

UNIVERSITY OF ZULULAND



**Substance dependency post-treatment relapse causes among youth
involuntary service users in UThungulu District, KwaZulu-Natal.**

By

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DECLARATION

I, the undersigned, Nkanyiso Mkhize, Student Number, 20051205 hereby declare that the work contained in this master's dissertation is my own, except where due acknowledgement is in the references. This dissertation has not been previously submitted to any university or institution of higher learning for any qualification.

Candidate Signature: Date:

DEDICATION

The accomplishment of this research work is wholeheartedly dedicated to my parents Mrs Beatrice Malozi Mkhize and the late Mr. Mzonyana Mkhize, my late aunties, Zanele (MaMkhize) Mnguni and Nana Mkhize for instilling good values in me through teachings on diligence and prayer.

To my late old lady and best woman ever, Nombuso *Makalalane* (MaShange) Mkhize for believing in education and more particularly for exploring avenues in ensuring that education was made a supreme priority for her grandchildren.

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ABSTRACT

The rate of substance dependency keeps increasing and is fast becoming a major concern in the social development sector both nationally and across the globe. With the escalation of substance dependence rates, demand for treatment has also increased concurrently. Nonetheless, the re-admissions prevalence started to take place because of relapse, which still shows an increase as well. The purpose of the study was to explore and describe the causes of relapse among youth who were treated for substance dependency on an involuntary basis in UThungulu District, KwaZulu-Natal. Using a qualitative research approach, semi-structured interviews were used to gather data from four social work practitioners and eleven service users who were selected using both purposive and snowball sampling strategies.

The research findings projects that in-patient treated and out-patient treated involuntarily service users both have a high risk of relapse after treatment for various reasons. The in-patient users regarded the treatment process as not worthy at all, and that it did not respond to their treatment needs. Further, they believed that the treatment overlooked that which initially caused them to depend on substances. The out-patient treated service users on the other hand found the treatment to be subjecting them to risks of environmental influences such as the availability of drugs and the company of persons with substances misuse addiction, which placed more likelihood for relapse while on treatment.

The research findings established that lack of motive is the core for all causes of users' negative attitude towards treatment and the post-treatment relapse thereof. Poverty and unemployment were revealed as the major shortcomings usually faced by service users after treatment, and which ultimately made them resort to drugs again. Furthermore, findings have shown that lack of resources, working tools and the lack of adequacy and expertise among social work practitioners compromised service provision to involuntary service users, as a result post-treatment relapse was more likely to occur.

The study recommends that sober living houses (SLH) be established to complement the half way houses (HWH) in order to prevent service users from being exposed to poverty, inequality, neglect and segregation and other life challenges

they face after treatment. The sober living houses or halfway houses are standalone facilities for people who have been treated for abusive drug use where they learn necessary skills to reintegrate to their families and the broader society (Volkow, 2018:21). There should be an intensive training on managing cases of substance abuse dependents amongst social work practitioners and supervisors. Clear policy guidelines and operational procedures for involuntary service users must be in place and must include the effective case management procedures and quality control avenues. Guidelines for effective aftercare services designed for involuntary service users must be considered to prevent relapse.

ACRONYMS AND ABBREVIATIONS

ANAADAC	American Association of Drug Abuse Counsellors
AODs	Alcohol and Other Drugs
ATS	Amphetamine Type Stimulant
CBT	Cognitive Behavioural Theory
CDA	Central Drug Authority
DSD-KZN	Department of Social Development – KwaZulu Natal
DSM-IV	Diagnostic Statistical Manual – Five
LDAC	Local Drug Action Committee
MET	Motive Enhancement Theory
MRC	Medical Research Council
NASW	National Association of Social Workers
NDMP	National Drug Master Plan
NPC	Newly introduced Psychoactive Substances
SACENDU	South African Community Epidemiology Network on Drugs Use
SANAB	South African Narcotic Bureau
SANCA	South African National Council on Alcoholism and Drugs Dependence
SWP	Social Work Practitioner
SLH	Sober Living House(s)
TCSWSA	Terminology Committee for Social Work in South Africa
UDDAC	Uthungulu District Drug Action Committee
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organisation

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CHAPTER ONE

GENERAL OVERVIEW OF THE STUDY

1.1 INTRODUCTION

This chapter outlines the background of the study. It gives a description of key concepts, statement of the problem, the aims and objectives of the study, the research questions and significance of the study as well as an outline of the chapters.

1.2 BACKGROUND OF THE STUDY

According to World AIDS Organization in Youth Drugs and Crime (2011:16) substance dependency is a worldwide social phenomenon that escalates at an alarming rate. South Africa's National Drug Master Plan (2006/2011:111) reveals that the scourge of substance abuse and dependency continues to ruin communities and families, particularly the youth. What worsens the problem of substance dependency is the fact that it goes hand in hand with criminal behaviours, automobile accidents, and economic losses due to reduced productivity, dysfunctional family life, and health problems resulting from the escalation of communicable diseases and premature deaths, disrespect for the law, domestic violence and child abuse (National Drug Master Plan, 2006/2011:110).

Caswell (2018:19) maintains that almost 70% to 80% of child protection cases that social workers handle would not need a social worker if substance abuse was taken out of the equation. On the other hand, Cess Well (2017:44) indicates that social workers often handle cases whereby there are multiple generations of drug users in one household. In this case, children are removed and ultimately families become degenerated and unpreserved.

On the other hand, the Treatment Improvement Protocol (TIP) services (2014:94) establishes that family structures have become more complex in the recent century, are growing from the context of a traditional nuclear family into single parent families, step families, foster families, adoptive families, and multigenerational families. Therefore, when a family member abuses substances the effect on the family may vary according to family structure but it may have a strong impact on role modelling,

trust, and concepts of normative behaviour, which have an ability to damage the relationships within the family as a unit.

According to Fakier, Myers and Parry (2009:69), South Africa's youth are a particularly important population to consider when it comes to substance use and dependency. The above authors argue that youths are the most vulnerable to substance dependency and its related mental disorders. This is in line with the South African National Council on Alcoholism and Drug Dependence (SANCA) Annual Report (2010/2011: 12) which highlights that "youth is the most vulnerable group in scourge of substance abuse; as a result, the government and independent organisations have made all efforts to alleviate the phenomenon through providing in-patient and out-patient treatment programmes."

Contrary to the above, the South African Community Epidemiology Network on Drug Use (SACENDU) (2009) discloses that even though avenues are explored for providing effective treatment programmes (in-patient and out-patient patterns), there is a worse shortcoming of relapse. Youth service users face the occurrence of compelling feeling to reuse drugs after treatment completion.

In the study conducted by Matseke (2010) on the epidemiology of drug abuse and treatment in South Africa, it was revealed that the escalating rates of substance abuse phenomenon goes abreast with the high rates of relapse. The findings of the study showed relapse rates as 50%, 33% for alcohol, and 65% for harder drugs such as cocaine, dagga and heroin. One among main reasons stated for the high relapse rates was the nature of care in terms of out-patients rather than in-patients care. Lack of motivation among the patients was found being one of the primary causes of relapse. The lack of funds to continue after-care services and lack of after-care facilities were also identified as challenges to alleviating the mounting scourge of substance dependency in South Africa (Matseke, 2010: 47).

Over and above the other studies finding lack of motivation and resources such as aftercare facilities as the cause of relapse, on the other hand, Green (2012:108) observes that there are other factors that contribute towards substance dependence and relapse. For instance, the shortage of resources such as the treatment centres

and easy accessible hospitals and health facilities for detoxification programme. Deducing from the aforementioned facts, the main challenge facing involuntary service users is to maintain absolute abstinence after treatment. This might be some behaviour perpetuated by the fact that they are compelled by circumstances to access treatment, something they do not personally choose; hence change is not their desired outcome (Green, 2012:108).

South African Community Epidemiology Network on Drugs Use (SACENDU, 2009:134) indicated that there had been a continuous increase in the proportion of young people in treatment for drug dependence, although there was a noted little reduction after the establishment of the network, i.e. in 1998 (two years after the network was established). Young people under 20 years contributed between 6% and 13 % of the total population of patients in treatment. Ten years later, the same age group made up approximately 20% of the total patient population. The network (SACENDU, 2009:161) attests that this increase is difficult to interpret but there is a belief that it could have been attributed by quite number of factors, including an increase in adolescents and youth treatment demands and the return to treatment by those who have relapsed.

The high volume of hazardous drugs that continuously enter society, mounting drug consumption and the relapse of patients who have been treated worsens the problem of high prevalence of substance dependency (Chiauzzi, 2009:361). Once the patient returns to the same drug after treatment or the alcoholic turns to drinking, they will lose control literally (to a point of relapse). In such cases, it is highly possible to find that treatment is criticised for failing patients instead of considering shortcomings that could have been looked at, such as patients who relapse due to poor motivation to change. Relapse after treatment is generally stimulated by the fact that substance dependency is not considered as a secondary problem. Dependency is not understood as a symptomatic indicator for causal problems and circumstances, this sometimes make treatment to focus more on dependency than to causes of dependency (Fakier, Myers & Parry, 2009:102).

In America, the provision of aftercare services did not reduce the rate of relapse among the alcoholics, however, treatment clients were found returning to the

environment from which they came, and when they are confronted with high-risk situations, many of them returned to unhealthy patterns of drug use because they lack necessary coping skills (Healy, 2012:191).

The researcher sees the manner in which users encounter treatment as the main aspect in which the treatment attempt highly depends on. The researcher accepts the assertions that, in order to understand the concept of substance dependence treatment and relapse, there is a need to first understand dependency as a symptomatic indicator of for causal problems. This study therefore, aims to find the nature and extent of these causes.

Furthermore, in considering the above reviewed literature it appears that a lot of focus has been given to voluntary service users. Many highlights had been on lack of resources, lack of aftercare as a cause of relapse. However, in the study on relapse among alcoholics, Healey (2009: 294) clarifies that there is need for deeper knowledge about why post-treatment relapse keeps on increasing. It was found in this study that all resources were provided including aftercare programmes, but the high relapse prevalence could not be alleviated. It is therefore on this basis that the researcher in this study seeks to investigate the causes of relapsing specifically among involuntary service users. The study aimed at establishing whether the current general intervention approach in substance dependency fairly responds to treatment needs for involuntary service users.

In this study, the researcher used a qualitative approach aimed at exploring the causes of substance dependency post-treatment relapse among youth who were engaged in treatment on an involuntary basis. The researcher used the cognitive behavioural theory and the motive enhancement model as the theoretical framework that guided the study. The study setting is UThungulu District in the province of KwaZulu Natal. The study primarily focused on youth aged between 18 and 35 years. The study also involved social work practitioners who coordinated substance abuse programmes in three Social Development Sector Agencies namely; South African Council on Abuse of Substances (SANCA) Zululand, Ongoye and Richards Bay Department of Social Development Service Offices as key informants.

1.3 DEFINITION OF KEY CONCEPTS

The key concepts are as follows:

1.3.1 Involuntary service user

According to Munirul (2012:56) an involuntary service user is a client who is engaged in either in-patient or out-patient treatment for substance dependency without having personally chosen to participate in the treatment. For this study, an involuntary service user refers to a client or a patient with substance dependency condition who is mandated by circumstances to consider the treatment. An involuntary service user can be a substance dependent client referred for an in-patient or out-patient treatment by a significant other when it is seen that the dependency condition is likely to put their social functioning at-risk. An involuntary service user can be a substance dependent client who is on treatment under the direction of a court order. The involuntary service user can also be an employee with a substance dependency problem who is engaged in treatment by employer because of a directive or a recommendation by Occupational Health and Wellness Team (Trotter, 2010: 142).

1.3.2 Post-treatment

Generally, the term post-treatment refers to a period after a particular treatment action. (The Terminology Committee for Social Work in South Africa, 2008:11). The Medical Researchers (2014:47) on the other hand defines post-treatment as relating to, typical of, or occurring in the period following treatment. In the context of drug dependency, the term post- treatment refers to either a conduct, circumstances pertaining to a treatment process or life style after the treatment of a pathological drug dependency (Clinical Treatment Models, 2013:87). The current study adopts this definition by the Clinical Treatment Models.

1.3.3 Substance dependency

The Psychology Diagnostic Statistical Manual for Mental Disorders – 5 (DSM-5) (2013) defines substance dependency as a substance use disorder with either moderate, mild or severe manifestation of impaired control, social impairment, risky use and pharmacological indicators such as tolerance and withdrawal. In this study substance dependency refers to a psychological condition with a notable cluster of behavioural, cognitive, and physiological harms that develop after repeated abuse of

substances (Goldberg, 2014:92). Moreover, the World Health Organization (2015:31) claims that this repeated abuse usually include a strong desire to take drugs, difficulties in controlling its use, persisting in its use despite the harmful consequences, a higher priority given to use drugs than to other personal and recreational activities and obligation, increased tolerance, and sometimes a physical withdrawal state.

1.3.4 Relapse

Relapse has been contextualised both as a discrete outcome or a process. Definitions of relapse also differ and typically have been either operationalised as a return to any use or a return to original problematic use before treatment. There have been several attempts to establish specific conceptual models for relapse among youth and adult populations (Health Behavioural Institute, 2015:04)

The Terminology Committee for Social Work in South Africa (2008) cited in Raheb (2016:11) defines relapse as a reversion to antisocial behaviour such as drug misuse after a period of seemingly satisfactory social adjustment. For this study, the researcher uses the definition by SACENDU (2009:17) that relapse refers to a spontaneous recovery that revolves the recurrence of pathological drug use after a certain period of abstinence, and that it is also a return to drug seeking behaviour after an in-patient treatment help.

1.3.5 Youth

The United Nations Educational, Scientific and Cultural Organization (UNESCO, 2017:19) posits that youth is well understood as a period of transition from the dependence of childhood to adulthood's independence, and awareness of our independence as members of the society. For this study, the researcher considers the definition by United Nations Population Studies (2008:31) that "it is a post-adolescent stage of development and early period of existence marked with growth and maturity onset between eighteen- and thirty-five-years age range."

1.4 STATEMENT OF THE PROBLEM

The statistical breakdown by the United Nations World Drug Report of 2014 projects high prevalence among youth (i.e. 6.2% of youth abusing opioids, 6.9% of youth abusing amphetamine, 11,6% of youth abusing cocaine and 25.5% of youth abusing cannabis). Even when means for treatment are explored, the primary shortcoming is that service users, particularly youth service users resort to dependence after they have been rendered a sincere treatment.

The problem of substance dependency continues to escalate across South Africa (SACENDU, 2009:99). Statistics South Africa (2016:261) outlined that out of all persons treated for substance dependency, 18.8% were heroin users while 5.7% used cocaine regularly. Methamphetamine made up to 23% while a staggering 38.4% of people were treated for cannabis dependency. Prescription dependency contributed a total of 5.4% of persons treated, with ecstasy making up 0.3% while hallucinogen dependency was at 3.2%. With statistics indicating an increase in drug dependency, relapse was assumed to be a major cause (Statistics South Africa, 2009:99).

Other research studies have taken place; the outcome indicates that there is a prevalent challenge of youth service users who fall into dependency after treatment interventions (Health Behavioural Institute, 2015:38). Study conducted on the influence of relapse on South African delinquent youth who are mandated and ordered by courts for treatment of drug dependency, the results showed about 73% of delinquent youth falling back into substance dependency behaviour after completing the term set out in the court order (We Do Recover, 2009: 41).

Considering that even when service users successfully complete treatment, there seems to be a tendency of reusing drugs that occurs afterwards, particularly among the involuntary youth clientele. The researcher realised that there is a need to undertake a study seeking to ascertain the causes of involuntary service users falling back into the substance abuse trap after obtaining treatment. Therefore, the main research question of the study was: *What are the causes of relapse among youth involuntary service users after they have obtained treatment?*

1.5 AIM AND OBJECTIVES OF THE STUDY

The aim of this study was to describe and explore the causes of relapse among youth involuntary service users after obtaining treatment. The specific objectives of the study were:

- To investigate the involuntary service users' understanding of the nature of treatment that they underwent.
- To examine the significance of the involuntary service user's self-motive in inhibiting the post-treatment relapse.
- To explore the involuntary service users' attitude towards the treatment process.
- To explore the role of social work practitioners in preventing post-treatment relapse among involuntary service users.

1.6 RESEARCH QUESTIONS

The research questions that guided the study are as follows:

- What is the involuntary service user's understanding of the treatment process?
- How significant is the involuntary service user's self-motive from the service users' in inhibiting the post-treatment relapse prevalence?
- What are the attitudes of involuntary service users towards the treatment process?
- What is the role of social work practitioners in preventing relapse among involuntary service users?

1.7 SIGNIFICANCE OF THE STUDY

This research aims at adding to the literature on causes of post-treatment substance dependency relapse, with a focus on involuntary service users. Government departments and organisations in the social development sector might benefit from the findings of the study in terms of developing and refining programmes on prevention, early intervention and treatment for substance abuse. The umbrella bodies and regulative entities specialising in substance abuse such as the Central Drug Authority (CDA) and Local Drug Action Committees (LDAC) chaired by Local Municipalities within UThungulu district could valuably benefit from the findings. They can use the findings to strengthen their operational plans and draw up effective local programmes of action.

The findings may be useful for policy making purposes and quality assurance in substance abuse service provision. In this regard, the findings might also enable effective monitoring and evaluation of already implemented policies and programmes for substance abuse. The study is exploratory in nature and is intended to provide more explanations about the causes of substance dependency and relapse. Therefore, its findings might also assist social work practitioners, specialists and custodians of substance abuse treatment to strengthen their existing treatment programmes or develop new programmes that might effectively address the causes of relapse.

The study's findings might also serve as a wake-up call to families and the neighbourhoods affected by the scourge of substance dependency in UThungulu District. They could discover that substance dependency and relapse are a serious problem. Moreover, the families and the neighbourhood at large could be conscientised about their specific role in fighting the phenomenon.

Moreover, the findings of the study are a useful resource to UThungulu District Drug Action Committee (UDDAC) since the committee legislatively carries a mandate to oversee the problems of substance abuse and to come up with relevant prevention strategies. Substance abuse has become an ever-increasing challenge facing youths in South Africa and across the globe. Therefore, the findings of this study might play a significant role in strengthening the present efforts to fight against the escalation of substance abuse and mitigate relapses.

1.8 CHAPTER OUTLINES

The study is made up of the following chapters:

CHAPTER ONE: GENERAL OVERVIEW OF THE STUDY

This chapter gives an introduction of the study. This chapter provides such detail as the background of the study, problem statement, objectives and research questions that guided the study. It includes the definitions of key terms, the significance of the study and an outline of the dissertation.

CHAPTER TWO: LITERATURE REVIEW

This chapter provides the review of relevant literature found to be complementing with the layout of the research topic, i.e. the trend of substance dependency and relapse in South Africa and the relationship between dependency and relapse. Furthermore, the post-treatment relapse in a global perspective and social workers' role in inhibiting the prevalence of youth involuntary service users' post-treatment relapse, are also covered in this chapter. This chapter presents the service users' state of understanding in terms of the nature of treatment they have gone through, the post-treatment relapse predictors revised from the national and the international context. The theoretical framework of the study, the motive enhancement theory and the cognitive behavioural theory are discussed in this chapter. Discussion also focuses on the applicability of the theories to the study.

CHAPTER THREE: METHODOLOGY

This chapter describes the research methods that were used in the study. It clarifies how the research process took place. Included in this chapter is the description of the study population, sample and sampling strategies, data collection method and instruments, methods of data analysis and ethical considerations.

CHAPTER FOUR: PRESENTATION OF FINDINGS AND DISCUSSION

This chapter contains the presentation, analysis and discussions of the findings. Discussion of the findings is based on both theoretical aspects and relevant literature from previous studies.

CHAPTER FIVE: SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This chapter provides the summary of the findings; makes conclusions and provides recommendations and limitations of the study.

1.9. CHAPTER SUMMARY

This chapter has provided a clear overview of the study. The chapter comprises the introduction, background of the study, definition of key concepts, statement of the problem, research questions, and significance of the study as well as the outline of

the chapters. The next chapter focuses on a review of the literature and description of the theoretical framework.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, a review of the relevant literature on substance dependency post-treatment relapse is conducted. The scope of the review focuses at the problem at a global and local (South Africa) level. The discussion highlights the causes and the impacts of the problem. Themes relating to post-treatment relapse that have been researched in the existing literature internationally and the local South African background are explored. Finally, a discussion of the theoretical framework guiding the present study is provided.

2.2 POST-TREATMENT RELAPSE FROM A GLOBAL PERSPECTIVE

The current state of concern in most countries across the globe, and arguably in South Africa in particular, is that adverse consequences of substance abuse and dependency are certainly apparent (SANCA South Africa, 2010/2011:50). Complaining about the lack of resources such as after-care facilities is not enough to apprehend the phenomenological scourge of substance dependency. A lot of research is still needed implement relevant interventions (Ramphela, 2013:270).

The United Nations Office on Drugs and Crime (UNODC) (2014:4) indicated that drug abuse and dependency is a pernicious global problem affecting 29 million people worldwide, where heroin and dagga were found to be leading categories. Furthermore, in 2016 the World Drug Report examined the health impacts of abusing opiates, cocaine, cannabis (dagga), amphetamine-type stimulants (ATS) and newly introduced psychoactive substances (NPS) was released. The report approximated that nearly 250 million pupils of age between 15 and 64 years used at least on drug. It also report revealed further that 29 million pupils were diagnosed with drug use disorders compared to 27 million indicated in the 2015 report.

The problem of drug dependency devastates not only the individual's health state, wellbeing and productivity, but it also puts the user's family and society in great danger of HIV and AIDS, crime, mental impacts and economic hardships. The most devastating issue within the phenomenon is that, although effective treatment

programmes are available, very few of users who seek treatment and the majority among the few that seek help relapse subsequently and return to drugs (Green, 2012:42).

The Behavioural Health Institute (2015:12) revealed that relapse is a common but great concern in both developed and developing countries confronted by a heavy toll of substance dependency. Relapse is believed to be coming from the complex and the dynamic interaction between the individual's intrapersonal factors (which involve the effect of drugs in the physical body) and the environmental issues. A discovery of these intrapersonal issues and environmental issues brings up the various sequential interactive events that lead to relapse and is very important for developing effective relapse prevention programmes.

Research conducted by the National Institute of Drug Abuse (2014:10) in developed countries such as the United States of America and Spain exposed the role of intrapersonal factors. Factors such as the effect of substances in the brain, and the body, negative emotions towards the treatment and poor control over self were discovered triggers of relapse. Furthermore, personal behaviours such as the controlling temptations and the impulse to consume drugs, failing to participate in meaningful and rewarding activities such as employment, prayer, and spiritual resonates were among the major precipitators of relapse identified in the study's findings.

Intrapersonal circumstances associated with family and society were also identified as significant predictors of relapse, i.e. lack of support and a loving relationship, conflict, poverty, family and neighbourhood with drug tolerance and lack of access to basic needs. Relatively, the research conducted by the World Health Organization (WHO) 2009-2011 in developing countries such as India, Malaysia, and Taiwan identified causes of relapse as conflict, peer pressure and negative emotions towards treatment (World Health Organisation, 2009:12). Moreover, a study conducted by Gonzalo (2014) on youth perceptions about substance use and relapse established that 90% of relapse was related to emotional reasons. In light of this finding, Gonzalo (2014:49) further clarifies that: "Many of youth with substance dependency problem presents also one or more co-occurrences of depression,

anxiety, panic attacks, trauma and stress, suicidal and self-mutilation, criminal and deviant behavioural tendencies.” In considering these highlights, it appears that substance dependency scourge is a secondary condition that might be caused or worsened by the underlying psychological factors (Gonzalo, 2014:113). It’s these underlying factors that cause a cycle of substance re-use for purposes of finding mechanisms of psychological distress and coping (Gonzalo, 2014:96). Moreover, Parry (2012:11) shares that if the underlying psychological factors such as depression, anxiety, and stress are not efficiently addressed during treatment there is always a high likelihood of relapsing after treatment.

Complimentary to the above posits, Glik (2014:40) argues that even though majority of the treatment programmes are effectively working at addressing the multiple psychological stressors simultaneously (with the use of standardised assessment for other problems and case management), these formal efforts are not extended even beyond formal in-patient treatment. This is in line with Hellen (2014:21) who posit that it is still possible that the positive outcomes observed in treatment could be much better if the so called “post-treatment maintenance services (i.e. Continued Care and Support Models)” could include emotion regulation and coping skills for dealing with negative emotions. Muniral (2012:13) posits that relapse is an utmost concern, and states that the scourge of substance dependency is at an alarming rate yet very few substance abusers consider treatment, and the majority among the few that participated in treatment relapse after a short while.

However, the researcher is of the opinion that these posits lack clarity on the category of the few users who participate in treatment in terms of voluntary and involuntary treatment, because categorising would have provided baseline information for establishing whether it is the involuntary or involuntary service user’s category that largely contributes to relapse at the post-treatment phase.

Based on the above deliberations by Muniral (2012:13), there are few service users who openly decide to seek treatment. The very few of service users that voluntarily consider going for treatment, subsequently fall into relapse incidents. Therefore, the researcher argues that there is a shortage of qualitative studies that could explore and explain the problem of relapse more clearly. This lack of research seems to be

even worse when it comes to suggesting the factors promoting relapse among involuntary service users.

The above-mentioned studies that were conducted in both developed and developing countries did not report the linkages and interactions among the general complex and failed to clearly track down the links to relapse in order to restructure the relevant interventions. This therefore clearly projects indications that the previous research did not devote enough attention to substance dependency post-treatment, particularly in relation to the involuntary service users' category. The next section focuses specifically on substance abuse in South Africa.

2.3 SOUTH AFRICA'S SOCIO-ECONOMIC AND POLITICAL FACTORS INFLUENCING SUBSTANCE ABUSE

Tracing back in the history of racial estates, South Africa is faced with the global triple challenges which has entrenched high levels of poverty, structural unemployment and inequality. These triple challenges had dominated the space of human social functioning in South Africa (Chetheni, 2018:09). In the highlight of apartheid historical background, inequality stands in the forefront of the triple challenges and the strong precipitator of other social ills such as crime, drug abuse, racism, xenophobia and crime which South Africa still face today (Chibba, 2016:13).

In the fight against inequality perpetuated by the apartheid system, violence was used in South Africa. The emerging of violence as a statutory strategy to fight the apartheid system yielded into a war of racism, and this precipitated collected trauma across the South African society (Carrigal and Matzopoulos, 2017:10). Apartheid, as a systemised institutionalised process of race-based discrimination, exploitation and oppression, left in its wake a deeply traumatised society. Many still feel that the extent of this collective trauma has not been addressed enough, and that it has a negative impact in the present democratic era achieved after the apartheid demise (Adonis, 2016: 11). The traumatic memories affect not only those who have personally experienced conflict and violence, but also future generations through what is called intergenerational transmission of trauma (Adonis, 2016:2).

In the light of these socio-political background conditions many in South Africa resorted into drugs in searching mechanisms for coping with life realities.

Corrigal and Matzopoulos (2017:6) establish that violence, alcohol and mental disorders have a strong link and they can produce a cycle of harmful outcomes. On the other hand, Chibba (2016:4) highlights that violence has gone a long to an extent that it is now more common within domestic environment and in the community at large. The South African youth who have repeatedly experienced violence in any form are more likely to manifest in meeting the diagnosis for post-traumatic disorders (PTSD), stress and major depression where alcohol and other drugs are a main source of dependence for coping sake.

Over and above this, Volkow (2018:17) also reveals that too rich and too poor economic classification in South Africa has opened a huge gap whereby socio-economic issues such as unemployment and poverty emerged and became uncontrollable. These economic circumstances resulted in stress and anxiety in many South African citizens. Upon these mental health issues of stress and anxiety, many fell into substance abuse as their means for coping and this has further impacted the human social functioning among South African citizens.

The researcher is of the view that there are substance dependence cases whereby relapse is guaranteed before it actual takes place. For instance violence survivors who are referred for treatment, any treatment intervention cannot bring about the effective outcomes should the treatment fail to address the extent of violence and its psychological impacts to a service user. The researcher take note of the assertions by Chibba (2015) that the South African historical background of violence as a results racial oppression and discrimination must have left its citizens in a state of a collective trauma whereby the misuse of drugs is a coping strength. Moreover, the general public's attitude towards the persons with substance misuse addiction need to change from negative point of view into a concern about health aspects of the service user. This is said on the basis that more mostly, the reality beyond drug misuse is the circumstances that service users cannot control.

Whilst the high prevalence of substance abuse faces South Africa (Nkosi and Ndou, 2012:11) treatment is most widely and generally recognised approach to curb substance dependence phenomenon. The following section discusses the approaches to treatment.

2.4 APPROACHES TO TREATMENT

Substance dependence is a chronic illness that is not simple to treat. What makes treatment for substance dependence disease not easy to treat is the fact that it is acutely compulsive, and that it affect both the brain and behaviour (Nkosi and Ndou, 2012:15).

There are two approaches to treatment in South Africa; these are inpatient and outpatient treatment avenues (Cetheni, 2018).

2.4.1 Outpatient treatment approach

The outpatient treatment approach involves many programmes for users who visit a counsellor or a treatment social worker on a particular regular schedule (Ngoepe, 2016:9). The majority of these programmes encompasses individual and group drug counselling sessions each week. It is a treatment approach that is less intensive and more cost friendly than inpatient treatment avenue (Volkow, 2018:6). Inpatient treatment approach is mostly recommended for service users who are at the beginning stage of addiction. It also recommended for users who would like to continue receiving support and guidance as they integrate back to society following the completion of an inpatient programme (Ngoepe, 2016:9).

2.4.2 Inpatient treatment approach

Inpatient treatment is usually known as the residential treatment. It is a treatment approach that is usually considered effective on the basis that it comprises of highly structured programmes in which patients remains at a residence for about 2 to 3 months period. It focuses on detoxification, influencing the service user's attitude, understanding and behaviour associated with drug use (Mhlungu, 2018:12). Inpatient treatment for substance dependence is mostly better suited to individuals who are severely addicted and who require more focused therapy and care (Ngoepe, 2016).

2.5 NATURE AND EXTENT OF SUBSTANCE ABUSE IN SOUTH AFRICA

Substances used and abused in South Africa can be classified into three categories, such as drugs that are extensively used, those that are moderately used and drugs which are used less often (Parry, 2015:5). In the first category, alcohol remains the most commonly abused drug in South Africa, followed by dagga (cannabis), woonga (nyaope) and the dagga –mandrax (white pipe) combination. Among the mostly abused drugs, there is also a considerable abuse of over-the counter and prescription medicines such as pain killers, tranquillisers (including the benzodiazepines), coughing mixtures (especially those made out of codaine), slimming tablets and solvents (especially glue). The second category includes drugs such as cocaine (both crack and cocaine powder), heroin, speed and ecstasy. In the latter category are the drugs such as opium, rohypnol, katramine and welconnal (Parry, 2015:6).

Except the classified categories for drugs used and abused, many substance users in South Africa are poly – substance dependent users whereby one user misuse one common drug in combination with one type of illicit drug. For instance, combinations such as alcohol and dagga; dagga and mandrax; dagga and heroine; dagga and woonga and alcohol and cocaine (SACENDU, 2012:14). According to Parry, Rich, Claire and Deluca (2012:22) South Africa is a hard-drinking country, a notable volume of about 5 billion litres of alcohol are consumed in the country on annual basis.

In the national study conducted in 2016 on self- reported alcohol use and binge drinking, results projected that in 48 World Health Organization's member countries, South Africa presented with the highest per capita alcohol consumption by individuals of the age from 15 years and above. The study's findings reveals that amid heightening prevalence on the abuse of alcohol and other drugs (AODs), South Africa is faced with the challenge of binge drinking among young people which has turned into a typical lifestyle (Vellis, 2017:21).

Furthermore, Vythilingum, Ross, Faure, Geerts and Stein (2018:33) concur with the discoveries about the binge drinking problems and further maintain that South Africa has harmful patterns of drinking. This is based on the manner and the circumstances

in which alcohol is consumed, heavy drinking patterns in public spaces, leaving many households without parental supervision, substances induced social ills such as gender-based violence, intimate partner violence, spread of HIV and AIDS, school violence and an economic crisis.

Moreover, Domingo (2018:4) argues that in few three years to come, South Africa is more likely to be in a worse substance dependency phase and its related problems due to the recent legalisation of cannabis for private use. The decriminalisation of cannabis might expose the country to worse mental health shortcomings and substance induced lasting cognitive deficits. Contrary to this legalising of dagga were the concerns that South Africans had about the government laws appearing to be not fair enough. Following the legalisation of cannabis, the South African government disbanded the South African Narcotic Bureau (SANAB), a dedicated drug fighting unit in the South African Police (SAPS) which have had some notable success in alleviating the scourge of drug abuse and its related crimes in the country (McIntosh and Livingstone, 2008:70).

In concurring with Domingo's (2018) argument, the Central Drug Authority of South Africa (2018:21) affirms that South Africa is in a serious crisis of substance abuse and its relating problems, with no good results in all attempts to handle the circumstance. The Central Drug Authority contends that legalisation of cannabis should have been brought with valuable control measures (Central Drug Authority of South Africa, 2018:19).

The different explanations seem to have raised awareness about the extent of drug abuse in South Africa. Different findings about the nature and extent of drug abuse appear to be of common opinion that there is a lot that needs to be done in terms of harm reduction, supply reduction and demand reduction. Doing these might assist in alleviating relapse and other treatment problems. The next section focuses on the trend of substance dependency and relapse in South Africa.

2.6 TREND OF SUBSTANCE DEPENDENCY AND RELAPSE IN SOUTH AFRICA

Voskuel (2015:61) explains that the abuse of drugs and drug dependency have been identified both internationally and locally (in South Africa) as a mounting phenomenon. The effects of this twin burden impacts not on the user only but the families and the society at large. The financial costs associated with the treatment of substance-related disorders gives pressure on budgeting and other financial resources needed to treat dependency. However, the said problem becomes worsened by relapse co-occurrences.

According to Myers (2012:6), there is an alarming rate on the use and abuse of legal and illegal drugs among youth is of utmost great concern in South Africa. The South African Recovery Centre (2015:4) agrees that there is an alarming rate of substance dependency, and that the mounting of dependency rate is taking a heavy toll worsened by the unattended issues of relapse. Therefore, it is clear that the problem needs mitigation, perhaps using a multi-sectoral approach.

The research conducted by Keen (2015: 13) on the prevalence of multi-addictions and current treatment by drug treatment centres in Durban, South Africa found that in-patient participants who had been treated for substance dependency before reported a poor response to it, with most relapsing soon (within one month) after discharge. Another concern was that several participants in the study had used drugs whilst in treatment. Some had been introduced to or learned about other drugs, which they continued to use after they were discharged. Participants were aware that some treatment centres do not apply the continuous drug test routine whilst in treatment facility. As a result, they believed that using drugs during their stay could not be spotted. This then obviously made it impossible for an in-patient service user craving for substances to maintain abstinence despite this participation in a drug programme. The professionals expressed deep concern where there was no budget to test for substance use amongst in-patients, as they were aware of the temptation to which their in-patients could be exposed.

2.7 SIGNIFICANT PUBLIC HEALTH CONCERN OF SUBSTANCE ABUSE IN SOUTH AFRICA

South Africa has been identified as having a major problem with substance abuse (Valuda & Bhana, 2017:322). Research has shown that substance abuse is expanding rapidly, destroying individuals, families and entire communities and undermining national economies. The negative impact of substance abuse cannot be under estimated (NDMP, 2013-2017:48). Prevalence rates for substance abuse in South Africa are more than double the world average, with the socio-economic consequences of such usage costing the country an estimated R130 billion (US\$ 12.5 billion) per annum (Central Drug Authority 2012). Available attempts to explore this problem have examined epidemiological trends as well as risk factors for adolescent exposure to substance use (Gopal, Collins & Morimuthu: 2017:9).

According to Parry and Lombard (2016:19) what worsens the high prevalence and the effects of substance abuse in a South African society is the mounting trend of polysubstance abuse whereby one drug user end up abusing more than one types of drugs repeatedly to a point of dependency. Although there is some evidence to suggest that polysubstance abuse may be common in South Africa, there has to date been no systematic attempt to explore the nature and scope of polysubstance use in the South African context (Stacey, 2014:04). Polysubstance abuse and dependence has been found to be associated with increased risks of progression to intravenous drug usage, behavioural dysregulation, unsafe sexual practices and HIV infection, subtle cognitive deficits including impaired executive functioning, suicidal behaviour and prospective death in substance abusers seeking treatment (SANCA, 2014). Moreover, Stacey (2014:121) argues that polysubstance abuse and dependency may in most instances a main source of relapse after treatment.

These identified risk factors are likely to be particularly prominent in a South African context characterized by not only high levels of substance abuse but also by: largely preadolescent initiation of drug usage, an estimated 3.4 million children who have experienced the death of one or both parents (UNICEF/UNAIDS 2015:61), estimates of population poverty of 52.9%; and high prevalence rates for exposure to childhood trauma (Statistics South Africa, 2014:39).

The psychosocial causes of drug abuse can be caused by various reasons such as easy access. One of the social causes of drug addiction, which usually further open likelihoods of relapse is easy access to drugs (Cas Well, 2019). Although drugs can be found almost anywhere, certain places have more drugs than others (Substance Dependence Recovery Guide, 2011:89).

If a family member or friend uses drugs, this can also allow easy access; peer pressure- Particularly in teens, peer pressure can have an effect on drug use. According to the Drug Addiction Support website, poor self-esteem can lead to acute drug abuse and dependence, because some people want to be accepted by their friends and considered cool. Gopal, Collins and Morimuthu (2017) argue that even those who don't have a healthy sense of self-worth are more likely to become dependent to drugs. The reason for this is that taking drugs temporarily makes you feel good and can fill a void caused by not feeling good about yourself and being distressed emotionally. Those who are feeling lonely and depressed or who suffer from anxiety are more prone to substance misuse addiction as well. If you are going through a rough time in life, you are more likely to use drugs in an attempt to dull the emotional pain. Examples of this kind of distress are death of a loved one, divorce, financial problems and getting fired or laid off from a job (SANCA, 2011:17).

There are many biological factors that are involved with substance misuse addiction. It is distinctly different from the non-addicted brain, as manifested by changes in brain metabolic activity, receptor availability, gene expression, and responsiveness to environmental cues. In the brain, there are many changes that take place when drugs enter a person's blood stream (Stacy, 2014:23). The pathway in the brain that the drugs take is first to the ventral tegmentum to the nucleus accumbens. The drugs also go to the limbic system and the orbitofrontal cortex, which is called the mesolimbic reward system (SANCA, 2015:12). The activation of this reward system seems to be the common element in what hooks drug users on drugs (dependency). While biological causes of drug dependency have been suggested, many people still believe psychological factors comprise the bulk of what causes drug dependency (Valuda & Bhana, 2012:46). Some of the psychological causes of substance misuse addiction appear to be coming from trauma, often when the person with substance misuse addiction is young. Sexual or physical abuse, neglect, or chaos in the home can all lead to psychological stress, which people attempt to "self-medicate" with

intent to decrease the stress's pain through drug use. This self-medication becomes a cause of drug dependence. Other psychological causes of drug dependence include: a mental illness such as depression; Inability to connect with others, lack of friends; poor performance at work or school and poor stress coping skills (Trenz, 2015:70).

Although there are many routes to drug abuse and drug dependency, once the dependence state has been reached, but it is absolute given that it is a severely chronic state that can consume years, rather than months. It is a difficult condition but not impossible to overcome within this long-term perspective. It is also clear that it is a condition of relapse and remission (World Health Organization, 2015).

Parry (2011:119) ascertains that very few substance dependant individuals achieve permanent abstinence in the first time of the attempt, and those that ultimately achieve it; the majority have had numerous attempts to escape. They may have tried to become abstinent, but only managed temporary reduction in dosage, and they may have become abstinent but resumed to drug taking afterwards. The Behavioural Health Institute (2015:3) brings to light that the abstinence cycle is an ultimate consequence of a treatment failure. The institute argues further that it is absolute and not treatment failure, instead the evidence of other research reveal that, a carefully undertaken assessment will likely to make treatment relevant to the individual needs of service users. This ultimately brings about abstinence maintenance by the service user without too much interventions of a professional.

Gibson and Parry (2008:248) argue that it is important that all those who work with substance dependent individuals understand the fluctuating conditions towards recovery. Therefore, the behaviour of resorting to drugs after treatment should not be considered as emanating from treatment failures, instead it should be viewed as an indication of severity of the underlying dependence problem. However, Hellen (2015:38) found, "many in-patients, upon discharge, had not continued with aftercare either at the drug treatment centre or with other groups such as Alcoholics Anonymous, or Narcotics Anonymous. The lack of follow-up and continuation of treatment as out-patients may be linked to the high relapse rates mentioned by participants." However, these findings were in line with Bernstein (2011:56) who

avers that “attendance after-care services helps to improve treatment outcomes, and ultimately curbs relapse”.

2.8 SUBSTANCE ABUSE LEGISLATIVE FRAMEWORK AND POLICY OUTLINE IN SOUTH AFRICA

In response to a mounting substance abuse problem in South Africa, there are two primary legislative elements, namely prevention of and treatments for substance abuse act no 70. Of 2008 and the national drug master plan (NDMP), they both serve as a fundamental national drug control framework (Cess Well, 2017:41).

2.8.1 Prevention of and treatment for substance abuse act (no. 70 of 2008)

When the global drug trade intensified, South Africa on the other hand continuously encountered a rapid escalation of substance dependency. In attempt to come with a comprehensive national response into scourge substance dependency the Prevention of and Treatment for Substance Abuse Act (No. 70 of 2008) was formulated.

As a primary legislative mandate, the act serves as as the uniform law to deal with the prevention of and treatment for substance abuse and the harm associated therewith, the treatment of service users in different treatment site and the reintegration of service users in their families and communities at large. As a legislative base on issues of substance dependency in South Africa, the prevention of and treatment for substance abuse act aim to:

- i. Reduce the escalation of substance dependency by providing a comprehensive national response.
- ii. Bring into place workable mechanisms that will combat the/or reduce the demand and harm caused by the abuse of substances by providing prevention, early intervention treatment and reintegration programmes.
- iii. Provide for the reintegration, and establishment of treatment centres and half-way houses.
- iv. Provide for the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres.

In Section 3 (1) the legislation outlines clearly that substance dependency has huge impact, and that reasonable measures must be taken by all government departments and all organs of the state. Here the legislation maintains that there is a need for the rendering of services aimed at discouraging the abuse of substances by the general citizens. Moreover, section 3(1) (b) clearly outlines the drug dependency drug dependency harm status quo, as a result the legislation appeal for the holistic treatment of service users and their families, and mitigating the social, psychological and health impact of substance abuse as the approach for reducing the harm of the scourge of substance dependency.

Seemingly, the legislation made a profound clarity by indicating the specific emphasis on the development and coordination of the three-way areas of intervention, namely demand reduction, harm reduction and supply reduction. However, the researcher is of the opinion that section 3 (1) (b) of the legislation should have included some provision on how relapse could be prevented and how relapse causes may be looked at.

2.8.2 Strategies and principles for demand and harm reduction

According to National Institute on Drug Abuse of America, across the globe there is a huge rate of substance dependency and relapse has notoriously contributed to this shortcoming. In South Africa, guiding principles were set out on the basis how the service provision to service users should be conducted with the aim to address the harms caused by substance dependency (Government Gazette, 2017:91).

Section 4 of the prevention of and treatment for substance abuse act (no 70 of 2008) well articulates that the focus of intervention should in both the service user and persons and families affected by substance dependency. In this regard, the section 4 (4) places the following emphasis:

- i. That treatment and other services rendered to service users must be in an environment that takes into consideration the educational, social, cultural, economic and physical needs of such person.
- ii. At all costs there should be a promotion of the prevention of exploitation of service users and persons affected by substance dependency.
- iii. Tangible means should be explored to prevent stigmatisation of service users.

- iv. There should be a promotion of respect for the person's human dignity by enabling participation of service users and persons affected by substance abuse in decision making process regarding their needs.

The researcher finds the demand and harm reduction strategies relevant to a call to address the crisis of substance dependency and relapse. There is still a gap. This gap is caused by the fact that relapse has never been given the full attention in a manner that balances the voluntary and involuntary treatment issues. The researcher is of the opinion that relapse need be looked at more broadly in a sense that it helps in determining its nature and extent of contribution towards substance dependency in general. The harm and demand reduction strategies seem to not consider relapse as a crisis. Moreover, in describing the involuntary user, the act considers one category of involuntary service users, namely the court committals or court ordered treatment as an involuntary treatment element. It does not consider the other elements of involuntary service users such as the service users compelled by family and significant others to consider treatment and employees compelled by employers through employee health and wellness avenues.

In view of the above mentioned, the researcher considers that extreme less is said about the relapse problem in the context of the involuntary service users. The concept of involuntary service users lacks broad descriptions that are inclusive of other mentioned above elements. This would further assist to clearly understand post treatment relapse and its causes. The researcher is of the opinion that there is a big role of policy framework in this regard.

The following section looks at the national drug master plan as another policy framework that may help to find more reasonable cause for substance dependency.

2.8.3 The national Drug Master Plan

In enabling the implementation of the directives and the recommendations provided for in the prevention of and the treatment for drug dependency act (act no 70 of 2008), a national drug master plan (NDMP) was formulated in South Africa. The primary purpose of the national drug master plan is to provide a policy direction and coordinate efforts to respond to substance abuse in South Africa with intent to make

South Africa a drug free nation. To meet these priorities, the plan proposes a balanced approach using an integrated combination of strategies, namely demand reduction, harm reduction and supply reduction; thereafter the plan ensured the setting out the outcomes which are embedded to said priorities (Government Gazette, 2017:41).

In as much as the national drug master plan holds a clear mandate in terms of its three pillars of harm reduction, demand reduction and supply reduction, however there is policy confusion around harm reduction whereby the law enforcement criminalise users and persons with substance misuse addicts. In that way, it is found to be working against the public health approach of restorative justice (National Evaluation System, 2017:92)

2.9 THE ROLE OF SOCIAL WORK PRACTITIONERS IN INHIBITING THE PREVALENCE OF YOUTH INVOLUNTARY SERVICE USERS' POST-TREATMENT RELAPSE

According to Ghodse (2015:244) social work is a pioneering profession from the initial phase up to the final phase of working with persons with substance misuse addiction. A social worker's role in substance misuse addiction intervention may vary with the setting and the context of case presented by the service users. Most quite often, social work practitioners perform roles such as client intake and assessments, develop treatment plans and counsel patients in individual or group settings (Vawda and Bhana:2012). Goldberg (2014:151) identifies that assessment is the most paramount therapeutic role of a social worker, and further specifies the aspects that the social worker assesses which include the service users' social functioning state and the individual needs. The social worker can offer help in social problems such as housing, welfare rights and financial difficulties, and can liaise with outside agencies and the courts in the case of service users who are referred to treatment by courts.

In highlighting the importance of social worker's role, Trotter (2011:142) emphasises that the social worker must work closely with the family of the service user. In the case where a parent is ordered to go for treatment, the social worker has a statutory responsibility for the interest and safety of the children of the person with substance misuse addiction. The social worker has a primary role of advising and supporting

the persons with substance misuse addiction before treatment. The advice and support play a valuable role in channelling the user's state of readiness for the treatment process.

The Drug and Alcohol Review Research Institute (2012:81) ascertains that a social worker's preliminary careful, detailed and thorough assessment of individuals with substance dependence problems is of utmost importance. Healey (2012:06) argues that in-depth assessment patterns by a social service professional should mainly seek to identify the nature and the severity of the dependence problem, assess the consequences of dependence, and determine the service user's strengths and weaknesses. The assessment should not only end with identifying strengths and weaknesses, but it must also arrive at the service user's degree of perceptions about going for treatment. Armed with this detailed information, it is possible to make the treatment respond to the user's expectations and individual needs.

Ghodse (2015:127) reveals the importance of the social worker's role in working with substance dependence. Part of these roles is the social worker's passionate explanation to a service user about the various assessments that the social worker conducts. Explanation needs to focus beyond the assessment criteria but must also explain to a service user that it aimed at ideal ambitions of wanting to make the treatment a success without any subsequent interference of relapse. Assessment always serves as an important tool that enables the practitioner working with a service user to probe how the service can be effectively rendered. Therefore, the next section focuses on the role of social work assessment.

2.9.1 The role of social work assessment

In ascertaining the role of social work in the problem of substance dependency and post treatment relapse, the Behavioural Health Research Institute (2015:7) articulates that, as a pioneering profession in fighting the scourge of substance dependency, more particularly against relapse prevalence, the social work assessment is of vital importance. The National Institute on Drug Abuse (2016:7) suggests that the social work assessment is a clinical and psychosocial instrument that can be used to measure the impact of dependency. It helps to determine the user's state of readiness for the treatment as well as refining the treatment plan

according to the individual needs of the service user. The social worker's assessment role can help a lot in eliciting detailed information that reveals the needs of the service users and devising a responsive treatment plan and prevent the probability of relapse (Ghodse, 2015:111).

According to Petterson (2009), cited in the Clinical Treatment Models (2013:92), the service user (when consulting a social work practitioner) may be interviewed initially in the social worker's office or in a community venue, but home visit is often helpful in permitting the first-hand appraisal of living conditions and the life style of the user. Ghodse (2015:117) discusses the supreme elements with emphasis that the assessment by a social work practitioner is not holistic without yielding the following:

- **The user's personal life history**

Having explored, defined, and understood the drug taking, it is necessary to find out about the life history of a substance dependent client, their environment, experiences and personality. To know this, it all helps the worker to explicitly understand the why and wherefores of the dependence. Reaching this understanding creates empathy between the substance dependant patient and the worker.

- **Drug history**

The social worker's assessment should probe lengthy about the user's drug history. The purpose of drug history is to obtain detailed information about the service user's drug taking behaviour both in the present time and in the past. To obtain accurate details, the social worker needs to maintain the professional principle of confidentiality and adopt a non-judgemental attitude; these will put the user at ease (National Institute on Drug Abuse, 2016:09).

Some substance dependant clients have been in conflict with the law, and they may have felt some rejection from the caring professions in the past. They may still be involved in illicit activities, and in that way, they may be suspicious of those who try to help them and become defiant towards professional help. It is therefore important that the social worker establishes some degree of empathy with them; it is necessary to understand the depth rationales behind their behaviours, much of which is a

learned response to pressure from families, peers and professionals (Healey, 2012:06).

Matseke (2010:83) suggests that the use of empathy in a substance abuse therapeutic process is of utmost importance. As the ability to understand and identify with another person's feelings, motives and situations empathy is more likely to put users at ease during the treatment process, and in that way, they are more likely to develop insight and self-determination. A good use of empathy by a social services practitioner (social worker) helps the substance dependant service user to have the degree of self-perceptions expand into wholeness. When the self-perceptions patterns of the user extend to wholeness, the service user is more likely to begin developing elements of hope, need for change and confronts realities about the presenting problem of substance dependency.

2.9.2 Assessment of other addictions

According to Keen (2015:234), the treatment of drug dependency is supposed to be preceded by formal assessments for other addictions beside substance abuse. The emphasis of working out other addictions concurrently with substance dependency is what is suggested by Herring (2011:101). The literature echoes that other additions such gambling addition, sex addiction, delinquency, financial spending, relationship patterns and emotional states are additional to substance dependency, and when not given attention they may stimulate relapse. Similar to these indications, Hellen (2015:53) further brings to light that ignoring these additional addictions, substance dependant service users are at greater risk of using them as a coping strategy in replacing the actual substance dependency.

According to South African Depression and Anxiety Group together with South African Substance Abuse Helpline (2014:12), the existence of other addictions to a substance dependency service user takes the same shape of co-occurrences such as stress, trauma and delinquency that when not thoroughly dealt with, are more likely to cause the cycle of return to drugs after treatment. Likewise, the existence of other addictions after substance dependency treatment can, at any given point serve as triggers where the service user finds repeatedly reminded of already treated dependency behaviour.

2.9.3 Family assessment

Family assessment is another key responsibility of a social worker. It is a process of obtaining in-depth information about the lifestyle and the background of the service user, through involving other members of the family. On the other hand, family assessment except obtaining the lifestyle background of the client, it also seeks to explore the extent of risks by ascertaining how the substance dependence behaviour of the service user may have been affected by family attitudes and dynamics, and the effect of substance dependence in the family (Paar, 2012).

The importance of family assessment is also prominent in the findings of the study conducted by Keen (2015:117), which brought to light that some substance users had been encouraged to gamble by their families to assist them in their efforts to abstain from substance use. The researcher further echoes the importance of family involvement in treatment as well as the important role of preventive education about addiction. While families may be well meaning, they need to be well informed in order to provide appropriate support and assistance to substance abusers.

Goldberg (2014:91) on the other hand posits that family assessment is of utmost importance in planning a treatment schedule, which will be responsive to the service user's needs. In this way, family assessment is value adding in the efforts to fight the scourge of relapse. Family assessment can play a valuable role in minimising post-treatment relapses, on the basis that, in particular it may indicate a need for family therapy and/or support for other members.

The National Association of Social Workers (NASWA) (2011:99) revealed in its inputs in 2011/2016 National Drug Master Plan that there is adequate need to implement the Evidence Based Psychosocial Treatment of Substance Abuse as an approach for curbing relapse after treatment. In that regard, social workers have a vital role to play mainly in developing policy, conducting research studies and developing effective standard operation procedures.

However, Quinn (2012:31) argues that even though well researched best practice models and treatment responsive approaches are in place, the major problem is that social workers who lack quality training and expertise in the treatment of substance

dependency and its related disorders. This brings clarity to the discoveries by the National Association of Alcohol and Drug Abuse Counsellors (2010:167) that social workers, particularly in the public practice domain are reported being the least interested in working with substance users compared to other professional disciplines. Furthermore, they are more pessimistic about substance users' prognosis and their own ability to work therapeutically with clients who present with substance dependency and dependency disorders. In line with these discoveries, Richardson (2008:119) suggests that the curriculum for social workers' professional training needs to be reviewed to ensure that it comprises enough strongest substance dependency courses, and related field placements.

The researcher considers the lack of quality training as a critical matter that requires attention by the Association of Social Work Education for quality controls. The researcher further considers ascertains by Richardson (2008:119) that the social work professional training curriculum be reviewed to maintain quality in practice. This is so because substance dependency is a complex subject, and requires a practitioner's good stand of expertise, on that note there would be means to curb relapse prevalence. Moreover, if the American National Association of Alcohol and Drug Abuse Counsellors (2010:44) found that social work practitioners are pessimistic about service users' prognosis, However, under such circumstances, services to service users can be compromised and relapse is more likely to take place.

The South African Government Gazette (2017) on the review of substance abuse policy and regulations, it brought to light that there is critical gap of skills concerning the substance dependence and treatment. There is therefore a need to develop a plan to encourage more people to study in the field of substance abuse treatment, and to oversee the development of accredited training courses on substance abuse. The training must target social workers and auxiliary social workers.

Giving more training and capacity building to social work practitioners, through putting in place effective standards of operation, supervision and support to social workers and monitoring systems all will strengthen the effective role of social workers. As Peterson (2016:26) emphasises that, "substance dependency is a very

complex subject, and that relapse is thereof a critical disease, as a result the strength of practitioners' expertise is of utmost importance for any desired intervention". Finally, the mounting post treatment relapse prevalence shall be efficiently alleviated.

2.10 SERVICE USERS' ATTITUDES TOWARDS TREATMENT

In the study conducted by Matseke (2010: 47) on the epidemiology of drug abuse and treatment in South Africa, it was revealed that the escalation in of the substance abuse goes abreast with the high rates of relapse. The findings of the study showed relapse rates as (50%) for cannabis, (33%) for alcohol, and (65%) for harder drugs such as cocaine, dagga and heroin. One among main reasons stated for the high relapse rates was the nature of care in terms of out-patient rather than in-patients care. Lack of motivation among the patients was identified as one of the primary causes of relapse. The lack of funds to continue after-care services and lack of after-care facilities were also highlighted in the study findings as predicaments to alleviating the mounting scourge of substance dependency in South Africa.

According to Green (2012:132), despite the presenting challenge on shortage of resources such as treatment centres, hospitalisation detoxification programmes, and access to self-help groups such as Alcoholics Anonymous (AA) groups and after-care programmes available to service users to seek assistance with their substance dependency problems. The major shortcoming facing involuntary service users is to maintain absolute abstinence after treatment. This might be behaviour perpetuated by the condition that they are compelled by circumstances to engage in treatment, they do not personally choose, as a result change is not their desired outcome.

The above research information clearly exposes the reality that a service user's state of readiness for the treatment is one of the things to carefully consider beforehand. A service user whose attitude is not well refined towards a positive state of readiness for the treatment is more likely to be difficult to work with. Generally, unmotivated clients are mostly resistant towards change; for example, the high-risky service users are usually the ones that resist change (Goldberg, 2014:96).

Considering the above, it is clear that substance dependant involuntary service users normally resist change. Their resistance requires a good practitioner, one who will not be overwhelmed by the user's attitude of resistance, instead a practitioner who will understand the resistance in the context of what the cognitive behavioural technique explained as, "person's thoughts, beliefs, attitudes and assumptions that distorts the positive behaviours". In line with these views, Deventer and Mojapelo (2013:7) aver that social work practitioners play an immense role in helping service user's to develop potential for change. When helping users to develop potential the practitioners would be enabling their client (service users) to live a more creative life, and that practitioners on that note must consider fostering the following behavioural elements that stimulate motive as a beginning as outlined by the National Institute on Drug Abuse (2013:10):

- Be willing to change. Ask yourself: 'Am I living in a way that is satisfying to me?' If not, be prepared to make changes. This does not necessarily refer to physical aspects of your life, rather it refers to the way you see things.
- Take responsibility. Do not blame others for your shortcomings.
- Examine your motives. Try to each life decision for growth, not to escape fear or anxiety
- Experience honestly and directly. Do not distort information and help to fit your way of seeing things.
- Make use of positive experiences. Repeat experiences that have given you feelings of amazements, renewal, humility or joy.
- Be prepared to be different. Accept your uniqueness. Think about the standards you use to judge yourself.
- Assess your progress. Look at yourself and, if necessary, renew your efforts. If you are bored with something, see it as a challenge and do something about it. Your opportunities for self – enhancement (National Institute on Drug Abuse, 2013:10).

Other scholars have also highlighted the critical role that social worker practitioner plays. For example, Trotter (2011:74) emphasized that the involuntary service user's resistance and negative attitudes require a practitioner's understanding that will be beyond substance dependency, but look at the dependency underlying precipitators, which the cognitive behavioural theory had considered as the predispositions of

depression, anxiety, trauma and other personal life experiences. Therefore, the initial scope of intervention in the treatment process should target what the proponents of the cognitive behavioural theory emphasised, that the user must be helped to learn to correct the negatively biased attitudes and beliefs that are based on faulty assumptions.

The researcher also esteems indications by Trotter (2011:74) that the only time where involuntary service users show positive response and compliance towards the treatment process is when they are mandated to treatment through the court order. However, this might be that the court mandated involuntary service users regard the treatment as an actual sentence. In that way they can easily relapse because their attitude towards the treatment is not about the change, instead legislative forces of the court (court order) compel them. Their mind is subjectively conscious about the consequences associated with failure to abide by the court order, rather than the treatment effort to change their unwanted dependency behaviour.

The negative attitudes therefore fades the user's attention from learning new coping styles to help them adjust in life without returning to dependant behaviour. However, this relate relevantly to the findings by Healey (2012:14). Healy (2012:14) found that after-care services did not reduce the rate of relapse among alcoholics, instead the treated service users were found returning to their neighbourhood environments after treatment, where when they are confronted with high-risks situations, majority resort to worse unhealthy patterns of drug use because they lacked necessary coping skills. This implies that to effectively deal with the resistance and other elements of negative attitudes of involuntary service users, practitioner's will need to strengthen their intervention expertise with a good combination of the motivational enhancement model and the cognitive behavioural model.

The Compulsory Treatment (2013:238) asserted in its revised treatment dynamics that, the negative attitude towards the treatment is a great concern even among young offenders with substance dependency diagnosis who are ordered by the court to attend treatment. Although there is little research-based information about how offenders perceive the court order mandate to attend drug dependency treatment, the procedural justice orientation suggests that offenders who view the mandates as

legitimate and useful are more likely to comply with the treatment, but they fall into a reuse of drugs after their treatment completion. The study conducted by Behavioural Health Institute (2014:62), used in-depth interviews with probationers and parolees who were forced through court orders to attend drug dependence treatment, and the results showed that offenders disliked being ordered to complete drug treatment.

In light of the above, the Behavioural Health Institute (2014:64) further ascertains that the concern should not only be about complying with the court system, rather it should be their developing insights about the treatment. However, these findings closely relate to research findings in a study conducted by Heidi and Anne (2015:73) which discovered that confrontational, and boot-camp style programmes usually further damaged young people's self-esteem and finally result in high relapse rates after programme completion.

Therefore, the researcher assumes that those working on enhancing positive attitudes towards treatment should focus on instilling good understanding of the treatment process. Instilling understanding may foster the service user's self-actualisation even before they get engaged in the treatment process. The following section will focus on the service user's state of understanding the treatment itself afterwards.

2.11 THE SERVICE USER'S STATE OF UNDERSTANDING OF THE NATURE OF TREATMENT

According to Adams (2013:48), substance misuse problems are lifelong battles. The number of times in which one tried to escape the condition matters not, what really matters is that a substance dependent makes a personal commitment to "self" to lead a healthier life. In line with these points, Quinn (2012:20) brought to light that many substance abuse dependents have attempted to quit the dependency on their own, and they have fallen into a trap of relapse more than once. Along their personal attempt to escape, they have discovered that quitting is a worse difficult fight with a lot of stumbles along the way. These personal experiences therefore make the dependents to develop the unreasonable perceptions which lead to negative attitudes towards treatment.

Ramphela (2013:276) discovered that negative attitudes are a common factor and the attitude is worse among substance dependants who have relapsed; and the substance dependants who once tried to escape the battle of drugs alone. Fears of withdrawal symptoms (such as depression, loneliness, insomnia and other sleeping problems leading to tiredness, anxiety, and constant craving) that the substance dependants have experienced at the stage of trying escape is a primary predictor of negative perceptions and attitudes towards the treatment. Additionally, Goldberg (2014:96) mentioned that the state of their mental feelings shifts from the significance of treatment consequences into fear of withdrawal symptoms.

Adams (2013:39) bring to light that the state of perceptions and attitudes towards the treatment destructs the effective and potential success of the treatment. The avoidance, fears about the withdrawal symptoms among substance dependents with history of post-treatment relapses is also another common predictor of negative gestures of substance dependent patients towards the treatment.

The National Institute of Drug Abuse (NIDA) (2009:51) points out that sometimes the service users' negative attitudes towards treatment can be precipitated by the fact that many of them were handled during their institutional treatment. This makes most dependents to prefer means of treatment be on out-patient basis than in-patient care.

The Behavioural Health Institute (2014:51) found that the issue of negative attitudes of substance dependents towards the treatment, especially those with a notable history of relapse has been a great concern since the 20th century. In line with these discoveries, Ghodse (2015:123) revealed that this shortcoming started to show up from the angle of delinquents who were compelled to a compulsory treatment of criminal behaviour (corrections and rehabilitation) and substance abuse among those with substance dependence related offences. The fact that the dependants were compelled and mandated for treatment, potential relapse was predictable. The dependants were found as patients with a wide range of problems, where they did not comply with the prescribed treatment regime, and they were found often going to extraordinary lengths to obtain more drugs.

According to McIntosh and Livingstone (2008) the patients are not negative towards the treatment; instead they fear the personal experience of withdrawal symptoms and other unknown adverse of life after treatment. The authors outlined the six phases of change that define the process of recovery from the use of addictive substances, and points clearly that an individual rarely moves through them in a linear manner. The authors further revealed that people with substance abuse disorders are more likely to move through the stages in a cyclical manner until they achieve the final results, i.e.

- Precontemplation - Here the individual finds it difficult to give up the intoxicating substance
- Contemplation - The individuals in this phase are thinking about the situation and decision if they really want to stop the dependency behaviour
- Preparation- In this phase the individual is getting ready to take action
- Action- The individual is actively engaged in discontinuing substances use
- Maintenance- In this phase efforts are made to sustain the remittance
- Termination - In this phase the maintenance programme is no longer needed, and the individual is empowered enough to function independently (McIntosh and Livingstone, 2008:78).

2.12 PREDICTORS OF POST-TREATMENT RELAPSE

Many people experiencing addiction, participate in treatment and soon afterwards relapse, and are not in a position to maintain a complete abstinence from drug and alcohol (NIDA, 2009). One of the primary factors impacting return to substance use is stress. Anglin et.al (2014:20) show that stress is a predictor of initial use of drugs and alcohol, the development of drug and alcohol dependence, and there is a likelihood of relapse after a certain period of abstinence. In addition to the direct effect of stress on substance use and dependence stress also contribute to a psychological distress, often experienced as a symptom of depression and anxiety (Wahler and Otis, 2014:48).

In America, various studies conducted on youth perceptions, use and relapse established that depression is often a result of stress, and that there is strong links between stress, addiction and relapse (Glic, 2014:251). Furthermore, a study

conducted by Voskuil (2015:15) in South Africa, in Cape Town on identifying relapse indicators in state subsidised facilities; stress was identified as the leading precipitator of substance dependency and relapse. For instance, chronic stress contributes to periods of time between treatment completion and relapse, when compared to individuals with fewer stress (Wahler and Otis, 2014:59).

Chronic stress emanating from environmental factors such as unemployment, economic hardships, and discrimination has also been implicated as specific relapse risk factors. A social-psychological theory (developed by Berlin in 1981) outlines that stress is predominant among persons of low Socio-Economic Status (SES) and other socially disadvantaged groups.

Moreover, according to Gonzalo (2014) as cited by Deventer and Mojapelo (2015:11) there is a close relationship between stress and relapse. Thus, stress varies with developmental differences, and environmental influences. Thus, adolescents, parental issues, peer pressure, school and learning problems were most dominant stressors, whereas for youth stress was mostly underpinned by life circumstances, emerging adult responsibilities, interpersonal and intimate relationships, these were leading to relapse.

Eden (2016:206) postulate that all the predictors of frequent drug dependency relapse, stress and depression are crucial causes of frequent relapse. However, the discovery about such determinants of relapse was matching to the fact that the difficulties and shortcomings came across after detention (treatment admission) mostly contributed to the recurrent relapse. He further clarifies that “this can be clearly explained where a lot of stressful events can happen after treatment admission, for instance, financial incompetence, unemployment, and unsupportive family”. These strains stimulate some individuals to determine ways that they can resolve their difficulties without using the ordinary means of obtaining them. Certainly, this is often through again criminal activities. This appears to be in line with the findings of Wahler (2015:203) and Joshua (2015:17) who have proven that after treatment relapse is induced by stress.

Except stress and depression being the major determinants mostly provoking service users to relapse, a study conducted by Johnson (2010:79) found that insufficient rehabilitation outcome is a second core predictor of frequent relapse. Unemployable vocational skills, unsupportive employment model, ineffective rehabilitation, and unaltered behaviour are issues in the rehabilitation or correctional system that lead to high rates of relapse among delinquents. These issues have a direct effect on unemployment after release and it could lead to other risk factors or relapse (Clinical Treatment Models, 2009:88).

Adams (2013:43) further outlines that there is a close relationship between the stress process and the process whereby the individual attempting abstinence from substance dependence and begin to use them again. The stress process refers to the instance where the individual experiences of life, appraises the event as standards and experiences the physiological and psychological outcomes. Briefly the social factors impact stress process and subsequent, the psychological distress, and stress subsequent psychological distresses associated with substance use after treatment.

Similarly, in a study conducted by Yang, Mamy, Gao and Xiao (2015:113) on predictors of relapse in Malaysia, it was found that during abstinence, their afterwards living conditions were confronted with challenges, such as adverse socioeconomic conditions, poor family or social support, interpersonal conflicts, and stigma and discrimination, all of which kept them from mainstream society. Relapse triggers reported by the participants focused primarily on negative feelings, interpersonal conflicts, as well as stressful events which evoked by the challenges congested in their lives.

Reviewed literature mostly helped to increase understanding about the mounting scourge of substance dependency. This review further outlined dynamics and shortcomings associated with substance dependency treatment. However, it did not efficiently give insight on what could be the causes of substance dependency after treatment. As a set of researched ideas, theories are also considered as an important element in explaining the problem of substance dependency and relapse. The following section contains the theoretical framework for the study. The Motive

Enhancement Theory and Cognitive Behavioural perspectives are covered in this section.

2.13 THEORETICAL FRAMEWORK

Generally, theory is a set of empirical ideas. It is developed to inform our understanding about issues so that interventions, predictions and actions towards the prevention are effective (Paar, 2012:411). According to DeVos (2011:33), to discover a clear shape of the research topic, it is crucial that different theories are discussed together with the literature. This is more important in a qualitative research, and it helps to genuinely identify gaps and carry on from where other researchers would have reached. In this light Hennink, Hutter and Bailey (2011:258) further highlight that embedding a research within a wider spectrum of scientific literature helps to distinguish the particular focus of the research subject, and to identify where it may bring new knowledge to the field of study. This study used the motivate enhancement theory and the cognitive behavioural theory. These theories are explained below:

2.13.1 Motive enhancement theory

The motive enhancement or motivational interviewing theory was founded in 1970s, and its work is extracted from Carl Rogers' person-centred theory. The motive enhancement theory acknowledges substance dependency as a problem, and that substance dependant service users relapse after treatment. The theory argues that lack of an internalised motive determine relapse.

The theory proponents posit that substance dependent service users' behaviour is controlled by ambivalence. They are aware of the dangers of their substance dependency behaviour but continue using substances anyway. These substance dependant service users may want to stop dependency behaviour but at the same time they may be reluctant to so. They get engaged in dependency treatment programme, but they will claim that their problems are not all that serious. The theory clarifies that all these are characterised as "ambivalence", which is a central problem, and that lack of motivation among service users can be a manifestation of this ambivalence (Guydish, 2012:42).

The motive enhancement theory affirms that lack of internalisation of motivation in a substance dependent causes relapse due to their inability to perceive discrepancy. The theory enlightens the importance of separating behaviour from the service user and helps to explore how important personal goals are being undermined by current dependency patterns. However, the theory emphasizes that without being enabled to develop internalised positive motives to change dependency behaviour, service users can not perceive and acknowledge discrepancy (Miller, 2010:24).

Apart from the ambivalence and discrepancy behavioural patterns, the motive enhancement theory proponents further regard resistance as a major behaviour causing relapse among service users (Garry, 2010:29). The theory brings to light that service users tend to view their dependency condition differently, and finally this predicts poor treatment outcomes.

Motive enhancement theory proponents emphasizes that relapse is also brought by the lack of a well-developed sense of self-efficacy, where service users find it difficult to believe that they can maintain behavioural change. In this light, the theory puts to light that instilling motives will then improve self-efficacy, and that improving self-efficacy requires inserting hope, positivism, and feasibility of change achievement (Miller, 2010:31).

In considering the fact that substance dependency treatment is about facilitating behaviour change which will bring about effective sobriety and abstinence after treatment. On this note the researcher engages a lot of focus on the motive enhancement theory, with the emphasis that in order to alleviate the probabilities of relapse internalised motives for behaviour change should be carefully looked at. This is in line with Apodaca and Longabaug (2009:126) who affirms that, in order to alleviate relapse among the involuntarily treated service users, it is important to inject hope and need for change, so that service users take responsibility in the whole treatment process.

In addition to this, Trotter (2011:107) asserts that “working with involuntary clients suggested that building self-esteem, self-efficacy and positive perceptions should be a prerequisite to avoid relapse”. However, in order to obtain more views, and

incorporate facets of the problem at hand, the researcher engages the cognitive behavioural theory.

2.13.2 Cognitive behavioural theory (CBT)

Cognitive behavioural theory (CBT) was initially developed for treatment of alcoholics, its practical goods caused it to be adopted even to other forms of substance abuse and dependence, and its outlined principles are applicable to both in-patient and out-patient settings. The theory incorporates cognitive and behavioural aspects (Wax, 2009:10).

Generally, the cognitive theory is based on the recognition that thoughts and feelings are closely related. An interpretation of ourselves, the future, and those around us affect the manner in which we feel and the manner we behave. Cognitive theory places greater emphasis that a person has power to make positive changes by actively working on modifying the destructive thoughts and behaviours. In light of this, the service users' behavioural attitudes associated with returning to substance dependency after treatment is stirred back by lack of cognitive empowerment (McHugh, 2012:14).

As a perspective based in a belief that thoughts and beliefs are interdependent and induce behaviours, the cognitive behavioural theory is of an affirm opinion that when substance dependency service users lack empowerment, they automatically become unable distortive thoughts. Hence, a pattern that keeps them hooked in a cycle of dependency behaviour, they are not in a position to detect onset of dependency triggers (Otto, 2012:72).

According to Wax (2016:19) cognitive behavioural theory stresses that the post treatment lapse is caused by service users' failure to face life realities. These fears about reality are perpetuated by lack of well-strengthened confidence and sense of self-determination, and ability to perceive future endeavours positively. This emanates from the theory discoveries that "the belief and assumptions that the person uphold can be interrupted and distorted by various effects (could it be childhood experiences, and learning experiences as an adult), as a result the person

may have negative beliefs which may for instance predispose towards low self-esteem, depression, anxiety or continued abuse of substances. In this regard, the theory assumes that service users resort back to dependency behaviour due to failure to examine errors and distortions in thinking. On that note relapse is caused by failure to learn to correct negatively biased attitudes and beliefs that are based on faulty assumptions and learn to cope without drugs.

Wax (2016:21) maintains further that according to cognitive behavioural theory, it is not drug dependency per se that causes relapse. It is however, the manner in which the treated service user responds to the triggers. On this note, the theory highlights the importance that service users need to learn how to identify these triggers as high-risk situations, such as:

- By talking to themselves through the negative consequences of dependency behaviour (e.g. losing a job, losing a house, losing important possessions, going to jail);
- By alternating abuse of drugs with finding sober activities;
- Working out holistic ways to manage stress and cravings and
- Carefully learn how to avoid drug users and refuse drugs (Wax, 2016:21).

The primary aim of the study was to ascertain the causes of post-treatment relapse among involuntary youth users, and the use of cognitive behavioural theory collaboratively with the motive enhancement theory thereof was found complimentary to the reviewed literature. Thus, there is a high prevalence of relapse and the reasons therein, but this was never specified in terms of voluntary and involuntary users. The adopted theoretical framework aided by explaining relapse with focus to involuntary service users.

The two theories gave insight and understanding about how relapse occurs among involuntary service users, for instance, substance dependence is described as a behaviour that contains certain beliefs and expectations. Using these theories, it became clear how treatment approaches can focus on these beliefs and expectations in order to alleviate addiction and prevent relapse. The theories places an emphasis that it is usually not just craving that may drive users into dependence but it may be certain experiences that may trigger thoughts and anticipation of drugs

(Wax, 2016:21). These will help in exploring the nature of these experiences that may trigger thoughts about returning to drugs. Moreover, the two theories further highlight that the fear to face life realities and ambivalence highly perpetuate relapse after treatment, it makes users to be resistant. The theories make clear indications on how the treatment can be made responsive to fears and ambivalence in order to promote and maintain positive change to service users with intent to prevent relapse. It is therefore for this reason that the researcher found the Cognitive Behavioural Theory and the Motive Enhancement Theory relevant to the study in terms of helping to explore and describe the causes of relapse and promote an understanding of why the youth return to substances after treatment.

2.14 CHAPTER SUMMARY

The research findings from the global perspectives and local studies in South Africa have all commonly attested on substance dependency and post-treatment relapse as interdependent problems. However, there is a notable gap in the relevant literature. Most of the studies conducted at local and global thresholds failed to locate the cause of substance dependence and post-treatment relapse in the context of involuntary service users. Extensive research, particularly in South Africa has been devoted to voluntary service users.

Based on reviewed literature, it is evident that post-treatment relapse is a major concern. However, it is not explicitly enlightening in terms of which angle between voluntary and involuntary these findings are based. Similarly, assumptions that lack of resources such as alcohol and drug treatment centres, lack of access, compared nature of care between out-patient and in-patient, lack of access to self-help groups such as Alcoholics Anonymous (AA) and after-care programmes may have a notable impact. Thus, these were found being not the primary cause of post-treatment relapse among youth involuntary users. Instead, findings cite the causes as lack of motive, where the service users are compelled to go for treatment without having personally developed positive motives for treatment intervention.

In a bid to get a more holistic view about the problem at hand, two theories (i.e. the motivational enhancement theory and cognitive behavioural theory) are adopted in the study. The chosen theoretical lens clearly describes and explains behavioural

patterns leading to a relapse. The reviewed literature has given insights about the problem of substance dependent service user's post-treatment relapse causes, among youth in particular. The next chapter explains the research methodology of the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Hennink, Hutter and Bailey (2011:9) state that research methodology is a systematic technique that guides and directs the whole process of conducting a study. As a guiding procedure, a research methodology assists the researcher towards getting clear information on specific concepts in relation to a research problem (Babbie and Mouton, 2007:126). In this chapter, the researcher describes the research methods used during the study and the reasons thereof. A description of the area of the study is provided; research design, study population, sample and the method of sampling used are explained. The data collection instrument used is also explained, as well as the data analysis, data quality and ethical considerations.

3.2 AREA OF THE STUDY

The study was conducted in UThungulu district. UThungulu district is situated in the North-Eastern part of the province of KwaZulu-Natal. The population of Uthungulu amount to 981 899 derived from six local municipalities namely; Mfolozi, Umhlathuze, Ntambanana, Umlalazi, Mthonjaneni and Nkandla. These municipalities are presented in Figure 3.1 below.



Fig 3.1: Map of UThungulu District showing the local municipalities and surroundings

The significant economic centres that shape the district are Richards Bay, whose harbour facilities are world class and have been the prime reason for large-scale industrialisation in the district, and Empangeni, an industrial and service centre whose higher – order services attract many people from rural settlements and other parts of the province. However, the pockets of wealth, in the district are surrounded by vast areas where many people live in abject poverty (Local Governments South Africa, 2013/2016). Rural poverty and unemployment, drug abuse and retailing, rampant crime, HIV/AIDS prevalence, truancy and school drop outs are major challenges in this district. Richards Bay has been identified as the industrial development zone and this is an initiative to boost the economic activities and attract jobseekers. Subsequently, this has precipitated dense populations due to the high number of people flowing to the district seeking jobs and other business interests (Local Governments South Africa, 2013/2015).

The following table highlights the breakdown of population density of UThungulu district and the poverty rates for all local municipalities within the district.

Table 3.1: Population statistics and poverty indicators of the Uthungulu District (2015/2017)

Municipalities within the District	Area (km²) in 2009	Area (km²) after 2011 Local Govt. Elections & % change		Population	No. of Households	Poverty Rate
uThungulu District Municipality	8,213.39	8,213.39	-	981,899	193,806	62.50%
Mfolozi (Mbonambi) Local Municipality	1,207.98	1,209.98	-	119,548	21,902	55.82%
Mthonjaneni Local Municipality	1,180.97	1,085.97	-	47,592	10,805	57.83%
Nkandla Local Municipality	1,497.58	1,827.58	-	129,040	22,666	72.76%
Ntambanana Local Municipality	1,082.75	1,082.75	-	95,359	15,029	56.65%
uMhlathuze Local Municipality	793.18	793.18	-	366,288	82,015	60.13%
uMlalazi Local Municipality	2,213.94	2,213.94	-	197,555	34,389	71.81%

Local Governments South Africa (2015/2017)

As shown in Table 3.1 above, UThungulu District is characterised by low levels of urbanisation, approximately 80% of the population of 981 899 live in the rural areas. More than 50% of the population is younger than 19 years of age. Almost 31% have no formal schooling. A further 18% entered the schooling system but left before completing the primary school level. Approximately 6% have tertiary education. Employment stands at 24% whereas the poverty rate is in a toll stand of 62.50%. The district has an unemployment rate of 24%, whereas 52% are not economically active. Moreover, the district has the aggregate household of 193,805 in which 78% is battling with the scourge of social issues such as unemployment, drug abuses, teenage pregnancy and truancy (Local Governments South Africa, 2015/2017).

In consideration of the high rate of substance abuse related criminal offences and other social ills (such as teenage pregnancy, truancy and school drop- out, child sexual abuse, sexual violence and HIV and AIDS) underpin by the scourge of substance dependency in the area, a lot of initiatives were undertaken such as the referrals to treatment facilities on involuntary basis as means of alleviating the substance dependency. However, relapse happened to turn to be another battle in the segment of fighting substance abuse (Integrated Development Plan, 2014/2015). The evidence of relapses appear to have made all sorts of interventions to address the scourge of substance dependency and its related problems to bring no success. This therefore formed the basis of triggers that influenced the researcher's interest to explore the causes of post-treatment relapse among youth involuntary service users in UThungulu District.

3.3 RESEARCH DESIGN

A research design refers to a key address where a researcher clearly addresses how it is planned to conduct the scientific inquiry by designing a strategy for finding out about the problem area that is being investigated (Babbie and Mouton, 2007:96). According to Blanche, Durrheim and Painter (2006:33), research design is a strategic based outline for action that serves as a bridge connecting research questions and the actual process of conducting a study. Babbie and Mouton (2007:94) further enlightens that a research design is a researcher's plan on how the researcher will go about handling the process of data collection and data analysis thereof.

Brynard and Hanekom (2012:43) further describe research design as a process that involves the multiple decisions about the way the data will be collected and analysed, to ensure that the final research output responds precisely or relates well to initial research questions. These multiple decisions that the researcher is required to consider when developing a design, should be aligned with four main dimensions, i.e. the purpose of the research, the context or situation within which the research is being carried out, the theoretical paradigm informing the research, and the research techniques used to collect and analyse data (Blanche et al., 2006) cited in Islamia (2016:17).

Hennink, Hutter and Bailey (2011:24) on the other hand argues that the multiple-dimensions needs to be carefully brought together logically to an extent that will maximise the trustworthiness of the findings. Babbie and Mouton (2007) cited in Islamia (2016:112) further reveal that the research design that links well the research questions to the actual execution of the research project is highly depended on the process of reflection on issues relevant to each of these four dimensions to finally bring about a coherent guide for action that will produce answers to the research questions.

However, this process of reflection is guided by two aspects (principles of decision making) i.e. design coherence and design validity, According to Babbie and Mouton (2007) cited in Islamia (2016:109), design validity refers to a standard set of research technical procedures that plays the valuable role of identifying and controlling the extraneous factors that may possibly influence the outcome of the study and confound interpretation of the results. Design validity is important in the study because it can help direct the process of the study towards the trustworthiness of the outcomes. This is a qualitative study, and the study is about the human experiences, therefore trustworthiness has to be maintained.

Design coherence on the other hand, it refers to a logical arrangement of research purposes and techniques within the research framework provided by a particular paradigm, in order to make the study able to achieve a broader set of objectives, including answering research questions.

To address the research problem logically and unambiguously, the researcher chose to use two designs namely; exploratory and descriptive research designs. According to De Vos (2011:95) the exploratory research design is carried out when researchers aim to gain full insight about situations, phenomenon, community or person. In this study, adopting the exploratory research design assisted in obtaining information on the causes of relapse in drug use among youth involuntary service users. When applied in the current study, the descriptive research design had helped to describe the behaviours, situations, subjects or phenomena and it further assisted in responding to questions of what, who, when, how and where that are aligned to a research question.

The present study deals with the relapse causes among the involuntarily treated youth. The study adopted the qualitative method. On this base therefore, the exploratory research design intensely assisted to ascertain the detailed reasons and facts about the relapsing by substance dependence youth service users who had been to treatment on an involuntary basis. Implementing the exploratory and descriptive research designs in the present study was found aligning well with the study's methodology. The descriptive design on the other hand strongly helped by describing the problem of relapsing by focusing research questions.

Blanche et al. (2006:160) attest that an exploratory research design is similar to a qualitative study because the qualitative studies are open-ended in nature. De Vos (2011:98) supposes further that, "the premise that qualitative research is open ended has caused many positivists researchers believe that qualitative research is always explorative, leaving the work of accurate descriptions and explanations to more rigorous quantitative." The blending of the exploratory and descriptive research designs for the study had also adopted the elements of the instrumental case study design. The premise here was to expand the insight on the causes of relapse into substance dependence, and to facilitate depth understanding (Miller, 2010:48). Moreover, bringing the elements of an instrumental case study design was aimed at assisting a researcher to enter the research field with proper knowledge of relevant literature before conducting the actual field research (De Vos, Fouche, Strydom & Delpont, 2011:321).

At the time of designing the case study, many of the youth who relapse into substance dependency after treatment were held as participants. Some characteristics featured in the sampling method were brought in as a criterion for defining the units of analysis (De Vos, 2011:322). Mills (2013:33) maintains that the research design is strongly informed by the type of research the study is about. The research type serves as a fundamental base that assists in balancing the compliment between the research topic, research questions and the research purpose (De Vos, 2011:99).

Every research has to begin with a clear delineation of the main aim of the investigation as this goes a long way to determine the research process or methodology adopted (Islamia, 2016:14). In this study, the researcher adopted the applied research type with an aim of getting answers about what cause involuntarily treated substance dependant youth relapse after treatment. Choosing the applied research type appeared to be in line with De Vos (2011:90) who argues that, “in order to maintain a flow of meaning in the study from the research methodologies, purpose of the study, data collection and analysis a researcher need to choose a type of research to underpin the research work. The adoption of applied research type was found suitable for the study on the basis that applied research endeavours on solving problems when it is applied in practice (Fusch and Ness, 2015:155). In relation to the study, researcher considers the applied research as a useful type of research that will play a big role in giving insights and solutions about the problem investigated.

3.4 RESEARCH APPROACH

The study used a qualitative approach. The primary reason for choosing the qualitative research approach was on the basis that qualitative research is more concerned about the in-depth understanding of human behaviour. On this note, it is more concerned about understanding the behavioural patterns of service users and the reasons why users return to certain substance dependency patterns after treatment (Brown, 2006:109).

As mentioned by De Vos et al. (2011:63), qualitative research enables the researcher to study human behaviour and interactions in a more systematic manner. In this light, Terre Blanche et al. (2007:76) reveal that the qualitative research approach allows the researcher to study selected issues in-depth, openness, and detailed mode. It identifies and attempts to understand the categories of information that emerge from the data. The qualitative approach is more commonly used to inductively explore phenomena, and to provide 'thick' descriptions of phenomena (Terre Blanche et al., 2007:48).

As a technique in research, qualitative approach has got advantages and disadvantages in its use. The main advantage in using the approach is that the researcher gets more detailed and rich data in the form of written descriptions or visual evidence (De Vos, 2011:66). In line with this, Babbie and Mouton (2011:83) attests that this method in research does not need a strict design plan before it begins which gives the researcher freedom to let the study unfold more naturally. On the other hand, the qualitative research approach has its own disadvantages. For example, the researcher becomes intensively involved, which might ultimately give the researcher a subjective view of the study and its participants. It is easier for a researcher to be biased because the researcher interprets the research according to own view points, which might skew the data gathered. Over and above this, qualitative research approach is very time consuming (Babbie & Mouton, 2011:85).

In support of the significance of a qualitative research approach, Creswell (2014:20) maintains that the qualitative research approach enables gathering multiples of data forms than relying on a single data source. Furthermore, the process in a qualitative approach makes the researcher to keep focus in learning the meaning that participants hold about the problem or issue than the meaning that the researcher bring to the research (Creswell, 2014:25).

3.5 RESEARCH METHODS

In this section, the researcher will provide a detailed explanation on the study population and sampling method that was used in the study. In addition, the data collection and the data analysis methods for the study will also be discussed.

3.5.1 Study population

Population refers to a larger pool within which the sampling elements are derived. The population encompasses all the elements that make up our unit of analysis (Creswell, 2014:52). Shamo (2009:92) also maintains that population refers to a totality of people, events, organisations units, case records, or any other sampling units with which the research problem is concerned about.

The target population for this study was youth aged between eighteen (18) and thirty-five (35) years who were from UThungulu District who involuntarily went for substance dependency treatment and have resorted to the same dependency problem afterwards. The researcher concentrated on youth who had been serviced by the three social development agencies, i.e. Ongoye- Esikhaleni Department of Social Development Service Office, Richards Bay Department of Social Development Service Office and SANCA Empangeni. It was within these three agencies where the researcher found social work practitioners who served as key informants.

The following inclusion criteria were used to select social work practitioners:

- The participants were social workers by profession and were affiliated with the South African Council for Social Service Professions (SACSSP)
- The Participants were assuming duties in the area of substance abuse
- The participants have worked with in the area of involuntary treatment and relapse
- The participants were fully stationed either in Richards Bay department of social development service centre, or SANCA Empangeni or Esikhaleni department of social development service centre.
- Participant should be of any racial group

Certain conditions were considered and resulted in some participants excluded from participating in the study:

- Participants who were social work practitioners but who have never worked in the field of substance dependence.

The following inclusion criteria were used to select youth participants:

- Youth aged between eighteen to thirty five years of age

- Both males and females
- Youth who were able to offer a written consent
- The youth who were living in UThungulu district in KwaZulu Natal
- The youth who have experienced substance dependency relapse following involuntary treatment
- Youth who have been treated either on in-patient or out-patient basis

Certain conditions resulted in some participants not being included in the study. Therefore, the following presents exclusion criterion:

- Participants with intellectual disabilities
- Participants with hearing and speaking disabilities

3.5.2 Sample and sampling method

Generally, research is time consuming and requires accuracy. Therefore, working with the whole set of aggregate study elements might lead to unintended inadequacies and biasness, therefore the consideration of sampling enables the process of research to be more controllable (Creswell, 2014:50).

Sampling is the selection of research participants from an entire population, and involves decisions about people, settings, events, behaviours, and or social procedures to observe (Babbie and Mouton, 2014:83). The major concern in sampling is representativeness. The aim is to select a sample that will be representative of the population about which the researcher aims to draw up conclusions (Creswell, 2014:112). However, representativeness is not a priority in qualitative research, which is the reason for the use of purposive sampling. Qualitative research samples purposively (Carter & Little, 2007:1316).

Another major concern of the sample is the size; a very small sample may be interpreted as unrepresentative in a quantitative study, the researcher then must ensure that the sample is large enough to allow ability to make references about the population (Hennink, Hutter & Bailey, 2011:122). De Vos (2011:222) posits that the size of the sample is grossly informed by the type of research method or approach applied in the study. The current study adopts the qualitative research approach, and would only need to make use of a small sample since the aim is not to generalise.

Eleven (11) youth aged between eighteen (18) and thirty-five (35) from UThungulu District who involuntarily got treated for substance dependence and relapsed afterwards were selected as participants for the study. Four social work practitioners served as key informants.

For sampling to be scientific it requires a precise and careful thinking not only about how many elements should be made part of the data collection process, but which elements should be included and how they should be selected (Creswell, 2014:112). In most instances, quantitative research is not interested in the particularities of the elements, but in the way that these elements together represent the broader population and make it possible to account for variations in that population. On the other hand, the qualitative research wants to make sense of feelings, experiences, social situations, or phenomena as they occur in the real world, and therefore want to study them in their natural setting, which intensively requires to work with the data context (and this is a constructive approach in qualitative research) (Babbie & Mouton, 2011:225).

Regardless of a research method, sampling stems from two subsets into types, i.e. probability sampling and non-probability sampling. Probability sampling enhances the likelihood of (i.e. selection of a set of elements from the entire population) accomplishing this aim and provides methods for estimating the degree of probable success (Creswell, 2014:55). The supreme rationale for the application of the probability perspective in a social science research is hypothesis testing (or statistical inference), which involves drawing conclusions about how the phenomena is or how the phenomena is likely to be based on data from the sample (Hennink, Hutter & Bailey, 2011:101).

However, probability sampling is generally expensive and sometimes time consuming to the vast of research in the Social Sciences, which compels most of researchers to rely on non-probability sampling (Babbie & Mouton, 2011:215). Furthermore, De Vos (2011:231) avers that in non-probability sampling, the selection of particular individuals is usually not known because the researcher does not know the population size, or the members of the population.

In the non-probability paradigm, each unit or a person in a sampling frame does not have an equal chance of being selected for the study. Non-probability sampling also uses purposive samples, which means that sampling depends not only on availability and willingness to participate, but that cases that are typical of the population are selected (Terre Blanche, 2007:321). For instance, if we wanted to study people who work as interpreters in health care settings, we could contact local clinics, non-governmental organisations (NGOs) and hospitals and find interpreters who are willing to participate in our study. We may even ask these interpreters to direct us to other colleagues (Terre Blanche, 2007:288). This process of systematically accessing elements of the study through contacts and references is called snowball sampling. In many instances, these two non-probability sampling methods; purposive and snowball sampling are adequate when conducting a qualitative study (Hennink, Hutter & Bailey, 2011:91).

In the current study, the researcher used both purposive and snowball sampling strategies. Firstly, the researcher purposively selected social work practitioners who directly work with youth with substance abuse problems to gather data. These social work practitioners who served as key informants subsequently referred the researcher to a relevant youth (of certainly 18-35 years of age) who have been to substance abuse treatment on involuntary basis and relapsed after treatment intervention.

The researcher purposively selected social work practitioners in three Social Development agencies. These were; Esikhaleni, Richards Bay and SANCA Empangeni. These three agencies routinely work with the youth who have substance dependency problem. Beside the fact that these practitioners participated in the data gathering process, to work with them as a point of entry was aimed at accessing the youth who possessed the features and elements necessary for the study. Thereafter, the social work practitioner per social development agency where data was collected referred the researcher to one or two service users. The service users further referred the researcher to other youth who had involuntarily been treated for substance dependency and relapsed.

During the process of recruiting participants, the researcher took into consideration that the study deals with human experiences where there could be some emotional explosion. The study is about youth who were treated substance dependence involuntarily. The researcher assumed that many of the participants might have already been coerced to go for their treatments. In this regard, ethical elements such as the written informed consent, mainly the adult consent and the voluntary participation had to be carefully considered in order to prevent exploitation. For instance, before data was collected, informed consent (adult consent) was obtained from social work practitioners who served as key informants. As key informants, social work practitioners further facilitated adult informed consent from the youth users, they explained to users about the principle of voluntary participation in the study. This was before referring the users to a researcher for data collection.

Snowball sampling was adopted because the researcher considered the fact that the nature of the study could make it difficult to access or to identify the youth who had been involuntarily been treated for substance dependency and had relapsed afterwards. Therefore, using both the purposive and snowball sampling methods enabled the data gathering process to be more sequential, proactive and be without limitations and shortcomings. Moreover, using both purposive and snowball sampling enabled the researcher to ascertain adequate information about the views on the causes of relapsing. The chosen sampling approach was therefore found to be the most relevant particularly given that the study took a qualitative approach.

3.6 DATA COLLECTION AND ADMINISTRATION

Data collection is highly influenced by the research approach and the research questions that the researcher aims to address (Moule & Hek, 2011:34). Semi-structured in-depth interviews were used as a data collection instrument. An in-depth interview is a one on-one method of collecting data which involve the researcher (interviewer) and the participant (interviewee) discussing specific topics in greater detail. An in-depth interview is further described as a conversation with a purpose on the basis that the researcher's main purpose is to elicit insight on specific issues and concerns using a semi-structured interview guide (Hennink, Hutter & Bailey, 2011:111).

An in-depth interview is not a two-way dialogue, instead it is a process in which the researcher asks questions and motivates the participants (interviewees) to share their perceptions (Babbie & Mouton, 2014:98). Along this process of the interview, the researcher and the participant do not adopt the “ask” and “respond” approach, but they also react on each other’s perceptions, appearance, identity and personality. Therefore, the in-depth interview is described as a specialised kind of knowledge producing conversation (Terre Blanche, 2007:286).

The interviews were conducted on a one on one basis for duration of approximately 30-45 minutes per participant. The researcher developed a semi-structured interview schedule which served as a guide in conducting personal in-depth interviews. The interview schedule was comprised both open-ended and close-ended questions. Expert specialists in substance dependency treatment and relapse were consulted for guidance therein. The researcher facilitated the interviews to be as conversational and jargon free as possible. Follow-up questions were then used (e.g. tell me more about that). Probes were not posed only for the sake of clarity but also for opening up the deeper layer of sharing from the participants’ side.

The researcher used an interview guide, a note book and a recording device. The note book was used for taking field notes, which assisted the researcher to record not only direct responses but also body gestures and other non-verbal expressions by the participants. On the other hand, the recording device assisted the researcher to accurately capture participants’ views. This data collection approach enabled the researcher to ascertain that adequate information about the participants’ attitudes, opinions, and feelings about the relapse of youth after treatment was collected.

Interviews were scheduled and conducted at the social workers’ consulting rooms because they were the most convenient setting for the participants. The interview schedules that were generated after a thorough literature search were originally written in English and later translated in IsiZulu to accommodate participants who were not either conversant or comfortable with the English language. An example of asked questions is; what type and the name of drug were you dependant into prior treatment, how long were you dependant on a drug, what do you consider as the

major cause of your substance dependency, how did you engage in treatment and what was your experience of the treatment process?

3.7 DATA ANALYSIS

After the data were gathered, it was analysed using the thematic data analysis approach. Thematic data analysis refers to a method of identifying, organising and indicating patterns (themes) within data (Braun & Clark, 2011:78). Aligned to this descriptive meaning is the explanation by Nowell (2017:11) that thematic data analysis is an analysis method that focuses on identifying patterned meanings across a data set.

The gathered data were analysed thematically adopting the Creswell's analytical spiral approach outlined in De Vos, Fouché, Strydom and Delpot (2011:404). When analysing a qualitative data using this approach, the researcher intensely engages in the process of an analytic cycle. The researcher enters the process of analysis with the volume of data requiring to be sorted, put in order, systematised and make sense of the data collected (De Vos, 2011:406).

The following paragraphs indicate clearly the implementation of eight different steps used for the study's data analysis process:

3.7.1 Planning for the recording of data

De Vos et al. (2011:404) state that the researcher should systematically plan for the recording of data in a manner that is appropriate to the setting, research participants that will facilitate analysis before data collection takes place. To ensure accuracy efficiently and quality in data gathering, a digital recording device was used. Furthermore, the approach of the study was interactive and fully includes the participants in the framing of questions and data gathering, and therefore the researcher's presence was considered as an integral part of the setting. Interviews took place at Richards Bay Social Development Service Office, Ongoye Social Development Service Office, and SANCA Zululand, all within UThungulu District. The researcher visited each site prior to conducting the interviews to prepare interview rooms and documentation sheets for manual note taking. All the participants managed to come on scheduled interview dates.

3.7.2 Data collection and preliminary analysis

According to Nowell (2017:20), data analysis in a qualitative research comprises a two-fold approach, i.e. data analysis during the course of data collection, and data analysis after the data gathering process. While at the point of gathering data with social work practitioners, the researcher discovered several ideas about directions for analysis. For example, some themes occurred in mind, and this was the actual data analysis. The nature of data collected aligned with the information needed for ascertaining substance dependency post-treatment relapse causes among youth involuntary service users in UThungulu District. There were no circumstances or issues that impacted on the data. In this light, the researcher had intensely used the two-fold approach to make meaning of the data elements obtained during the field and after the course of data collection.

3.7.3 Managing data

Data managing is the first intensive phase or step in data analysis away from the research field where a researcher organises their data into file folders, index cards or digital archives (De Vos, 2011: 407). A lot was noted in the course of the study, for instance, while gathering data with youth involuntary service users, the researcher noticed some slang languages, words and analogies used by participants. The researcher asked for clarity from participants and ensured that there were recorded elaborative explanations manually converted into clear meanings for ease analysis purposes at the time data were converted into text unit. Because a digital recording device was used during data collection, the researcher further listened to the recordings, transcribed the interviews verbatim, properly labelled and coded them to make the retrieval of data much easier and manageable.

3.7.4 Reading and writing memos

This phase involves reading and re-reading the data in order to become familiar and intimate with its content (Nowell, 2017:20). At this stage, the researcher gained familiarity with the data collected from the field by transcribing it into written words. The process of transcribing data was done by reading and re-reading the data after which the researcher noted down initial ideas while reading the data repeatedly. This

whole familiarisation process helped the researcher to understand the prominent themes.

3.7.5 Generating categories and coding the data

After the researcher was confident with the data collected, the process of coding began. The prominent features of the data were coded systematically according to the data set from the field. De Vos et al. (2011:410) emphasize that the phase on “coding the data” demands the highest level of data awareness, focus to the data and openness. The researcher applied the coding schemes to the categories and themes, and comprehensively marked the passages in the data context using codes. The similarities, patterns and the subjects addressed in the data were thoroughly considered. The words and phrases that were coded into categories were noted by means of writing them down. The whole process of categorising and coding played a valuable role in enabling the researcher to identify themes and sub-themes.

3.7.6 Testing emergent understanding and searching for alternative explanations

De Vos (2011:415) states that this stage entails evaluating data usefulness in enlightening or addressing the research questions, and how significant they are to the unfolding story about the social problem being studied. In validating data usefulness, the researcher did not discover any negative instances of patterns.

3.7.7 Interpreting and developing typologies

This phase involves developing a detailed analysis of each theme, working out the scope and focus of each theme determining the story of each (De Vos 2011:409). It also involves deciding on relevant and informative names of each theme. In the study, the researcher embarked on data analysis to refine the specifics of each theme, and the overall story the analysis tells. Clear and precise definitions and proper names for each theme emanating from the scope of the analysis were generated accordingly.

3.7.8 Presenting the data

The final stage of the analytical spiral entails the combining or linking of the analytic narratives and data extracts and contextualising the analysis in relation to the existing literature (Nowell, 2017:23). The interpretation of data extracted from the discussions by participants and the analysis thereof, it showed well relating back to the research questions and the reviewed literature. The interpreted data is well presented in Chapter Four of this study.

3.8 DATA QUALITY

According to Lincoln and Guba (2005:112) data quality is the emphasis about the importance of quality in the research process instead of its evaluation outcomes. Data quality should begin to manifest at the onset of the literature review where a researcher must maintain controls in exploring the existing literature, which definitely leads the establishment of quality in the data gathered. Literature controls assist the researcher to keep focused on the subject of study (problem area). It renders with the framework of the study and it's identified areas of knowledge which the study aims to expand on (De Vos et al., 2011:411). In ensuring accuracy in the study, Guba's (2005) element of quality criterion for qualitative inquiry was adopted. Trustworthiness and its four criteria were strongly applied in the study as described below:

3.8.1 Credibility/authenticity

According to Lincoln and Guba (2005) in De Vos et al. (2011: 420), credibility refers to the degree to which the research represents the actual meaning of the research participants. The truth value was highly maintained in the process of the study. The data gathering, recording and analysis were exactly what transpired in in-depth interviews. The researcher was guided by ethical considerations in the process, and never deviated from the approved data collection instrument (interview guide). Moreover, the researcher also considered that the findings of the study be returned to the Social Development Sector (SANCA and the Department of Social Development) in KwaZulu Natal in order for them to determine if the findings truly reflect their experiences of post-treatment relapse causes among youth involuntary service users.

3.8.2 Transferability

Moon (2016:48) describes transferability as “the usefulness and relevance of the research findings to other contexts.” For Lincoln and Guba (2010:420), transferability refers to the degree to which the phenomenon and findings described in one study are applicable or useful to theory, practice and future records. The researcher is of the opinion that the findings of the study are trustworthy, useful enough to be used by social work practitioners in substance dependency and relapse problem. The findings may also assist the families of service users in determining their role in assisting service users’ in the fight against post treatment relapse. The study itself can be utilised by future researchers as a bench marking source, given that there is shallow research on substance abuse and relapse that focuses on involuntary service users.

3.8.3 Dependability

Dependability is an equivalence of reliability quantitative research. It refers to the consistency and reliability of the research findings and the degree to which research procedures are well documented in a manner that allows someone outside the research to follow, audit and critique where necessary (Moon, 2016:11). Taking into account the consistency in the applied methodology, ethical considerations adhered to, confident research findings were produced. Similar findings could be obtained in the case where more studies on the causes of substance dependency post-treatment relapse among involuntary youth service users were to be successively undertaken adopting similar research process applied.

3.8.4 Conformability

Conformability is the degree to which the findings of the study are an exact sole function of the subjects (participants) and the actual conditions of the inquiry (Guba, 2010:421). In this study, the researcher ensured a high value of trust and honesty. The researcher avoided conflicts of interests associated with biasness, personal motives and interests. Although there was no auditing undertaken to determine compliance, the researcher is confident that the findings are well aligning to research conclusions.

3.9 PILOT STUDY

Pilot study refers to a procedure in which a research's instrument for data collection is tested and validated by administering it to a small group of participants from the intended test population (De Vos, 2011:237). In validating the effectiveness of the interview guides two (2) youth persons of the ages eighteen (18) to thirty-five (35) from UThungulu District, and one social work practitioner from Lower Umfolozi Service Office for the Department of Social Development, were used for testing and authenticating the data collection instruments. This process helped the researcher in several ways, for instance to identify some gaps such as the level of understanding of the questions, improving the instruments by making it clearer, for instance asking relevant questions in the right manner and removing ambiguities. A pilot study process further helped the researcher to improve interviewing skills. Having discovered these mistakes made the researcher to correct them before start collecting data with the actual participants.

The researcher conducted the pilot study exactly in a manner in which the actual study was planned. The use of a pilot study was found useful as the researcher had a chance to test the protocol of the research, and also to look again at the chosen sample recruitment strategy proposed, in terms of its feasibility. Nonetheless, the findings of the pilot study were not included in the final research report. Similarly, participants who participated in the pilot study were excluded from the main study sample.

3.10 ETHICAL CONSIDERATIONS

Neuman (2014:261) argues that ethics are an essential part of rigorous research. The researcher need to show respect for ethics in practice, for instance, the ethical issues encountered every day during data collection (Fusch & Ness, 2015:92). As a scientific investigation, this research was conducted on the grounds of ethical considerations, outlined as follows:

3.10.1 Informed consent

Among the primary concerns in the ethical context is informed consent (Hennink, Hutter & Bailey, 2011:183). In a qualitative research, informed consent is described

as the primary determinant of the ethicality of the research which possesses standard components of the provision of appropriate information, participants' competence and understanding, voluntariness in participating, and freedom to decline or withdraw after the commencing of the study (Babbie and Mouton, 2006:384). Informed consent is also a voluntary decision by the participant or any other person acting on behalf of the actual participant to serve as a key respondent in the study (De Vos, 2011:127). The participant can only be in a position to consent after having been furnished with all the key information about the study, i.e. background of the study, purpose of the study, objectives of the study and the benefits for participation (Hennink, Hutter & Bailey, 2011:163).

A written informed consent form was availed before engaging with participants. The researcher explained to participants that the main subject of the study was on substance dependency and relapse among youth service users who were involuntarily treated. More explanation was about the study's aims, methods used to ascertain data and the intended uses of the outcomes. After completing collecting data with the key informants (social work practitioners), the researcher emphasised to social work practitioners that they should not refer the youth for data collection without having received their informed consent. All youth who participated in the study had firstly gave their informed consents and gave the forms to social work practitioners before engaging with the researcher for data collection. At the time of engaging with the researcher ethical aspects were explained to them in order to make them to not feel compelled to participate in the study. Such a critical consideration of ethics was taken into cognisance on the basis that the nature of the study was involving certain degree of emotions since the participants were the youth who have been to treatment on involuntary basis.

3.10.2 Privacy and confidentiality

The researcher understood that substance dependency and relapse could be something that every person with substance misuse addiction might find it difficult to talk about (Hennink, Hutter & Bailey, 2011:53). Therefore, all the participants were assured that in pursuit of confidentiality, the participants' names and personal identities were not asked and reflected in any of the used transcript manuals.

Information based on feelings, views, suggestions and understanding furnished by participants was manually recorded in the field note and kept confidential.

Any sensitive information provided by participants during the course of the study was treated confidentially and remained unknown to anyone other than the researcher. The researcher also ensured that good values of respect, honest, integrity and compassionate were clearly maintained in the course of the study.

3.10.3 Voluntary participation

Voluntary participation in social science qualitative research refers to a participant's engaging in the study on a free-will basis, without any fear or prejudice (Hennink, Hutter & Bailey 2011:53). Substance dependence is a sensitive subject because it is a psychosocial phenomenon aligned to personality, emotional and trauma issues of an individual (Fakier, 2009:326). Therefore, the researcher ensured that clear explanations were made to participants about their rights to voluntarily participate, and their rights to withdraw from participating in the study at any stage when they feel uncomfortable. Participants were also made aware that they were free to withdraw participation at any given point in time when they would have felt that participation was not in their best interest or participation seemed to be detrimental to their well-being.

3.10.4 Avoidance of harm

Qualitative researchers need to ensure that the approaches upon which their research is grounded does not exploit the study participants or involve deception in order to conduct the research (Terre Blanche, 2007:60). Considering the sensitivity of the subject on substance dependency and relapse, the researcher had to explain to participants the possibilities of having the evoking of emotional internalised issues. The researcher then urged participants to indicate if at any stage of their participation they find themselves being emotionally and psychologically not at ease so that they will be referred for a debriefing therapy arranged with Mo-life Medical Centre at Empangeni. The researcher ensured that participants were not harmed during the course of the study. Furthermore, deceptions were avoided by not withholding information from participants and by not offering incorrect information to participants.

However, after the interview process, none of the participants indicated a need for debriefing; however, they were all encouraged to contact the researcher or a research assistant should they find a need for debriefing in a period of a week after the interview process. This was in line with the concluded arrangements with the Mo-Life Medical Centre.

3.10.5 Actions and competence of the researcher

Researchers are at all cost obliged to ensure that they are effectively competent, possess integrity and are well skilled to carry out proposed studies, these compelling expectations are more when researchers are conducting studies on sensitive subjects (De Vos, 2011: 319). With intent to elicit rich and thick data, the researcher had timeously attended in-housed formal learning classes on qualitative research facilitated by an experienced research supervisor. The researcher also had individual consultations with the allocated research supervisor where a lot of knowledge on human research processes was acquired.

Except the fact that substance dependency and relapse found to be a sensitive subject in human inquiry, but there were so many issues of cross-cultural boundaries encountered during the course of the study. For example, some of the participants viewed their problem of substance dependency and post-treatment relapse as highly influenced by their cultural background. In this instance, the researcher maintained ethical responsibility of respecting participants' customs and norms.

3.10.6 Publication of findings

Moon (2016:11) asserts that study findings need to be made available in a written form to the public, if not, they will bear no meaning, raise no awareness and do not contribute to the body of knowledge. A report containing findings and recommendations will be written and handed to the Department of Social Development in KwaZulu Natal headquarters as per request upon their granting of permission to conduct the study. In compiling the research report, the researcher will maintain accuracy, objectivity, honesty and avoid fabrication and plagiarism. A final dissertation will be submitted to the University of Zululand library. Moreover, after the

findings and recommendations, the researcher will prepare at least one research article for publication in a peer reviewed academic journal.

3.11 CHAPTER SUMMARY

In this chapter, the researcher explained the approach and framework in which the data was collected and analysed. Contained in this chapter is also a depth description of the whole research process. In the next chapter, the researcher presents the findings of the study.

CHAPTER FOUR PRESENTATION OF FINDINGS AND DISCUSSIONS

4.1 INTRODUCTION

This chapter presents the findings of the study based on the themes that emerged. Five themes were extracted from the data collected, and they are presented and discussed. Direct quotations from the interviews held with the participants are mobilised for illustrative purposes, and the findings are aligned to relevant literature reviewed. The findings of the study are also interpreted in view of the theoretical framework discussed in chapter two namely, the cognitive behavioural theory and the motive enhancement theory (Munirul, 2012:21). The specific objectives of the study were:

- To investigate the involuntary service users' understanding of the nature of treatment that they underwent.
- To examine the significance of the involuntary service user's self-motive in inhibiting the post-treatment relapse.
- To explore the involuntary service users' attitude towards the treatment process.
- To explore the role of social work practitioners in preventing post-treatment relapse among involuntary service users.

4.2 PROFILES OF THE PARTICIPANTS

The researcher managed to reach out to fifteen participants who comprised four social work practitioners and eleven youth service users. Twenty service users were intended, nevertheless only eleven were considered as data saturation was reached. This section therefore lays out the participants' information in terms of age, race, gender and experience in the field of substance abuse and treatment. Firstly, the biographical information of social work practitioners is indicated in Table 4.1 as follows:

Table 4.1 Biographical information of social work practitioners

Name (Pseudonym)	Age	Race	Gender	Years of experience in substance abuse cases	Qualification
SwPx01	29	African	Female	3	BSW
SwPx02	35	African	Female	7	BSW
SwPx03	30	African	Male	5	BSW
SwPx04	31	African	Male	1	BSW

Table 4.1 above indicates that among the interviewed social work practitioners, seven years was the longest service in working on substance dependence and relapse. Nevertheless, it is shown in the table that they were not in possession of any specialised training and capacity building on substance abuse, particularly on the basis of involuntary service users except the generic knowledge they had gathered in the Bachelor of Social Work degree. Among the four social worker participants interviewed, two were males and two were females. Table 4.2 below shows the biographical information of service users.

Table 4.2 Biographical information of service users

Name (Pseudonym)	Age	Race	Gender	Employment// Occupational status
Userx1	28	African	Male	Retrenched/ currently unemployed
Userx2	31	African	Male	Suspended
Userx3	26	African	Male	Unemployed/ Secondary education incomplete
Userx4	23	African	Male	Unemployed/ university education incomplete
Userx5	20	African	Female	Currently enrolling for grade 11
Userx6	23	African	Male	Unemployed/ Secondary education incomplete
Userx7	21	African	Female	Currently enrolling for grade 11
Userx8	28	African	Female	Unemployed/ currently on work suspension
Userx9	26	African	Male	Unemployed
Userx10	18	African	Male	Currently enrolling for grade 9
Userx11	31	African	Male	Currently unemployed after work dismissal

Table 4.2 indicates that the largest number of participants interviewed was between the ages of twenty and thirty years of age. This suggests that young pupils begin to battle substance abuse and dependency at a tender age. For instance, at the age of 23 years, the youth is already battling the scourge of relapse. All the participants mentioned that they were never married nor involved into any intimate relationship, but were involved in love affairs before their drug dependence. The study interviewed eight males and three females.

The current study findings indicate that all the participants interviewed both the social work practitioners and service users were Africans. This is an indicator that the population of UThungulu District has a dominance of Africans.

4.3. AN OVERVIEW OF THE THEMES AND SUB-THEMES

The analysis of the findings after a data collection process yielded several themes and sub-themes. These themes and sub-themes are presented in Table 4.3 below.

Table 4.3: Themes and sub-themes

Main Theme	Sub-Theme
<p>Theme 1 Understanding the treatment process</p>	<ul style="list-style-type: none"> • Insight on the treatment process • Unrealistic change and change management
<p>Theme 2 Self- motive's significance in reducing post-treatment relapse</p>	<ul style="list-style-type: none"> • The importance of motives and its role in reducing resistance. • Preliminarily facilitation of motives • Post-treatment stigmatisation elements
<p>Theme 3 Attitude toward the treatment</p>	<ul style="list-style-type: none"> • Service users instantly loose interest towards treatment. • Treatment compliance shortcomings.
<p>Theme 4 Role of social work practitioners in preventing relapse among involuntary service users</p>	<ul style="list-style-type: none"> • Lack of resources • Lack of understanding of substance abuse intervention protocol. • Inappropriate use of approaches for helping process
<p>Theme 5 Implications of dual addictions</p>	<ul style="list-style-type: none"> • The treatment oversight on other addictions

The identified themes and sub-themes are presented and discussed in the following sections:

4.4. THEME 1: SERVICE USERS' UNDERSTANDING OF THE TREATMENT PROCESS

From the interviews conducted, the researcher found that the service users had a clear understanding of the treatment that they had undertaken, and that such understanding had no meaning to them on the basis that they were not ready to stop drugs. These findings are aligning with Adams (2013:42) who maintains that when perceptions and attitudes towards treatment are negative, they can destruct the potential success of the treatment process. Ramphele (2013:274) confirms that, after treatment service users maintain a good knowledge about drug abuse through psycho-education, but it all becomes meaningless because they are not into stopping drugs. No matter how much understanding of the treatment service users could have, resistance and anxiety overwhelm them (McIntosh & Livingstone, 2008:48).

Based on the theme on service users' understanding of the treatment process, the following sub-themes were identified; these are insight about treatment process and unrealistic change and change management. The discussion is aligned to direct quotes obtained from participants during data collection, the literature reviewed in Chapter Two and the theoretical lens.

4.4.1 Sub-theme 1: Insight on the treatment process

Participants were asked about their expectations and needs when they went for treatment. The researcher found that eight out of eleven interviewed service users went for in-patient treatment, while only two went through out-patient treatment. All service users who went for treatment on in-patient basis revealed that they expected to go through a psychological, social and physiological assessment process, and to have treatment aligned to the findings of these assessments. Users were concerned that such patterns of assessment did not take place.

In light of these findings, one participant was quoted saying:

I think the treatment process was too generalised and not evidence based. Assessment was basic, it did not further involve radiological examination to give an indication of how much damage caused by abused substances in my internal body health (UserX1).

Another participant mentioned that:

Stress and depression made me to depend on substances for coping sake. Going for treatment feared me that I would subject myself to worse stress. Anyway, treatment did not help, no professional assessment was done to find the cause and the main cause of stress was not attended. I found myself back on drugs after treatment (UserX11).

Out of eleven participants interviewed, seven indicated that they had the treatment process not responding to their needs as per their expectations. Similar to these findings, Gonzalo (2014:50) argues that chances of a relapse outbreak are high when treatment needs of service users are not met. Gonzalo (2014:49) further outlines that the only way to know the needs of service users is through the detailed assessment. The assessment must seek to identify the nature and severity of the dependency problem, assess the consequences, and determine the service users' strengths and weaknesses through strengths, weaknesses opportunities (SWOT)analysis and threats ions about the treatment. This will help to curb post-treatment relapse. The Behavioural Health Institute (2015:87) also maintains that it is the assessment that the service user's need.

The motive enhancement theory, when applied in the context of treatment relapse clarifies that what perpetuates the lack of insight about the treatment is not only the negative attitude that users could have towards the treatment, but also the lack of good treatment procedures such as effective assessment tools can make the treatment fail to meet the needs and expectations of the users. The researcher critically views the assertions by the theory as playing a valuable role in raising as awareness about the significance of an assessment. The researcher regards the prominence of assessment as the only way through which the practitioners involved in treatment would fairly determine the needs of the service users. The researcher is of the opinion that if the treatment processes fails to accommodate the needs of a service user, it is absolutely not an evidence based kind of treatment for substance dependence. As a result the perception towards treatment will be negative.

Another four service users were involuntarily treated for substance dependence on an out-patient basis mentioned that they did not develop insight and understanding about the treatment. The participants pointed out that going through treatment being in the same neighbourhood surrounded by drugs made them not to take the treatment process seriously. Participants further revealed that they found the out-

patient treatment expecting a certain degree of commitment, self-determination and self-care; which were all impossible. Participants explained that going for treatment on involuntary basis is generally a challenge, and that there are worse challenges when a service user is treated on an out-patient basis.

In light of the above, participants were quoted pointing out that:

Going for treatment on an out-patient basis make one feel that there is so much expected from the service user, yet at that time going for treatment was someone else's idea, something not coming out from the service user's own will (UserX04).

Out-patient treatment process has some challenges causing the client unable through the treatment process. Postponed sessions by social workers and lack of money for travelling are all challenging, at the end we end up in drugs again (UserX05).

I have found that outpatient treatment puts lot of emphasis on stopping drugs than looking at what caused the abuse of drugs. It could be much better if there was a specialised way of treating involuntary out-patient service users (UserX02).

However, Wahler and Otis (2011:50) commended out-patient treatment stating a merit that it is structured to enable service users to continue their daily activities such as work and other significant tasks. Nonetheless, Quinn (2012:20) argues that out-patient treatment have slim opportunities for an absolute recovery on the basis that the service user is at risk of being exposed to the same influences and triggers that can stimulate return to substances. Service users may still have access to substances while on treatment.

Over and above this, Adams (2013:49) submits that daily life troubles can grossly interrupt the service user from concentrating on the treatment process and recovery. Out-patient treatment service users have very limited access to counsellors when compared to those who received treatment in residential environments (Parry, 2011:110). Most participants identified a common challenge that of often postponement of scheduled appointments by practitioners (social workers and psychologists). Consequently, out-patient service users would fail to follow through the treatment sequence. However, the researcher found these posits correlating to what Quinn (2012:20) and Parry (2011:105) maintain.

All the four interviewed service users who were involuntarily treated for substance dependence on an out-patient basis communicated their anxious state of feelings stimulated by the fact that they were still surrounded by drugs while on treatment. This is in line with Quinn (2012:18) who maintained that out-patients that are treated as involuntary service users are at risk of being exposed to drug use triggers. In view of these discussions, the researcher is of the idea that out-patient can still be a good treatment approach when it is aligned with good social support. Out-patient treatment could be a successful treatment approach should it involve the family of the users, this could strengthen the user's interpersonal relations with the family. In this way the treatment process would lay a good foundation for the integration of users with the society. When applied in the context of the study, the cognitive behavioural theory regards the cause of return to drugs after treatment is due to a lack of cognitive empowerment, the theory regards the treatment of involuntary users as impossible without good cognitive essentials such as family support.

4.4.2 Sub-theme 2: Unrealistic change and change management

Participants were asked about the techniques they had learnt from the treatment to assist them to not return to substances. Eight of eleven interviewed service users revealed that lot of useful knowledge about drugs' physiological and psychological effects was imparted to them, and that there were lot of emphasis on change management. All the eleven participants explained that the acquired knowledge did not help at all because they found quitting drugs very difficult after treatment. They had found themselves in misery, isolation and at risk after treatment, which stimulated a return to drugs after treatment. One participant stated:

I ended up in a state whereby I regretted to have been to treatment. I was all by myself after treatment (UserX5).

Participants revealed that they had found life very difficult after treatment. They had to live with unanticipated experiences such as neglect by immediate family members, significant others and the neighbourhood at large.

My family treated me as the very same person I was before treatment, they could not understand the process of change I was working on, I think they could not understand what could be their role thereof (UserX6).

I was still associated with delinquency acts. If anyone lost money or any other valuable possession, I was the first person to be suspected (UserX3).

Some of the interviewed service users claimed that their lives after treatment were subjected to exploitation, isolation and neglect. They base this on the basis that their significant others, immediate families and the society at large were not ready to integrate with them; on this light the participants maintained that:

- i. Their families did still not believe that they were in a process of change and spoken very discouraging words towards their attempt to change.
- ii. Their neighbourhood could not welcome them into their homes, their peers from the neighbourhood were warned by their parents to not socialise with them, and they were of the view that they could orientate these peers into substances.
- iii. They were associated with delinquent behaviour and were not expected to take part in activities that taken place in the neighbourhood.
- iv. They were commonly referred to as **amaphara** which is interpreted to mean “**a thief and useless somebody**”
- v. They have found their sub-systems such as peers, families and neighbourhoods completely disconnected from them after treatment, not considering them as humans, fear them, not trusting them judging them and all these ultimately induced neglect. The only world that showed hands of welcome towards them was the world of persons with substance misuse addiction.

In light of all the facts mentioned by participants, one participant was quoted saying:

Life is lonely after treatment. There is so much neglect. We battle with re-adjustments whilst faced with boredom (UserX9).

After treatment I have found myself having a lot of time doing nothing since I am unemployed. And remember, the emphasis during the treatment while at the facility was that I needed to change my substances dependant peers, and I had to drop all of them. I left them in drugs at the time I went for in-patient admission (UserX4).

Upon my return home from the facility, I found almost everybody running away from me. I ended up socialising with the very same substance dependant peers, and finally I was back into a worse scenario of substance dependency (UserX9).

Another participant was quoted bringing to light that:

Upon my return from treatment, I had no means to sustain living as a youth. I then decided to join a pyramid business where I was selling perfumes and getting paid on a commission basis. I battled even to have customers because almost everybody from my community was assuming that I was selling stolen products (UserX6).

*Some could not allow me to enter their households when I was doing a door to door selling. They were saying I was not into selling instead I wanted to observe how I could break into their houses at night. I have found my life in a worse mess ***(crying)**, I found myself with lot of stress which led to a loss of hope (UserX03).*

The other two interviewed service users who were treated on an out-patient basis revealed that the knowledge and awareness was relevant, and that it could not be applied in their daily living because they relapsed while they were on the programme. In this regard, the participants shared as follows:

I did not have time to look at how the skills and knowledge were helpful because I returned to drugs while I was attending the programme. I suppose this has discouraged my counsellor (UserX07).

The knowledge I gained along treatment process was very relevant, and it helped making lot of sense to me, but it was very difficult to work it out alone in terms of applying it to my daily routine because I was not ready to stop drugs (UserX9).

Beside, this knowledge is very powerful at the time it is shared by social workers during sessions, one becomes aware of his role thereof, but when you are now alone and you are supposed to apply what you were taught is not easy (UserX7).

I think if there was a way of supervising closely, may be it could be figured out how I am doing, where I am failing and how much of support do I need (UserX09).

Seemingly, service users treated on an in-patient basis and those treated on an out-patient basis had challenges with implementing the knowledge, skills and awareness acquired during the treatment process. The only difference found was that those service users who were treated on an out-patient basis relapsed while they were still undergoing the treatment programme. The out-patient treated service users indicated their state of readiness and lack of follow up avenues while they were on the programme as reasons using the acquired knowledge, skills and awareness for their recovery aims. This was correlating with Trotter (2010:140) who emphasises that unless involuntary service users are made to realise a need to

change, any means of intervention might worsen the situation. The author further maintains that the means of helping involuntary service users to see a need for changing their substance dependence behaviour must certainly target resistance and instil insight and resiliency.

The researcher identified a similarity between the emphasis made by Trotter (2010:140) about the users' state of readiness strongly relating with what kept on coming up during the data gathering. For instance, among the interviewed service users one made the same highlighting by stating that:

Treatment is sometimes complicated because of a clash between the treatment goals and the users' state of readiness to stop drugs. In this way, treatment seems to be pushing the user to stop drugs with less effort to consider the extent of his/her readiness to do so (UserX07).

In consideration of the above provisions by a participant, the researcher noted that from all the eleven interviewed service users, the issue of state of readiness kept recurring throughout the. This therefore seems to a researcher as an indicator that perhaps involuntary service users require a certain degree of motivation in order to change the dependence behaviour, and prevent relapse. The next section looks at the significance of self-motive in reducing post-treatment relapse.

4.5 THEME 2: SELF MOTIVES' SIGNIFICANCE IN REDUCING POST-TREATMENT RELAPSE

One of the objectives of the study was to examine the importance of self-motives to the service users in inhibiting relapse. From the data collected, the findings brought to light the worth of motives from service users before they are engaged in treatment. The gathered responses during the course of data collection were analysed in a thematic pattern and there were sub-themes identified thereof, these were motives importance and resistance reduction, poor motives for treatment and relapse, facilitation of motives enhancement, and life after treatment. These sub-themes are discussed, and when discussed they are supported with direct quotes, information from the reviewed literature and the theoretical lens.

4.5.1 Sub-theme 1: Importance of motives and its role in reducing resistance.

Most participants (eight out of eleven service users) maintained that they had no self-motives towards the treatment process. They further mentioned that not having self-motivation towards treatment made them to participate in the treatment process without willingness to stop substance dependence behaviour. The lack of willingness had made participants to have a faulty compliance whereby they showed compliance to significant others who referred them other than them quitting the dependency behaviour. In this regard, participants were quoted saying:

Honestly, I had no idea of what the treatment was all about. I had no intents to quit drugs at all. For me, to comply with the whole treatment thing, it was all about respecting my parents' efforts in taking the initiative that I go for treatment (UserX08).

I was sentenced mandatory in-patient treatment by the regional court. I had no intention on treatment and stopping drugs. Instead, I was terrified by the fact that should I not comply court order; I was going to be considered for a direct imprisonment. (UserX3).

I feel that treatment was compelling and emotionally straining. I was so looking forward to my discharge day as I was coping at the treatment facility. It then took me about two weeks to return to drugs after I was discharged from New Lands Park Centre in Durban (UserX11).

I was not ready to quit drugs. Stress of being an unemployed graduate was among personal issues that made me to fear living without drugs. Then my little attempt to maintain abstinence was unsuccessful (UserX09).

Furthermore, among the eleven participants, four indicated that they had no motives to change their substance dependency conditions. Various reasons were mentioned in this regard, which include; lack of willingness, change of focus from treatment into source of referral for treatment and fear of psychological factors such trauma, stress and depression. These were the reasons given by participants for their lack of motives towards the treatment. These findings are aligned to the study conducted by NIDA (National Institute of Drug Abuse of America) in 2009, which highlighted that many people experiencing addiction participate in treatment and immediately relapse afterwards and are not in a position to maintain the absolute abstinence from drug and alcohol. In relation to these similar findings, Muniral (2012:56) asserts that the leading cause of relapse, mainly among the drug and alcohol misuse addiction who are considered for treatment on mandatory basis is lack of motivation at the individual level.

The current study identified psychological factors such as stress and anxiety as triggers of relapse after treatment. These findings concur with those by Parry and Gonzalo (2014:21) that if not given attention during the treatment, depression, stress, and anxiety can trigger relapse, especially if the service user lack motives for self-determination to change substance dependency behaviour.

Other researchers from the Behavioural Health Institute (2014:60), South Africa National Council on Alcoholism (SANCA) (2012:11) and World Health Organization (2015:25) identified self-motive as the key area in breaking the cycle of post-treatment substances re-use, and that the self-motive brings the service user to realise the importance of change will and the identification of treatment needs. Participants were asked about how motivated they were in changing their substance dependency behaviour prior to treatment and the extent of motivation after treatment.

During the course of data collection, nine out of eleven service users revealed that they had no change motives at the time they went for treatment (both in-patient and out-patient). Participants further agreed to the fact that without the strength of motives there is more probability of relapse. All the participants stated that going for treatment on involuntary basis made them to cease the treatment course without having developed insight and resiliency about changing substance dependence behaviour, as a result, a return to substances was much easier. In this regard, one participant stated that:

I was forced through the court order to go for in-patient treatment; my whole idea thereof was to comply with the periodic order issued by the court (UserX2).

Another participant maintained that:

After repeated incidents of testing positive to alcohol at the onsite accessing breathalyser at work, occupational doctor and the employee health and wellness practitioner suggested that I go for in-patient treatment. I was very afraid of possibilities of being fired. Because I was not ready to quit drugs, as a result my whole focus was into complying with the recommendations of rehabilitation than working on stopping addiction and stopping behaviour (UseX11).

From the participants' point of view, it is clear that lack of self-motives have caused substance dependant users not to see the significance of taking responsibility to change their behaviour. Most participants mentioned that they had no hope for

changing their addiction at the time they went for treatment. There were many reasons that were discovered to be contributing to the lack of willingness to quit substance dependency such as trauma, depression and anxiety. These reasons have brought up resistance, and according to the participants, the resistance to change was a result of fear of unresolved stress. All this perpetuated the cycle of drugs re-use. Out of all the eleven participants, seven reported that they were subjected to stress and anxiety after treatment, and that this happened to an extent that they ended up regretting having gone through the treatment avenues.

However, this complements previous research, which maintains that some psychological factors such as depression, stress and anxiety are the root causes of substance dependency, for instance, general life events and experiences exposed users' to stress, depression and anxiety, and substance dependency was chosen to cope with the reality of these psychological factors. Therefore, when the service users are taken for treatment, the treatment attempt should not only address issues of substance use, but must also go deep to uproot the cause of these psychological factors as they are underpinning issues, in that way the treatment would have been responsive to the needs of the service user (Gonzalo, 2014:101).

4.5.2 Sub-theme 2: Self- motives facilitation

According to Muniral (2012:14), relapse is a serious problem, and it contributes grossly towards the accumulating prevalence of general substance dependence. The author also discovered that very few substance users who consider treatment, and that the majority among the few that consider treatment relapse after a short space of time. Nonetheless, the findings of the study have brought to light that relapse is a reality, and that lack of service users' self-motives is at the centre for relapse after treatment. One of the sub-themes that emerged herein was the importance of self-motives, and the manner in which self-motives should be facilitated before the start of the treatment process.

Ten participants reported that it could be much better if the social work practitioners prepared them before any pattern of treatment commenced. In light of this, one participant was quoted saying:

The treatment process as a whole begins with social workers. We work with them almost from the beginning of the treatment journey; we end up in a good relationship with them. They should take that advantage of good relationship to prepare us for treatment so that we find within ourselves a need to change dependency behaviour that on its own could bring about good outcomes of the whole treatment idea (UserX10).

The motivation of service users by social workers before further referring them for treatment might have a tremendous role in enhancing self-determination, thus prevent relapse among the involuntary service users. The findings were correlating with the research inputs, for instance, Ghodse (2015:240) bring to light that social work is the pioneering profession in working on substance dependence and its related problems.

The research by Goldberg (2014:15) discovered that through an effective assessment process which must include the service users' social functioning state, support system and connections, service users' individual needs and exploration of most required resources within and beyond the treatment process. Moreover, Trotter (2010:140) concurs on the premise that social practitioners can facilitate self-motives before users are engaged in the treatment process, and that the facilitation must be about advising and supporting the service user in a manner that channels the user's state of readiness for the treatment process.

4.5.3 Sub-theme 3: The elements of post-treatment stigmatisation

When participants were asked about the degree of motivation after treatment, all interviewed participants mentioned that their life turned into an unanticipated battle of neglect and isolation. The various forms of stigma were coming from the fact that participants were not accepted by their families and the society at large. As a result, they were subjected to neglect and isolation, which brought about elements of stress. Most participants could not cope with the stigma, and they ultimately ended up on drugs.

Some of the participants' views in this regard were quoted as follows:

I was subjected to emotional exploitation after treatment. It was difficult to change. I battled to have someone who could understand me and give me support. I was often criticised about the things I did prior treatment by family and the neighbourhood at large (UserX08).

I received many discouraging words from my relatives and immediate neighbourhood members about my recovery journey; this happened in a way that it instilled an idea of failure to me, especially because I was treated on court committal basis (UseX02).

These findings are aligned to one of the studies conducted by the World Health Organization (2009) on substance abuse after treatment re-adjustment challenges. The findings of that study indicated that intrapersonal circumstances associated with family and society were also identified as significant predictors of relapse. These were lack of support and loving relationships, and ill-treatment from family and neighbourhood. Considering that the quoted participants highlighted the scourge of discouragement and ill-treatment, it is assumed that such these experiences on their own had played a role in the relapse of involuntary service users. According to the Behavioural Health Institute of America (BHI) (2015:171), recovery is a tricky process that requires a multi-tasked approach, which must include working with service users' systems. These attempts lay foundations where service users' could be sustained with means to cope with the recovery challenges.

Stigmatisation, neglect and isolation by friends, families and the neighbourhood at large were found to be more or less common among all service users who participated in the study. During data gathering, participants were of the view that the stigmatisation, neglect and isolation were perpetuated by that the treatment was not inclusive of families and significant others. Participants stressed that should the treatment process became inclusive of their families, they could be supportive accordingly, and that they could have felt accepted after treatment. They were also considerate that being accepted would have strengthened insights in their recovery process, and that even the judgemental attitude from the society would have been alleviated.

Similarly, in a study conducted by Yang, Mamy, Gao and Xiao (2015:113) on predictors of relapse in Malaysia, it was found that during abstinence, the service users' after-treatment living conditions consisted of challenges, such as adverse socioeconomic conditions, poor family or social support, interpersonal conflicts, and stigma and discrimination, all of which kept them from mainstream society. Relapse triggers reported by the participants in this study focused primarily on negative

feelings, interpersonal conflicts, as well as stressful events, which were evoked by the challenges that characterised the lives of service users.

4.6 THEME 3: SERVICE USERS' ATTITUDE TOWARDS THE TREATMENT PROCESS

One of the objectives of the study was to ascertain the service users' attitude towards the scope of the treatment process. From the data gathered, it was found that the lack of motives made most of the service users not to be interested in seeking treatment, and that very few that had interest quickly loose insight along the treatment process. The findings indicated that involuntary service users complied with the treatment at the onset of the process, but the extent of such compliance was meant to adhere to referral sources and not the referral cause. Matseke's (2010:47) study on the epidemiology of substance dependence portrayed a high prevalence of substance abuse as resulting from heightened rates of clientele rendered treatment on a mandatory basis. Furthermore, relapse identified as being underpinned by lack of interest in treatment because service users' lack insight about treatment and have fear of life after treatment.

In connection with the theme on attitude of service users towards the scope of the treatment process, the following sub-themes were identified: a) few users showing insight, instantly loose interest towards the treatment, b) users are ready to stop drugs and treating dependency but adhering into referral systems such as families, significant others and work place officials. Direct quotes of identifying information obtained from participants during data collection, and literature review are all aligned to sub-themes.

4.6.1 Sub-theme 1: Service users' instant loss of interest and disengagement from the treatment programme

Nine out of eleven interviewed participants revealed that they had a negative attitude towards the treatment process. Participants specified that the attitude they had was not that they were taking the treatment process for granted, but they were not happy about the fact that the treatment idea was dictated to them. Participants were quoted saying:

When they got tired of my stealing of household accessories my parents decided that I go for treatment; nonetheless, I feel like the whole plan for treatment was all behind me, and this caused me to feel intimidated (UserX10).

I was recommended for treatment by the regional court, and I was so negative towards the treatment, nobody had asked what had led me to drugs. How I wish I had a chance to explain because I could share my struggles behind dependency problem (UserX01).

The other two participants revealed that they were not against the treatment process but in the middle of the programme, they literally lost interest about almost everything and requested to be disengaged from the treatment. These findings are correlating to Ramphele (2013:276) who states that the negative attitude towards the treatment by mandated service users is a common factor, and fear of stopping drugs may all be underpinned by the fear of withdrawal symptoms, and this may drive thoughts and views about the treatment scope being negative.

Furthermore, the Cognitive Behavioural Theory (CBT) provides that thoughts and feelings are closely related. The person's interpretation and the future determine the generic behaviour and self-conduct. In relation to involuntary treatment and the service users' attitude thereof, the users' attitudes can be mostly against the whole treatment idea should the core of their thoughts, beliefs and feelings not be sincerely considered. Treatment for substance dependency must be based on a reached consensus with the user. On that note, the user will be enabled means for self-determination (NIDA, 2009:111).

4.6.2 Sub-theme 2: Treatment compliance shortcomings

When participants were asked about their understanding of the treatment process that they participated in, one participant indicated being against the treatment. The participant did not demonstrate an understanding of reasons about his state of being negative, but he firmly maintained that while on treatment, he was uncertain and not at ease to the extent that he began to demand to be disengaged. From this point of data collection, negative attitudes and conflicts of interests between the referring sources and the service user were elements that began to unfold.

All the eleven interviewed service users reported that they had their focus during the treatment process focused on referring sources than to work towards abstinence and

recovery. Three of the eleven users reported that they were mandated for treatment through court orders, which came with intensely binding conditions. The users further revealed that they then had their focus was on the verdict and its conditions. Participants shared that:

I have committed plenty of crimes before, and many of them were substance abuse related offences; as a result my biggest fear was that I was going to accumulate criminal records should I fail to comply with conditions of the court order (UserX3).

It felt so bad when I was sent for treatment; I knew that treatment wouldn't succeed. I was angry about the whole process. I felt like, the court did not accept my dependence as an illness, and that made me feel judged. I am back to drugs now, and in a worse state (UserX1).

The findings here are correlating to what the National Institute of Drug Abuse (NIDA) (2014:41) that most court mandated substance dependants' treatment is a set for relapse, for many reasons. However, these reasons aligned with what was gathered from the participants when they stated their negative attitudes, conflicts of interests and shifting of focus from treatment and recovery to mandatory referral sources as reasons to relapse after a court mandatory treatment. The institute further maintains that all the cases of court mandated dependency treatment lack continuum care (after care and support) which could play a valuable role in guiding and mentoring service users towards the absolute recovery.

4.7 THEME 4: SOCIAL WORK PRACTITIONERS' ROLE IN PREVENTING RELAPSES AMONG INVOLUNTARY SERVICE USERS.

One of the objectives of the study was to ascertain the social workers' role in preventing post-treatment relapse among involuntary service users. In the data collected, it was discovered that social work practitioners did not play a mentoring role in inhibiting the high prevalence of post-treatment relapse. There were certain sub-themes that emerged out of this process, these included, poor work resources, lack of understanding of intervention protocol in substance abuse cases, quick referrals to in-patient treatment facilities, and knowledge of appropriate approaches to be applied when working with involuntary service users.

All the four participants who participated in the study attested that there is a role of social workers and other disciplines such as psychology, nursing and psychiatry in

inhibiting prevalence of relapse, particularly among youth involuntary service users. The participants highlighted that social work had challenges that impeded their efforts in inhibiting substance dependency and relapse.

4.7.1 Sub-theme 1: Lack of resources

All participants posited that they encountered challenges of not having enough resources, and that these shortcomings have prevented them from rendering services fairly. Below are some of the responses shared by the participants during the course of data collection:

The area of substance dependency lack appropriate understanding in terms of clinical treatment roles in conjunction with traditional social work roles, case management systems, quality controls and research. This has caused us to be not sure about the relevancy of help we provide (SwPX01).

First of all substance abuse needs to be understood as a critical area of social] work service provision. On this note, we should not lack resources the way we do (SwPX2).

Except the lack of infrastructure such as treatment facilities, we do not prescribed assessment tools, and other appropriate clinical instruments. The currently used intake (SWS2) and assessment instrument (SWS5) are too generic for use in substance abuse cases (SwPX4).

I have never done any assessment in almost all cases of substance dependency that were assigned to me. I only did intake, investigated their authenticity, and then referred them for in-patient treatment (SwPX01).

Furthermore, other participants were quoted saying:

I have never done proper assessment in all cases. There was this on case that I was not able to attend thoroughly since I was changed to coordinate other programmes. After about 7-8 months, the client (the service user's mother) came to the office again, from then I started the process of placing the service user. I have no idea of the outcomes of the process, but I believe who ever took over the case had handled everything accordingly (SwPX03).

Work tools, case management strategies, supervision and quality control are a biggest challenge. Due to a lack of working tools, I ended up downloading some assessment tools from the internet; I am using them currently for the assessment and other tasks (SwPX4).

Transport has been one of the challenges we have experienced in working in the field of substance dependency, as a result plenty of my cases were without after-care services, and I am sure that had exploited my clients a lot (SwPX02).

The responses of social work practitioners who participated in the study revealed that there is a valuable role of the social work profession in reducing the heightened prevalence of relapse, and that there are certain challenges demeaning this role. Participants identified lack of resources mainly the assessment tools as the major shortcoming that contributes grossly in relapse. These findings are complemented by literature; which brought to light that the major role of the social work profession is the assessment. Without the accurate social work assessment there is more likelihood of treatment not to directly respond to the needs of the service user, which may ultimately influence absolute relapse (National Institute of Drug Abuse, 2014:52). Social work assessment is a clinical instrument that can be used to measure the impact of dependency. Through the appropriate assessment, the social worker can assist a lot in terms of determining the service user's degree of readiness for the treatment.

Except the importance of assessment tools and its unavailability, another shortcoming mentioned by social work practitioners during the data collection was the lack of resources. These include shortage of treatment facilities, easy access to hospitalisation detoxification programmes, half-way houses and Alcoholics Anonymous (AA) self-help programmes. These findings were correlating to a study conducted by Matseke in 2010 on the epidemiology of drug abuse and treatment in South Africa. The study revealed that apart from the lack of motives, one of the major causes of relapse is the lack of financial resources, which ultimately compromises the provision of after care programmes (Matseke, 2010:83).

4.7.2 Sub-theme 2: Knowledge and understanding of intervention procedures.

When participants were asked about what they considered to be the primary cause of relapse among youth involuntary service users, all the four social work practitioners mentioned that their current case load in substance abuse cases are mostly the involuntary cases. However, their work approach appeared to be mostly based voluntary cases. The participants considered this as a knowledge gap, and that it has made them to fail their clientele of service users. One participant was quoted saying:

Having discovered about such deeper meaning and differences between the voluntary and involuntary service users made me to realise that even

our current work processes need not to apply one and the same procedures and approaches. However, my biggest problem thereof is the lack of understanding of where to start (SwPX03).

A clear understanding of substance dependency intervention procedures and terms of reference is very important in order for social work practitioners to draw up treatment plans derived from the appropriate and accurate assessment they had conducted. A practitioner's precise understanding of intervention procedures in substance dependence should begin from knowing that involuntary and voluntary service users are not the same, and that they can never deal with these two categories using common approaches and knowledge. All the participants agreed that their lack of understanding of work procedures made them to be quick in sending service users' to treatment facilities before exhausting their roles.

The current findings are related to the findings of the study conducted by Quinn (2012:13) which maintains that social workers lack quality training and expertise for the treatment of substance dependence and its related disorders. Social workers, particularly in the public practice domain are reported to be more pessimistic about user's prognosis and their own to work therapeutically with clients who present with acute substance dependency (NAADAC, 2010:17). Moreover, Richardson (2008:25) concurs that there is a lack of expertise by social workers in the field of drug abuse, and suggested that the curriculum for social work professional training need to be reviewed in order to ensure that it contains enough substance abuse accurate and strengthened.

4.7.3 Sub-theme 3: Lack of appropriate approaches in the helping process with involuntary service users

Participants were asked if the intervention approach that they apply when working with involuntary service users is the same approach applied when working with ordinary voluntary service users. In response, participants mentioned that just as they lack appropriate work tools, even their work processes and procedures are not specified in terms of voluntary and involuntary categories, these include programmes and other services. One participant was quoted stating that:

My current work procedures do not separate the involuntary and voluntary service users, this include the generic approach in our interventions (SwPX02).

These findings relate to Richardson (2008:20) who argued that the current approach of handling substance abuse cases in the social development sector particularly in the public domain, are lacking understanding that voluntary and involuntary elements are not the same. The approaches are different in terms of interests and desires for treatment, insights for treatment and other post-treatment dynamics, For instance, voluntary service users can cope with challenges such as dealing with the negative attitudes from people, change management, disconnecting from substances and substance dependent peers, whereas the involuntary service user battles with a lot of treatment dynamics from the onset of engaging up to the post-treatment phase.

The other participant was quoted saying:

When you talk about the appropriate use of approaches, models and theoretical techniques I am noting that I still battle in this area in terms of understanding appropriate theories and treatment models (SwPX01).

It appeared during data collection that participants lacked appropriate knowledge and understanding of the relevant theoretical lens, which could assist them in making analysis and drawing up treatment plans on assigned cases. It was discovered in the course of data collection that there was lack of case management systems, quality controls and support, which somehow appeared as a neglect to service users.

In light of the mentioned discoveries, one participant said:

Post-treatment relapse is a reality. I have never worked in a case up to an after-care level of intervention, reason for this was not only the lack of resources, but even myself I do not think I follow the procedure accordingly and this had an impact on service users (SwPX02).

I have had two incidents of mob killing where service users were killed by members of the community. The genuine reason for their killing is still unknown as yet, but the assumption is that they got involved in delinquency acts (SWPx04).

These findings are similar to Quinn's (2012:36) recommendations that the crisis on the lack of knowledge, understanding and the expertise by social workers requires more capacity building interventions.

4.8 THEME 5: IMPLICATIONS OF DUAL ADDICTIONS

During the data collection process, dual diagnosis also emerged as a notable factor responsible for stimulating relapse. The interviewed service users indicated that multiple addictions were a major implication in the process of substance dependency treatment. The following sub-theme emerged from the theme on the implications of dual addictions.

4.8.1 Sub-theme 1: Treatment oversight on other behavioural addictions

According to Williams (2017:103) there are instances where the use of drugs connects to other behavioural addictions, and that these behavioural addictions have a strong potential to stimulate relapse. Nonetheless, the indications of other behavioural addictions such as gambling and sex came out during the data collection. Some of the participants had the following to share:

I am partially a sex worker. Although sex work is not something permanent but I consider myself addicted to sex because I have multiple sex partners whom I am involving in sex with for financial gains. At the time I went for treatment of substance dependence I did not disclose my other addictions problem, neither practitioners could not find this by any means of their intervention procedures (UserX08).

*I am convinced that after treatment I tried to maintain abstinence from drugs, while on the other hand I battled with sex work without taking drugs just to numb my conscience. Whenever I were to engage in a sexual activity an idea of taking drugs was a gross screaming thought. Ultimately, I am back to drugs ***(Crying)***.... I think I am fine regardless of adverse consequences (UserX08).*

I also have a gambling problem apart from drug abuse behaviour. It actually started with gambling which caused me financial problems, upon battling with stress of financial predicaments I ended up on heroin as means of relief from stress (UserX11).

My use of heroin worsened to an extent that I was recommended for treatment. But the treatment itself could not deal with gambling, yet for me drugs were not a problem at all, instead the major problem was gambling and it was never included in the treatment procedures (UserX11).

Both the South African Depression and Anxiety Group (SADAG) and the Substance Abuse helpline (2014:12) further echo the relationship between substance dependence and other addictions. They maintain that these behavioural addictions can stimulate relapse if they are not dealt with during the course of the treatment. Nonetheless, the researcher found these posits aligning with the core findings of the

study, and they are supported by Herring (2011:100) who argued that sometimes it is not drugs per se that are a primary need for treatment. Instead, it is the other addictions that when they are not dealt, they stimulate a return to drugs as a typical mechanism for coping. Therefore, the treatment itself must be relevant enough to go the extra mile to tackle other addictions. In this way, the treatment of substances without dealing with the user's other addictions can cause relapse.

Furthermore, Fakier et al. (2009:102) maintain that sometimes the most post-treatment relapse stimulants is a failure to consider substance dependency as a secondary issue brought by other circumstances. Based on these findings, and their relationship with other researchers' posits, the researcher argues that perhaps the current treatment procedures requires a review with intent to make it be more evidence based and responsive to treatment needs of service users.

4.9 CHAPTER SUMMARY

This chapter provided the analysis and interpretation of the research findings in relation to themes and sub-themes that were identified. Nonetheless, the context of the presented findings of the study revealed that there are different causes of youth involuntary service users to relapse after treatment. The findings brought to light that post-treatment relapse among youth involuntary service users is a real problem.

The study's findings suggested that the service users' lack of motives, which underpin the conflicts of interests between the service user and the treatment process, lack of resources including the assessment tools perpetuated relapse. Social workers' lack of understanding of the concept of involuntary service users in relation to the service provision scope, lack of case management systems and lack of sound knowledge and skills in substance abuse treatment are among what the study found to be the causes of relapse. Furthermore, the strong lack of after-care services for substance dependence cases contributes grossly to the heightening prevalence of post-treatment relapse.

From the service user's point of view, the study's findings reveal that issues of financial problems and inability to sustain livelihoods, neglect and stigma from the society subjected service users to loneliness and inability to cope with life realities

after treatment. As a result, substance dependents service users return to drugs as a mechanism for coping. The context of findings also raises concerns about failure to make the treatment process look at other addictions exactly the same as substance dependence, as an unnoticed most relapse stimulant. The next chapter is the conclusion; it shall merge the research objectives and analysis with intent to find out if there were common accomplishments.

The next chapter outlines the summary of the findings and highlights whether the research objectives were met. This final chapter will also provide a layout of the study's limitations, makes recommendations based on the conclusions of the study and make suggestions for future studies.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter provides the summary of findings, conclusions and recommendations as well as suggestions for future research. The study's outcomes have brought clear indications of implications of social work practice in substance dependency and relapse; these are discussed in this chapter. Limitations of the study are also highlighted this chapter.

5.2 SUMMARY OF THE FINDINGS

The study used a sample of fifteen participants comprising eleven youths who had been to treatment for substance dependence on an involuntary basis, and had relapsed, and four social work practitioners who were working in the field of substance abuse at the time the data was collected, all from UThungulu district in KwaZulu- Natal. Among the four social work practitioners, two of them were males and the other two were females. Among the eleven youth participants, eight of them were males whereas the three were females. All the eleven youth participants were between eighteen and thirty one years of age. None among the youth participants was employed, six were never employed and two were suspended at work. Two participants were high school learners while one participant was a university education incomplete.

Moreover, Out of eleven interviewed participants were all Africans and Zulu origins but very fluent in English. All the participants were poly-substance dependent users at the time of the interview. Eight out of the eleven interviewed youth involuntary service users were mostly abusing alcohol substitutable with dagga. Of the three who were abusing nyaope/woonga, they revealed lack of interest in alcohol, and that they were attracted into inhalants such as glue and spirits. The summary of the study's findings is based on the four objectives that are discussed in the following sections.

5.3 AIM AND OBJECTIVES OF THE STUDY

The study's main aim was to explore the causes of relapse amongst youth involuntary service users in UThungulu District. The aim of the study was attained through use of the qualitative research approach. The following objectives were achieved:

Objective 1

i) To investigate the service users' state of understanding of the nature of treatment that they underwent

This objective was achieved in a discussion in Chapter Two Section 2.8 and in Chapter Four section 4.4. Commonalities were discovered between the literature review and the research findings relevant to this objective. For instance, section 2.8 in the literature review revealed that service users treated on a mandatory basis had distorted perceptions about treatment, which induces negative attitudes about the treatment process. Findings from the current study on the other hand also show in section 4.4 that service users treated involuntarily had a negative attitude towards the treatment rendered, and this tended to undesirably influence their scope of understanding of the nature of treatment.

In terms of soliciting the service users' attitudes towards the treatment, the findings further brought to light that there were two categories concerned, the in-patient treated service users and the out-patient treated service users. Regarding the in-patient treated service users, findings of the current study established that they perceived the treatment as not worthy; they found treatment not responsive to their needs. There is a contrast between the users' expectations of nature of treatment and the structure of the treatment process. The participants revealed that they felt like the treatment overlooked their actual issues, needs and problems that caused them to depend on substances. They further revealed that even themselves, allowed their focus to shift from treatment significance into their fears of withdrawal symptoms. Participants cited lack of contemplation as the major cause of relapse after treatment.

In terms of the out-patient treated users, the findings indicated that users demonstrated a negative attitude for a number of reasons. Service users found

treatment comprising challenges such as the risks of environmental influences, the availability of drugs, and that the treatments demand certain level of commitment from the user's counterpart, and that which is not easy in their case of involuntary treatment. Moreover, the findings established that involuntarily out-patient treated users were at risk of resorting to dependency on substances while they were still receiving treatment. The findings also revealed that lack of an understanding of the nature of the treatment was very common among both in-patient and out-patient treated service users on the basis that they had their state of willingness not worked out thoroughly before engaging in treatment processes.

Shortcomings of unrealistic change and change management kept on unfolding in the findings of the study under this objective. Participants viewed the core of the treatment process as placing lot of emphasis on users to change substance dependence behaviour and avoid substance dependent peers, but all these emphases were found difficult for users to work on after treatment. The participants agreed that there was a prominent psycho-educating during the treatment process that focused on the origins of drugs, their effects on human functionality and prevention strategies. However, all these become useless after treatment, instead the unanticipated shortcomings of such, included isolation, emotional misery and neglect. Emotional exploitation and discrimination were among what service users experience after treatment, and they increased the likelihood of relapsing.

Objective 2

ii) **To examine the significance of the involuntary service user's self-motive in inhibiting the post treatment relapse**

The current study examined the significance of self-motives among involuntary service users in inhibiting post treatment relapse. This was found to be the key avenue in alleviating post-treatment relapse. These findings are in Chapter Two section 2.9 and in Chapter Four section 4.5 which established that in order to inhibit the relapse, involuntary service users must be assisted to develop motives to change from substance dependent behaviour to a drug free life styles. The development of self-motives reduces resistance and help users to set their own goals for treatment. Findings indicated that eight out of eleven the interviewed involuntary service users revealed that participating in a treatment process without having developed inner-will

made them to proceed with the whole process of treatment without willingness to stop drugs. They considered going for treatment without any intention to escape drug dependence but simply to satisfy significant. The findings further highlighted that lack of self-motives made the mandatory treated users to easily lose insight of treatment and ultimately fall to relapse. These findings were similar common to findings on a qualitative study on triggers of relapse by the National Institute of Drug Abuse in America (NIDA) in 2009.

Most of the interviewed participants emphasized that lacking self-motives subjected involuntary treated service users to a lack of contemplation and self-determination. Several factors such as stigmatisation and other psychological factors such as stress, anxiety and depression, made post-treatment life difficult. Without a good foundation of self-motives, service users are more likely to fall into a worse drug reuse cycle due to a lack of inner strength.

Objective 3

iii) To explore the involuntary service user's attitude towards the treatment process

This objective was achieved in a discussion in Chapter Two Section 2.7 and Chapter Four's section 4.4. In exploring involuntary service users' attitude towards the treatment process, most of the findings were similar to those obtained when examining the significance of the involuntary service users' self-motives, particularly the part of "the motives' importance and resistance reduction". The negative attitude towards treatment was a common element of outcomes noted between the two objectives.

Beside the negative attitudes, the findings clearly indicated that involuntary users treated on an in-patient basis instantly loose interest upon their admission at the treatment facility. According to participants, their negative attitude towards treatment did not mean that they were taking the role of treatment for granted; instead they cited being not at ease with the treatment because they lacked intrinsic motivation.

Objective 4

iv) To determine the role of social work practitioners in preventing post-treatment relapse among involuntary service users

The researcher noted a strong complement between the projections in Chapter Two section 2.6 and the discussions in Chapter Four section 4.7, where it is maintained that should social work practitioners play their role efficiently, the post-treatment relapse among involuntary service users could be alleviated. The research findings established that sometimes social work practitioners fail to play their role due to several reasons, such as lack of resources needed in their practice and generic understanding of the practice related procedures involved in dealing with substance abuse, mainly in the context of involuntary service users.

In terms of the lack of resources, social workers do not have appropriate assessment tools for working with substance dependent clientele. The lack of resources further extends to impact the after-care avenues. Participants in the current study showed that poor resources go a long way to include the shortage of treatment facilities, whereas there is a high rate of cases with need for substance dependence treatment.

In terms of poor understanding of the intervention protocol, the findings of the current research maintained that social work practitioners have no efficient understanding of clinical procedures for dealing with substance dependency for treatment aims, particularly for involuntary service users. The participants in this research showed that they had of role of motive enhancement before referring involuntary service users to any mode of treatment. The findings on the other hand intensely maintained that practitioners lacked capacity building, insight and proper case management.

The research participants brought to light that the majority of their case loads in substance dependence were involuntary clientele. However, the policies, work norms and standards were more about voluntary service users, which therefore were determined to be a lead in the lack of efficient role from the practitioners' part.

Apart from the lack of professional competence among social work practitioners, the research findings indicate that there is a gap of lack of effective supervision and

mentoring. This was found not only affecting the level of competence of social work practitioners but compromised the quality of service to users due to lack of quality control and efficient case management strategies. Research participants maintained that they would often refer service users to in-patient treatment facilities without initial procedures done such as users' appropriate assessment, users' family assessment, history of drug dependence and effects thereof, working on users' insights about treatment, and preliminary construction of after-care plans. Participants cited lack of resources such as transport and practice tools as the cause of inadequacy. The research findings established that service users were rejected by the helping systems soon after treatment. Users were battling with surviving on their own as they faced new life challenges without support after treatment; they found themselves resorting to drugs again.

Poor assessment avenues leading into treatment not being responsive into treatment has been a major concern among the itemised findings of the study. However, the participants affirmed that they had no proper assessment tools designed for substance abuse screening purposes. Some of the participants further shared that they normally used other tools downloaded from the internet, which were sometimes not well understood. The research findings established that lack of appropriate assessment had indeed compromised the treatment needs of service users. Most service users had dual addictions problem, and that only a practitioners' well administered assessment could assist in obtaining these addictions.

Social work practitioners agreed that poor after-care avenues were among the main challenges in practice. Thus, findings highlighted that there was a lack of a managed after-care. However, lack of resources and poor case management systems were the major cause of a compromised quality in the helping process, which made relapse among most likely to take place.

5.4 CONCLUSIONS

Based on the reviewed literature and the research findings, one may conclude that there is a high rate of post-treatment relapse in UThungulu District, and that several factors contributed to the problem of post-treatment relapse. Firstly, from research point of view, literature on substance dependency and substance dependency policies in general, it appears that very little attention given to involuntary service users. Furthermore, the substance dependency helping processes and policy lens in general were found focusing more on voluntary service users.

Findings demonstrated that involuntary service users, both treated on in-patient and out-patient treatment modes demonstrate distorted perceptions and negative attitudes towards the treatment. This emanates from service users' participation in the treatment process without any trace of willingness; hence, the treatment process fails to identify the main cause of dependence. The out-patient treated users in particular, did not develop positive perceptions about treatment; they were at risk of progressing to severe drug dependence while they were still on treatment. These challenges tend to perpetuate post-treatment relapse.

An analysis of the findings indicated that there was quality psycho-education on substances and their effects, and the emphasis on behaviour change. Service users found it difficult to work on change management due to the difficulties they faced after treatment. These difficulties included discrimination and neglect by family and society, socio-economic hardships; unemployment and lack of skills and boredom. The above were some of the after-treatment challenges that made it difficult for service users to survive the post-treatment phase. They increased the likelihood of relapsing.

Furthermore, one may conclude that another major cause of relapse after treatment is the service users' lack of motives for treatment. Lacks of motives make users find no sense in the whole treatment process idea because they have no inner sense of will and strength. As a result, they enter the treatment process while taking drugs and unwilling to stop drug dependence.

Drawing from the findings, one may conclude that most of the caseloads on substance dependence were involuntary cases, yet social work practitioners appeared to be not efficient in terms of expertise and understanding of the practice guidelines and policy for substance abuse, mainly the involuntary service user. The lack of competence among social work practitioners was due to several reasons. These included lack of understanding of the practice procedures for substance dependence mainly in the involuntary context, lack of resources, poor assessment avenues and shortage of treatment facilities. Lack of good supervision, mentoring and lack of case management systems affected the quality of service provision, and opened gaps for post-treatment relapse.

The empirical findings of the study found that service users were subjected to life challenges after treatment. However, one may argue that the current poor case management systems seem to have compromised aftercare avenues. Consequently, users were neglected and left without means of sustaining livelihoods as a result user are neglected and left without means of sustaining livelihoods, hence they chose to return to drugs as a solution.

5.5 RECOMMENDATIONS

Based on the research findings and the reviewed literature, it is recommended that:

- The Department of Social Development together with all stakeholders in the social development sector must ensure that there are well- managed aftercare services for service users inclusive of involuntary service users. The aftercare services must address concerns of boredom and unemployment as these are the major factors affecting users social functioning after treatment. In working together with the Local Drug Action Committees at a local government sphere, the department of social development must put measures to ensure that aftercare services effectively strengthen human relations, integrate service users with their families and communities as this could play a valuable role in preventing the exploitation and stigmatisation facing service users after treatment. The aftercare model must bring to place avenues such as skills audit, skills development, and the linking of service users with opportunities that will enable them to sustain livelihoods after treatment. This will play a valuable role in fostering self-reliance.

- To prevent the exploitation, neglect, and discrimination of service users after treatment, Sober Living Houses/ Half Way Houses be established as means for the reintegration of service users who were mandated for treatment as a result of delinquent behaviour. This will mitigate against incidents of mob-killing of service users after treatment. The SLH strategy will enable users to return to the community safely after some appropriate interventions by different appropriate role players.
- Social work education institutions (mainly universities) should strengthen the practice training of social work practitioners by ensuring that their curriculums strongly include teachings and research about the involuntary substance dependency treatment. The institutions should consider the responsibility of providing capacity building and support to their neighbouring organisations and health facilities rendering substance dependency treatment services; this must include the developing of well researched resources such as assessment tools and treatment models designed for the involuntary service users. This will strengthen the level of knowledge and good calibre of expertise in the field of substance dependence and relapse among social work practitioners. In this way, service delivery will be strengthened, and ultimately the heightening treatment relapse prevalence could be alleviated.
- As a pioneering role player in the provision of substance abuse services, the department of social development should develop effective case management systems. The case management system must put in place clear roles of a social work supervisor in ensuring that each case of substance abuse is handled according to the required standards of social work professional practice. In the face of effective case management systems, a monitoring and evaluation model designed for involuntary substance dependence treatment should be formulated in order to ensure quality and bridging the gap of treatment dynamics between the voluntary service users and the involuntary service users.

- The department of social development at its macro level of policy making must consider developing guidelines, norms and standards, practice protocol and the treatment programmes designed for the treatment of involuntary service users in both in-patient and out-patient settings.
- The Central Drug Authority (CDA) should work closely with the South African law enforcement agencies to strengthen the harm reduction, supply reduction and demand reduction mandate. This could assist in addressing the unlawful entering of drugs in South Africa.

5.6 SUGGESTIONS FOR FUTURE STUDIES

This study was limited to causes of post treatment relapse among youth involuntary service users aged between eighteen and thirty-five years from UThungulu district. However, many teenagers who had received treatment on an involuntary basis relapsed after treatment. However, the causes of youth involuntary users may vary with those of teenage users. It is therefore suggested that future research should focus on the causes of post-treatment relapse among youth and teenagers and compare the outcomes.

Aftercare has been described as the prominent phase in substance dependence treatment process. Aftercare services play a valuable role in strengthening human relations. Aftercare service fosters cohesion and social support among substance dependence service users. This study has found lack of aftercare as a prime cause of return to drugs among youth involuntarily treated for substance dependence as users experience exploitation, discrimination and stigmatisation after treatment. It is therefore suggested that future studies should look into factors leading into a lack of provision of aftercare services by social work practitioners responsible for substance abuse treatment programmes.

As leading professionals in the treatment of substance dependence and the prevention of relapse, social work practitioners supposed to be a fountain of knowledge and expertise in the area of substance dependence. This study discovered that social work practitioners lack insight about the concept of involuntary

service users, particularly their role in the course of treatment. Social work practitioners are found with an idea that voluntary and involuntary service users are in the same, and that they could be treated in the same approach. On this note therefore, future studies should research about the strategies for strengthening social work interventions in substance dependency treatment relapse. The results thereof could assist in putting to place the mechanisms for quality assurance and strengthen substance dependence service provision.

5.7 IMPLICATIONS FOR SOCIAL WORK PRACTICE

Post-treatment relapse is seen as a major contributor to the high prevalence of substance abuse in South Africa. To curb the problem, social work fraternity needs to consider the prominence of involuntary service users. This must influence the scope of service provision by letting legislation, policies, norms and standards, policy guidelines and intervention protocol to include the category of involuntary service users. As a primary legislation, the Prevention of and treatment for substance abuse act no. 70 of 2008 need to close the gap between voluntary service users and the involuntary service users. When defining the term “involuntary service users” the act’s legislative provisions must expand the scope of the conceptual layout of the involuntary service users to include other categories not only the court committal category.

There must also be an effective capacity building drive in the social work fraternity at all levels, from the generic practice level up to management and administration level. Focus should be on involuntary users, and the role played by social work practitioners in mitigating substance dependence and post-treatment relapse.

In order to curb the discrimination and neglect endured by service users after treatment, social work practitioners must construct clear guidelines on work streams with pure terms of reference on working with families of service users. This will ultimately secure support system for users, where feasible, social work practitioners must create an awareness and psycho-educate the families of users on the effects of substance dependence, their role in the treatment process and after treatment care. Nonetheless, this must be preceded by a well-administered family assessment. Social workers must consider the assessment of users and that of families as a crucial exercise in the process of dependency treatment.

Social workers must consider the importance of advocacy function in mitigating towards substance abuse, mainly among involuntary users. They must advocate for social justice and cohesion for service users. On this note, the social work fraternity must create community engagement platforms where communities are taught about substance dependence treatment and their role in helping and supporting other members during the treatment and upon their return to the community after treatment. This will on the other hand secure service users' social functioning and create conducive environments after treatment completion. The effective community engagement approach shall foster the aftercare services. This approach of working with communities may lay good foundation for the rendering of effective aftercare services to service users, inclusive of involuntary service users.

5.8 LIMITATIONS OF THE STUDY

Having adopted a qualitative approach, the study was obviously characterized by several methodological limitations. Should the study have used both qualitative and quantitative approaches, the researcher was going to have a large sample where more quantified data about substance dependence and relapse would have been obtained. Having the study conducted on qualitative basis only, a small sample had to be used; as a result, the ultimate findings cannot be generalised to a bigger population. The study only looked at youth involuntary service users aged between eighteen to thirty-five years. This limited the study as the researcher had to exclude data that would have been gathered from other participants outside the age bracket.

5.9 CONCLUSION OF THE STUDY

The current study succeeded in ascertaining what could be the causes of youth involuntary service users to relapse after treatment. The study was conducted in UThungulu District in KwaZulu-Natal using a qualitative approach with eleven involuntary service users and four social work practitioners. All four objectives of the study were met. Several research suggestions and recommendations that were found relevant to the mitigation of post-treatment relapse among youth involuntary service users were discussed. The major suggestion made is the establishment of Sober Living Houses to complement the Halfway Living Houses for the protection of service users from harm and exploitation. Thus, a need to strengthen aftercare services with effective utilisation of families and communities as a support system.

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APPENDIX A: INTERVIEW GUIDE FOR SOCIAL WORK PRACTITIONERS

SECTION A: BIOGRAPHICAL INFORMATION OF PARTICIPANTS

1. Age, race and gender
2. Are you a South African citizen/ If not what is your country of birth?
3. Besides your Social Work Qualification, are you in possession of any specialised training in substance dependency by accredited institution/ service provider?

SECTION B: THE PRIMARY ROLE OF SOCIAL WORKERS IN PREVENTING POST-TREATMENT RELAPSE

1. How long have you been working in the field of substance dependency/ substance abuse?
2. Have you worked with youth involuntary service users?
3. If yes, what would be your comment with regard to the prevalence of post-treatment relapse?
4. As a practitioner what do you consider as the primary cause of youth involuntary service users to relapse into worse substance dependency after having been into treatment?
5. Does the intervention approach that you apply when working with involuntary service users is the same approach that you apply in working with ordinary voluntary service users?
6. What role do you think Social Work Practitioners need to play to prevent the said phenomenon?

APPENDIX B: INTERVIEW GUIDE FOR YOUTHS WHO RELAPSED

SECTION A: BIOGRAPHICAL INFORMATION

1. What is your age, race, gender?
2. Are you a South African citizen/ If not what is your country of birth?
3. Marital status
4. What is your highest qualification?

SECTION B: SUBSTANCE DEPENDENCE

1. What type and name of drug were you dependent into prior treatment?
2. How long were you dependent on the drug?
3. What do you consider as the main cause of your substance dependency circumstance?

SECTION C: THE SERVICE USERS' ATTITUDES TOWARDS THE SCOPE OF THE TREATMENT PROCESS

1. How did you go about engaging in the treatment process?
2. What can you consider as your personal experiences about the treatment process?
3. How relevant and responsive was the treatment process in dealing with triggers/ main causes of your substance dependence?

SECTION D: THE SERVICE USERS' STATE OF UNDERSTANDING ABOUT THE NATURE OF TREATMENT THAT THEY HAVE BEEN EXPOSED INTO.

1. What were your expectations and needs when you went for treatment?
2. Did you find your expectations well met after treatment?
3. What techniques did you learn from the treatment to help you to not prone into substances anymore?

SECTION E: THE SIGNIFICANCE OF SERVICE USERS' SELF-MOTIVE IN INHIBITING POST-TREATMENT RELAPSE

1. How motivated were you in changing your substance abuse behaviour prior the treatment?
2. Who played a significant role in triggering the above motives?
3. How was the extent of motivation after treatment?

SECTION F: POST TREATMENT RELAPSE

1. How long after treatment did your relapse reaction start to show up?
2. What do you consider as the main cause for your relapse?
3. How long have you relapsed?
4. Anything that you want to say about involuntary treatment and relapse?

APPENDIX C: INFORMED CONSENT FORM

Participant consent declaration

Title of the research project: Substance dependence post-treatment relapse causes among youth involuntary service users in Uthungulu District, KwaZulu Natal.

Researcher: Nkanyiso Nkazimulo Mkhize,

Masters' student at University of Zululand, Social Work Department has requested my permission to participate in the above mentioned research project.

I am aware that:

1. The purpose of the research project is to explore and describe the causes of substance dependency post-treatment relapse among youth involuntarily service users.
2. The University of Zululand has given ethical clearance certificate to this research project and that I may request to see the certificate anytime I wish to do so.
3. The Kwa-Zulu Natal Department of Social Development through the office of the Head of Department has also given the permission to conduct the research project, I may at any time request to see the permission
4. I will participate in the project by partaking in depth interviews conducted by the researcher and his assistant.
5. My participation in the research is voluntary and should I feel at any stage that I want to withdraw from participation, I may do so without any fear of adverse and negative consequences.
6. I will not get any compensation for my participation in the study but I will only get transport money, and that light meal and refreshments will be provided on during the day of during the interviews.

7. I am aware that there may be risk associated with my participation in the project.

7.1. The following risks are with my participation:

- emotional reaction

7.2. The following steps have been taken to prevent the risk:

- Participants will be referred for a debriefing counselling by a social worker or psychologist at.

8. I will not receive feedback regarding the results of the study.

9. All the information I provided during the interview will be kept confidential, and that there will be no using of my identifying particulars, instead the researcher will use pseudonym.

10. My signing this informed consent serves as a declaration that I am not waiving any legal claims, right or remedies.

11. A copy of this informed consent declaration will be given to me, and the original will be kept on record by the researcher.

I,

Attest that I read the above information /confirm that the above informed has been explained to me in a language that I understand and I am aware of this document's content. I had a right to ask all the questions that I wished to ask and they have been answered to my best satisfaction. I fully understand my role and all what is expected of me during this research project.

Participant's signature: _____

Date: _____

Researcher's signature: _____

Date: _____

APPENDIX D: KZN DSD PERMISSION LETTER



social development
Department
Social Development
PROVINCE OF KWAZULU-NATAL


FAX	: (033) 264 5435	OFFICE OF THE HOD
Telephona / Ucingo / Telefon	: (033) 264 5402	205 Hoozen Haffjee, Pietermaritzburg
Enquiries / Imbuzo / Naniis	: Mr S Shabangu	Private Bag X9144, Pietermaritzburg
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Candidate: Master's Degree in Social Work
Sibeko Medical Centre
43 Joubert Street
PAULPIETERSBURG
3180

Attention Mr N. Mkhize

SUBJECT: REQUEST FOR PERMISSION TO CONDUCT RESEARCH FOR THE FULFILMENT OF MINIMUM REQUIREMENTS OF A MASTERS DEGREE IN SOCIAL WORK (A DISSERTATION MASTERS PROGRAMME)

1. Reference is made to your letter dated 22 August 2016 in respect of the above subject matter.
2. The Department of Social Development is hereby granting you an approval to conduct research on substance dependency post-treatment relapse causes among youth involuntary service under uThungulu District as well as the participation of the Social Work Practitioners employed by the Department (Ongoye and Richards Bay Service Office) and SANCA Zululand.
3. You are kindly requested to ensure that confidentiality is maintained; any sensitive information provided by participants during the course of the study will remain unknown to anyone other than the researcher; the ethics and the ethical standards of Social Work Profession must be maintained. Furthermore the results of the research must be shared with the Department.
4. Your cooperation in this regard will be appreciated.



Ms N.G. KHANYILE
HEAD OF DEPARTMENT
DATE: 07/11/2016

APPENDIX E: UNIZULU ETHICAL CLEARANCE LETTER

UNIVERSITY OF ZULULAND
RESEARCH ETHICS COMMITTEE
 (Reg No: UZREC 171110-030)



RESEARCH & INNOVATION

Website: <http://www.unizulu.ac.za>
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 Fax: 035 902 6222
 Email: ManqeleS@unizulu.ac.za

ETHICAL CLEARANCE CERTIFICATE

Certificate Number	UZREC 171110-030 PGM 2016/340						
Project Title	Substances dependency post-treatment relapse causes among youth involuntary service users at uThungulu District in KwaZulu Natal						
Principal Researcher/ Investigator	N Mkhize						
Supervisor and Co-supervisor	Dr P Gutura						
Department	Social Work						
Nature of Project	Honours/4 th Year		Master's	x	Doctoral		Departmental

The University of Zululand's Research Ethics Committee (UZREC) hereby gives ethical approval in respect of the undertakings contained in the above-mentioned project proposal and the documents listed on page 2 of this Certificate.

Special conditions:

- (1) This certificate is valid for 2 years from the date of issue.
- (2) Principal researcher must provide an annual report to the UZREC in the prescribed format [due date-31 October 2017]
- (3) Principal researcher must submit a report at the end of project in respect of ethical compliance.

The Researcher may therefore commence with the research as from the date of this Certificate, using the reference number indicated above, but may not conduct any data collection using research instruments that are yet to be approved.

Please note that the UZREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the documents that were presented to the UZREC
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research

Classification:

Data collection	Animals	Human Health	Children	Vulnerable pp.	Other
X					
Low Risk		Medium Risk		High Risk	
		X			

The table below indicates which documents the UZREC considered in granting this Certificate and which documents, if any, still require ethical clearance. (Please note that this is not a closed list and should new instruments be developed, these would require approval.)

Documents	Considered	To be submitted	Not required
Faculty Research Ethics Committee recommendation	X		
Animal Research Ethics Committee recommendation			X
Health Research Ethics Committee recommendation			X
Ethical clearance application form	X		
Project registration proposal	X		
Informed consent from participants	X		
Informed consent from parent/guardian			X
Permission for access to sites/information/participants			X
Permission to use documents/copyright clearance			X
Data collection/survey instrument/questionnaire	X		
Data collection instrument in appropriate language		Only if necessary	
Other data collection instruments		Only if used	

The UZREC retains the right to

- Withdraw or amend this Certificate if
 - Any unethical principles or practices are revealed or suspected
 - Relevant information has been withheld or misrepresented
 - Regulatory changes of whatsoever nature so require
 - The conditions contained in this Certificate have not been adhered to

- Request access to any information or data at any time during the course or after completion of the project

The UZREC wishes the researcher well in conducting the research


Professor Gideon De Wet
 Chairperson: University Research Ethics Committee
 Deputy Vice-Chancellor: Research & Innovation
 12 December 2016

CHAIRPERSON UNIVERSITY OF ZULULAND RESEARCH ETHICS COMMITTEE (UZREC) REG NO: UZREC 171110-30
12-12-2016
RESEARCH & INNOVATION OFFICE

APPENDIX F: LETTER FROM THE EDITOR



To Whom It May Concern,

RE: EDITOR'S LETTER

I write this letter at the request of Mr. NKANYISO MKHIZE. The letter serves to outline the scope of activities that I did in the editing of the master's dissertation submitted, titled:

Substance Dependency Post – Treatment Relapse Causes among Youth Involuntary Service Users in UThungulu District, KwaZulu-Natal

STUDENT DETAILS:

Nkanyiso Mkhize

Student Number: 20051205

Department: Social Work University of Zululand

The following activities were done;

- Spelling check
- Grammar check
- Document layout (formatting of headings and sub-headings)

I am a qualified and experienced teacher of English, having majored in English at bachelor's level, and have a PGCE with an English major. I combine my English Language competence with expertise in Research Methods, which I lecture at undergraduate level. From 2015, I have edited over 70 master's dissertations and seven PhD theses. I started editing PhD theses before I graduated with one of my own. However, I do not take responsibility of additions or subtractions done post my edit. Secondly, I am not responsible for the Reference List, in terms of compliance with the reference style and/or missing references.

Faithfully

Kemist Shumba

078 315 06186

B.A (UZ), PGCE (GZU-Zim) Hons, MSocSci, Ph.D (UKZN)

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