Outcomes

STUDY OBJECTIVES	PHASE & METHOD	MANUSCRIPT DETAILS	KEY FINDINGS	KEY RECOMMENDATIONS	LOCATION IN THE THESIS
1. To describe national policies governing SUD aftercare service provision in South Africa.	Phase 1: Policy analysis	**Manuscript 1:** Aftercare services to persons with Substance Use Disorders: Analysis of South African policy Published 13 April 2020 in the Journal of Drugs: Education, Prevention and Policy	Four key findings: ***First, eight circulating policies identified.*** Eight policies pertinent to aftercare were identified. It was evident that the nature of the available aftercare content in these policies were vague and disorganised with no coherent section dedicated to aftercare.	There should be a section dedicated to aftercare in every relevant policy to explicitly guide aftercare service provision.	Manuscript 1 in Chapter 4
			Second, aftercare service provision policies are undefined. The South Africa policies frame SUD management as acute; therefore, the aftercare service provision package is undefined. Although the UNODC endorses a chronic approach (lifelong), it also does not have a comprehensive policy for lifelong recovery management. Individual and family counselling is suggested. In addition, reintegration services to be prioritised	There is a need for **the development of Recovery Management (that is, lifelong orientated) National Minimal Norms and Standards (RMNMNS)** for the M&E of aftercare services and clearly outlining the expected standard of recovery management (also known as aftercare) services. The aftercare services policy should, therefore, include individual and family counselling and reintegration services.	
			Third, mechanisms of service delivery areas are absent. There is an absence of mechanisms for the delivery/implementation planning of policies Moreover, no platform exists for stakeholder collaboration at the implementation level (community-based and facility-based care) for effective and coherent service delivery of the aforementioned packages.	RMNMNS could offer a blueprint for recovery management and mechanisms of service delivery. This could assist, inform and guide the collaboration plans of stakeholders in service provision, including aftercare, which is mostly fragmented.	

			Despite these policies emphasising strong stakeholder collaboration.		
			Fourth, Cursory M&E Strategies Policies have no aftercare M&E but cursory M&E strategies for prevention programmes, which are specifically activity-based as opposed to outcomes-based.	To strengthen M&E strategies is pertinent and timely as it will ensure that outcomes-based strategies are implemented for aftercare. In addition, empirical research should form an integral part of policy formulation and development and should inform M&E strategies.	
2. To describe SUD aftercare implemented at the district level	Phase 2 qualitative design (interviews and focus groups with Service providers and service users)	**Manuscript 2**: Perspectives of Service Providers on Aftercare Service Provision for Persons with Substance Use Disorders at a Rural District in South Africa. Submitted to the Journal of Substance Abuse Treatment, Prevention, and Policy.	Findings revealed that aftercare service provision was not guided by policy, programmes or specific packages due to the lack of specific policies and policy awareness by the service providers at the service delivery (implementation) level.	There is a necessity to **increase specific awareness of pertinent policies for the service providers, particularly** those at the fieldwork/service provision level.	Chapters 5 and 6
			Implementation service providers expressed how the policy of meeting targets for priority programmes was impeding service provision. For example, targets for SUDs were on prevention programmes only.	Policies and priority programmes should be meticulously **planned with equitable** allocation of resources to allow equitable provision of services, hence not prioritising certain programmes whilst neglecting others.	
			Some service providers describe aftercare services provided at a district level, which included **school visits, individual counselling, home visits, family** Intervention and reintegration services.	A **conducive collaborative environment** will facilitate intersectoral consolidated aftercare response and plan. The use of existing collaboration structures such as war rooms and Operation *Sukuma Sakhe* should be strengthened and extended to treatment service provision.	

		Published.	The findings reveal **inadequate and poor intersectoral coordination** among stakeholders. Aftercare needs for service users (family and persons with SUD) were unmet.	Both manuscripts 2 and 3 affirm the **necessity of a well-coordinated, family-centred, lifelong-orientated** aftercare service provision among service providers, which must be responsive to the needs of service users.	
			Aftercare Services were generally poor and limited and, where provided, followed an acute model, thus terminated shortly after discharge. The paucity of success stories and good teamwork at hospitals within the mental health teams demonstrated the value and strength of integrating aftercare services for persons with SUDs in the mental health system.	Aftercare services should be integrated into existing systems of care to offer comprehensive, coordinated and integrated sustainable service delivery.	
		Manuscript 3: Aftercare needs post inpatient treatment in a South African rural context: perspectives of persons with substance use disorders and their families Submitted at the African Journal of Primary Health Care and	**Aftercare needs of persons with SUDs and families include:** 1. Family intervention as part of aftercare services 2. Vocational needs as a preventive mechanism 3. The types (regular visits to home, access to self-help/support groups, and increased frequency of individual counselling) and nature (person-centred aftercare, easily accessible professional assistance, the necessity for lifelong aftercare/recovery management) of aftercare services. 4. Reintegration needs to assist with reintegration into home and	Findings **indicate the need for a context-specific aftercare model** to guide aftercare programmes, which should be responsive and cognisant of the individualised needs of persons with SUDs and family members, as established in manuscript 3.	

		Family Medicine. Review in progress.	community. Addressing stigmatisation challenges.		
3. To explore barriers and enablers within SUD aftercare		**Manuscripts 2 and 3:**	Numerous **barriers to service delivery were identified and framed using systems thinking, to mention a few. (Refer to manuscript 2 for more details.)** 1. Implementation (facility and community-based care) Poor inter-sectoral collaboration Family denial and family's limited knowledge of the recovery process. 2. Coordination (management and M&E) Poor communication among stakeholders rendering services within the same community Limited awareness of each stakeholder's roles, responsibilities and scope of practice. 3. Control (M&E and District M) evaluation of SUD Services: poorly managed and monitored 4. Intelligence (Policy and Provincial) Limited accountability and reporting of NGOs to local institutions Absence of aftercare statistics in Provincial reports	The model should guide service providers on how to mitigate service provision barriers. In addition, the model should capitalise on the opportunities presented by the enablers for service provision.	Chapters 5 and 6

			5. Policy level. (National and provincial) SUD programs not prioritised by DoH and DoSD NGOs reporting renewal at the policy level only Lack of standard of care Lack of policy awareness		
			So**me systematic enablers were noted at different levels of service provision:** 1. Implementation Team approach at hospitals and clinic level by DoH The high level of motivation of a PWSUD Strong family support Telephonic follow-ups from ITCs 2. Coordination The necessity of collaborating with community caregivers. 3. Control (M&E and District M) Maximising on war rooms Considering a ward-based approach 4. Intelligence (Policy and Provincial) No enablers recorded 5. Policy level. (National and provincial) Policies in place	The enablers appeared to aid collaboration of multiple stakeholders to a limited extent; therefore, should be strengthened and extended to aftercare services at all levels of service provision. At the implementation level, this could be achieved through the use of, *inter alia*, clinic cards and community caregivers. Demonstrated integration of services at DoH reiterates the necessity for integrated services. **Existing structures of collaboration,** such as war rooms (ward-based meetings of stakeholders), should be used to promote the collaboration of stakeholders. At a coordination level, a case **manager or coordinator** is required to coordinate aftercare services among stakeholders. This could be a social worker as per the ward-based approach used at Social Development (DoSD).	
4. To describe monitoring and		Manuscript 2	There was superficial/inadequate M&E of aftercare services, compounded by the absence	M&E should be outcome-based.	Chapter 5

evaluation strategies of SUD aftercare service provision at district level.			of aftercare statistics recorded due to competing priorities at specific governmental departments such as DoH and DoSD.	Whilst working with priority programmes, there must be a space for inclusion of other programmes in the M&E strategies.	
			Little support of SUD programmes, characterised by **inadequate provincial reporting means,** was noted as a barrier to service provision.	**Accountability** of state-funded NGOs should be operationalised both locally and provincially, as well as the local institutions they work with, such as hospitals and service centres.	
			Furthermore, NGOs rendering services at the community level are monitored at a provincial level with no accountability at the local level at the facilities they service, such as hospitals and service centres.	Comprehensive monthly reports should include SUDs details inclusive of aftercare and all collaborative stakeholders as opposed to reporting in silos. This could foster collaboration and inter-sectoral service delivery as expressed in the NDMP of 2019-2024 (18) and Substance Use Act (16).	

7.3 PHASES OF THE STUDY

The study was divided into two phases:

Phase one focused on policy analysis. Existing SUD policies were reviewed to establish the aftercare policy contents. Eight policy documents relevant to aftercare were analysed using the Walt and Gilson (55) Policy Analysis Triangle Framework for Health Policy Analysis (55). The Policy Analysis Triangle Framework was used to identify and analyse the aftercare policy content, the relevant aftercare actors and role players (local and international), and the process and context (local and international) of policy making and service delivery (55). The Beer's Viable System Model (VSM) (46, 47, 51) was included to extend the analysis, which assisted in identifying the five key functions in a system, namely implementation, coordination, control, development and policy (46, 47, 51). The system of aftercare provision comprises multiple components and interactions, with the associated complexities of human services, which were explored in the policy analysis.

Phase two of the study adopted a qualitative study design within a systems-thinking framework (46, 47, 51). The study explored the perspectives of all service providers at all levels of service provision as prescribed by Beer's Viable System Model (VSM) (47) on aftercare service provision for persons with SUDs in a rural district in South Africa. This ensured that the perspectives of stakeholders at all relevant and intersecting components (fieldwork, coordinators, managers, and policymakers) of the SUD aftercare system were included to contribute to the design of a SUD aftercare model. Furthermore, phase two explored the perspectives of persons with SUD and their families in aftercare service provision for persons with SUDs and aftercare needs post-inpatient treatment in a South African rural context. The findings from both phases were consistent with each other each other and triangulated each other. This provided an in-depth understanding of aftercare services and duly informed the content of an aftercare model from the experiences and perspectives of service users and providers.

The overall aim of the study is addressed in section 7.4, where a proposed aftercare model is presented based on the findings of the study. This proposed model also addresses

objective 5 of the study. The findings demonstrated the nature of aftercare services that are not integrated into the SUD treatment system and mental health care system, that are poorly coordinated among stakeholders, and are generally poor and limited. Furthermore, the needs of persons with SUDs and their families clearly demonstrate the nature and extent of aftercare required to meet their needs. Generally, the findings warrant aftercare services that are integrated into the SUD treatment system so that they are well-coordinated, person-centred and responsive to the needs of persons with SUDs and their families and are lifelong orientated to meet the continual support needs and the relapsing nature of the SUD condition. Therefore, the proposed model adopts the recovery management approach promulgated by WHO and UNODC, which is a more comprehensive strategy and is lifelong orientated. However, as the recovery management lacks integration, the proposed model of care is presented with new terminology and an integrative strategy which includes the integration of all the stakeholders.

7.4 A PROPOSED INTEGRATED RECOVERY MANAGEMENT MODEL

7.4.1 Proposed terminology for the model

7.4.1.1 Integrated Recovery Management Model of Care

The Integrated Recovery Management Model of Care (IRMMC) is based on new terminology aligned with adoption a fresh recovery management approach adopted by the NDMP 2019-2024 and was initially proposed by the WHO and UNODC (5). The findings of this study demonstrated the need for integrated services so that recovery management services are not a stand-alone sub-system of care but integrated in the SUD system of care. For this reason, a new terminology (IRMMC) is proposed as opposed to the term aftercare „model“ initially contemplated in the conception and data collection of this study.

7.4.1.2 Lifelong orientated services

Lifelong-orientated services terminology is proposed to replace chronic-orientated services as promulgated by NDMP 2019-2024 (14), the WHO and UNODC (5). A biopsychosocial approach (lifelong), as opposed to a disease model, is preferred to promote person-centredness.

7.4.2 Purpose of the IRMMC

The IRMMC aims to achieve person-centred recovery outcomes by guiding stakeholders on how to collaboratively provide and maximise recovery management services. Ultimately, this is to reintegrate the person with SUD into the context of the family, work/school and community and sustain recovery through comprehensive support of collaborative efforts from multiple stakeholders. In addition, the model aims to reduce relapse incidences; however, cognisant to the fact that SUD is a relapsing condition, a relapse management approach is also proposed as part of the IRMMC. The following principles will guide the achievement of this aim.

7.4.3 The principles of IRMMC

The principles of IRMMC emanated from the study findings. They are offered considering present policies such as the NDMP 2019 – 2024 and the International Standard for Treatment, UNODC (refer to Table 7.2).

Table 7.2: Principles of IRMMC

Lifelong orientated approach

- Accommodate/accept lapse and relapse as a common cycle for recovery.
- Lifetime intervention or as long as may be required
- Multiple re-entry points in the treatment system to accommodate relapse

Developmental approach

- Embraces self-reliant and human emancipation (recovery capital) therefore client and family centered services.
- Follows and commits to outcome-based monitoring and evaluation processes
- Embraces and maintains intersectoral and interdisciplinary collaboration
- Culturally sensitive

Asserting human rights and responsive to individual needs

- Minimise stigmatisation, vulnerability and marginalisation of service users
- Special needs population such as persons with disabilities and pregnant women to be well accommodated

Relapse Management and Prevention

- Acceptance that relapse is part of the treatment process and that individuals can re-access treatment service.
- Whilst preventing relapse, managing relapse should be pivotal

Offering a comprehensive and coherent response by all stakeholders

- Effective continuity of care that encompasses general medical care, management of comorbid SUDs, psychiatric and physical health conditions.
- Effective coordination between criminal justice, health, social and other departments.
- Integrated team approach, linkages with complementary services and constant monitoring.

Cognisant of the context of resource constrained environment.

- Provides for rural and disadvantaged communities

Follows principles of universal health coverage

- Services that are accessible, attractive and affordable.

7.4.4 Phases: IRMMC

Within the IRMMC, recovery services are categorised into phases within a continuum from ITC to community. From a systems perspective, recovery management should commence prior to discharge and be afforded throughout the lifetime of the service user. Each phase is guided by designed outcomes and indicators that are person-centred. See Figure 7.1 provides more details on each phase. Annexure 16, augments the information in Figure 7.1. The preparation of the person with SUD for each phase is an essential step for the IRMMC to succeed, Figure 7.2. provides a guide on how to prepare the user for each phase of the model. Furthermore, each phase must be monitored and evaluated continuously, thus Figure 7,3 provides strategies for M&E of each phase. However, for M&E to be successful, someone must be a custodian for it. A Social Worker from DSD per municipal ward is proposed to be the Case Manager which involves being a custodian of M&E for each phase. Figure 7.4. outlines the role of the case manager in the IRMMC.

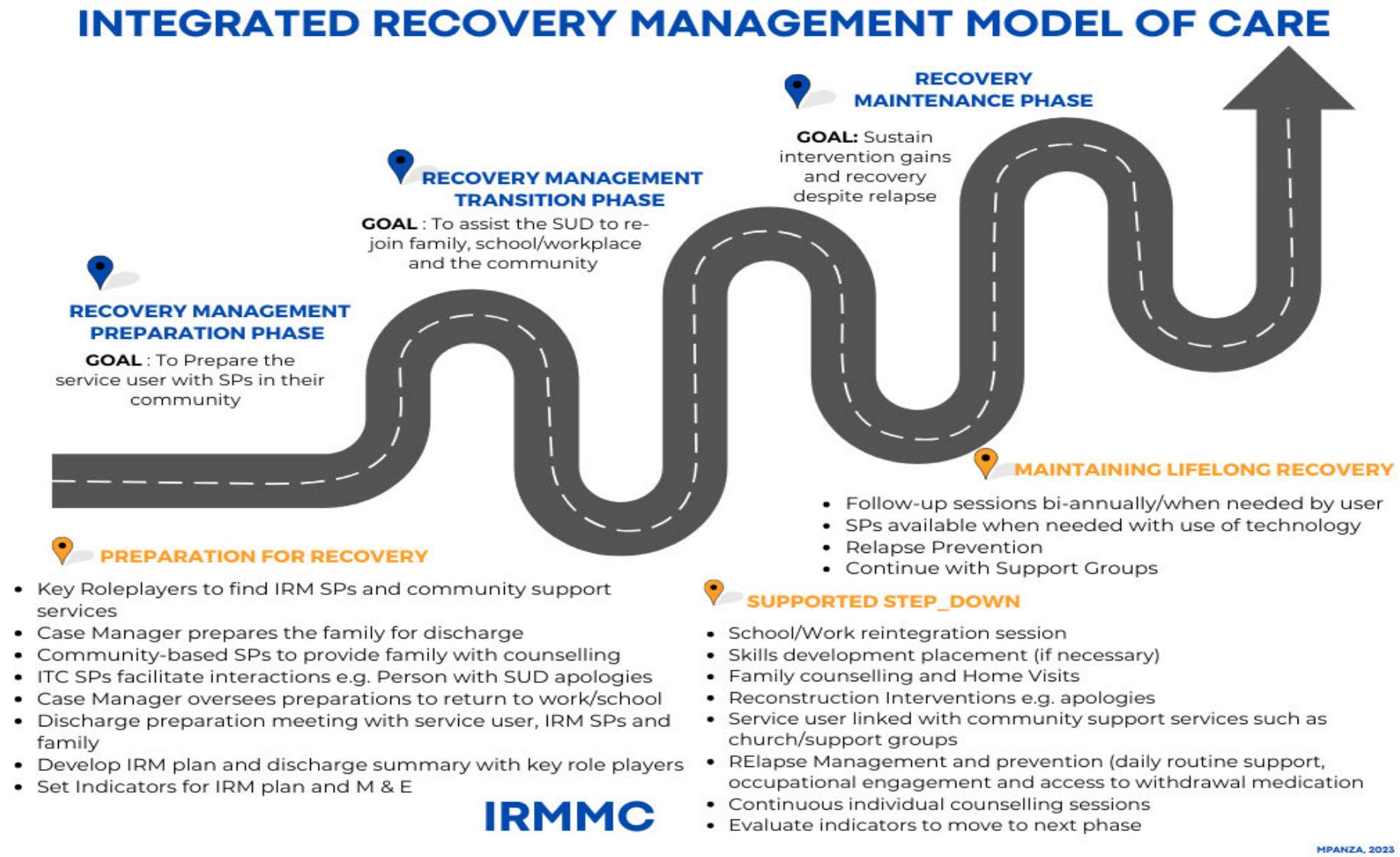

Figure 7.1: Representation of Phases of Recovery

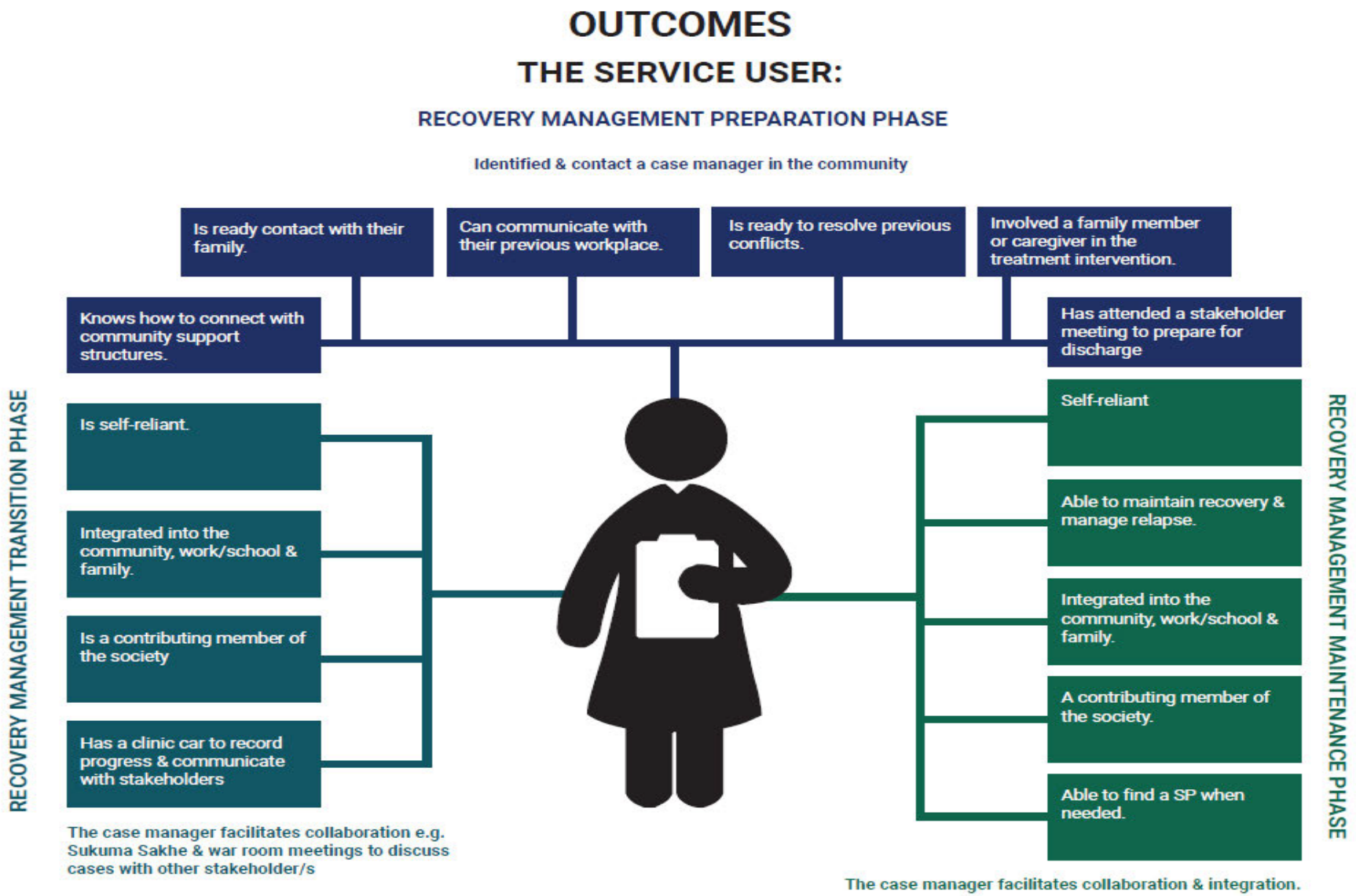

Figure 7.2 Preparation of the user

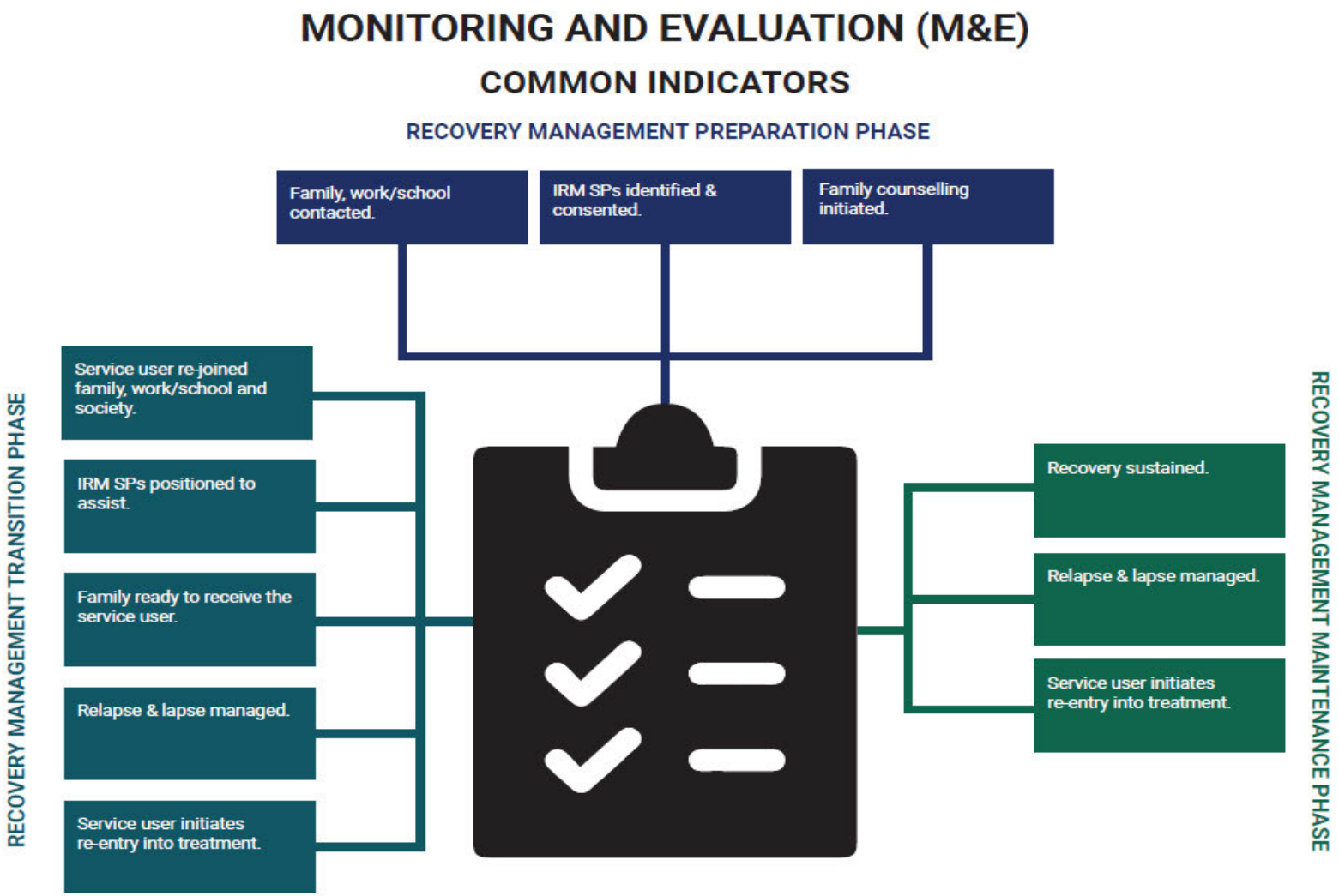

Figure 7.3 Monitoring and Evaluation of the IRMMC

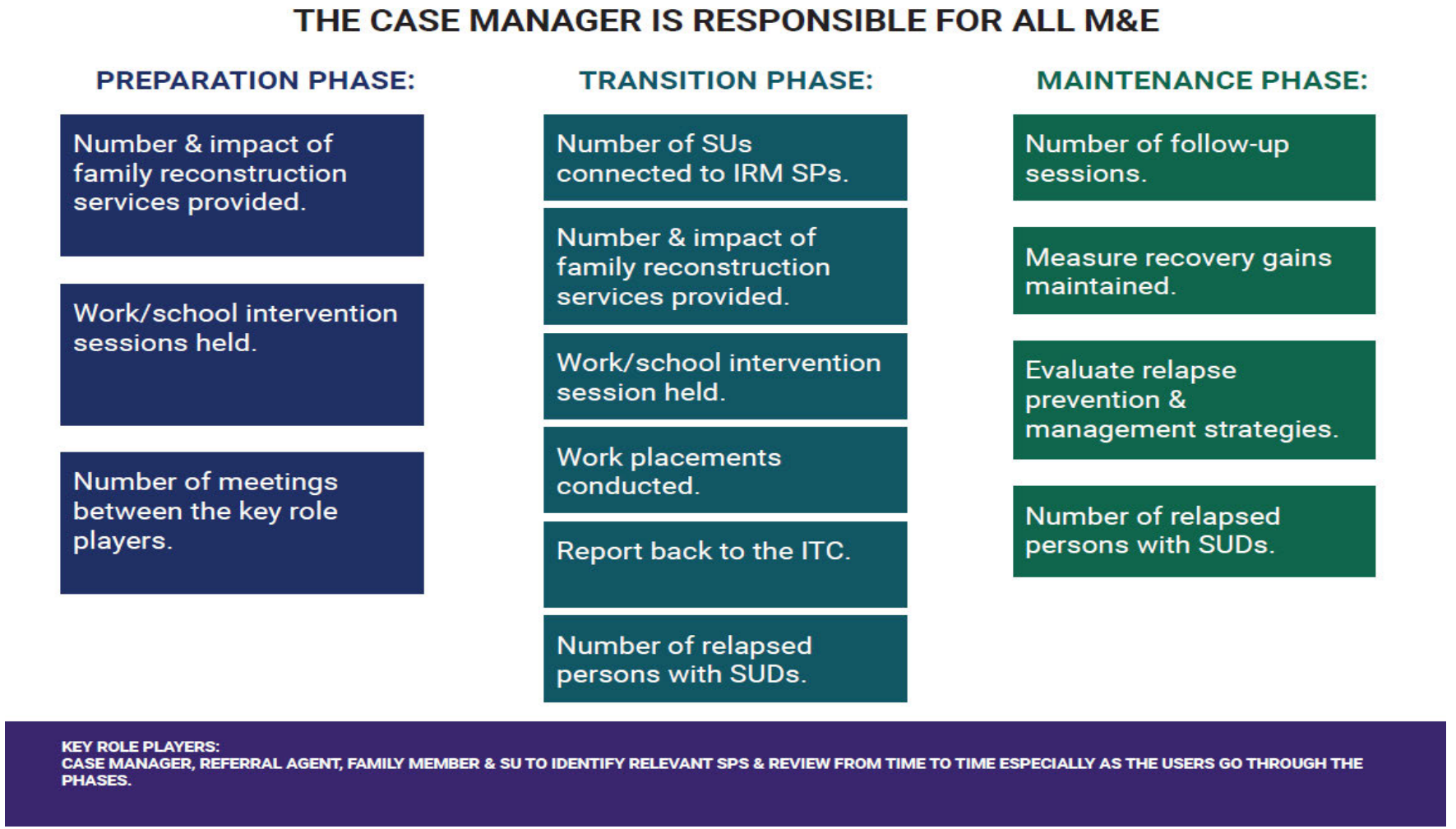

Figure 7.4 Case Manger's Role for the IRMMC

7.4.5 Proposed Relapse Management Intervention Strategies

Recovery management intervention mostly focuses on relapse prevention. However, persons with SUDs may relapse at any stage of recovery and are generally referred to the ITCs for readmission (24). SUD has been adopted as a chronic condition by key role players such as WHO, UNODC (5) and NDMP 2019-2024 (14); therefore, there is a need to manage relapse instead of focussing on relapse prevention only. A relapse management intervention strategy is proposed and is a key component of the integrated recovery management model. Relapse Management Intervention Strategy will guide service providers as demonstrated in Figures 7.5 and 7.6 (p. 140). The success of the relapse management intervention is dependent upon the efficient functioning of the outpatient intervention programme.

Relapse management should entail the following:

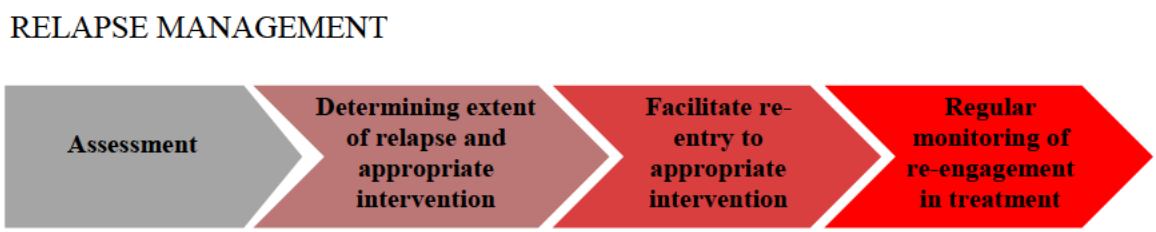

Figure 7.5: Illustration of Relapse Management

7.4.6 Proposed IRMMC Diagrammatic Presentation

The proposed model depicts an integrated model as it offers combined and comprehensive service to the existing systems of SUD. The model is presented with due cognisance of South African policies, in particular the NDMP 2019–2024, Acts (i.e., No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008), WHO and UNODC Treatment Standards (5). This model is inclusive of roles and functions (responsibilities) of key stakeholders, underlining principles, sites and policies of care within a continuum. (Refer to 7.6. for the visual illustration of IRMMC).

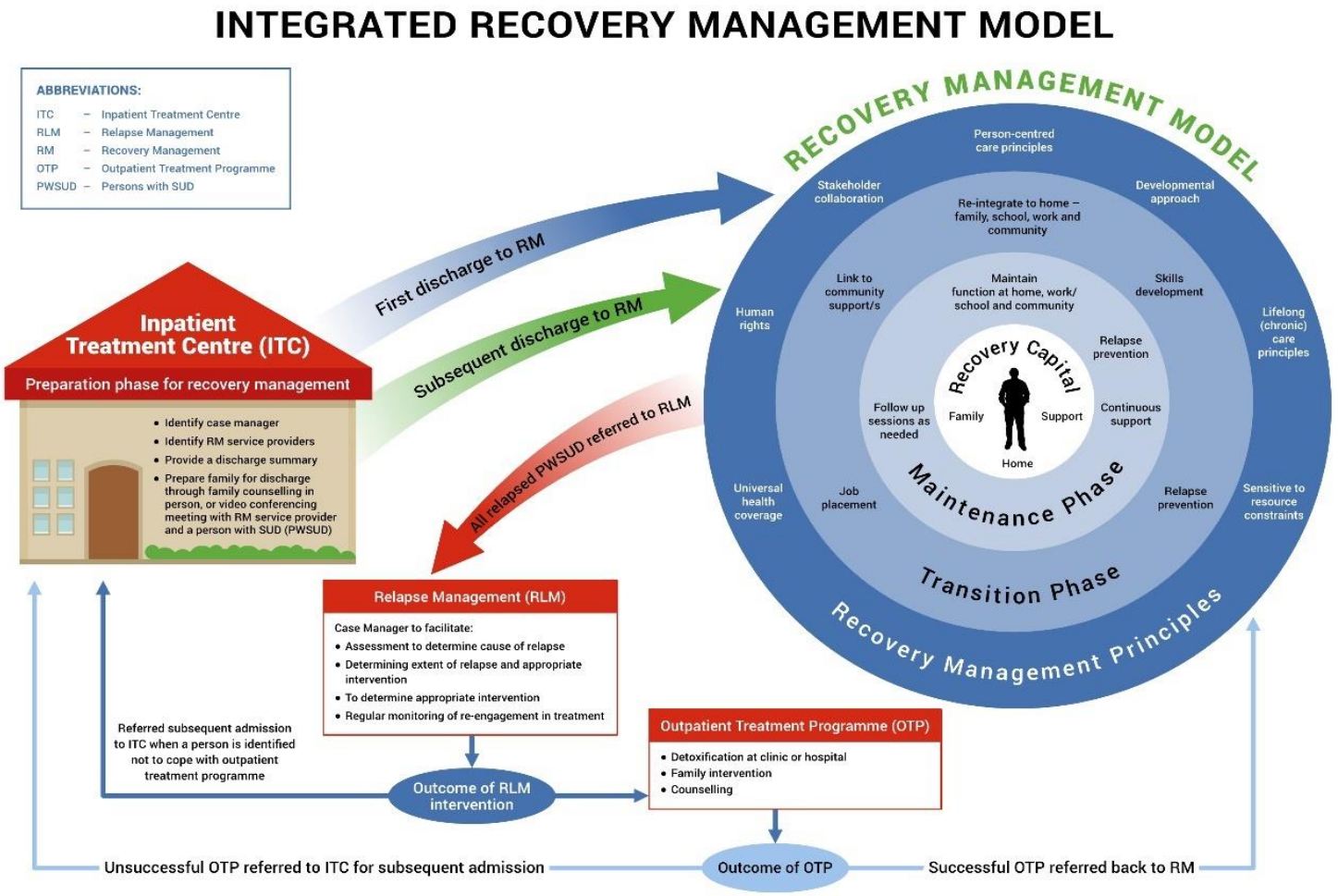

Figure 7.6: Graphic representation of Integrated Recovery Management Model of Care (IRMMC)

7.5 RECOMMENDATIONS

The following recommendations are offered for conditions that would enable full implementation of the IRMMC:

7.5.1 Integrated recovery management services should be integrated within the existing systems of care. Although a sub-system, it must be integrated within all aspects of the SUD system of care.

7.5.2 The success of the proposed relapse management intervention strategy is incumbent upon efficient outpatient programmes. Therefore, the outpatient programme should be strengthened, and detoxification services should be made available and easily accessible at local health facilities such as clinics and hospitals, which should include medication for withdrawals.

7.5.3 The IRMMC would require the strong collaboration of all stakeholders in the provision of intervention/treatment services.

7.5.4 The key leading government departments, i.e. DoH and DoSD, would need to work hand in hand with clearly identified channels of communication.

The SUD system recommendations are summarised and framed with the systems theory for the success of the proposed IRMMC model in Figure 7.7 SUD System Recommendations aligned to systems thinking:

Implementation and coordination - fieldwork level
A case manager is an integral service provider for the success of the integrated recovery management model and also ensuring collaboration of stakeholders to achieve inter-sectoral collaboration. Furthermore, extend the types of recovery management service providers to include faith-based persons such pastors, municipal mayors, ward councillors and so forth and as identified by each service user to ensure client centeredness.

Control - district level
The service providers responsible for monitoring and evaluation of the substance use programmes should strengthen the monitoring and evaluation by following outcome - based monitoring strategies. Such indicators should be developed in consultation with all relevant stakeholders, especially case managers. In general, these include a successful reintegration of the intersecting work, family and community environment.

Development - Provincial level
It is recommended that NGOs be funded for integrated recovery management service provision to support the government departments. However, monitoring and evaluation must be conducted in collaboration with the institutions they support i.e. reports and statistics should be corroborated by hospitals and DSD facilities. Regular needs analysis must be conducted to ensure the relevance of services rendered in each context.

Policy - Provincial level
A policy paradigm shift is required in South Africa to improve on policy directives that embrace a chronic/lifelong approach to SUD. This includes providing guidance on relapse management as oppose to relapse prevention only. In addition, policies should consider the inclusion of prescripts on recovery management requirements such as regular check-ups, person centred and without termination, which is chronic/lifelong orientated as articulated in the UNODC and WHO.

Policy - National Level
There is a need to develop a Recovery Management National Minimal Norms and Standards (RMNMNS) for the M&E of Recovery Management services and clearly outlining the expected standard of recovery management (also known as aftercare) services.

Figure 7.7: SUD System Recommendations Aligned to Systems-Thinking

7.6 STRENGTHS AND LIMITATIONS OF THE STUDY

7.6.1 Strengths and Novelty

Two South African policies, namely the National Drug Master Plan (NDMP) 2013–2017 and the Anti-substance Abuse Plan of Action (AAPA) 2011, endorsed the development of an aftercare and reintegration model to guide service provision. However, such a model has not been developed to date. This study, therefore, responds to both a research and policy gap by proposing an aftercare model of care by exploring the rural context and perspectives of a number of stakeholders, which include service users, persons with SUDs and their families, and service providers from NGOs and government departments. Furthermore, the model provides strategies for the integration of services and stakeholder collaboration. Relapse management is integrated into this model as a key aspect in the adoption of a lifelong approach to SUD. In addition, the findings of this study can be used to inform policy formulation, strengthen the move to lifelong-orientated SUD services, review of current strategies/approaches, and service users' needs concerning aftercare services in rural areas.

7.6.2 Limitations of the study

The following were determined as limitations of the study:

Access to and commitment of persons with SUDs: The initial intention was to interview the sample until saturation was reached. However, due to the accessibility and availability constraints of persons with SUDs, it was not possible to sample until saturation was reached. Furthermore, the service users were sampled from one district, future study should consider sampling more than one district.

Participation of provincial service providers: Despite several efforts to secure and recruit a larger sample cohort to reach saturation of provincial service providers, not everyone consented to participate. However, those who were successfully recruited engaged comprehensively in policy imperatives and service provision for persons with SUDs. *The study was limited to the implementation and review of the model*. The next logical step would be to implement and review the model for further refinement to establish applicability within the South African context. In addition, studies are needed to

explore feasibility of the proposed model and develop a roll-out plan in terms of identifying all new resources required, and how would it impact other services. Such studies would help to identify what would contribute to successful uptake of the model.

7.7 CONCLUSION

The study proposes an integrated recovery management model for persons with SUDs post-discharge from an ITC. The intersecting systemic complexities of providing aftercare services in a rural context in South Africa were evident in this study and strongly demonstrated the weaknesses and inadequacies within a fragile system, which are a challenge to the service providers. In addition, a dire need for an aftercare model that is integrated into the existing SUD system and responsive to the needs of persons with SUD was established. Furthermore, the study emphasised policy inadequacies in guiding aftercare services in a resource-constrained context. In response to these challenges, the study contributed to new knowledge on how the complexities of providing aftercare services can be navigated via integration and comprehensively with the collaboration of stakeholders. In addition, the proposed model is explicitly expressed in and aligned to South African policy documents such as the NDMP and Substance Abuse Act No. 70 of 2008, with due cognisance of the UNODC and WHO chronic treatment approach (lifelong). Relapse management is embraced and integrated into this model to safeguard lifelong-orientated recovery management services. Subsequently, the proposed aftercare model is named an integrated recovery management model of care to guide recovery management services.

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ANNEXURES

ANNEXURE 1: EDITING CERTIFICATE

EDITOR'S CERTIFICATE

P O BOX 1432
WANDSBECK 3631

22 May 2023

Mr December Mpanza
University of KwaZulu-Natal

EDITING OF PHD THESIS

AN INTEGRATED MODEL OF AFTERCARE FOR SUBSTANCE USE DISORDER CLIENTS IN KWAZULU-NATAL

AUTHOR: December Mandlenkosi Mpanza (Student No: 202202205) NGAP Scholar

I confirm that I have edited the above PhD thesis, inter alia, the Title page, Abstract, Acknowledgements, Dedication, References, Illustrations, Table of Content, Tables, Figures, Abbreviations and Annexures. Chapters 1 –7 were addressed for clarity, consistency, layout and style. The contents were edited via track changes, WhatsApp and emails discussions. Changes and clarifications in the body of the text are for the sole discretion of the author.

Editorial advice was provided on the following:

- matters of substance and structure
- paragraph and sentence structure
- language, academic tone, phrasing, presentation of figures and tables
- verbosity, circumlocution, grammar, spelling and punctuation.
- content clarification
- overall presentation of content

DR L M LOMBARDOZZI

ANNEXURE 2: ETHICAL CLEARANCE LETTER (UKZN)

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

13 November 2017

Mr D M Mpanza (205502205)
Discipline of Public Health Medicine
School of Nursing and public Health
mpanzad@ukzn.ac.za

Dear Mr Mpanza

Protocol: An integrated model of aftercare for substance use disorder clients in KwaZulu-Natal.
Degree: PhD
BREC Ref: BE274/17

EXPEDITED APPLICATION

A sub-committee of the Biomedical Research Ethics Committee has considered and noted your application received on 04 May 2017.

The study was provisionally approved pending appropriate responses to queries raised. Your response received on 02 November 2017 to BREC correspondence dated 14 June 2017 have been noted by a sub-committee of the Biomedical Research Ethics Committee. The conditions have now been met and the study is given **full ethics approval** and may begin as from 13 November 2017.

This approval is valid for one year from **13 November 2017.** To ensure uninterrupted approval of this study beyond the approval expiry date, an application for recertification must be submitted to BREC on the appropriate BREC form 2-3 months before the expiry date.

Any amendments to this study, unless urgently required to ensure safety of participants, must be approved by BREC prior to implementation.

Your acceptance of this approval denotes your compliance with South African National Research Ethics Guidelines (2015), South African National Good Clinical Practice Guidelines (2006) (if applicable) and with UKZN BREC ethics requirements as contained in the UKZN BREC Terms of Reference and Standard Operating Procedures, all available at http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx.

BREC is registered with the South African National Health Research Ethics Council (REC-290408-009). BREC has US Office for Human Research Protections (OHRP) Federal-wide Assurance (FWA 678).

The sub-committee's decision will be **RATIFIED** by a full Committee at its next meeting taking place on **12 December 2017.**

We wish you well with this study. We would appreciate receiving copies of all publications arising out of this study.

Yours sincerely

[redacted]

Professor J Tsoka-Gwegweni
Chair: Biomedical Research Ethics Committee

cc supervisor: naidoopa@ukzn.ac.za
cc postgraduate administrator: samlalm@ukzn.ac.za

ANNEXURE 3: ETHICAL CLEARANCE AMENDMENTS LETTER (UKZN)

UNIVERSITY OF
KWAZULU-NATAL
INYUVESI
YAKWAZULU-NATALI
RESEARCH OFFICE
Biomedical Research Ethics Administration
Westville Campus, Govan Mbeki Building
Private Bag X 54001
Durban
4000
KwaZulu-Natal, SOUTH AFRICA
Tel: 27 31 2604769 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za
Website: http://research.ukzn.ac.za/Research-Ethics/Biomedical-Research-Ethics.aspx

21 December 2017

Mr D M Mpanza (205502205)
Discipline of Public Health Medicine
School of Nursing and public Health
mpanzad@ukzn.ac.za

Dear Mr Mpanza

Protocol: An integrated model of aftercare for substance use disorder clients in KwaZulu-Natal.
Degree: PhD
BREC Ref: BE274/17

Your application for Amendments dated 07 December 2017 to change participants to include family members for the above study has been **noted and approved** by a sub-committee of the Biomedical Research Ethics Committee.

The above approval will be ratified at the next committee meeting to be held on 13 February 2018.

Yours sincerely

[redacted]

Mrs A Marimuthu
Senior Administrator: Biomedical Research Ethics
PP/AM

cc supervisor: naidoops@ukzn.ac.za
cc postgraduate administrator: ramlalm@ukzn.ac.za

ANNEXURE 4: ONLINE ETHICS CERTIFICATES

Zertifikat
Certificat
Certificado
Certificate

TRREE

Promouvoir les plus hauts standards éthiques dans la protection des participants à la recherche biomédicale
Promoting the highest ethical standards in the protection of biomedical research participants

Clinical Trials Centre
The University of Hong Kong

Certificat de formation - Training Certificate

Ce document atteste que - this document certifies that

zinhle mkhize

a complété avec succès - has successfully completed

Introduction to Research Ethics

du programme de formation TRREE en évaluation éthique de la recherche
of the TRREE training programme in research ethics evaluation

[redacted]

Release Date : 2021/02/28

Professeur Dominique Sprumont
Coordinateur TRREE Coordinator

FMH

FPH

Ce programme est soutenu par - This program is supported by :

Certificate of Completion

The National Institutes of Health (NIH) Office of Extramural Research certifies that **December Mpanza** successfully completed the NIH Web-based training course "Protecting Human Research Participants".

Date of completion: 12/11/2016.

Certification Number: 2254905.

ANNEXURE 5: GATE KEEPER PERMISSION REQUEST LETTER

Gate keeper address:

Subject: Request for Permission to Conduct Research

Research Title: An integrated model of aftercare for substance use disorder clients in KwaZulu-Natal.

Dear Sir/Madam

My name is December Mpanza, currently working and reading for a PhD in Public Health Medicine at the School of Health Sciences at the University of KwaZulu-Natal. I hereby request permission to conduct research at your institution/s on the title as mentioned above. This study proposes an integrated model of aftercare for SUD clients post the public facility inpatient treatment phase in KwaZulu-Natal. This model may improve aftercare services for substance use disorder clients. Furthermore, the study is conducted in fulfilment of the requirements for the PhD in Public Health (Medicine).

The estimated duration of participation will on the methods used as indicated below.

Phases	Method	Duration	Tick
Phase Two	Interview	45min to 1 hour	
	Focus Group	45min to 1h30	
	Interview	2-3 hours	

All efforts will be made not to disrupt the day to day running during data collection. Please refer to the attached information document for more information and contact details of my supervisors and Ethics Committee should you need to contact them.

This research project has been provisionally approved by the Biomedical Research Ethics Committee of the University of KwaZulu-Natal (Ethics no: BE274/17) pending your

permission to conduct this study in your institution/department. See enclosed ethics provisional approval document and research proposal for more information. A full ethics approval will be provided after you have given permission.

Your assistance is highly appreciated.
Thank you.

Yours sincerely

Mr December M Mpanza, BOT (UKZN)
MOT (UKZN), Researcher/PhD Candidate
Discipline of Public Health Medicine
Tel: 031 2608375/ Cell: 0828442938
Email: Mpanzad@ukzn.ac.za

ANNEXURE 6: INFORMATION DOCUMENT FOR STUDY PARTICIPANTS

Dear Potential Participant

Thank you for reading this information document before deciding to participate in the study.

Research Title: An Integrated Model of Aftercare for Substance Use Disorder Clients in Kwazulu-Natal.

Purpose of the study

This study aims to propose an integrated model of aftercare for SUD clients post the public facility inpatient treatment phase in KwaZulu-Natal. This model may improve aftercare services for substance use disorder clients. This study is conducted in fulfilment of the requirements for the PhD in Public Health (Medicine)

Description of the study

This study has been approved by the University of KwaZulu-Natal Ethics Committee (BREC Ethics Ref No: BE274/17) and the permission to conduct the study has been obtained from your institution (see attached proof). If you are willing to participate in this study, you will be required to sign the Consent Form. You may be asked to participate in different phases i.e., Phase two: interview and docent method interview or phase three: Delphi Method and or Nominal Group Workshop. Should you agree to participate in an interview, you will be requested to answer questions in relation to your experience in providing aftercare services. If you are a service user, you will be asked to participate in the Docent Method, which will involve walking interviews and taking pictures of your sites of interest in your recovery journey post discharge from an inpatient treatment facility. You may be asked to participate in the Delphi Method where you will be asked to anonymously answer questions via email.

The information collected from this process will be transcribed through a verbatim procedure and then analysed for the completion of this study. Thereafter, a publication will be done and communicated with you. It will also be published for societal benefit and improved service delivery.

Duration of your participation in this study

The estimated duration of your participation will depend on which method you are requested to participate in. It is indicated with a tick on the table below:

Phases	**Method**	**Duration**	**Tick**
Phase Two	Interview	45min to 1 hour	
	Focus Group	45min to 1h30	
	Interview	2-3 hours	

The following ethical principles are considered:

Benefits

Your participation in this study will contribute to the generation of new knowledge and insight into the experiences of service providers working in rural areas as well as service users. This could result in improved service delivery of substance abuse services in rural areas. A report will be sent to you.

Participation and Withdrawal

You have the right to choose to participate in the study without any coercion, and you may withdraw at any given point without incurring any repercussions or any form of victimisation.

Risks

The risk in this study is minimal as you will not be subjected to any procedures that involve physical contact or sensitive/stress-inducing questions. However, should you feel your safety and/or welfare is threatened in any manner, you have the right to inform the researcher of this and decide whether to withdraw from or continue with the study.

Confidentiality

Confidentiality will be ensured throughout the study by using pseudonyms. Your identity and the name of your institution will not be disclosed nor published in any form. The information gathered will be used for data analysis in this study only and will be reported on aggregate than specific institutions. Furthermore, the information will be kept in lockable storage accessible only to the researcher and the supervisor.

Transparency and Honesty

The researcher will not withhold any relevant information from you and will do his best to answer questions or give clarity where needed in an honest and transparent manner.

Complaints/ concerns or queries channel

As mentioned above, the participation is voluntary, and you may withdraw at any point without any explanation or incurring consequences. If you are interested in participating in the study, please complete the **Consent Form for Participation in the Study, attached.**

Should you require further information about this research project or have any concerns, you may contact the researcher or supervisor of the project (details provided below). Should you not be satisfied with either of them, you may escalate your query or concern to the Postgraduate Administrator or UKZN Ethics office (details provided below)

Your participation is greatly appreciated.

Yours sincerely

[redacted]

Mr December M Mpanza, BOT (UKZN), MOT (UKZN),
Researcher/PhD Candidate Discipline of Public Health Medicine
Tel: 031 2608375/ Cell: 0828442938
Email: Mpanzad@ukzn.ac.za

Ms Dineo Oliphant
Administrative Officer Discipline of Public Health Medicine
Tel: 031 2604383
Email: oliphant@ukzn.ac.za

Dr Pragashnie Govender, BOT (UDW); MOT (UKZN), PhD (UKZN)
Research Supervisor
Tel: 031 2608258
Email: naidoopg@ukzn.ac.za

Dr Anna Voce, BScOT; PGDip Adult Education; Mcommhealth; PhD
Research Co-supervisor
Tel: 0312604493
Email: voceas@ukzn.ac.za

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
Research Office, Westville Campus
Govan Mbeki Building
University of KwaZulu-Natal
Private Bag X 54001, Durban, 4000
KwaZulu-Natal, South Africa
Tel: 27 31 2602486 - Fax: 27 31 2604609
Email: BREC@ukzn.ac.za

ANNEXURE 7: INFORMED CONSENT FORM

Research Title: An Integrated Model of Aftercare for Substance Use Disorder Clients in Kwazulu-Natal.

I, _____ confirm that the study has been clearly explained to me and any concerns or questions have been answered to my satisfaction. Furthermore, any questions arising along the way will be addressed. I am aware that my participation is voluntary and as a result I can withdraw at any given point without incurring any penalties whatso- ever. I understand my identity or any information that identifies me will be kept confidential.

I am aware that should I have any questions or concerns, I can raise them directly with the researcher Mr DM Mpanza in person or via email: mpanzad@ukzn.ac.za or cell no 0828442938 / Tel: : 0318442938. I understand I have as second option to contact the research supervisors Dr P Govender via email: naidoopg@ukzn.ac.za or Tel no 0312608258 or Dr A Voce via email: voceas@ukzn.ac.za or Tel no: 0312604493. Should I not be satisfied with the above-mentioned individuals, I may escalate my query or concern to the administrator of the BIOMEDICAL RESEARCH ETHICS ADMINISTRATION, Research Office, Westville Campus, Govan Mbeki Building, University of KwaZulu-Natal, Private Bag X 54001, Durban, 4000, KwaZulu-Natal, SOUTH AFRICA, Tel: 27 31 2602486 - Fax: 27 31 2604609, Email: BREC@ukzn.ac.za. All this information has been provided in the information documents.

I have been apprised of my rights and the researcher's responsibilities. I have read and understood the information document and the contents of this form. I hereby give my consent freely by signing to take part in this study. I am aware that signing this form does

not exempt the researcher from ethical responsibility, professional conduct and institutional responsibility as well as my right to withdraw at any given time.

I consent to participation in the study ☐

I consent to discussions being digitally-recorded ☐

Signature of Participant	**Date**
Witness Signature	**Date**

ANNEXURE 8: DEPARTMENT OF HEALTH GATE KEEPER LETTER

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

330 Langalibalele street
Private Bag X9051 PMB 3200
Tel: 033 395 2805/3189/3123 Fax: 033 394 3782
Email: hrkm@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management (HKRM)

Reference: HRKM255/17
KZ_2017RP25_230

11 July 2017

Dear Mr D Mpanza
(University of KwaZulu-Natal)

Subject: Approval of a Research Proposal

1. The research proposal titled **'An integrated model of aftercare for substance use disorder clients in KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at KZN-DoH, Umkhanyakude Health District.

2. You are requested to take note of the following:
   a. Make the necessary arrangement with the identified facilities before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to hrkm@kznhealth.gov.za

For any additional information please contact Ms G Khumalo on 033-395 3189.

Yours Sincerely

[redacted]
Dr E Lutge
Chairperson, Health Research Committee
Date: 11/07/17

Fighting Disease, Fighting Poverty, Giving Hope

ANNEXURE 9: DEPARTMENT OF SOCIAL DEVELOPMENT GATE KEEPER LETTER

social development
Department:
Social Development
PROVINCE OF KWAZULU-NATAL

FAX	: 033-264 2075	HUMAN RESOURCE DEVELOPMENT
Telephone/Ucingo/Telefoon	: 033 264 2078	174 Mayors Walk Road
Enquiries/Imibuzo/Navrae	: Mr VW Gumede	Private Bag X9144
Email address	: velaphi.gumede@kznsocdev.gov.za	Pietermaritzburg
Reference/ Inkomba/ Navrae: S6/5/3		3200

Mr D Mpanza
University of Kwazulu Natal
Private Bag X 54001
Durban
4000

Contact No: 0828442938/0312608375
Email: mpanzad@ukzn.ac.za

Dear Mr D Mpanza

PERMISSION TO CONDUCT RESEARCH IN AN INTERGRATED MODEL OF AFTERCARE FOR SUBSTANCE USE DISORDER CLIENTS IN KWAZULU-NATAL

Kindly be informed that the permission has been granted by the Head of Department for you to conduct research at the Department of Social Development for you to fulfil the requirement of your PhD. Your presentation during the interview was explicit to the chosen topic.

The permission authorizes you to: -

a) Meet with Mr Byroo to obtain more information on restorative programmes;
b) Interview management at their consent whom you deemed relevant to your research project and maintain high level of confidentiality; and
c) Share your findings with the Department and present the recommendations to the Provincial Structure of your proposed model of aftercare for substance use disorder clients.

Wishing you success during your research project.

Yours Faithfully

[redacted]

DR MJ NGCONGO
CHIEF DIRECTOR: HUMAN RESOURCE MANAGEMENT

DATE 09/10/2017.

ANNEXURE 10: NGO 1 GATE KEEPER LETTER

Ophondweni Area
(Next To Ophondweni Clinic)
Ward 9, Jozini, 3968

P.O. Box 77446, Jozini, 3969

Cell: 082 629 3038 | Fax: 086 562 7126
Email: info@sord.org.za | Web: www.sord.co.za

NPO Number: 044-074

To: Mr December Mpanza

From: Solid Foundation for Rural Development

Subject: Grant of permission to conduct a study or Research

This serves to confirm the request to conduct research to Solid Foundation for Rural development (SORD) The details of the research requirement shall be discussed with you on the date of arrival.

It should be noted again that we would love to get the feedback and be presented to us of any findings be it compliments or weaknesses if any.

Thanking ahead

[redacted]

GS Mpontshane Mr

Centre Manager

ANNEXURE 11: NGO 2 GATE KEEPER LETTER

ALCOHOL AND DRUG
HELP CENTRE
PO BOX 1709
NONGOMA
3950
Tel/Fax: (035) 831-0677
Email: sancangoma@lantic.net
PB0:930052264

NONGOMA
SANCA

IKLINIKI LOKUSIZA ISIFO
SOPHUZO NE-ZI-DAKAMIZWA
PO BOX 1709
NONGOMA
3950
Ucingo/fax: (035) 831-0677
Email: sancangoma@lantic
PB0:930052264

18 August 2017

Attention: Mr DM Mpanza

PhD Student Public Health

University of KwaZulu-Natal

RE: Permission to conduct research at SANCA Nongoma and its satellite offices for a study titled: An integrated model of aftercare for substance use disorder clients in KwaZulu-Natal.

Dear Mr Mpanza

I have pleasure to inform you that SANCA Nongoma Management Board has given you permission to conduct a study titled: an integrated model of aftercare for substance use disorder clients in KwaZulu-Natal, with ethics reference BE274/17. You are requested to share the findings of the study with SANCA Nongoma participants upon completion. Please inform the Centre in advance before your proposed schedule visit for data collection.

We are happy that you decided to conduct your said study in the deep rural areas of Nongoma and Jozini. We will endeavour to assist and cooperate with you where possible.

Should you require any further information please contact us as per our telephone number and address shown above. We look forward to meeting with you in the near future.

Yours truly

[redacted]

Dr. SV Mathe (PhD)

DIRECTOR

ANNEXURE 12: INTERVIEW GUIDE FOR INPATIENT TREATMENT CENTRE

Semi-structured interview questions for inpatient treatment facility service providers

Semi-structured interview with service providers in the inpatient treatment facility. The se service providers are at the core of the initiation and preparation of aftercare. The content of this stage will be influenced by the findings from phase one policy analysis. This interview will partly meet objective 2, 3, 4, 5 and 6:

Interview: B*road questions will be followed by probes*

Objective 4: To explore barriers and enablers of SUD aftercare at district level in rural areas.

1. Please share your experience/s in preparing (initiation of aftercare during admission) your clients for aftercare.
   Follow up:
   - Is there anything/information you give to your clients for aftercare purposes?
   - What is your experience in interacting with the family and referral agents during initiation of aftercare?

   Probes:
2. What challenges (barriers) have you experienced in preparing your clients for aftercare?
   Follow up: communication with referral agents and family.
   Probes:
3. What helps/assist you (enablers) to prepare your clients for aftercare?
   Follow up:
   Probes:
4. What relapse prevention service do you provide? What are the challenges or enablers thereof?
5. May you describe your experience in interacting with the families during their loved ones admission.
   Follow up: How has the family been involved in the treatment planning especial aftercare and reintegration plan? Are there any challenges or enablers.
   Probes:

Objective 3: To describe SUD aftercare implemented at a district level.

6. As far as you know, what aftercare programmes are implemented at a district of UMkhanyakude?
   Follow up: Which aftercare programmes do your clients go through after you have discharged them.
   What aftercare programmes are expected to be provided?
   Probes:
7. From your knowledge, what aftercare programmes your previous clients received thus far?
   Follow up:
   Probes
8. Who provides aftercare at the UMkhanyakude District?
   Follow up: which service provider/sare involved?

Objective 5: To describe monitoring and evaluation strategies of SUD aftercare services

9. How do you monitor and evaluate your aftercare preparation of aftercare?
   Follow up: Do you have guidelines on how to monitor your preparation of aftercare?
   Probes:

Objective 2: To describe SUD aftercare policies in use at a district level in KwaZulu-Natal.

10. What policies/documents govern your initiation and preparation of aftercare services
    Probes:
    - Do you know your role as described by the national norms and standards?

Objective 6: To propose a district level model of aftercare for SUD clients.

11. **What would you recommend** should b**e included in a model of aftercare for SUD clients?**
    Follow up: What do you think is needed for our aftercare programme to be effective?
    Probes**:**

ANNEXURE 13: INTERVIEW GUIDE FOR SERVICE PROVIDERS

Semi-Structured Interview Questions for District Service Providers

This interview aims to meet objective 2, 3, 4, 5 and 6. These service providers are at the initiation, maintenance and retention of aftercare. The content of this stage will be influenced by the findings of phase one policy analysis

Interview: *broad questions will be followed by probes*

Objective 4: To explore barriers and enablers of SUD aftercare services at the district level in ruarla areas

1. you please share your experience/s in providing aftercare?
   Probes:
2. What challenges (barriers) have you experienced in providing aftercare?
   Probes:
3. What helps/assist you (enablers) to provide aftercare?
   Probes:

Objective 3: To describe SUD aftercare programmes implemented at a district level.

4. What aftercare programmes do you follow when providing aftercare?
   Probes:
5. you share your experience in implementing this aftercare programme?
   Probes:
6. What helps/assist (enablers) you to provide this programme?
   Probes:
7. What challenges/barriers do you face in providing this programme?
   Probes:

Objective 5: To describe monitoring and evaluation strategies of SUD aftercare services

8. How do you monitor and evaluate your aftercare services?

   Probes:

9. What do you do to initiate aftercare for your clients?

   Probes: what do you do during referral to ensure aftercare upon discharge?

10. What guidelines do you follow in monitoring and evaluating aftercare?

    Probes:

Objective 2: To describe SUD aftercare policies in use at a district level in KwaZulu-Natal.

11. What policies do you use or follow in providing aftercare?

    Probes:

12. What policies do you know guiding aftercare services?

    Probes:

13. What can you recommend for policies that guide aftercare services?

Objective 6: To propose a district level model of aftercare for SUD clients.

12. What would you recommend to be included in a model of aftercare for SUD clients?
    Follow up: What do you think is needed for our aftercare programme to be effective?
    Probes:

ANNEXURE 14: INTERVIEW GUIDE FOR SERVICE USERS – PERSONS WITH SUBSTANCE USE DISORDERS

Warm-Up interview:

The researcher and participant together will plan the journey they will undertake on the walking interview. They will identify the sites of interest to be explored, then draw up the itinerary. Given the rural context, this journey might take two days or more, depending on the areas identified.

Walking interview:

The participant will lead the researcher to the sites of interest for their aftercare services. This will be an informal interview driven by a participant (docent). The researcher will ask questions in relation to the sites of interest identified by the participants and also take photographs during the interview. This process is flexible and directed by a participant.

Wind-Down interview:

The participant and researcher will sit down for a discussion, which will be guided by the photographs taken and the interview script.

Objective 4: To explore barriers and enablers of SUD aftercare services at the district level in ruarla areas

1. Could you please share your experiences in aftercare services since discharge?
   Probes:
2. What challenges have you experienced in the aftercare services?
   Probes:
3. What assists/enables/makes it easy for you to participate in aftercare?
   Probes:

Objective 3: To describe SUD aftercare programmes implemented at a district level.

4. What type of aftercare have you received thus far?
   : how often?
5. What was done for you to attend aftercare when discharged at the inpatient facility?

Probes: what information for aftercare services in your area were you provided with upon discharge?

How long has it been since you left the rehab centre?

ANNEXURE 15: INTERVIEW GUIDE FOR SERVICE USERS – FAMILY MEMBER OF A PERSON WITH SUBSTANCE USE DISORDER

Objective 4: To explore barriers and enablers of SUD aftercare services at the district level in ruarla areas

1. Could you please share your experience in aftercare services since discharge?
   Probes:
2. What challenges have you experienced in aftercare services?
   Probes:
3. What assists/enables/makes it easy for you to participate in aftercare?
   Probes:

Objective 3: To describe SUD aftercare programmes implemented at a district level.

4. What type of aftercare have you received thus far?
   Probes: how often?
5. How were you assisted in attending aftercare when you were discharged from the inpatient facility?
   Probes: what information for aftercare services in your area were you provided with upon discharge?

   How long has it been since you left the rehab centre?

ANNEXURE 16: TABLE FOR PHASES OF IRMMC

More Details for the Infographic Representation of Phases of IRMMC

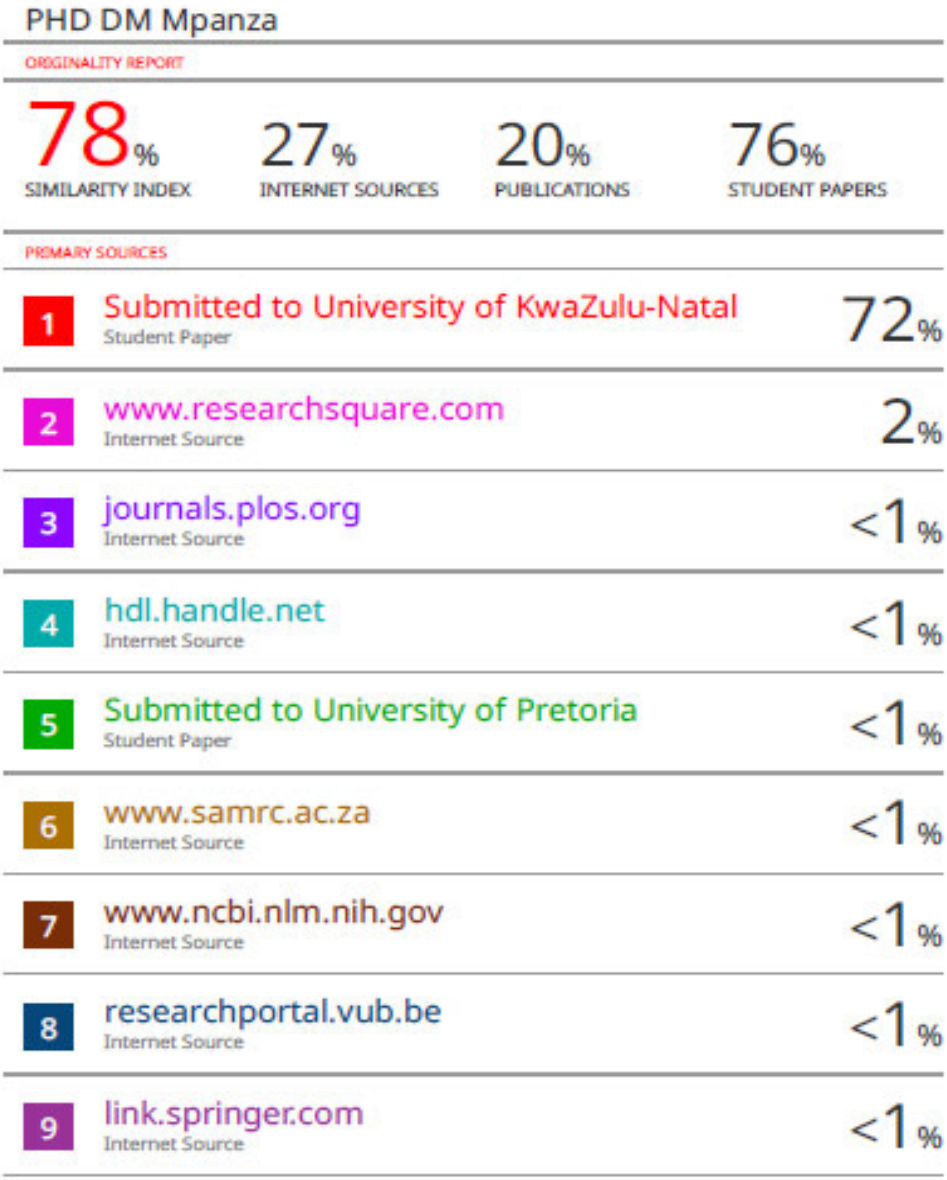
	Phases of the Integrated Recovery Management Model Care (IRMMC)		
Items	**Recovery Management Preparation Phase**	**Recovery Management Transition Phase**	**Recovery Management Maintenance Phase**
Description	Commences during admission at an ITC focusing on preparing the service user for recovery management services.	Commences immediately after discharge, focusing on facilitating reintegration and transitioning from ITC to the community.	Commences immediately after the transition phase has ended. Focuses on maintaining lifelong recovery.
Goal	To prepare for the transition and reintegration of the service user whilst at the ITC. Reconnect and strengthen communication between the service users and service providers within their community.	To assist the service user to transition from ITC and reintegrate into the community, school, workplace and family.	To maintain intervention gains and sustain recovery despite lapse or relapse.
Key activities	Case manager, referral agent and ITC SPs, in consultation with family and service user, identify IRM SPs and community support services. (video call meeting) The case manager supervises the preparation of the family for discharge. Community-based SPs to provide family counselling to address any previous acrimony and conflict with the SUD. ITC SPs facilitate family and service user interaction to strengthen family support, e.g., service users may be given a chance to apologise for any wrongs they may have committed previously	School/work reintegration session Skills development placement when necessary. Job placement if unemployed. Continuous family counselling and education, including home visits. Family and community reconstruction interventions, e.g., provide an opportunity to apologise. Link the service user with appropriate community support services such as self-help support groups and faith-based support. Community-based SPs assist in relapse prevention by restructuring a daily routine, encourage occupational engagement and facilitate access to withdrawal medication. Continuous Individual Counselling sessions.	Follow-up sessions bi-annually or when needed by the user. Service providers are available when needed, including the use of technology. Relapse prevention Continue with support groups .

	Case manager to oversee the preparation for return to the workplace or school for reintegration of service user. Meet and greet meeting with service user, IRM service providers and family to prepare for discharge. Develop an individualised IRM plan with indicators in collaboration with the referral agent, service user, family member, aftercare service provider, and case manager at the community level. Develop individualised recovery indicators for monitoring and evaluation. ITC develops the discharge summary with the IRM plan.	Relapse management and prevention programme. Evaluate indicators to move the service user to the next phase.	
Outcomes	An informed service user who has established communication channels with all the support structures within the community. A prepared SUD to initiate contact with the family who is expecting to receive them. An established communication system with previous workplace or employer A prepared SUD to establish contact with those they previously were in conflict with and to commence resolution efforts. Case Manager at the identified ward (community) level, and contact initiated. Significant family members or caregivers identified and involved in treatment intervention.	A self-reliant service user that is well integrated into the community, workplace/school and family. A contributing member of the society economically and socially.	A self-reliant service user who is able to maintain recovery and manage lapse and relapse/s. Ultimately, a service user that is well integrated into the community, workplace/school and family. A contributing member of the society economically and socially, although may experience relapse, is able to manage and seek assistance from a service provider when necessary.

Integration and Collaboration areas	Case Manager at the community level to be identified and facilitate collaboration. Stakeholder meetings to prepare for discharge and aftercare.	Case Manager at the community level (ward) to facilitate collaboration and integration. Operation *Sukuma Sakhe* and war room meetings to discuss cases with other stakeholder/s. Clinic Card to record progress and serves as a means to communicate with other stakeholders.	Case Manager at the community level to facilitate collaboration and integration.
Monitoring and Evaluation	Common Indicators Contact with family, work/school and society initiated. IRM Service Provider/s identified and consented. Family counselling was initiated to prepare them to receive and support the service user. Monitoring and Evaluation: The Case Manager is responsible for all monitoring and evaluation. Number of family reconstruction services provided. Evaluate the impact thereof. Work/school intervention/preparation session/s conducted. Number of meetings between case manager, referral agents, family and ITC service providers.	Common Indicators Fully integrated service user to family, work/school and society. IRM Service Provider/s ready to render the service Family ready to receive and support the service user. Relapse and lapse managed Service user initiates re-entry into the treatment/intervention system. Monitoring and Evaluation: Case Manager responsible for monitoring and evaluation. Number of service users connected to IRM service providers Number of family reconstruction services provided. Evaluate the impact thereof. Work/school intervention/preparation session conducted. Work placements conducted Report to the ITC. Number of relapsed persons with SUDs	Common Indicators Recovery sustained Relapse and lapse managed Service user initiates re-entry into the treatment/intervention system. Monitoring and Evaluation: Case Manager responsible for monitoring and evaluation. Number of follow-up sessions Measure recovery gains maintained Evaluate relapse prevention and management strategies. Number of relapsed persons with SUDs
Key role-players	Case manager, referral agent, family member and service user to identify relevant service providers and review them from time to time, especially as the users go through the phases.		

ANNEXURE 17: TURNIT IN REPORT THESIS

Similarity index of 78% of which 72% is student paper's (this PhD) first submission to Turnit in-UKZN. This could not be changed.



PHD DM Mpanza

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