UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

The aftercare needs of *nyaope* users in the Hammanskraal community

by

Sonto Hleziphi Mahlangu

A mini-dissertation submitted in partial fulfilment of the requirements for the degree

MASTER OF SOCIAL WORK (HEALTH CARE)

in the

Department of Social Work and Criminology

at the

UNIVERSITY OF PRETORIA

FACULTY OF HUMANITIES

SUPERVISOR: DR L.S. GEYER

September 2016

DECLARATION OF ORIGINALITY

The **Department of Social Work and Criminology** places great emphasis upon integrity and ethical conduct in the preparation of all written work submitted for academic evaluation.

While academic staff teach about referencing techniques and how to avoid plagiarism, you too have a responsibility in this regard. If you are at any stage uncertain as to what is required, you should speak to your lecturer before any written work is submitted.

You are guilty of plagiarism if you copy something from another author's work (e.g. a book, an article or a website) without acknowledging the source and pass it off as you own. In effect, you are stealing something that belongs to someone else. This is not only the case when you copy work word-for-word (verbatim), but also when you submit someone else's work in a slightly altered form (paraphrase) or use a line of argument without acknowledging it. You are not allowed to use work previously produced by another student. You are also not allowed to let anybody copy your work with the intention of passing it off as his/her work.

Students who commit plagiarism will not be given any credit for plagiarized work. The matter may also be referred to the Disciplinary Committee (Students) for a ruling. Plagiarism is regarded as a serious contravention of the University's rules and can lead to expulsion from University.

The declaration, which follows, must accompany all written work while you are a student of the **Department of Social Work and Criminology**. No written work will be accepted unless the declaration has been completed and attached.

Full names of the student: **Sonto Hleziphi Mahlangu**
Student number: **25433572**
Topic of work: **The aftercare needs of *nyaope* users in the Hammanskraal community**

Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.

2. I declare that this **mini-dissertation** is my own work. Where other people's work has been used (either from a printed source, Internet or other source), this has been properly acknowledged and referenced in accordance with departmental requirements.

3. I have not used work previously produced by another student or any other person to hand in as my own.

4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

SIGNATURE……

DATE:……..……

ACKNOWLEDGEMENTS

I would like to extend my appreciation to the following people:

- I would like to thank my Heavenly Father for giving me the guidance, strength and perseverance to compile this mini-dissertation.
- My supervisor Dr L.S. Geyer, for his professional guidance, encouragement and support throughout this study.
- My family for their continuous support and encouragement.
- My brother Mr June Solomon Shoba for his love and support.
- My daughter Mpilwenhle Mahlangu, for being my inspiration to complete this study.
- The participants who were willing to take part in this study.
- My colleagues at the Department of Social Development, especially Portia Mmakgosi Chaane and Keatlegile Mabelane, for their continuous support throughout this study.

SH Mahlangu

Pretoria, 2016

Abstract

The aftercare needs of *nyaope* users in the Hammanskraal community

Researcher: Sonto Hleziphi Mahlangu

Supervisor: Dr LS Geyer

Degree: MSW (Health Care)

Institution: University of Pretoria

The trend of new drugs entering the drug market has intensified in South Africa. Currently in South Africa, there is a fairly new drug on the market known as *nyaope* which is being abused mostly by the youth in the townships. *Nyaope* is a drug consisting of heroin, dagga and other elements like rat poison, cleaning detergents and even crushed antiretroviral drugs. Failure to find a solution to drug abuse can lead to economic problems and handicap the social development of the country, as well as threatening the life and health of the people involved. In the South African context, the value of aftercare has been downplayed and there has been relatively little emphasis on aftercare and reintegration services in both research and practice. Therefore, it was the goal of this study to explore and describe the aftercare needs of *nyaope* users from both the users' and the significant others' points of view in Hammanskraal.

In order to achieve this goal, a qualitative research was adopted to explore and describe the aftercare needs of *nyaope* users from both the users' and the significant others' points of view. Due to the nature of the study, the researcher had two sampling groups, namely (1) *nyaope* users and (2) significant others. The study was guided by a collective case study design. Semi-structured interviews were used as a data collection method for this study and two distinct interview schedules were developed and used for *nyaope* users and significant others, respectively. The researcher aimed at answering the following two research questions: (1) "Based on the views of *nyaope* users, what are the aftercare needs of *nyaope* users in the Hammanskraal community?"; and (2) "Based on the views of significant others, what are the aftercare needs of *nyaope* users in the Hammanskraal community?" From the raw data, the researcher implemented thematic analysis as stipulated by Braun and Clarke (2006) in analysing the data. The researcher used credibility and triangulation in establishing the trustworthiness of the data analysis.

The findings from the two sets of samples were unpacked in three sections, namely, findings from the *nyaope* users, from significant others and the combined data with the aim of triangulation.

The key findings from *nyaope* users and the significant others are as follows:

> The key findings from ***nyaope* users** were that *nyaope* use has a negative impact on the physical, psychological, spiritual well-being of the users. Causes of relapse were identified as a lack of support from the government and family members, personal problems that users encounter during the recovery process, going back to the same environment and being coerced to go for treatment. Furthermore, *nyaope* users indicated that they value the trust of community members that is often lost and can be regained by a change of lifestyles following treatment and getting volunteering opportunities in order to create awareness at local schools. The users indicated that they could achieve total abstinence if they can change the type of lifestyle they were living before, such strategies include going for treatment, adopting a more conducive and healthy lifestyle, get adequate support from their families, attending group sessions following treatment, the implementation of an adequate aftercare programme that could assist in preventing relapse, the creation of employment and spiritual support during and post treatment.
>
> The key findings from the **significant others** were that families are victims of theft due to *nyaope* users' stealing to sustain their habits. As a result significant others are left with feelings of disappointment and hurt. *Nyaope* also impacts negatively on family relationships in a manner that there is a lack of communication and ineffective communication among family members. The significant others identified the causes of relapse as a lack of educational programmes in communities, high unemployment rate, a lack of spiritual support, inadequate aftercare programmes and the return to the same community and friends following treatment. Significant others also indicated that *nyaope* users require volunteering opportunities in communities as a form of reintegration and that *nyaope* users need to change their lifestyles following treatment in order to regain trust from the community. Significant others recommended that *nyaope* users require support from family, spiritual support from spiritual leaders and psychosocial support in order for them to maintain total abstinence.

Recommendations pertaining to the aftercare and reintegration needs of and service delivery to *nyaope* users in the Hammanskraal community are: (1) Education and awareness in communities on the impact of *nyaope* use should be the core element of the prevention strategy, (2) Due to the fact that *nyaope* users are shunned and shamed by community members due to their smoking habits, it is crucial for communities to be educated on reintegration services of *nyaope* users back into communities, (3) Family members need to be empowered through life skills education in preparation for them to be part of the recovery process of the *nyaope* user, (4) Involvement of religious institutions should be strengthened, (5) The Department of Sports and Recreation should create recreational activities that will occupy the youth during the day, (6) The Department of Public Works should create

employment opportunities and make them accessible to *nyaope* users following treatment, (7) The South African Police Service should work on reducing the quantity of drugs available on the streets of Hammanskraal; the suppliers of *nyaope* must be arrested and prosecuted, (8) Social workers need to receive capacity building workshops that stress the importance of aftercare services to addicted persons, (9) The Department of Social Development should consider increasing the duration of treatment from six weeks to a more adequate period, for example, six months because a high relapse rate is witnessed following the six weeks period, (10) More referrals to a treatment centre should be done through section 33 of the Prevention of and Treatment of Substance Abuse Act 70 of 2008 to ensure completion of the treatment period, (11) Awareness programmes should be strengthened where *nyaope* users who have completed treatment, could raise awareness at local schools and (12) The Department of Social Development should deliver a clear aftercare and reintegration programme and monitor it.

Future research could focus on the following: (1) The current study be expanded beyond Hammanskraal to other townships in order to undertake comparative studies in South Africa, (2) A larger scale study that could make it possible for generalisations to be made, (3) More scientific research needs to be conducted by research councils, such as the HSRC, on *nyaope*, aftercare and reintegration, (4) More research needs to be conducted where all ethnic groups are considered in order to reflect the demography of the diverse population of South Africa, (5) Future research needs to be conducted and target female users to obtain their perspectives and (6) Through intervention research, an effective aftercare and reintegration programme for *nyaope* users in the Gauteng Province, and the rest of South Africa, could be developed and standardised.

Key words:

Aftercare and reintegration services

Drug abuse

Gauteng Province

Hammanskraal

Nyaope

Relapse

Significant other

South Africa

South African townships

Substance abuse

Substance addiction

Substance use disorder

TABLE OF CONTENTS

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1:

GENERAL INTRODUCTION

1.1 INTRODUCTION

Globally, it is estimated that during 2012 between 162 million and 324 million people of the world population, aged 15-64, used an illicit drug. These drugs were mainly a substance belonging to the cannabis, opioid, cocaine or amphetamine-type stimulants group (United Nations Office on Drugs and Crime [UNODC], 2014:1). South Africa is no exception to the rule – in fact, alcohol and other drug use and abuse are increasing (Dada, Plüddemann, Parry, Bhana, Nawda, Perreira, Nel, Mnwabe, Peltzer & Welman, 2012:1). The South African Community Epidemiology Network on Drug Use (SACENDU) outlined the fact that the statistics for first time admission at treatment centres was high in KwaZulu Natal (84%), Northern Region of South Africa (84%) and the Gauteng Province (96%) of which the majority were Black service users (Dada, Burnhams, Erasmus, Parry, Bhana, Timon & Fourie, 2015:1). These proportions have remained fairly stable, except for an increase in the Gauteng Province.

The trend of new drugs entering the drug market has intensified in South Africa. Currently in South Africa, there is a fairly new drug on the market known as *nyaope* which is being abused mostly by the youth in the townships. “Nyaope is a cheap drug cocktail comprising heroin, marijuana and other elements like rat poison, cleaning detergents and even crushed pills used in the treatment of AIDS patients” (Ghosh, 2013:6). For the year 2015, SACENDU has released a report that the use of *nyaope* continues to pose a problem, with 4% of patients in the Gauteng Province admitted for *nyaope* use (Dada, Burnhams, Erasmus, Parry, Bhana, Timol & Fourie, 2015:2). In a study that was conducted at a secondary school in Atteridgeville by Moodley, Matjila and Moosa (2012:6) the prevalence of *nyaope* use was estimated at 2.9%. In the Hammanskraal office of the Department of Social Development (DSD) in the Gauteng Province ten people addicted to *nyaope* are referred to treatment centres on a monthly basis (Makhubela, 2015).

Drug abuse among the youth is a serious concern owing to potential short and long term outcomes for the health and safety of the individual, as well as the family and community members (Moodley et al., 2012:3). The DSD in Hammanskraal is bombarded with a high number of applications to admit *nyaope* users to treatment centres. Heavy drug use causes road traffic accidents, suicide, violence and high risk sexual behaviour (Moodley et al., 2012:6). Weich, Perkel, Van Zyl, Rataemane and Naidoo (2008:156) mention that the use of heroin in combination with other drugs has also become popular. It includes *nyaope* and *pinch* (mixture of cheap heroin and dagga and *sugars* (mixture of low quality heroin and cocaine, mixed with dagga).

The *Gauteng Department of Social Development's Annual Performance Plan* (DSD, 2015:123) indicates that the number of service users who have accessed public in-patient treatment centres in the year 2015 was 1 360. Furthermore, it is indicated that the number of people who received treatment for drug addiction and who participated in aftercare programmes, were 9 056 in the Gauteng Province. The researcher was curious to identify whether the aftercare needs of *nyaope* users are attended to in the aftercare programmes that are offered. As a point in case, at Hammanskraal office of the DSD, the drug abuse relapse rate was 400 service users for 2014/15 (DSD, 2014:97).

The purpose of the research was to explore and describe the aftercare needs of *nyaope* users in the Hammanskraal community from both the users' and significant others' points of view.

The following concepts are used in this study and need to be interpreted uniformly:

- **Aftercare:** "Aftercare is a care aimed at sustaining the gains attained in the initial treatment phase and to prevent relapses by offering support for participation in self and mutual help and other programmes" (Popovici, French & McKay, 2008:550).
- **Drug abuse:** Drug abuse is defined in Masombuka (2013:22) as follows:

> a state, psychic and sometimes also physical, resulting from interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence.

- ***Nyaope*:** "Nyaope is a cheap drug cocktail comprising heroin, marijuana and other elements like rat poison, cleaning detergents and even crushed pills used in the treatment of AIDS patients" (Ghosh, 2013:6).
- **Significant other:** "Important people in an individual's life with whom a person shares a bond and who holds a special place in one's life" (Lottër, 2010:3) and "[a]ny person who is important in affecting an individual's development of social norms, values and personal self-image" (*Penguin Dictionary of Psychology*, 2009:739). For the purpose of the research, a significant other was considered to be a partner, husband, wife, niece, nephew, brother or sister or any person who has an important effect/influence on or who is considered with the well-being of a *nyaope* user.
- **Substance abuse:** "Substance abuse refers to the misuse and abuse of legal or illicit substances such as nicotine, alcohol, over the counter and prescription medication, alcohol concoctions, indigenous plants, solvents and inhalants as well as the use of illegal or elicit substances" (DSD, 2013:19).

- **Substance addiction:** "A chronic, relapsing brain disease that is characterised by compulsive drug seeking and use, despite harmful consequences" (National Institute on Drug Abuse, 2014:2).
- **Treatment:** "Treatment is a plan of clinical interventions mutually agreed by the client and the therapist/counsellor to decrease or cease substance abuse" (Chetty, 2011:12).

1.2 THEORETICAL FRAMEWORK

The theoretical framework that informed the study was the disease theory of addiction.

The disease theory of addiction states that "addiction involves pathological changes in the brain that result in overpowering urges" (West, 2005:76). The disease theory of addiction seeks to explain the development of addiction and individual differences in susceptibility to and recovery from it. It proposes that addiction fits the definition of a medical disorder. West (2005:77) mentions that in this theory, the concept 'craving' is defined as "an urgent and overpowering desire". West (2005:77) furthermore states that this theory captures what seems to be the central phenomenology of addiction: "a desire that is so strong and all encompassing that it sweeps all other considerations before it in a myopic and single minded search for the object of that desire".

Therefore, drug addiction is conceptualised as a disease (Miller, Gorski & Miller, 2002:5). This is supported by the American Psychiatric Association (2013) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) which classifies substance abuse a disorder, viz substance use disorder. Additionally, similar to other diseases, such as diabetes and cancer, drug addiction has specific symptoms which keep the body from functioning properly. As it has been seen with the most people using *nyaope,* some start falling asleep, some do things that they would not normally do when they are sober (Molefe, 2014). It is true that as the disease progresses it causes problems that appear to be mental problems. People who are dependent on drugs are not of weak character, they abuse drugs because of their disease.

Substance dependency is not a hopeless condition, like most other chronic illnesses it is treatable (Miller et al., 2002:6). Nevertheless, it is not only a physical disease. There are also psychological, behavioural and social components to the disease. This means that the disease not only affects the body, but also how the person thinks and feels how the person acts and how he/she relates to other people. Recovery from substance dependency means recovery in all areas, physical, psychological, behavioural and social. Hence, it is said that part of the recovery is understanding the disease and how it affects all areas of a person's life, as well as understanding what is necessary to restore health to all areas.

Drug addiction is also seen as a chronic illness (Miller et al., 2002:6) and substance dependent individuals must first learn to compensate for their problems created by the disease and then adapt to the disease. It is also mentioned by Miller et al. (2002:55) that because drug addiction is a chronic illness there is a high risk of relapse. There is always the danger that it may re-occur.

Recovery requires long-term total treatment which promotes physical recovery (healing of the body), psychological recovery (healing of the attitudes and beliefs), and behavioural recovery (re-adjusting to a lifestyle of health rather than illness). Similarly, people addicted to *nyaope* require treatment (Miller et al., 2002:56) that focuses on the following:

- Recognition that addiction is a disease
- Belief in the ability to recover
- Take action to allow the recovery process to begin.

Acceptance of the disease concept makes it easier for some people to enter treatment. Another factor that is important for the disease theory of addiction is that it is clearly understandable to people and provides an explanatory construct for the differences in their drug taking behaviour compared to others. The researcher used the disease theory of addiction as a guide for the study, the users of *nyaope* were considered to be “ill people” who present with a chronic illness. The theory guided the researcher in believing that such people can abstain from drug use and live a normal life. The research explored the physical, psychosocial and behavioural challenges that people experience, that prevent them from abstaining from *nyaope* use.

Acceptance of the disease concept could encourage *nyaope* users to allow the recovery process to take place. As part of the recovery process, *nyaope* users could gain the courage to take part in the aftercare and reintegration services. Hence it is necessary for them to identify their aftercare needs after undergoing treatment. In addition, this study also explored the views of the significant others of *nyaope* users.

1.3 RATIONALE AND PROBLEM STATEMENT

Maluleke (2013:106) recommends that there should be more scientific enquiry on issues of aftercare and reintegration services among substance-dependent persons in South Africa. The statement made by the previous researcher thus underscores the fact that more research should be conducted with regards to aftercare and reintegration services among people addicted to drugs.

The percentage of drug abusers is increasing in communities irrespective of the support/efforts that the communities provide, as well as what the different stakeholders and the DSD are doing to eradicate this social problem (DSD, 2013:72). Moodley et al. (2012:7) allude that the failure to find a solution to drug

abuse can lead to economic problems and handicap the social development of the country, as well as threatening the life and health of the people involved.

This study attempted to address this research gap and explore and describe the aftercare needs of *nyaope* users in Hammanskraal from the users' and the significant others' points of view. The study provided recommendations with regard to aftercare and reintegration services, as there are minimal studies focussing on drug aftercare and reintegration services in Hammanskraal (Molefi, 2014). Van der Westhuizen (2010:103) mentions that there is a lack of focus on aftercare, as well as a lack of information pertaining to the contents of aftercare programmes. The DSD and other stakeholders could benefit from the research in identifying the aftercare needs of *nyaope* users. The research questions of the study were:

1. "*Based on the views of nyaope users, what are the aftercare needs of nyaope users in the Hammanskraal community?*"
2. "*Based on the views of significant others, what are the aftercare needs of nyaope users in the Hammanskraal community?*"

1.4 GOAL AND RESEARCH OBJECTIVES

The **goal** of this study was to explore and describe the aftercare needs of *nyaope* users from both the users' and the significant others' points of view in Hammanskraal.

In order to achieve the research goal, the following **research objectives** needed to be reached:

- To contextualise aftercare and reintegration services delivered to *nyaope* users in South Africa.
- To describe the aftercare and reintegration services available to *nyaope* users in Hammanskraal.
- To identify the aftercare needs of *nyaope* users, specifically in the physical, psychosocial and behavioural domains, who have relapsed after initial treatment in Hammanskraal from both the users' and the significant others' points of view.
- To make recommendations to relevant role players pertaining to the aftercare and reintegration needs of and service delivery to *nyaope* users in the Hammanskraal community.

1.5 OVERVIEW OF RESEARCH METHODOLOGY

The research was rooted in a constructivism paradigm. “In constructivism paradigm, participants become active and involved in all the phases of the process and indeed become partners in the total endeavour” (De Vos, Strydom, Schulze & Patel, 2011:7). The study was qualitative in nature as the researcher focused on the perceptions that *nyaope* users, and significant others, had with regards to aftercare services, not the meaning that the researcher brings to the research (Creswell, 2009:47). Applied research was the most suitable for this study. Merriam (2009:3) states that applied research is undertaken to improve the quality of practice of a particular discipline in this study the aftercare and reintegration services of *nyaope* users in the Hammanskraal community. The appropriate research design for this study was the case study design. The case study is particularly useful to employ when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest, in its natural real-life context (Fouché & Schurink, 2011:321). The researcher deemed the collective case study as the most appropriate design to attain the goal of the study (Fouché & Schurink, 2011:320). A collective case study design was chosen because the researcher combined/compared data obtained from the users and the significant others, i.e. triangulation (Yin, 2003:42).

The researcher’s population were the *nyaope* users and the significant others in the Hammanskraal community. The community or population is the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned (Strydom & Delport, 2011:391). However, the sampling for this study was in two phases. *Firstly*, SANCA Hammanskraal used purposive sampling (Strydom & Delport, 2011:392) to identify the *nyaope* user and the significant others on their case load who met the following criteria:

- Be able to converse in English, isiZulu or Northern Sotho;
- Reside in Hammanskraal;
- Must be 18 years or older, and;
- The *nyaope users* must have had undergone treatment and relapsed between 2013 and 2015.

Secondly, for stage two sampling, only the people who volunteered (i.e., volunteer sampling) their participation following recruitment from SANCA, were interviewed by the researcher (Strydom & Delport, 2011:394). The overall purpose of the use of the two sampling methods was to collect the richest data. Data was collected to the point of data saturation when six *nyaope* users and six significant others were interviewed.

For the purpose of this research, semi-structured interviews were utilised as a data collection method. The researcher developed two separate interview schedules (see App. D and E) to evidence that she was well prepared for the interviews and to

convey her competency (Bernard, 2000:191). The researcher wanted to gain a detailed picture, of *nyaope* users' needs with regards to aftercare and reintegration services (Strydom, 2011:351), by exploring the views of both users and their significant others. For the study, the interviews were audio recorded. The process of thematic analysis was used as posited in Clarke and Braun (2013:121-123).

The researcher used credibility and triangulation in establishing the trustworthiness of the research (Schurink, Fouché & De Vos, 2011:419). Furthermore, a pilot study was firstly undertaken to determine whether the two interview schedules were suitable (Strydom, 2005:202). The pilot study used the same criteria for the sampling, except that the participants were recruited from SANCA Soshanguve. The findings of the pilot study were not included in the main study.

Ethical considerations, such as no deception of participants, voluntary participation, avoidance of harm, debriefing of respondents, violation of privacy/anonymity/confidentiality and informed consent (see App. B and C) were observed. The researcher obtained ethical clearance (see App. A) from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria. Additional permission was obtained from SANCA Hammanskraal (see App. F).

More detail pertaining to the research methodology is captured in Chapter 3.

1.6 LIMITATIONS

The study had the following limitations:

- The sample only consisted of six *nyaope* users and six significant others from SANCA Hammanskraal; hence, generalisations cannot be made based on the findings.
- There is limited literature on *nyaope* and aftercare services in South Africa, thus making the knowledge and supportive information difficult to access.
- Only significant others and *nyaope* users conversant in English, Northern Sotho and IsiZulu from a black community took part in the study. Thus other ethnic groups are excluded from the study.
- The majority of participants were male, thus limiting a female perspective.

1.7 CONTENT OF THE RESEARCH REPORT

The remainder of this research report consists of the following chapters.

Chapter 2: *Nyaope* addiction and aftercare and reintegration services to users

The second chapter of the research report contextualises the prevalence of *nyaope* use among the youth, classification of *nyaope* and the trends of substance abuse in both the African context and South Africa. The national policies with regards to aftercare and reintegration services are contextualised, as well as relapse and aftercare and reintegration services to *nyaope* users from the government and NGO's are discussed in detail.

Chapter 3: Research methodology, research findings and interpretations.

The third chapter discusses the research methodology applied to the study. In addition the research findings are outlined and interpreted.

Chapter 4: Conclusions and recommendations

The last chapter discusses whether the goal and objectives of the research were accomplished. Conclusions are drawn and recommendations made for future research and to relevant stakeholders regarding the aftercare needs of *nyaope* users in the Hammanskraal community.

The next chapter contextualises nyaope addiction and aftercare and reintegration services to users.

CHAPTER 2:

NYAOPE ADDICTION AND AFTERCARE AND REINTEGRATION SERVICES TO USERS

2.1 INTRODUCTION

Nyaope use is fast becoming a public health problem. For this reason, strategies to curb the increased usage need to be explored by the South African government. Most literature has cited a number of risk factors associated with *nyaope* use. Mokwena and Huma (2014:352) have linked the pattern of drug use to regional and country variations, socio-economic status, racial and geographical differences.

The chronic use of substance can cause serious, sometimes irreversible damage to the user's physical and psychological development (Lebese, Ramakuela & Maputle, 2014:329). As a result, *nyaope* users endure body pains, which push them to increase both the amount and the frequency of use (Mokwena & Huma, 2014:352).

This chapter focuses on the following research objectives of the study:

- To contextualise aftercare and reintegration services delivered to *nyaope* users in South Africa.
- To describe the aftercare and reintegration services available to users in Hammanskraal.

Therefore, the researcher will discuss the prevalence of *nyaope* use among the youth (the age group who mostly abuse *nyaope*) and also identify the category of drugs in which *nyaope* is classified. The researcher will also debate the extent of use of *nyaope* in the African continent and South Africa. The national policies and legislation with regard to aftercare and reintegration services will also be discussed, specifically the National Drug Master Plan 2013-2017, the Prevention and Treatment of Substance Abuse Act 70 of 2008 and the Drugs and Drug Trafficking Act 140 of 1992. Relapse and a slip will be conceptualised and relapse prevention models discussed. The relapse risk factors will also be identified and discussed. Additionally, services from the government and NGO's pertaining aftercare and reintegration services to *nyaope* users will also be discussed.

Below, the researcher will discuss the prevalence of nyaope among the youth of South Africa.

2.2 PREVALENCE OF *NYAOPE* USE AMONG THE YOUTH

Substance abuse among the youth continues to constitute a major problem facing the world, particularly in South Africa (Mohasoa & Fourie, 2012:30). This is evident as many townships and street corners are crowded with *nyaope* users on a daily basis. This has resulted in an increase in the burden of mental health across communities (Mokwena & Huma, 2014:352).

South Africa is experiencing a dramatic increase in the use of various illicit drugs, to the extent that the United Nations World Drug Report (2010) identified the country as one of the drug centres of the world (Mokwena & Huma, 2014:352). It is a worrisome phenomenon in most villages and urban areas of South Africa, because youth are dying morally, socially, psychologically and physically (Lebese et al., 2014:329). Many children start smoking as early as 8 years, hence the half dazed looks, poor personal hygiene and slowness in movement. Mokwena and Morojele (2014:374) concur with the above statement that drug abuse also limits reasoning capability; it also contributes to other health and social challenges like engaging in risky sexual behaviour, which increases vulnerability to HIV infections.

Drug addiction is also associated with crime, accidents and violent behaviour on a social level (Van der Westhuizen, Alpaslan & De Jager, 2013:2). The use of *nyaope* continues to pose a problem, with 8% of patients in the Gauteng Province admitted for *nyaope* use and 6% of patients in the Western Cape, KwaZulu Natal, Eastern Cape, Mpumalanga and Limpopo (Dada, Burnharms, Erasmus, Parry, Bhana, Timol & Fourie, 2015:1). However, dagga is the most common primary substance of abuse among patients seen at treatment facilities in KwaZulu Natal and Gauteng, accounting for 40% and 36% of all patients, respectively (Dada, Erasmus, Burnhams, Parry, Bhana, Timol, Fourie, Kitshoff, Nel & Weimann, 2015: 3)

The debate will now shift to the prevalence of *nyaope* on the African continent.

2.2.1 African continent

There are an estimated 15.5 million substance dependant users worldwide and Southern sub-Saharan Africa is one of the regions most affected (West, 2005:48). However, reliable and comprehensive information on the drug situation in Africa is not available (UNODC, 2014:13). Likewise, Africa is known for its role as a transit area for drugs (UNODC, 2014:31), due to its insufficient or ineffective border controls. Drugs that are contained in the new drug *nyaope* are easily shipped in and out of Africa by opportunistic syndicates. These local syndicates are also taking advantage of weakened criminal justice systems, bribing their way out of airports and exporting large quantities of drugs (Maiden, 2008:42). The most popular drug on the African Continent is dagga, where the usage stands at 12.4%. Moreover, methamphetamine is at 16% in the continent. Dagga is cultivated and produced in the West and Central Africa, respectively.

However, heroin is estimated at between 28.6 % and 38 million people globally. Although there are no reliable estimates that are available in Africa, many experts from Africa perceive an increase in this type of drug use as this continent stands at 0.92 and 2.29 million using heroin (UNODC, 2014:22). Moreover, it is stated that the annual prevalence of heroin use in West and Central Africa is above the global average. Based on the latest available responses to the annual report questionnaire, South Africa is also believed to be a major consumer market, deriving its heroin

supply from South-West Asia via East Africa and the Near and Middle East. The number of new psychoactive substances on the global market more than doubled over the period 2009-2013 (UNODC, 2014:208). Additionally, polydrug use has been a common occurrence among both recreational and drug users in Africa.

Below the researcher will be discussing the prevalence of *nyaope* in South Africa.

2.2.2 South Africa

In South Africa, expert perception is that there is some increase in the use of heroin and methamphetamine and some decrease in the use of crack cocaine, with use of other drugs being stable (UNODC, 2014:14). Treatment facilities report that dagga remains the most common illicit substance used, particularly among young people. Almost half of the admissions at treatment centres were primarily related to dagga use disorders.

Heroin, methamphetamine and dagga are some of the drugs that are contained in *nyaope* (Grant, 2014:4). In the Western Cape, the most common primary substances of abuse reported by 28 treatment centres/programmes were alcohol, and heroin, together comprising 93% of all admissions (Dada et al., 2015:2). However, in KwaZulu Natal dagga is the most used substance, at 40%. A total of 929 patients were treated during 2014 in KwaZulu Natal. The Eastern Cape has a high percentage of methamphetamine and dagga usage that stands at 27%. Additionally, the Gauteng Province reported 3372 admissions to 15 treatment centres in 2014 (Dada et al., 2015:2). Alcohol and dagga remains the most abused drug in Gauteng. However, in the Gauteng Province, *nyaope* use stands at 8%, hence it is listed as a primary substance of abuse in this province. The Northern Region, which includes Mpumalanga and Limpopo, have 68% of drug use, specifically dagga and heroin (Dada et al., 2015:2). In the Central Region, comprising the Free State, Northern Cape and North West, alcohol is the commonly used at 39%, and dagga being the second used at 31%.

Moreover, in statistics released by the South African National Council on Alcoholism and Drug Dependence (SANCA), a major trend over the past seven years is that the percentage of clients treated for alcohol as the primary substance of abuse has decreased from 49% in 2006/7 to 31%, which is equal to dagga in the 2012/13 reporting year (SANCA, 2012). This means that *dagga* users have increased from 18% to 31% over this seven-year period. It has become crucially important to emphasise the harmful effects of dagga use, especially for young people in the 14 to 17 year age group who represent 44% of all clients treated for dagga as the primary substance of abuse. Heroin/opiate abuse ranks third with 9% (980 clients) indicating it as their substance of choice. The highest incidence of clients who reported heroin as their primary substance of abuse (38%) occurred at SANCA Witbank (SANCA, 2012). It is encouraging to note that methamphetamine (Tik) decreased by 2% to 5%. The trend among young people to use heroin in combination with other drugs

such as cocaine (Sugars) and dagga remains a serious concern (SANCA, 2012). The number of CAT users at 3% has fortunately remained the same as for 2011. The other substances of abuse percentages remained largely unchanged in comparison to the year 2011. This trend correlates closely with the SACENDU research findings.

As a means to combat substance abuse in South Africa, the government developed a national strategy to respond to this social ill (Mawoyo, 2011:2). This strategy is known as the National Drug Master Plan (NDMP). One of the most celebrated elements of the NDMP is its emphasis on localising the fight against illicit drug use (Hodza, 2014:33). Localisation refers to the process of empowering local organisations, neighbourhoods, communities and individuals to be key actors in creating and implementing strategies for combating drug abuse. Thus far, the country is still facing an increasing number of users who are using *nyaope* regardless of the national strategy. Hodza (2014:34) concurs with the statement by saying that the drug problem in South Africa is extremely serious, with drug usage reported as being as twice the world norm. Drug policies are available and amended from time to time, to guide service delivery, especially at the aftercare and reintegration level, in terms of dealing with the drug abuse problem in South Africa. Pertinent policy documents will be discussed to contextualise the main issues linked to drug abuse, such as *nyaope*, in the country.

It is important to understand *nyaope* as a term and below the debate will be about the classification of *nyaope*.

2.3 CLASSIFICATION OF NYAOPE

Nyaope is classified as a Novel Psychoactive Substances (NPS) and it is widely used among young black people in various townships of South Africa (Mokwena & Morojele, 2014:374). The NPS's are regarded as an ever increasing group of compounds, which may be synthetic, semi-synthetic or natural and are often sold as alternative to known illicit drugs. *Nyaope* is easily accessible on the streets of South African townships because it was not seen as an illegal drug and is cheaper. Furthermore, Mokwena and Huma (2014:354) highlight that in several South African media publications, the drug is known by different names in different areas of the country. In KwaZulu Natal it is known as 'sugars', as 'whoonga' in the Western Cape, 'pinch' in Limpopo and Mpumalanga and 'kataza' in Johannesburg.

Nyaope is rumoured to contain illegal substances (dagga, methamphetamine and/or heroin) and household products such as rat poison or detergents, combination of antiretroviral medications and sugar, to make it more potent in producing a hypnotic effect (Mokwena & Huma, 2014:353). Other authors concur with this above mentioned statement by saying that *whoonga* is suspected to contain illicit substances (e.g. dagga, methamphetamine and/or heroin), household products (detergents or rat poison) and antiretroviral medications (Rough, Dietrich, Essian, Grelotti, Bensberg, Gray & Katz, 2013:1). However, in a study that was conducted to

identify the composition of *nyaope* in all samples that were taken from different townships the composition were in all samples, caffeine, drugs of abuse such as opiates, codeine, morphine, methyl-dioxy amphetamine (MDA) and heroin (Khine, Mokwena, Huma & Fernandes, 2015.54). Contrary, in the same study the samples did not show any inclusion of rat poison but the anti-retroviral drug was found to be present (Khine et al., 2015:55). There are also reports of HIV-positive patients being robbed their ARVs through illegal trade. Other authors concur with the above statement by adding that there are reports of a number of primary health care facilities being broken into, with ARV's stolen by the thieves (Chinouya, Rikhotso, Ngunyulu, Peu, Mataboge, Molaudzi & Jiyane, 2014:114). Furthermore, it is stated that *whoonga* is the only drug that has the potential to collapse the government's carefully planned national ARV roll out programme (Shembe, 2013:28). The fact that ARV's are implicated in the *whoonga* cocktail has had devastating consequences in terms of ARV theft, the emergence of ARV illegal trade that sees both HIV-positive patients willingly selling their medication and the corrupt health officials removing ARV's from shelves and selling them.

Since *nyaope* is manufactured, mixed and sold illegally, there are no specifications for the drug components and their amounts vary in composition, as well as the amounts of the various additives (Mokwena & Huma, 2014:354). In addition, it is relatively cheap to buy, with an average price of R25 to R30 a joint, and has thus become easily accessible even to primary school children (Mokwena, 2015:2).

The national policies and legislation with regard to aftercare and reintegration services will be discussed below.

2.4 NATIONAL POLICY AND LEGISLATION WITH REGARD TO AFTERCARE AND REINTEGRATION SERVICES

In the next section, the NDMP will be debated pertaining to aftercare and reintegration services.

2.4.1 National Drug Master Plan 2013-2017

The National Drug Master Plan 2013-2017 (NDMP) "is a national strategy that guides the operational plans of all government departments and other entities involved in the reduction of demand for, supply of and harm associated with the use and abuse of, and dependence on, dependence-forming substances" (DSD, 2013:22). The strategy is being implemented in communities by the Department of Social Development (DSD). As mentioned previously, one of the elements of the NDMP is localising the fight against illicit drug use. The NDMP provides for each community to have a Local Drug Action Committee (LDAC). It is mentioned that achieving the goals of harm reduction, supply reduction and demand reduction LDACs needed to be created (Hodza, 2014:35). Mainly, LDAC's mandate is to ensure that local action is taken to localise the NMDP. By means of LDACs, localisation that is stressed in the study by Hodza (2014:35), will be achievable

because local people know their problems and are capable of developing local solutions for local problems. Furthermore, it is mentioned that the impact of alcohol and other drug abuse continues to ravage families, communities and society. Substance dependent individuals are also negatively affected by the use as their physical health, psychological and social well-being are affected (Louw, 2009:79).

In the NDMP (DSD, 2013:45) it is accepted that a single approach, such as either criminalising or decriminalising substances abuse, will not solve the problem. Instead a number of strategies should be applied in an integrated way. The NDMP (DSD, 2013:65) highlights a few strategies:

- **Demand reduction**, by reducing the need for substances of abuse through prevention methods by educating the community;
- **Supply reduction**, "or reducing the quantity of the substance available on the market by, for example, destroying cannabis (dagga) crops in the field" (DSD, 2013:65); and
- **Harm reduction**, this includes dealing with the harm caused by drugs by admitting those addicted to treatment centres and using aftercare and reintegration services to prevent relapse.

The NDMP was designed to bring together government departments and other stakeholders in the field of substance abuse to combat the use and abuse and dependence forming substance and related problems (DSD, 2013: 66). Hence many NGOs are witnessed playing a role in combating substance abuse. In the NMDP aftercare and reintegration services is clustered in the harm reduction strategy. It is argued that harm reduction focuses on limiting and ameliorating the damage caused to individuals or communities who have already succumbed to temptation of substances (DSD, 2013:68). This strategy is often criticised because it is seen to be condoning the use of the substance because the focus will be on mending the damage that occurred because of the substance. Hence it has been mentioned in the NDMP that it has been debated by the Central Drug Authority (CDA) that the term "harm reduction" should be replaced by "harm prevention" (DSD, 2013: 68).It can thus be debated that harm reduction in a form of primary prevention, can be accepted as it does not wait for a person to be hooked on drugs. Moreover, the NDMP sights primary prevention, treatment programmes and aftercare and reintegration services to be reducing harm.

The NDMP advocates for a balanced integrated approach to substance abuse. All strategies must be applied in curbing the scourge of substance abuse. Demand reduction refers to preventing the on-set of drug usage, eliminating all conditions/ factors that may test an individual to use substances (DSD, 2013:62). This strategy includes poverty reduction and creating employment opportunities for the youth that are sustainable. As mentioned by Makhubela (2015), policy is rich, but implementation is poor. One of the cited contributory factors of individuals using

nyaope is that there is a high unemployment rate. In addressing the scourge of *nyaope* usage, the government should stick into making sure that they create employment opportunities that keep the users from the streets. Furthermore, education and empowerment to communities can keep community members focused and the youth will not be easily hooked on drugs. DSD implements the *Ke-moja* programme that focuses on providing and encouraging role modelling of individuals who encourage resistance to drug use (Makhubela, 2015).

Supply reduction means that drug supply must be reduced. *Nyaope* is easily accessible and available to the users. There is a need for improved control over distribution and production of drugs. In achieving the supply reduction strategy, there should be successful prosecutions for offences relating to drug use. Questions to whether there are successful prosecutions of suppliers of the drug *nyaope,* still remains to be confirmed by research.

Social workers can play a role in harm reduction and demand reduction strategies. Demand reduction by social workers includes creating awareness and educating the communities about substance abuse. However, social welfare services in general has the statutory obligation to provide aftercare and reintegration services to promote the client's acquisition of housing and work or education, after discharge actively and to ensure that the client acquires personal support or treatment in order to 'exit' from substance abuse successfully (Ekendahl, 2009:260). Therefore, Maluleke (2013:31) suggest that social workers can play a role of a case manager, where they deal holistically with the substance dependant persons. Case management is a set of functions that help substance abuse clients access the resources they need to recover from their substance abuse problem (Maluleke, 2013:31).

The debate will now shift to legislation.

2.4.2 Prevention of and Treatment of Substance Abuse Act 70 of 2008

In the Prevention of and Treatment of Substance Abuse Act 70 of 2008 in Section 4, inter-sectoral strategies for reducing demand and harm caused by substance abuse are outlined. For the purpose of the study the researcher will focus on aftercare and reintegration for substance users. The below stated strategies are outlined and are supposedly used to reduce the demand and harm caused by substance abuse. The researcher will debate the strategies outlined.

(i) The integration of people who have undergone the formal treatment episode into their families and communities;

(ii) Individuals to be equipped with additional skills to maintain their treatment gains, sobriety and avoid relapse;

(iii) The establishment of mutual support groups to enhance their self-reliance and optimal social functioning; and

(iv) The link between service users and resources for their further development and well-being.

The Prevention of and Treatment of Substance Abuse Act 70 of 2008 in Section 30, outlines that the minister, in consultation with other ministers and organs of state will prescribe integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce, family and community life. This section expresses the seriousness of the government in addressing the issue of substance abuse. Although it is nicely stated in the policy documents, some people may still argue that the government still lack practicality (Makhubela, 2015). Policies take time to be implemented into practice. It is also highlighted in the Act that substance users need to be put in a form of aftercare and reintegration service.

Makhubela (2015) argues that as it now stands at DSD, aftercare and reintegration services to *nyaope* users are not clear, such services are not available currently although the policies state and stress the importance of aftercare. Awareness campaigns at communities in preparing the communities in welcoming the users back into society are conducted on a monthly basis but the impact has not been measured. Some NGOs dealing with substance abuse, are working hard in implementing the measures that are identified in the Prevention of and Treatment of Substance abuse Act 70 of 2008. Makhubela (2015) alluded that the DSD is working together with some NGOs and are part of Local Drug Action Committee (LDAC).

SANCA Hammanskraal does provide aftercare and reintegration services in a form of individual counselling, group therapy, family therapy and extensive utilisation of self help groups (SANCA, 2012).

Legislation states clearly that people must be equipped with additional skills to maintain abstinence and avoid relapse. On the contrary, it is argued in the Gauteng Province, that *nyaope* users are relapsing after treatment (Makhubela, 2015). Some are admitted more than once to treatment centres, but relapse after treatment and some even abscond before the treatment is complete. Even though Act 70 of 2008 outlines the strategies, Makhubela (2015) is of the opinion that there is no formal monitoring of social workers by their supervisors or managers to ensure that they provide the above-mentioned services to *nyaope* users. Drug addicted persons have specific expectations from social workers pertaining to the rendering of aftercare services (Van der Westhuizen, 2010:163); hence the present study envisaged to explore the aftercare needs of *nyaope* users in the Hammanskraal community.

Van der Westhuizen (2010:103) concludes in her research in the Western Cape amongst drug addicted youth, that relapse remains a threat to drug-dependent people after they leave treatment, and aftercare services need to become an important part of their complete treatment regime. Van der Westhuizen (2010:103)

opines that there is a lack of focus on aftercare, as well as a lack of information pertaining to the contents of aftercare programmes in South Africa. McKay (2001:9) concurs with these statements when he mentions that the continuum of care/aftercare is relatively understudied and the clinical effectiveness, cost effectiveness and benefit cost of various combinations of primary and continuing care are virtually unexplored. It is these observations by Van der Westhuizen (2010) and McKay (2001) that motivated this study.

Next, the researcher will discuss the Drugs and Drug Trafficking Act 140 of 1992 with regards to *nyaope* use in the country.

2.4.3. Drugs and Drug Trafficking Act 140 of 1992

After the amendment of the Drugs and Drug Trafficking Act 140 of 1992, *nyaope* was classified as an illegal drug as from 2014. The Gauteng community has waited long for the criminalisation of the drug. Community members are affected directly by *nyaope* as some are parents of the *nyaope* users. Others are victims, as crimes are perpetrated against them by the users to feed the addiction. Skosana (2014:5) mentions in the *Mail and Guardian* that SANCA believes that classifying *nyaope* as an illegal drug "will lead to the arrest and conviction of people dealing in nyaope, thus reducing the availability of nyaope on the streets". If they are arrested, the court can refer offenders to treatment centres through diversion programmes. A person who has committed a crime qualifies for a diversion programme once she/he has admitted to a crime, making amends for what they have done and initiating a healing process for themselves, their families, the victims and the community. The goal of a diversion programme is for offenders to rejoin the law-abiding community and prevent re-offending. Though provisions are made for diversion programmes, it is equally important that people addicted to drugs receive aftercare services after completion of the diversion programme. They also require necessary reintegration skills that prepare them to function in their communities.

McKay (2001:212) states that "due to the relapsing nature of the disorder, individuals receiving treatment for substance abuse are generally urged to participate in some form of lower intensity continuing care, also known as aftercare, after their initial phase of higher intensity treatment has ended". Likewise, aftercare and reintegration services are of great importance as they can reduce relapse.

Many *nyaope* users relapse after treatment; the researcher therefore discusses relapse and factors associated with relapse in the following section. The researcher starts by conceptualising relapse in the next section.

2.5 CONCEPTUALISATION

As every drug abuse treatment practitioner knows, relapse, the resumption of substance use after a period of abstinence is a frustrating but frequently part of the recovery process. Several substances including *nyaope* have a high relapse rates following treatment. Moreover, one of the greatest problems in treatment of substance use disorders is preventing relapse after abstinence or controlled substance use has been achieved (Emmelkamp & Vedel, 2006:35). It is possible for relapse to occur more than once after treatment. Miller et al. (2002:209) mentioned that planning for a relapse is the best way of preventing it. It is necessary to have the best aftercare and reintegration services that could prevent drug users from relapsing. However, failing to acknowledge the possibility of a relapse increases the risk.

Nelson (2012:117) mentions that relapse is not a once off event (that of the actual return to the old behaviour) but a process. The process is thought to be cognitive, behavioural and effective, that is, involving the person's thoughts, behaviours and actions. Moreover, it is important for service users to know that if relapse occurs they can re-enter the cycle of change and try again.

Below the researcher will discuss slips as a motivating factor to a relapse.

2.5.1 Slip

A slip is an episode of alcohol and other drug use following a period of abstinence, while relapse is a return to uncontrolled alcohol and other drug use following a period of abstinence (Fisher & Harrison, 2013:169). The disease model of addiction can promote the idea that a slip inevitably leads to relapse. Others can argue that when a *nyaope* user "slips", he/she is at the edge of relapse. When a slip occurs (as it is likely to), the client may experience guilt, anxiety or hopelessness. These negative emotions may lead further to heavier use (Fisher & Harrison, 2013:170).

In reality when a user returns from the treatment centre he/she may experience a 'slip' or 'lapse' and any 'slip' is seen as a relapse and a return to pre-treatment abuse of substances (Chetty, 2011:18). Therefore, relapse needs to be seen as a challenge and opportunity for learning to occur rather than an indication of failure. Mokwena (2015) alludes that there are high relapse rates of *nyaope* users who have accessed some form of treatment.

Considering the increase in the demands for treatment, an adequate treatment period and ongoing aftercare services are vitally important in preventing adolescent relapse and ensuring the maintenance of recovery (Van der Westhuizen & De Jager, 2009:77). Because of the many detrimental physical and psychological effects of substance abuse, it is critical for researchers and clinicians to understand factors that predispose clients to relapse as well as factors that protect them from returning to substance use (Giordano, Clarke & Furter, 2014: 114). In most literature, relapse

is always associated with certain risk factors. Reasons for relapse are many and encompass both internal and external factors. The biggest mistake or blunder in substance abuse programme is that in most cases aftercare services seem to be excluded in many treatment plans. It is argued that substance abuse treatment should include detoxification, treatment programme and aftercare (Van der Westhuizen et al., 2013:3). Furthermore, research shows that focusing on the lack of existing aftercare programmes or practice guidelines, as well as specific needs of substance abusers following treatment, have the potential to address the concern regarding substance abuse addiction in a relevant manner.

Below the researcher will discuss the concept of relapse.

2.5.2 Relapse

It is difficult to assist an individual to maintain long term recovery from substance abuse (Jeewa & Karasim, 2008:44). Many treatment centres are rigid in the use of their programmes and depend on aftercare to improve recovery rates.

McKay (2001:212) states that due to the natural occurrence of a relapse after treatment, all individuals are encouraged to participate in some form of aftercare. Jeewa and Karasim (2008:44) furthermore argue that aftercare focuses on improving communication between the client and the family, empowerment using life skills, reviewing and resolving existing problems and inviting patients to visit and 'refresh' when necessary. McKay (2001:213) holds the view that aftercare, or continuum of care, prevents relapse.

The models of relapse prevention are discussed below.

2.6 RELAPSE MODELS

Having a formal relapse prevention plan can be beneficial to a professional working with substance abuse. These relapse prevention models are also applicable when dealing with a *nyaope* user.

The cognitive behavioural model and the Cenaps model will be discussed in detail.

2.6.1 Cognitive behavioural model

The relapse prevention model proposed by Marlatt and Gordon suggest that both immediate determinants (e.g. high risk situations, coping skills, outcome expectancies and the abstinence violation effect) and covert antecedents (e.g. life style factors and urges and cravings) can contribute to relapse (Larimer, Palmer & Marlatt, 1999:12). The strategies of relapse prevention in this model can be used with any client who wants to maintain a behaviour change (Fisher & Harrison, 2013:172).

In most literature, it is argued that substance abuse is always associated with relapse. When a substance dependent person goes for treatment there is always a

possibility of a relapse. Marlatt (1985) argues that those who believe in Cognitive Behavioural model are particularly interested in studying the determinants of addictive habits, including situational and environmental antecedents, beliefs and expectations and the individual's family history and prior learning experiences with the substance or activity. Annis (1990) criticises traditional solutions to relapse that the principles that guide the maintenance of a behaviour change may be different from the principles that determine the initiation of change (Fisher & Harrison, 2013:173). In other words, a person may enter treatment under coercion, be exposed to and accept the disease concept of addiction and discontinue his or her substance usage. However, this same individual may be unable to maintain abstinence.

The model has two phases. The first phase identifies that once a service user has made a change in their behaviour, the maintenance of this change continues until the service user encounters a 'High Risk Situation'. HRS's are any situations or mood states in which a service user might be 'triggered' to return to old behaviours (Nelson, 2012:123). This model explains that after a substance dependent individual has gone for a rehabilitation process, if he/she comes back to the same environment he/she has been occupying before the process, relapse could be triggered. It has been witnessed with the *nyaope* users in Hammanskraal that they come back to the same environment after rehabilitation or treatment. Triggering factors in this case could be being around people who are using substances, feeling low or depressed and seeing old substance paraphernalia (needles, pipes etc.). Furthermore, Nelson (2012:127) suggests that identifying in detail as much as possible the 'where, when, with whom, doing what and feeling what' of situations that are high risk for them, could help identify situations to avoid and to be wary of.

Equally, it can also be a good idea for the service user to write a relapse prevention plan at this stage, in which they can identify these coping strategies (Nelson, 2012:128). Similarly, for *nyaope* users, it can be of great help, researchers can be able to make to prevent future relapses. The current research could also be of great help as it aims to identify the aftercare and reintegration needs of *nyaope* users in the Hammanskraal community.

Nelson (2012:128) further identifies the second part of Marlatt and Gordon's (1985) model and it relates more to long term maintenance of behaviour change. This part of the model primarily emphasises the importance of maintaining a balanced lifestyle. This might mean having a good balance between work and family life, sleeping well, eating healthy and exercising regularly to be able to cope as much as possible with everyday stressors. According to the model, service users should focus on maintaining a balanced lifestyle and be aware of when their lifestyle is becoming unbalanced. With regard to relapse prevention, those who believe in this model are particularly interested in studying the determinants of addictive habits, including situational and environmental, beliefs and expectations and the individual's family history and prior learning experiences with the substance.

2.6.2 Cenaps model

The Cenaps model of Relapse Prevention and Therapy (CMRPT) is a comprehensive method for preventing drug dependent individuals and is viewed as a method for preventing service users from returning to alcohol and other drug use after initial treatment, and for early intervention should chemical use occur (Gorski, 1990). The disease concept is the underlying philosophy of this model. This means that the disease affects the biological, physical, psychological and social functioning of the individual (Fisher & Harrison, 2013:170). It is further argued that CMRPT integrates the disease model of chemical addiction and assistance based counselling methods with recent advances in cognitive, affective, behavioural and social therapies. CMRPT is based on the biopsychosocial model, which states that chemical addiction is a primary disease or disorder resulting in abuse of and addiction to mood altering chemicals. However, recovery from this disorder/disease is possible. Hence is also stressed that total abstinence plus personality and lifestyle change are essential for full recovery. The relapse prevention programme outlined in the Cenaps model is for clients "who believe that they have the disease, require abstinence and need to use recovery tools, but are unable to maintain abstinence" (Fisher & Harrison, 2013:171). This model does not support the notion that *nyaope* users must be coerced to treatment, it believes that *nyaope* users who go to treatment willingly stand a better chance of maintaining abstinence.

The Cenaps model uses a variety of procedures in relapse prevention, including client self assessment of problems that might result in relapse, education about relapse, identification of the signs of the relapse progression, strategies to manage or modify the signs and the involvement of others, such as family members (Fisher & Harrison, 2013:172).

The Cenaps model is designed in two levels:

The counselling level: Patients need to learn new ways of thinking and acting that will allow them to manage high risks situations and other problems that occur in their lives without using drugs. Patients are taught to identify and more effectively manage the thoughts and feelings that get in the way of learning new and more effective ways of dealing with problem situations.

The psychotherapy level: It focuses on teaching clients how to identify and manage the core personality and lifestyle problems that cause them to keep putting themselves in high risk situations. It teaches them how to identify and change the core belief systems and unconscious life rules that are created and maintain their personality and lifestyle.

Next, high risk situations that trigger relapse will be identified and discussed.

2.6.3 Relapse risk factors

Below the researcher will discuss causes of relapse in a form of risk factors. Other authors refer to these risk factors as high risk situations. The high risk situations are those situations in which there is an increased desire to use, where the drug of choice may be readily available (Swanepoel, 2014:14).

2.6.3.1 Intrapersonal risk factors

Pre-clinical studies have found that stress exposure, in addition to the drug itself, is a potent stimulus in reinstating drug seeking behaviour in dependant people (Sinha, 2001:350). In addition, the notion that substance abusers have poor coping skills to deal with drug cues, craving and stress has led to the development and validation of coping skills based cognitive behavioural interventions for addictive behaviours. Stress and negative effect states are known to increase impulsivity and decrease self control. In a study conducted by Thothela, Van der Wath and Janse Van Rensberg (2014:80) participants verbalised that they yearned for relief of painful emotions and for the positive emotional state associated with substance use. In other cases individuals who are stressed use drugs as a coping mechanism for the stress. Lebese et al. (2014:335) concur with what is discussed above by mentioning that people are overwhelmed by the challenges in their own personal lives, their families and the society in which they live and that most of them suffocate due to the lack of support. Hence they resort to drug use at a very early age. People who abuse drugs do not realise that the use of substances will not solve their problems, instead, the use of substances aggravates their problems.

2.6.3.2 Social risk factors

Age is viewed as a connecting factor affecting peer influence on substance abuse (Adewuyi & Akinsola, 2013:83). The new tasks for development are highlighted as children become focused on friendship formation, skills learning and evaluation. Furthermore, the most important thing is what their friends and peers say and think, from the language of that particular group up to the dress code. In the process of one learning new skills, chances of being caught up in substance use are high in a company of friends. This is also acknowledged by Shembe (2013:91) that curiosity was another major contributing factor for participants to use *whoonga*.

Unemployment and poverty is cited as another reason for relapse (Swanepoel, 2014:16). The financial dependence and reliance on other people bring anger and hopelessness that leads users straight to relapse (Thothela et al., 2014:85). However, boredom due to unemployment is considered as high risk situation when facing unemployment. Not only does drug abuse increase the chances of losing one's employment, it also decreases the chances of gaining employment. The addicted individuals are therefore locked in a situation which further exacerbates their circle of poverty, and in turn contributes to further drug use (Mokwena & Morojele, 2014:380). Furthermore, a co-dependent relationship with the drug dealers

is cited as another risk factor (Thothela et al., 2014:82). Many users are being controlled or manipulated by drug dealers and end up coerced to go back to using drugs.

2.6.3.3 Environmental risk factors

Substance users have a strong desire for substance because these substances are easily available in their families, communities and they afford to buy them (Lebese et al., 2014:335). One of the participants in the study that was conducted by Mokwena and Morojele (2014:379) responded to the question of ease/difficulty of access to *nyaope*, that it is very easy, it is even easier if you have money and that the dealers are everywhere. Adewuyi and Akinsola (2013:86) concur with the above statements by highlighting that, now these hard drugs are as common as analgesic drugs. *Nyaope* users often gather in public spaces like taxi ranks and parks to smoke together.

The age of initiation into substance use is also a vital indicator of risk, exposure and the possibility of the harmful use of substance (Mudhovozi, Maunganidze, Maseko, Ngwenya, & Netshikweta, 2014:353). In the case of *nyaope* users who start by smoking "dagga" later become regular smokers of *nyaope* (Makhubela, 2015). Additionally, lack of stimulating activities and personal structure in their lives contribute to the continuing use of substances (Thothela et al., 2014:83).

2.6.3.4 Physical factors

Painful withdrawal symptoms are part of drug addiction and a precipitating factor to relapse (Van der Westhuizen & De Jager, 2009:83). With *nyaope* users, stomach craps are experienced when the drug is not taken; the term that is often used by the users is "gophatlhoga" meaning abdominal cramps (Mokwena & Huma, 2014:352). These abdominal cramps increase the urge to use and get healed from such pains.

As it has been identified above that aftercare and reintegration services are significant after the treatment of drug abuse, the researcher will discuss the available aftercare and reintegration services in South Africa.

2.7 AFTERCARE AND REINTEGRATION SERVICES TO *NYAOPE* USERS

The period after leaving treatment has a high risk of relapse and adequate support should be provided to the client during this period so that the positive progress made during treatment is not lost (Gossop, Stewart & Marsdan, 2007:57). This is because treatment by itself is often not of a sufficient duration to ensure that a person is able to maintain the progress they have made. Aftercare services are designed for individuals who have already completed treatment. As a matter of fact, for individuals suffering from substance dependence, detoxification and formal treatment are only the beginning of the recovery process, with aftercare and ongoing support and reintegration services being an essential component of successful interventions (Myers, Harker, Kader & Mazoko, 2008:34).

Aftercare services aim to provide individuals with additional tools that equip them to maintain their treatment gains, including remaining alcohol and/or drug free, avoiding relapse, and rebuilding their lives and reintegrating into society (Gossop et al., 2007:59). In conclusion, Gorski (2001:4) concurs that ongoing treatment in the form of aftercare is vitally important in preventing relapse. As such, aftercare services may include the following components: low intensity family services, ongoing mental health services, ongoing low intensity relapse prevention and skills training services, and social support services.

In the South African context, the value of aftercare has been downplayed and there has been relatively little emphasis on aftercare in both research and practice (Myers et al., 2008:58). In South Africa, aftercare services are generally provided in the following types of settings (Myers et al., 2008:58):

- **Formal treatment services**: typically by service providers providing ongoing relapse prevention counselling of lower intensity. Only a small number of programmes have sufficient resources to provide any form of aftercare and generally clients are referred to other organisations and to self-help groups for these services.
- **Halfway houses and sober living establishments** (e.g. secondary and tertiary care facilities) that provide some low intensity counselling and support services or access to these services.
- **Self-help/mutual-help support groups in community settings** that consist of individuals at various stages of recovery and who act as a source of support to each other. Such groups are the most common form of continuing care in South Africa.

SANCA Hammanskraal offers individual counselling, group therapy, family therapy and extensive utilisation of self-help groups as their strategy to deliver aftercare programmes (SANCA Pretoria, 2012).

The literature review thus far highlighted the strategies of the NDMP 2013-2017 pertaining to substance abuse, and the amendment of the Drugs and Drug Trafficking Act 140 of 1992 which resulted in the criminalisation of *nyaope.* However, many inputs are needed to curb the scourge of *nyaope* in Hammanskraal as it has been revealed that not many studies have been conducted with regards to aftercare and reintegration services (Van der Westhuizen, 2007:103). The literature review has divulged that a lack of or poor aftercare services is associated with drug relapse (McKay, 2001:213).

It is argued that substance abuse treatment should include detoxification, treatment and aftercare (Van der Westhuizen, Alpaslan & De Jager, 2013:3). Moreover, considering the increase in the demands for treatment an adequate treatment period

and ongoing aftercare services are vitally important in preventing adolescent relapse and in ensuring the maintenance of recovery (Van der Westhuizen & De Jager, 2009:77). Although treatment programmes are available there are still demands for drug rehabilitation and users still relapse after treatment. The above mentioned problem is acknowledged in the NDMP and the White Paper for Social Welfare (Republic of South Africa, 1997) that emphasises the fact that treatment for substance addiction is important and the importance of relapse prevention programmes as part of the treatment plan.

Below the researcher will discuss services that the government provide with regards to substance abuse.

2.7.1 Government services

The DSD has a duty in fighting drug abuse in the country (Namathe, 2012:2). Namathe (2012:4) mentions that in 2010 the DSD conducted door-to-door campaigns in some areas of the nine provinces. Among the findings of the campaigns were that there was a lack of adequate treatment services to people abusing substances; drugs are easily accessible and available; and no recreational facilities and programmes are offered (Namathe, 2012:4).

The role of the DSD is to develop, implement and review policies, programmes and services to address the scourge of substance abuse (Namathe, 2012:3). With the criminalisation of *nyaope,* the government was implementing its role of reviewing policies. The other objective of the DSD is to develop and transform programmes related to prevention, early intervention and treatment for substance abuse (DSD, 2013:121). Social workers employed by the DSD provide prevention programmes at early childhood development centres and local schools; including primary, secondary and high schools, respectively. Using the *Ke-Moja* programme, learners are educated about the psychosocial impact of drugs and substances and the prevention thereof.

Chibambo (2014:1) mentions that the DSD has introduced mobile social services busses to reach out to communities where they do not have offices and in areas where there are no crèches. Education is the principal means of preventing substance abuse among the youth. The prevention aspects are largely implemented through the Life Orientation Learning Area of the school curriculum, specifically the life skills programme (DSD, 2013:117). The DSD aims to prevent drug abuse from an early age. For the purpose of the study the researcher will focus on people who went through treatment for *nyaope* addiction in the Hammanskraal community. Drug users can easily access the drugs in the community, even when prevention programmes are delivered at local schools and in the media. Currently the DSD is funding well established skills development centres with a specific focus on unemployed and vulnerable youth as the targeted service users. *Nyaope* users largely receive skills training during aftercare services on referral by the designated

social workers in the skills development centres. However, due to lack of a standardised referral system and specialised aftercare programmes for *nyaope* users, the success rate has been unsatisfactory (Makhubela, 2015).

As it now stands, DSD social workers are expected to run aftercare and reintegration groups for *nyaope* users who have completed the treatment programme. However, such groups are challenged by poor attendance of members (Makhubela, 2015). Group sessions are also offered for significant others of *nyaope* users, the challenge experienced is also poor attendance. Thereafter, users are referred to skills development centres available in communities. In preparation for reintegration of *nyaope* users into the community, DSD renders education and awareness campaigns at local schools and community meetings as a form of preparing the community to welcome *nyaope* users back into the communities (Makhubela, 2015).

DSD has been leading the work on drug and substance abuse services. However, the NDMP states that drug and substance abuse services should be rendered collaboratively by all government departments wherein interdepartmental partnership is to be maintained. Furthermore, the NDMP indicates that the leading stakeholder should be the municipalities/local government spearheading the intervention processes (DSD, 2013:4). However, to this date DSD still remains the leading government department in rendering drug and substance abuse services with *nyaope* users being the leading recipients of their services.

After an exposition of the role and function of the DSD, the next section will consider the role of NGOs in combating drug abuse.

2.7.2 Services by NGOs

NGOs and NPOs play a huge contributory factor in combating substance abuse in the country of South Africa. A number of NGOs that are available to the people addicted to *nyaope* in the Tshwane metro (the research site of this study) will be identified and services rendered will be outlined.

2.7.2.1 SANCA

NGOs play a huge role in combating substance abuse, especially through the delivery of direct services. In South Africa, services offered by NGOs vary from outpatient treatment programmes for substance use disorders, to day-patient services (where service users attend a facility on a daily basis), and intensive outpatient services (where services are provided 3-5 times per week), as well as less intensive options where service users attend a facility 1-2 times per week (Myers & Fakier, 2007:13). SANCA has, in the past, been the leading NGO in the field of substance abuse prevention and treatment offering a variety of prevention, education and treatment services (Maiden, 2008:56). Hence it offers a range of services ranging from assessment and referral, detoxification, inpatient treatment, community education and development and youth programmes.

Currently, the in-patient treatment centre in Tshwane enjoys full registration with the DSD and also meets the criteria pertaining to norms and standards (SANCA, 2012). The treatment centre in Tshwane has a multi-disciplinary team as part of its structure to ensure delivery of a holistic treatment service. The SANCA National out-patient programme has been standardised and was presented at training workshops at all the SANCA organisations during 2011. Both the in- and out-patient programmes comply with the norms and standards for substance abuse treatment services. The average duration of an in-patient treatment programme for adults is between 21 and 28 days. Out-patient treatment programmes range from early intervention, with a minimum of seven sessions to comprehensive out-patient treatment programmes lasting up to 16 weeks (SANCA, 2012).

This study was conducted in Hammanskraal with participants from the caseload of SANCA, the only NGO in the area which assists the community in combating substance abuse. This NGO refers clients to treatment centre through its programmes, to be specific when there is a need for an inpatient service for a user, services at Pretoria North are utilised. The SANCA Rehabilitation Clinic in Hammanskraal has opened outpatient programmes in Babelegi, where such services are provided for free (Maluleke, 2014:7). The clinic offers a six week programme to youth who are addicted to different drugs, such as dagga and *nyaope*. The clinic operates in partnership with the DSD, which subsidises them. The aftercare services that SANCA provides include group sessions that take a duration of 12 months, focusing on both group therapy and family therapy. *Nyaope* users are also provided with individual counselling (SANCA, 2012). They also conduct prevention and awareness campaigns at local schools, clinics, taxi ranks, community meetings and through door to door campaigns.

Below the researcher will ascertain the role that Open Disclosure Foundation play as an NGO that specialises in substance abuse.

2.7.2.2 Open Disclosure Foundation

Open Disclosure Foundation is an NGO that is based in Soshanguve specialising in substance abuse. It offers outpatient services to substance users within the Soshanguve Township. Moreover, they specialise in counselling of service users and their families (Open Disclosure Foundation, 2016). They have a social worker within their organisation who assists in referring clients to Dr Fabian and Florence Ribeiro Treatment Centre. Substance users are expected to attend four pre-sessions before they can be referred to a treatment centre.

After completion of treatment, users are included in an educational group for a period of six weeks (Open Disclosure Foundation, 2016). However, their aftercare programme is also hampered by poor attendance. After completing the six week

aftercare programme the users are then referred to Mabopane Outreach, which is an NGO that offers skills development programmes. Other services that Open Disclosure Foundation offers are door-to-door campaigns, where communities are asked their views on combating substance abuse in the community. Additionally, Social Auxiliary Workers conduct prevention and awareness campaigns at local schools. They also attend workshops and training provided by the Department of Social Development because Open Disclosure Foundation is part of LDAC.

Below, services that are offered by Stabilis as an inpatient and outpatient service provider will be determined.

2.7.2.3 Stabilis Treatment Centre

Stabilis is an NPO registered by the DSD as a detox and treatment centre for the treatment of substance dependents and their appropriate systems, with its aim to restore joy of living by the development of alternative lifestyles without addictive substances (Stabilis, 2016). It offers outpatient and inpatient services. In inpatient treatment, constant medical supervision is placed over each patient. Detoxification is also provided and psychiatric observation and assessment are more intensive and accessible. Their outpatient service is mostly suitable for people who need to continue to work or attend school. Additionally, the rehabilitation programme consists of group and individual therapy (Stabilis, 2016). Furthermore, the organisation also runs an aftercare support programmes that are presented by the Alcoholic Anonymous and Narcotics Anonymous.

2.8 SUMMARY

Substance abuse in South Africa is highly prevalent and continues to be a major cause of mortality and a risk factor for both communicable and non-communicable diseases (Burnhams & Parry, 2015:1). *Nyaope* is specifically the most used substance in the townships of South Africa and it is a burden to the country's economic, social and the public health system. The main focus of the study was to identify the aftercare needs of *nyaope* users in the Hammanskraal community. The researcher has discussed the prevalence of *nyaope* use in South Africa and other African countries. Legislation and policies of this country have been looked at and debated with regards to *nyaope*. Relapse and its risk factors have also been conceptualised. However, there are models that assist in preventing substance abuse relapse. Government and services by NGOs with regards to aftercare and reintegration services were also debated.

In Chapter 3 the focus will be on the research methodology used in the study and the research findings and an interpretation thereof.

CHAPTER 3:

RESEARCH METHODOLOGY, RESEARCH FINDINGS AND INTERPRETATION

3.1 INTRODUCTION

This chapter outlines the research methodology that was applied in the study, as well as the research findings and the interpretation thereof. Chapter 3 will be divided into two sections, where Section A will outline the research methodology in detail and Section B will outline the research findings and offer an interpretation thereof.

This chapter focuses on the following research objective of the study:

- To identify the aftercare needs of *nyaope* users, specifically in the physical, psychosocial and behavioural domains, who have relapsed after initial treatment in Hammanskraal from both the users' and the significant others' points of view.

SECTION A: RESEARCH METHODOLOGY

The methodology followed in this study is subsequently described.

3.2 RESEARCH QUESTION

Owing to the qualitative nature of the study, two research questions were formulated, namely:

1. "*Based on the views of nyaope users, what are the aftercare needs of nyaope users in the Hammanskraal community?*"
2. "*Based on the views of significant others, what are the aftercare needs of nyaope users in the Hammanskraal community?*"

3.3 RESEARCH APPROACH

In this study, *nyaope* users identified their needs with regards to aftercare and reintegration services following treatment for *nyaope* addiction. Furthermore, the significant others also had an opportunity to express their views regarding the required aftercare and reintegration services. In the literature review it was highlighted that poor aftercare services or a lack thereof are associated with relapse. This qualitative study afforded the *nyaope* users an opportunity to voice their aftercare and reintegration needs (De Vos, Strydom, Schulze & Patel, 2011:7).

The study was qualitative in nature as the researcher focused on the perceptions that *nyaope* users, and the significant others, had with regards to aftercare services, not the meaning that the researcher brought to the research (Creswell, 2009:47). Equally important, qualitative researchers stress the socially constructed nature of reality, the intimate relationships between the researcher and what is being studied and the situational constraints that shape inquiry (Denzin & Lincoln, 2011:8). The

qualitative approach was used to answer the complex nature of *nyaope* addiction and the route to recovery. The researcher captured the individual's point of view, with regard to the aftercare and reintegration services of *nyaope* users (Denzin & Lincoln, 2011:8).

Qualitative researchers tend to collect data in the field at the site where participants experience the issue or problem under study (Creswell, 2007:37). Therefore the researcher went to Hammanskraal to interview the participants. The purpose was to explore and describe the aftercare needs of the *nyaope* users from both the users' and the significant others' points of view in Hammanskraal.

3.4. TYPE OF RESEARCH

Merriam (2009:3) states that applied research is undertaken to improve the quality of practice of a particular discipline. Applied researchers hope their work will be used by administrators and policy makers to improve the way things are done. The type of research for this particular study was applied research. Applied researchers work on human and societal problems, hence the researcher interviewed both *nyaope* users and their significant others about a societal problem, namely, '*nyaope* addiction' and the aftercare and reintegration needs of service users (Patton, 2002:217).

South Africa is faced with high rates of substance abuse and many drug users are relapsing after receiving treatment. In conducting this research, the researcher aimed at formulating pragmatic recommendations pertaining to the delivery of aftercare and reintegration services to *nyaope* users in Hammanskraal. Hence, it is mentioned by Patton (2002:216) that the purpose of applied research is to contribute knowledge that will help people understand the nature of a problem in order to intervene, and thereby allowing communities to be more effective in controlling their environment.

3.5. RESEARCH DESIGN

The appropriate research design for this study was the case study design. Qualitative case studies share with other forms of qualitative research the search for meaning and understanding during which the researcher is the primary instrument of data collection and analysis. The investigative strategy is inductive, and the end product yields rich descriptions (Merriam, 2009:39).The case study is particularly useful to employ when there is a need to obtain an in-depth appreciation of an issue, event or phenomenon of interest, in its natural real-life context (Fouché & Schurink, 2011:321). The current study was an in depth study, that explored and described the aftercare needs of *nyaope* users in Hammanskraal from both the users' and significant others' points of view. Therefore, the researcher deemed the collective case study as the most appropriate design to attain the goal of the study (Fouché & Schurink, 2011:320). The collective case study design was chosen because the researcher was combining/comparing data obtained from the users and the significant others, i.e. triangulation (Yin, 2003: 42).

The detailed qualitative accounts often produced in case studies not only help to explore or describe the data in real-life environments, but also help to explain the complexities of real life situations which may not be captured effectively through experimental or survey research (Gülseçen & Kubat, 2006:100). The disadvantages of a case study design is that it provides very little basis for scientific generalisation since they use a small number of subjects, some being conducted with only one subject (Gülseçen & Kubat, 2006:100).

Based on the discussion the researcher judged the collective case study design as the most suitable because it enabled her to penetrate the in-depth thoughts of the participants regarding the aftercare needs of *nyaope* users from both the users' and the significant others' points of view and ultimately to triangulate the research data.

3.6. STUDY POPULATION AND SAMPLING

The researcher's population were the *nyaope* users and the significant others in the Hammanskraal community. Hammanskraal is a township about 40 km north of the South African capital city of Pretoria (Nxumalo & Gare, 2015:6). The inhabitants are black people since Hammanskraal was formerly a black township in the homeland of Bothuthatswana. Poverty and unemployment are common. A large number of the Hammanskraal population lives in an informal settlement. The community or population is the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned (Strydom & Delport, 2011:391). The researcher recruited both *nyaope* users who have undergone and relapsed after an initial treatment between 2013 and 2015 and who were at the time of the study on the case load of SANCA in Hammanskraal and a significant other (e.g. partner, husband, wife, niece, nephew, brother, sister) for data collection purposes.

The sampling for this study was in two phases. *Firstly*, SANCA Hammanskraal used purposive sampling (Strydom & Delport, 2011:392) to identify the *nyaope* user and a significant on their case load who met the following criteria:

- Be able to converse in English, isiZulu or Northern Sotho;
- Reside in Hammanskraal, and;
- Must be 18 years or older.

In addition, the *nyaope users* must have had undergone treatment and relapsed between 2013 and 2015. SANCA Hammanskraal provided the details of the researcher to potential participants. *Secondly*, for stage two sampling, only the people who volunteer (i.e., volunteer sampling) their participation were interviewed by the researcher (Strydom & Delport, 2011:394).Qualitative inquiry typically focuses in-depth on a relatively small sample, even single cases selected purposefully

(Patton, 2002:230). The overall purpose of the use of the two sampling methods was to collect the richest data. Six respondents from each sampling group, that is six participants in aftercare for *nyaope* addiction, and six of the significant others, were interviewed and saturation point was reached.

3.7 DATA COLLECTION

The data collection method, issues of trustworthiness and data analysis are discussed below.

3.7.1 Data collection method

As mentioned by Patton (2002:78), the primary focus of data collection will be on what is happening to individuals in a setting and how individuals are affected by their setting.

For the purpose of this research, semi-structured interviews were utilised as a data collection method. The respective interview schedules are attached as Appendices D and E. The researcher wanted to gain a detailed picture, of *nyaope* users' needs with regards to aftercare and reintegration services (Strydom, 2011:351), by exploring the views of both users and their significant others. The researcher developed an interview schedule to evidence that she is well prepared for the interviews and to convey her competency (Bernard, 2000:191).

The researcher asked the ***nyaope* users** questions such as:

1. Tell me more about your addiction to *nyaope,* e.g. when did it start, how did you come to know about *nyaope*, how was it introduced to you?
2. What effects does *nyaope* have on you, psychologically, socially, physically, behaviourally and spiritually?
3. Who do you consider as support systems (if any) ? describe the support you receive
4. What have you done thus far to deal with your addiction?
5. What do you think caused the relapse?
6. What are your needs for support in order to maintain abstinence?
7. What are your needs for reintegration into the community?
8. How would you like to be supported by social workers?
9. What would you suggest must treatment centres do differently during treatment to help you maintain abstinence?
10. What do you consider your strengths/asses/things that make you proud and/or unique?
11. How do you spend your time when you are not using drugs?

The following questions were asked to the **significant others of the *nyaope* users**:

1. Can you tell me about your child's/ partner's/ husband's/ wife's/ niece's/ nephew's/ brother's/ sister's addiction to *nyaope*?
2. What effect does your child's/ partner's/ husband's/ wife's/ niece's/ nephew's/ brother's/ sister's addiction have on you and the whole family?
3. What do you think can be done to deal with this addiction?
4. What do you think are the needs for support for your family member to remain abstinent, specifically in the physical, psychosocial and behavioural domain?
5. How would you like your family member to be supported?
6. What would you expect from social workers to support your family member to maintain abstinence?
7. What do you think are your family member's needs pertaining to aftercare?
8. How do you think can your family member be best reintegrated into the community?
9. Who is in the best position to provide support to your family member after treatment for *nyaope* abuse?

The most important advantage of using the semi-structured interview method for this study was that *nyaope* users and significant others could seek clarification if they did not understand the questions (Terreblanche, Durrheim & Painter, 2006:58). The interviews were audio recorded. Although Creswell (2009:69) believes that the researcher's presence may bias responses, the researcher as a professional social worker, avoided bias by all means by stating in the informed consent that the aim of the study was to explore and describe the aftercare needs of *nyaope* users form their own and significant others' points of view.

3.7.2 Data analysis

The process of thematic analysis was used as posited in Clarke and Braun (2013:121-123). Thematic analysis is essentially a method for identifying and analysing patterns in qualitative data. The process starts with familiarising oneself with the data, coding, searching for themes, reviewing the themes, defining and naming the themes and it concludes with writing the research report.

For the study, the interviews were audio recorded. The researcher started by familiarising herself with the data by listening and re-listening to the audio recordings (Braun & Clarke, 2006:124). It is important that the researcher should familiarise herself with the data until information that is relevant to the study is noticed by the researcher (Clarke & Braun, 2013:204). As the researcher used interviews which were recorded, the interviews were transcribed into written form in order to conduct a thematic analysis (Braun & Clarke, 2006:80). Transcription is seen as another way of familiarising oneself with the data. The researcher also planned to explore the latent meaning of the data. A thematic analysis at the latent level goes beyond the semantic content of the data, and starts to identify or examine the underlying ideas,

assumptions and conceptualisations and ideologies that are theorised as shaping or informing the semantic content of the data (Braun & Clarke, 2006:78).

After the researcher had familiarised herself with the data, coding began. Codes identify a feature of the data (semantic or latent content) that appears interesting to the analyst and refer to the most basic segment, or element of the raw data or information that can be assessed in a meaningful way regarding the phenomenon (Braun & Clarke, 2006:81). This means that different codes be sorted into potential themes and collating all the relevant coded extracts within the identified themes (Clarke & Braun, 2013:80). The researcher used “mind maps” to sort the different codes into themes and sub-themes (Braun & Clarke, 2006:89).

Once the themes and sub-themes had been identified, they were reviewed in the next step. The available themes were refined, for example, if there were not enough data to support them, they were not regarded as themes (Clarke & Braun, 2013:90). For example with the *nyaope* users’ responses, strengths of the users were identified as a theme but lacked adequate information to support it.

After the researcher has read all the collated extracts for each theme, they must appear in a coherent pattern (Braun & Clarke, 2006:91). Data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes (Clarke & Braun, 2013:90).

At this point, the researcher defined and further refined the themes that she presented for analysis, and analysed the data within them (Clarke & Braun, 2013:92). The researcher identified the ‘essence’ of each theme and constructed a name for each theme (Clarke & Braun, 2013:93). The task of writing up the thematic analysis is to tell the complicated story of your data in a way which convinces the reader of the merit and validity of the analysis (Braun & Clarke, 2006:121).

3.7.3 Trustworthiness

The researcher used credibility and triangulation in establishing the “truth value” of the research. “The goal of credibility is to demonstrate that the inquiry is conducted in a manner that will ensure that the subject has been accurately identified and described” (Schurink, Fouché & De Vos, 2011:419). This meant that the research would explore what was actually set out to be explored and described.

“Trustworthiness is established when findings as closely as possible reflect the meaning as described by the participants” (Lincoln & Guba, 1985 in Lietz, Langer & Furman, 2006:444). The researcher used peer debriefing to ensure trustworthiness. This was done with a colleague, who had a general understanding of the nature of the study, and with whom the researcher could review perceptions, insights and analyses (Babbie, 2008:277). The researcher went through the hard copies of the transcribed material with a colleague and identified the themes and sub-themes from the hard copies.

The researcher also used triangulation to ensure trustworthiness. This entails gathering data through several sampling strategies so that slices of data at different times and in different social situations, as well as on a variety of people, are gathered (Bryman,2011:1142). For the study the researcher used two data sources, namely *nyaope* users and significant others. The results were combined and compared when the data were analysed (*i.e.*, triangulated).

3.7.4 Pilot study

One participant from each participant group from SANCA Soshanguve was selected through purposive sampling with the same recruitment criteria. The participants had the same characteristics as those who were participating in the main study (Strydom, 2005:202). One *nyaope* user that had undergone treatment at SANCA Soshanguve was interviewed. The interview schedule was pretested during the pilot study with a *nyaope* user from SANCA, Soshanguve. Furthermore, the researcher interviewed one significant other to the *nyaope* user who resided in Soshanguve. The participant had a child/ partner/ husband/ wife/ niece/ nephew/ brother/ sister who have undergone treatment at SANCA, Soshanguve and relapsed after initial treatment. The pilot study helped in identifying possible problems that may come up during the main study. The purpose of the study was explained to the participants. They also had to volunteer to take part in the study and were expected to sign the informed consent form. The interviews were audio recorded as in the main study. However, data obtained from the pilot test was not used for the main study. The interview schedule for *nyaope* users was altered for the main study as one of the participants in the pilot study suggested that the researcher must add a question that explores the strengths of the *nyaope* users.

3.8. ETHICAL CONSIDERATIONS

The following ethical considerations were of elevated importance in the study and received prudent consideration.

3.8.1 Informed consent

The researcher made use of an informed consent letter (see App. B and C), which clearly stated that participation is voluntary (Babbie, 2004:79). Both groups of participants, being the *nyaope* users and the significant others, had to sign a separate informed consent letter. In the informed consent letter, the research topic was stated and the aim of the study. The participants read the informed consent and the researcher was available if there were questions they wanted to clarify. The researcher made sure that the signed consent forms were treated and stored with the utmost discretion (Strydom, 2011:117). The informed consent letter indicated that the research data will be stored for 15 years in line with the University of Pretoria's pertinent policy.

3.8.2 Violation of privacy/anonymity/confidentiality

The researcher made sure that she respects the privacy of the participants (Babbie, 2004:87). The researcher knew the identity of the participants because she interviewed them, but ensured confidentiality by not disclosing the names/identity of the participants in the research findings (Babbie, 2004:90).

3.8.3 Debriefing of respondents

The researcher discussed the feelings of participants about the project, immediately after each interview (Strydom, 2011:122) as a way of debriefing.

3.8.4 Avoidance of harm

One may accept that harm to participants in the social sciences will be mainly of an emotional nature, although physical injury cannot be ruled out completely (Strydom, 2011:115). Equally, the researcher had an obligation to protect participants within all possible reasonable limits from any form of discomfort that may emerge from the research project (Creswell, 2007:64). The researcher avoided harm by clearly explaining the purpose of the study and its conceivable impact on the participants. In the case where emotional harm occurred, although no emotional was anticipated, participants were referred to the offices of the DSD and SANCA in Hammanskraal, for further counselling. Nevertheless, the researcher did not encounter any situation where one of the participants were harmed and required further counselling.

3.8.5 Voluntary participation

Participation should at all times be voluntary and no one should be forced to participate in the study (Strydom, 2011:116). The researcher explained the purpose of the study, stress that participation cannot be coerced (Strydom, 2011:116) and that a participant may withdraw from the study at any point without any negative consequences.

3.8.6 Deception of participants

Deception refers to misleading participants, deliberately misrepresenting facts or withholding information from participants (Strydom, 2011:118). The researcher was candid with the participants about the aim of the study.

3.8.7 Publication of the findings

The findings of the study must be introduced to the public in a written form; otherwise even highly scientific investigation will mean very little and will not be viewed as research (Strydom, 2011:126). Equally important, researchers should never manipulate results in order to confirm hypotheses or points of view. The researcher notified the participants about the dissemination of the findings in a mini-dissertation as well as a potential journal article or conference presentation through the informed consent letter.

This study received ethics clearance from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria (see App. A) before it was implemented. In addition, SANCA Hammanskraal also offered permission to conduct the study with clients on their case load (see App. F).

The next section of the chapter outlines the research findings and offers an interpretation thereof.

3.9 SECTION B: RESEARCH FINDINGS AND INTERPRETATION

As mentioned earlier, the researcher had two samples of participants, namely the *nyaope* users and their significant others. Semi-structured interviews were utilised to collect data; subsequently the data will be presented separately before it will be combined and triangulated. Although some of the participants expressed themselves in languages other than English, only the direct or translated English quotes are offered in this section of the chapter. Section 1 will outline the findings pertaining to the *nyaope* users; Section 2 will focus on the significant others, while Section 3 highlights the triangulated data.

3.9.1 Section 1: *Nyaope* users

Sub-section 1: Biographical information

This section will focus on the biographical information as well as the discussion of data presented by the *nyaope* users.

TABLE 1: BIOGRAPHICAL INFORMATION OF THE *NYAOPE* USERS

Participants	1	2	3	4	5	6
Gender	Male	Male	Male	Male	Male	Male
Age	23	23	29	21	29	33
Racial group	Black	Black	Black	Black	Black	Black
Religion	Christian	Christian	Christian	Christian	Christian	Christian
Number of children in the family of origin	1	7	4	2	1	7
Position in the family structure	Only child	Last born	Second born	First born	Only child	Last born
Home language	Sepedi	Sepedi	Sepedi	IsiZulu	Sepedi	Xitsonga
Employment status	Unemployed	Unemployed	Unemployed	Unemployed	Unemployed	Employed
Relationship status	Single	Single	Single	Single	Single	Widow
Highest level of education	Level 4 ABET	Grade 12	Grade 11	Grade 11	Grade 11	Grade 12
Current round of treatment	Second	Second	Second	Fifth	Second	Second
Treatment received at government/private institution	Government	Government	Government	Government and private	Government	Private

The biographical information of the *nyaope* users reveals that all of the participants were male. All participants acquired some high school education with the majority of them completing Grade 12. The biographical information also outlines that all of the participants relapsed after an initial treatment and that they mostly received their treatment at a government/public treatment centre. Moreover, the table shows that the majority of the participants did not have formal employment at the time of the study. Additionally, the majority of the participants were Sepedi speaking and identified themselves as Christian. Interestingly, most participants in the study were treated for the second time, whilst their position in the family varied from being an only child, first, second and last born.

Sub-section 2: Themes and sub-themes

This sub-section discusses the data from the *nyaope* users as classified into themes and sub-themes. The themes and sub- themes are outlined below:

TABLE 2: PRESENTATION OF THEMES AND SUB-THEMES OF NYAOPE USERS.

Themes	Sub-themes
Theme 1: Impact of nyaope on users	Sub-theme 1.1: Physical impact Sub-theme 1.2: Psychological impat Sub-theme 1.3: Social impact Sub-theme 1.4: Spiritual impact
Theme 2: Causes of relapse	Sub-theme 2.1: Lack of support from family Sub-theme 2.2: Lack of support from government Sub-theme 2.3: Personal problems Sub-theme 2.4: Being aroung friends who are addicted to *nyaope* Sub-theme 2.5: Psychologically or mentally unprepared for treatment Sub-theme 2.6: Going to the same environment following treatment
Theme 3: Needs for reintegration into the community	Sub-theme 3.1: Change of lifestlye asfter succesful completion of treatment Sub-theme 3.2: Require trust from the community Sub-theme 3.3: Require volunteering opportunities or opportunities for community service Sub-theme 3.4: Eliminating theft/ stealing from community members
Theme 4: Needs for support in order to maintain abstinence	Sub-theme 4.1: Change of lifestlye after treatment Sub-theme 4.2: Family support after treatment Sub-theme 4.3: Group sessions after treatment Sub-theme 4.4: Aftercare programmes following treatment
Theme 5: Recommendations from service users	Sub-theme 5.1: Increase the duration of treatment Sub-theme 5.2: Create job opportujnities and make them accessible for users after treatment Sub-theme 5.3: Spiritual support from spiritual leaders

DISCUSSION

Theme 1: Impact of *nyaope* on users

The data revealed that *nyaope* users are affected by *nyaope* at a physical, psychological, social and spiritual level. The physical impact will be discussed first.

Sub-theme 1.1: Physical impact

The data outlines that *nyaope* users experience body pains when they have not taken the drug which presents in, amongst others, stomach cramps. The persistent pain drives the user to want to take *nyaope*. The said statement concurs with what is mentioned in the disease theory of addiction that "addiction involves pathological changes in the brain that result in overpowering urges" (West, 2005:76). After taking the drug the user experiences a pleasurable state of relaxation. Some of the participants' views include the following:

> *"It makes you sleep; more especially when you have had too much, it makes you relax."*

> *"In my body, I feel okay when I have smoked it, but when you have not smoked you feel stomach cramps, your joints becomes painful, your muscles becomes stiff and you sweat a lot."*

Moreover, it has also been shown that people who are smoking *nyaope* look older and their physical appearance change. Because of the common unhygienic nature of *nyaope* users, many of them are susceptible to illnesses. The WHO (2009) indicates that besides the direct loss of health due to addiction, drugs are a leading cause of death due to oesophageal cancer, liver cancer and homicide. The verbatim quotes of the participants with regard to appearance are as follows:

> *"Nyaope users do not take a bath; they do not care about hygiene."*

> *"Physically, nyaope has ruined my body; I do not look like people of my age."*

> *"…nyaope makes you loose weight, ya ... it finishes you."*

It has been confirmed that drug addiction is associated with damaging physical, mental and social health, and interferes with crucial developmental tasks (Van der Westhuizen & De Jager, 2009:76).

Sub-theme 1.2: Psychological impact

It has been identified that addiction to *nyaope* interferes with one's state of psychological well-being. Among other impacts, is the psychotic impacts such as seeing or hearing things that are not there (Montesh et al., 2009:97). Hence, the disease theory of addiction views addiction as a medical disorder. The desire becomes so strong and all encompassing that it sweeps all other considerations before it, in a myopic and single minded search for the object of that desire (West, 2005:77). The following quotes are representative of the contributions of the participants regarding this aspect:

> *"…..your head becomes mixed up, just a little bit, not to say you become mad, but it is always on your mind constantly."*

> *"Nothing goes on in your mind, during that time you do not think of anything."*

> *"When I have smoked it, it kills my mind. I avoid stress just by smoking it."*

The above concur with the statement that substance dependent individuals are also negatively affected by the use as their physical health, psychological and social well-being are affected (Louw, 2009:79). This is supported by the American Psychiatric Association (2013) in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) that classified substance addiction as a disorder.

Sub-theme 1.3: Social impact

It was identified that *nyaope* has a negative impact on relationships with family and the community as a whole. Additionally, there are poor interpersonal interactions with others; relationships mostly between the user and parents or siblings are ruined. Most *nyaope* users defer to stealing from their community members just to feed their addiction. As a result, the communities lose trust in the users and blame them for everything wrong or negative that is going on within the community. It is evident that *nyaope* users end up being shunned by the communities because of their criminal element, dropping out of school, losing their jobs and poor future prospects (Mokwena & Huma, 2014: 359). Some of the participants' views are quoted below:

> *"It ruins relationships with other people, like your parents, friends and those who care about you and those who are close to you."*
>
> *"It makes people lose trust in you because you steal their money."*
>
> *"We are no longer respected in the community, the community members do not take us seriously."*

Studies have shown that illegal drug use is "almost automatically" associated with criminal behaviour (Montesh et al., 2015:96). Other researchers concur with the above mentioned statement by highlighting that drug addiction is also associated with crime, accidents and violent behaviour on a social level (Van der Westhuizen et al, 2013:2).

Sub-theme 1.4: Spiritual impact

The participants also expressed that *nyaope* has tremendously affected their relationship with a Higher Power. Some have indicated that they have seized attending church because they are always busy 'hustling' for money to feed the addiction. The participants' views include:

> *"I can say that nyaope has created a distance between myself and God, I do not go to church anymore…"*
>
> *"I was a type of person who attended church services on a regular basis, but since I started smoking, I no longer go to church."*
>
> *"There was no way I could go to church because when it was time for church I had to go and hustle so that I can get money to feed the addiction."*

Van der Westhuizen and De Jager (2009:87) purport that spiritual support, involvement in church activities and spiritual growth are key areas to address when planning aftercare services to the substance dependent person. Dealing with a *nyaope* user who has no relationship with God can be detrimental, hence it is important to include spiritual support at a treatment centre.

In the next theme the researcher is discussing the findings on causes of relapse.

Theme 2: Causes of relapse

The causes of relapse have been identified as lack of support from family, lack of support from government, personal problems, peer pressure, psychologically or mentally unprepared for treatment and going back to the same environment after receiving treatment.

Sub-theme 2.1: Lack of support from family

It has been identified that family members do not support the user after treatment. This is due to the fact that family members are often victims of crime, they lose hope in the user and they endure pain associated with their significant other being a victim of *nyaope*. Some of the participants' views are encapsulated in the quotes below:

> *"My last relapse was caused by these things, lack of support from my family."*
>
> *"I went back to smoking because I did not get the necessary support, plus other people just assumed that I did not stop, so I just went back and smoked."*
>
> *"We need support, lot of support from our parents."*

This finding has highlighted the importance of involving family members of the person addicted to drugs to take part in preparatory groups that are held prior to treatment and in groups post-treatment. These groups could assist with unresolved feelings experienced by the user. This statement concurs with the finding that the benefits of family involvement in aftercare are associated with better treatment compliance and outcomes (Van der Westhuizen et al., 2011:364). Hence it has been indicated that there is a need to make the treatment centres aware that families need to be involved during the treatment process of the addicted individual so that it becomes easy for the families to continue supporting the individual after they have completed the rehabilitation process (Mzolo, 2015:2).

Sub-theme 2.2: Lack of support from government

Lack of support from the government has been identified as another contributing factor to relapse. The users felt that there are no programmes that assist them in maintaining abstinence after treatment. The users outlined lack of recreational activities and poor support from social workers after treatment. It has been proven through research that a lack of aftercare services is associated with relapse (McKay, 2001:9).The following statements are representative of the contributions of the participants regarding this aspect:

> *"What can help me is that I should attend group sessions…"*

"The government can help me with programmes after rehab."

"The government can build us recreational facilities and sporting grounds."

"I want a chance to attend group sessions and spend the whole six weeks at a rehab."

It is well stated in the NDMP that in demand reduction the focus is on preventing the on-set of drug usage, eliminating all conditions/ factors that may test an individual to use substances (DSD, 2013:62). Hence, the participants have stressed the importance of having recreational activities in their communities of which they feel they are lacking in the Hammanskraal community.

Sub-theme 2.3: Personal problems

Users are overwhelmed by challenges they face in their own lives, their families and in societies they live in. Users resort to smoking *nyaope* to cope with their problems and to ease their burdens. The identified problems include financial challenges and spousal relationships. Due to the pleasurable state of relaxation that comes after the smoking of the drug, users view the drug as a solution to their problems. The following statements are representative of the contributions of the participants regarding this aspect:

"I have financial problems; I have children I have to feed at home and accounts to pay."

"I had a girlfriend and we had problems, so a thought crossed my mind for me to go and see my old friends and took two puffs, then I got hooked again."

"I am a bread winner, I do not have support for these type of things, somewhere I get stressed by all this."

The above finding concurs with the statement that pre-clinical studies have found that stress exposure, in addition to drug itself, is a potent stimulus in reinstating drug seeking behaviour in dependant people (Sinha, 2001:350). The researcher can therefore conclude that personal problems can be included as a cause of relapse after treatment. This was also confirmed in a study on adolescents that substances are used in order to deal with socio-emotional challenges (Geyer, Le Roux & Hall, 2015:33).

Sub-theme 2.4: Being around friends who are addicted to *nyaope*

During the interviews the participants highlighted that they are influenced by their friends to go back to their smoking habits. These results concur with the findings of the research that was conducted by Lebese et al. (2014) where peer pressure has

been identified as a contributing factor to substance abuse. Some of the participants' views include the following:

> *"When I am there my friends smoke … And then I decided to join my friends and smoke."*

> *"…a thought crossed my mind for me to go and see my old friends and took two puffs, and then I got hooked again."*

The literature highlights that if the family fails to give acceptance to the user, the user will turn to other means in order to meet this need (Bezuidenhout & Joubert, 2003:43). As a result peers strongly influence the users' decision to revert back to drug abuse (Van der Westhuizen & De Jager, 2009:81). The findings of this research reiterate the above statement, namely that peer relationship plays a role in substance abuse. Consequently, when the *nyaope* user comes back to the same environment with same friends they are bound to trigger the craving (Mzolo, 2015: 40).

Sub-theme 2.5: Psychologically or mentally unprepared for treatment

It has also been highlighted by the participants that they were coerced to go for treatment by their families and parents. They stressed that it is crucial for the user to go to the treatment centre voluntarily. The seriousness and level of determination of the user to quit the drug will yield positive results. Some of the participants' views are:

> *"For you to quit, it must come from your heart, it has to come from within you."*

> *"I was not ready in my heart. It is like I was forced to quit nyaope. I was still very much in love with it before I was taken to a treatment centre."*

> *"I was really addicted, it did not come from me to get rehabilitated."*

As the disease theory of addiction states clearly that the acceptance of the disease concept makes it easier for some people to enter treatment, lack of readiness as identified by the participants will obviously lead to relapse because the users have not accepted the fact that they have a chronic illness. Thus it is mentioned that acceptance of the disease concept could encourage *nyaope* users to allow the recovery process to take place (West, 2005:78).

Sub-theme 2.6: Going back to the same environment after receiving treatment

Participants have shared a great frustration with regards to their environment. The fact that after going to a treatment centre they go back to the same environment discourages many of them. Some are even discouraged from going to treatment because they have witnessed their peers relapsing after treatment. The following

statements are representative of the contributions of the participants regarding this aspect:

> *"My relapse was caused by coming back to the same streets."*
>
> *"Even the last time, I relapsed because I came back to the same friends, they continued with their smoking, that is the reason I ended up smoking again."*
>
> *"When I am sitting alone at home I become bored and broke, then I decided to go back to the streets and hustle."*

The NDMP stipulates that demand reduction is important and should focus on, eliminating all conditions/ factors that may test an individual to use substances (DSD, 2013:62). Furthermore, the Cognitive Behavioural Model explains that if a substance dependent individual has gone through a rehabilitation process and he/she returns to the same environment, relapse could be triggered (Nelson, 2012:123). The above findings show a lack of implementation of this particular strategy as outlined in the NDMP, in the community of Hammanskraal.

Next, the needs for reintegration into the community are discussed.

Theme 3: Needs for reintegration into the community

The participants' needs for reintegration into the community have been identified as a change of lifestyle after successful completion of treatment, they require trust from the community, volunteering opportunities and eliminating theft/stealing from community members.

Sub-theme 3.1: Change of lifestyle after successful completion of treatment

The participants highlighted that in order for them to be reintegrated back into the community, they need to change their lifestyles after treatment. This can be achieved when aftercare programmes are in place and in operation to prevent relapse. After completion of treatment, participants need recreational opportunities to keep them occupied. Recreational facilities are amongst the best strategies that can be easily used to combat substance abuse amongst teenagers (Lebese et al., 2014:342). Members of the community will be able to allow them back into the community if they witness that they have changed. The following statements are representative of the contributions of the participants regarding this aspect:

> *"I think [what I need to do is] to change my lifestyle because when you smoke there are certain things you do that you will not be doing when you have smoked nyaope."*
>
> *"The community will welcome you when you have changed your lifestyle."*

> *"What I can do is to go back to church when I come from rehab and not go back to my same old life."*

Life skills, including anger management, refusal skills and relaxation, could support the addicted person in his/her effort to prevent relapse and to adapt to a sober lifestyle (Van der Westhuizen & De Jager, 2009:83). Once the *nyaope* user has adapted a sober lifestyle he/she can be best reintegrated into the community. Other researchers speak of environmental protective factors that can be implemented in curbing drug use in communities; suggestions include recreational activities and centres (Geyer et al., 2015:332).

Sub-theme 3.2: Require trust from the community

The users highlighted the importance of gaining trust from community members. The users acknowledged the fact that communities have lost trust in them because they steal from them. Participants stressed the fact that if they can eliminate stealing from their neighbours, they can regain that trust. It is evident that the *nyaope* users steal in order to feed their habit of smoking. They feel that if the community members trust them, it will encourage them to quit. Community members have lost hope in the *nyaope* users. As a result they blame them for every crime that is committed in their communities. The following statements capture the contributions of the participants:

> *"... it makes people lose trust in you, because you steal their money."*

> *"You can never be a good person in the eyes of the community when you are smoking nyaope."*

> *"The community will welcome you when you have changed your lifestyle, that is why I am a changed person."*

The social repercussions of *nyaope* include being shunned by their communities due to the criminal element, dropping out of school and poor future prospects (Mokwena & Huma, 2014:359). However, a lack of acceptance by the community is associated with labelling, which can alienate users, putting them at risk and therefore contributing to relapsing (Van der Westhuizen et al., 2013:9). Therefore, it is important for *nyaope* users to be trusted by community members.

Sub-theme 3.3: Require volunteering opportunities or opportunities for community service

The users highlighted that they would like to merge with non-profitable organisations that work with the youth, children, victims of abuse and substance abuse that could keep them busy, whilst they are still looking for tertiary education opportunities or employment opportunities. Users want to create awareness amongst children at local schools and the community surroundings. The following are the contributions of the participants:

> *"I now want to start something in the community; I want to be an aerobics instructor for women. I will do this for free. I see it as my way of giving back to the community."*

> *"They must also invite me to be part of their motivational talks at local schools*."

> *"They must involve us, we can tell other children about what drugs can do to people and to a person's body*."

Due to the addictive nature of *nyaope*, it is easy for individuals to get hooked on the drug. Hence, awareness campaigns and school health prevention and promotion should be initiated and strengthened in combating addiction (Lebese et al., 2014:343). Other researchers concur with the above statements by indicating that awareness campaigns could safeguard young people against drug use (Geyer et al., 2015:333). Furthermore, education and empowerment to communities can keep community members focused and the youth will not be easily hooked on drugs. DSD implements the *Ke-moja* programme that focuses on providing and encouraging role modelling of individuals who encourage resistance to drug use (Makhubela, 2015).

The next theme is about the participants' needs to maintain abstinence.

Theme 4: Needs for support in order to maintain abstinence

The needs of users to maintain abstinence were identified as change of lifestyle following treatment, family support after treatment, group sessions after treatment and aftercare programmes after treatment.

Sub-theme 4.1: Change of lifestyle following treatment

The value of a healthy lifestyle to increase self-efficacy must be noted (Van der Westhuizen & De Jager, 2009:85). The findings obtained from *nyaope* users concur with the above statement. *Nyaope* users need to change the type of lifestyle they were living before going for treatment and adopt a more conducive and healthy lifestyle. This includes surrounding oneself with positive people and keeping busy. Some of the participants' views have been quoted below:

> *"It is staying positive and the fact that I have friends who call me into order when I am out of line."*

> *"When I come back from [the] treatment centre, they can help me with programmes. If something does come up, they must let me know, something like plumbing and electrical opportunities."*

> *"The community will welcome you when you have changed your lifestyle."*

It is mentioned in Nelson (2012:128) that it is important to maintain a balanced lifestyle. This might mean having a good balance between work and family life, sleeping well, eating healthy and exercising regularly to be able to cope as much as possible with everyday stressors. Service users should focus on maintaining a balanced lifestyle and be aware of when their lifestyle is becoming unbalanced (Nelson, 2012:128). The Cenaps model of relapse prevention stresses that total abstinence plus personality and lifestyle change are essential for full recovery (Fisher & Harrison, 2013:120).

Sub-theme 4.2: Family support after treatment

Family support was highlighted to be an important element that contributes positively to an individual to maintain sobriety after treatment. This finding concurs with the views of Van der Westhuizen et al. (2011:364) that family members can support one another, they are able to communicate openly and honestly, and resolve conflict, they are able to change destructive behaviours in the family, family bonds are strengthened, and the user is provided with emotional and practical support when dealing with cravings. Nevertheless, family members need to be included and educated with regards to giving support to a *nyaope* user. Some of the participants' views have been quoted below:

> *"You know if your family members stop judging you and support you, you also become strong emotionally."*
>
> *"We need support, a lot of support from our parents."*
>
> *"I need my parents to believe in me, give me all the necessary support."*

Families and parental factors contribute towards the capacity of the substance dependent persons to overcome any challenges ahead of them (Maluleke, 2013:86). Equally, a family should be viewed as an integral part of aftercare services, considering the facts that the addiction occurred in the family, that the family could have participated in and perpetuated the addiction, that addiction harmed the family, and that the family is an important potential treatment and recovery source (Van der Westhuizen et al., 2013:8). Therefore, family therapy can be of utmost importance for families with a person addicted to *nyaope* in treatment centres as families could also learn coping mechanisms and how to support their adolescents (Mzolo, 2015: 15).

Sub-theme 4.3: Group sessions after treatment

The users also stressed the importance of attending group sessions post treatment. The users identified the need for self-help groups such as Narcotics Anonymous that are not available in Hammanskraal. These groups can assist them to form new, healthy, interpersonal relationships and to learn to function in the community (Van der Westhuizen & De Jager, 2009:84). Many of the participants felt that talking to

someone about the problem of substance abuse helped them to ease the burden. Therapy, as part of aftercare services, should be available, and focused on information and referrals, family therapy, skills to deal with cravings, forming of new perceptions, and the development of life skills (Van der Westhuizen & De Jager, 2009:86). Some of the participants' views include the following:

> *"We also need to come to aftercare group sessions to avoid relapse."*
>
> *"What can help is that I should attend group sessions…"*
>
> *"Attending pre-sessions and attending more sessions after finishing treatment."*

Section 31 of the Prevention of and Treatment for Substance Abuse Act 70 of 2008 makes provisions for the establishment of support groups, in that service users and persons affected by substance abuse may, as prescribed, establish support groups that focuses on integrated ongoing support to service users in recovery (Swanepoel, 2014:35).

Sub-theme 4.4: Aftercare programmes following treatment

The users emphasised that if the government can implement an adequate aftercare programme, relapse after treatment can be prevented. The aftercare programme they are longing for must include therapeutic intervention from social workers after treatment. Another important element that was stressed was that a skills development centre should be available where participants could enhance their skills. The views of the participants included the following:

> *" ...then you can be able to take me back to a treatment centre and when I come back, go for security guard training and obtain a certificate, I will keep busy."*
>
> *"When I come back from the treatment centre they can help me with programmes."*
>
> *"All I want to add is that all they can do is to get me [application] forms or skills development centres…"*

The literature review has divulged that a lack of or poor aftercare services is associated with drug relapse (McKay, 2001:213). Conversely, participants are longing for adequate aftercare programmes as indicated in the views above. The importance of prescribing integrated aftercare and reintegration services aimed at the successful reintegration of a service user into society, the workforce and family and community life has also been outlined in the Prevention of and Treatment of Substance Abuse Act 70 of 2008, Section 30; nonetheless, the findings of the research indicate that it has not yet been achieved and a lot still needs to be done.

The next theme will be discussing the findings on the recommendations from service users.

Theme 5: Recommendations from service users

Nyaope users are well aware of the high relapse rate after treatment. They expressed their views on what they think should be done at treatment centres and after discharge. They recommended that the duration of treatment should increase, jobs opportunities should be created and be accessible for them after treatment and that they require spiritual support from pastors during and after treatment.

Sub-theme 5.1: Increase the duration of treatment

It is without doubt that the duration of the treatment is frustrating many *nyaope* users. However, the six weeks that is allocated at the government treatment centre is too little in their views. The majority of the participants that were interviewed accessed their treatment at a government treatment centre. They feel that due to the extent of their addiction, it takes a bit longer for the drug to be successfully detoxified from their systems. There is a strong believe that if the duration of the treatment can be increased from 6 weeks to six months or more, positive results can be yielded. The following statements are representative of the contributions of the participants regarding the aspect:

> *"I am not satisfied with the duration of the treatment."*
>
> *"The treatment period was too little. I needed more than 6 weeks, I was an addict."*
>
> *"People are not happy with the treatment they receive there, the food, the staff and the duration of the treatment, that place is 'kak'."*

Considering the increase in the demands for treatment, an adequate treatment period and ongoing aftercare services are vitally important in preventing relapse and ensuring the maintenance of recovery (Van der Westhuizen & De Jager, 2009:77). As mentioned by the authors, an adequate treatment period is essential, the users feel that the given treatment period currently is inadequate. Research has shown unequivocally that good outcomes are contingent on adequate treatment length (Swanepoel, 2014:65).

Sub-theme 5.2: Create job opportunities and make them accessible for users after treatment

Unemployment has dire consequences for families and communities who are plagued by *nyaope* use (Mokwena & Morojele, 2014:380). Creating employment opportunities for users who have successfully finished treatment is seen to be among other solutions. Nonetheless, taking *nyaope* users to an aftercare programme

that is inclusive of skills development will make job opportunities accessible for the users as well. The participants voiced their views as follows:

> *"They must help me with employment and school, tertiary education."*
>
> *"I must place my focus in school and finding a job for me to keep busy and doing eight things."*
>
> *"When you are working, you can concentrate on your job, there is a slight possibility that you can go back to drugs."*

Participants are aware of the fact that employment opportunities would keep them away from the streets and their addict ways, hence it is mentioned that poverty is a contributory factor to *nyaope* use (Mokwena & Fernandes, 2014:43). It is mentioned that strong collaboration between community structures and government departments are needed to address the challenges posed by the negative social environment, which include addressing the unemployment rate in predominantly black communities (Mokwena & Morojele, 2014:381).

Sub-theme 5.3: Spiritual support from spiritual leaders

Nyaope users feel that they need spiritual support at the treatment centre and when they are also discharged from the centre. They believe that the restoration of their relationship with a Higher Power will give them courage and peace that will help them in remaining sober. They indicated that spiritual support should be incorporated as part of the healing process at the treatment centre and continued to aftercare. The following statements are representative of the contributions of the participants regarding this aspect:

> *"If only they can open a church for users to have some relationship with God, have spiritual upliftment."*
>
> *"Now I wish that God can help me become a better person…I can become a better person and start attending church and community meetings."*
>
> *"That place needs God because people get admitted and then relapse."*

This finding concur with the statement of the authors that addressing spiritual needs of the addicted person is a part of total recovery from the addiction, and spirituality gives the user hope and confidence (Van der Westhuizen & De Jager, 2009:87). The positive outcome of one's spirituality is determined in the study that was conducted by Mason, Deane, Kelly and Crowe (2009: 1934) that higher spirituality is associated with abstinence self-efficacy. Furthermore over 80% of participants in the same study considered that spirituality would be helpful in the maintenance of recovery,

completion of the treatment programme and help to prevent a relapse (Mason et al., 2009:1935).

In the next session the views of significant others will be identified and discussed.

3.9.2 Section 2: Significant others[1]

Sub-section 1: Biographical information

TABLE 3: BIOGRAPHICAL INFORMATION OF THE SIGNIFICANT OTHERS

Participants	1	2	3	4	5	6
Gender	Female	Male	Female	Female	Female	Female
Age	40	50	56	58	71	40
Racial group	Black	Black	Black	Black	Black	Black
Home language	IsiZulu	Venda	Sepedi	Sepedi	IsiZulu	Xitsonga
Relationship to the user	Mother	Father	Mother	Mother	Grandmother	Sister
Current round of treatment for your significant other	Fifth	Sixth	Second	Third	Third	Second
Treatment received at a government of private centre	Government	Government and private	Government	Government	Government	Government

The biographical information of the significant others reveals a majority of participants to be female. It shows that all participants are mother figures to the *nyaope* users. Their significant others received treatment mostly at a government treatment centre and their significant others have all relapsed from initial treatment. The participants' age ranged between 40 to 71, and all identified themselves as Black. They were from the Sepedi, isiZulu, Tshivenda and Xitsonga tribe.

[1] It should be noted that the significant others were not necessarily direct family with the participants reported on in Section A.

Sub-section 2: Themes and sub-themes

This sub-section discusses the data from the significant others as classified into themes and sub-themes. The themes and sub- themes are outlined below:

TABLE 4: PRESENTATION OF THEMES AND SUB-THEMES OF SIGNIFICANT OTHERS

Themes	Sub-themes
Theme 1: Impact of *nyaope* on the family	Sub-theme 1.1: Subjects/victims of theft Sub-theme 1.2: Experience disappointment and hurt Sub-theme 1.3: Experience distress about their significant others' whereabouts Sub-theme 1.4: Lack of communication among family members
Theme 2: Causes of relapse	Sub-theme 2.1: Lack of educational programmes Sub-theme 2.2: Lack of employment Sub-theme 2.3: Lack of spiritual support Sub-theme 2.4: Lack of adequate aftercare programmes Sub-theme 2.5: Being around friends who are addicted to *nyaope*
Theme 3: Needs for reintegration into the community	Sub-theme 3.1: Volunteering opportunities Sub-theme 3.2: Change of lifestyle Sub-theme 3.3: Trust from community
Theme 4: Type of support needed to maintain abstinence	Sub-theme 4.1: Emotional support Sub-theme 4.2: Spiritual support Sub-theme 4.3: Psychosocial support

DISCUSSION

Theme 1: Impact of *nyaope* on the family

The significant others of *nyaope* users have identified the impact that *nyaope* have on them and the family as subjects/victims of theft, experience disappointment and hurt, experience distress about their significant others' whereabouts and lack of communication among family members.

Sub-theme 1.1: Subjects/victims of theft

The significant others have indicated that their families are victims of theft due to the nature of stealing that is associated with *nyaope* use. *Nyaope* users do not start stealing in the neighbourhood but start at their homes. They steal all valuable materials with the purpose of selling them and securing money to feed their addiction. Some of the participants' views are quoted below:

> *"…he takes my dishes and sells them, more especially electrical appliances."*

> *"It affects us because sometimes when we complain about him stealing from us, our parents do not take it well."*

> *"We discovered that the clothes we bought for him went missing, we discovered that he sells them in order to feed his addiction."*

The above statements by the participants are also evident in another study by Mokwena and Huma (2014:358) which indicated that *nyaope* users steal anything that they can lay their hands on, including shoes, blankets and meat from their families. Contrary, there was only one participant who felt strongly with regards to the issue of a diversion programme. Her view is quoted below:

> *"It must not be voluntarily, it should be through a binding court order, the user will have rules that he needs to abide to but if he goes voluntarily it will be easy for him to discharge himself."*

However, if *nyaope* users are arrested after their criminal behaviour, the court can refer offenders to treatment centres through diversion programmes (Skosana, 2014:5). A person who has committed a crime qualifies for a diversion programme once she/he has admitted to a crime, making amends for what they have done and initiating a healing process for themselves, their families, the victims and the community.

Sub-theme 1.2: Experience disappointment and hurt

Parents have certain expectations from their children. Every parent wishes that his/her child will be a successful person. *Nyaope* deprives parents an opportunity to experience a success of a child. Parents are disappointed and always experience psychological distress when they think about their children's addiction. The following statements are representative of the contributions of the participants regarding the aspect:

> *"It hurts us a lot. If you have a child who smokes, it also feels as if you are also smoking and [are] addicted."*

> *"…I had big dreams for my son, I wanted him to go to tertiary and become an independent person, but now it will not happen"."*

> *"It hurts me because his future is ruined."*

The above findings confirm that often family members of those who are actively addicted experience high degrees of anger, fear, hurt, abandonment, guilt and hopelessness (Giordano et al., 2014:121). Family members may choose to distance themselves from individuals who abuse substances, and/or individuals who abuse substances may choose to isolate themselves from their families. However, the findings of that study suggest that strengthening family bonds is beneficial in the treatment of clients with substance abuse problems (Giordano et al., 2014:121).

Sub-theme 1.3: Experience distress about their significant others' whereabouts

The participants indicated that they always experience distress when their children leave the house in the morning. They worry about what will happen and whether they will return home. *Nyaope* users are involved in criminal activities and communities end up taking law into their own hands through mob justice. Some of the participants' views are quoted below:

> *"You become worried about your child who is a nyaope user because a lot of things can happen to him; he could be beaten up by community members."*
>
> *"It hurts because if something bad happens to him at the place where he smokes, we will not know."*
>
> *"He left the comfort of his own bed to sleep on [the] ground at the train station, all because of nyaope."*

It is indicated that parents may experience stress if they don't know where their child is or if he/she is still alive (Marimuthu, 2015:84). It is with no doubt that family members play an important role in the lives of those who abuse drugs. It often becomes difficult for families to assist in this regard, if the user has left home. Hence it is indicated that drug abuse is associated with a high level of unpredictability and therefore drug users may disappear for days on end without contacting their families (Barnard, 2005:14).

Sub-theme 1.4: Lack of communication among family members

Participants have stressed the fact that having a family member who is addicted to *nyaope* can ruin relationships among family members. There is a lot of anger from other family members that leads to fighting in the family. Some family members resort to stopping communication with the user in a form of maintaining peace. The following statements are representative of the contributions of the participants regarding the aspect:

> *"They feel that we are excluding him from the family, so this causes quarrels and fights in the family."*
>
> *"Eh, there is no peace in the family; we just treat each other with silence…"*
>
> *"My husband works in Kimberley, he does not even talk to these two anymore."*

In a study by Chetty (2011:24) it is stated that the lack of family support is also seen as a major factor contributing to relapse. The relapse is often due to a lack of communication and ineffective interaction between the substance abuser and his/her

family. Conversely, the above statements proves that the immediate family's normal lifestyle may be severely disrupted (Marimuthu, 2015:84)

The next theme will be discussing the causes of relapse.

Theme 2: Causes of relapse

The participants identified the causes of relapse as the lack of educational programmes, lack of employment, lack of spiritual support and lack of adequate after care programmes.

Sub-theme 2.1: Lack of educational programmes

The participants stressed that a lack of educational programmes in communities contributes to relapse. The significant others refer to vocational training facilities to educational programmes that *nyaope* users can go to after treatment. They stress that it is important that these opportunities must be accessible, meaning that *nyaope* users should be able to attend for free. Some of the participants' views are quoted below:

> *"It is by taking him to school."*
>
> *"I thought that they received some kind of life skills training for them to forget about nyaope and that environment."*
>
> *"What can be done is that he must get a school, I don't know if there is a school or college that he can go to for free."*

In the Prevention of and Treatment of Substance Abuse Act 70 of 2008 it is outlined as one of the strategies that individuals will be equipped with additional skills to maintain their treatment gains, sobriety and avoid relapse. Therefore, the above finding by the significant others of *nyaope* users concur with the statement by Makhubela (2015) that policies take time to be implemented into practice. Additionally, it has been highlighted that educational facilities are the best tool that should be provided to communities to help in the fight against substance abuse among users (Lebese et al., 2014:341).

Sub-theme 2.2: Lack of employment

Unemployment has been said to be contributing dearly to substance abuse. The participants mentioned that they want the government to assist in providing job opportunities to users after they have finished treatment. The following statements are representative of the contributions of the participants regarding the aspect:

> *"He can be best supported by getting him a job when he comes back from the treatment centre."*
>
> *"If it is not education then it has to be employment opportunities."*

> *"…So if the government can have an aftercare programme, and create jobs, maybe these people might change."*

The Drugs and Drug Trafficking Act 140 of 1992 states clearly that people must be equipped with additional skills to maintain abstinence and avoid relapse. Therefore literature states that in recent years, South Africa has experienced high unemployment rates for persons aged between 15 and 64, and although there are slight quarterly variations, the overall country unemployment rate remains at 25% (Mokwena & Morojele, 2014:375). The above statements by the significant others concurs with the statements by other researchers that drug abuse increase one's chances of losing employment and it also decreases the chances of gaining employment (Mokwena & Morojele, 2014:380).

Sub-theme 2.3: Lack of spiritual support

The participants have identified that *nyaope* users relapse because they lack spiritual support. The reason for the lack of spiritual support is that many *nyaope* users do not attend church once they become addicted. It is difficult for pastors of churches to reach out to them because they distance themselves from such institutions. The participants offered the following inputs:

> *"This family is affiliated to the Zion Christian Church but my son does no longer go/attend to church."*

> *"Every time he went out, I tried telling him that he must not go back to the same group of friends, he should go to church every Sunday. I tried my best."*

> *"That [treatment centre] needs God; their relationship with God needs serious rekindling."*

Gossop (in Masombuka, 2013:94) explains that the early teachings of the Christian church played a significant role in minimising the use of drugs. Hence, *nyaope* users felt that lack of spiritual encouragement can lead to further relapse. However, the practice of spirituality within one's daily routine is significant to solidifying a foundation for a positive recovery cycle (Morris, Johnson, Losier, Pierce & Sridhar, 2013:80).

Sub-theme 2.4: Lack of adequate aftercare programmes

The participants mentioned that they witnessed relapse of their significant others due to the fact that when they come back from treatment they roam around the same streets and go back to the same friends. Nonetheless, if the government can introduce an aftercare programme that could keep the users occupied, the participants felt that the high relapse rate could be prevented. The following statements are representatives of the contributions of the participants regarding the aspect:

> *"If there is an aftercare programme he will be able to choose what he wants to do…"*
>
> *"If he can have something to keep him busy during the day, he can become clean."*
>
> *"So if the government can have an aftercare programme and ask them what is it they want and create jobs, maybe these people might change."*

The Prevention of and Treatment of Substance Abuse Act 70 of 2008 highlights the fact that substance users need to be put in a form of aftercare and reintegration service. Contrary, as it now stands, DSD social workers are expected to offer aftercare and reintegration groups for *nyaope* users who have completed the treatment programme. However, such groups are challenged by poor attendance of members (Makhubela, 2015). It is evident by statements by the significant others that the said aftercare programme is lacking in the Hammanskraal community.

Sub-theme 2.5: Being around friends who are addicted to *nyaope*

The participants have also highlighted the fact that friendships contributed negatively to *nyaope* users. Furthermore, it has been said that there is a lot of negativity amongst friends who smokes *nyaope* with regards to receiving treatment. Some of the participants' views are quoted below:

> *"He had to ruin it when his friends were constantly dropping by to check on him."*
>
> *"… because when he comes from the treatment centre he goes back to the same friends and do the same things they used to do."*
>
> *"When he comes back from rehab he comes back to the same environment, so there is no use."*

The Cognitive Behavioural Model explains that after a substance dependent individual has gone for a rehabilitation process, if he/she comes back to the same environment he/she has been occupying before the process, relapse could be triggered (Larimer, Palmer & Marlatt, 1999:12). In another study, the influence of friends and other associates was seen as an external locus of control that is always blamed for the initial taking of the drug or continued use of the drug (Mokwena & Fernandes, 2014:47).

Next, the needs for reintegration into the community are discussed.

Theme 3: Needs for reintegration into the community

The needs for reintegration into the community has been identified as that users need volunteering opportunities, they require change of lifestyle, eliminating stealing from communities and trust from communities.

Sub-theme 3.1: Volunteering opportunities

It has been identified that users need to be given volunteering opportunities so that they can be able to regain the trust from community members. In this regard volunteering opportunities are associated with creating awareness of *nyaope* to other children in the community. Some of the participants' views are:

> *"If he can talk to the community, when he came back from treatment the first time, he went to schools and motivated learners."*
>
> *"They must for example clean churches or NGO's so that he regain trust from the community."*
>
> *"I want my child to be allowed to talk to other children in the community, tell them about the results [consequences] of nyaope."*

As stated in the Prevention of and Treatment of Substance Abuse Act 70 of 2008, Section 30, service users should be allowed to share long-term sobriety experiences. Such experiences can be shared in awareness campaigns that are often delivered in local schools and the community at large. This is viewed to can yield positive results on the user as it can help in rebuilding their lives and reintegrating into society (Gossop et al., 2007:59).

Sub-theme 3.2: Change of lifestyle

The significant others indicated that for the users to be reintegrated back into the communities, a change of lifestyle is required. As it has been mentioned earlier that drug abuse is associated with criminal activities. Conversely, the significant others indicated that when *nyaope* users stop stealing from their community members, it will become easy for them to be trusted again. *Nyaope* users need to live life positively after receiving treatment. However, it is important that the substance-dependent persons assume new roles and responsibility when they have been reintegrated into the community (Maluleke, 2013:30). Some of the participants' views have been quoted below:

> *"He can be reintegrated back to the community if he change his ways."*
>
> *"His behaviour must change and he must get a job."*
>
> *"They will see that he has changed when he no longer roaming around the streets and when he does what is expected of him."*

The Cognitive Social Learning Model is applicable in this regard, as it primarily emphasises the importance of maintaining a balanced lifestyle. This might mean having a good balance between work and family life, sleeping well, eating healthy and exercising regularly to be able to cope as much as possible with everyday stressors. According to the model, service users should focus on maintaining a balanced lifestyle and be aware of when their lifestyle is becoming unbalanced (Nelson, 2012:128). Community members will be able to allow users back into the community if they are completely changed persons.

Sub-theme 3.3: Trust from community

It has been indicated that the only thing that hinders the users to be reintegrated into communities is lack of trust from community members. *Nyaope* users require trust after successful treatment. Among other things, change of life style, cutting relationships with fellow *nyaope* friends and eliminating theft has been identified to help in regaining that trust. The participants shared the following views:

> *"The boys are no longer trusted in the community, they are blamed for everything."*
>
> *"They will see that he has changed when he is no longer roaming around the streets and when he does what it is expected of him."*
>
> *"If only community members can trust them, maybe they can be motivated to quit, 'nyaopers' are not easily trusted, they have to change in order to be trusted again."*

Communities often view substance abusers as negative influences and distance themselves leaving the recovering substance abuser feeling rejected and isolated. However, community members form an essential part that could assist users to reach full recovery. Hence, it is mentioned that incorporation of the community in educative processes can sustain discipline and generate collaborative strategies to resolve social problems like drug abuse and crime (Chetty, 2015:60) Communities should therefore change their thinking and embrace the substance abuser following treatment as a new member into their fold and guide the person and prevent further abuse (Chetty, 2011:24).

Next, type of support that is needed by *nyaope* users in maintaining abstinence is discussed.

Theme 4: Type of support needed to maintain abstinence

The significant others have identified that *nyaope* users require help in order for them to maintain abstinence. They highlighted the needs for support to be emotional, spiritual and psychosocial.

Sub-theme 4.1: Emotional support

Emotional support is required from the family in order to maintain abstinence. Significant others of *nyaope* users need to be included in the healing process of the user. It is important for parents to be involved in their children's lives, not only to meet the financial needs and not being there to attend to the emotional needs. However, families need training and support to be able to support *nyaope* users (Van der Westhuizen et al., 2011:364). Some of the participants' views are:

> *"We need to stop cursing him and calling him names. Instead we should sit down with him and try to show him the way."*
>
> *"He needs to get support from us but he must be willing to get healed from addiction ways."*
>
> *"He must receive the best support from us his parents, support from both of us."*

The above findings concur with the finding by Maluleke (2013:86) that family involvement and support form part of aftercare and reintegration services. Additionally, when a family motivates the user by inhibiting the sponsorship of drugs and using derogatory words to demotivate the user, then that can enable that person to change (Swarthout, 2016:150).

Sub-theme 4.2: Spiritual support

The participants continued to discuss the needs of their significant others to be spiritual intervention in order to maintain sobriety. Spiritual support and the users' involvement in church activities and spiritual growth are vital elements and could help the users to remain clean. Some of the participants' views have been quoted below:

> *"He needs to follow me to church."*
>
> *"Church can keep him busy because he will be encouraged there."*
>
> *"My son's behaviour needs God's intervention; I believe God will help him this time so that he remains clean from nyaope."*

In another study it is indicated that when parent realise that their children's addiction problem is persisting despite talking to them, they tried to get religious help from faith-based organisations (Masombuka, 2013:93). The above statement concurs with the findings of this research that spiritual support is beneficial in maintaining abstinence of *nyaope* users. Spiritual activities are a valuable factor contributing to successful completion of therapy (Morris et al., 2013:79).

Sub-theme 4.3: Psychosocial support

The participants also highlighted the importance of psychosocial support for *nyaope* users. The majority indicated that psycho-therapy should be offered pre and post-treatment during group sessions. This finding concurs with the statement by Meyer (2005:292) that treatment of substance addiction should include preparation for treatment, treatment itself and also aftercare services to ensure that the addicted individuals develop skills to maintain sobriety. Some of the participants' views are:

> "*They can give him advices and coaching on life in general."*
>
> *"These children need to attend group sessions after rehab."*
>
> *"I want social workers to advice him, make him see that what he is doing is wrong."*

Conversely, social welfare services in general has the statutory obligation to provide aftercare and reintegration services to promote the clients acquisition of housing an work or education, after discharge, actively and to ensure that the client acquires personal support or treatment in order to 'exit' from substance dependency (Ekendahl, 2009:260).

In the next session, the researcher will triangulate the data obtained from significant others and *nyaope* users.

3.9.3 Section 3: Triangulation of research findings

The researcher had two data samples, the *nyaope* users and the significant others. Similarities and differences of the data will be discussed below.

3.9.3.1 Sub-section 1: Similarities of data from *nyaope* users and significant others

One similarity between two sets of participants is that *nyaope* addiction is encouraged by friendships. It has been clear that *nyaope* users are introduced to *nyaope* by friends. Similarly, friends also play another role in leading a treated user to relapse. Consequently, going back to the same environment after receiving treatment has been identified by both participant groups as a risk factor to relapse. Going back to the same environment constitute to the users living the same lifestyle they were living before going to a treatment centre. Moreover, the above identified risk factors for relapse can be overcome by an aftercare programme. The participants are longing for support from the government in curbing the scourge of *nyaope* use. Thorough intervention by the government will mean that an aftercare programme inclusive of life skills programme and therapeutic intervention after treatment. Thus creating employment opportunities that will be accessible to the users after treatment with the aim of keeping them busy is seen as an amicable solution.

Another similarity that has been identified is the fact that the users need spiritual intervention in order for them to maintain abstinence. Some participants indicated that spiritual intervention should be inclusive from the early stages of treatment, in the pre-session to the treatment centre and to the aftercare programme. The participants also identified emotional support both from the family and the government. However, the emotional support from the government has been identified that it must come from social workers who will provide counselling after users receive treatment.

Both participant groups indicated that they require to be trusted by community members. In achieving that they suggested that users be given volunteering opportunities after treatment and that they must eliminate stealing from the community. It was also suggested that communities should be included in the recovery process of *nyaope* users.

3.9.3.2 Sub-section 2: Differences of data from *nyaope* users and significant others

Nyaope users have identified an important element that some of them were taken to treatment centres with the pressure from parents and that they were not ready to quit the drug. Significant others of users are hurt and frustrated by the users' addiction and they end up coercing them to get the necessary help to quit the drug even when they are not ready. Furthermore, personal problems were cited as another cause of relapse among *nyaope* users. It was indicated by the significant others that *nyaope* users should be placed in a diversion programme. One significant other felt that *nyaope* users should be admitted to a treatment centre through a binding court order as a way of preventing relapse as stated in the Prevention of and Treatment of Substance Abuse Act 70 of 2008, Section 33.

It has been identified that the duration of treatment is too short according to the *nyaope* users.

3.10 SUMMARY

The study afforded the researcher an opportunity to explore and identify the aftercare needs of *nyaope* users, specifically in the physical, psychosocial and behavioural domains, who have relapsed after initial treatment in Hammanskraal from both the users' and the significant others' points of view. The participants viewed the causes of relapse after treatment as lack of educational programmes, lack of employment, lack of spiritual support, lack of adequate aftercare programmes and being around friends who are addicted to *nyaope.*

The participants were able to identify their needs in order to maintain abstinence from the physical, psychosocial and behavioural domain. The participants identified emotional support from the family and the government, spiritual support, psychosocial support, change of lifestyle after treatment, strong medication during

detoxification at the treatment centre, aftercare programmes after treatment, increasing the duration of treatment and creation of job opportunities and making them accessible to the users after treatment as their most important needs to avoid relapse.

The triangulation of data assisted the researcher to grasp the aftercare needs from the users' points of view as well as the significant others' points of view ideally.

In Chapter 4 the focus will be on the key findings of the study, the conclusions and recommendations.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This chapter concludes the mini-dissertation. The researcher will offer a summary of the whole research process and draw conclusions from the findings and make recommendations for aftercare and reintegration services to *nyaope* users in the Hammanskraal community and for future studies. This chapter will also highlight whether the research questions are answered or not.

4.2. RESEARCH GOAL AND OBJECTIVES

The **goal** of the study was to explore and describe the aftercare needs of *nyaope* users from both the users' and the significant others' points of view in Hammanskraal.

The goal of the study was reached through accomplishing the following **research objectives**:

- **Objective 1**: To contextualise aftercare and reintegration services delivered to *nyaope* users in South Africa.

The in-depth literature review focused on *nyaope* addiction and aftercare and reintegration services to users in South Africa. In Chapter 2 the researcher accomplished the objective by contextualising the aftercare and reintegration services delivered to the *nyaope* users by highlighting the prevalence and the extent of *nyaope* use in South Africa. The national policies and legislation mandating and regulating aftercare and reintegration services were discussed, specifically the National Drug Master Plan 2013-2017, the Prevention and Treatment of Substance Abuse Act 70 of 2008 and the Drugs and Drug Trafficking Act 140 of 1992. The policies indicated the programmes and services to be rendered to the *nyaope* users in South Africa.

- **Objective 2:** To describe the aftercare and reintegration services available to *nyaope* users in Hammanskraal.

This objective was also accomplished in Chapter 2 where the researcher focused on services that are offered to *nyaope* users in Hammanskraal by describing the different services rendered by NGOs and the Department of Social Development. Based on the literature review in Chapter 2, it was established that the period after leaving treatment has a high risk of relapse and adequate support should therefore be provided in order to sustain the positive progress made during treatment. As the duration of treatment is limited, and due to the chronic nature of addiction, a person is not able to maintain the progress they have made. Aftercare services are designed

for individuals who have already completed treatment. However, in the South African context, the value of aftercare/reintegration services has been downplayed and there has been relatively little emphasis in both research and practice. Thus it has been discovered that SANCA Hammanskraal offers individual counselling, group therapy, family therapy and extensive utilisation of self-help groups as their strategy to deliver aftercare/re-integration programmes.

- **Objective 3:** To identify the aftercare needs of *nyaope* users, specifically in the physical, psychosocial and behavioural domains, who have relapsed after initial treatment in Hammanskraal from both the users' and the significant others' points of view.

The empirical study was carried out through a collective case study design where semi-structured interviews were used to collect data with the aim of answering the two research questions. Six *nyaope* users and six significant others were interviewed at Hammanskraal to a point of data saturation.

The objective was accomplished as evident in Chapter 3 of the study.

- **Objective 4:** To make recommendations to relevant role players pertaining to the aftercare and reintegration needs of and service delivery to *nyaope* users in the Hammanskraal community.

The research objective was met as indicated in paragraph 4.5 of this chapter where the researcher makes recommendations to practice and future research.
This study aimed to answer two research questions, namely:

1. "*Based on the views of nyaope users, what are the aftercare needs of nyaope users in the Hammanskraal community?*"
2. "*Based on the views of significant others, what are the aftercare needs of nyaope users in the Hammanskraal community?*"

The two questions of the study were successfully answered as indicated in the next section, namely the key findings.

4.3 KEY FINDINGS

Below are the key findings from the literature review, and the empirical data from the *nyaope* users and the significant others with regard to the aftercare needs of *nyaope* users.

4.3.1 Key findings from literature

The following are the key findings from the literature review in Chapter 2:

- The youth of South Africa are suffering morally, socially, psychologically and physically because of substance abuse.
- *Nyaope* is easily accessible on the streets of South African townships.
- The NDMP was designed to bring together government departments and other stakeholders in the field of substance abuse to combat the use and abuse and dependence forming substance and related problems. In the NDMP aftercare and reintegration services is categorised as harm reduction strategies.
- The Prevention of and Treatment of Substance Abuse Act 70 of 2008 outlines that the minister, in consultation with other ministers and organs of state will prescribe integrated aftercare and reintegration service aimed at the successful reintegration of a service user into society, the workforce, family and community life.
- SANCA believed that the classifying of *nyaope* as an illegal drug would lead to the arrest and conviction of people dealing in *nyaope*; thus reducing the availability of *nyaope* on the streets.
- Relapse is conceptualised as a road to recovery/mitigating the harm associated with substance addiction.
- Treatment for substance addiction by itself is not sufficient to ensure abstinence.
- The DSD has a duty in fighting drug abuse/addiction in the country. Currently the DSD is funding well established skills development centres with a specific focus on unemployment and vulnerable youth as the targeted service users.
- SANCA has been one of the leading NGO in the field of substance abuse, prevention and treatment offering a variety of prevention, education and treatment services.

4.3.2 Key findings from the *nyaope* users

The following are the key findings from interviews with the *nyaope* users of the Hammanskraal community.

- *Nyaope* impacts negatively on the physical well-being of the users in a manner that it interferes with crucial physical developmental tasks.
- *Nyaope* impacts negatively on the psychological well-being of the users in a sense that users see and hear things that are not there, namely hallucinations.
- *Nyaope* impacts negatively on the users' social well-being as the addiction creates distance and lack of communication in the families of *nyaope* users.
- Addiction to *nyaope* impacts negatively on the users' relationship with a Higher Power; *nyaope* users lose spirituality and a relationship with a God.
- A number of causes of relapse have been identified, such as:
    - Not having adequate support from family members.
    - Lack of support from the government.
    - Personal problems that the users encounter during the recovery process.

- Going back to the same group of friends and the same environment after receiving treatment.
- The majority of the users indicated that they are coerced to go for treatment by their parents while they are still fond of the drug, hence the high relapse rate.

- The users indicated that they value the trust from the community that is often lost and feel that if they can acquire the trust of the community they can be reintegrated into the community. The *nyaope* users added the following:
  - The users felt that they can regain the trust of the community if they change their lifestyle after treatment; as a result, they can be reintegrated into the community.
  - The users also felt that they can regain the trust of the community members if they can be given volunteering opportunities. Users want to create awareness to children at local schools and the community surroundings.
- Users made the following recommendations with regards to them staying in total abstinence following treatment.
  - *Nyaope* users need to change the type of lifestyle they were living before going for treatment and adopt a more conducive and healthy lifestyle.
  - Family support was highlighted to be another important element that contributes positively to an individual to maintain abstinence after treatment.
  - The users also stressed the importance of attending group sessions post treatment.
  - The users emphasised that if the government can implement an adequate aftercare programme, relapse after treatment could be prevented.
  - In addition the users recommended that the duration of treatment should be increased to avoid relapse.
  - Creating employment opportunities for users who have successfully finished treatment, was seen to be another solution.
  - *Nyaope* users felt that they need spiritual support at the treatment centre and when they are also discharged from the centre.

4.3.3 Key findings from significant others

The following are the key findings from interviews conducted with the significant others of *nyaope* users in Hammanskraal.

- The significant others have indicated that their families are victims of theft, due to nyaope users' stealing to sustain their habits.
- A feeling of disappointment and hurt has been highlighted among significant others of *nyaope* users.
- Drug abuse is associated with unpredictability, disappearing acts is common among the users. *Nyaope* also impacts negatively on the relationships in the family in a manner that there is a lack of communication and ineffective interaction among family members and the *nyaope* user.

- The significant others have identified that relapse is caused by:
  - Lack of educational programmes in communities.
  - The high unemployment rate has been cited to cause relapse among *nyaope* users.
  - A lack of spiritual support for the users. *Nyaope* users loses their relationship with a Higher Power once they become addicted on the drug. They distance themselves from religious institutions and it becomes difficult for spiritual leaders to reach out to them.
  - Inadequate aftercare programmes.
  - Return to the same community and friends after receiving treatment, trigger relapse.
- The significant others of the users have indicated that *nyaope* users need volunteering opportunities in the community as a form of reintegration services.
- The significant others have also indicated that *nyaope* users need to change their life style after receiving treatment in order to regain the trust of the community.
- Significant others of *nyaope* users have made recommendations with regards to what is required for *nyaope* users to maintain abstinence following treatment:
  - *Nyaope* users need emotional support from the family.
  - They also require spiritual support from spiritual leaders.
  - Psychosocial support has also been indicated to be essential.

4.4 CONCLUSIONS

Conclusions will be drawn from the key findings from the literature, the *nyaope* users and the significant others, respectively.

4.4.1 Conclusions from literature

- Substance abuse contributes to other health and social challenges like crime, stigma, being shunned and engaging in risky sexual behaviour which increases vulnerability of HIV infections.
- Despite the criminalisation of *nyaope*, it is still supplied in the townships.
- Despite the development of the NDMP, the country is still facing an increasing number of users who are using/abusing *nyaope*.
- Although it is explicitly stated in policy documents, i.e. The Prevention of and Treatment of Substance Abuse Act 70 of 2008, it may still be argued that the government still lack practicality. It is mentioned as it now stands at DSD, aftercare and reintegration services are not currently fully operational although the policies state and stress the importance of aftercare.
- The use of *nyaope* is increasing continuously in the townships of South Africa despite the illegalisation of *nyaope* as a drug and was confirmed by SANCA.
- One of the greatest problems in substance abuse treatment is preventing relapse after abstinence has been achieved.
- Aftercare, ongoing support and reintegration services are essential components of successful interventions.

- Due to a lack of a standardised referral system and specialised aftercare programmes for *nyaope* users at DSD, the success rate seems to be unsatisfactory.
- *Nyaope* users from Hammanskraal are accessing the outpatient programme at SANCA.

4.4.2 Conclusions from *nyaope* users

- *Nyaope* impacts negatively on the well-being of users as it causes serious bodily harm.
- The chronic use of substance can cause serious, sometimes irreversible, damage to the user's psychological development, e.g. hallucinations.
- Addiction to *nyaope* hinders the user's interaction with significant others.
- Dealing with a *nyaope* user who has no relationship with a Higher Power can be detrimental, hence it could be important to include spiritual support at a treatment centre.
- Addressing the identified causes of relapse could ensure long-term recovery of the users:
  - Limited involvement of the whole families impacts negatively on the users.
  - The government's efforts in curbing the scourge of substance abuse are inadequate in the community of Hammanskraal.
  - Psychosocial problems hinder the recovery process to take place.
  - Returning to the same environment after treatment is not conducive for recovering addicts as drugs are easily accessible.
  - The users' willingness to undergo treatment could be beneficial in avoiding relapse.
- *Nyaope* users value the trust of the community and this could be used to develop an appropriate aftercare programme for users and to reintegrate them back into the community.

4.4.3. Conclusions from significant others

- The criminal activity of *nyaope* users result in them being shunned and shamed by family members.
- Parents are disappointed and experience psychological distress when they think about their children's/significant others' addiction; in essence psychological intervention is also required for families.
- Families are deprived from functioning to their optimum level due to one family members' addiction to *nyaope*.
- The identified causes of relapse are:
  - The unemployed youth are tempted to resort to drug abuse in dealing with the boredom that comes with unemployment and lack of educational activities.
  - It seems that vocational training and job opportunities ought to be prioritised by government to help recovering addicts to remain sober.

- The practice of spirituality within one's daily routine is significant to solidifying a foundation for a positive recovery cycle.
- Aftercare programmes are challenged with poor monitoring by management and there is a general poor attendance of available aftercare services.
- Change of lifestyle equates dismantling old friendships which triggers cravings and results in relapse.

- It seems important that the substance-dependent person assumes new roles and responsibilities when they have been reintegrated into the community, so that they can regain trust of community members.
- Among other things, change of life style, dismantling old friendships and eliminating theft has been identified to help in regaining trust.
- The significant others of *nyaope* users have made recommendations with regards to what is required for nyaope users to stay in total abstinence that could be used to design appropriate aftercare and reintegration services.

Recommendations for future research and practice are discussed in the next session.

4.5. RECOMMENDATIONS

Recommendations are presented in two sub-sections. *Firstly*, recommendations to relevant role players pertaining to the aftercare and reintegration needs of *nyaope* users in the Hammanskraal community. *Secondly*, recommendations for future research are presented in another section.

4.5.1 Recommendations to relevant role players on aftercare and reintegration services

- Education and awareness in communities on the impact of *nyaope* use should be a core element for the prevention of relapse as these were prioritised by the participants.

- Due to the fact that *nyaope* users are shunned and shamed by community members due to their smoking habits, it is crucial for communities to be educated on reintegration services of *nyaope* users and its benefits to the recovery process.

- Family members need to be empowered through life skills education in preparation for them to be part of the recovery process of the *nyaope* user.

- Involvement of religious institutions should be strengthened. The role/impact of spirituality and religion be investigated and be incorporated into the aftercare and reintegration programme.

- The Department of Sports and Recreation should create recreational activities that will keep the youth occupied during the day.

- The Department of Public Works should create employment opportunities and make them accessible to *nyaope* users following treatment. For example, deliberately linking them to the EPWP.

- The South African Police Services should work on reducing the quantity of drugs available on the streets of Hammanskraal; the suppliers of *nyaope* must be arrested and prosecuted.

- Social workers need to receive capacity building workshops that stress the importance of aftercare services to addicted persons and empower them with the necessary knowledge and skills to deliver appropriate aftercare and reintegration services.

- The Department of Social Development should consider increasing the duration of treatment from six weeks to a more adequate period, for example, six months because a high relapse rate is witnessed following the six weeks period, allegedly due to the treatment period being too short.

- More referrals to a treatment centre should be done through a diversion programme or through section 33 of the Prevention of and Treatment of Substance Abuse Act 70 of 2008, i.e. admission of involuntary service users to treatment centre to ensure that users complete the treatment period.

- Awareness programmes should be strengthened where *nyaope* users who have completed treatment will raise awareness at local schools.

- The Department of Social Development should deliver a clear aftercare and reintegration programme and monitor it as it should aim at teaching life skills and coping strategies to *nyaope* users.

- Emotional support to nyaope users should be provided by both social workers and significant others.

4.5.2 Recommendations for future research

It is recommended that:

- The current study be expanded beyond Hammanskraal to other townships in order to undertake comparative studies in South Africa.
- The current study was on a small and exploratory scale; therefore other studies are required on a larger scale that would make it possible for the generalisation of findings.

- More scientific research needs to be conducted by research councils, such as the HSRC, on *nyaope*, aftercare and reintegration for researchers to access reliable literature on *nyaope*, aftercare and reintegration services.
- More research needs to be conducted where all ethnic groups are considered in order to reflect the demography of the diverse population of South Africa.
- Future research needs to be conducted and target female users to obtain their perspectives as well.
- Through intervention research an effective aftercare and reintegration programme for *nyaope* users in the Gauteng Province, and the rest of South Africa, could be developed and standardised.

REFERENCES:

Adewuyi, T.D. & Akinsola, E.F. 2013. Age and peer influence on substance abuse among undergraduates. *Ife Psychologia*, 21(2):83-90.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC: American Psychiatric Association. Available: http://www.dsm5.org/pages/default/aspx (Accessed 2015/09/040).

Babbie, E. 2004. *The practice of social research.* 10th ed. Wadsworth; Thomson Learning.

Babbie, E. 2008. *The practice of social research*. 4th ed. Wadsworth: Thomson Learning.

Babbie, E. & Mouton, J. 2001. *The practice of social research.* New York: Oxford University Press.

Barnard, M. 2005. *Drugs in the family: The impact on parents and siblings.* New York: Joseph Rowntree Foundation.

Bernard, H.R. 2000. *Social Research Methods: Qualitative and Quantitative Approaches.* California: Sage.

Bezuidenhout, C. & Joubert, S. 2003. *Child and youth misbehaviour in South Africa*: *A holistic approach.* Pretoria: Van Schaik.

Braun, V. & Clarke, V. 2006. Using thematic analysis in Psychology. *Qualitative Research in Psychology,* 3(2):77-101.

Bryman, A. 2011. Triangulation. *Encyclopaedia of Social Science Research Methods,* 1:1142-1185.

Burnhams, N.H. & Parry, C. 2015. The state of interventions to address substance-related disorders in the South African workplace: implications for research, policy and practice. *South African Journal of Psychology*, 1(13):1-13.

Centre for Substance Abuse Treatment. 2005. Substance abuse relapse prevention for older adults: a group treatment approach. Available: http://www.ncadi.samha.gov (Accessed 2015/09/08).

Chetty, R. 2015. Social complexity of drug abuse, gangsterism and crime in Cape flats' schools, Western Cape. *South African Journal of Criminology*, 1(3):54-65.

Chetty, M. 2011. *Causes of relapse post treatment for substance dependency within the South African Police Services*. Pretoria: University of Pretoria. (MSW Mini-Dissertation).

Chibambo, M. (Socdevcommunications@gauteng.gov.za). 2014/04/28. *An innovation by the department to meet the shortage of social infrastructure.* E-mail to Sonto Mahlangu (Sontomahlangu@gauteng.gov.za).

Chinouya, M., Rikhotso, S.R., Ngunyulu, R.N., Peu, M.D., Mataboge, M.L.S., Molaudzi, F.M. & Jiyane, P.M. 2014. 'Some mix it with other things to smoke': perceived use and misuse of ARV by street thugs in Tshwane District, South Africa. *African Journal for Physical, Health Education, Recreation and Dance,* 1(1):113-126.

Clarke, V. & Braun, V. 2013. Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist,* 26(2):120-123.

Creswell, J.W. 2009. *Research Design: Qualitative, Quantitative and Mixed Methods Approaches*. 3rd ed. London: Sage.

Creswell, J.W. 2007. *Qualitative inquiry and research design: choosing among five approaches.* 2nd ed. California: Sage.

Dada, S., Burnhams, N.K., Erasmus, J., Parry, C., Bhana, A., Timol, F. & Fourie, D. 2015. Alcohol and drug abuse trends: January 1996 - June 2014 (Phase 39). *South African Epidemiology Network on Drug Use* (SACENDU).Available: http://www.mrc.ac.za.adarg/sacendu/sacenduupdateJune. (Accessed 2016/10/13).

Dada, S., Erasmus, J., Burnhams, N.H., Parry, C., Bhana, A., Timol, F., Fourie, D., Kitshoff, D., Nel, E. & Weimann, R. 2015. Monitoring alcohol, tobacco and other drug abuse trends in South Africa (July - December 2014). *South African Community Epidemiology Network on Drug Use* (SACENDU), 18(1):1-18.

Dada, S., Burnhams, N. M., Johnson, K., Parry, C., Bhana, A., Timol F., & Fourie, D. 2014. Alcohol and drug abuse trends: January-June 2014 (Phase 36). *South African Community Epidemiology Network on Drug Use* (SACENDU). Available: http:// www.sahealthinfo.org/admodule/sacendu/UpdateJune2012.pdf (Accessed: 2015/08/11).

Dada, S., Burnhams, N. H., Parry, C., Bhana, A., Timol, F., Wiford, A., Fourie, D., Kitshoof, D., Welmann, R. & Johnson, K. 2014. SACENDU Research Brief. *South African Community Epidemiology Network on Drug Use* (SACENDU), 16(2):1-16.

Dada, S., Plűddemann, A., Parry, C., Bhana, A., Nawda, M., Perreira, T., Nel. T, Mnwabe, T., Peltzer R.I. & Welman, R. 2012. Monitoring alcohol & drug abuse trends in South Africa. *South African Community Epidemiology Network on Drug Use* (SACENDU), 15(1):1-16.

Denzin, N. & Lincoln, Y.S. 2011. *The SAGE handbook of qualitative research.* California: Sage.

Department of Social Development. 2015. *Department of Social Development Annual Performance Plan 2015-16.* Available:

http://www.socdev.gpg.gov.za/...final%20annual%20 perfomance%20report (Accessed 2016/10/11).

Department of Social Development. 2014. Department of Social Development Annual Performance Plan 2014-2015. Available: http://www.socdev.gpg.gov.za/...final%20annual%performance%20report (Accessed 2015/08/08).

Department of Social Development. 2013. *National Drug Master Plan 2013-2017.* Available: http://www.dsd.gov.za/index*2.php?.php=comdocman&task=docview&gid=414&itemid=3 (Accessed 2014/02/12).

De Vos, A.S., Strydom, H., Schulze, S. & Patel, L. 2011. The sciences and the professions. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots: for the social sciences and human service professions.* 4th ed. Pretoria: Van Schaik.

Drugs and Drug Trafficking Act 140 of 1992 (Published in the *Government Gazette*, (33601) Pretoria: Government Printer).

Ekendahl, M. 2009. Alcohol abuse compulsory treatment and successive aftercare: A qualitative study of client perspectives. *International Journal of Social Welfare.* 18(1): 260-269.

Emmelkamp, P.M.G. & Vedel, E. 2006. *Evidence based treatment for alcohol and drug abuse: A practitioner's guide to theory, methods and practice*. New York: Taylor and Francis.

Fakier, N. & Myers, B. 2008. Alcohol and drug abuse research unit. *Audit of substance abuse treatment facilities in Free State, Limpopo, Mpumalanga, North West & Northern Cape (2007-2008): Technical report.* Cape Town: Medical Research Council.

Fisher, G.L. & Harrison, T.C. 2013. *Substance abuse: Information for school counsellors, Social Workers, Therapists and Counsellors*. 5th ed. Boston: Pearson.

Fouché, C.B. & Delport, C.S.L. 2011. Introduction to the research process. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. In De Vos, A. S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Geyer, S., Le Roux, L., & Hall, H. 2015. Exposure to substance use in the social environment: The experiences of adolescents in the Tshwane metropole. *The Social Work Practitioner-Researcher*, 27(3):322-343.

Ghosh, P. 2013. *Nyaope:* cheap drug cocktail ravaging black townships of South Africa. Available: http://www.16times.com/nyaope-cheap-drug-cocktail-review (Accessed on 2015/10/24).

Giordano, A.L., Clarke, P.B. & Furter, R.T. 2014. Predicting substance abuse relapse: the role of social interest and social bonding. *Journal of Addictions and Offender Counselling*, 35(1):114-127.

Gorski, T.T. 2001. Adolescent relapse prevention. Available: http://tgorski.articles/adolescent (Accessed 2015/09/08).

Gossop, M., Stewart, D. & Marsdan, J. 2007. Attendance at narcotics anonymous meetings, frequency of attendance and substance use outcomes after residential treatment for drug dependence: a five year follow up study. *Addiction,* 103:119-125.

Grant, L. 2014. Interactive graphic: SA's drugs of choice. *Mail & Guardian*. 03 July:4.

Grobler, H. 2009. *Social work case work: Only study guide for SCK 3016/WFC 301L*. Pretoria: University of South Africa.

Gülseçen, S. & Kubat, A. 2006. Teaching ICT to teacher candidates using PBL: A qualitative and quantitative evaluation. *Educational Technology & Society*, 9(2):96-106.

Hammwebacher, M. & Lyvers, M. 2015. Factors associated with relapse among clients in Australian substance disorder treatment facilities. *Relapse factors,* 11(6):387-394.

Hodza, F. 2014. Localising the fight against illicit drug use in South Africa: a social development policy masterstroke?. *OIDA International of Sustainable Development,* 7(10):33-44.

Jeewa, A. & Karasim, M. 2008. Treatment for substance abuse in the 21st century: a South African perpective. *SA Family Practice*, 50(6):44.

Kheswa, J. & Tikimana, S. 2015. Criminal behaviour, substance abuse and sexual practices of South African adolescent males. *Journal of Psychology*, 6(1):10-18.

Khine, A.A., Mokwena, K.E., Huma, M. & Fernandes, L. 2015. Identifying the composition of street drug nyaope using two different mass spectrometer methods. *African Journal of Drug & Alcohol Studies.* 14(1):50-56.

Larimer, M.E., Palmer, R.S. & Marlatt, G.A. 1999. Relapse prevention: an overview of Marlatt's cognitive-behavioural model. *Alcohol Research & Health*, 23(2):151-160.

Lebese, R.T., Ramakuela, N.J. & Maputle, M.S. 2014. Perceptions of teenagers about substance abuse at Muyexe village, Mopani district of Limpopo Province,

South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, 1(2):329-347.

Lietz, C.A., Langer, C.L. & Furman, R. 2006. Establishing trustworthiness in qualitative research in social work. Implications from study regarding spirituality. *Qualitative Social Work,* 5(4):441-458.

Lötter, R. 2010. *Significant others experiences of coming out process of a lesbian individual*. Pretoria: University of Pretoria. (MA Mini-Dissertation).

Louw, A. 2009. Personality Development. In Louw, D & Louw, A. (Eds). *Adult Development and Ageing*. Bloemfontein: University of the Free State.

Makhubela, R.M. 2015. Interview with social worker, Department of Social Development. 17 March. Soshanguve.

Maluleke, B. 2014. SANCA fights substance abuse in Hammanskraal. *Hammanskraal News.*13 March: 3.

Maluleke, T.F. 2014. Perceptions of social workers regarding their role in aftercare and reintegration services with substance-dependent persons. Pretoria: University of Pretoria. (MSW Mini-Dissertation).

Maiden, R.P. 2008. Substance abuse in the new South Africa. *Employee Assistance Quartely,* 14(3):41-60.

Marimuthu, B.A. 2015. 'An emotional rollercoaster': Vignetters of family members of illicit drug users. *Southern African Journal of Criminology,* 3(1):83-95.

Masombuka, J. 2013. *Children's addiction to the drug "nyaope" in Soshanguve township*: *Parents experiences and support needs*. Pretoria: University of South Africa. (MA Dissertation).

Mason, S.J., Deane, F.P., Kelly, P.J. & Crowe, T.P. 2009. Pilot study: Spirituality and Religiosity. *Substance Use & Misuse*, 44(1):1926-1940.

Mawoyo, T. 2011. An assessment of the sustainability of substance abuse organisations in South Africa. Cape Town: University of Cape Town. (MA Dissertation).

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

Merriam, S.B. 2009. *Qualitative research and evaluation methods.* 3rd ed. California: Sage.

Miller, M., Gorski, T.T. & Miller, D.K. 2002. *Learning to live again: A guide for recovery from alcoholism*. New York: Warner Books.

Mohasoa, I.P. & Fourie, E. 2012. Substance abuse amongst adolescents: A case study of Zeerust, North West Province, South Africa. *New voices in Psychology*, 8(1):30-43.

Mokwena, K.E. & Fernandes, L. 2014. Exploring the role of external locus of control in the use of nyaope: a qualitative enquiry. *Botswana Journal of African Studies,* 28(1):41-50.

Mokwena, K.E. & Huma, M. 2014. Experiences of *'nyaope'* users in three provinces of South Africa. *African Journal for Physical, Health Education, Recreation and Dance,* 1(2):352-362.

Mokwena, K. & Morojele, N. 2014. Unemployment and unfavourable social environment as contributory factors to nyaope use in three provinces of South Africa. *African Journal for Physical, Health Education, Recreation and Dance*, 1(2):374-384.

Molefe, J.M. 2015. Interview with Social Worker, Department of Social Development. 26 February. Themba.

Montesh, M., Sibanda, O.S., Basdeo, V. & Lekubu, B.K. 2015. Illicit drug use in selected high schools in Mamelodi Township. *South African Journal of Criminology*, 3(1):96-113.

Moodley, S.V., Matjila, M., & Moosa, M.Y.H. 2012. Epidemiology of substance use among secondary school learners in Atteridgeville, Gauteng. *SAJP,* 18(1):4-9.

Morris, D.N., Johnson, A., Losier, A., Pierce, M. & Sridhar, V. 2013. Spirituality and substance abuse recovery. *Occupational Therapy in Mental Health*, 29(1):78-84.

Mudhovozi, P., Maunganidze, L., Maseko, M., Ngwenya, F. & Netshikweta, L.M. 2014. Patterns of substance abuse among high school students. *African Journal for Physical, Health Education, Recreation and Dance,* 1(2):348-358.

Mudavanhu, N. & Schenck, R. 2014. Substance abuse amongst the youth in Grabouw Western Cape: voices from the community. *Social Work/Maatskaplike Werk*, 50(3):370-391.

Myers, B. & Fakier, N. 2009. Provision of mental health services in South African substance abuse treatment facilities. *International Journal of Mental Health and Addiction*, 7:441-449.

Myers, B. & Fakier, N. 2007. *Alcohol and drug abuse research unit. Audit of substance abuse treatment facilities in Gauteng and KwaZulu Natal (2006-2007): Technical report.* Cape Town: Medical Research Counsel.

Myers, B., Harker, N., Kader, R. & Mazoko, C. 2008. *A review of evidence based interventions for the prevention and treatment of substance use disorders.* Cape Town: Medical Research Council.

Myers, B. J., Louw, J. & Pasche, S. C. 2010. Inequitable access to substance abuse treatment services in Cape Town. *Substance Abuse Treatment Policy,* 5(28):15-19.

Myers, B., Louw, J. & Fakier, N. 2008. Alcohol & drug abuse: removing structural barriers to treatment for historically disadvantaged communities in Cape Town. *International Journal of Social Welfare,* 17:156-165.

Myers, B & Parry, C.D.H. 2005. Access to substance abuse treatment services for black South Africans: findings from audits of specialist treatment facilities in Cape Town and Gauteng, *South African Psychiatry Review*, 8(15):15-19.

Mzolo, M.P. 2015. Exploring family support for adolescents after rehabilitation for drug abuse. Pretoria: University of South Africa. (MA Dissertation).

Namathe, M.F. 2012. *Role of social development in combating substance abuse.* Available: http://www.safmh.org.za//images/socialdevelopment+substanceabuse.pdf (Accessed 2015/08/12).

National Institute on Drug Abuse. 2014. *Drug facts: Understanding Drug Use and addiction*. Available: https:www.drugabuse.gov/publications/drugfacts/un. Accessed 2016/09/05).

Nelson, A. 2012. *Social work with substance users*. Los Angeles:Sage.

Nxumalo, Z. & Gare, L. 20145. Community tourism in Hammanskraal (Gauteng). Available: http://www.gttp.org/wp-content/upload/2015/08/04/SAP (Accessed 2016/10/12).

Open Disclosure Foundation. 2016. Mission possible. Available: http://www.opendisclosure.org.za/content.html (Accessed 2016/02/12).

Parry, C., Morojele, N., Myers. B. & Plűddeman. R. 2011. Addiction research centres and nurturing of creativity. The alcohol and drug abuse research unit at the South African Medical Research Counsel-strengthening substance abuse research and policy in South Africa. *Addiction*, 108:14-19.

Patton, M.Q. 2002. *Qualitative research and evaluation methods.* 3rd ed. California: Sage.

Penguin Dictionary of Psychology. 2009. 4th ed. Rosebank: Penguin Books.

Popovici, I., French, M.T. & McKay, J.R. 2008. Economic Evaluation of Continuing Care Interventions in the Treatment of Substance Abuse: Recommendations for Future Research*. Evaluation Review,* 32(6):547-568*.*

Prevention of and Treatment for Substance Abuse Act 70 of 2008 (Published in the *Government Gazette*, (32150) Pretoria: Government Printer).

Republic of South Africa. 1997. Ministry for Welfare and population development. *White Paper for Social Welfare*. (Notice 1108 of 1997. *Government gazette,* 386(18166). Pretoria: Government Printer).

Rough, K., Dietrich, J., Essien, T., Grelotti, D.J., Bansberg, D.R., Gray, G & Katz, I.T. 2013. Whoonga and the abuse and diversion of Antiretrovirals in Soweto, South Africa. *AIDS Behav*,18 (1):1378-1380.

SANCA Pretoria. 2012. Castle Carey clinic: rehabilitation centre for substance abuse. Available: http://www.addictionrehab.co.za.treatmentprogrammes (Accessed 2015/09/05).

Schurink, C.B., Fouché, C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Shembe, Z.T. 2013. The effects of whoonga on the learning of affected youth in Kwa-Dubeka Township. Pretoria: University of South Africa. (MA Dissertation).

Sihna, R. 2001. How does stress increase risk of drug abuse and relapse?. Psychophamacology(Berl), 158 (1): 343-359.

Skosana, J. 2014. Ivory Park's operation "thiba nyaope" provides support for addicts and their affected families. *Mail & Guardian*, 6 June: 36.

South African Community Epidemiology Network on Drug Use. 2012. Monitoring Alcohol and Drug Abuse Treatment Admissions in South Africa: Phase 33. Available: http://www.sahealthinfo.org/admodule/sacendu/sacenduphase33.pdf (Accessed 2015/09/02).

Stabilis Treatment Centre. 2016. Our Programmes. Available: http://www.stabilis.org.za (Accessed 2016/02/12).

Strydom, H. 2005. The pilot study in the quantitative paradigm. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 3rd ed. Pretoria: Van Schaik.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Strydom, H. & Delport, C.S.L. 2011. Sampling and pilot study in qualitative research. In De Vos, A.S. (Ed.), Strydom, H., Fouché, C.B. & Delport, C.S.L. *Research at grass roots for the social sciences and human service professions*. 4th ed. Pretoria: Van Schaik.

Swanepoel, I. 2014. The causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province. Pretoria: University of Pretoria. (MSW Mini-Dissertation).

Swarthout, J. 2016. Getting a loved one started in recovery: invitational intervention. Available: www.fireengineering.com (Accessed 2016/08/22).

Terreblanche, M., Durrheim, K., & Painter, D. 2006. *Research in Practice: Applied Methods for the Social Science.* 2nd ed. Cape Town: Cape Town University Press.

Thomas, R. 2014. Abuse of antiretroviral drugs combined with addictive drugs by pregnant women is associated with adverse effects in infants and risk of resistance. *SAJCH*, 8(2):18-79.

Thothela, S., Van der Wath, A.E. & Janse van Rensberg, E.S. 2014. Factors contributing to relapse of mental health care users treated for substance induced psychotic disorder in a psychiatric hospital in Gauteng, South Africa. *African Journal of Nursing and Midwifery*, 16(1):15-88.

United Nations Office on Drugs and Crime. 2014. *The World Drug Report 2014*. New York: UN Printers.

Van der Westhuizen, M.A. 2007. *Relapsing after treatment: exploring the experiences of chemically addicted adolescents*. Pretoria: University of South Africa. (MA Dissertation).

Van der Westhuizen, M.A. 2010. *Aftercare to chemically addicted adolescents: Practice guidelines from a social work perspective*. Pretoria: University of South Africa. (DPhil Thesis).

Van der Westhuizen, M., Alpaslan, A. & De Jager, M. 2011. Preventing relapses amongst chemically addicted adolescents: exploring the state of current services. *Social Work/Maatskaplike Werk*, 47(3):350-370.

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

Van der Westhuizen, M. & De Jager, M. 2009. Relapsing after treatment: exploring the experiences of chemically addicted adolescents. *Social Work/Maatskaplike Werk*, 45(1):76-90.

Weich, L., Perkel, C., Van Zyl, N., Rataemane, S.T. & Naidoo, L.2008. Medical Management of opioid dependence in South Africa. *South African Medical Journal,* 98(4):280-283.

West, R. 2005. *Theory of addiction.* Oxford: Blackwell Publishing.

World Health Organization. 2009. *Improving health systems and services for mental health*. Geneva: World Health Organisation.

Yin, R.K. 2003. *Case study research: Design and methods.* 3rd ed. Thousand Oaks. Sage.

APPENDIX A

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

27 November 2015

Dear Prof Lombard

Project:	**The aftercare needs of Nyaope users in the Hammanskraal community**
Researcher:	**S Mahlangu**
Supervisor:	**Dr LS Geyer**
Department:	**Social Work and Criminology**
Reference number:	**25433572 (GW20151129HS)**

Thank you for the application that was submitted for ethical consideration.

I am pleased to inform you that the above application was **approved** by the **Research Ethics Committee** on 26 November 2015. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Karen Harris
Acting Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail:Karen.harris@up.ac.za

Kindly note that your original signed approval certificate will be sent to your supervisor via the Head of Department. Please liaise with your supervisor.

APPENDIX B

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Humanities
Department of Social Work & Criminology

INFORMED CONSENT FORM: PERSON USING NYAOPE

Researcher: Sonto Mahlangu
Tel. Numbers: Cell: 076 7271 371
Office: 012 730 0173

Participant's name: _____

1. **Title of the study:** The aftercare needs of *nyaope* in the Hammanskraal community.
2. **Purpose of the study:** The goal of the study is to explore and describe the aftercare needs of *nyaope* users from both the users' and significant others' points of view.
3. **Procedures:** I agree to take part in this study. I expect to be interviewed by the researcher one-on-one and my responses will be recorded and later transcribed, documented and analysed. I am aware that the interview will not take more than an hour of my time.
4. **Risks and harm:** There are no physical risks in participating in the study; however, I am aware that the information I am going to share with the researcher might cause emotional distress for me. The researcher is obliged to refer me to a counsellor/social worker at the Department of Social Development or SANCA Hammanskraal for counselling (should I require further counselling).
5. **Benefits:** I understand that there are no financial benefits for participating in this study. However, the results of the study will assist the researcher to gain a better understanding of the aftercare needs and reintegration services of *nyaope* users in the Hammanskraal community.
6. **Participant's rights:** I am aware that participation in this study is voluntarily and that I can withdraw at any time should I wish to do so without any negative consequences and I am not coerced by the researcher to participate.
7. **Confidentiality:** I am aware that the interview be recorded with an audio recorder. The recording will only be listened to by the researcher (Sonto Mahlangu) and she will not disclose my name or identity in her research findings.

I am well aware of the aim of the study and that the researcher will use the research findings for the submission of a mini-dissertation for her master's degree. The findings of this study may be published in a journal or presented at a conference.

I am aware that, in accordance with University of Pretoria policy, the data will be archived for a period of 15 years in the Department of Social Work and Criminology.

I hereby consent voluntarily to participate in the above project.

Department of Social Work & Criminology
Room 10-21.1, Level 10, Building
University of Pretoria, Private Bag X20
Hatfield 0028, South Africa
Tel +27 (0)12 420 2325/2030
Fax +27 (0)12 420 2093
Email Antoinette.lombard@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Signed at _____ on this_____ day of _____201___

_____ _____

Signature of participant Signature of researcher

APPENDIX C

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA
Faculty of Humanities
Department of Social Work & Criminology

INFORMED CONSENT FORM: SIGNIFICANT OTHER OF A PERSON USING NYAOPE

Researcher: Sonto Mahlangu
Tel. Numbers: Cell: 076 7271 371
Office: 012 730 0173

Participant's name: _____

1. **Title of the study:** The aftercare needs of *nyaope* in the Hammanskraal community.
2. **Purpose of the study:** The goal of the study is to explore and describe the aftercare needs of *nyaope* users from both the users' and significant others' points of view.
3. **Procedures:** I agree to take part in this study. I expect to be interviewed by the researcher one-on-one and my responses will be recorded and later transcribed, documented and analysed. I am aware that the interview will not take more than an hour of my time.
4. **Risks and harm:** There are no physical risks in participating in the study; however, I am aware that the information I am going to share with the researcher might cause emotional distress for me. The researcher is obliged to refer me to a counsellor/ social worker at the Department of Social Development or SANCA Hammanskraal for counselling (should I require further counselling).
5. **Benefits:** I understand that there are no financial benefits for participating in this study. However, the results of the study will assist the researcher to gain a better understanding of the aftercare needs and reintegration services of *nyaope* users in the Hammanskraal community.
6. **Participant's rights:** I am aware that participation in this study is voluntarily and that I can withdraw at any time should I wish to do so without any negative consequences and I am not coerced by the researcher to participate.
7. **Confidentiality:** I am aware that the interview be recorded with an audio recorder. The recording will only be listened to by the researcher (Sonto Mahlangu) and she will not disclose my name or identity in her research findings.
8. **Deception of participants:** I am well aware of the aim of the study and that the researcher will use the research findings for submission of a mini-dissertation for her master's degree. The findings of this study may be published in a journal or presented at a conference.

I am aware that, in accordance with University of Pretoria policy, the data will be archived for a period of 15 years in the Department of Social Work and Criminology.

I hereby consent voluntarily to participate in the above project.

Department of Social Work & Criminology
Room 10-21.1, Level 10, Building
University of Pretoria, Private Bag X20
Hatfield 0028, South Africa
Tel +27 (0)12 420 2325/2030
Fax +27 (0)12 420 2093
Email Antoinette.lombard@up.ac.za

Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Signed at _____ on this_____ day of _____201___

_____ _____

Signature of participant Signature of researcher

APPENDIX D

INTERVIEW SCHEDULE: PERSON USING NYAOPE

Semi-structured interview: The aftercare needs of *nyaope* in the Hammanskraal community.

Section A: Demographic information

1. Gender: _____
2. Age: _____(years)
3. Racial group: _____
4. Religion/spirituality(if any): _____
5. Home language: _____
6. Number of children in the family of origin:_____
7. Position in the family structure (e.g. first born):_____
8. Employment status:_____
9. Relationship status (e.g. single, engaged, married):_____
10. Highest education (e.g. school grade) completed: _____
11. The current treatment is your [Tick the appropriate box]
    - □ 2nd round
    - □ 3rd round
    - □ 4th round
    - □ 5th round
    - □ 6th round

12. Where did you MOSTLY receive your previous treatment for drug abuse (e.g. private/government rehabilitation centre):_____

Section B: Open questions

1. Tell me more about your addiction to *nyaope*.

   Possible probes:

   - When did it start?
   - How did you come to know about *nyaope?*
   - How was it introduced to you?

2. What effects does *nyaope* have on you?

   Domains to explore:
   - Psychological
   - Social
   - Physical
   - Behavioural
   - Spiritual/religious

3. Who do you consider support systems (if any)?

Possible follow-up question:

- Describe the support you receive

4. What have you done thus far to deal with your addiction?

5. What do you think caused the relapse?

6. What are your needs for support in order to maintain abstinence?

    - Physical
    - Psycho-social
    - Behavioural
    - Spiritual/religious

7. What are your needs for reintegration into the community?

8. How would you like to be supported by social workers?

9. What would you suggest must treatment centres do differently during treatment to help you maintain abstinence?

10. What do you consider your strengths/assets/things that make you proud and/or unique?

11. How do you spend your time when you are not using drugs?

APPENDIX E

INTERVIEW SCHEDULE: SIGNIFICANT OTHER OF A NYAOPE USER

Semi-structured interview: The aftercare needs of *nyaope* in the Hammanskraal community.

Section A: Demographic information

1. Gender: _____
2. Age: _____(years)
3. Racial group: _____
4. Home language: _____
5. How are you related to the *nyaope* user? _____
6. The current treatment of your significant other is his/her [Tick the appropriate box]:
   - □ 2nd round
   - □ 3rd round
   - □ 4th round
   - □ 5th round
   - □ 6th round
7. Where did your significant other MOSTLY receive his/her treatment for drug abuse (e.g. private/ government rehabilitation centre)?

Section B: Open questions

1. Can you tell me about your child's/ partner's/ husband's/ wife's/ niece's/ nephew's/ brother's/ sister's addiction to *nyaope*?
2. What effect does your child's / partner's/ husband's/ wife's/ niece's/ nephew's/ brother's/ sister's addiction have on you and the whole family?
3. What do you think can be done to deal with this addiction?
4. What do you think are the needs for support for your family member to remain abstinent?

   Possible domains to explore:

   - Physical
   - Psycho-social
   - Behavioural
   - Spiritual/religious

5. How would you like your family member to be supported?
6. What would you expect from social workers to support your family member to maintain abstinence?

7. What do you think are your family member's needs pertaining to aftercare?

8. How do you think can your family member be best reintegrated into the community?

9. Who is in the best position to provide support to your family member after treatment for nyaope abuse?

APPENDIX F

S
A
SANRA
C
A

PRETORIA/SOSHANGUVE
HAMMANSKRAAL

South African National Council on Alcoholism
& Drug Dependence
Suid-Afrikaanse Nasionale Raad i/s Alkoholisme
organisasie
en Dwelmafhanklikheid

P O Box/ Posbus 16383
Pretoria North/Noord
0116

Tel: (012) 717 8239 / (012) 542 1121
Fax/ Faks: (012) 542 3030
E-mail: karabo@sancapta.co.za
Website: www.addictionrehab.co.za

Registered as Nonprofit organization
001-675 NPO
Geregistreer as Nie Winsgewende

Date: 06 November 2015

TO: Department of Social Work & Criminology: University of Pretoria

RE: PERMISSION TO CONDUCT A MASTER'S STUDY

This letter serves to confirm that Sonto Hleziphi Mahlangu is granted permission to conduct her Master's study at SANCA Soshanguve/Hammanskraal.

For any clarity, please do not hesitate to contact me.

Regards

K Kolokoto
Operational Manager