REHABILITATED SUBSTANCE ABUSERS' EXPERIENCE OF AFTERCARE
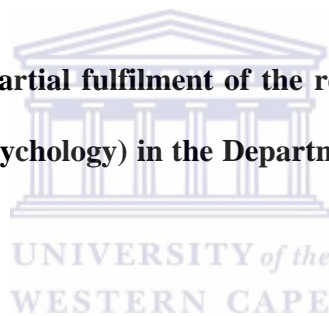
FOLLOWING COMPLETION OF INPATIENT TREATMENT

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A mini-thesis submitted in partial fulfilment of the requirements for the degree of Magister Artium (Clinical Psychology) in the Department of Psychology, University of the Western Cape

UNIVERSITY *of the* WESTERN CAPE

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ABSTRACT

Substance abuse is a public health concern in South Africa, and Western Cape Province in particular has been identified as having alarming rates of substance abuse. Substance abuse is the cause of some of the most pervasive and costly problems in society. Substance abuse is associated with various social problems such as crime, violence, unemployment, poverty, risky sexual behaviours, the escalation of chronic diseases such as AIDS and TB, and dysfunctional family life – and these problems are often interlinked. Furthermore, substance disorders place a huge strain on the health and welfare system of South Africa. In- and outpatient treatment facilities exist in communities to assist with alleviating the problem of substance abuse. Aftercare facilities are a form of outpatient service for substance abusers who have completed inpatient treatment. The primary aim of aftercare is to assist recovered substance abusers to maintain treatment gains by abstaining from substance use and to facilitate their reintegration with their families and communities. The purpose of the present study was to explore and obtain an in-depth understanding of the experiences of rehabilitated substance abusers in aftercare, following their completion of inpatient treatment. The sampling method for the study was purposive, and the sample consisted of two female and six male participants. Participants' attendance at the aftercare programme was verified with the aftercare co-ordinator. Semi-structured interviews were conducted and data were analysed using interpretative phenomenological analysis. Results of the study found that, overall, participants had a positive experience of aftercare. Furthermore, results indicated that aftercare played a vital role in assisting participants to maintain treatment gains.

KEYWORDS:

Substance abuse; rehabilitated; aftercare; inpatient treatment; experience; Western Cape;

qualitative research; interpretative phenomenological analysis

DECLARATION

I declare that 'Rehabilitated substance abusers' experience of aftercare following completion of inpatient treatment' is my own work. It has not been submitted before for any degree or examination to any other university, and all the sources I have used or quoted have been indicated and acknowledged as complete references.

STACEY CHANTAL ELIAS   September 2016

Signed: ....

ACKNOWLEDGEMENTS

I acknowledge God for the opportunity that He has graced me with to pursue a Master's Degree in Psychology and for the necessary perseverance and determination.

I thank my closest family members and closest friends who have continually motivated, supported and encouraged me. I especially remember my encouraging mother who passed away in December 2015. My 8 month old daughter Leah, you are my inspiration.

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I thank the participants and the staff at the government-funded treatment facility for gladly participating in my research study and for their assistance.

DEDICATION

I dedicate my thesis to all those who are fighting the plague of substance abuse in South Africa.

And to all those who have recovered from the illness and to those who are still struggling to overcome the illness.

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CHAPTER ONE

INTRODUCTION

1.1. Background of substance abuse

South Africa is a developing country characterised by many social problems such as high rates of unemployment, crime and lack of adequate healthcare resources (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). Substance abuse has been identified as a growing problem in South Africa (Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010). Furthermore, slightly more than 13% of the South African population have used a substance during their lifetime (Peltzer et al., 2010). According to Butcher, Mineka and Hooley (2007), substance abuse involves the regular use of mind- and mood-altering substances by an individual which results in hazardous behaviours and, that despite negative consequences, the individual continues with the persistent use of the substance.

Alcohol and drug abuse was highlighted by former President Nelson Mandela in his opening address to Parliament in 1994, as a problem among the social pathologies that needed attention (Ramlagan, Peltzer & Matseke, 2010). Chopra and Saunders (2004) stated that, with South Africa's integration into the global economy, it was stripped of the many protective trade barriers that once protected it. Furthermore, Ramlagan et al. (2010) documented that South Africa experienced changes in the illicit drug trafficking market after 1994 as a result of the political and social transformations that occurred. Consequently, as a result of a rapidly changing social and economic climate, coupled with increased availability of drugs and the demand for them, the national drug abuse problem has increased. Distressingly, results from a study conducted by Ramlagan et al.

(2010) found South Africa to be the largest market for illicit drug use in Sub-Saharan Africa.

In South Africa, Western Cape Province has been identified as having an alarming rate of substance abuse (Strebel, Shefer, Stacey & Shabalala, 2013). This finding is supported by data obtained from the South African Community Epidemiology Network on Drug Use (SACENDU) (Plüddemann, Parry, Bhana, Dada, & Fourie, 2010). In a report from SACENDU which includes data on treatment admissions from 8217 patients seen across 61 centres/programmes in the second half of 2009, results indicated that substance abuse in Western Cape Province was escalating. Furthermore, results of the South African Stress and Health Study (SASH) found that Western Cape Province had a prevalence rate of substance abuse and dependence of 18.5%, in comparison with the national average of 13.3% (Burnhams, Dada & Myers, 2012).

To assist in addressing and alleviating the problem of substance abuse within the Western Cape, various treatment services exist in the community. Such services include inpatient and outpatient rehabilitation centres, aftercare groups, support groups and other community organisations that assist in the prevention and reduction of substance abuse. Individuals admitted to inpatient substance abuse facilities receive treatment and rehabilitation as well as skills development (Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008). One aspect of the services offered by inpatient treatment facilities is aftercare. Aftercare and reintegration services are aimed at the successful reintegration of a service user into society, the workforce, family and community life (Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008). Aftercare is an

outpatient service for substance abusers who have completed their inpatient treatment programme. Essentially, aftercare services should allow service users to interact with other service users, their families and communities; allow service users to share long-term sobriety experiences; promote group cohesion among service users; enable service users to abstain from substance abuse; and that aftercare groups must focus on the successful reintegration of a service user into society, family and community life and prevent the recurrence of problems in the family environment for the service user that may contribute to substance abuse (Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008).

Substance abuse has indeed been identified as a significant public health concern within Western Cape Province (Burnhams et al., 2012). Although various treatment facilities exist in communities, relapse among recovering abusers is still concerning. Rehabilitated substance abusers often return to the same communities where their initial drug use started, which increases their vulnerability to relapsing (Chetty, 2011). In South Africa, both legal and illegal drugs are readily available to people at the broader societal and specific community levels (Morojole, Parry & Brooke, 2009). Consequently, opportunities for relapse in South Africa are great as a result of the availability of legal and illegal drugs. Based on data obtained from SACENDU, relapse rates for cannabis use in 2009 were 50%, while patients with alcohol abuse problems had a relapse rate of 33%, and those using cocaine and heroin relapsed in 65% of cases.

1.2. Rationale

In the Western Cape, various treatment services are offered (Myers et al., 2008 cited in Isobell, 2013). Aftercare services should assist rehabilitated substance users to maintain their treatment gains and to prevent relapse. This aim is supported by Weich (2008), who identified that there was a need for external resources such as Narcotics Anonymous to support substance users in maintaining their treatment gains and preventing relapse. Transitioning from an often safe, protected and structured environment such as a treatment facility to the community can be challenging for rehabilitated substance abusers (Chetty, 2011). Aftercare services therefore aim to support the rehabilitated substance user and are meant to assist with easing this transition process. This aim is supported by Van der Westhuizen (2007) who documented that social support such as self-help groups play a vital role in assisting individuals with recovery.

Most research that has been studied by the researcher on substance abuse and treatment focuses on evaluating the effectiveness of treatment programmes and identifies the predictors for treatment completion. Very few studies could be located that focus on aftercare services in South Africa as well as the rehabilitated substance abusers' experience of such service programmes. The Western Cape Drug Forum (2005) also identified the need for the development of aftercare services in 2005, thus indicating the lack of focus on aftercare. Hence there is limited research that facilitates an understanding of rehabilitated substance abusers' experience of aftercare. The present study therefore aimed to explore and obtain an in-depth understanding of rehabilitated substance abusers'

experience of aftercare after completion of an eight-week in-patient programme at a government-funded treatment facility in the Western Cape.

1.3. Aim of the study

The aim of the study was to obtain an in-depth understanding of rehabilitated substance abusers' experience of aftercare.

1.4. Objectives of the study

- To explore participants' experience of aftercare.
- To identify features of aftercare that rehabilitated substance abusers perceived to be beneficial in assisting them to maintain treatment gains.
- To identify features of aftercare that participants experienced as least helpful.
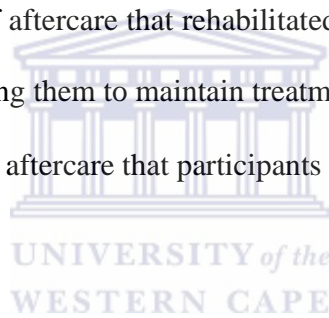
CHAPTER TWO

LITERATURE REVIEW

2. Introduction

The literature review aims to contextualise the study by providing literature on the problem of substance abuse in the country and the significance of aftercare facilities.

2.1. Substance abuse as a significant public health concern in South Africa

South Africa has been identified as having a major problem with substance abuse. The problem of substance abuse not only affects the abuser, but its ripple effects also extend to family members, communities, local businesses, and private and government resources (Prevention of alcohol and other drug use policy, 2013). South Africa has experienced an increase in drug trafficking and the use of heroin, cocaine and amphetamine-type stimulants since 1994 (Parry & Pithey, 2006; Pluddemann, Myers, & Parry, 2008). The country`s lax border controls and weak criminal justice system, among other factors, have been identified as making it a desirable location for the shipment of drugs (Parry & Pithey, 2006; Pluddemann, Myers, & Parry, 2008). Prevalence rates for substance abuse in South Africa have been found to be double the world average, with the socio-economic consequences of such usage costing the country an estimated R130 billion per annum (Central Drug Authority, 2012).

South Africa has also been identified as being one of the countries in which methamphetamine use is more prevalent (Degenhardt, et al., 2009). Adam, Myers, and Pasche (2010) have documented that substance-related problems have increased in South

Africa, with the lifetime prevalence rate for substance use disorders estimated to be around 13%. Myers et al., (2014) have documented that there is a high prevalence of substance use disorders in South Africa, with approximately 6% of the adult population meeting DSM-IV diagnostic criteria for a substance use disorder during 2013-2014.

According to Morojele, Parry, Brook, and Kekwaletswe (nd) substance abuse is a major problem among young people in many communities in South Africa, with structural factors such as poverty and unemployment making substance abuse particularly devastating and difficult to solve in poorer and marginalised communities. A recent study on methamphetamine use among high school students in Cape Town, South Africa, found a lifetime prevalence of methamphetamine use of 9%, which is higher than the lifetime prevalence in the USA (Pluddemann, Flisher, Mcketin, Parry, & Lombard, 2010).

The country`s alarming rate of substance abuse evidently has detrimental effects on the nation's health and economy. Substance abuse continues to ravage communities and families and goes hand in hand with poverty, reduced productivity, unemployment, dysfunctional family life, escalation of chronic diseases and premature death (Fellingham, Dhai, Guidozzi, & Gardner, 2012) Various studies have also reported on the association between substance abuse and risky sexual behaviour and the human immunodeficiency virus (HIV) (Degenhardt et al., 2010; Peltzer et al., 2010). Wechsberg et al. (2014) have reported in an article that substance abuse, especially among South African women, is linked to risky sexual behaviours, including inconsistent condom use, numerous casual partners and transactional sex.

Substance abuse is also strongly associated with violence in the South African context (Seeking & Thaler, 2011), which in turn increases the burden on trauma units, policing needs, and private and public organisations (Prevention of alcohol and other drug use policy, 2013). Thus there is an overwhelming amount of pressure on the health system of the country (AOD Prevention Policy, 2013). Furthermore, substance abuse treatment services are limited in South Africa, and existing services are overwhelmed by the demand for treatment (Fourie, Myers, Sorsdahl, Stein & Weich, 2012). Increase in the use of substances has inevitably resulted in increased need for treatment services, which in effect costs the City of Cape Town millions of Rands to offer treatment services (Prevention of alcohol and other drug use policy) (City of Cape Town, 2013). Based on the above literature, it is evident that substance abuse is a growing phenomenon within South Africa and affects people of all genders, ages and cultural backgrounds. It also has detrimental effects on the economy of the country. The following chapter explores substance abuse in the Western Cape specifically, given that the research study was conducted within the Western Cape.

2.2. Substance use in the Western Cape

Substance-related problems are particularly prevalent in Cape Town, the capital of the Western Cape Province, as compared with other parts of the country (Adams et al., 2010).The first South African Stress and Health Study (SASH), which was a nationally representative study, found that Western Cape Province had a significantly higher lifetime prevalence rate for substance abuse and dependence (18.5%) than the national average of 13.3% (Stein et al., 2008 cited in Burnham et al., 2012). According to Fourie et al. (2012),

the SASH also indicated an earlier onset (21 years) of substance-related disorders within the Western Cape.

Findings from epidemiological studies indicate that alcohol, cannabis, heroin and cocaine rank amongst the most common primary substances of abuse among patients presenting at specialist treatment centres in South Africa, with the abuse of methamphetamine ('tik') being particularly high amongst adolescents in the Western Cape (Plüddermann, et al., 2010). Historically, alcohol and dagga have been the substances abused most frequently in the Western Cape; however, a dramatic increase in the abuse of heroin (9% – 11%) and methamphetamine (tik) (42%) has been noted (Plüddemann et al., 2010). Treatment data from SACENDU have indicated that, compared with other provinces, use of methamphetamine as a primary drug of abuse is highest in the Western Cape, and it is regarded as a more dangerous drug, making the users prone to increased violence (Modernisation Progamme, 2010).

Research findings have indicated that the Western Cape has one of the highest rates of fetal alcohol spectrum disorders (FASD) in the world, with 75 out of every 1000 children being affected (Bell, 2009 cited in Modernisation Progamme, 2010). Data obtained from the National Survey on Drug Use and Health in 2007 showed that 8.3 million children live with at least one parent who had abused or who was dependent on either alcohol or an illicit drug during the previous year. Furthermore, substance abuse has also been found to be associated with neonatal mortality (Tzilos, Hess, Kao & Zlotnick, 2013).

Binge drinking amongst the youth, especially male, is high in many communities, and rural areas appear to have higher rates of binge drinking than urban areas (Modernisation

Progamme, 2010). Alcohol appears to be more socially accepted within communities but, when alcohol is coupled with dysfunctional relationships, it plays a major role in facilitating crime in the province (Modernisation Progamme, 2010).

In terms of crime, South African Police Services (SAPS) statistics show that the Western Cape has the highest rate of drug-related crime in South Africa (52 000 cases in the 2008/2009 financial year) (Modernisation Progamme, 2010). As documented in the Modernisation Progamme (2010) the Western Cape accounted for almost half of all South Africa's drug-related crime on SAPS records i.e. 52 000 out of 117 000 in 2008/2009. Furthermore, research findings have indicated that 9.1 % of child sexual offences cases in the Western Cape involved an offender under the influence of alcohol, and that 67 % of domestic violence in the Western Cape was alcohol related .

Based on the above literature, it is evident that substance abuse is a particularly concerning issue within the Western Cape, with the province having the highest rates of substance abuse compared with the other provinces of South Africa. Although South Africa is still under-resourced in terms of the availability of treatment facilities, there still remains a variety of services available for those with substance-related problems. Various studies have, however, indicated that although substance users complete their treatment programme, relapse is still of great concern in the country. The following chapter explores the problem of relapse amongst recovering substance abusers.

2.3. Relapse

Several definitions of relapse exist but, for the purpose of the present study, relapse refers to the resumption of substances or behaviours associated with drugs after receiving

substance abuse treatment. Various theories on substance abuse suggest that individuals possess a hereditary predisposition to the disease of substance dependence, which is referred to as a 'disease concept' (Johnson, 2003). Inherent to the disease concept is the acknowledgement that substance dependence is a disease of relapse (Chetty, 2011). According to Marlatt, Parks and Witkiewitz (2002) as cited in Chetty (2011), individuals wanting to change health–related behaviours will experience setbacks or lapses that will sometimes worsen and become relapses. This is supported by Perkinson (2004) cited in Chetty (2011) who states that alcoholism is a chronic relapsing brain disease. Accordingly, the possibility for recovering substance users to return to drugs is concerning.

Studies conducted in the USA estimate that between two-thirds and four-fifths of both adults and adolescents begin use again in the six months after an episode of community- or hospital-based drug or alcohol treatment (Hunt, Barnett, & Branch, 1971 cited in Ramo & Brown, 2008).

Based on data obtained by SACENDU, in 2009 there was a 23% repeat of admissions of substance abusers to treatment facilities in South Africa. The report further documented that relapse rates for cannabis were 50%, for alcohol 33% and, among those using cocaine and heroin, relapse in 65% of cases.As substance abuse already affects the economy of the country, having patients return to treatment who have relapsed places further demands on the country's resources. This fact is supported by findings which were documented In the City of Cape Town Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014 (CoCT AOD) (2011). Reports documented that, owing to high relapse rates and repeat admissions of 2 - 3 admissions, the City of Cape Town spent up to R100 000 for

inpatient treatment in individual cases instead of the estimated R25 000 per patient for a 6-week admission. Alarmingly, the report indicated a relapse rate of 60% for inpatient rehabilitation.

2.4. Determinants for relapse

The reasons for relapse amongst recovering substance abusers are plentiful. In a study by Pasche (2009), factors such as conflict within the family environment and association with peers who used substances were found to have contributed to the reasons for relapse amongst adolescents. A study by Van der Westhuizen (2007) examined adolescents' perceptions of the reasons why they relapsed after having received free-of-charge inpatient treatment. Results from the study indicated that factors such as parental support, peer pressure, negative feelings, reasoning abilities, life skills deficits, physiological factors and the substance users' social context were strongly associated with relapse.
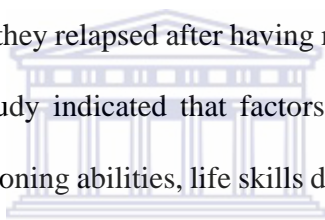
Golestan, Abdullah, Ahmed and Anjomshoa (2010) conducted a study which explored the significance of family factors on drug use and its effects on relapse amongst male adolescent opiate users in Iran. Their study comprised 226 adolescents between the ages of 13 and 20 who were selected from 10 rehabilitation centres. The participants answered self-administered questionnaires which included factors such as parental substance use, family conflict and family structure in relation to their drug use and relapse. Results from the study highlighted important relationships between these factors and relapse in adolescents. Adolescents who had negative family environments (e.g., high parental substance use, high level of family conflict and family structure) were found to be placed in relapse situations again.
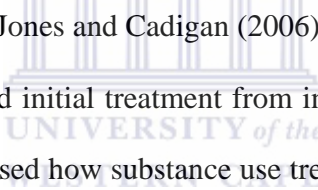
Chetty (2011) conducted a study where he examined the causes of relapse post treatment for substance dependency within the SAPS. The majority of participants in his study attributed their main cause for relapse to intrapersonal determinants; for example, experiencing feelings of anger, frustration and anxiety. Exposure to peer pressure and boredom was also identified as a cause for their relapse. Furthermore, participants reported that temptation, urges and cravings as well as being in the presence of people consuming alcohol were too difficult to resist.

2.5. The need for aftercare

Various studies have found that the utilisation of outpatient mental health aftercare, following episodes of acute inpatient substance abuse treatment, results in better outcomes (Walker, Donovan, Kivlahan, & O'Leary, 1983 as cited in Schmitt, Phibbs, & Piette, 2003). Active involvement in aftercare is also associated with reduced readmission rates (Peterson, Swindle, Phibbs, Recine, & Moos, 1994 as cited in Schmitt et al., 2003). The literature below further makes reference to the importance and need for aftercare.

Lo Sasso, Byro, Jason, Ferrari, and Olson (2010) examined the benefits and costs associated with mutual-help community-based recovery homes. Although such a recovery home is not identical to traditional outpatient aftercare programmes, there are similarities in the nature of the services provided and support offered. The results of their study showed that costs for treatment and care received were incrementally high but that the benefits in terms of reduced illegal activity, incarceration and substance use substantially outweighed the costs (Lo Sasso, et al., 2010).

In a longitudinal study using a sample of participants, Jason, Davis, and Ferrari (2007) explored the need for substance abuse aftercare. Information on abstinence, social support, self-efficacy, employment, criminal history and medical care utilisation was gathered from a sample of 604 men and 293 women. Their results indicated that receiving abstinence support, guidance and information from recovery home members committed to the goal of long-term sobriety, might enhance residents' abstinence self-efficacy as well as reduce the probability of a relapse (Jason, et al., 2007). Based on the findings from both studies, it can be deduced that a positive relationship exists between receiving post-treatment care among recovering addicts and the impact it has on maintaining sobriety and in turn reducing the probability of relapse.

In a review article by Pelissier, Jones and Cadigan (2006) on the literature on aftercare for criminal offenders who received initial treatment from in-prison substance use treatment programmes, the authors discussed how substance use treatment, patterns of drug use and responses to them, which occur after release from the federal prison system, highlight the difficulties of assessing the effectiveness of aftercare services. Their findings after reviewing various articles highlighted that the certainty about aftercare effectiveness was not well substantiated or well understood. They also argued that research on aftercare focused upon differences between treated and non-treated groups, without a comprehensive description of the aftercare treatment and its rationale and relationship to in-prison treatment (Pelissier, et al., 2006). As their article highlights the limitations in research regarding aftercare and specifically the effectiveness of aftercare services, this gap in the literature can be bridged by gaining information on patients' experiences of aftercare in their reintegration.

Although the literature provides valuable information that highlights the importance and impact of treatment for substance abusers following inpatient care, it has been conducted internationally and therefore the results cannot directly be applied to the diverse South African context. Furthermore, the focus on reintegration as well as post-treatment care is focused on that of ex-prisoners who are in programmes post release from prison to maintain their sobriety from substance abuse.

2.6. Theoretical framework

2.6.1. Interpretive phenomenological analysis

According to Pietkiewicz and Smith (2014), the primary goal of interpretive phenomenological analysis (IPA) is to investigate how individuals make sense of their lived experiences. Within this theoretical framework, people are assumed to be self-interpreting beings (Taylor, 1985 cited in Pietkiewicz & Smith, 2014), implying that they are actively engaged in interpreting the events, objects as well as people in their lives (Pietkiewicz & Smith, 2014). As stated by Schwandt 1994 cited in Andrade 2009, IPA provides a deep insight into the complex world of the lived experiences from the point of view of those who live them. The researcher's role in IPA is critical as they attempt to gain a more thorough understanding of the subject's experiences. The researcher further attempts to make meaning of the subject's experiences through a process of analysis. The researcher thus plays an active role in the process by means of analysis and interpretation. Interpretive research assumes that reality is socially constructed, and the researcher becomes the vehicle by which this reality is revealed (Walsham, 1995a, 1995b cited in Andrade, 2009). The analytical process in IPA is described in terms of double

hermeneutic or dual interpretation process (Pietkiewicz and Smith, 2014). Essentially, the subject firstly makes meaning of their lived experiences, and secondly the researcher attempts to decode that meaning so as to make sense of the participants' meaning making.

In conclusion, based on the fundamental principles of IPA, it is an appropriate and useful framework for the present study. It allowed participants to provide their accounts of their lived experiences through their own subjective lenses. The researcher gained insight into the rich and complex experiences of the participants' worlds. It further allowed the researcher to identify collective themes amongst the participants' narratives; and finally it allowed the researcher to make interpretations of participants' experiences. More specifically, the researcher attempted to make sense of the participants' accounts who were trying to make sense of their own lived experiences. According to Pietkiewicz and Smith (2014), there is no such thing as an uninterpreted phenomenon.
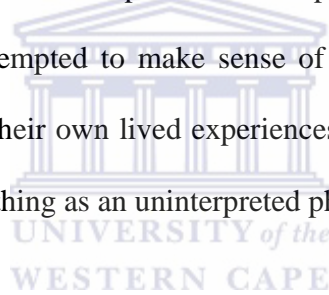
CHAPTER THREE

METHODOLOGY

3.1. Introduction

The methodological background of the study is elaborated upon in this chapter. It includes a description of the research design, participants, data collection and analyses, reliability and validity, the procedure employed and lastly the ethical considerations are discussed.

3.2. Research design

This study adopted a qualitative approach which drew on the interpretive paradigm. According to de la Rey and Pretorius (2004), the main aim of a qualitative study is to explain the ways whereby people come to understand and account for issues, events and behaviours in their lives. Furthermore, qualitative studies are concerned with the manner in which individuals 'make sense' of their worlds and realities and how they perceive these (Willig, 2001).

This study used an interpretive phenomenological research design. IPA explores in detail how participants make sense of their personal and social world (Smith & Osborn, 2007). Furthermore, it is concerned with the meanings that particular experiences, events and states hold for participants (Smith & Osborn, 2008). It explores the participants' subjective accounts of their experiences as opposed to providing an objective account or statement. IPA also involves a double hermeneutic which is a two-stage interpretation process. This approach refers to participants trying to make sense of their world and the

researcher trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2008; Pietkiewicz & Smith, 2014).

The IPA approach was particularly relevant to the present study as it allowed the researcher to capture and explore the personal lived experiences of the participants. Furthermore the research design allowed the researcher to take an active role in interpreting participants' interpretations of their accounts of their experiences.

3.3. Research setting

The study was conducted in Cape Town, Western Cape Province. The setting was a registered, non-profit, government-subsidised, inpatient treatment facility. The patient population comprised 29 men and 11 women over the age of 18 who reside on the Cape Flats and surrounding areas in the Western Cape (e.g. George). Patients are referred mainly by outpatient treatment facilities and are admitted on a voluntary basis for a period of 8 weeks followed by an outpatient service (aftercare) of 6 months. During the 8-week inpatient treatment, patients are allowed 2 weekends home in their 6th and 7th weeks of treatment. Upon returning to the treatment facility, all patients are tested for substances. Patients undergo a therapeutic programme by a multi-disciplinary team of mental health workers consisting of psychologists, psychiatrists, registered counsellors, occupational therapists, social workers and registered nurses. Some of the therapeutic services offered by staff include cognitive behaviour therapy, dialectic behaviour therapy, family therapy, social skills training and physical training.

The outpatient component of the programme comprises a 6-month aftercare phase which is held on Saturday mornings at the treatment facility. The group meets for a period of 2 hours. The aftercare programme is facilitated by the aftercare programme co-ordinator who is supported by a social worker. Random drug testing occurs during the aftercare phase. The aftercare service is mostly unstructured and patients generally speak about the lowlights and highlights of their week, amongst other topics. Skills gained during treatment are also practised and discussed during aftercare.

3.4. Participants

The sample comprised 8 participants (2 female and 6 male), all more than 18 years of age. The participants had each completed an 8-week inpatient programme for substance abuse and were involved in the aftercare programme at the government-funded rehabilitation facility. Participants were purposely selected with the assistance of the aftercare programme co-ordinator. The inclusion criteria for the study included that participants were 18 years and older; must have completed their 8-week inpatient treatment; and that they were attending the aftercare programme on Saturdays between 10h00 and 12h00 at the treatment facility. Participants should have attended at least 4 aftercare sessions at the treatment facility and might also be attending other aftercare groups in the community. Pseudonyms were used to protect participants' identities.

3.5. Data collection

In-depth interviewing as a method of data collection was used for the study. Semi-structured interviews were conducted with each participant individually in a private room at the treatment facility. Semi-structured interviews were used as a guide to ensure

that certain areas of questioning were covered (Willig, 2001). Semi-structured interviews also allowed probing of interesting areas that arose, but also followed the participants' interests and concerns (Smith and Osborn, 2007), making it suitable for the present study which is concerned with participants' experiences. Apart from the guided interview questionnaire, additional questions were asked during the interview process. Interviews were recorded and transcribed verbatim by the researcher. All data collected were handled with strict confidentiality by the researcher.

3.6. Procedure

Ethical clearance was sought and obtained from the Higher Degrees Commitee of the University of the Western Cape. Thereafter, a meeting was held with the CEO of the rehabilitation facility regarding the study, and permission was obtained to conduct research at the treatment centre. The researcher was referred to the Aftercare Programme Co-ordinator to assist with further arrangements. Participants were purposively selected with the assistance of the Aftercare Programme Co-ordinator. Participants were selected on the basis of the set selection criteria and their indicated voluntary participation. The Aftercare Programme Co-ordinator provided the researcher with the full names and contact phone numbers of the participants. Participants were telephonically contacted by the researcher and suitable times were set up to meet the participants. Information sheets were distributed to the participants and the following points were explained: aims of the study; participants' rights; possible risks and benefits of the study; the voluntary nature of the study; and that suitable assistance would be provided should anyone experience harm resulting from participation in the study. Participants were then provided with consent

forms whereby they gave their written informed consent to participate in the study. Interviews were conducted over four Saturdays in one month at the rehabilitation facility in the Western Cape. Interviews were conducted before 10h00 and after 12h00, depending on availability of the participants, to ensure that they did not miss their aftercare sessions between 10h00 and 12h00 at the centre. Prior to the interviews being conducted, the researcher ensured that all necessary material was in place and that the room was private and suitable for conducting interviews. All interviews were audio-recorded and transcribed verbatim.

3.7. Data analysis

Data were analysed using IPA. This involved a two-stage analysis or a double hermeneutic, which involves participants trying to make sense of their world and the researcher trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2008). IPA combines an empathic hermeneutic with a questioning hermeneutic; thus, interpretation involves an understanding in the sense of identifying or empathising and understanding as a way of attempting to make sense of the participants' responses (Smith & Osborn, 2008). The first stage involved identifying themes within the texts and then connecting the themes which were identified. While attempting to identify themes, the researcher reads and rereads the transcript closely in order to become as familiar as possible with the account (Smith & Osborn, 2008). With thorough rereading, the researcher was able to identify themes, links and discrepancies. The second stage requires a more analytical ordering as the researcher attempts to make sense of the connections between themes which are emerging (Smith & Osborn, 2008). Themes which

start to cluster are checked in the transcript to make sure that the connections work for the primary source material, i.e. the actual words of the participant (Smith & Osborn, 2008).

3.8. Rigor: reliability and validity

For the purpose of the present study, Guba and Lincoln's four criteria for establishing the trustworthiness of qualitative data were used (Guba & Lincoln, 1985 cited in Shenton, 2004).

The first criterion was that of *credibility,* which refers to ensuring that the study measures what it was intended to. To address this consideration, the researcher met with the relevant persons at the treatment facility (i.e. the CEO and aftercare programme co-ordinator) to clearly inform them of the aim of the research and sample criterion. The researcher maintained contact with the aftercare programme co-ordinator to ensure that suitable participants were selected. Further addressing the criterion of credibility, the researcher provided detailed descriptions of the phenomenon which assisted in conveying the actual situations that were investigated. Participants' responses were entered in italic type. The researcher also maintained a reflective commentary allowing the project to be evaluated again. Pseudonyms were provided for participants.

The second criterion was *transferability*, which concerns the extent to which the findings of the study can be applied to other situations. According to Morrow (2005), it is the reader's decision whether or not the findings are transferable to another context. The researcher therefore provided detailed descriptions of the phenomenon under investigation. Providing thick descriptions allows readers to have a proper understanding of the phenomenon and enables them to compare instances of the phenomenon described

in the research report with those that they have seen emerge in their own situations (Shenton, 2004).

Dependability is concerned with whether the study will yield similar results if it were repeated, using the same methods, participants and context. To address this issue, the researcher provided a thorough methodology that can enable future researchers to repeat or conduct further research in the area.

Lastly, *confirmability* concerns the objectivity of the researcher. According to Shenton (2004), the concept of confirmability relates to research objectivity and to ensuring that the research findings are the result of the experiences and ideas of the research participants, and are not borne out of characteristics and preferences of the researcher. In addressing this factor, the researcher attempted to remain cognisant of factors such as her personal background, race and gender which might or could have influenced the interview process. Furthermore, the researcher attempted to identify and remain cognisant of her own preconceived biases which were taken into account while analysing data. The researcher maintained a reflexive journal to facilitate this process.

3.9. Reflexivity

Shaw (2010) proposes that when researcher and research subjects are both living and experiencing beings, it is necessary to reflect on how that might affect the research process. Malterud (2011) described reflexivity as an approach of looking analytically at the background of information production, mainly via the influence of the researcher throughout every stage of the research progression.

As the researcher, and one coming from a background of familial substance abuse as well as having previously worked in the area of interest, it was extremely important to become aware of and reflect on my own experiences and feelings about the research topic and subjects. Owing to my experience as a substance abuse counsellor, I initially felt that I could imagine to some extent how the participants would respond to the questions. These thoughts were largely influenced by my past experiences in working with substance abusers. I also had to be conscious of my role as a researcher and not take on the stance of a therapist. Therefore, I had to separate my own personal experiences with substance abuse and treatment from those of the participants. Initially, it seemed challenging but, by starting and maintaining a reflexive journal, I was aided in separating my own experiences from those of the participants. The journal assisted me in truly engaging with, and being focused on, the participants and their experiences. I also believe that, as a researcher, I was non-judgmental and respected the participants and the experiences that they encountered.

3.10. Ethical considerations

Ethical clearance was obtained from the Higher Degrees Commitee of the University of the Western Cape, and ethical considerations were maintained within those stipulated by the Committee. Permission was sought from the CEO at the rehabilitation facility to conduct interviews with their clients attending the aftercare programme. Written informed consent was obtained from the participants. Furthermore, each participant was handed an information sheet regarding the aims of the study, the participants' rights, and the possible risks and benefits of the study. Participants were also informed about the

voluntary nature of the study and that they could withdraw from the study without any consequences being imposed by the researcher. Participants were informed that suitable assistance would be provided if they were to experience any harm resulting from participation in the study. Participants were further informed that interviews would be audio-taped and transcribed verbatim and that information would be managed by myself and my supervisor. Confidentiality of the participants was ensured and maintained throughout the research process. The confidentiality of the rehabilitation facility was also ensured and maintained.

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CHAPTER FOUR

RESULTS

4.1 Introduction

The aim of the present study was to explore rehabilitated substance abusers' experience of aftercare following completion of inpatient treatment. The study focused on the experiences of eight rehabilitated individuals participating in an aftercare programme. The objectives of the study included exploring participants' experiences of aftercare; to identify features of aftercare that rehabilitated substance abusers experienced as beneficial in assisting them to maintain treatment gains; and, lastly, to identify features of aftercare that participants experienced as least helpful.

The present chapter is divided into three parts. Part 1 focuses on participants' perceptions of the factors that contributed to their substance abuse. Part 2 describes participants' motivating factors to seek and enter treatment. Lastly, Part 3 focuses on participants' experiences of aftercare.

4.2 PART 1: Reasons for using substances

Five main themes emerged from the participants' accounts of their reasons for using substances, namely (1) difficult family dynamics, (2) sense of normalcy and availability of substances, (3) peer pressure, (4) belonging and (5) coping with negative emotions. Themes which emerged also provided insight into the role that aftercare played in the participants' recovery.

4.2.1. Difficult family dynamics

Several participants identified difficult family dynamics as a trigger for their initial substance use, as is evident from the accounts provided by Gary and Ryan below. In these cases, substance abuse was appraised by participants as a way of coping.

> **Gary:** *'My parents were always fighting. My dad drank a lot and would hit my mommy. I couldn't take it anymore man. I was angry. The drugs made me feel better. It takes away that junk feeling then I didn't still worry about their problems. I was in my own world.'*

> **Ryan:** *'I stayed with my aunty and uncle. My parents didn't raised me up. I dunno* [don't know] *why. My cousins used to tease me about it a lot and I felt crap. My uncle smoked buttons* [mandrax] *you see, now he always looked so relaxed after he smoked. That house wasn't* reg [right] *for me, so I also tried it.'*

4.2.2. Normalcy and availability of substances

Participants also appraised drug use as normal within their communities and easily accessible, and attributed their substance use to these factors.

> **Jason:** *'It's all around me where I live. The merchant was just down the road and all the kids were trying it so I wanted to see what this* tik [crystal methamphetamine] *was about.'*

> **Marco:** *'Everyone, everywhere was doing it. It's normal where I live. They were all talking about it, how* kwaai [cool] *it is. I just tried it a few times for fun, my family couldn't even see a difference so there was no problem for me just to try.'*

4.2.3. Peer pressure

For some participants, peer pressure from friends, romantic partners and family members was ascribed as being influential in their substance abuse. Kim, for example, attributed her initial substance use to pressure from her boyfriend, as can be seen in her narrative below.

> **Kim:** 'I dated this guy who I was very in love with and he told me to try. I wasn't comfortable at first but he kept on saying that I must and that he will look after me. He supplied me with drugs and at first it was just every now and then. You know here and there. But then it got out of hand and I needed it more, like every day I wanted to use 'cause of the cravings.'

Similarly, Amy experienced pressure from her friends to use drugs:

> **Amy:** 'I was too stervy [stuck-up] I didn't drink or smoke. My so-called friends said that about me. They showed me how to use and I was more confident and lost a lot of weight also, I started wearing like skimpy clothes and got a lotta attention and free wine and drugs like that.'

Jason and Marco expressed similar sentiments:

> **Jason:** 'I used to sit there with the kids by the merchant, they were like whole time telling me I must try this stuff. They kept on man that I must.'

4.2.4. Belonging

Some participants described experiencing feelings of rejection from their family members which played a role in triggering their initial substance use. Furthermore, participants spoke about not having a sense of belonging, which they believed contributed to their use of substances.

> **Amy:** *'I was always the more shy and quiet one. I didn't fit in right, but when I drank and smoked with them, then I felt like I belonged somewhere. It felt good for a little while.'*

Amy talks above of how drinking and smoking gave her a sense of belonging; it made her feel as if she fitted in with her peer group who were abusing substances.

4.2.5. Coping with negative emotions

A few participants attributed their substance use to being a way of coping with difficult emotions including anger and frustration.

> **Marco:** *'If she, my wife, like work on my nerves, then I would get so angry at her, at everything, man. Then I have a problem with everyone and that time I must smoke so that feeling can go away.'*

> **Tyrone:** *'Like at times I didn't feel good, not nice, so I smoked and I worked a lot, was frustrated, angry and so* ja [yes], *the drugs made feel easy again.'*

4.3 PART 2: Motivation for seeking and entering treatment

Part 2 explores participants' motivations for seeking and entering treatment. Three primary motives for treatment were identified from participants' narratives, namely (1) the loss of important relationships, (2) awareness of the physical health effects of substance abuse, and (3) the impact on employment.

4.3.1 Loss of important relationships

The loss of important relationships with significant others was identified as a motivating factor for participants to seek and enter treatment. Below, participants provide descriptions of relationships which had been negatively affected by their substance abuse and which they wanted to repair.

Marco: '*My wife said she was going to divorce me and take my children away from me if I don't stop. I didn't think she was serious and I thought* ja [yes] *I won't stop now. But then she started taking my children to her family on weekends and they wouldn't let me see my children, I couldn't take it anymore. So I went to the social worker there in my area and I told her that I needed help.*'

Abdul: '*I would get so aggressive that I would fight with my family, like hit or so or break things in the house. I started stealing their stuff. My father would repay for the damages and my mother got so depressed that she had to go on medication pills. I knew now I had a problem, but the cravings are so strong. But then my mother, she was hospitalised and she rejected me. I felt so bad, it's my mother. I had to get help then, it was hard.*'

4.3.2. Awareness of the physical health effects of substance abuse

A few participants reported that they became physically ill as a result of their substance abuse. The awareness of the physical health impact of substance abuse served as a motivating factor for participants to seek treatment.

> **Jason:** *'I was getting sick a lot, like with the flu, but I didn't care as long as I had my fix. One day I got so sick with my chest that I had to stay in hospital. The doctor told me that I must stop with my drugs otherwise I will die from chest problems so* ja [yes] *I got help from the social worker.'*

> **Amy:** *'When I got a STD so I realised I must stop with my nonsense because I would only sleep around when I was high.'*

> **Kim:** *'People would make comments about how thin I was looking already but I thought it's none of their business. But I was looking like a dead dog, man, thin and always coughing so I went to the clinic. I was scared, I thought I had TB and I thought I must start to change.'*

4.3.3 Impact on employment

Experiencing employment-related problems as a result of substance abuse was another motivating factor for treatment. Abdul provides an account of how his substance abuse affected his ability to be productive at work, which eventually resulted in him being dismissed from his place of employment.

> **Abdul:** *'My work also suffered because I wasn't really productive, wasn't performing and off course I lost my job. My father cut me off, he wasn't giving me*

money. I had nothing and at the same time my mother was also so ill. At this point I seeked help.'

Another participant stated the following:

Tyrone: *'I was still going to work like normal and acting normal. No-one could notice anything. One day my friend at work saw my* pakkie [packet] *in my bag and told me that I must stop but I didn't. I didn't listen and it got worse, I started staying out of work a lot and coming late. They gave me warnings at work but they still helped me. You see they good people. They gave me time off, to like make right and go for outpatient treatment and I* nogal [actually] *was doing* oraait [alright] *at first. But then I* dunno [don't know] *what happened, I* suma [just] *became* erg [worse]*, smoked more and then they sent me for inpatient but then I didn't want to go at first. I checked I can stop on my own, man, like smoke less or so. But you* mos [like] *think you big and can do it alone, but I couldn't.'*

4.4 PART 3: Participants' experience of aftercare

The aim of the present thesis was to obtain an in-depth understanding of participants' experiences of aftercare following completion of inpatient treatment. The current section thus presents the main findings which emerged from participants' descriptions of their experiences of aftercare. Five themes emerged from the participants' accounts, namely (1) belonging; (2) support and encouragement; (3) structure; (4) coping with challenging relationships and (5) convenience and accessibility.

4.4.1. Belonging

A common theme which emerged amongst participants was that of experiencing a sense of belonging and acceptance in aftercare. This experience appears to have emerged from their relations with other group members.

The following two narratives are of participants who describe experiencing a sense of acceptance and belonging from fellow group members even after they relapsed. Their experiences of relapse were also normalised for them.

> *Jason: 'I wasn't the only one. They didn't push me away. I was still there, still part of the group. They told me that people often relapse. That I wasn't alone.'*

> *Abdul: 'They didn't judge me. They still accepted me and I got better. So I carried on with my recovery. I'm clean again.'*
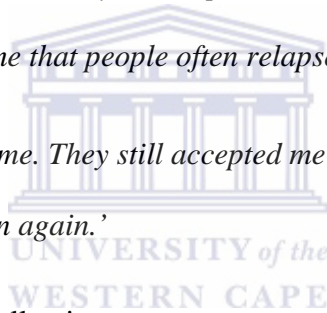
Another participant stated the following:

> *Tyrone: 'People here will understand 'cause you go through the same things, maybe live in the same area. Stole, smoked like, so you see you can't judge the other when you did the same. So I accept you and you accept me. We don't judge, man.'*

4.4.2. Support and encouragement

Common amongst participants were their experiences of support and encouragement. Participants also attribute the support and encouragement to positively assisting them with recovery.

Marco: 'I mean, I am still struggling, sometimes I do feel like I want to give up. It's harder on the outside. But people in aftercare, they motivate me, remind me of how far I came and why I mustn't give up and relapse. I have children, they important.'

Jason: 'It's harder when you back in your own environment and things can get you down. But the support and encouragement I get here is very good. It helps me to go on, to fight the battle. Not to relapse.'

The following participant spoke of difficult family relations and explained that he did not feel supported by his family in his recovery. He experienced aftercare as a place where he received support during recovery.

Ryan: 'My family can't support me, man, but here I get that. I get that from others, the support and help I need to go on.'
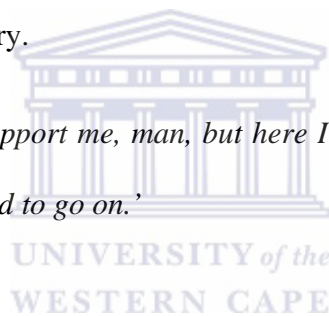
4.4.3. Sense of structure

Participants described experiencing a sense of structure by attending aftercare. Having this structure seemed to play a role in assisting participants to maintain recovery. Prior to treatment, participants reported having had very little structure. Participants appeared to appreciate the continued sense of structure that they experienced in aftercare.

Jason: 'Saturdays was my day to use, but now I come here. It keeps me busy. I have a structure like 'cause then I go to meetings later. I need that so that I don't go walking around again.'

Kim: 'Inpatient was structured and although it was difficult, it was what I needed. It was safe. I still get some sort of structure now by attending aftercare. I enjoy that.'

Above, Kim highlights the importance that having structure was for her.

> *Abdul: 'In the week I go to NA meetings and then I attend aftercare on Saturdays. I know the time it starts and ends and I can plan around that. I feel more organised. I appreciate that kind of organisation and structure.'*

4.4.4. Coping with relationship challenges

Several participants reported that they experienced aftercare as playing a vital role in assisting them to cope with relationship challenges that they experienced during reintegration. Below are some of the participants' accounts.

> *Gary: 'I can talk to my family now, in a normal way. They accept me 'cause I changed my ways. We learn in treatment and in aftercare that we must change our ways. If we struggle, then we come here and talk about i,t then you don't feel alone.'*

Kim describes below her positive experiences of aftercare in relation to the relationships that she damaged as a result of her substance abuse.

> *Kim: 'Coming to aftercare is a positive thing 'cause for instances I found helpful ways here to restore my relationships that I damaged. I mean I took a lot from my family when I was in active.'*

> *Tyrone: 'Ja, my relationships are better! I changed. They helped me here. I care about the relationships, you know, that I broke and today I have all my, like I've got good relationships with the family, you know.'*

4.4.5. Convenience and accessibility

Participants gave descriptions which implied that they experienced the aftercare service as convenient and accessible. Participants believed that these factors aided in their recovery.

> ***Jason:*** *'I used to get cravings a lot, like when I was still early in recovery but then I phone my sponsor or one of the other guys. They help me and then I come to the groups and I get advice. It's harder when you alone, back home, not so much in treatment still. But aftercare saves me. Because they support you also.'*

Above, Jason speaks about experiencing cravings early on in recovery. He further speaks about being able to contact his sponsor as well as other aftercare group members. His description above highlights that he experienced the service as easily accessible, especially during challenging times.

> ***Ryan:*** *'Yes, you come Saturday mornings so it's easy to take a train for me, man, if there's money then I have no problem. I can't like now go to night NA meetings 'cause I don't have transport.'*

> ***Abdul:*** *'It's convenient to come to group on a Saturday. It's the weekend so people are generally free. I can get to NA meetings during the week, too, I have transport but some don't, so coming here on a Saturday morning is convenient for them.'*

4.5. Participants' perceptions of the benefits of aftercare

Participants were asked whether they felt that aftercare benefitted them in any way. Some of the participants felt that aftercare assisted them in coping with various relationship

challenges. Furthermore, participants felt that they benefitted when previously acquired skills and information were repeated in the group and, lastly, they felt that aftercare helped in preventing relapse.

4.5.1. Sharing of skills and coping strategies

Repetition of previously acquired skills and information was a factor that participants perceived as assisting them in maintaining the skills which they deemed as necessary for maintaining their recovery.

> *Abdul: 'I finished the programme two years ago and sometimes I forget about the skills that I learnt. It's very helpful when especially new people come in and they remind you of those skills again by talking about it again. So it's repeated. Then the older ones can tell the new ones how we dealt with it and that's how we still use those skills. And the new ones are fresh and remind the older ones of the skills and tools.'*

> *Marco: 'When you leave treatment, then you remember all your tools and you excited to use it but over time it's like you can forget. When the new ones join aftercare, then they like how you were first, so they like talk about all that skills and you remember it again. That's how you keep your skills also,* ja [yes].'

Both Abdul and Marco explain that as a result of the repetition of information, they are assisted in remembering information which they had acquired during inpatient treatment. The participants also speak about the benefits of having group members who are at different stages of their recovery, which influences the sharing and remembering.

4.5.2. Positive role models

Some of the participants felt that aftercare helped to prevent relapse by equipping them with skills which they deemed as necessary to facilitate their reintegration back into their families and communities.

Tyrone: '*I always listen to how others handled things and like the tools they used, man. 'Cause sometimes I think I can't and like I will use again, but I hear what others did. How they did it.*'

Tyrone speaks about being motivated to use his skills when he learns of how other group members implemented their skills.

Amy: '*I'm not very long here but I have already learnt from the others, like the older ones. They can tell you how they handled things, e.g. like the cravings when you leave. Then I try to use the tools they speak about it because it helped them.*'

4.6. Features of aftercare that participants experienced as least helpful

Participants were asked whether they had any encounters or experiences of aftercare that they perceived as not being beneficial or which they experienced as being least helpful. In response, some participants reported that they did not have any negative experiences whereas a few provided recommendations for the aftercare programme which could make their aftercare experience more beneficial. Themes which emerged from their responses included receiving sponsorship and the presence of a professional person in the group.

4.6.1. Sponsorship

Participants identified a need for sponsorship in the form of money to be used for transport purposes as well to supply beverages and snacks for the group. Finances were a stressful factor for Ryan (see below), in terms of having money for travelling to and from aftercare.

> **Ryan:** *'I think we need to be sponsored, man. We want to come here but sometimes we don't have taxi fare apply and don't* wanna [want to] *steal train 'cause that's like old behaviour. So if you don't have money, then how can you come here and you want to be here.'*

Ryan was asked to think about how his financial needs could affect his experience of aftercare. He stated the following:

> **Ryan:** *'Er, well, then I* mos [just] *can't attend and then I can lose all that skills. Like lose my recovery 'cause I don't have money to come here. I stress, sometimes I sit here then I think how am I going to make next week?'*

From Ryan's description, the fact that he is not receiving monetary sponsorship to attend aftercare at times affects his experience of aftercare and his ability to be fully present in the group; as he states: *'I stress, sometimes I sit here then I think how am I going to make next week?'*

> **Tyrone:** *'Maybe if we can get money. From the centre or the government or whoever, then we can buy more things. Like things to eat and drink, man. People*

travel far and early and maybe don't eat at home or have food, then you come sit here still with a empty stomach.'

Tyrone was also asked to think about how it affects his experience of aftercare when or if he sits in the group with an empty stomach.

Tyrone: *'I can't think so. Like concentrate. So I don't like that.'*

Tyrone feels that the aftercare group should be sponsored to purchase snacks and beverages. Hence for him, not being fed and attending the two-hour group session affects his ability to concentrate.

4.6.2. Professional input

A few of the participants identified the presence and input of a professional staff member as an important matter to enhance their experience of aftercare.

Kim: *'Aftercare is very helpful and all, but I think we could, like, benefit from a professional person in the group. So maybe I experience that as a lack. Like something that can maybe become negative. Like if there isn't proper advice, so you need a professional.*

Amy: *'No, I just feel like we need a psychologist here because some of us have very serious problems and we need professional input. Not just advice. Not saying anything wrong but professional advice can help you more. Like you will maybe feel more confident with the advice.'*

Abdul: *' Perhaps a trained case worker should join us to get professional advice.'*

All three participants above felt that a professional worker was needed in the group so as to receive professional guidance which in turn could enhance their experience of aftercare.

CHAPTER 5

DISCUSSION

5.1. Introduction

The present chapter provides a discussion of the main findings that emerged from the study. It provides an analysis of participants' interpretations which is contrasted with existing literature on the different aspects of substance abuse and experiences of aftercare and psychotherapy.

In the chapter, participants' perceptions of the factors that contributed to their substance abuse are firstly presented. Thereafter, motivating factors to seek and enter treatment is presented, followed by participants' experiences of aftercare.

5.2. Reasons for using substances

The study found that some of the predominant reasons ascribed by participants for substance abuse included difficult family dynamics, normalcy and availability of substances, peer pressure, belonging, and coping with negative emotions. Similar findings have been reported in the literature.

Family dynamics: Difficulty family dynamics and conflicted relationships with significant others were one of the factors that participants appraised as precipitating their substance abuse. In terms of the literature, factors such as family disruption, ineffective supervision, criminality and drug use within the family have been found to be risk factors for substance abuse (World drug report, 2004). Similarly, within the present study, negative familial relationships and drug use within families were found to play a

significant role in the abuse of substances. Familial risk factors for substance abuse within the family, such as rejection by parents, parental and sibling substance use, divorce in the family, and conflict in the family have been identified in various studies (Jeremy, 2013; Madu & Matla, 2003 cited in Golestan, Abdullah, Ahmad & Anjomshoa 2010) Furthermore, Madu and Matla, cited in Golestan, et al., 2010 identified that family conflict was significantly associated with more drug use among adolescents in South Africa. According to the present study, the impact of living amongst family members where tension and discord were rife proved to be challenging for a number of the participants. Substance abuse and the associated feelings produced, played a role in helping participants to distance themselves from difficult family dynamics. Participants' substance abuse in the midst of difficult family dynamics was thus used as a means of coping. In a study by Tolan, Szapocznik and Sambrano (2007) they found that a negative relationship between parent/s and child usually creates conflict between the two and predicts the chances of the child engaging in illicit drug use. Furthermore, in a review of studies about substance abuse, by Hawkins, Catalano and Miller (1992), it was documented that family conflict such as persistent serious conflict between primary caregivers, or caregivers and children, increased the risk of problem behaviours such as substance abuse. Findings from the review support the findings from the present study, which indicate that difficult family relations between caregivers as well as caregivers and children precipitate and maintain substance abuse. According to Gruber and Taylor (2006), unstable and inconsistent family and living environment factors resulting from substance-using caretakers have been linked to the incidence of psychological and emotional development problems among their children. With reference to the previous

statement, one participant within the present study described his home environment as unloving, abusive and unstable. He was exposed to substance abuse within the home. The participant developed emotional problems as a result, and engaged in substance use.

Normalcy and availability of substances: Participants in the present study attributed their initiating substance abuse to the availability of drugs within their communities and to substance abuse being perceived as normal. A number of studies (Prinsloo, Ladikos & Neser, 2005, cited in Morojele, Parry, Brooke & Kekwaletswe nd) found that both legal and illegal drugs are readily available to many young people in South Africa at the broader societal and the specific community levels. Within the study, participants felt that the availability of drugs in their communities had a direct effect on their initiation and maintenance of their substance abuse. Besides the availability of drugs in the community, the perceived normalcy of substance abuse proved to be another factor in the initiation and maintenance of participants' drug abuse. Participants described substance abuse as an 'everyday occurrence'; creating the impression that exposure to substances within their communities was almost unavoidable. Hence, for participants in the present study, being constantly exposed to and indirectly or directly receiving the message that substance abuse was normal, precipitated their drug abuse. Additionally, the availability of substances made for easy accessibility. Findings from the World drug report (2004) emphasise that the widespread availability of drugs is indeed a risk factor for substance abuse. This finding is further supported in a review of studies about substance abuse which highlighted that the availability and normalising of drugs in communities is associated with increased risk for substance abuse (Hawkins et al., 1992).

Furthermore, Snyder, Milici, Slater, Sun & Strizhakova (2006) emphasise that societal norms and portrayals of drinking and drug use in films and advertisements encourage drinking and other drug use.

Peer pressure: Various studies have indicated that peer pressure plays a role in the initial and continued abuse of substances and is also a determinant for relapse (Foo, Tam & Lee, 2012; Van der Westhuizen, 2007; Morojele et al. nd). It has been documented by the UNODC (2004) that internal pressure, whereby the individual feels that it is safer to take drugs than risk losing the support of the group and the identity, status or social prestige, and self-concept which goes with drug taking, was a potent factor for substance abuse. Also, in a study by Foo, et al. (2012), the authors found a similarity between peer influence and substance use. This similarity was explained in two ways, namely socialisation and the selection process. In the article, it was emphasised that peer influence was the outcome of socialisation, which implies that an individual's peers have an influence on the individual. Foo, et al. (2012) make reference to the social development model which explains that the growth of pro-social and anti-social behaviour along a person's life course, and the degree of involvement with and reinforcement from individuals who use substances, is an influence for a person's increased substance use. The above literature supports findings from the present study which clearly identifies peer influence as a contributory factor in participants' substance use. Furthermore, research by Peltzer, Ramlagan, Mohlala & Matseke (2007) in South Africa suggests that most individuals start using illicit drugs with friends. Research further supports that substance abuse by friends encourages others to use drugs and also influences their choice of friends (Brook et al., nd cited in Mudavanhu, 2013).

Sense of belonging: A dearth of literature exists on the fundamental importance of forming healthy relationships and its contribution to the overall wellbeing of individuals (Baumeister & Leary, 1995; Makinen & Johnson, 2006; Levi, Johnson, Clouthier, Scala & Temes, 2015). Baumeister and Leary (1995) argue that having a sense of belonging is a fundamental human drive, i.e. that humans have a pervasive drive to form and maintain at least a minimum quantity of lasting, positive and significant interpersonal relationships. Research further highlights that experiencing a lack of belonging leads to a variety of detrimental behaviours that cause various undesirable effects, including decrements in health, emotions and adjustment (Baumeister & Leary, 1995; Levi, et al., 2015). Furthermore, Makinen and Johnson (2006) hold that human experiences are strongly influenced by the quality of their relational bonds with other people. Within the present study, relationship factors were associated with substance abuse, i.e. a link exists between experiencing a lack of belonging and substance abuse. For several participants in the study, experiencing a lack of belonging contributed to the initiation and maintenance of their substance abuse. Findings from the present study are therefore in support of previous research highlighting a relationship between a lack of belonging and detrimental behaviours and undesired effects.

Difficult emotions: Inability to cope with difficult emotions and to healthily self-soothe was associated with substance abuse by participants in the present study. The prominent emotions identified in the study included anxiety, frustration and anger. The literature includes research on the relationship between experiencing negative emotions and using substances (Cheetham, Allen, Yucel & Lubeman, 2010.) According to Measelle, Stice, & Springer (2006) cited in Cheetham, Allen, Yucel & Lubeman (2010), individuals who

experience greater levels of negative affect are at higher risk of using drugs or alcohol as a coping mechanism (e.g., to improve mood or provide distraction from unpleasant feelings). This view supports the findings from the present study which indicated that participants used substances as a coping mechanism to soothe or numb them from emotions that they experienced as overwhelming. Within the study, participants described their feelings as unbearable and identified a need to escape and rid themselves of those feelings. Using substances thus served this purpose for them. Furthermore, in a review of studies concerning affect dysregulation and substance abuse by Cheetham et al., (2010), it was highlighted that, for addicted individuals, the negative affective states produced by withdrawal were an important motivating factor in continued use. Also, Chetty (2011) conducted a study where he explored the causes of relapse post treatment for substance dependency amongst members within the South African Police Services (SAPS). In his study, it was highlighted that the majority of the respondents identified intrapersonal determinants such as experiencing negative emotional states (e.g. anger, frustration and anxiety) as well as exposure to peer pressure and boredom, as constituting a high-risk situation for their relapse. The above literature thus supports findings from the present study, which highlights a relationship between negative emotions and substance abuse.

5.3. Motivations for seeking and entering treatment

In the present study, participants provided a range of reasons for seeking and entering treatment including loss of important relationships, experiencing employment-related challenges, and health problems as a result of their substance abuse. In terms of the existing literature as to why people seek and enter treatment, some of the following

reasons were cited: normal developmental life changes, relationship issues, work-related problems and financial difficulties, chronic illness or depression, grief and bereavement, the criminal justice system, and pressure from loved ones (Vessey & Howard, 1993; Grella & Joshi, 1999).

Loss of important relationships: Research has shown a link between difficulties in interpersonal relationships and substance abuse, i.e. challenging relationship dynamics can serve as a motivating factor for substance abuse. Price and Simmel (2002) explored the influence of male partners on women's addiction and recovery. In their study, they emphasised a relationship between alcohol and drugs and women's past and current relationships. Covington (2002) cited in Price and Simmel (2002) suggests that some women may use drugs or alcohol to fill a void from what is missing in a relationship, whereas others may use drugs to maintain a relationship. Furthermore, Price and Simmel (2002) highlight that various relationship dynamics can influence substance users to seek treatment. Riehman, Hser, and Zeller, 2000 cited in Price and Simmel (2002), however, state that women are more vulnerable than men to the influence of partners on their decision to seek treatment. In another study, Grella and Joshi (1995) explored gender differences in the factors associated with substance abuse and treatment. One of the influential factors in entering substance abuse treatment was that of family relationships. Interestingly, their results conveyed that nearly all of the men in the study who were living with a spouse or partner reported that they had been influenced positively by that person to enter treatment. Other factors that influenced both genders to seek and enter treatment were related to problems they encountered with their spouse owing to their drug use; their spouse putting pressure on them to enter treatment; and that their family or

friends encouraged them to stop using drugs. Similarly, results from the present study indicate that participants were influenced by relationship dynamics with significant others to seek and enter treatment. In light of this influence, substance abuse is not only limited to the abuser but its effects expand to loved ones and the broader community as well. For example, Ammerman, Ott & Tarter, (2009) as cited in Mudavanhu (2013) highlighted that excessive alcohol intake not only affects the user but also their families and people living around them. This can also be said of other substances as well. Lastly, for participants in the study, the realisation of how they affected their relationships, the accompanying disappointment they experienced from damaging their relationships, family pressure, and the withdrawal of the family's support, motivated participants to seek treatment.

Awareness of the physical health impact of substance abuse: A vast amount of literature exists that expands on the association between substance abuse and the development of serious illnesses. The World Drug Report (2012) states that negative health consequences are some of the biggest effects of drug abuse on society. In South Africa, substance abuse has been closely linked with diseases such as tuberculosis, sexually transmitted diseases, as well as HIV/AIDS. Parry (2000) cited in Chetty (2011) found that the abuse of alcohol is a contributing factor to chronic conditions such as heart disease, cirrhosis and malignancy. As highlighted in research, substance abuse indeed has devastating effects on health. The literature also points to health concerns as motivating factors to enter substance abuse treatment (Grella and Joshi, 1995; Beuster and Arnott cited in Chetty 2011; Toole, Pollini, Ford & Bigelow, 2006). Toole et al., (2006) conducted a study where they explored physical health as a motivating factor for substance abuse treatment.

The study population consisted of substance-using adult patients admitted to an urban acute care hospital who were also admitted to a joint medicine–substance abuse treatment day hospital programme. Results from the study indicated that physical health concerns were the most frequently cited reasons for wanting to enter substance abuse treatment at baseline. Beuster and Arnott (2007) cited in Chetty (2011) also documented that patients with serious health problems might be more motivated to seek treatment for their dependency on alcohol. In another study by Grella and Joshi (1995), the effect of substance abuse on mental health was identified as a motivating factor to enter treatment. Similarly, within the present study, it was found that health concerns related to substance abuse was a motivating factor for participants to seek and enter treatment. Results from the present study are therefore consistent with earlier studies that identified health concerns as a motivating factor to enter substance abuse treatment.
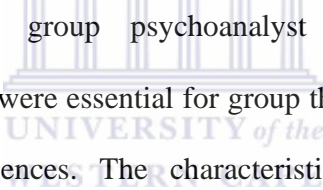
Impact on employment: Employment invariably constitutes a large part of the average working person's life. Studies have indicated that employment-related problems such as productivity, threat of job loss and pressure from an employer, have played a role in motivating substance abusers to seek and enter treatment (DiClemente, Bellino & Neavins, 1999; Weisner, Mertens, Tam & Moore, 2001; Battjes, Gordon, O' Grady, Kinlock & Carswell, 2003). Weisner et al. explored factors that affect the initiation of substance abuse treatment in managed care. Results from the study indicated the following: (1) participants who were drug-dependent were less likely to begin treatment than those dependent on alcohol only; and (2) measures of motivation such as workplace pressures and patients' perception of the importance of alcohol treatment predicted starting treatment for individuals who were alcohol dependent only, or alcohol and drug

dependent. Furthermore, the results indicated that, for men, receiving pressure from the workplace predicted seeking treatment and longer times of stay than was the case for women. Other studies have indicated similar findings – that men, as opposed to women, are more likely to enter treatment owing to work-related pressures (McGovern, Angres, Shaw & Rawal, 2003). In another study, which included 263 inpatients for alcohol treatment, employment-related factors, such as threat of job loss, were identified as a motivating influence to initiate treatment (Krampen 1989 cited in DiClemente et al., 1999). Furthermore, patients in the study by Krampen 1989 cited in DiClemente et al., 1999) who entered treatment owing to external threats such as threat of loss of job or driver's licence or their spouse, experienced better treatment outcomes than did patients without such motivating factors From the above literature, it is evident that employment-related factors indeed serve as a motivating factor to seek and enter treatment. Similarly, findings from the present study indicated that problems related to employment played a role in motivating participants to initiate treatment. For participants in the present study, factors such as being unable to find suitable employment, productivity negatively affected, warnings from the employer, and threat of work termination, motivated participants to seek and enter treatment.

5.4. Participants' experience of aftercare

The primary aim of the study was to explore and capture rehabilitated substance abusers' experience of aftercare following completion of inpatient treatment. The functions and purpose of aftercare can be likened to the functions of group therapy and, similarly, participants' experiences of aftercare can be contrasted with the experiences and benefits

of group therapy. The literature indicates that the benefits of group therapy often include patients experiencing an increased sense of support and connectedness, a decrease in self-criticism and negativity, increased resourcefulness in finding solutions, and more confidence in trying out possible solutions amongst others (Adler, 2013; Koukourikos & Pasmatzi, 2014). These findings can be contrasted with the participants' experiences of aftercare within the present study, which found that participants experienced aftercare as providing them with a sense of belonging as well as being supportive and encouraging. Participants also experienced aftercare as providing structure and assisted them in coping with challenging relationships. Furthermore, they experienced aftercare as convenient and accessible.

Belonging: Psychiatrist and group psychoanalyst Irvin Yalom identified 11 characteristics that he believed were essential for group therapy and that could contribute positively to patients' experiences. The characteristics were instillation of hope, universality, imparting information, altruism, corrective recapitulation of the primary family group, development of socialising techniques, imitative behaviour, interpersonal learning, group cohesion, catharsis and existential factors (Addiction Messenger, 2004; Yalom & Leszcz, 2005). Yalom defined the concept of universality as clients learning that others within the group have similar experiences (Addiction Messenger, 2004; Yalom & Leszcz, 2005). The concept of universality can be likened to participants' experiences of belonging. In their study, the theme of belonging was facilitated when participants learnt that they shared similar feelings and experiences as others. Yalom also stated that universality amongst group members helps patients feel less alone as they learn that others have similar experiences (Addiction Messenger, 2004; Yalom & Leszcz

2005). True for the participants in the present study, they reported feeling less alone and isolated as they came to discover that they shared similar experiences. From feelings of isolation and loneliness, participants experienced feelings of belonging within aftercare and even went as far as describing the group as a familial structure. A study by Docherty (2004) explored the experiences, functions and benefits of a cancer support group. Participants from three different cancer support groups were involved in the study. Significant to the present study was that respondents from her study also experienced a great sense of belonging within the group which positively aided in their psychological wellbeing. As for participants in the present study, members in the cancer support groups also referred to the group as a family, with their shared experiences establishing a foundation for trust and friendship. Interestingly, participants in the cancer groups felt that they experienced greater support from fellow group members as opposed to hospital staff who were treating them; and participants in the present study found greater support in the group than from their loved ones. Thus, the importance of support amongst group members was emphasised.

Support and encouragement: Common amongst participants was their experience of support and encouragement. Receiving support and encouragement from the aftercare facilitator and fellow group members appeared to be a strong protective factor for participants to deal with various challenges and to continue their recovery. For some participants, the encouragement they received from their group members was the main or only source of support, as they felt they had little or no support outside the aftercare group. Polcin and Korcha (2015) conducted a study that examined motivation to maintain sobriety amongst residents of sober living houses (SLHs). An SLH is defined in the study

as a type of recovery home for individuals with alcohol and drug problems. Amongst participants from their study, the importance of the social environment was largely emphasised as a motivator for sobriety. Factors such as peer support and experiences of unity engaged residents in ways that they felt would be difficult to replicate outside the SLH context. Furthermore, participants appreciated the value of their experiences and felt that it benefitted them to maintain abstinence. Participants in the study also had a shared sentiment that the care and concern which they received from fellow residents had become important reasons for them to stay sober. The findings from Polcin and Korcha are therefore similar to findings from the present study, which highlights the experiences of support from fellow recovering addicts in maintaining sobriety.

Structure: Participants spoke of previously living very unstructured and unorganised lives while they were abusing substances. This resulted in participants neglecting or failing to maintain certain responsibilities, e.g. work commitments, house chores and taking care of the family. Hence, adjusting to the structure of the inpatient programme was initially quite challenging for many of the participants. However, as the programme continued, participants started adjusting to the structure and also experienced having structure in their lives as a positive and protective factor. While in aftercare, participants continued to experience this sense of structure and routine in their lives by attending the two-hour group on Saturday mornings. For many participants, it was especially common to abuse substances over weekends, i.e. on Saturdays. Knowing where and when they were to attend aftercare and other support groups assisted participants in planning and organising their daily activities more effectively, which helped them to stay away from people and places associated with their former drug abuse. In essence, having and

experiencing a sense of structure assisted participants to continue their recovery and maintain treatment gains. Participants actively took responsibility. Lastly, participants felt that aftercare was structured in such a manner that it allowed all members to be involved in and contribute to the discussions. Participants' experiences of structure where aftercare was concerned thus played a significant role in the maintenance stage of their behaviour change.

Coping with relationship challenges: Difficult relationship dynamics were identified as a trigger and a maintaining factor for participants' substance abuse. Furthermore, problematic relationships were acknowledged as a precipitant factor for participants to relapse and return to previous behaviours which were associated with their substance abuse. During treatment, patients were taught and equipped with skills for various areas of their lives, one such area being their relationships. However, some participants still experienced major challenges within their relationships once they returned to their loved ones after completing treatment. In the study, participants experienced aftercare as playing a vital role in assisting them to cope with relationship challenges that they experienced during reintegration. Participants had positive experiences of aftercare in terms of receiving assistance with their relationship difficulties. Du Toit (2008) cited in Van Der Westhuizen (2010), emphasises the importance of in-patient treatment programmes being followed up with aftercare services. Furthermore, Du Toit (2008) cited in Van Der Westhuizen (2010) highlights that aftercare should address the restoration of family relationships, amongst other factors. This necessity is due to the significant role that families often play in the lives of substance abusers. Thus, addressing familial concerns in terms of restoration is indeed associated with behaviour change. As found in

the present study, participants experienced aftercare as positively assisting them with various relationship challenges.

Convenience and accessibility: Participants experienced the aftercare service as accessible and convenient in terms of the location, time and day on which the group met. Easy accessibility to group members and sponsors was another shared experience that participants had. Participants referred to the availability of group members and sponsors in and out of group time. Experiencing various challenges during reintegration is common amongst recovering substance abusers. They often return to the same communities where their drug use had been initiated. Thus, having access to supportive group members whom they can share their challenges with, in and out of group time, appeared to be beneficial for participants. Docherty (2004) who explored the experiences, functions and benefits of a cancer support group, found similar results to those of the present study: participants in the cancer support groups highlighted that access to other patients in the group and receiving information from them contributed positively to their psychological wellbeing. In a study by Vanderplasschen, Colpaert and Broekaert (2009), the authors measured abstinence and relapse among alcohol abusers after receiving intensive, residential treatment in specialised units in five Belgian psychiatric hospitals. From the study, the domains 'psychiatric problems' and 'patients' personal perspectives' were identified as the best predictors of relapse and re-admission. Also, 'patients' living situations' predicted relapse; and specific variables that independently predicted relapse were 'satisfaction with day activities' and 'number of days with problems due to alcohol'. Less severe psychiatric problems at the start of treatment and more severe psychiatric problems and negative feelings of wellbeing at the time of follow-up were independent

predictors of re-admission. The researchers also found that, six months after the patients' initial treatment episode, more than half of all respondents (54%) had been using alcohol regularly. Therefore they had relapsed. One of the recommendations that the researchers included in their study to prevent relapse was that participation in aftercare needs to be encouraged amongst patients. Furthermore, Vanderplasschen et al. (2009) recommended that aftercare should be made easily accessible and flexible for patients to reach to encourage attendance. Findings from the present study in fact highlight the importance of accessibility and convenience in encouraging participants to attend aftercare. These factors contribute positively towards participants' experiences of aftercare.

5.5. Participants' perceptions of the perceived benefits of aftercare

Participants were presented with the question of whether they felt that aftercare had any benefits; and, more specifically, if they believed that they had positively benefitted from attending aftercare. All participants in the present study reported that aftercare was beneficial, and specifically in assisting them to maintain their treatment gains. Two themes emerged: participants felt that the sharing of skills and coping strategies, and having positive role models in aftercare, assisted them in maintaining their treatment gains.

Sharing of skills and coping strategies: Patients were involved in a structured therapeutic programme during their inpatient treatment. Participants were aided with skills to assist them in their substance abuse treatment, and they reportedly found the skills helpful. The shared sentiment which patients held was that it was often easier to remember and apply their skills whilst in treatment owing to factors such as support and being often

confronted with the necessary skills. Participants verbalised that, over time, they seemed to 'forget' some of the skills which were once taught to them during their inpatient programme. However, participating in the aftercare programme positively influenced patients in terms of maintaining the necessary skills required for their recovery. They felt that the constant repetition of skills through teaching and sharing was refreshing and assisted them in maintaining and applying the skills. Similar findings were made in Docherty's (2004) study which explored the experiences, functions and benefits of cancer support groups. Overall, participants in the cancer support groups experienced improved psychological wellbeing as a result of information and knowledge sharing in the group. Furthermore, participants in Docherty's study felt that information through the development of knowledge and understanding provided them with a sense of control. Similar results were obtained in a study by Newton, Larkin, Melhuish and Wykes (2007) who explored young people's experiences of group therapy as an early intervention for auditory hallucinations. The qualitative study included eight participants who had completed a cognitive behavioural group intervention. Semi-structured interviews were used to collect data which were analysed using interpretative phenomenological analysis (IPA). Participants in Newton et al.'s (2007) study also emphasised the sharing of coping strategies and skills, and experienced the group as reinforcing the use of successful strategies and teaching more effective ways of coping.

Positive role models: Another factor which participants identified as beneficial was that they had the opportunity to witness others progress and learn from fellow members' experiences. This not only taught participants how to implement skills but also influenced their own self-belief and recovery. Peers who were progressing successfully in their

recovery served as positive role models within the aftercare group. A similar theme emerged in Newton et al.'s (2007) study, namely that participants had benefitted by learning and being able to help others. Participants in the Cognitive Behavioural Therapy (CBT) group who had made progress in terms of managing their illness felt that they were positive role models for members who were struggling. Participants were thus able to learn from and be inspired by those who were functioning more effectively. Furthermore, participants benefitted from having positive role models; they were exposed to suggestions for coping and hope for the future as first-hand evidence that voices could be overcome. Within the present study, having the opportunity to learn from the example of others, positively assisted participants in maintaining their treatment gains and ultimately in preventing relapse.

5.6. Features of aftercare that participants experienced as least helpful

Participants were also presented with the question of whether they had any encounters or experiences of aftercare that they perceived as not being beneficial or which they experienced as being least helpful in their recovery. The majority of participants reported that they had not had any negative experiences in terms of aftercare. They further explained that their overall aftercare experience was beneficial and positive. Also in response to this particular question, a few participants instead gave recommendations that they felt could enhance their experiences of aftercare. The following themes emerged: sponsorship, and the presence of a professional person in the group.

Sponsorship: A few of the participants spoke about their experiences of financial difficulty which they believed to some extent affected their aftercare experience, or could

in the future negatively affect their experience. Participants were explicit about the importance of attending aftercare but felt that, as a result of their own lack of personal funds, they were not certain whether they would be able to continue regular aftercare attendance. This was a concern as participants felt that inconsistent attendance would negatively affect their experience of aftercare and, ultimately, of recovery. Essentially, lack of finances could become a barrier for participants to access and continue their treatment. Financial constraints have indeed been identified as a barrier to accessing drug treatment, especially amongst the black and coloured disadvantaged communities of South Africa (Myers, Louw and Pasche, 2010; Myers 2013). Myers et al. (2010) highlight in their study that the high costs associated with South African public transport and the potential loss of income associated with difficult and lengthy commutes may make lengthy travel unaffordable to South Africans from poor communities with competing financial priorities and low incomes. Evidence from the present study as well as others indeed highlight lack of finance as potentially detrimental to accessing and continuing substance abuse treatment, especially amongst economically disadvantaged populations.

Professional input: Some participants felt that having a professional person (counsellor, psychologist, social worker) present during the group would enrich their experience of aftercare. Although participants verbalised being satisfied with the help of their group members and aftercare facilitator, they believed that receiving 'professional advice' would probably enhance their experience in aftercare. One participant in particular stressed the importance of the presence and input of a professional person as a result of the nature of the problems which group members were experiencing in their personal lives. In Newton et al.'s (2007) study, participants emphasised the importance of their

group facilitator using psychological skills and techniques to enhance their group experience and bring about positive change.

5.7. Theoretical application

The aim of the present study was to obtain an in-depth understanding of rehabilitated substance abusers' experience of aftercare following completion of inpatient treatment. An interpretive paradigm was used as a framework for the study. Interpretive research is concerned with the way in which people make sense of the world, as well as the way that they experience events (Willig, 2008). An interpretive approach was relevant in the present study as the aim was to explore participants' experiences and the particular meanings associated with their experiences. In the present study, the researcher acknowledged participants' narratives of their experiences as their reality and attempted to explore their perceptions of that reality. Firstly, participants made meaning of their lived experiences, which was followed by the researcher decoding those messages in an attempt to make sense of participants' meaning making – referred to as the double hermeneutic. The researcher's interpretations play a key role in this kind of study by bringing subjectivity to the fore, backed with quality arguments (Garcia & Quek, 1997, cited in Andrade, 2009). The researcher had the opportunity to gain insight into the researched topic and translated it into a form that is intelligible to readers (Andrade, 2009).

The research process for the researcher was rewarding and insightful. As the researcher, I developed a keen interest in the topic as a result of my own experiences with familial substance abuse and because I had previously worked as a registered counsellor at the

facility where the research was conducted. I initiated the study because I wanted to develop a deeper understanding in this area, and because I was optimistic about contributing towards positive change for substance users. I felt that more needed to be done to assist in combating the plague of substance abuse within the community. I was deeply moved by the effect that substance abuse had on users, their loved ones and the broader community. Gaining entry into the lives of substance abusers and their families often felt for me like a reflection of my own family and the challenges we faced with substance abuse. I therefore felt that I could strongly relate to the participants' experiences and that, because I had prior knowledge and experience with substance abuse, this would be advantageous to the study. It contributed to me feeling sufficiently comfortable to probe participants for more information to generate deeper discussion. I also felt that my being comfortable and relaxed allowed participants to feel at ease and open up. Nonetheless, several feelings were evoked for me by participants' narratives. I experienced feelings such as sadness and despair at the enormous challenges that participants described. I also felt angry at the 'governmental systems' and even at the centre itself for not 'doing enough'. These of course were my own judgements. Lastly, I experienced pride and joy when participants spoke of how they had made progress and felt that the programme had positively influenced their lives. Throughout the research study, I was aware of my own internal feelings and reactions and constantly had to reflect on my process with regards to the topic. I attempted to remain cognisant of my role as the researcher and not the 'helper or counsellor'. Nonetheless, as reflective as I attempted to be, my own experiences in the area indeed might have influenced my interpretations of participants' narratives. Furthermore, participants' awareness of my previous

employment at the centre could also have had an influence on their narratives of their experiences with aftercare; keeping in mind, however, that I had not worked closely (group, individual or family therapy) with any of the participants whom I interviewed. I felt that my experience and prior association with the centre might have affected me so as to think of or interpret participants' experiences more favourably in some areas. I also felt strongly about some areas; for example, lack of sponsorship and the financial challenges affecting participants' ability to attend aftercare. I felt that I was influenced by the fact that I was aware that many of the patients attending the programme were often from socially disadvantaged backgrounds. I felt upset by the lack of resources, finances and sponsorship which was an obstacle for participants to continue with an aftercare programme, which could essentially determine their recovery.

5.8. Limitations

One major limitation of the study is that the sample of participants was only from one government-funded inpatient treatment facility. One therefore has to be careful about applying the results found to groups in other settings. One also has to be open to the possibility that participants might have been biased in perhaps providing more favourable commentary about their experiences owing to their affiliation with the treatment facility. Concerns about the veracity of the participant's commentaries are therefore questionable. Although questions were posed in such a manner as to elicit the in-depth experiences of participants, it could in fact seem as if participants were evaluating the programme and facilitator.

Further, the sample consisted of an unequal number of genders, i.e. four men and two women. The study does therefore not make reference to whether men and women have different experiences of aftercare in their reintegration. One therefore cannot ascertain from the results whether the aftercare needs of male and female participants are different.

According to Duncombe & Jessop (2013), rapport building is a crucial element of qualitative research. Rapport building allows the participants to gain familiarity with the researcher and thus gain trust, which also ensures that the participants are more honest and willing to offer information during the data collection process (Duncombe & Jessop, 2013). Unfortunately, minimal time was spent with the participants prior to being interviewed; hence, it was not possible to develop a strong, trusting relationship.

Lastly, the study does not provide data on whether people from different social classes and communities have different experiences and different aftercare needs.
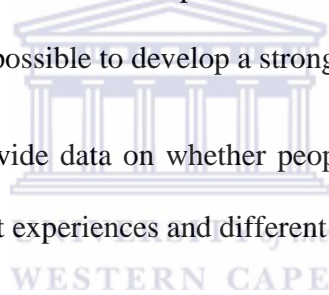
5.9. Recommendations

In light of the literature regarding relapse after completion of treatment and the literature on the need for aftercare and the purpose of aftercare, further extensive research on rehabilitated substance abusers' experiences of aftercare is essential. As the results of the present study are limited to the experiences of participants at one treatment facility, future research should include a much broader sample within the Western Cape, which will provide more diverse results of rehabilitated users' experiences of aftercare.

As men and women may experience different challenges upon returning to their communities after rehabilitation, future research can therefore explore this aspect which

can then aid in the implementation of gender-specific programmes in aftercare. The same concept could apply to people from different social classes.

5.10. Conclusion

Substance abuse has been identified as a major problem within South Africa and more specifically within Western Cape Province. Its effects go far beyond relationships, often destroying them, and place huge strains on the nation's economy, health and criminal justice systems. Although substance abuse treatment facilities exist, the literature highlights that substance abuse is still a major concern and that there are generally insufficient facilities for the number of treatment seekers. Aftercare facilities play a vital role in assisting rehabilitated substance abusers to successfully reintegrate with their communities. Further, such facilities aim to assist rehabilitated abusers to maintain their treatment gains and, ultimately, to prevent relapse. The role of aftercare facilities is therefore essential in fighting the problem of substance abuse. The aim of the study was to obtain an in-depth understanding of rehabilitated substance abusers' experiences of aftercare. The objectives of the study were to identify features of aftercare that rehabilitated substance abusers perceived to be beneficial in assisting them to maintain treatment gains and to identify features of aftercare that participants experienced as least helpful. These findings could assist organisations who intend to set up aftercare facilities and also assist established facilities. Various themes emerged from the study, which was of eight participants in an aftercare programme. The first theme was participants' reasons for starting substance abuse. The five primary reasons were: difficult family dynamics, normalcy and availability of substances, peer pressure, belonging, and negative emotions.

Findings on the sub-themes for starting substance abuse are consistent with earlier studies on exploring reasons for using substances. Another interesting theme which emerged was that of participants' motivations for seeking and entering treatment.

Three sub-themes were extrapolated, namely loss of important relationships, awareness of the health consequences of substance abuse, and the impact on employment. The literature also supports findings from the present study which make reference to participants' reasons for seeking and entering treatment. Lastly, participants' experiences of aftercare were noted. Participants in the study experienced aftercare as providing them with belonging, support and encouragement, and structure. Participants also experienced aftercare as assisting them with relationship challenges and being convenient and accessible. Similar results were extrapolated from the literature that made reference to patients' experiences with different forms of group therapy. Participants also provided insight into the features of aftercare that they experienced as least beneficial and also provided recommendations that they believed could improve their experience of aftercare.

REFERENCES

Addiction Messengers. (2004). Ideas for treatment improvement. *The Addiction Technology Frontier Centre, 7* (4), 1-4.

Adler, J.M. (2013). Clients' and therapists' stories about psychotherapy. *Journal of Personality (81)*6, 595–605

Alaska Division of Behavioral Health. (2011). *Risk and protective factors for adolescent substance abuse. Alaska: Health and Social Sciences.*

Andrade, A. D. (2009). Interpretive research aiming at theory building: Adopting and adapting the case study design. *The Qualitative Report*, *14*(1), 42-60.

Battjes, R.J., Gordon, M.S., O' Grady, K.E., Kinlock, T.W., & Carswell, M.A. (2003). Factors that predict adolescent motivation for substance abuse treatment. *Journal of Substance Abuse Treatment, 24*(3), 221–232

Burhams, N. H., Dada, S. & Myers, B. (2012). Social service offices as a point of entry into substance abuse treatment for poor South Africans. *Substance Abuse Treatment, Prevention and Policy,7*(22).

Brown, S.A., & Ramo, D.E. (2008). Classes of substance abuse relapse situations: A comparison of adolescents and adults. *Psychology of Addictive Behaviors, 22*(3), 372-379.

Butcher, J. N., Mineka, S, & Hooley, J. M. (2007). *Abnormal psychology* (3rd edition.). Upper Saddle River United States of America: Pearson Education, Inc.

Baumeister, R. F., & Leary, M.R. (1995). The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin 117*(3), 497-529.

Central Drug Authority. 2012. Substance use and abuse in South Africa. Paper presented at the National Mental Health Summit, Pretoria, South Africa, 12 April 2012.

Cheetham, A., Allen, N. B., Yücel, M., & Lubman, D, I. (2010). The role of affective dysregulation in drug addiction. *Clinical Psychology Review 30*, 621-634.

Chetty, M. (2011). Causes of relapse post treatment for substance dependency within the South African Police Services. Unpublished master's thesis, University of Pretoria, South Africa.

Chopra, M. & Sanders, D. (2004). From apartheid to globalisation: Health and social change in South Africa. *Hygiea Internationalis,* 4(1), 153-174.

City of Cape Town. (2011). Alcohol and other drug harm minimization and mitigation strategy, 2011-2014. Retrieved from http://www.capetown.gov.za/en/CityHealth/Documents/CCT_AOD_Strategy_October2011.pdf

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *Health in South Africa, 374*(1), 817-834.

Covington, S. S. (2008). Women and addiction: A trauma-informed approach. *Journal of Psychoactive Drugs, 5,* 377-385.

Degenhardt, L., Mathers, B., Guarinieri, M., Panda, S., Phillips, B., Strathdee, S. A., et al. (2010). Meth/amphetamine use and associated HIV: Implications for global policy and public health. *International Journal of Drug Policy, 21*(5), 347-358.

De le Rey, C. & Pretorious, T. (2004). A brief introduction to research approaches in psychology. In N. Duncan & L. Swartz (Eds). *Psychology an introduction* (pp. 27-31). Cape Town: Oxford University Press.

DiClemente, C. C., Bellino, L. E., & Neavins, T. M. (1999). Motivation for change and alcoholism treatment. *Alcohol Research and Health, (23)*2, 86-92.

Docherty, A. (2004). Experience, functions and benefits of a cancer support group. *Patient Education and Counselling 55*, 87-93.

Duncombe, J., & Jessop, J. (2013). Doing rapport and the ethics of faking friendship. In M. Mauthner, M. Birch, J. Jessop, & T. Miller (Eds), *Ethics in qualitative research* (pp. 108-123). DOI: http://dx.doi.org/10.4135/9781849209090.n6

Fellingham, R., Dhai, A., Guidozzi, Y., & Gardner, J. (2012). The 'war on drugs' has failed: Is decriminalisation of drug use a solution to the problem in South Africa? *South African Journal of Bioethics and Law, 5*(2). 2-60.

Foo, Y., Tam, C., & Lee, T. (2012). Family factors and peer influence in drug abuse: A study in rehabilitation centre. *International Journal of Collaborative Research on Internal Medicine & Public Health, 4(3) 190-202.*

Fourie, D., Myers, B., Sorsdahl, K., Stein, D., & Weich, L. (2012). The effectiveness of a hospital-based intervention for patients with substance-use problems in the Western Cape. *South African Medical Journal*, 102(7), 634-635.

Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin (112)*1, 64-105.

Golestan, S., Abdullah, H.B., Ahmad, N.B, & Anjomshoa, A. (2010). The role of family factors on the relapse behavior of male adolescent opiate abusers in Kerman (a province in Iran). *Asian Culture and History (2)*1, 126-131.

Republic of South Africa (2009). Prevention of and Treatment for Substance Abuse Act, 2008. *Government Gazette 32150*(562)

Grella, C. E., & Joshi, V. (1999) Gender differences in drug treatment careers among clients in the national drug abuse treatment outcome study. *Drug Alcohol Abuse, 25*(3), 385-406.

Gruber, K.J., & Taylor, M. F. (2006). A family perspective for substance abuse: Implications from the literature. *Journal of Social Work Practice in the Addictions, 6,* (1/2), 1-29.

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

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

Jeremy, A. (2013). The temporal effects of parental divorce on youth substance use. *Substance Use Misuse, 48*(3), 290-297.

Johnson, S.L. (2003). Therapist's guide to substance abuse intervention. New York: Academic Press.

Johnson, S.M., Makinen, J.A., & Millikin, J.W. (2001). Attachment injuries in couple relationships: A new perspective on impasses in couple's therapy. *Journal of Marital Family Therapy, 27*(2), 145-55.

Koukourikos, K., & Pasmatzi, E. (2014). Group therapy in psychotic inpatients. *Health Science Journal, 8*(3), 197–207.

Lo Sasso, A. T., Byro, E., Jason, L. A., Ferrari, J. R., & Olson, B. (2012). Benefits and costs associated with mutual-help community-based recovery homes: The Oxford House model. *Evaluation and Program Planning*, *35*(1), 47-53.

Malterud, K., (2001). Qualitative research: Standards, challenges, and guidelines. *Lancet*, *358*, 483-488.

Morojele, N., Brook, J., Parry, C., & Kekwaletswe, C. (nd). Alcohol and drug abuse. 14

Mudavanhu, N., (2013). *An exploratory study on the reasons for substance abuse among the youth in Grabouw, Western Cape Province, South Africa*. Unpublished master's thesis. University of the Western Cape, Bellville.

McGovern, M. P., Angres, D. H,, Shaw, M., & Rawal P. (2003). Gender of physicians with substance use disorders: Clinical characteristics, treatment utilization, and post-treatment functioning. *Substance Use Misuse 38*(7), 993-1001.

Modernisation Programme. (2010). *Workstream on the prevention and treatment of harmful alcohol and drug use. Substance abuse blueprint*. n.p.

Morrow, S.L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260.

Myers, B.J. (2013). Barriers to alcohol and other drug treatment use among Black African and Coloured South Africans. *BMC Health Services Research, 13*(77), 2-11.

Myers, B.J., Louw, J., & Pasche, S.C. (2010). Inequitable access to substance abuse treatment services in Cape Town, South Africa. *Substance Abuse Treatment, Prevention, and Policy, 5*, 28. http://www.substanceabusepolicy.com/content/5/1/28

Myers, B., Louw, J., Pasche, S. (2011). Gender differences in barriers to alcohol and other drug treatment in Cape Town, South Africa. *African Journal of Psychiatry*, *14*, 146-153.

Myers, B., Petersen, Z., Kader, R., Koch, J.R., Manderscheid, R., Govender, R., & Parry, C.DH. (2014). Identifying perceived barriers to monitoring service quality among substance abuse treatment providers in South Africa. *BMC Psychiatry 14*(31), 2-10.

Newton, E., Larkin, M., Melhuish, R., & Wykes, T. (2007). More than just a place to talk: Young people's experiences of group psychological therapy as an early intervention for auditory hallucinations. *British Psychological Society, 80* (1), 127–149.

Parry, C. D. H., & Pithey, A. L. (2006). Risk behaviour and HIV among drug using populations in South Africa. *African Journal of Drug & Alcohol Studies, 5*(2), 139-156.

Pelissier, B., Jones, N., & Cadigan, T. (2007). Drug treatment aftercare in the criminal justice system: A systematic review. *Journal of Substance Abuse Treatment, 32*(3), 311-320.

Peltzer, K., Ramlagan, S., Mohlala, G., & Matseke, G. (2007). Illicit drug use trends in South Africa. Pretoria: Human Sciences Research Council.

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

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal, 20*,(1), 7-14.

Pluddemann, A., Myers, B. J., & Parry, C. D. H. (2008). Surge in treatment admissions related to methamphetamine use in Cape Town, South Africa: Implications for public health. *Drug and Alcohol Review 27,* 185-189.

Plüddemann, A., Parry, C., Bhana, A., Dada, S., & David, F. (2010). Drug abuse trends in South Africa (July to December 2009).Pretoria: SACENDU.

Pluddemann, A., Flisher, A. J., Mcketin, R., Parry, C. D., & Lombard, C. J. (2010). Methamphetamine use, aggressive behavior and other mental health issues among high-school students in Cape Town, South Africa. *Drug and Alcohol Dependence*. doi: 10.1016/j.drugalcdep.2009.11.021

Polcin, D.L., & Korcha, R. (2015). Motivation to maintain sobriety among residents of sober living recovery homes. *Substance Abuse and Rehabilitation,* 1. 103-111.

City of Cape Town. (2013). *Prevention of alcohol and other drug use policy*. AOD Prevention Policy. Cape Town: City of Cape Town.

Price, A. & Simmel, C. (2002). *Partners' influence on women's addiction and recovery: The connection between substance abuse, trauma, and intimate relationships.* Berkeley: National Abandoned Infants Assistance Resource Center, University of California at Berkeley.

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

Republic of South Africa. (2009). No. 70 of 2008: Prevention of and Treatment for Substance Abuse Act, 2008. Pretoria: Government Gazette No 32150.

Schmitt, S. K., Phibbs, C. S., & Piette, J. D. (2003). The influence of distance on utilization of outpatient mental health aftercare following inpatient substance abuse treatment. *Addictive Behaviors, 28*(6), 1183-1192.

Seeking, J. & Thaler, K. (2011). Socio-economic conditions, young men and violence in Cape Town. MICROCON Research Working Paper 49. Brighton: MICROCON.

Shaw, R. L. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, *7*(3), 233-243.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*, 63-75.

Smith, J.A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (ed). *Qualitative Psychology*. (2nd edn). London: Sage.

Snyder, L.B., Milici, F.F., Slater, M., Sun, H., & Strizhakoa, Y. (2006). Effects of alcohol advertising exposure on drinking among youth. *Archives of Paediatrics and Adolescent Medicine, 160*(1), 18-24.

Sorsdahl, K., Stein, D. J., Weich, L., Fourie, D., & Myers, B. (2012). The effectiveness of a hospital-based intervention for patients with substance-use problems in the Western Cape. *South African Medical Journal, 102* (7), 634-635.

Strebel, A., Shefer, T., Stacey, M., & Shabalala, N. (2013). Lessons from the evaluation of a public out-patient substance abuse treatment programme in the Western Cape. *Social Work, 49*(1), 38-52.

Toole, T. P. O., Pollini, R. A., Ford, D., & Bigelow, G (2006). Physical health as a motivator for substance abuse treatment among medically ill adults: Is it enough to keep them in treatment? *Journal of Substance Abuse, 31*, 143-150.

Tolan, P.H., Szapocznik, J., & Sambrano, S. (2007). Opportunities for development prevention of substance abuse. In P. Tolan, J. Szapocznik, & S. Sombrano (Eds.), *Preventing youth substance abuse: Science-based programs for children and adolescents.* (pp. 241-252) Washington, DC: American Psychological Association.

Tzilos, G., Hess, L., Kao, J.C., & Zlotnick. (2013). Characteristics of perinatal women seeking-treatment for marijuana abuse in a community-based clinic. *Archives of Women's Mental Health, 16*, 333-337. DOI 10.1007/s00737-013-0358-7

Vanderplasschen, W., Colpaert, K., & Broekaert, E. (2009). Determinants of relapse and re-admission among alcohol abusers after intensive residential treatment. *Arch Public Health, 67*, 194-211.

Van der Westhuizen, M. A., (2007). *Exploring the experiences of chemically addicted adolescents regarding relapse after treatment.* Unpublished master's thesis, University of South Africa, Pretoria.

Van der Westhuizen, M., Alpaslan, A. H., & De Jager, M. (2013). Aftercare to chemically addicted adolescents: An exploration of their needs. *Health SA Gesondheid 18*(1), Art. #599, 11 pages. http:// dx.doi.org/10.4102/hsag. v18i1.599

Wechsberg, W. M., Myers, B., Kline, T.L., Carney, T., Browne, F.A., & Novak, S.P. (2012). The relationship of alcohol and other drug use typologies to sex risk behaviors among vulnerable women in Cape Town, South Africa. *Journal of AIDS & Clinical Research, 1*(15), 2-8.

Weich, E.M.(2008). Medical management of opioid dependence in South Africa. *South African Medical Journal, 98*(4), 280. http://dx.doi.org/10.7196/samj.319.

Weisner, C., Mertens, J., Tam, T., & Moore, C. (2001). Factors affecting the initiation of substance abuse treatment in managed care. *Addiction 96(5),*705-716.

Western Cape Drug Forum. (2005). *Treatment and aftercare portfolio: Business plan.* Cape Town: Western Cape Drug Forum.

Willig, C. (2001). *Introducing qualitative research in psychology adventures in theory and method*. Buckingham: Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology*. (2nd edn.). New York: Open University Press.

Yalom, D. I., & Leszcz, M. (2005). *The theory and practice of group psychotherapy.* 5th edn). New York: Basic Books.

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APPENDIX A
INFORMATION SHEET

Project Title: Rehabilitated substance abusers experience of after-care following completion of in-patient treatment

What is this study about?
This is a research project being conducted by Stacey Elias at the University of the Western Cape and I'm inviting you to participate in this research project. The purpose of this study is to explore rehabilitated substance abusers experience of aftercare.

What will I be asked to do if I agree to participate?
Individual interviews will be conducted and you will be asked to participate in interviews regarding your experience of aftercare. Interviews will be roughly an hour. The kind of question that will be asked is, for example, (do you feel that aftercare helps you to cope with stressful situations at home?). All questions asked will be related to your experience of aftercare.

Would my participation in this study be kept confidential?
I will do my best to keep your personal information confidential. I will need to tape record information in the interviews. Myself and my supervisor will be the only ones who will have access to the recordings and these tapes will be destroyed once the information is captured. If a report or article is written about this research project, your identity will be protected as far as possible

What are the risks of this research?
There are no known risks associated with participating in this research project.

What are the benefits of this research?
This research will contribute to others in the field of substance abuse. Furthermore, it will contribute to organizations involved in the planning and delivering of aftercare services. It will hopefully also aid in improving services.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw from it at any given time without being penalized.

Is any assistance available if I am negatively affected by participating in this study?
The utmost is done to protect you from experiencing any harm as a result of your participation in this study. If however, you feel negatively affected by this research in any way, suitable assistance will be sought for you.

What if I have questions?
This research is being conducted by Stacey Elias at the University of the Western Cape. If you have any questions about the research study itself, please contact Stacey Elias, email: staceyelias007@gmail.com or 078 440 7099.

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:
Dean of the Faculty of Community and Health Sciences
University of the Western Cape
Private Bag X17
Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

APPENDIX B

CONSENT FORM FOR PARTICIPANTS

Title of Research Project: Rehabilitated substance abusers experience of after-care following completion of in-patient treatment

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.

Participant's name………………………..

Participant's signature……………………………

Date………………………

Witness` name:……………………………….

Witness` signature:……………………………….

 Date………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact me:

Study Coordinator's Name: Stacey Elias

University of the Western Cape

Private Bag X17, Belville 7535

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APPENDIX C

INTERVIEW GUIDE

1. When did you complete your in-patient treatment programme?

2. How long are you attending the aftercare programme?

3. Are you attending any other aftercare groups?

4. Do you feel that aftercare helps you cope with challenges you may experience in society/family?

5. Do you feel that aftercare helps you maintain the things you learnt in inpatient treatment?

6. Do you feel that aftercare helps you to abstain from drugs?

7. Is there anything you do not like or find useful about aftercare?

8. Have you ever relapsed while being in aftercare?

9. Did aftercare help you reduce your intake again or help you stop using again?

10. If you could make any changes or add anything to an aftercare programme, what would it be?