AN EXPLORATORY STUDY INTO THE NATURE OF AFTECARE SERVICES FOR RECOVERING SUBSTANCE ABUSERS

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BY

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DEDICATION

This manuscript is dedicated to all clients of Etegameno Rehabilitation and Resource Centre (ERRC), and the aftercare groups. I chose this topic for you! It was an honor and privilege to work with you.

Thank you once more!
ACKNOWLEDGEMENT

I wish to thank my Heavenly Father who granted me the strength and abundant blessings to develop this Thesis. Furthermore, I would like to express my gratitude to the following people:

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• To all social workers and related professionals, for their willingness to participate in the interviews;
• To Ms. Leonie Munro who assisted me with editing and formatting the thesis; and
• To my lovely husband, family and friends who supported and encouraged me during my studies.
DECLARATION

I, Angela //Naobes hereby declare that ‘Exploratory study into the Nature of Aftercare Services for Recovering Substance Abusers’ is a true reflection of my own research, and that this work or part thereof has not been submitted for a degree in any other institution of higher education.

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ABSTRACT

The Ministry of Health and Social Services (MoHSS) established the first National Alcohol and Drug Rehabilitation Center, called Etegameno Rehabilitation and Resource Center (ERRC), in 2004. It serves to provide treatment and rehabilitation services to alcohol and drug dependent individuals and families during a period of five and a half weeks. Clients who completed treatment at the Centre are invited into an aftercare programme which entails support and follow up counselling. It has been established by the Centre that rehabilitated substance abusers experiences relapse due to lack of adequate aftercare services in the community.

The purpose of the study was to explore the nature of this aftercare services by assessing the scope; the activities and the stakeholder’s role in the aftercare services.

The study used the qualitative approach to provide in-depth information in understanding the needs of the recovering substance abuser in the aftercare services. The research population consisted of 40 participants including, individuals who completed the alcohol and drug treatment programme at ERRC, families of recovering substance abusers, members of the aftercare groups, and key informants. The research design applied was the Phenomenological Design to assess the full description of participant’s experiences in participating in the aftercare programme.

The method of data gathering was face-to-face interviews guided by semi-structured interview schedules. The interviews were recorded and field notes were processed after the interviews. The raw data was analysed by revealing themes and patterns by identifying documents that are linked to the setting.

The results indicated that recovering substance abusers need support from families and stakeholders involved in maintaining their recovering. The recovering substance abusers
experienced that it is difficult to have an ordinary life after rehabilitation because inpatient treatment centers provided safe, structured environment in which negative influencing factors were removed from a client’s daily experience.

Employment or job-related training was identified as an essential part of aftercare services. There is a need to introduce effective, cultural and gender sensitive spiritual programme in order to promote an individualized inclusive and holistic approach to meet the needs of recovering substance abusers.

There is a need for developing an aftercare services guideline which could be helpful for professionals responsible for the creation and management of aftercare groups.

The study recommends the development of Evidence-Based Aftercare Guidelines for social workers, related professionals and members of the aftercare services.
LIST OF ABBREVIATIONS

AA  Alcoholics Anonymous
AIDS  Acquired Immune Deficiency Syndrome
CDC  Centers for Disease Control and Prevention
DPD  Dependent Personality Disorder
DSM  Diagnostic and Statistical Manual
DSM - III  Diagnostic and Statistical Manual of Mental Disorders third edition
DSM - IV  The Diagnostic and Statistical Manual of Mental Disorders fourth edition
DSWS  Directorate of Social Welfare Services
ERRC  Etegameno Rehabilitation and Resource Centre
GAD  Generalized Anxiety Disorder
HIV  Human Immunodeficiency Virus
IAS  International AIDS Society
LSD  Lysergic acid diethylamide
MoHSS  Ministry of Health and Social Services
NA  Narcotics Anonymous
NGO  Non-Governmental Organisation
OCPD  Obsessive - Compulsive Personality Disorder
OLCADA  Okakarara Live and Care Against Alcohol and Drug Abuse
OSARC  Omaheke Substance Abuse Referral committee
OASIS  In geography, an oasis (plural: oases) or cienega (Southwestern United States) is an isolated area of vegetation in a desert, typically surrounding a spring or similar water source. The word OASIS comes into English via Latin: oasis from Ancient Greek.
OPRA  Organization for the Prevention and Rehabilitation of Addiction
RP  Relapse-Prevention
SAMHSA  Substance Abuse and Mental Health Services Administration
STIs  Sexually Transmitted Infections
TC  Therapeutic Community
WHO  World Health Organization
UN   United Nations
UNAM University of Namibia
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CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 ORIENTATION TO THE STUDY

The (World Health Organization [WHO], 2005) defines substance abuse as the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. The most commonly mentioned drugs in the literature include alcohol, marijuana, cocaine, amphetamine and opiates. The (United Nations [UN], 2010) reported that approximately 185 million people globally, over the age of 15 years, were consuming drugs by the end of the 20th Century. It is estimated that about 76.3 million people struggle with alcohol-use disorders, contributing to 1.8 million deaths per year. As is the case with some global issues, substance abuse is unequally represented in the developing world, with marginalized groups and communities being the most vulnerable to this reality (WHO, 2005). Aftercare is a service in the community that assists recovering substance abusers accomplish specific goals to free themselves from alcohol/drug abuse. Aftercare goals include reducing the frequency and severity of relapse; fostering social integration; helping families complete their recovery and ensuring the ex-addict’s adaptation to employment (Stevens, 2003).

“Alcohol and drug addiction are major drivers of the HIV/AIDS epidemic in many parts of the world” (Howe, 2009, p.12). This was the theme of several presentations on the implications of drug and alcohol dependence in HIV prevention and treatment at the 5th International AIDS Society (IAS) Conference. Since Namibia has the fourth highest AIDS prevalence rate in the world, alcohol and drug addiction is among the main causes of the spread of sexually transmitted infections (STIs), including HIV and AIDS (MoHSS, 2006). In
Sub-Saharan Africa analyses claim that drinkers have a 70% higher risk of contracting HIV, compared to non-drinkers. Eastern Europe and Central Asia have experienced an epidemic in terms of drug abuse since the 1990’s, resulting in intravenous drug users now making up 85% of people living with HIV and AIDS (WHO, 2006).

Apart from the situations in Eastern Europe and Central Asia, the following research results reflect the situation of substance abuse in Namibia:

A brief study of alcohol consumption patterns conducted in Katutura (a township of Windhoek, Khomas Region, Namibia) by the (Ministry of Health and Social Services [MoHSS], 2009) showed that 48% men and 26% women meet the World Health Organization’s (WHO) criteria for hazardous and harmful drinking behaviour.

The Social Impact Assessment and Policy Analysis Corporation (2010) highlights that over 47.9% of Namibians who consume alcohol are of the opinion that they consume more than is good for them; 35.2% skip one meal per day in order to drink alcohol and 11.3% had sought treatment. Skipping a meal per day to consume alcohol is an important indicator for social workers to measure the seriousness of alcohol abuse. According to this assessment, Windhoek is the “drinking capital” of Namibia where 69.9% of the adult population consumes alcoholic beverages. Northern Namibia has 26%, while Southern Namibia has 65.2% drinking adults. This information prompts the importance of aftercare services as it will assist addicts recovering from hazardous drinking.

The current substance abuse treatment and aftercare services in Namibia range from residential rehabilitation facilities to self-help groups including government and private sectors, Social Work support programmes, community based counseling services, faith-based organisations, self-help groups and medical interventions. However, it is clear that there is a gap in service delivery, since there are many communities who do not have local
access to any form of support related to substance use. For example, in the North of Namibia where over 50% of the adult population consumes alcohol, there is no rehabilitation center. Other evident gaps showed that even if aftercare services are available, there is a lack of access to detoxification facilities to provide symptomatic relief of physical dependence from alcohol or/and drugs. Inequitable access to treatment is further exacerbated by the cost of some intensive services, which prevents the majority of people from accessing specialist treatment (MoHSS, 2009).

The Ministry of Health and Social Services has identified the need to develop a national alcohol policy to provide a comprehensive national response for combating substance abuse in Namibia. As part of this policy’s implementation plans, the MoHSS, particularly the Directorate of Social Welfare Services (DSWS), established Etegameno Rehabilitation and Resource Center (ERRC), an alcohol and drug rehabilitation center. It is situated in Brakwater, 25 kilometers north of Windhoek and provides treatment and rehabilitation to alcohol and drug dependent individuals and support to families. Adams (2007) identified high rates of relapse as one of the major challenges recovering substance abusers face after discharge from the inpatient treatment centers.

Often recovering substance abusers experience a relapse partially due to a lack of adequate aftercare services in the community. Aftercare services are to assist families and recovering substance abusers to establish and maintain an alcohol and drug free lifestyle after the completion of an inpatient treatment programme (Ch’ien, 2008). ERRC has established 32 aftercare groups within 13 Regions of Namibia. The purpose of these aftercare groups are to follow up and support the progress of recovering substance abusers discharged from the center.
The purpose of the study is to evaluate the nature of the aftercare services for recovering substance abusers. The researcher aims to investigate whether the activities of the aftercare services are relevant in terms of addressing the needs of the recovering substance abusers.

1.2 PROBLEM STATEMENT

The statement of the problem proposes to establish the problem leading to the study. According to the case studies done by the social workers of Etegameno Rehabilitation and Resource Centre (2004 - 2010), the following factors contribute to the lack of sustainable abstinence from alcohol or drugs: the recovering substance abuser spends little time on self-evaluation; they are less open with significant others and resist shifting their attention in the direction of change. Most of the clients who undergo treatment at ERRC are unemployed. “Unemployment is among the most dominant factors of relapse, and it increases the risk of adult anti-social behaviour, including alcohol abuse and illicit drug-use” (Barber, 2003, p. 143). A need exists for a stronger link between inpatient treatment providers and vocational rehabilitation programmes, to increase the number of clients who could be employed upon completion of the treatment programme (Jason, 2006).

1. Hyperactivity, poor impulse control, antisocial conduct and a history of suicidal attempts are cited as precursors to alcoholism and drug addiction (Bill, 2007).

2. Another social problem that affects the sobriety of the recovering substance abuser is dysfunctional family relationships. If family members are not involved in the treatment programme, they tend to undermine the much needed support of recovering substance abusers; and minimise the potential of long-term sobriety. The purpose of the family support sessions in aftercare programme is to offer comfort, hope and support to the families of compulsive drinkers, as well as to educate them about addictive relationships (Allen, 2006).
3. A need has been identified to evaluate the effectiveness of the aftercare services in Namibia. Due to the fact that relapse occurs so often after treatment, it has become necessary to evaluate the efficacy of these services.

4. The aftercare service teaches recovering substance abusers skills and knowledge on how to be able to identify and examine their underlying addictive behaviours, assumptions and beliefs in order to take responsibility for their own actions, emotions and thoughts (Van Wormer, 2005).

1.3 AIM AND OBJECTIVES OF THE STUDY

1.3.1 Aim of the study

The overall aim of the study is to explore the nature of aftercare service through exploring the experience of individuals in the aftercare services and assessing the activities and the role stakeholder’s in the aftercare service.

1.3.2 Objectives of the study

In order to explore the nature of the aftercare service, the study aimed to achieve the following objectives:

1. To identify the needs of the recovering substance abusers participating in aftercare service.

2. To explore gaps in aftercare services in fulfilling the needs of recovering substance abusers.

3. To provide recommendations to the Ministry of Health and Social Services regarding research findings.
1.3.3 Research questions

Based on the problem statement, the following research questions were formulated in accordance to De Vos, Strydom, Fouche and Delport (2005):

1. What do recovering substance abusers, family members, aftercare groups, and social workers perceive to be major positive and negative aspects of aftercare service?
2. To what extent is the aftercare service delivery achieving the intended goals?
3. What resources are needed / have been made available for the aftercare service?
4. What is the nature of aftercare services?

1.4 SIGNIFICANCE OF THE STUDY

The results of the study can be instrumental in enabling social workers and related professionals to deliver aftercare services to recovering substance abusers. The result of the study will add valuable information in filling the service gap in Namibia and meeting the needs of recovering substance abusers.

1.5 SUMMARY

An alcohol misuse places a heavy burden on social welfare system in Namibia. In response, the government of Namibia is developing a national alcohol policy to implement alcohol and drug prevention, treatment and aftercare services. The purpose of the alcohol policy is to minimise substance abuse related to risk and potential harm to society. Substance abusers are admitted to inpatient treatment programmes to resolve their alcohol problems, but this is only the first step. The question remains after the completion from inpatient treatment programme: Do these recovering substance abusers obtain sufficient aftercare services to ensure long term recovery? Are the aftercare services fulfilling the needs of recovering substance abusers?
Thus, a need has raised to evaluate the nature of aftercare services for recovering substance abusers. The purpose of the study was to explore the nature of aftercare services through exploring the experience of individuals in the aftercare service; assessing the activities and the stakeholder’s role in the aftercare services.

Aftercare services are to assist families and recovering substance abusers to establish and maintain an alcohol and drug free lifestyle after the completion of an inpatient treatment programme (Ch’ien, 2008).

The outline of the study commence with chapter one that will discuss the overview of the study. Secondly, chapter two: the literature study, followed by chapter three: research methodology and chapter five: the conclusions and recommendations on the study.
CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter focuses on the reviewing literature of aftercare services for recovering substance abusers. Discussions are categorized into two main sections. Section one covers the discussions about the overview of features on addiction and recovering substance abuser and Section two review literature on nature of aftercare services.

SECTION II

THE DYNAMICS OF ADDICTION

2.2 OVERVIEW OF SUBSTANCE ABUSE

In 1978, the philosopher Hertz Levine said that there was little or no concept for addiction. People were fully responsible for their action by virtue of reasons and free will. It was assumed that people got intoxicated because they wanted to, not because they had to. In Levine’s own words, “alcohol did not permanently disable the will, it was not addicting, and habitual drunkenness was not regarded as a disease” (Barber, 2003, p. 13).

Towards the end of eighteenth century and beginning of nineteenth century, medical practitioners such as Benjamin Rush, coined the term “disease of the will” and declared habitual drinking as a disease characterised by loss of control. Alcoholism was declared since then, as a progressive illness with common symptoms such as compulsion to drink; the behavioural consequences and psychoactive substance dependency (Heather & Robertson, 2002).
Psychoactive substance dependency is a condition in which the person has lost the free-will to decide whether or not to use or even abuse psychoactive substances. This condition is caused by the effect of the psychoactive substances, interactively, on the body, the brain, the mind and emotions. Substance abuse has an effect on an individual’s motor- and muscle functioning. It retards the activities of the brain and spinal cord. These factors could cause impairment such as faulty depth perception, poor peripheral vision, distorted colour vision and reduced night vision. Psychoactive substances composed of alcohol, opioids, cannabinoids, sedatives or hypnotics, cocaine and other stimulants including caffeine, hallucinogens, tobacco, volatile solvents and other substances (Brodie & Redfield, 2001).

As mentioned by Levine (1978) that there was little or no concept for addiction in the 70’s. It is an accurate observation because substance use was infrequent in those century compare to the accessibility of substances since eighteenth century and beginning of nineteenth century. Thus, Benjamin Rush identified habitual drinking as a disease characterised by loss of control in which the person has lost the free-will to decide whether or not to use or even abuse psychoactive substances. The researcher agrees with Benjamin Rush that substance abuse is a progressive illness that can lead to common symptoms such as compulsion to drink; the behavioural consequences and psychoactive substance dependency. In order for a person to recover from dependency, it is relevant that a support system is needed to recover the person from addiction. That support system is the aftercare services.

In this study, aftercare services teach recovering substance abusers skills and knowledge on how to be able to identify and examine their underlying addictive behaviours, assumptions and beliefs to take responsibility for their own actions, emotions and thoughts.

Aftercare specifically refers to the services provided by a treatment center to those who have completed one of its programs. The services typically include a variety of clinical services, as
well as some type of social networking. Studies have shown that the more treatment a recovering substance abuser receives, the better his or her chances of abstaining from alcohol or drugs. In addition to receiving therapeutic services, the recovering substance abusers receive referrals to outside resources and agencies, support for attending fellowship meetings, continued monitoring of medications, one-on-one family therapy, and living sober resources (Davidson, 2007).

The purpose of aftercare service is to provide support for recovering substance abusers and families about issues faced during recovery, such as developing coping strategies for addiction; building stronger relationships with friends and family members; finding and maintaining employment; and locating resources in the community (Van Wormer, 2005).

2.2.1. Different themes and approaches to alcohol/drug addiction

It is relevant to understand the different approaches to alcohol addiction that relate to the nature of aftercare services needed for recovering substance abuser. The following components are hallmarks of quality substance abuse aftercare service.

2.2.1.1 Health “Disease” Model

“The Health “Disease” Model describes problematic drinking, as the corollary of chronic illness of alcoholism” (Davidson, 2007, p. 120).

Davidson (2007) classifies the Health “Disease” Model in the following five types of alcoholism:

Alpha alcoholism

An alpha alcoholic is the person who needs alcohol regularly and who becomes anxious if not available. It’s a psychological dependency on alcohol, with no physical dependency. The
person will not experience withdrawal symptoms upon the cessation of drinking. Alpha alcoholism is not necessarily progressive; indeed some drinkers remain psychologically dependent without deteriorating physically or mentally.

**Beta alcoholism**

Beta alcoholism is not a progressive syndrome; it too is a form of pathological drinking, which is manifested through continuous bodily damage. It entails heavy drinking resulting in physical harm, but no dependency.

**Gamma alcoholism**

Gamma alcoholism is the most prevalent form of alcoholism. This alcoholism refers to physical dependence with loss of control. Gamma alcoholics are both symptomatic and physically dependent, including emotional and psychological impairment which develops tolerance and withdrawal symptoms to alcohol.

**Delta alcoholism**

The delta alcoholic does not lose control; does not get drunk; violent or pass out. It entails the inability to abstain for even a short period of time. This person cannot stop drinking without experiencing withdrawal symptoms.

**Epsilon alcoholism**

Epsilon alcoholism is characterised by long periods of abstinence and binge drinking. The epsilon drinker goes on binges; often for no apparent reason of undetermined duration, but which usually lasts until the person collapse. The interval between binges may be weeks, months or years.
There are both advantages and disadvantages in using the term ‘alcoholism’. Many practitioners find the disease concept useful. Conceptualising it as an illness has allowed a far more vulnerable approach within the social setting (Jason, 2006). Hoffmans (2003) for instance, argues that the concept of ‘disease’ suggests a medical problem where people are seen as physically addicted and are subject to powerful cravings. This ‘medicalisation’ of the term links it to a whole range of beliefs concerning diseases and illnesses. It tells the client that recovering from this illness is the responsibility of others, which diminishes the need for self-help.

Consequently, the term may dissuade people from seeking help, because they do not want to be labelled as alcoholic. As a result, the WHO (2006) suggested replacing the term “alcoholism” with “alcohol/drug dependence syndrome or substance abuse (Hoffmans, 2003).

2.2.1.2 Alcohol/drug dependence syndrome is defined as:

“A state-psychic and sometimes physical-resulting from the interaction between a living organism and a drug characterised by behavioural and other responses that includes 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” (Brady, 2005, p. 92).

Brady (2005) also classifies alcohol/drug dependence syndrome into the following two forms of dependencies:

Physical dependency

This condition develops when the person’s body experience a continuous craving or a need for psychoactive substance. When a person discontinues the use of substance, severe craving
for the substance may occur with physical signs of discomfort. Such signs are linked to withdrawal symptoms and tolerance.

Withdrawal from alcohol or drugs is characterised by the development of withdrawal symptoms twelve hours after the reduction of intake following prolonged use. Withdrawal consists of symptoms such as tremor of the hands, tongue or eyelids, nausea or vomiting, anxiety, depressed mood or irritability, illusion, headache or insomnia (Levin, 2000).

Tolerance is defined as “the decrease in the sensitivity to the effects of alcohol that occurs as a result of previous exposure to it” (Kalant, 2004, p. 42). Three types of tolerance have been described namely, acute, rapid and chronic. Acute tolerance occurs within the duration of a single exposure to alcohol. Tolerance to the effect of the second dose of alcohol, given between 8 hours and 3 days after the effect of the first dose have disappeared, is termed rapid tolerance. Chronic tolerance occurs after repeated administration of alcohol (Edwards, Marshall, & Christopher, 2003).

Tolerance means that the user’s body becomes use to the drug and during every use needs more and more of the drug or even a stronger type of drug to achieve the desired effect. It may also happen that a substance abuser who once had a high tolerance for the drug or alcohol may experience a jolting intolerance as they grow older. This means the odd reversal in tolerance takes place in older, chronic substance abusers. The liver is no longer efficient, and the experienced substance abuser now gets drunk on the first drink. The integrity of the nervous system is compromised (Kalant, 2004).

Apart from physical dependency, the psychological longing for alcohol or drug may also occur.
Psychological dependency

“The person desires the ‘pleasant’ effect caused by the substance which causes an illusion of happiness and well-being” (Kalant, 2004, p.22).

Substance use begins as a conscious choice that over time escalates out of control and becomes compulsory. The key to understanding addiction lies in both the way in which the substance affects the brain, particularly neuro-transmitters - the power of the psychological defence and the denial system of the person. The speed with which a given individual becomes addicted, depends on the substances, the frequency of use, the means of ingestion and the individual’s own psychological, social, physical and genetic make-up (Howe, 2009). Other literature studies view addiction as a learned behaviour which is discussed in the following sub–heading.

2.2.1.3 Addiction as learned behaviour

The following definitions were provided by the WHO Expert Committee on Drug Dependency (2006):

“A chronic behavioural disorder manifested by repeated drinking of alcoholic beverages in excess of the dietary to the extent that it interferes with the drinker’s health, social or economic functioning” (Hustard, Barnett, Borsari, & Jackson, 2010, p. 32).

The modern psychological view is that “addictive behaviour is a learned behaviour and should comply with the rule that governs all learning” (Wikler, 2000, p. 45).

Wikler (2000) who views addiction as a learned behaviour stated that the use of drug reinforces drug-seeking behaviour by providing immediate and powerful reinforcement. The basic claim is that through observation and communication, people learned drinking and drug-taking from parents, peers, media and personal experiences. In researcher’s opinion,
addictive behaviours are socially acquired and multiply determined by past learning experiences (George, 2007).

Social scientists in the behavioural tradition commonly object to the disease approach as having little clinical or scientific utility. This point raises logical contradiction involved in the disease approach to treatment. Meaning-alcoholics cannot control their drinking, yet the only cure for alcoholism is lifelong abstinence. This view can produce curious outcomes indeed, as when hospitalised alcoholics are told that they suffer from incurable disease, only to be excluded from treatment programme the moment they display the symptoms of the disease (Mello & Mendelson, 2004).

2.2.2 Characteristics of a substance abuser

Significant knowledge on the characteristics of addiction can strengthen effective aftercare services with individuals suffering from substance dependency. The discussion under this heading is structured around the characteristics of substance abuser.

In the early editions of the Diagnostic and Statistical Manual of Mental Disorders third edition (DSM –III), alcoholism and drug abuse were not treated as disorders. Instead, they were categorised as sociopathic personality disturbances because substance abuse was seen as a symptom of other problems. A separate category was created in Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM–IV), and since then the biology and psycho–social nature of substance abuse has been acknowledged. It is characterised by compulsive and uncontrolled drug consumption, despite its negative effects on the drinker's health, relationships, law and social standing (Barlow, 2001).

Recent research on the personality characteristics of substance abusers shows that there is no unitary phenomenon known as the “alcoholic personality”, nor can alcoholics be
distinguished from non-alcoholics on the basis of scores of personality tests. However, there are certain aspects of personality that are relevant in the development of addiction, such as cognitive distortion and neurological predisposition. The cognitive distortion is characterised by hyperactivity, anti-social behavior and depression. Depression may be both the cause and effect of chemical use. It has been identified as a major variable of relapse in empirical studies, because of its symptoms that are associated with feelings of hopelessness, low self-esteem, and a lack of concentration (Davidson, 2007).

Psychological components play an important role in the etiology and continuation of addiction. An identical twin study reveals that identical twins born of an alcoholic parent, has a 60% probability of also becoming an alcoholic. Presumably, the other 40% had a psychological resistance to development of the disease, which hindered its occurrence. Research into personality traits commonly associated with alcoholism, indicated that obsessive–compulsive traits, rigidity of thinking, low frustration tolerance, perfectionism and defence mechanism may precede development of alcoholism (Hilarski, 2005).

2.2.2.1 Obsessive - compulsive personality disorder (OCPD)

The Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM IV), defines obsessive-compulsive personality disorder (in Axis II Cluster C) as: “A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness, and efficiency, beginning by early adulthood and present in a variety of contexts (Barlow, 2001). This disorder is indicated by four or more of the following:

1. When a person is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost.
2. When a person shows perfectionism that interferes with task completion e.g., is unable to complete a project because his or her own overly strict standards are not met

3. When a person is excessively devoted to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)

4. Overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)

5. Unable to discard worn-out or worthless objects even when they have no sentimental value

6. Reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things

7. Adopts a miserly spending style toward both self and others; money is viewed as something to be saved for future catastrophes.

8. Shows rigidity and stubbornness

Since the early 1990s, considerable research continues to characterize OCPD and its core features including the tendency for it to run in families along with eating disorders and alcoholism. Hustard et al. (2010) reported that 75.8% cases of OCPD were diagnosed with major depressive disorder, 29.4% with generalized anxiety disorder (GAD), 29.4% with alcohol abuse/dependence, and 25.7% with drug abuse/dependence. It is the researcher’s opinion that substance abuse related psychological and behavioural characteristics may derive, in part from obsessive-compulsive symptoms.

2.2.2.2 Rigidity of thinking

According to Davidson (2007), rigidity of thinking is motivated by fear of “doing something wrong” and receiving negative feedback. Low self-esteem seemingly causes the need to narrow once choices to act safe from ridicule, rejection, disapproval, or making mistake in judgment that might have other negative consequences. Similarly, Hilarski (2005) also adds
that it is the state of being unable to trust one’s own ability to know what’s right. The person seeks approval or they may go by the rules they were taught as a child, too fearful to decide for themselves on any issue that might be controversial.

In contracts to the study, the activities in the aftercare services would provide recovering substance abuser with ability to reflect internally and externally to themselves to recognise that contentment comes from attempting to learn to change things that needed changing and embrace to others in openness and up rightful manner.

2.2.2.3 Low frustration tolerance

George (2007) found in the study of prevalence to co-morbidities of addiction, that alcohol-dependent persons are characterised by traits such as being more assertive, dominant, companionable, carefree and venturesome as compared to non-dependent people. The study showed that alcohol-dependent patients also obtained significantly higher scores on the neuroticism dimension.

Neuroticism is a fundamental personality trait characterised by anxiety, fear, irritability, anxiety, resentment, frustration, jealousy and loneliness. This indicates that recovering substance abuser could be significantly more emotional, frequently anxious and/or depressed (Barlow, 2001).

Thus, understanding the emotional causes of addiction, guided the study on an overview to integrate aftercare services into the path for sobriety and recovery.

2.2.2.4 Perfectionism

Carlson (2010) argued for two contrasting types of perfectionism, classifying people as tending towards normal perfectionism or neurotic perfectionism. Normal perfectionists are more inclined to pursue perfection without compromising their self-esteem, and derive
pleasure from their efforts. Neurotic perfectionists are prone to strive for unrealistic goals and feel dissatisfied when not reaching their goals. Carlson (2010) offers several strategies that have proven useful in helping people change from maladaptive towards healthier behaviour.

Contemporary research supports the idea that these two basic aspects of perfectionistic behaviour, as well as other dimensions such as non-perfectionism, can be differentiated. Non-perfectionism has been labelled differently, and is sometimes referred to as positive striving perfectionism.

Nelson (2012) disagrees with the terminology of normal vs neurotic perfectionism, and holds that perfectionists desire perfection and fear imperfection. Individuals believe that other people will accept them, only if they are perfect. Perfectionism itself is thus never seen as healthy or adaptive, and the terms normal or healthy perfectionism are contradictions, since absolute perfection is impossible to measure. He argues that perfectionism should be distinguished from striving for excellence, in particular with regard to the meaning given to faults, because those who strive for excellence can take faults or imperfections as incentive to work harder.

Perfectionism addiction connection is based on the need to tranquil the inner voices of doubt and existential dissatisfaction that plague perfectionists. Perfectionists insist on a level of performance that is impossible to achieve in the vast majority of instances; they must constantly cope with feelings of frustration, disappointment, guilt, shame, and personal inadequacy, which leaves them vulnerable to the soothing and sedating traces of alcohol and/or drugs (Nelson, 2012).

In contrast, many perfectionists have ability to avoid substances because of the need to always be in control. Perfectionism is not an at risk factor for addiction in every instance
however, when those who possess this trait are introduced to drugs and alcohol, their chances of eventually falling into dependency are undoubtedly greater than for those who lack this particular trait (Hustard, et al., 2010).

Hustard et al. (2010) maintains that recovery from substance abuse in perfectionist presents a long-term challenge. Holding themselves to such high standards in every aspect of their lives, they do not usually react well to setbacks in recovery. This can leave substance abusers unprepared to handle the occasional relapses that most recovering addicts and alcoholics experience at various points.

Perfectionists often have challenging time admitting when they need help and those struggling to overcome addiction may hold back important information from their therapists, avoiding support group meetings, or decline to let their friends and family members provide moral support. Addicts going through recovery must be willing to show humility and accept the insight and assistance of others. Addicts and alcoholics who recognize perfectionism in themselves need to talk about what they are thinking and feeling in their therapy sessions and in support/aftercare group meetings (Carlson, 2010).

2.2.2.5 Defence mechanism

A defence mechanism is “the act or technique of coping mechanisms that reduce anxiety generated by threats from unacceptable or negative impulses” (Guqaza, 2012, p. 43). Defence mechanism means the lack of acknowledgement of a psychoactive substance dependent person to his/her dependency. In Freudian psychoanalytic theory, defence mechanisms are psychological strategies brought into lay by the unconscious mind to manipulate, deny, or distort reality to defend against feelings of anxiety and unacceptable impulses to maintain one's self schema (Carlson, 2010). Vaillant (1992, as cited in Hustard et al., 2010) classifies
defence mechanism in four levels namely, pathological, immature, neurotic and mature
defences. These four defences, in conjunction, permit one to effectively rearrange external
experiences to eliminate the need to cope with reality. The following are the characteristics of
Vaillant's categorization of defence mechanisms which could be a significant part of the
treatment and aftercare process for recovering substance abusers (Kelly & Donovan, 2001):

**Denial**

Denial is defined as arguing against an anxiety-provoking stimulus by stating it doesn't exist;
resolution of emotional conflict and reduction of anxiety by refusing to perceive or
consciously acknowledge the more unpleasant aspects of external reality (Yasmin Jiwan, 2011).

Van Wormer (2005) also maintains that denial is one of the basic human defense mechanisms
that might continue indefinitely in addictive problems. Due to the guilt feelings, the
recovering substance abuser insist that s/he can quit any time they so wish. Denial is used
when a threat can no longer be eluded or eliminated. The only alternative to address the
anxiety may be to ignore or deny the existence of the threat. For example, the alcoholic might
say: “I am not an alcoholic because I only drink in the evening and over weekends. I drink
much less than my neighbour. I go to work every day and, therefore, I do not have a
problem.”

Relating to the study, denial begins when an individual is untrue about the severity of his /her
substance abuse problem. As supported by Van Wormer (2005), a carefully kept lie, told over
and over, forms the basis for substance abuser’s altered sense of reality. The addicted
individual begins to believe that those around them are the ones with the real problems.
Substance abuser would supply justifications for reasons of substance abuse such as: the real
problem is other people judging them; their family distresses them, so they need to unwind with alcohol and drugs; or their lack of employment opportunities.

Denial is considered one of the most primitive of defence mechanisms because of its characteristic of early childhood development. Davidson (2007) argues that children of addicts or alcoholics have higher incidences of substance abuse because children often keep their emotions hidden, and have a higher incidence of serious mental health issues such as anxiety and/or depression.

Support from aftercare services could assist recovering substance abusers gains insight into the reality of their situation. The recovering substance abuser would most likely talk to people who have already achieved sobriety that will be highly beneficial at helping to see beyond denial.

Furthermore, denial in recovery of ex–addict in the recovery and aftercare programs should not be overlooked. According to Carlson (2010), it is possible for an ex–addict to escape addiction and still live in denial. Once the individual does not overcome such challenges, it could mean that person could develop denial in recovery. This can include: refusal to accept being free from alcohol and/or drugs is only the start of recovery journey; the belief that once stayed sober long enough, they will then be able to drink alcohol or use drugs sensibly; refusal to acknowledge other challenges in life. People in recovery can fall into other types of addiction such as workaholism and exercise addiction and will use denial to ignore the destructiveness of their new obsessions.
**Reaction formation**

In psychoanalytic theory, reaction formation is a defensive process in which emotions and impulses which are anxiety-producing or perceived to be unacceptable are mastered by exaggeration of directly opposing tendency (Edwards. et al., 2003).

Reaction formation is when a person seeks to cover up something unacceptable by adopting an opposite stance. For example, due to anxiety that a person experience as a result of his/her substance abuse, a person becomes an advocate for the fight against substance abuse. This may be a conscious concealment but also may well occur at the subconscious level such that they do not realize the real cause of their behaviour (Davidson, 2007).

Davidson (2007) called the exaggerated compensation that appear in reaction formation ‘overboarding’ as the person is going overboard in one direction to distract from and cover up something unwanted in the other direction. Deep-rooted feelings of anxiety and fear resulting from social stigma are causes of the occurrence of reaction formation.

**Displacement**

Displacement is a defence mechanism in which libidinal energy is purportedly redirected from a desired (but inaccessible) goal to a substitute. This entails directing an emotion towards a substitute target. For example, the child of the psychoactive substance dependent harbours aggressive thoughts towards his/her parent. However, the child does not make his/her anger known out of fear of being punished. S/he, therefore, displaces the anger by taking it out on his/her younger brother (Royce, 2001).
**Projection**

Projection occurs when people avoid negative evaluation of themselves by seeing their own unpleasant thoughts or actions in other people. Projection is the misattribution of a person’s undesired thoughts, feelings or impulses onto another person who does not have those thoughts, feelings or impulses (Kelly & Donovan, 2001).

This refers to purging oneself of threatening characteristics by attributing them to others. For example, if a person is criticising his/her neighbour about his/her alcohol usage, it might be that s/he is saying more about him-/herself than about his/her neighbour (Royce, 2001).

**Rationalisation**

Rationalisation occurs when you unconsciously give yourself a false explanation of your own behaviour. As Freud described, rationalization was supposed to be an automatic self-protective reaction, carried out by the unconscious part of the ego. A person would explain his/her behaviour by giving socially acceptable reasons that are untrue. For example, the dependent may attribute his/her excessive alcohol usage to so-called anxiety neurosis, which s/he may suffer from (Davidson, 2007).

In the Freudian view, rationalisation is to justify your behaviour or to make excuses for ones behaviour.

**Manipulation**

Manipulation aims to change the perception or behaviour through dishonest, deceptive, or even abusive strategies. According to Edwards et al, (2003), successful psychological manipulation primarily involves the manipulator concealing aggressive intentions and behaviours; knowing the psychological vulnerabilities of the victim to determine what
strategies are likely to be the most effective; and having a sufficient level of ruthlessness to have no doubts about causing harm to victim.

An enormous extent of work goes into maintaining an addiction: planning, purchasing, using, and covering it up. Some users anticipate drug use way before it actually happens; there is obvious preoccupation with planning and using. As the alcohol and/or drug use progresses, the substance abuser needs to become more skilled and resourceful in financing the addiction. Substance abuser may persistently borrow money, sell possessions, pawn valuables, and even steal.

2.2.2.6 Co–dependency and enabling substance abuse behaviour

Definitions from National Institute on Drug Abuse:

“Co-dependency occurs when another individual, possibly the addict's spouse or family member is controlled by the addict's addictive behaviour.”

Royce (2001) stressed that enabling behaviour occurs when a co-dependent helps or encourages the addict to continue using drugs, either directly or indirectly; protecting him from the consequences of his/her behaviour. Examples of individuals involved in enabling behaviour are a spouse hiding the addict's dependency from neighbours or their children by untruthful for the addict and giving the addict money to buy drugs. Enabling occurs because loved ones generously provide money to the addict in the naive hope that no lies are being told and in the hope that it will help the addict recover.

It is the researches opinion that families living with the substance abuser learned to believe that love, acceptance, security, and approval are contingent upon taking care of the addict in the way the addict wishes. Unfortunately, this excessively care giving behaviour tends to foster even more dependency on the part of the addict.
Royce (2001) further suggests “Tough love” approach as an effective approach for families enabling substance abuse behaviour. The family must remain tough and not give in to the addict influences. This means that the addict may become homeless while sleeping in shelters. In some cases they may even be arrested and end up in jail. It is thus, essential that the family not attempt to rescue their loved one.

Studies shows that once the co-dependent and enabling behaviour discontinues it then become the choice of the addict to decide whether or not they want to recover from addiction. Many addicts are able to reach a point where they want to recover because they cannot stand to lose any more of what they formerly had. In any event, it is only when the addicted person is face with actual consequences that they can start to make better decisions.

2.2.3. Causes of substance abuse

Theories and explanations have been proposed to describe the reasons individuals become addicted to substances. Research on the causes of addiction is not conclusive, and multiple factors may contribute to the cause of substance abuse.

The following multiple factors are identified by Escandon and Galvez (2007) as common causes for substance abuse:

2.2.3.1 Harmful drinking and drinking problems

The cause of heavy drinking and drinking problems can be understood within the context of an overall view of what “normal” drinking is. Extensive research has shown that the higher the average consumption of alcohol in a population, the higher almost all types of alcohol–related problems are, for example drinking and driving offences, mortality due to cirrhosis of the liver, domestic violence, crime etc.
Patterns of alcohol consumption are characterised by the affects how the drinking problems occur within a person. For example, different drinking problems are likely to occur in a woman who drinks four glasses of wine every day as compared with a woman who drinks two classes of wine in a days but who then drinks nothing for two or three weeks. The woman who drinks four glasses of wine every day will most likely be addicted to alcohol and could experience almost all types of alcohol–related problems in health, relationships, law and social standing (Levin, 2000).

2.2.3.2 Political and economic causes of drinking problems

Reducing the real price of alcohol tends to increase the overall consumption of alcohol by population. Major influences upon per–capital consumption in a population include factors amendable to political manipulation such as taxation licensing laws and trade agreements, Escandon & Galvez (2007).

Many of the influences upon the economics of alcohol consumption are not deliberately manipulated, but follow in the wake of social change. The influence of supply upon demands for alcohol indicates that the alcohol supply system such as production, distribution, wholesale, and import/export and retail sales would be an important consideration in any analysis of alcohol policy in relation to public health and safety. Factors such as density and distribution of outlets may influence local incidence of alcohol–related road accident and violence. To ensure effective cooperation between law enforcement agencies, government and communities, effective alcohol policies should be strengthened.

2.2.3.3 Socio–cultural causes of drinking problems

Acceptability of alcohol consumption plays an important part, which is determined to a large degree by social and cultural values. In culture and societies, there is a mixture of cultural
influences encouraging or discouraging drinking. One of the elements of culture is religious practice. It has been observed that religious observance is correlated with lower rates of drinking problems (Escandon & Galvez, 2007).

Culture can influence the pattern and context of alcohol consumption. The pattern of alcohol consumption may in turn be an important determinant of substance abuse as it may be accompanied by social consequences such as marital disharmony, cultural practices or interpersonal violence.

2.2.3.4 Stress and life events

Alcohol relieves anxiety and thus used as a means of coping with stressful events. An increased frequency of life events precedes the onset of alcohol misuse. Heavy drinking tends to cause further stress in the form of the social problems that generates life events such as divorce, unemployment and ill health (Levin, 2000).

2.2.3.5 Psychological component to drinking behavior

The psychological characteristics of an individual may be seen as a product of their genetic constitution and environment in which they live. Psychological theories of drinking behavior are identified in the following themes: firstly, there are psychodynamic theories which explain drinking as a result of early experiences and relationship. Secondly, the cognitive and behavioral theories explain drinking as a learned behavior and thirdly, it has been suggested that certain personalities are particularly vulnerable, perhaps because of a tendency to use alcohol to deal with stress, anxiety, depression or other problems (Escandon & Galvez, 2007).
2.2.3.6 Mental health disorders

A mental disorder, also called a mental illness or psychiatric disorder, is a mental or behavioural pattern or anomaly that causes either suffering or an impaired ability to function in ordinary life (disability), and which is not developmentally or socially normative. Mental disorders are generally defined by a combination of a person feelings, actions, thoughts or perceptions. This may be associated with particular regions or functions of the brain or rest of the nervous system, often in a social context. Mental disorder is one aspect of mental health.

According to World Health Organization (WHO, 2006) mental health includes "subjective well-being, perceived self-efficacy, autonomy, competence, intergenerational dependence, and self-actualization of one’s intellectual and emotional potential (http://www.the free dictionary.com/mental health).

Barlow (2001) stated that addiction is common in people with mental health disorders. On the other hand although substance abuse and mental health disorders like depression and anxiety are closely linked, one does not directly cause the other. According to reports published by Coll, Doumas, and Haustveit (2010),

- Approximately 50% of individuals with severe mental disorders are affected by substance abuse.
- 37 % of alcohol abusers and 53 % of drug abusers also have at least one serious mental illness.
- Of all people diagnosed as mentally ill, 29 % abuse either alcohol or drugs.

Alcohol and/or drugs are often used to self-medicate the symptoms of depression or anxiety. Substance abuse thus causes side effects and in the long period degrades the very symptoms initially numbed or relieved. Mental disorders are caused by a complex interplay of genetics,
the environment, and other outside factors. If one is at risk for a mental disorder, drug or alcohol abuse may drive one over the edge. Substance abuse, thus may abruptly increase symptoms of mental illness or trigger new symptoms (Levin, 2000).

Levin (2000) further maintains that alcohol and drug abuse also interact with medications such as antidepressants, anti-anxiety pills, and mood stabilizers, making them less effective. When mental health disorders are untreated, the substance abuse increases. And when substance abuse increases, mental health disorders usually degrade.

All causes can induce both pleasant and unpleasant effects. The next sub heading explores different types of substances and effects.

2.2.4 The effects of substance abuse

The effect of substance depends on number of variables, including the type of substance use, the amount taken, the route of administration (whether it is ingested, smoked or injected), and previous experience of using (Barber, 2003).

“A substance is a drug, legal or illegal, that is used or abused by a person as a drug of choice which is having a desired or excited effect on the person. The ongoing repetition of such substance influences the physical, social and emotional behavior of the user” (Barber, 2003, p. 47).

The most commonly used substance are divided into the following three categories namely, stimulants, depressants and hallucinogens (Nelson, 2012).

2.2.4.1 Stimulants

The effect of stimulants increases energy, confidence and feelings of euphoria and elation. The user may also experience a reduction for sleep and appetite. Evidence suggest that the
user would become both physically dependent and suffer from negative psychological symptoms. Various types of stimulants are tobacco, cocaine, amphetamine and methamphetamine.

2.2.4.2  **Depressants**

“Depressants are drugs that slow down the central nervous system and have the opposite effect of stimulants as it reduce anxiety, muscular relaxation and induce inhibition” (Nelson, 2012, p. 36).

Regular use of these substances can lead to physical and psychological dependency and users can suffer from health problems such as cirrhosis of liver, high blood pressure, and damage to the brain, trembling, sweating, anxiety and severe vitamin deficiencies. Depressants consist of drugs such as alcohol, cannabis, benzodiazepines, heroin, volatile substances such as glue, solvents and petrol (Nelson, 2012).

2.2.4.3  **Hallucinogens**

Hallucinogens are taken to produce a sensory experience of something that does not exist outside the mind (a hallucination). These drugs are naturally occurring in certain fungi, cacti and plants, but are also often manufactured in laboratories (Escandon & Galvez, 2007).

According to Escandon and Galvez (2007), hallucinogen users can experience powerful hallucinations and mild dream–like feelings. The use of the drug can cause “out of body” and “near death” experiences. Sometimes a muscular rigidity can occur so that the user remains in the same position until the drug has worn off, on average up to about three to four hours. Adverse effects can include interference with speech, vision, concentration, paranoia, agitation and aggression. Hallucinogens consist of drugs such as ecstasy, ketamine, magic mushroom, lysergic acid diethylamide (LSD).
The sign of all addictions are that the individual loses control and, as a result, experience negative consequences as mentioned above. Oddly, the loss of control can facilitate the start of change, and can open the doorway for treatment.

### 2.2.5 Treatment

Addiction is treatable and many treatment programmes and approaches are available to support alcoholics and drug addicts who have decided to discontinue their substance use. Regardless of how someone came to be diagnosed as being alcohol-dependent or how s/he came to realize s/he has a serious drinking problem, the first step to treatment is a sincere desire to be helped. Alcoholics who are pressured into treatment by social pressure or forced to quit by circumstances, rarely succeed in the treatment centers (Hustard. et al., 2010).

Treatment is defined as the “rehabilitation process of alcohol-related illness or alcoholism as part of the comprehensive approach” (Laberg, 2002, p. 89). Laberg (2002) adds that treatment settings are provided by professionals and non–professionals in primary care, residential rehabilitation, psychiatric hospitals and community alcohol teams. In Namibia, the treatment programmes vary from detoxification, psychiatric treatment to counseling centers. There are six treatment centers namely the Nova Vita, Okonguarri Psychotherapeutic center, two “My 24/7 Wellness” Centers in Swakopmund and Usakos, the Mental Health Unit and the Etegameno Rehabilitation and Resource Centre (Adams, 2007).

In recent times, the treatment of addiction has been dominated by the transtheoretical model proposed by Prochaska and DiClement (1997). The model seeks to provide an integrative framework capable of guiding practices in which drug misuse will pass through the following five stages of change (Heather & Robertson, 2002).
2.2.5.1 Stages of change

Precontemplation Stage

The first stage of change is called precontemplation stage. During this stage, the addict is resistant to change, normally even to the extent of denying that a problem exists. A precomtemplator is someone who gives little or no thought to their problem. Working with a precomtemplator must certainly be one of the most challenging task in treatment of addiction. The researcher is of opinion that the aim of the treatment program will be to sow a seed of doubt in the user’s mind about their drug –using behaviour to reconsider their resistance to change (Robertson, 2002).

Contemplation to preparation stage

During the next stage, called contemplation, the user begins to think about cutting down the substance use. In fact, the contemplator usually doesn’t want change. The user is just starting to weigh up the pros and cons of substance use. The substance user is confronted with consequences which gradually shift their attention to change (Heather & Robertson, 2002).

Action stage

In the action stage, “the user reduces the intake of substance or abstains altogether. The focus is to work intensively with the individual to reinforce fundamental principles towards change” (Heather & Robertson, 2002).

Maintenance stage

Coping behaviors, self–efficacy and high risk situations will be addressed during this stage. The researcher is of the opinion that the above mentioned interventions will aim at enhancing the individual’s coping skills to support drug–free entertainment options and promote a culture consistent with relapse prevention and treatment options (Barber, 2003).
2.2.5.2 Different types of treatment approaches

Many forms of treatment exist, for instance transactional analysis, reality therapy and gestalt methods have been modified for chemical dependency. The five most significant treatment modalities are the moralistic/religion approach, psychodynamic orientation, the Alcoholics Anonymous (AA) Twelve–Step Treatment approach, motivational interviewing and the behavioural/cognitive framework (Sandmaier, 2002).

Moralistic/Religion approach

In the United States there are religious-oriented shelters and halfway houses for recovering substance abusers including private, churches and community resources. This treatment occurs in the form of preaching, praying and work therapy. According to the moralistic view, substance abuse is a “willful misconduct”, which derives from weakness in one’s moral character (Laberg, 2002).

“The definition of spirituality found in recovery describes transpersonal aspects of individual connections to God or other forms of a higher power, whereas religion is associated with social practices, beliefs, ritual, and form of governance” (Laberg, 2002, p.19).

In Social Work literature, the religious approaches have been challenged often in light of historical reference to Christian churches and ideologies. It challenged their credibility on allegations of anti-seminist, racism, classism, sexism, heterosexism, and cultism which contributed to professional distance from recovery programs. Arguing for socio–spiritual approach to recovery, the concern included the understanding that specific religious beliefs excluded many who need help, and fear religious ideology (Morell, 2001). To address these concerns Morell (2001) encouraged social workers to draw upon the spiritual based social justice tradition by using the Twelve–Step approach adopted by Bill Wilson, founder of Alcoholics Anonymous (AA).
Alcoholics Anonymous (AA)

Alcoholics Anonymous (AA) was found in the USA in 1935 by Bill Wilson who was an alcoholic. There are now more than 51,000 groups and over one million members in 170 countries worldwide. AA is a fellowship of men and women who share experiences, strengths and hope with each other to recover from alcohol or drug addiction. The path to sobriety, according to the AA model, is a recovery journey of many small steps. It is a journey not of one individual in isolation but of a substance abuser in the fellowship of recovering substance. The number of people at the meeting will vary from group, but are typically around 10 to 20 people. Some of those present will have been attending AA for years, whereas others are attending for first time. The only requirement for membership is a desire to stop using substances (Robertson, 2002).

Alcoholics Anonymous is not allied with any sect, denomination, politics, organization or institution. The primary purpose is predicated upon (Ch’ien, 2008) four key elements: (1) Changing addictive beliefs, attitudes and behaviour; (2) General agreement with the health model, suggesting that some individuals are physically vulnerable to developing alcoholism and drug addiction; (3) Beliefs that total abstinence from all mood altering chemicals and lifestyle changes are necessary for successful treatment; and (4) Adherence to the principles of Alcoholic Anonymous and Narcotic Anonymous in the Twelve-Step Treatment programme.

The researcher is of the opinion that Alcoholics Anonymous has had a profound influence in humanizing social attitudes towards people with substance dependency. The AA meetings has unique atmosphere, marked by a seeming informality, but an underlying and purposeful method of working to maintain alcohol and/or drug free lifestyle.
**Twelve-Step Treatment programme**

The Twelve-Step Treatment programme provides a blueprint for spiritual development recovery that assists recovering substance abusers to see and acknowledge lack of power in their lifetime as a result of addiction. The steps require from individuals to develop a spiritual orientation to relate to their higher power to utilise it for freedom from the bondage of addiction (Ch’ien, 2008).

The following are the processes of healing through the Twelve-Step Treatment programme (Escandon & Galvez, 2007, p.57):

**Step 1:** Admitting powerlessness over alcohol – that one’s life had become unmanageable.

**Step 2:** Came to believe that a power greater than the individual could restore one to sanity.

**Step 3:** Made a decision to turn one’s will and life over to the care and direction of God, as one understood Him.

**Step 4:** Made a searching and fearless moral inventory of oneself.

**Step 5:** Admitted to God, to oneself, and to another human being, the exact nature of one’s wrongdoings.

**Step 6:** Complete readiness to have God remove all these defects of character.

**Step 7:** Humbly ask God to remove one’s shortcomings.

**Step 8:** Made a list of all persons one had harmed, and became willing to make amends to them all.
Step 9: Made direct amends to such people wherever possible, except when doing so would injure them or others.

Step 10: Continued to take personal inventory and when one is wrong, to promptly admit it.

Step 11: Sought, through prayer and meditation, to improve one’s conscious contact with God, as one understood Him, and to pray only for knowledge of His will for one, and the power to pursue it.

Step 12: Having had a spiritual awakening as the result of these steps, the effort is made to carry this message to alcoholics, and to practice these principles in all aspects of one’s life.

**Psychodynamic therapy**

The treatment focuses on achieving self-understanding and individual responsibility in restoring self-control. Psychodynamic therapy is supportive during the post-treatment and relapse prevention phase. The following basic assumptions (Laberg, 2002) are based on the psychodynamic approach:

- Alcoholism/addiction is not a disease but a symptom of an underlying psychological condition;
- Alcoholics have less control and less emotional stability than nonalcoholics;
- Drinking problems may be alleviated through abstinence or learning techniques of controlled drinking;
- Treatment focuses on early childhood trauma as well as on psychological coping-mechanisms that were learned during childhood.
**Behavioural/Cognitive Approach**

The behavioural and cognitive treatment approach entails learning new coping techniques to reverse the dysfunctional drinking process and to change the behavioural and thinking processes. The basic function of this approach is to provide education and assistance on addictive process; and to restore coping mechanisms that substance abusers can overcome the addiction (Jason, 2006).

**Motivational interviewing**

Motivational interviewing was developed by William Miller in 1982 as one of the significant models to help people who have problematic substance use. Motivational interviewing is a directive, client–centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (Edwards. et al., 2003).

Evidence based motivational interviewing is strong in areas of addictive and health behaviour as it appears to improve outcome when added to other treatment approaches. It is combined with range of other theories and interventions such as social psychology, motivational psychology, stages of change, cognitive dissonance and person–centred counselling (Rollnick & Miller, 2006).

According to Rollnick and Miller (2006), the essence of motivational interviewing is as important as knowing the skills and strategies used in this approach. The authors outlined the following key points to convey motivational interviewing:

- Motivation to change is elicited from the service user, and not imposed from outside the individual. Motivational interviewing relies on identifying and activating the service user’s intrinsic values and goals to stimulate behaviour change and not on coercion, treats or bribes.
• It is the service user’s task, not the practitioner’s, to articulate and resolve ambivalence. The practitioner’s task is to facilitate expression of both sides of the ambivalence impasse, and guide the service user toward an acceptable resolution that triggers change.

• Direct persuasion is not an effective method for resolving ambivalence, as these tactics generally increase service user’s resistance and diminish the probability of change.

• The counselling and communication style is generally a quiet and eliciting one. Direct persuasion, aggressive confrontation and argumentation are the conceptual opposite of motivational interviewing and are explicitly proscribe in this approach.

• The practitioner is directive in helping the client to examine and resolve ambivalence. The specific strategies of motivational interviewing are designed to elicit, clarify, and resolve ambivalence in client–centred and respectful atmosphere.

• The therapeutic relationship is more of a partnership than of expert recipient role. The practitioner respects the client’s autonomy and freedom of choice regarding behaviour change.

The following part of this chapter focused on the advisable steps to recover from addiction.

2.2.6 The Recovery Journey

In 2007, the Substance Abuse and Mental Health Services Administration (SAMHSA) offered the following working definition for recovery:

“Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.”
2.2.6.1 Goals of Recovery

Tasks such as planning, goal-setting, decision-making and communication, all have a role to play in the maintenance of sobriety. Maintenance of sobriety occurs one day at a time. Putting these objectives into operation involves management tasks and skills. The following management tasks could apply to the recovery process (Kelly, 2002).

Planning and structuring one’s day to include prayer, meditation and attending AA meeting, serves to structure one’s daily activities to maximize personal satisfaction. To set effective goals is also implicit in managing recovery. The goals should be specific, measurable in a specific timeframe. Decision-making is another vital recovery function which could be utilised in services of recovery. Responsible decision-making involves six-steps namely: defining the problem, information gathering, analysing the information, developing options and monitoring the outcome of recovery (Room, 2000).

Room (2000) claims that communication is a vital recovery task, because it is important to communicate needs and concerns of others during recovery, and likewise to develop good listening skills, particularly during the groups and individual sessions.

Kelly (2002) adds that reaching out to other recovering substance abusers and securing the necessary help and resources are often needed in recovering process. It is essential to know when help is needed; knowing how to ask for help; and developing the confidence to execute this process.

Determining recovery goals means keeping the goals in mind on a daily basis and using it to guide daily affairs. Daily recording and reflecting on personal goals keeps the recovering substance abuser more focused on achieving recovery goals. Goals could be determined through the following two areas (Stevens, 2003):
**Physical/medical** - Taking care of your personal health especially during the first year of recovery. The neurotoxin effects of drug and/or alcohol abuse could linger for months during the initial treatment process. The study on neurological and cognitive effects of addiction shows that most neuro-psychological damages incurred during active addiction. During the first year of recovery, sufficient care should be done to abstain from substances use.

**Psychological recovery** - Psychoactive drug abuse leads to emotional mismanagement and severe mood-related difficulties. Substance abusers in active addiction, regularly experience extreme anxiety, fear, depression, despair, grief, shame, guilt and other negative emotions. The neurotoxin effects of alcohol and drugs on nervous system can cause further emotional turmoil associated with addiction. Together with abstinence and rest, as well as appropriate therapy, many of these emotional and mood-related problems are resolved without difficulty during the first few months of recovery. Awareness of dysfunctional maladaptive attitudes, beliefs, traits and behaviours is important, as the substance abuser lays the foundation for recovery.

The O’Conell Dysfunctional Attitude Survey was developed by Ivan Miller for recovering substance abusers to measure their strengths and weaknesses in several areas such as validation, achievements, affective control, perfectionism, egocentricity and drives. The result of this survey was used to contrast emotional, psychological and spiritual goals in recovery. Recovery goals assist the recovering substance abuser in eliminating character defects. It could be anticipated that behavioural traits could become less maladaptive and dysfunctional, and more adaptive and evolutionary (Stevens, 2003).

These recovery goals are associated with the Whole Persons Recovery Model, which is explained as next:
**The aspects of Whole Persons Recovery Model**

Bellis (2006, p.78) states “no person should be considered recovered who has not remained drug-free in the community for at least two years.” Recovery is virtually impossible unless a former substance abuser considers all aspect of Whole Person Recovery Model. The Whole Person Recovery Model usually includes a deeply felt renewal of understanding and respect for moral values and a reverence for life.

Bellis (2006) argues that major changes in values appear to go hand-in-hand with the growth of commitment and abstinence in the Whole Person Recovery Model. Religious practices often become important in recovery, which is one of the aspects of Whole Person Recovery Model. Spiritual awakening in recovery supports recovering substance abuser making decision to turn one’s will and life over to the care and direction of God or of Higher power.

The researcher support this view, however, not all recovering substance abuser turn to religion, but most of them draw strength and guidance from an established source of moral or spiritual authority in the Whole Person Recovery Model (Chassin, 2003).

O’Connell, David and Bevvino (2007) describes recovery journey as a progressive process which is demonstrated in the following stages:

**Detoxification stage**

Detoxification treatment includes abstinence from alcohol in a controlled environment and close monitoring of vital signs of withdrawal symptoms. If substance abusers abruptly stop using drugs, withdrawal symptoms and severe drug cravings might occur within few hours. These discomforts vary in their intensity, duration, the type of substance use and according to the person’s drug-taking history (Ch’ien, 2008).
Mild sedatives and certain non-addictive medications are prescribed during the detoxification process to relieve the muscle cramps, insomnia and other symptoms of withdrawal. Some service providers deny substance abusers any treatment to ease withdrawal symptoms. This is a painful withdrawal approach—referred to as “cold turkey”. A substance abuser who had been subjected to ‘cold turkey’ once, go to great lengths not to experience it again. ‘Cold turkey’ is detoxification without any medication. It is used to avoid any re-addiction on any medication during the process of detoxification (Fals-Stewart & O'Farrell, 2003).

**Rehabilitation Stage**

Rehabilitation stage focuses on replacing addictive habits with others habits that are unrelated to the drugs. This stage usually occurs in a treatment center. The aim of this stage is to prevent emotional instability in recovering substance abuser from causing a relapse (Laberg, 2002).

Ch’ien (2008) suggested that those who enter rehabilitation will pass through the following four stages:

1. **Initiation into treatment.** This is when the individual first arrives at the treatment center. This could be a time of diversified emotions, and often the recovering substance abuser will be dealing with the effects of drugs or alcohol used. Some people will be initiated into treatment against their will, and thus feel doubtful of success at this stage.

2. **Early abstinence.** The individual has now committed themselves to go along with the treatment programme. This could be a difficult period because of withdrawal symptoms the recovering substance abuser experience. This might be the first time
that the individual had to deal with life without a substance support, which might be a difficult stage.

3. **Maintaining abstinence.** This can be a treacherous period because it involves moving from rehabilitation back to the society. The individual will have been encouraged to build an armoury of recovery tools during their time in rehabilitation, and now it will be the time to use these tools. This is the time when people are most at risk of relapse. As long as they remain committed to recovery they will make it through this period.

4. **Advanced recovery.** Once people have been sober more than 5 years, they will usually have created a comfortable life away from addiction. The risk of relapse never completely goes away, but maintaining alcohol and/or drug free life, has become a habit. The individual will have faced many challenges during the preceding years, and this will make it easier to deal with any future challenges that come their way.

**Social Integration**

The aim of the social integration is to live an orderly, restructured life; one that is adapted to the social environment. It allows recovering substance abusers to have a clear, realistic and sober view of the future. One should do away with objects, places and people that can be associated with the addiction; and to have a strategy for stressful situation in order to prevent relapse (Laberg, 2002).

Once inpatient treatment is completed, the next step in the recovery process is aftercare service, which will be discussed in the next section.
SECTION III
AFTERCARE SERVICES

2.3 INTRODUCTION

Aftercare services will assist recovering substance abuser into their next transition back into their normal routines and lives. This section will review the literature on the nature of aftercare services for recovering substance abusers.

2.3.1 Definitions of aftercare services

Aftercare is a service in the community that assist recovering substance abuser accomplish specific goals such as reducing the frequency and severity of relapse; fostering social integration; helping families complete their recovery and ensuring the ex-addict’s adaptation to employment (Stevens, 2003).

Aftercare is a forum on which clients might explore achievements, milestones, obstacles or challenges, and day– to-day issues which confront them; and receive feedback and support from the social worker, group facilitator and the other participants” (Chassin, 2003).

It is widely accepted that without strong aftercare services for at least a year or more, most clients would relapse into re-addiction, no matter what form of primary rehabilitation received. Aftercare should not be an afterthought. All clients learn that aftercare is at least as important as rehabilitation. When the client is still fully involved in an inpatient treatment program, introduction to the aftercare program should take place. The clients should be able to visit the facilities offered by aftercare services and meet some of the successful sober addicts in the aftercare programme (Marlatt, 2006).
Correspondingly, the aftercare service should be viewed as an essential phase of the rehabilitation programme. Making new friends, reducing drug craving, developing daily routines, and new recreation activities outside of the institutional structure, is part of the aftercare service to prepare the client to re-adapt to society. Self-help groups are one of the methods in aftercare service delivery. Without self-help groups as transition of culture, most recovering substance abusers would find the new style of living even more challenging (Marlatt, 2006).

It is the researcher’s opinion that, aftercare services are essential to help minimize the risk of recovering substance abusers falling back into addictive behaviours and self-destructive patterns, and keep them moving forward on the road to a completely drug-free lifestyle.

### 2.3.2 Key features of effective aftercare services

#### 2.3.2.1 Non-institutional community settings

The key element of the aftercare services involves non-institutional community settings, where the aftercare group could have both informality and confidentiality. A room in a local social club or community hall, with few undesirable influences is ideal. The membership standards should ensure that only clients, who are truly motivated for aftercare, join the group (Doumas, 2010).

Doumas (2010) argue that aftercare groups and their members are often pulled down by substance abuser who needs primary rehabilitation. Aftercare services are not a pre–motivational stage for primary rehabilitation. Aftercare renders service to recovering substance abuser after primary rehabilitation focusing on active support to recovering substance abusers with the association of successful role models such as ex-addicts who processing in recovery.
The non-institutional community settings support gradual community exposure and re-integration to allow recovering substance abuser to venture into the community. Aftercare groups are uniquely valuable since recovering addict may have no other support at first but that of the other recovering people to serve as influential advisors (Stevens, 2003).

Stevens (2003) also add that effective aftercare service providers are more than counsellors, more than group leaders, and much more than record keepers” (p.23). Aftercare staff should join in the social activities with clients; to do home visit to meet the needs of recovering substance abusers and families.

Ensuring the ex-addict’s adaptation to employment, it is an essential key element in the aftercare services. This will be discussed in the following sub heading.

2.3.2.2 Adaptation to work and responsibilities

The aftercare service requires establishing comfortable and honest relationships with people throughout the community. Jobs, skills, new friendships and opportunities of all sorts come most readily to recovering substance abusers. With the appropriate guidance, the recovering substance abuser could reach out to neighbours, coworkers, fellow students and ex-addicts to adjust to work and tasks in everyday life (Rosenberg, 2001).

2.3.2.3 De-addiction and rejoyment

“De-addiction refers to losing the desire to use drugs, even when the recovering addict is in a situation which proved to be very tempting” (Cook, 2003, p. 256).

Rejoyment is the term use to indicate that a person has developed new drug-free skills and interests which bring pleasure and joy into their lives. After a year of addiction, drug craving and an inability to enjoy life without drugs could become deep-seated features of both mind
and body. These challenges are major factors in relapse, and are best overcome through specialized guidance in the aftercare programme (Cook, 2003).

2.3.3 What Services Can Be Found in Aftercare Programmes?

There are several components that can comprise a substance abuse aftercare and intervention programme. The following components are hallmarks of quality substance abuse aftercare programmes (Chassin, 2003):

2.3.3.1 Counselling

Ongoing counselling can be utilized to support recovering substance abusers identify the underlying mechanisms for their addictions. These sessions are normally done in a group setting but individual sessions can be available if there are unique circumstances. The frequency of these counselling sessions is greatest when the individual has just left rehabilitation and gradually tapers off over time. Depending on the situation, an aftercare programme may also include drop-in counselling or crisis counselling options.

2.3.3.2 Relapse Prevention

“The term “relapse” originates from the “disease” notion of “addiction” and indicates a return to the disease state after a period of remission” (Nelson, 2012, p. 33).

The word ‘remission’ is used to describe the absence of the symptoms of the disease. Obtaining remission or a continuous state of sobriety is the primary goal of substance abuse treatment (Stephens, 2004).

“A “lapse” (slip) indicates a one–off or short–term return to old behaviours, but not a complete return to old behaviours” (Caroll, 2000, p. 76).

Marlatt (2006) illustrates the following five steps, commonly associated with a relapse:
1. Irrelevant decisions
2. A high–risk situations
3. A no–coping response
4. A feeling of helplessness and low self–control
5. A positive expectancy that alcohol or drugs would make the substance abuser feel better.

In the first stage of relapse, the recovering substance abuser would make irrelevant decisions, for example, accepting an invitation which is harmless but not realizing that this person would bring along a bottle of alcoholic beverage. These and other irrelevant decisions put people in a high-risk situation, which is the second stage. High risk situations are any situation that increases the individual’s likelihood of engaging in identified problem behaviours (e.g. heavy drinking), and then provide a number of cognitive and behaviour strategies for reducing a person’s susceptibility to relapse in those situations. During the second stage, the recovering substance abuser could find an opened bottle of wine left over. If they are not prepared to do so, or have no campaign to put into action, the next stage of having no usable coping-response is reached. This leads to feelings of helplessness, low self-control. During the final stage of relapse, the recovering substance abuser will continue drinking, because of the positive effect of alcohol reinforcing continued drinking to reduce the stress, guilt and self-blame (Marlatt & Gordon, 2005).

The disease model is very strong that one must abstain at all cost because a slip or a lapse could be seen as a major failure. People seem to react as though one slip seems to have ruined months of abstaining (Marlatt & Gordon, 2005). Velleman (2006) argues that this principle is untrue. He reasons that people relapse because of uncontrollable urge and the inability to maintain change. This argument is useful because it does not help us to understand why the relapse occurs, but provides an opportunity to take action to prevent a relapse.
“Relapse prevention are techniques focusing on replacing conditioned or automatic responses to certain events with healthier behaviour, as well as correcting the erroneous or careless thinking which so often accompanies a part of relapse” (Caroll, 2000, p.46).

Relapse prevention specialists Coll, Doumas & Haustveit (2010) identified the combination of biological, psychological and social limitations as distant and destructive patterns of thoughts and behaviour. An individualised treatment approach would seek to locate these limitations, and establish the kind of thinking patterns that immediately precedes the drinking episode.

The following are typical examples of thoughts that precipitate substance use in a recovering substance abuser (Dunn, 2008, p.10):

- “Life is not worth living. Who cares anyway?”
- “What is the point of going on?”
- “I cannot stand the strain on my nerves.”
- “My life is just one big mess.”
- “I will never get through this ordeal without a drink.”
- “If I take one drink, I have failed totally.”

Relapse-prevention (RP) is an important component of addiction treatment. The RP model proposed by Marlatt (2006) suggests that both immediate determinants (e.g. high-risk situations, coping skills, outcome expectancies, and the abstinence violation-effect) and covert antecedents (e.g. lifestyle factors, urges and cravings) could contribute towards a relapse occurring. The RP model also incorporates numerous specific and global intervention strategies which allow the therapist and the client to address each step of the relapse process. Specific interventions include identifying specific high-risk situations for each client, and enhancing the client’s skills for coping with those situations, increasing the client’s self-
efficacy, eliminating myths regarding the effects of alcohol, managing lapses, and restructuring the client’s perceptions of the relapse process.

2.3.3.3 Triggers that stimulates relapse

Triggers are any activity, feeling or condition that stimulates failure, rejection or abandonment or even personality traits of passivity, under-assertiveness or dependency and addiction cycle (Roffman, 2000).

The two major drivers of the addictive process are excitement-seeking and tension-reduction. These are often triggered by a particular starting stimulus. This is called "trigger mechanism" for the addiction. Trigger mechanism is the emotion or occurrence that starts a given cycle of addictive behaviour (McKim, 2000).

McKim (2000) says that, trigger mechanisms such as boredom, starts the addictive craving for an unmet need. The roots of trigger mechanisms such as anxiety, isolation, boredom, depression, crises and sense of failure can be traced to experiences one might have disliked as a child.

Self-centred needs are major trigger for many addictions. These needs are known as "polarised narcissism." It is usually found in people who have suffered from early life disruption or damage, and who’s nurturing and dependency needs had not been met. Such people often develop a deep desire for instant gratification. The needs of others never enter the picture because they focus only on their own needs (Roffman, 2000).

The researcher is of the opinion that relapse prevention is a major component of substance abuse aftercare programmes in helping individuals who are newly recovered develop healthy and proactive ways to deal with the stressful situations that in the past would lead to relapse.
2.3.3.4  **Cognitive Therapy**

Evidence suggests that a substantial part of cognitive therapy states these core beliefs develop addictive beliefs that taking drugs will result in desirable consequences. Permissive beliefs may be developed that may allow the patient to justify continued drug use, even when this does not achieve the desired result. With this therapeutic approach to drug recovery the patient’s core beliefs are examined and the patient is shown how those beliefs are dysfunctional. The therapist will prescribe behavioural exercises and assign homework in the aftercare programme (McKim, 2000).

2.3.3.5  **Emotion Regulation**

This concept is emerging in drug and alcohol aftercare services to help individuals identify negative emotional states and prevent the compulsive behaviours that can lead to drug use and abuse.

2.3.3.6  **Educational session on addiction**

The process of recovering and coping techniques on how to deal with relapse should be educated to addicts, families and communities. It encourages communities not to be punitive towards people who relapse after an intensive treatment programme, but to show that the relapse is both a serious and manageable occurrence (Astley, 2004).

2.3.3.7  **“Tennant Creek”**

The ‘Tennant Creek’ aftercare programme includes a variety of activities aimed at helping recovering substance abusers maintaining sobriety when discharged from a residential care. The programme is part of a wider strategy to deal with prevention and intervention in alcohol-related problems. It provides recreational activities such as gyms, outdoor activities, hunting
or fishing outings and alcohol-free discos to encourage healthy - sober lifestyle. (Wattendorf, 2005).

2.3.3.8 Self-help groups

According to Rosenberg (2001) the aftercare service within the self-help approach is best suited to peer groups where social learning is encouraged. Self-help groups offer support to develop strong relationship amongst its members to nourish values of cooperation and mutual concerns. It is an organisation whose rules are made (at least in part) by the members who help members overcome problems with authority and discipline. Most substance abusers do not easily submit to non-addicts’ authority figures or even a counsellor. As members identify more strongly with the group experience and the benefits of discipline, they tend to internalise its authority and acquire self-discipline.

A successful group is described as an intimate community dedicated to its own set of beliefs that fosters positive change in each member’s feelings, thinking and behaviour. A well-developed self-help organisation could make its intimate membership network available to each other on a 24 hour basis, like few professional services would do. Self-help groups come in all sizes and levels of organization; a group focusing on coping with virtually every major life-problem. Probably the most successful and certainly the best-known self-help organisation in the world, is Alcoholics Anonymous (Mohler-Kuo, 2003).

2.3.3.9 Therapeutic community

The Therapeutic community (TC) is another increasingly popular form of aftercare in the addiction field, adopted by and for different cultures worldwide. Therapeutic community is a residential program initially run entirely by the ex-addicts. Today, most TCs include professional counsellors, and incorporate a wide range of rehabilitation services and styles.
The focus of the TC is placed on moderate methods of peer support and social learning (Inciardi et al., 2001).

2.3.3.10 Professional-led aftercare groups

It’s a small group of recently drug-free clients who is guided and supported by a professional service. The group effectiveness depends on how well it engenders important aftercare qualities. Constructive partnership is developing in many settings between professionals and aftercare groups (De Leon, 2000).

2.3.3.11 Cottage Programme

The Cottage programme offers motivational sessions to recovering substance abusers. It is a small group of concerned persons—not more than 10—meeting to provide solutions that empower recovery and to reconnect families (De Leon, 2000).

2.3.3.12 Halfway House

The Halfway house is a residential programmes for recovering addicts who are “half-way” into the community. Substance abusers who graduate from an institutional programme are placed in a halfway house. Most halfway houses require the residents to obtain basic house rules of orderliness and discipline; they have to participate in regular activities, such as peer group meetings of follow up counselling. The recovering substance abuser staying in the halfway house is expected to spend most of the day in the community, employed and involved in building a new drug-free lifestyle. The residents assume responsibility for the management and maintenance of the house. Once the desired progress is achieved, the recovering substance abuser will be discharged from the facility. Halfway houses could also be a resource for aftercare clients who relapse. Clients, who experience a relapse and seek help promptly, are often able to keep their jobs and would not have to return to primary rehabilitation. It is a bridge that helps recovering substance abusers move from institutional
control to unsupervised freedom in the community. It also functions as unique transit terminals, where people on the journey to recovery can get their life in order, before setting out more independently (Mohler - Kuo, 2003).

### 2.3.3.13 Vocational Rehabilitation

Employment represents the most complex challenge to persons in rehabilitation. Adaption to work is an essential aspect to recovery. If the recovering substance abuser cannot support themselves through legitimate labour, they have little chance of remaining drug-free, and might feel they have little reason to do so (McKim, 2000, p. 37).

The vocational programme has become regular components of aftercare services by providing recovering substance abusers with job-related training as well as assistance in finding employment. The theory that employment reduces drug-use is not easy to demonstrate by way of a typical vocational programme, because those who have worked in such programme knows that drug addicts usually drop out of job-related training programme; or, if they found employment, they often don’t keep it for long, for one or other reason. The less severity of the problem the more likely the person stands to benefit from vocational services (Laberg, 2002).

The vocational rehabilitation programme would offer as a safe and supportive environment, where recovering substance abusers and their family members could obtain training and develop vocational skills to foster social integration (McKim, 2000).

### 2.3.3.14 Aftercare Programmes for women

“Female addicts are not as readily visible as their male counterparts, often because communities do not acknowledge that there are signs of addiction, or because men more often than women does the more dangerous work of procuring the drugs, while women tend
to use drugs brought to them. Female addicts need rehabilitation no less than men because they face similar problems in terms of addiction” (Laberg, 2002, p. 12).

Female addicts need a special form of programming to address experiences men usually don’t experience. The experiences that are hidden by female addicts could leave profound psychological scars.

Women addicts find it difficult to enter a residential programme because of responsibilities of having to care for and support children. Pregnancy among women addicts is yet another frequent barrier. The psychological problems women addicts encounter could benefit from the female peer support group programs, by trained female professionals and aftercare groups of female peers and role models. It is exceedingly difficult for most women to share and resolve their concerns in largely male peer groups or with male counsellors. Many women substance abusers harbour deep-seated fears towards men. Therefore, the aftercare programme-staffed by women-is valuable. This program offer women a protective, family-like environment. Aftercare programmes for women could also incorporate training in home-making and parenting skills which were not adequately developed in many clients because of the addiction (Laberg, 2002).

2.3.3.15 Trager therapy

Trager therapy is one of the relaxation methods used as part of an aftercare group to help prevent relapse into addictive behaviors. This approach is based on the idea that new behaviours are best learned when mental and physical activities are combined. Through the body we talk directly to the mind. Movement is essential for awakening and stimulating the brain to learn new behaviours. The Trager therapy contributes to a lifestyle which facilitates healing and helps us lead a healthy life (Hustard et al., 2010).
2.3.4 Aftercare services available in Namibia for recovering substance abusers

Etegameno Rehabilitation and Resource Centre has initiated the establishment of the umbrella body called Organisation for the Prevention and Rehabilitation of Addiction (OPRA) to assist, support and provide sober addicts to stay sober and prevent relapses through the delivery of aftercare services. The main aim of the body is to solicit funds to promote the objectives of the organisation. The organisation strives to accomplish the following in aftercare services (ERRC report, 2011):

- To contribute towards treatment and rehabilitation of people suffering from addiction through counseling and therapy.
- To assist sober addicts to stay sober and prevent relapse through the delivery of aftercare services.
- To provide whole person recovery model through the implementation of the multi-professional team approach.
- To support addicts who completed rehabilitation/treatment services through reintegration into their families and the rest of society and to link them to income generating activities.

Ministry of Health and Social Services has established the following 32 support groups within 13 regions which affiliates under OPRA:

Hardap Region (Established in 2005)
- Cross community
- People’s Morality
- River of Hope

Omaheke Region (Established in 2005)
- Omaheke Substance Abuse Referral committee (OSARC)
Karas Region (Established in 2006)
- Karasburg Support Group
- Reach-Out Support Group

Khumas Region (Established since 2005)
- Circle of Friends
- Blue Cross Namibia
- Christian Dependency Ministry
- King’s Daughters
- Katutura Youth

Kavango Region (Established in 2007)
- Nyaungana support group
- Rundu Aftercare group

Omusati Region
- Andara Aftercare Group

Otjozondjupa Region (Established 2007)
- Okakarara Live and Care Against Alcohol and Drug Abuse (OLCADA), Okakarara
- Tsumkwe Aftercare Group

Ongwena Region (Established in 2007)
- Engela Aftercare Group

Caprivi Region (Established in 2008)
- OASIS support group

Erongo Region (Established in 2009)
- Walvis Bay Aftercare Group
- Swakopmund Aftercare Group
- Henties Bay Aftercare Group
- Usakos Aftercare Group
- Omaruru Aftercare Group
- Okombahe Aftercare Group
- Huisen Aftercare Group
- Karibib Aftercare Group

Oshikoto Region (Established in 2007)
- Lean-on-Me Support group

Oshana Region (Established in 2010)
- Eudafano Support Group

Kunene Region (Established in 2011)
- Khorixas Aftercare Group
- Anichab Aftercare Group
- Erwee Aftercare Group
- Bergsig Aftercare Group
- Fransfontein Aftercare Group

The Aftercare Groups are comprised of volunteers and social workers, including families of the recovering substance abusers, employers, colleagues, sober alcoholics, drug-free dependents and community leaders. The aftercare group focuses on rendering a support service to recovering individuals and families. It is a small group of concerned persons, meeting at a houses or church/school buildings in the community to provide aftercare services within the community. Committees are established in all aftercare groups to coordinate the activities; the families of the recovering substance abusers are assistance to support their families who wants to overcome alcohol and drug addiction (ERRC report, 2010).
2.3.5 What makes aftercare service an effective tool for rehabilitation?

Numerous agencies and organizations have published recommendations on "what works" in aftercare services, but in many cases there is little consistency regarding the specific programs they recommend. The reason for this inconsistency is a lack of uniformly applied scientific standards for what “works”. Results from two studies conducted by National Institute on Drug Abuse speak to the important role which treatment and treatment professionals play in facilitating clients’ engagement in aftercare services. The first study investigated how treatment programs' theoretical orientation influences clients' participation in, and benefits derived from, aftercare groups. Findings indicated that clients in aftercare groups and eclectic treatment programmes (combining 12 - step and cognitive-behavioural approaches) had higher rates of subsequent attendance than did clients in the cognitive-behavioural treatment programmes. Moreover, programme orientation moderated the effectiveness of aftercare participation as the degree of programmes effectiveness and positive relationship between. The second study extended the investigation to cost effectiveness and reported that compared to patients treated in cognitive - behavioural programmes, those treated in aftercare service oriented programmes had significantly greater involvement in aftercare groups at follow-up, fewer outpatient continuing care visits after discharge and fewer days of inpatient care resulting in 64% higher annual costs in cognitive-behavioural programmes (Chassin, 2003).

Another factor that can make aftercare programme effective is employment. Employment provides more than the income necessary to support adequate material conditions. It also provides structure and routine. It provides opportunities to expand one’s social network to include other productive members of society. In addition to all this, it can contribute to enhanced self-esteem and other psychological health (Laberg, 2002).
Laberg (2002) further maintains that structured programme are more effective in aftercare service, when they are centred on a full diagnostic and assessment of recovering substance abuser. In contrast aftercare services could be ineffective because it is voluntarily, and a large number of recovering substance abusers do not participate and are subsequently discharge into the community without any pre-discharge preparation.

2.3.6 Family involvement

The families of substance abuser become deeply ashamed of the destructive actions of their family members suffering from alcohol and drug problems. Families might become secretive and withdraw from normal interactions with the community. The expenses devoted to the cost of drugs might place severe strain on the families of substance abusers (Levin, 2000).

The family, as a living system, has not only been affected by the addiction, but might actually perpetuate or enable it unknowingly. As in the case of the addict, the whole family needs help to make their own journey to ‘recovery’. Families need to overcome the shame of addiction and become more active in their neighbourhoods. The families should learn how to cope with the recovering substance abuser; how to be supportive, and yet stand firm. It is essential that they know how to face problems, perhaps even a relapse (Levin, 2000).

The following are the appropriate vehicles for services providers, when working with the family (Ch’ien, 2007):

The programme must educate the family about addiction and recovery. The aftercare services should offer open lecture which family members would be able to attend freely. It should provide simple written material that explains drug addiction, and how people recover from it. Aftercare programme and the family should be allies. In order for clients to commit
themselves to the rigours of an aftercare programme or to adhere to its recovery principles in the home, it is vital that family members support the programme (Levin, 2000).

The researcher agrees that families must feel a part of the aftercare programme; they must understand and approve of it; families must have confidence in the aftercare service providers; families must feel that the aftercare service providers trust and respect them. Families can be helped even if the recovering substance abuser makes no change. Family members who wish to talk about their problems should have access to capable counsellors, to offer relevant guidance and reliable information. Families often need other forms of service and, even though the rehabilitation programme might not be able to meet those needs directly; the aftercare staff should have the appropriate information about where help might best be obtained (Heather & Robertson, 2002).

2.3.7 Community education

“The community needs to know that recovering substance abusers can recover and that they usually reach a point where they want to stop using the chemical substance, but cannot do so without long-term assistance” (Velleman, 2006).

Communities need to know how to support recovery efforts in everyday life through understanding what addictive lifestyles are; how it develops; the effects it has on families, which rehabilitation programme are available, why addicts relapse, and the journey to recovery (Velleman, 2006).

To get recovery underway, substance abusers are, commonly, removed from society and admitted to hospital or inpatient rehabilitation centres. Managers of such institutions should consider that clients must ultimately return and re-adapt to their community. Treatment centres should, as far as possible, depict the natural environment. Institutionalisation seems to
exacerbate the stigma that accompanies addiction. The more prison-like and isolated the programme, the less likely it is that the people in the community would seek to be associated with the recovering substance abusers (Mohler-Kuo, 2003).

Concerned citizens should be mobilising to serve as volunteers in aftercare service as one of the best ways to reduce barriers between institutions and communities.

2.3.7.1 The importance of involving volunteers

Volunteers could work directly with clients as instructors, tutors, coaches or in another facet, where necessary. The role of volunteers is to act as a companion and mentor for the recovering substance abuser (Davidson, 2007).

“Volunteers bring to relationship, joy and care which often the full-time service providers cannot always muster” (Davidson, 2007, p.76). Volunteers should be carefully selected as positive role model with qualities which clients would wish to emulate. Volunteers need well-defined tasks which are enhanced through an orientation, training and supervision programme. Supervision entails nurturing the spirit of the volunteer in order to facilitate effective teamwork. Ceremonies to honour volunteers, especially when it takes place within the community, are ideal for sustaining their commitment and stimulating the spirit of community service and volunteerism (Velleman, 2006).

2.3.7.2 Ex-addicts as volunteers

Ex-addicts, who have achieved the goal of recovery, are the most valuable human resource for aftercare services. The following are several key tasks which ex-addicts /recovering substance abuser as volunteers could perform (De Leon, 2000):

- Helping to counsel recovering substance abusers;

- Co-leading self-help support groups;
• Serving as mentors to other recovering substance abusers who are coping with social-reintegration;

• Helping to counsel family members of recovering substance abusers;

• Encouraging active addicts to submit for treatment;

• Helping planners and policy-makers understand recovery needs;

• Helping to coordinate activities associated with recovery, within the community; and

• Educating the public about the problems associated with addiction and recovery.

2.3.7.3 NGOs as programme partners

Non-Governmental Organisations (NGOs) should be encouraged to become involved in aftercare services, to offer unique services linked to the positive elements in the community. The government-run programme stands to benefit from forging a partnership with community-based NGOs. The NGO members could serve as volunteers or become part of a community network involved in aftercare programmes. NGOs which focuses on the provision of activities such as international cooperation, self-help groups or neighbourhood sport clubs, would be of immense value (Levin, 2000).

2.4 SUMMARY

This chapter demonstrates the underlying knowledge and assumptions from related literature studies regarding the dynamics of addiction and aftercare services.

The layout of the chapter paid attention to the history and definition of substance abuse; the causes and effects of substance abuse; the stages of addiction, the recovering process and the content of the aftercare services.
The Alcoholism and Drug Addiction Research Foundation (2008) claims that recovery is a lifelong process which tends to unfold in a sequential, predictable fashion. It is important to deal proactively with recovery to anticipate concerns and address it as it may arise. Addictive behaviours are socially acquired and multiply determined by past learning experiences, situational antecedents, and biological make-up, cognitive processes and reinforcement contingencies. The effects of substance will depend on a number of variables, including the amount taken, the type of substance, the route of administration (whether it is ingested, smoked or injected), and previous experience of using (Barber, 2003).

Treatment settings are provided by professional and non-professionals in primary care, residential rehabilitation, psychiatric hospitals and community. The Twelve-Step Treatment programme was identified as a main vehicle in recovery, as it focuses on spiritual orientation to achieve self-understanding and individual responsibility in restoring self-dignity. All other aspects of Whole Person Recovery Model require a continuous abstinence to prevent the instability from causing a relapse (Laberg, 2002).

Relapse-prevention (RP) is an important component of addiction treatment. The RP model proposed by Marlatt (2006) suggests that both immediate determinants (e.g. high-risk situations, coping skills, outcome expectancies, and the abstinence violation-effect) and covert antecedents (e.g. lifestyle factors, urges and cravings) could contribute towards a relapse occurring. The RP model also incorporates numerous specific and global intervention strategies which allow the therapist and the client to address each step of the relapse process. Specific interventions include identifying specific high-risk situations for each client, and enhancing the client’s skills for coping with those situations, increasing the client’s self-efficacy, eliminating myths regarding the effects of alcohol, managing lapses, and restructuring the client’s perceptions of the relapse process.
The essential element in achieving recovery is by means of aftercare services. The key elements of aftercare service are adaptation to work and responsibilities; de-addiction and re-joyment and personal growth and self-acceptance (Rosenberg, 2001).

Aftercare services should support gradual community exposure and re-integration to allow recovering substance abuser to venture into the community. Self-help groups are uniquely valuable since recovering addict may have no other support at first but that of the other recovering people to serve as influential advisors (Stevens, 2003).

Aftercare programme and the family should be allies. Families must feel a part of the aftercare programme; they must understand and approve of it; families must have confidence in the aftercare service providers. Communities need to know how to support recovery efforts in everyday life through understanding what addictive lifestyles are; how it develops; the affects it has on families, which rehabilitation programme are available, why addicts relapse, and the journey to recovery (Velleman, 2006).

To get recovery underway, substance abusers are, commonly, removed from society and admitted to hospital or inpatient rehabilitation centres. Managers of such institutions should consider that clients must ultimately return and re-adapt to their community. Therefore, communities should be mobilised to serve as volunteers in aftercare services as one of the best ways to reduce barriers between institutions and communities. The role of volunteers is to act as a companion and mentor for the recovering substance abuser. The NGO members could serve as volunteers and become part of a community network involved in aftercare programmes (Davidson, 2007).

Aftercare services should be viewed as an essential phase of the rehabilitation process of recovering substance abusers. The recovering substance abusers are helped to explore
achievements, milestones, obstacles or challenges, and to receive feedback and support from
the social worker and aftercare group members.
CHAPTER THREE

RESEARCH METHODOLOGY

3.1. INTRODUCTION

The chapter covers an overview of the methodology used in the study. The discussion in the chapter is structured around the research design, population sampling, data collection, data analysis and ethical considerations.

3.2. PURPOSE OF THE STUDY

The purpose of the study was to explore the nature of after care services for recovering substance abusers in Namibia. The researcher saw the necessity of conducting this study because evidence suggests that recovering substance abusers in Namibia currently are experiencing relapse after inpatient treatment programmes due to the lack of adequate aftercare services in the country.

The research design was Phenomenology Design to explore the lived experiences of individuals in the recovering process of aftercare services. The researcher aimed to study the experience of recovering substance abusers, the families of recovering substance abusers, the members of aftercare groups and key stakeholders in the provision of the aftercare service.

3.3. RESEARCH DESIGN

The researcher employed a phenomenological research design to achieve the objectives of this study. The study is an explorative, descriptive and contextual qualitative study.
3.3.1 Qualitative approach

The researcher used the qualitative approach to explore specific facets of the aftercare service and to give voice to participants’ experiences. The researcher used explorative, descriptive and contextual qualitative research design.

3.3.2 Phenomenology

The phenomenological research approach was most appropriate to the aim of the study, which is to explore and understand the lived experience of individuals in the aftercare service. It allowed participants, through in–depth interviews, to elicit the meaning of their experience of being involved in the aftercare service.

Qualitative phenomenology was employed for the purpose of: (Streubert & Carpenter 2003).

• It provides in-depth information in understanding the experience the recovering substance abuse experience after inpatient treatment programme.

• Fostering human responsibility in the construction of realities.

• Tightening the bond between experience and the concepts and theories used to explain the participant experiences.

• The findings of the study can assist service providers in enhancing the service delivery of quality aftercare service to recovering substance abusers.

3.3.3 Descriptive research

Reason for using the descriptive method in this study was to understand the experiential meaning of being involved with people in need of aftercare services. A descriptive approach in data collection in qualitative research gives the ability to collect accurate data on and provide a clear picture of the phenomenon under study (Mamabolo, 2009).
This means that the researcher collects data of experiences of participants being involved in aftercare service.

3.3.4 Contextual research

The contextual studies focused on specific events in “naturalistic settings”. Naturalistic settings are uncontrolled real-life situations. Research done in a natural setting refers to an enquiry done in a setting free from manipulation (Streubert & Carpenter 2003). This means that the study was done where aftercare services were performed. The phenomenon is studied for its intrinsic and immediate contextual significance (Mamabolo, 2009).

3.3.5 Explorative research

Burns and Grove (2003) define exploratory research as research conducted to gain new insights, discover new ideas and/or increase knowledge of a phenomenon.

In this study, the researcher selected the exploratory method to gain new insights; discover new ideas and increase knowledge of experience of being involved in the aftercare services. The researcher therefore entered the research field with curiosity from the point of not knowing and to provide new data regarding the phenomena in the context (Burns & Grove, 2003).

3.4 RESEARCH METHODOLOGY

According to Polit and Beck (2006), research methodology refers to the ways of obtaining, organising and analysing data. The research methodology in this study consisted of population, sampling, procedure, research instruments, data collection and data analysis.
3.4.1 Population

Population is defined as “the aggregate or totality of those conforming to a set of specification” (Polit & Hungler, 2004, p. 87). It is also further defined by Babbie (2010) as “that group of people about whom we want to draw conclusions” (p. 116).

For the purpose of this study the population consisted of recovering substance abusers who completed an inpatient treatment programme either ERRC or any other inpatient treatment centers and attending aftercare services; a family member of any recovery substance abuser who completed inpatient treatment programme, aftercare group members and professionals working in the field of substance abuse prevention, treatment and aftercare services.

3.4.2 Sampling

Sampling refers to the process of selecting a portion of the population that conforms to a designated set of specifications to be studied. A sample can thus be referred to as a “subset of a population selected to participate in the study” (Reiter, Stewart & Bruce, 2011, p. 56).

A total number of 40 participants were identified, comprising of ten recovering substance abusers, ten family members of recovering substance abusers, ten members of the aftercare groups and ten key informants, namely social workers rendering aftercare services to recovering substance abuser.

The researcher used non–probability sampling to select 40 participants according to the purposive sampling method. The method was chosen because the researcher wanted to develop a rich or dense description of experiences regarding recovering substance abusers.
The participants that were chosen met the criteria set for the study. Clear identification and formulation of criteria for the selection of participants were provided to collect the richest possible data (De Vos et al., 2005).

The following selection criteria were used for each category:

**Recovering substance abuser**

i) Only participant who completed an inpatient treatment programme either ERRC or any other inpatient treatment centers.

ii) Recovering substance abuser who completed inpatient treatment programme and is integrating into society for more than a year.

iii) Recovering substance abuser attending aftercare services.

iv) Can communicate in English.

**Family member of recovering substance abuser**

i) A family member is not necessary the relative of the sampled recovery substance abuser; it can be a family member of any other recovery substance abuser who completed inpatient treatment programme.

ii) A family member who is supporting the recovering substance abuser.

iii) A family member that at least attended sessions with the aftercare groups.

iv) Can communicate in English.

**Aftercare group members**

i) Active member in the aftercare group for more than 6 months.

ii) Can communicate in English.

**Key informants**

i) The key informants having knowledge in the field of substance abuse and rendering aftercare services to recovering substance abusers and families.
ii) Can communicate in English.

3.4.3 Research instruments

Face-to-face interviews were the main research tool and primary instrument. The researcher played a major role in conducting the interviews without the help of research assistants (Streubert & Carpenter 2003).

The researcher used a semi-structured interview with each group targeted study population, namely: the recovering substance abusers, the families of recovering substance abuser, members of an aftercare group, and key informant. Face-to-face interviews were used to understand the perception of lived experience by recovering substance abusers. The interview schedules were developed with open – ended questions. A tape recorder and field notes were used during the interviews. According to De Vos (2005), this approach reflects the open and accepting style of interviewing that seeks to elicit the genuine views and feelings of participants.

3.4.4 Procedure

A pilot study was conducted with one recovering substance abusers; one family member; one member from the aftercare groups; and key informant for the purpose of testing the interview schedules. Pilot testing is defined as a small-scale study conducted prior to the main study on a limited number of subjects from the population at hand. Its purpose is to investigate the feasibility of the proposed study and to detect possible flaws in the data collection instruments (Van Der Walt & Van Rensburg, 2006).

The purpose of the pilot testing was to establish whether participants would understand and effectively respond to the questions. The pilot testing revealed that some of the questions needed to be rephrased.
Invitations were delivered and appointments made with the selected participants. Before the researcher conducted each interview, she explained that the interviews will be semi-structured and that probing questions would be determined by the information given by the participant, she also asked permission to record the interviews. The participants were ensured about confidentiality before signing the informed consent forms indicating their acknowledgment to participate voluntarily in the study.

The interviews were conducted for 45 minutes with each participant although some interviews were longer. All interviews were done in English. Open-ended questions were asked allowing participants to respond in their own words (Polit & Hungler, 2001).

The researcher rephrased and repeated questions as to gain information. The researcher repeats in her own words, the ideas, opinions and feelings of interviewees correctly (De Vos et al., 2005).

Observations were made about the environment and social settings in which the recovering substance abusers were living as well as the availability of resources in the communities. The whole interview was tape-recorded and the researcher abstracted data from the material after the interview.

Debriefing sessions lasting 15 minutes were held after each interview to identify the underlying factors that may have influence participant’s responses. After the interviews, the researcher analysed the information on the tape recorder and translated the interviewee’s responses into meaningful description (De Vos et al., 2005).
3.4.5 Data collection

In-depth, semi-structured, open, face-to-face interviews were conducted. The researcher gathered descriptive data through interviewing.

3.4.5.1 Conducting interviews

Researcher employed the following step by Giorgi (2009) to conduct interviews:

a. The researcher made appointments with each participant.
b. The researcher created a quiet room conducive to conversation; chairs were arranged to enhance face-to-face interviewing
c. Tape recorder were prepared
d. Before the researcher conducted each interview, she acknowledged the time and willingness of participant to be part of the study.
e. Written permission to conduct interviews and permission for tape recording was obtained from participants.
f. The researcher explained that the interview will be semi-structured and that probing questions would be determined by the information given by the participant.
a. The researcher used open-ended questions to encourage participants to speak by closely following the content and meaning of their verbal and non-verbal conversation.
b. In order to understand the progress of conversation, the researcher asked for clarification from the participants by repeating in her own words the ideas, opinions and feelings of participant.
c. The researcher showed sensitivity to the uniqueness of each participant throughout the interview by using the attributes in Social Work, namely empathetic understanding, active listening, non-judgmental and flexibility.
d. The whole interview was tape-recorded and the researcher abstracted data from the material after the interview was over.

### 3.4.5.2 Interview schedules

A set of predetermined questions were arranged in separate themes recommended by (Schuman, 1997, as cited in Mamabolo, 2009). It was meaningful to arrange the questions to guide the researcher to ensure that the interview gives the specific information required for the purpose of the study.

Field notes were used to write down preconceptions, observations, and interpretation experienced during the course of the interview. The field notes were used not only to record non-verbal behaviour, the participants’ body language such as eye contact and the participants’ behaviour were also noted (Creswell, 2007).

### 3.4.6 Data analysis and coding procedures

According to Creswell (2007), data analysis is conducted to reduce, organize and give meaning to data.

This section will give a detailed explanation of the data analysis and procedures utilised to analyse the interview transcripts of the participants in this study. The discussion is structured according to the categories and subcategories that were identified through the analysis of the data that were collected to explore the experiences of recovering substance abusers, family members, aftercare groups and key informants.

#### 3.4.6.1 Data Analysis

Tesch’s method of data analysis was applied in this research study to analyse the data collected through the phenomenological one-on-one interviews with recovering substance abusers, family members, aftercare groups and key informants. The analysis process involved the following eight steps:
1. The researcher carefully read through all the transcriptions, making notes of ideas that came to mind; replayed the tape after the interview to listen to voice, tone, pauses and responses as well as to the entire content.

2. The researcher selected one interview and listen it to try to get meaning in the information, writing down thoughts and descriptions.

3. After going through the transcripts, the researcher arranged the similar topics in groups by forming columns labelled major topics; unique topics; and also leftovers.

4. The researcher then abbreviated the topics as codes and wrote the codes next to the appropriate segment of the text.

5. The researcher found the most descriptive wording for the topics and converted them into themes and categories. Lines drawn between the categories indicated interrelationship of categories.

6. Final decision was then made on the abbreviation of each category and the codes were arranged alphabetically.

7. The data belonging to each category was put together in one place and preliminary analysis performed.

8. Recoding of the data was done where necessary.

Computer software was utilised for efficient data storage and retrieval (Streubert & Carpenter 2003)

3.4.6.2 Coding

Coding is the process of organizing and sorting your data. Codes serve as a way to label, compile and organize your data. Data can be coded according to categories and sub-categories identified by reading and re-reading the data collected (Creswell, 2007).
After the analysis of the participant’s transcriptions, the researcher used the content analysis technique to analyse the collected data. A classification or coding system using common themes and categories that emerges was then created. The researcher categorized recurring themes into subcategories, recurring categories into broader categories which eventually led to the construction of major categories. Colour coding, filed notes and word tables were utilized for the data analysis. This means that all the information with the same meaning was coded with the same colour where after it was posted on the board and word tables.

This process was repeated three or four times in some cases to ensure the integrity of the process. The data analysis was a lengthy and on-going process and continued until saturation of the themes and sub-themes were achieved. The results are indicated in table 2 and further elaborated upon in chapter 4.

3.4.7 Measures to ensure trustworthiness

Trustworthiness refers to adherence to high standards such as adequacy and solidity of the research design. Qualitative researchers submitted that without rigor, the research will be worthless Giorgi (2009).

Some researchers use terms such as reliability and validity when they define trustworthiness. Terre Blanche et al., (2006) asserts that validity and reliability are two factors which any qualitative researcher should be concerned about while designing a study, analysing results and judging the quality of the study.

Neuman (2011) has proposed that trustworthiness be seen in terms of its validity and reliability and evaluated according to credibility, transferability, dependability and conformability, member checking and audit trail. These following concepts were used to provide evidence of the validity and reliability of the research study.
3.4.7.1 Credibility

Credibility has been defined as the extent to which science is recognized as a source of reliable information about the experience lived by participants. The credibility of a research study can be established through peer de-briefing, prolong filed experience, pilot study, persistent immersion in the data and the field, triangulation, reflexivity, acknowledgement of negative or deviant cases and member checking.

To ensure credibility the researcher employed the following measures:

- Peer de-briefing
  
  Peer debriefing is a process of exposing oneself to a disinterested peer in a manner paralleling an analytic session and for the purpose of exploring aspects of the enquiry that might otherwise remain only implicit in the inquirer's mind. Peer debriefing exposes a researcher to the searching questions of others who are experienced in the methods of enquiry, the phenomenon or both (Polit & Hungler, 2004).
  
  In this study, the researcher exposed the research work to colleagues in the field of substance abuse for constructive criticism.

- Prolong engagement
  
  Prolonged engagement is the investment of sufficient time to achieve certain purposes: learning the “culture”; testing for misinformation introduced by distortions either of the self or of the participants; and building trust (Mamabolo, 2009).
  
  The researcher stayed in field until data saturation occurred, therefore interviews were carried out until data saturation occurred were the researcher experienced that the quality of information obtained from the participants were rich and adequate (Creswell, 2007).
Prolonged engagement is one of the strategies that increased credibility of this study. The researcher worked at Etegameno Rehabilitation and Resource Center, where aftercare services are performed. This reflects the researcher’s prolonged engagement with participants of the phenomenon under study. Enough time was spent with the participants to develop a trusting relationship with them during the interviews and member checks (Polit & Hungler, 2004).

- **Triangulation**

Triangulation is defined as the mixing of data or methods so that diverse viewpoints or standpoints cast light upon a topic. The mixing of data types, known as data triangulation, is often thought to help in validating the claims that might arise from an initial pilot study (De Vos et al., 2005).

A pilot study was done to test the process of the study whereby the research design for the prospective research study was tested to gain information, which could improve the major study. A pilot study was conducted with one recovering substance abusers; one family member; one member from the aftercare groups; and key informant for the purpose of testing the interview schedules. The purpose of the pilot testing was to establish whether participants would understand and effectively respond to the questions. These viewpoints were then compared for similarity and differences.

- **Reflexivity**

Reflexivity entails the researcher being aware of his/her effect on the process and outcomes of research based on the premise that “knowledge cannot be separated from the knower and that, there is only interpretation” (Neuman, 2011,p. 32).

The researcher is part of and not divorced from the phenomenon under study and, in the study, was constantly taking the position of a main research tool. The researcher explored
personal feelings and experiences that might influence the study and integrated this understanding into the study to promote objectivity. The analysis of the researcher’s experience made the researcher aware of possible biases and preconceived ideas. Bracketing was implemented throughout the study and each phase of the research was carefully approached using bracketing (to lay aside what is known) and intuiting (looking at the phenomenon) to avoid bias and approach the phenomenon with an open mind (Polit & Hungler, 2004).

- **Member checking**

Participant debriefing or member checks involved the researcher returning to the participants and checking the findings with him/her to confirm their experience as true (Polit & Hungler, 2004).

The researcher did member checks with the participants’ feedback. The participants checked categories that emerged from the data, and after the themes were finalised the researcher discussed the interpretation and conclusions with them.

### Transferability

Transferability involves evidence of external validity achieved through the presentation of ‘thick descriptions’ which allow the reader to determine whether the conclusions of the research are in fact relevant to their own circumstances and therefore to them (Cresswell, 2007). Participants’ own responses and words were used to illustrate the various real-life contexts and views across the range of answers given.

Transferability also refers to the extent to which the findings can be applied in other contexts, or with other participants. The researcher approached the participants that had experience and knowledge of the phenomenon under study, i.e. that were involved in aftercare services. Transferability was ensured through the process of member checks and sharing the findings with social workers and aftercare group members who did not participate in the study. This
would enhance the possibility that the findings have the same meaning for other social workers and aftercare group members (Neuman, 2011).

- Literature control

During the process of literature control the results were compared and contextualised with other studies as well as relevant literature available (Polit & Hungler, 2004).

A literature control was done to refer to similar findings from other studies where possible. The researcher intended to contribute to the academic knowledge to substance abuse and aftercare services. Literature control was conducted after the data collection and analysis process in order for the researcher to stay objective (Cresswell, 2007).

3.4.7.3 Dependability

According to Streubert and Carpenter (2003), dependability is related to consistency of findings. This means that if the study were repeated in a similar context with the same participants, the findings would be consistent. In qualitative research the instruments to be assessed for consistency are the researcher and the participants, such as the better understanding of the researcher, the research participant fatigue and also changes in the participant’s life-world as they themselves experience.

The following dependability strategies were implemented to ensure and increase the consistency of this research study:

- Field notes, transcript of each interview and tape recording were used.
- Peer evaluation and discussion took place where research protocol was discussed. These discussions enabled the researcher to establish the stability, applicability of the research design and the progress of the research plan (Mamabolo, 2009).
• Code – recoding procedures: Consensus discussion between the researcher and if dependent coders took place in order to reach an agreement on themes and categories (Creswell, 2007).

3.4.7.4 Confirmability

Streubert and Carpenter (2003) stated that confirmability is the degree to which the findings of the research study were the product of the focus of the inquiry and not the biases of the researcher involved in this inquiry. Strategies of confirmability that were implemented to increase the neutrality of this research were:

• Reflexive analysis: Reflexive analysis was of importance, as it ensured that the researcher was aware of her influence on the data and this research study. The researcher explored personal feelings and experiences that might influence the study and integrated this understanding into the study (Neuman, 2011).

• Auditing of the research process: The use of audit strategies is a systematic collection of materials and documents so that dependent or external auditors come to comparable conclusions about the data. The purpose of confirmability is to illustrate that the evidence and thought processes give another researcher the same conclusions as in the research context (Streubert & Carpenter, 2003). Mr. Wamundila Chilinda, a research consultant, served as the auditor with experience and familiarity with qualitative methods of data collection and analysis. He reviewed the audit trail which consisted of the raw data (transcripts). These items were reviewed with an interest in determining if the findings could be traced back to the raw data.

Finally, the data analysis focused on ensuring that there was logic and clarity associated with the coding process and thematic development process.
3.5 RESEARCH ETHICS

The ethical measures in this study include consent, confidentiality and anonymity, privacy, right to withdraw from the study and dissemination of results.

3.5.1 Consent

The researcher’s request for permission to conduct the study was forwarded to the Ministry of Health and Social Services and was obtained. Written permission (informed consent) was also sought from participants for the interviews (Polit & Hungler, 2004).

3.5.2 Confidentiality and anonymity

Polit and Hungler (2004) state that “confidentiality means that no information that the participant divulges is made public or available to others” (p.143). The anonymity of a person or an institution is protected by making it impossible to link aspects of data to a specific person or institution. Confidentiality and anonymity are guaranteed by ensuring that data obtained are used in such a way that no one other than the researcher knows the source. In this study no names were attached to the information obtained, but codes were used.

According to De Vos (2005), privacy refers to agreements between persons that limit the access of others to private information. In this study, the researcher ensured that when participants described their experiences of being involved in aftercare services, the information given was not divulged. In this study, privacy was also maintained by not attaching participant’s names to the information.

3.5.3 The right to withdraw from the study

The participants were informed that they could withdraw from the study at any time if
they wished to. This right was explained to them prior to engagement in the study, before the interview (Mouton, 2001). This right is part of the informed consent (see Annexure E).

3.5.4 Dissemination of results

Results were disseminated in the form of a research report. The report would stimulate readers to want to study it and also determined its feasibility for implementation (De Vos, 2005).

The report should not expose the secrets or weaknesses of the aftercare service to the readers, but should recommend improvements of the service.

3.6 SUMMARY

The research design in this study was phenomenological research approach which is to explore and understand the lived experiences of individuals in the aftercare service. The present study is an explorative, descriptive and contextual qualitative study. The method of gathering information was semi-structured interview with recovering substance abuser, families of recovering substance abuser, members of aftercare groups and key informants. The researcher gathered descriptive data through interviewing. The data was analysed and coded in key categories that were develop into themes and sub-themes.

The ethical measures in this study included consent, confidentiality and anonymity, privacy, right to withdraw from the study and dissemination of results.
CHAPTER FOUR

PRESENTATION AND INTERPRETATION OF RESULTS

4.1 INTRODUCTION

This chapter outlines the qualitative findings of four categories of participants: the recovering substance abuser, family member, aftercare groups, and key informants. The results of the study are discussed in terms of themes, sub–themes, patterns, direct quotations (in italics) and interpretations.

4.2 RESULTS OF STUDY

4.2.1 Category one: Recovering substance abuser

Table 1: Profile of the participants

<table>
<thead>
<tr>
<th>Participant (P)</th>
<th>Gender</th>
<th>Age</th>
<th>Region</th>
<th>Name of the Aftercare group</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>45</td>
<td>Hardap Region</td>
<td>Cross Community Aftercare group</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>36</td>
<td>Omaheke Region</td>
<td>Omaheke Substance Abuse Referral Committee (OSARC)</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>38</td>
<td>Khomas Region</td>
<td>King’s Daughters</td>
</tr>
<tr>
<td>4</td>
<td>M</td>
<td>32</td>
<td>Otjozondjupa Region</td>
<td>Okakarara Live and Care Against Alcohol and Drug Abuse (OLCADA)</td>
</tr>
<tr>
<td>5</td>
<td>M</td>
<td>38</td>
<td>Omusati Region</td>
<td>Andara Aftercare Group</td>
</tr>
<tr>
<td>6</td>
<td>M</td>
<td>25</td>
<td>Erongo Region</td>
<td>River of Hope</td>
</tr>
<tr>
<td>7</td>
<td>M</td>
<td>28</td>
<td>Khomas Region</td>
<td>Katutura Youth</td>
</tr>
<tr>
<td>8</td>
<td>M</td>
<td>31</td>
<td>Kunene Region</td>
<td>Khorixas Aftercare group</td>
</tr>
<tr>
<td>9</td>
<td>M</td>
<td>45</td>
<td>Hardap Region</td>
<td>Cross Community Aftercare group</td>
</tr>
<tr>
<td>10</td>
<td>F</td>
<td>42</td>
<td>Kunene Region</td>
<td>Fransfontein Aftercare group</td>
</tr>
</tbody>
</table>
The results of the study are summarised in Table 2 and discussed in terms of themes and sub-themes of recovering substance abusers.

**Table 2:** Identified themes and sub-themes on experiences of recovering substance abusers in aftercare services

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub-themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong>&lt;br&gt;4.2.1.1 The commencement of aftercare service.</td>
<td><em>Sub-theme 1: Experiences of moving from rehabilitation to normal living</em>&lt;br&gt;- Referral to aftercare services&lt;br&gt;- Preparedness of joining aftercare services</td>
</tr>
<tr>
<td><strong>Theme 2:</strong>&lt;br&gt;4.2.1.2 The needs of the recovering substance abusers in aftercare service.</td>
<td><em>Sub-theme 1: Relapse prevention</em>&lt;br&gt;- Family support&lt;br&gt;- Keep triggers and cravings in control&lt;br&gt;<em>Sub-theme 2: Progress in recovery</em>&lt;br&gt;- Spirituality progression&lt;br&gt;- Socializing without alcohol and/or drugs&lt;br&gt;- Employment</td>
</tr>
<tr>
<td><strong>Theme 3:</strong>&lt;br&gt;4.2.1.3 Activities of aftercare service in fulfilling the needs of recovering substance abusers.</td>
<td><em>Sub-theme 1: What types of services are you receiving?</em>&lt;br&gt;- Professional services&lt;br&gt;- Self-help groups&lt;br&gt;- Home visits and follow-ups</td>
</tr>
</tbody>
</table>
4.2.1.1 Theme 1: The commencement of aftercare service

The purpose of aftercare service is to provide support for recovering substance abusers and their families about issues faced during recovery: developing coping strategies for addiction; building stronger relationships with friends and family members; finding and maintaining employment; and locating resources in the community, for example (Van Wormer, 2005).

The key enquiry in this section was to identify how recovering substance abusers entered the aftercare services. The following are sub-themes identified during one-on-one interviews with recovering substance abusers.

Sub-theme 1: Experiences of moving from rehabilitation to normal living

Rehabilitation provides sufficient support: the whole environment is aimed towards helping individuals overcome their addiction. Leaving rehabilitation means losing much of this support. If people are not prepared before severing such support then relapse can occur sooner than thought. The participants’ expressions on their journey back into the society are as follows.

"In rehab there is no temptation; it was very difficult for me to come out." (Participant 6)

"I didn’t wanna leave the rehab, I was afraid of what was waiting for me outside; I made a lot of mess before I went to rehab." (Participant 8)

"Staying in rehab is good; it is a supportive atmosphere." (Participant 10)

In support of the above, Nelson (2012) confirmed that substance abusers in rehabilitation centers are protected from temptation. When they return to a normal living environment they will once again be faced with temptations. He suggested that treatment centers should take responsibility in preparing discharged clients to aftercare services.
• Referral to aftercare services

The majority of the participants reported that they were referred by the inpatient treatment center to an aftercare service. Below are the answers provided by some of the participants:

“I was referred by ERRC.” (Participant 1)

“I was told by the social workers of ERRC to join the aftercare service.” (Participant 3)

“I heard about aftercare service in the rehab center.” (Participants 5)

The relationship between the inpatient treatment centers and the aftercare services is vital. Clients should be brought into an aftercare service by inpatient treatment centers as a part of a treatment programme. Treatment centres should prepare clients to return and re-adapt to their community with the support of the aftercare service (Mohler-Kuo, 2003). Introduction to an aftercare service should take place while the client is fully involved in the inpatient treatment programme. Clients should become familiar with activities offered by aftercare services and also meet some of the successful sober addicts in the aftercare service (Marlatt, 2006).

On the other hand some participants shared that they were already members of the aftercare groups before they entered an inpatient treatment programme. Examples of them sharing such information are presented below.

“Before I enter the rehabilitation center, I was already part of aftercare group.” (Participant 2)

“I joint the aftercare group before rehab. My social worker that referred me to rehab center send me to the aftercare group.” (Participant 4)
According to Doumas (2010), the membership standards for aftercare service should ensure that only clients who complete primary rehabilitation should be allowed to join aftercare groups. He argues that aftercare groups and their members are often pulled down by a substance abuser who needs primary rehabilitation. Aftercare services are not a pre-motivational stage for primary rehabilitation. Aftercare renders service to a recovering substance abuser after primary rehabilitation which focuses on active support to recovering substance abusers by means of the associating of successful ex-addict role-models progressing in recovery.

Barber (2003) states that the key to an easy transition from rehabilitation to normal living is preparation. An effective treatment programme focuses on preparing a client to move to the outside world. It will be up to the individual to make the best use of the available resources whilst still in a treatment programme.

• Preparedness of joining aftercare services

Some of the participants shared lack of willingness to commence with aftercare service after inpatient treatment programme. The essential need of the aftercare services was considered to not be important by some participants; some felt that they were confident enough to recovery on their own. Participants expressed themselves as follows.

“I felt that I didn’t need aftercare, because I was strong enough to cope on my own.”
(Participant 2)

“I did not take aftercare important. My wife was the one going, but later I joined her”
(Participant 5)

Ch’ien (2008) states that no matter how confident or strong one is to stay sober it can
however be easy to fall into the same vicious cycle of addiction. An overconfident mind-set will hinder any recovering substance abuser to withstand the risk of continuing addiction. It is therefore important to link with aftercare services. Aftercare services can mean the difference between maintaining sobriety and relapsing after exiting an inpatient treatment programme. Regardless of how long sobriety has lasted, or how well recovering substance abusers have done, addiction can always creep up again. Maintaining sobriety is a lifelong process that does not have any room for overconfidence. Aftercare services help provide support and encouragement for both family members and recovering substance abusers. Often there is still a great deal of tension between a recovering substance abuser and family members because of events that occurred during the period of alcohol and/or drug use. It is important that both parties attend aftercare service to support each other (Levin, 2000).

Some participants also revealed that they were willing to be linked to an aftercare service as evident below in terms of what they stated.

| “I was willing to join the group, because I made a choice never to drink again.” (Participant 1) |
| “Yes I was willing to join the group; I didn’t had a problem.” (Participant 3) |
| “I was prepared for aftercare services.” (Participant 4) |
| “Aftercare works, if you want it to work, it all depends from you.” (Participant 6) |

The Transtheoretical Model of Change reverses this dynamic by emphasising client readiness as a key component to recovery. In other words understanding an addict’s readiness to change allows treatment providers to understand barriers to successful treatment and to improve client satisfaction. Individuals in this stage are aware of the risks associated with their behaviour and the potential benefits of making a change (Heather & Robertson, 2002).
Barber (2003) also maintains that preparedness includes learning what to expect when discharged home and also developing coping strategies to deal with challenges faced. It is helpful to think of rehabilitation as a training ground. The outside world is where this training will be put into action. The harder people work to prepare to enter the outside world the greater will be their chances of finding success afterwards.

4.2.1.2 Theme 2: The needs of the recovering substance abusers in aftercare service.

According to Davidson (2007), aftercare service provides support and instruction for recovering substance abusers to maintain sobriety. It builds a solid foundation for recovery. The needs of recovering substance abusers were identified by viewing their experiences about life after rehabilitation, and whether it would be possible to stay sober after exiting an inpatient treatment programme.

Sub - theme 1: Relapse prevention

Three of the participant relapsed after exiting the inpatient treatment programme. The longest abstinence period was 12 months, followed by seven and two months, respectively. They stated the following.

“\textit{I was doing good for 2 months; I just took one drink... my family use to have parties and I felt out}” (Participant 1)

“I stayed for 7 months without alcohol.” I guess what caused it, is the breaking up of my marriage.” (Participant 4)

“I stayed for a year.” I felt I can have one drink again.”(Participant 3)

“It’s difficult if you families are still drinking, in front of you.” (Participant 8)

Prochaska and DiClemente’s Model of Change indicates that it is very common to relapse in
the contemplation, action and maintenance stages. Relapse is part of recovery: a person must be on guard against triggers to relapse at any stage. Within six months recovering substance abusers have the ability to change their behaviour. This is the stage when people most depend on their own willpower; they could fall back into old patterns of behaviour because they become too relaxed about the effort of maintaining sobriety. There is therefore a risk that people who feel this way can begin to take their recovery for granted. When their mood level is negatively disrupted or they hit a bad patch, they may very quickly go from loving their sober life to hating it. People should definitely enjoy their new life away from addiction, but it is important to remain cautious of any threats to recovery (Ch’ien, 2007).

“Memory can play tricks on people, and the individual can begin romancing the drink or drug” (Marlatt, 2006, p.67). This is a situation where recovering addicts are only able to remember the times when substance abuse made them feel good. People can develop the risky notion that if they can stay away from alcohol or drugs for a certain amount of time, it will mean that they will be safe to use these substances again. Marlatt (2006) further maintains that while abstinence does give the body and mind a chance to heal, it is not going to restore the ability to be a social drinker or a recreational drug user with a modest habit. If people become dependent on a substance, there is probably no way to reverse the clock. The only feasible solution is total abstinence.

Several factors can trigger people in maintenance to relapse: stress, crisis, apathy, boredom, a loss of environmental or emotional support, and also major life events such as job change, relationship break downs, or death in the family (Stephens, 2004). Relapse is considered the unofficial sixth stage of change; it can also occur frequently in other stages. It depends on the behaviour change of a person. For an alcoholic who has committed to total sobriety, relapse
may be a single drink such as in the case of participant 1 cited above. In addition, individuals in recovery can hardly be expected to remain sober if family members keep drugs or alcohol in the home. For recovery to work, the entire family must be committed to it. Individuals in recovery can always obtain alcohol or drugs if they truly desire to do so. It is thus important to make sure that substances are not readily available so that immediate temptation can be avoided. If a family has always kept alcohol or other substances on hand for social events or special occasions, it is important to keep in mind that it may be necessary for everyone to institute a lifestyle change to support a loved one during recovery.

Other participants responded that did not have a relapse as evident in the below statements.

“I make a decision on the 24 May 2010 not to drink and up to now I ‘am still sober.” (Participant 2)
“I am still sober for more than 5 years since Etegameno.” (Participant 5)

Both of these participants had several past attempts to abstain from substances. This is consistent with some literature in terms of each time a person quits drinking for a while and then starts up again that person has learned something on what is needed to quit successfully (Velleman, 2006). Dunn (2008) refers to people who can continue for a long time without relapsing as having the dry drunk syndrome. They treat sobriety as an endurance test. This means that life in recovery tends to be highly unsatisfactory. Such individuals can be full of anger and resentment. Eventually, they reach a stage where staying sober just no longer feels worth the effort.

• Family support

Some participants felt that support from the family contributed positively to their recovery. This is evident in the following statements.

“You can never walk this road alone, you need your family.” (Participant 2)
The literature addresses sentiments expressed in above statements. In order for clients to commit themselves to adhere to recovery principles when at home, it is vital that family members support the recovering substance abuser (Levin, 2000). Levin (2000) further maintains that a family’s approach to supporting a recovering substance abuser should be balanced. The family approach should take the threat of relapse seriously without stifling the recovering person’s ability to dependency. Families living with a substance abuser learn to believe that love, acceptance, security, and approval are contingent upon taking care of the addict in the way the addict wishes. Unfortunately, this excessively care giving behaviour could foster more dependency on the part of the addict: families are warned to be careful to not become enablers. It is important that a family needs to be aware that when living with a recovering addict or alcoholic it is important for them to maintain an alcohol and/or drug-free and sober lifestyle (Levin 2000).

• **Keep triggers and cravings in control**

A trigger mechanism is an emotion or occurrence that starts a given cycle of addictive behaviour (McKim, 2000). Finding strategies or ways of resisting these feelings and situations is the key to successful and sustained recovery from substance misuse. The participants view life after rehabilitation as difficult. They shared triggers, experiences and skills learned to manage cravings. Below are some examples of feelings expressed by the participants.

“My biggest trigger was going to the specific bar me and my friends used to hang out.”

(Participant 5)
“It is very difficult to handle triggers, especially if you are just at home, not working.”

(Participant 1)

“We learned about triggers a lot at Etegameno, but when I come out it was very difficult to practise it, especially, because stress I got from families was too much.” (Participant 3)

“Etegameno help me a lot to handle my craving, I learned about the thought stopping technique.” (Participant 2)

According to Roffman (2000), triggers prompt cravings which are strong desires for a certain substance. When addicted individuals have completed a rehabilitation programme and have quit using harmful or addictive substances, they will need to continue with their daily lives free of drugs or alcohol. However, there is a chance that those in recovery may relapse and return to drug or alcohol use. According to statistics provided by the National Institute on Drug Abuse, between 40% to 60% of those in recovery from addiction are likely to suffer at least one relapse during their lifetime; up to 17% of relapses may even occur after five years of being free of harmful or addictive substances.

Roffman (2000) adds that learning how to identify triggers, such as emotional triggers, places, people, and even attitudes, such as lack of motivation, can help reduce the risk of relapse. Developing strategies to manage cravings such as the thought-stopping technique are core aspects of most addiction recovery programs. Thought–stopping is a now discarded behavioural technique that involves discontinuing negative or unwanted thoughts by suppressing them. In a recent review of strategies, Yale psychologists Aldao and Nolen-Hoeksema (as cited in Davidson, 2007) found that suppression strategies for thoughts and emotions are not effective; they are associated with greater anxiety and depression leading to thought rebounding. Other strategies such as problem-solving, acceptance and cognitive
restructuring, are associated with less anxiety. It is important to have an accountability plan to help prevent a relapse by keeping triggers and cravings controlled.

Sub – theme 2: Progress in recovery
Recovery requires a long-term series of changes in building a meaningful life in areas such as spirituality, socializing without alcohol and/or drugs, and reaching out to help others as identified by the participants.

- **Spirituality progression**
All participants identified themselves as being Christians. Religion and spirituality were identified as an important factor in treatment and aftercare services. The following are transcripts of what the participants stated.

| “With the help of God I am today sober for more than 5 years.” (Participant 5) |
| “Going to church took me away from alcohol and drugs.” (Participant 1) |
| “Cross (name of aftercare group) is very religious, it helps me to start a relationship with God.” (Participant 8) |
| “You can’t do this without God.” (Participant 3) |

Many scientific studies support the use of spirituality as a tool in addiction recovery, leading to the development of multiple tools that incorporate spiritual reflection and action. According to research by Project MATCH, a program of the National Institute on Drug Abuse, spiritually focused addiction treatment programmes have resulted in 10 % abstinence rates than other forms of treatment. Many recent change models incorporate spirituality with psychological, physical, and social variables in order to provide a comprehensive treatment approach. Alcoholics Anonymous (AA) was among the first popular recovery programme to
explicitly connect spirituality with addiction treatment and recovery: linking the spiritual aspects of addiction recovery with the physical and mental aspects.

Research has shown that being part of a faith-based community, participating in religious activities, or associating with a network of individuals sharing similar beliefs, increases self-esteem, wellbeing, and a feeling of belonging. Such members would be less likely be engaged in substance use (Ch’ien, 2008).

- **Socializing without alcohol and/or drugs**

The participants shared the need to socialize without alcohol and/or drugs. In some of the aftercare groups, social outings are part of the programme. Recovering substance abusers participate in social activities such as ‘braai’ parties, day trips, playing chess, etc. The statements below highlight the participants’ experiences in terms of social activities in aftercare services.

```
“At Cross, we make “braais” without alcohol.” (Participant 4)

“We sometimes go hang out at clubs without alcohol.” (Participant 3)

“Every weekend we organize a chess game at one of the members place.” (Participant 5)
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According to Escandon and Galvez (2007), social events without substances are essential in recovery. Socializing allows sharing experiences, making new friends and creating a supportive environment for everyone. In contrast, living without alcohol or drugs does not mean recovering substance abusers cannot attend social events where alcohol is present. In early recovery, one may avoid attending weddings or other social events where people may be drinking or drugging. Sooner or later, one will attend one of these events, knowing that picking up a drink or a drug to be sociable is not an option. One has to remain vigilant at all times and maintain one’s desire to stay sober (Laberg, 2002).
• Employment

Half of the participants interviewed were unemployed. All participants indicated employment as being an essential part of recovery process. Below are some of the participants’ views on employment.

“To have a job, even if its little salary is important for me to stay busy and focus.”

“Boredom (unemployment) is the devils pillow…” (Participant 5)

“I am not working and it gives me stress.” (Participant 7)

“Drugs are used to fill up the emptiness of unemployment. So we need jobs to keep away from boredom that leads to drug use.” (Participant 9)

“I am tired of being dependent on families. If I can just find a job.” (Participant 4)

“To have a job is important to staying sober.” (Participant 3)

“Job and aftercare goes together. This aftercare groups must get us jobs man.” (Participant 1)

“We need jobs and vocational trainings.” (Participant 2)

Being unemployed is associated with increased rates of mental disorders, such as depression, anxiety, frustration linking to higher rates of substance use disorders, and relapse. Employment increases a person’s self-worth, stabilizes his or her living circumstances, and facilitates a person’s integration within community (Hoffmans, 2003). McKim (2000) stated that if recovering substance abusers are unable to support themselves through legitimate labour, they have little chance of remaining drug-free. A job can promote self-worth, thus lowering the chances of depression as well as destructive behaviours. In other words an aftercare service should offer job-related training to recovering substance abusers. Such training could serve to generate employment and foster social integration. An aftercare programme can do little about general economic conditions; however it can certainly improve
the recovering substance abusers’ employment prospects by enhancing employable skills and supporting them to continue growing and developing (Hoffmans, 2003).

Sub - theme 1: What types of services are you receiving?

- **Professional services**

Only three participants shared that they received professional services from social workers and psychologist in aftercare services. Most of the recovering substance abusers had a session with professionals before admission to treatment centers. However, they said that after they were discharged from centers there is a lack of professional service. Below are the statements to support these findings.

“*I got some counselling from my social worker after I came back from rehab.*” (Participant 7)

“I went to mental hospital to take my medicine; I also talk to the psychologist about my plans after Etegameno.” (Participant 8)

“*After I came from rehab, I went to social worker of our town to know where the aftercare groups are meeting.*” (Participant 4)

Professional services are occupations requiring special training in the arts or related science. A professional service necessitates confidentiality standards accessing to provide effective treatment and referral alternatives according to a client’s physical, emotional, spiritual and psychological needs. Therefore, despite the best intentions of aftercare groups, there are occasions when professional intervention is necessary to stop the downward spiral of destruction that can be the direct result of alcoholism and/or drug addiction (Chassin, 2003).

- **Self -help groups**

Participants indicated that the common services received from the aftercare groups, are self -
help groups. Below are examples of such statements.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The aftercare service I go to is support group with other people who also have alcohol problems.”</td>
<td>Participant 3</td>
</tr>
<tr>
<td>“We come together as a group to support each other.”</td>
<td>Participant 7</td>
</tr>
<tr>
<td>“In Cross, we help each other, if you fall, we will support you.”</td>
<td>Participant 9</td>
</tr>
<tr>
<td>“Aftercare groups are the best thing for us to learn from each other.”</td>
<td>Participant 5</td>
</tr>
<tr>
<td>“This is the only aftercare service I am getting, to meet every Sunday afternoons with the people who I can talk to and who understands me.”</td>
<td>Participant 6</td>
</tr>
</tbody>
</table>

According to Rosenberg (2001), an aftercare service within the self-help approach is best suited to peer groups where social learning is encouraged. Self-help groups offer support to develop strong relationship amongst its members to nourish values of cooperation and mutual concerns. Active involvement in mutual aid/support groups significantly improves one’s chances of long-term recovery.

Self-help groups are nonprofessional. They include members who share the same problem and voluntarily support one another. Mutual aid groups have a greater impact on recovering substance abuser. Such groups involve social, emotional and informational support which focuses on taking responsibility for one’s own alcohol and drug difficulties and recovery.

- **Follow-ups home visits**

All participants stressed the need for follow-up services. Only one participant indicated receiving home visits by a social worker. Three received telephonic follow-ups by staff members of ERRC. Below are the statements some participants.
“Those years’ social workers were visiting us at our houses.” (Participants 4)

“I was called twice by the staff of Etegameno to find out how I am doing, I think it’s a good thing.” (Participants 6)

“I felt good when Auntie Monica (a staff member of ERRC) called me; she wanted to know how I was doing.” (Participants 7)

“There is a need for social workers to visits us at our homes; they must come see how we are living.” (Participants 9)

“Social workers must come see where we are staying; in aftercare groups we don’t show our true colours.” (Participants 9)

“Home visits will be the best aftercare service in my opinion.” (Participants 10)

Researchers have shown that follow-up services keep track of change behaviour: they form the basis of any effective treatment programmes. Follow-ups could identify changes in the recovering substance abuser, including making any adjustments in further treatment options (Velleman, 2006).

4.2.2 Category two: Family member

Table 3: Profile of the family member

<table>
<thead>
<tr>
<th>Participant (P)</th>
<th>Gender</th>
<th>Age</th>
<th>Region</th>
<th>Name of the Aftercare group</th>
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<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>25</td>
<td>Erongo Region</td>
<td>Uis Aftercare group</td>
</tr>
<tr>
<td>2</td>
<td>F</td>
<td>32</td>
<td>Kunene Region</td>
<td>Anichab Aftercare group</td>
</tr>
<tr>
<td>3</td>
<td>F</td>
<td>29</td>
<td>Kunene Region</td>
<td>Khorixas</td>
</tr>
</tbody>
</table>
The study looked at several factors involved in addiction remission and relapse rates. Supportive relationships/families were identified as playing a major role in sustained abstinence. The results of the study, in terms of the experiences of family members supporting recovering substance abusers, are summarised in Table 4.

**Table 4:** Identified themes and sub-themes on experiences of families

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub - themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong></td>
<td><strong>Sub - theme 1: Rebuilding the family through trusting relationships”</strong></td>
</tr>
<tr>
<td>4.2.2.1 Experience of families regarding outcome of aftercare service.</td>
<td>• New communication skills</td>
</tr>
<tr>
<td></td>
<td>• Lack of knowledge on aftercare services</td>
</tr>
<tr>
<td></td>
<td>• Family Involvement</td>
</tr>
</tbody>
</table>
4.2.2.1 Theme 1: Experience of families regarding outcome of aftercare service.

Families are overall pleased when a substance abuser makes a life changing decision to discontinue with the addiction. Families emphasised that it is not an easy task living with a substance abuser. Some reasons given by them are presented below.

“It is not easy to live with an alcoholic; we lost many things because of his stealing.” (Participant 1)

“I thought I lost him forever; he was in prison.” (Participant 3)

“It’s painful to see how your love one begs on streets, just to get another drink.” (Participant 5)

“We used to fight every day when he comes home drunk.” (Participant 10)

After the recovering substance abuser has received treatment, families experience uncertainty. One of the participants’s stated the following.

“Although you don't want to be a babysitter, you still have to monitor them in and out because you don’t know what will happen next.” (Participant 9)

Monitoring and check-ups will not add any value to a recovering substance abuser. However, it is important that supportive relationships are built so that both parties can feel they are playing a major role in sustained abstinence (Royce 2001).

Sub - theme 1: Rebuilding the family through trusting relationships

Some of the family members shared being vulnerable whilst in the process of adjusting to sober living of a loved one because an enormous amount of trust was broken. The statements below are related to experiences of families.
“You can’t trust an addict completely.” (Participant 2)

“It’s very difficult to trust because it hurts so much when that trust is broken.” (Participant 4)

“Too many things happened in our marriage, trust was broken long time ago.” (Participant 7)

“It is not easy to trust addict especially drug addicts.” (Participant 8)

“To trust is not easy, too many things happened.” (Participant 9)

“Trust can be built step by step.” (Participant 3)

It is believed that working on a solid, grounded recovery programme, such as an aftercare programme, means that trust will slowly start to be restored among family members. One of the first steps recovering alcoholics/addicts should commit to involves earning trust that was lost due to their addiction. They should not only earn family trust, but take on the personal challenge of rebuilding trust for themselves (Marlatt, 2006).

In the aftercare process, recovering substance abusers should thus look forward to rebuilding that trust. They should want to prove to their loved ones as well as themselves that they are capable of being trusted once again. Therefore, it is important for family and friends to give this process a substantial amount of time, at least six months accountable behaviour change in a recovering substance abuser.

• New communication skills

The majority of families shared that aftercare services had improved their communication. Below are examples of their expressions.

“In the aftercare groups we learn how to communicate with one another, it opens up those wound.” (Participant 6)
“Communication is important in home.” (Participant 4)

“We never communicate, after both of us attended aftercare groups we learn a lot.” (Participant 7)

“In Cross we learn to talk to one another. Both me and my husband are happy.” (Participant 9)

Dunn (2008) states that unresolved issues of trauma, injury, betrayal, fear, and lack of social skills that have been masked by substance abuse, steadily became unmasked by sobriety. The skills of effective communication and relief from past resentments are necessary for recovering families to accomplish constructive supportive relationships. It is important to understand that the family dynamic in drug and alcohol addiction is incredibly powerful. Addressing an unhealthy imbalance in communication is the first step in moving one’s loved one toward addiction therapy. This type of positive family involvement can also help lead the rest of the family towards a journey of recovery and self-discovery.

• Lack of knowledge on aftercare services

Some of the family members shared they had very little knowledge on the aftercare services. They did not see any purpose they served in aftercare services; they knew that aftercare services are helpful for the recovering substance abuser, but not necessary for them. Below some sentiments of family members.

“Aftercare service is important for the person having the alcohol/drug problem.” (Participant 3)

“I was there once at the aftercare groups; I know what they are doing, but it’s not for me. I don’t drink; it’s my brother who was drinking.” (Participant 5)

“I don’t know why I must go to aftercare groups; I was not the one at rehab.” (Participant 8)
• Family involvement

Three family members said that they cared about their loved one recovering. However, they showed lack of support because of other social commitments. Families revealed the following.

“I like the fact my brother is attending the aftercare group, I just don’t have time to go with him.” (Participant 6)

“I am very busy I don’t have time for it, but I like what they are doing.” (Participant 9)

“I know I must support them, but I just don’t do it, I was there once but not always.” (Participant 2)

Families should make time to attend aftercare meetings on a regular basis in order to continue with a constructive programme of support and ongoing education. Alcohol and drug addiction are both considered ‘family diseases’. Family involvement with people combating drug and alcohol addiction requires continual attendance at meetings during and after the formal inpatient or aftercare session. By continuing to attend aftercare meetings, friends and family of an addicted individual can continue to stay out of the destructive cycle of enabling and co-dependency and fully realize the benefits of addiction therapy (Dunn, 2008).

4.2.3 Category three: Aftercare group member

Table 5: Profile of aftercare group member

<table>
<thead>
<tr>
<th>Participant (P)</th>
<th>Gender</th>
<th>Age</th>
<th>Region</th>
<th>Name of the Aftercare group</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>F</td>
<td>45</td>
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<td>Cross Community Aftercare group</td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>38</td>
<td>Hardap Region</td>
<td>River of Hope Aftercare group</td>
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</tbody>
</table>
The following section outlines the experience of aftercare members as to their meaning of aftercare service and what activities are rendered to recovering substance abusers. The results of this section are summarised in Table 6.

**Table 6: Identified themes and sub-themes on experiences of aftercare group member**

<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub – themes</th>
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<tbody>
<tr>
<td><strong>Theme 1:</strong></td>
<td><strong>Sub - theme 1:</strong></td>
</tr>
</tbody>
</table>
| 4.2.3.1. What is an aftercare service? | *How is aftercare services conduct and by whom ?*  
  • What are the activities in aftercare service  
  • Comparisons of actual activities against the stated program plans from ERRC |
| **Theme 2:** | **Sub –theme 1: Achievements of aftercare groups**  
  • Discontinue smoking  
  • Social networking |
| 4.2.3.2. Experiences of group members in aftercare service. | **Sub –theme 2 : Challenges and needs of aftercare groups** |
4.2.3.1 Theme 1: What is an aftercare service?

Participants shared common answers that an aftercare service aims at offering support for people who have experienced problems with alcohol and/or drugs. Half of the participants added that it is a service for rehabilitated substance abusers who are ready to reintegrate into communities. The following transcripts relate to aftercare service definitions.

“Aftercare is a service in the community for all substance abusers.” (Participant 7)

“If you come out from rehab you enter aftercare service, to help you stay clean.” (Participant 5)

“Aftercare is support groups that help people with alcohol and drug problems.” (Participant 9)

“Aftercare groups are helping people coming out from rehab.” (Participant 4)

“If you come out from rehab you must join the aftercare service for support.” (Participant 2)

According to Doumas (2010), the membership standards for aftercare service should ensure that only clients who have completed primary rehabilitation are permitted to join aftercare groups. Based on the comments of participants in this study the researcher is of the opinion that aftercare services are for all substance abuser whether entering or not entering primary
rehabilitation or completing rehabilitation. Although the definitions of aftercare services are explain appropriately by the participants, the researcher is however concerned about the membership of the aftercare groups. Aftercare refers to services provided to those who have completed a rehabilitation programme. According to Doumas (2010), aftercare services are not a pre–motivational stage for primary rehabilitation. Aftercare renders service to recovering substance abusers after primary rehabilitation by focusing on active support to recovering substance abusers with the association of successful ex-addicts role models progressing in recovery.

*Sub - theme 1: How is aftercare services conducted and by whom?*

The researcher investigated the nature of aftercare services by assessing the activities of aftercare services. The following key question was asked.

- **What are the activities in aftercare service and how and by whom are the services conducted?**

The highest rated response was group sessions, which are conducted by the members themselves. Most of the members are ex-addicts themselves who do not have qualifications to conduct group sessions: only three members had basic and national counselling certificates. Some said they had personal experience of substance abuse and others said they gained skills and knowledge from ERRC during their treatment period which they used during group session. Below are some of their statements.

“I have level one counselling certificate from Philippi Trust.” (Participant 2)

“I have basic counselling certificate.” (Participant 3)

“I have a national certificate in counselling from Philippi Trust.” (Participant 10)

“Yes I conduct group session, I have all experience of what substance abuse is; I was there.”
“I don’t have any qualification, but the information I got from Etegameno, I used those notes.” (Participant 6)

We don’t have training in counselling, but we are conducting the session; if we don’t do it, which will do it? Social workers are not coming to our meeting.” (Participant 9)

Studies have found that lack of a sound training and strong foundation of therapeutic principles can be a risky path for unqualified counsellors. Aftercare services typically include a variety of clinical services. A recovering substance abuser should receive therapeutic services from a qualified counsellor including referrals to outside resources and agencies, continued monitoring of medications, one-on-one family therapy, and living sober resources (Davidson, 2007).

Aftercare services are not simply attending fellowship group meetings, as indicated in the results. Fellowship meetings are one form of aftercare service: it is suggested that a qualified counsellor attends to personal matters discussed in such aftercare group sessions. Van Wormer (2005) supports this by stating that unqualified ex-addicts who perform group counselling will more than likely use the approach that worked for them which will not be necessarily or appropriate for other persons. Recovering addicts might operate from a limited frame of reference if they are not trained as counsellors. Qualified therapists or counsellors should facilitate the groups. Qualified counsellors would attempt putting aside their own personal beliefs, assumptions, and prejudices when working with clients.

- **Comparisons of actual activities against the stated programme plans from ERRC**

The programme plans from ERRC regarding aftercare services consist of the following
objectives to accomplish its purpose (ERRC five years Annual Plan, 2011 – 2015).

- To assist sober addicts to stay sober and prevent relapse through the implementation of the multi professional team approach (spiritual, psychological, social and mental).
- To support addicts who complete rehabilitation/treatment services through reintegration into their families and the rest of society and to link them to income generating activities.

The actual activities stated by the participants in all aftercare groups are as follows:

- Fellowship meetings
- Group session
- Social events
- Awareness raising through radio talks, information dissemination and education on the consequences of alcohol and drug abuse.

In comparison to the operation of actual activities of aftercare groups and planned activities of ERRC, it seems that the after care groups lack accomplishing the planned activities of ERRC. It only provides a support group where substance abusers and families attend to learn about the practical experiences of staying sober; share experiences on coping strategies; and develop healthy interaction skills, group counselling, debriefings and social events.

4.2.3.2 Theme 2: Experience of group member in aftercare service

Participants shared positive experiences and benefits of attending aftercare groups. The statements below are related to the positive experiences of attending an aftercare group.

“We learn from each other how to cope with problems.” (Participant 2)

“Aftercare motivates us to stay sober.” (Participant 1)
“People in the group is very supportive.” (Participant 3)

“It feels good to talk to someone that understands your problem, especially daily things we experience at homes.” (Participant 5)

“Aftercare is the best; you meet sober people who are very motivating” (Participant 6)

“Aftercare groups are good for me and my family, because we learn how to cope with family issues.” (Participant 9)

Aftercare group meetings are an opportunity for individuals to form close, supportive bonds with both their counsellor and fellow group participants. These sessions will have the effect of rejuvenating an individual’s motivation thereby reducing the risk of relapse. Persons in recovery are faced with new challenges, thus they will be encouraged to find new coping strategies (Heather & Robertson, 2002).

By providing continuing counselling, support groups and transitional living, aftercare programs add an extra level of accountability that helps prevent individuals from returning to old habits of substance abuse. Aftercare provides a safe environment for individuals (i) to connect with recovering substance abusers, and (ii) to get access to motivational speakers, and practical guidelines for coping with stress and daily challenges (Hoffmans, 2003).

Hoffmans (2003) is of the opinion that aftercare services also benefit family members and other loved ones. Aftercare services may include one–on-one counselling sessions for spouses, parents, partners, and children. Group therapy meetings, as well as educational meetings about co-occurring disorders and addiction, provide important resources and support for families.
Sub-theme 1: Achievements aftercare services

Emphasis was placed on activities aimed at making recovering substance abusers see the benefits attributed to living sobriety lifestyles. The following achievements were shared by the member of the aftercare groups.

- **Discontinue smoking**

Some of the aftercare group members shared resolution and achievements to quit smoking. Below are the positive expression made by participants.

“*Our aftercare group is moving to another level, where we trying something that we thought we will never do; smoking…*” (Participant 7)

“*Most people in recovery don't want to quit smoking, but it is possible and we have tried it and yes some of us are succeeding.*” (Participant 10)

Quitting smoking during treatment, or right after treatment for addiction, can actually increase one’s chances of maintaining sobriety. Quitting smoking has immediate as well as long-term benefits for the addict and loved ones. Quitting smoking greatly reduces the risk of developing smoking-related diseases. Smokers who are in recovery from substance abuse can stop smoking without starting to drink again. Quitting smoking supports people to have more control of their lives, and being less anxious and less depressed than they felt when they smoked (George, 2007).

- **Social networking**

Participants shared meeting sober friends as one of their achievements in the aftercare groups. Below are some of their statements.

“*Reaching out to sober friends was a good thing for us.*” (Participant 6)
Recovery is maintained by involvement in recovery support systems, including fellowship meetings or community support group. Having a solid support system is essential. The more positive influences one has in your life, the better one’s chances for recovery. Recovering from drug addiction is not easy, but with people you can turn to for encouragement and guidance, it is less tough.

Sub-theme 2: Challenges and needs of aftercare groups

- **Poor attendance**

Aftercare members complained that poor attendance in groups meetings are a major challenge. They expressed themselves as follows in the below statements.

```
"Sometimes we are just two at the meeting, it’s not nice."
(Participant 4)

"People are not coming for the meetings; it is really a problem"
(Participant 6)

"I can remember when last we met, we don’t meet."
(Participant 8)

"We meet for one hour on Tuesdays and Thursdays, but people are not coming."
(Participant 9)
```

Advocates of the twelve-step treatment programme recommend that members continue to attend for the rest of their lives. Regular attendance at recovery meetings will encourage individuals to continue to put in the necessary effort required in their recovery. People in recovery can easily go off track. By regularly attending recovery meetings, an individual will be surrounded by other people who will be able to spot the danger signs.
• Lack of social workers involvement

The aftercare members complained about the lack of social workers’ involvement. They were demoralised if social workers do not assist in aftercare services delivery. Below are complaints by the participants.

“Honestly, our social worker is not coming to our meeting.” (Participant 2)

“I don’t know what the job of that social worker is, he is never available.” (Participant 7)

“Social workers are not coming to meeting.” (Participant 8)

“We really don’t get enough support from our social workers.” (Participant 10)

One of the essential aspects of aftercare service is the presence of professional involvement. Evidence for the important role that treatment professionals play in fostering engagement in aftercare services comes from an AA membership survey where half of respondents reported motivation being introduced to the fellowship by a treatment professional. Professional involvement can powerfully influence a recovering substance abuser’s level of affiliation with aftercare groups. When social workers are involved in aftercare services this results in increasing the likelihood that a recovering substance abuser will continue to improve even after professional treatment has ended (Robertson, 2002).

• Transport

The aftercare members complained about transport challenges faced when there is a need for a home visit. They felt helpless if they are unable to reach out to others. Below are examples of such sentiments of the participants.

“We like to visit client at the homes, but we don’t have transport.” (Participant 3)
"Transport is a big problem; we like to do home visits in far location such as Okahandja Park and so on." (Participant 6)

"We wanna reach out to people, but we don’t have transport." (Participant 8)

"Can the government help us with petrol so that we visit the people at their houses and bring people to the meetings? It’s really a struggle." (Participant 9)

Transport affects the availability of service delivery. Lack of appropriate and affordable transport hinders individual access to facilities and movement of aftercare workers (Ch’ien, 2008).

- **Incentives**

The participants identified the need for incentives such as allowance, retreats, trainings, awards and networking opportunities provided to aftercare members to motivate effective aftercare services delivery. They expressed themselves as follows.

"We are actually supporting the government with this work and it time they recognize our work." (Participant 1)

"We want to be paid to do this work; we cannot work on empty stomach."(Participant 7)

"Etegameno must do more; not just once in a year reunion. Spent more money on aftercare groups, give us trainings where we can get certificated." (Participant 3)

"We like to network with other aftercare groups but, we don’t have money."(Participant 4)

Incentives such as allowance, retreats and networking opportunities, increases motivation, retains and even draws in new members in the aftercare group. Volunteers need skills and knowledge on substance abuse counselling which could be enhanced through suitable trainings (Velleman, 2006).
4.2.4 Category four: Key Informants

Table 7: Profile of key informants

<table>
<thead>
<tr>
<th>Key Informant (KI)</th>
<th>Gender</th>
<th>Age</th>
<th>Region</th>
<th>Description of KI</th>
<th>Name of the Aftercare group</th>
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</thead>
<tbody>
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<td>MoHSS</td>
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<td>Key informant</td>
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<td>(social worker)</td>
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The following section outlines the results of key informants regarding their experiences concerning the helpfulness and usefulness of activities of aftercare services and possible factors influencing aftercare service delivery. The results of this section are summarised in Table 8.

Table 8: Identified themes and sub-themes on experiences of key informants
<table>
<thead>
<tr>
<th>Themes</th>
<th>Sub – themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theme 1:</strong></td>
<td><strong>Sub - theme 1: The gaps in aftercare service provision</strong></td>
</tr>
</tbody>
</table>
| 4.2.4.1 Social worker’s experiences regarding rendering aftercare services | • The role of stakeholder in aftercare services  
• Needs of social workers in effective service delivery |

### 4.2.4.1 Theme 1: Social worker’s experiences regarding rendering aftercare services to recovering substance abusers

The key informants consistently indicated significantly more positive experiences and expressed higher levels of interest in supporting clients to take responsibility for their own recovery. Below are some of their expressions.

“I am proud of clients that enter aftercare services, it is a voluntarily choice. We are here to assist sober addicts in taking responsibility not to go back to old behaviours” (Key informant 2)

“I am very positive about aftercare service; ERRC is doing a great job providing support to sober addicts to stay sober and not to relapse.” (Key informant 4)

In contrast, some key informants raised concerned about the limitations of aftercare groups. Common concerns raised included: the risk that members become overly dependent on the group; usefulness of the groups are limited in time (i.e., only needed in early recovery) or in scope (i.e., deals with only substance abuse while clients have multiple issues).
Sub-theme 1: The gaps in aftercare service provision

The key informants identified the major gaps in service delivery. Convenience (e.g. lack of transportation), and scheduling as an obstacle to attend aftercare groups, for example. Such identified gaps are presented below.

“I like to attend aftercare groups, but the time schedule they meet is not always convenient for me. They meet during weekends; which is not always possible for me to attend.” (Key informant 5)

“One can arrange flexi hours at work, that’s not a problem; but we cannot take leave every week because there are other work and clients we also need to attend.” (Key informant 7)

“Pressure at work for social workers is greater than it’s ever been, and it can take a toll on job satisfaction” (Barber, 2003, p. 89). Social workers generally report high levels of job-related stress. This pressure is certainly related to high workloads and challenging services delivery of clients. Social workers thus need to implement strategies to maintain the clearest possible boundaries in order to perform duties within their scope of schedules.

- The role of stakeholder in aftercare services

The key informants felt that stakeholders, such as community based organisations, churches local business, and line ministries, should be part of funding and should support aftercare services. The quote below is an example of such an opinion of key informants.

“Aftercare service is the most important service to keep addicts sober therefore, joint efforts such as government, local businesses and churches should take hands supporting aftercare services.” (Key informant 6)
Stakeholders who focus on the provision of activities such as funding aftercare groups or neighbourhood recreational activities would be of immense value for aftercare services in terms of drawing from resources (Levin, 2000).

- **Needs of social workers in effective aftercare service delivery**

Key informants raised a common need for capacity building with regards to specialist training in addiction and/or mental health. They expressed their needs as follows.

```
“Expanding our knowledge on substance abuse will add great value to service provision.”
(Key informant 8)

“It’s time government invest in specialist social workers, such as social workers trained in mental health or substance abuse; I don’t mean weekly workshop where we receive attendance certificates; send us abroad or to universities that can train us in specialities.”
(Key informant 10)
```

In Namibia, social workers are employed in a variety of settings, including mental health hospitals, child welfare, substance abuse treatment institutions, and private practices. A social work diploma/bachelor's degree is the minimum formal education required to practice social work. Specialized training in substance abuse and mental health is needed to effectively assess and treat mental, behavioural, and emotional disorders.

The next section focuses on the discussions of cross cutting themes in all groups and possible factors influencing the domains identified.

**4.2.5 Cross cutting themes identified in all groups**

All groups agreed that religion plays an important aspect in aftercare service. Key informants and aftercare members added that there is a need to introduce effective cultural and gender
sensitive spiritual programmes to promote an individualized inclusive and holistic approach to meet the needs of recovering substance abusers. Both groups of participants also cited peer support; help with recovery; and the opportunity to improve one’s life as the major benefits of aftercare services. The major limitation of aftercare services, cited by both groups of participants, is succinctly expressed by a recovering substance abuser: “Aftercare works, if you want it to work, it all depends from you.” (Participant 6). Thus, aftercare services cannot benefit persons who are not ready or willing to seek help.

Both groups indicated that there is a need for employment and vocational rehabilitation for recovering substance abusers. Job-related training in aftercare service was identified by both groups as an essential aspect to recovery.

4.2.6 Comparison of services that aftercare is doing vs supposed to do (from experiences from aftercare members and key informants)

The key informants suggested that aftercare services are supposed to render services after a recovering substance abuser had completed an inpatient treatment programme. These services should include therapeutic services, aftercare groups, and continued monitoring of medications. The experience of the aftercare members is that substance abusers who need assistance and desire to stop substance usage should be placed in an aftercare group to get motivational counselling by experienced group members or social workers. There is a difference between the two groups in terms of their description of what aftercare services should entail. The difference was identified as potential stumbling blocks for rendering aftercare services to the target population. The difference between the two groups may be due in part to the fact that key informants based their answers on knowledge and professional experience while the aftercare members’ answers, on the other hand, were likely to have been based on their personal experience.
4.3 SUMMARY

The results of face-to-face interviews of four categories of participants, namely the recovering substance abuser, family member, aftercare groups and key informants, are presented in this chapter. The results were combined and conclusions were stated regarding the participants’ respective experiences of aftercare services.
CHAPTER FIVE

RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This chapter presents the conclusions of the study, recommendations, reflection on the findings and the literature summarizing, limitations of the study, contributions to the body of knowledge and directions and suggestions for future research. The chapter ends with a summary of important points and outcomes of the study.

5.2 CONCLUSIONS

The following conclusions were drawn based on the set objectives and according to themes that emerged in the study.

5.2.1 Objective 1: Identify the needs of the recovering substance abusers participating in aftercare service:

Participants were able to share their experiences (positive or negative) of aftercare services in their own understanding. The main themes that emerged were experiences of moving from rehabilitation to normal living. The recovering substance abusers experienced that it is difficult to have an ordinary life after rehabilitation. This is because inpatient treatment centers provide safe and structured environment in which negative influencing factors are removed from a client’s daily experience.

The needs of the recovering substance abusers were identified by viewing their experiences about life after rehabilitation. Six months immediately following rehabilitation were identified as the most delicate and critical period in the life’s of recovering substance abusers. Several effects can trigger people in rehabilitation to relapse including stress, crisis, apathy,
boredom, a loss of environmental or emotional support, and major life events such as occupation change, relationship break downs, or death in family (Stephens, 2004).

Families support contributed positively to their recovery as it was identified as one of the needs of recovering substance abuser. It was also noted that families living with a recovering addict or alcoholic should be aware of maintaining an alcohol and/or drug-free and sober lifestyle (Levin, 2000).

Learning how to identify triggers was identified as the need of recovering substance abusers. According to Roffman (2000), triggers prompt cravings which are strong desires for a certain substance. Once an addicted individual has completed a rehabilitation programme and has quit using harmful or addictive substances, these individuals will need to continue with their daily lives free of drugs or alcohol.

Employment or job-related training was identified as an essential part of recovery process. In support of the above McKim (2000), states that if recovering substance abusers are unable to support themselves through legitimate labour, they have little chance of remaining drug-free.

5.2.2 Objective 2: To explore gaps in aftercare service in fulfilling the needs of recovering substance abusers

The lack of professional service involvement was identified as one of the gaps in aftercare service delivery. Social workers were blamed for not fully involved in aftercare services as expected by aftercare group members. Aftercare member expressed feelings of demoralization if social workers are uninvolved with follow up home visits of recovering substance abuser. It, therefore, is concluded that professional involvement powerfully
influences recovering substance abuser’s level of affiliation within aftercare groups. Constructive partnership is developing in many setting between professional and aftercare groups. When social workers are involved in aftercare services it increases the likelihood that recovering substance abuser will continue improving (Robertson, 2002).

The difference in the accurately description of what aftercare services should be has been identified as potential stumbling blocks for rendering aftercare services to the accurate target population.

In comparison to the operation of actual activities of aftercare groups and planned activities of ERRC, the findings suggest that the after care groups lack accomplishment of the planned activities of ERRC. It only provides support group where substance abusers and families attend to learn about the practical experiences of staying sober. Aftercare services supposed to render services after recovering substance abuser had completed an inpatient treatment programme. Aftercare is a forum on which clients might explore achievements, milestones, obstacles or challenges, and day-to-day issues which confront them; and receive feedback and support from the social worker, group facilitator and the other participants (Chassin, 2003,).

The major gaps in service delivery were also identified as convenience (e.g. Lack of transportation) and scheduling as an obstacle to attend aftercare groups.

The need for capacity building for social worker and aftercare members with regard to rendering effective aftercare services was also identified a service provision gap. The social workers raised a common need for capacity building with regards to specialist training in addiction and/or mental health.
5.2.3 Objective 3: To provide recommendations to the Ministry of Health and Social Services regarding research findings.

The recommendation on aftercare services emphasises the introduction of a comprehensive aftercare programme, having an elaborate system of health care resources, referrals, detoxification facilities, mental health care treatment and counselling services.

5.4 REFLECTION ON THE STUDY’S FINDING AND LITERATURE

Rehabilitation provides sufficient support as the whole environment is aimed towards helping the individual overcome their addiction. Leaving rehabilitation means losing much of this support and if people are not prepared adequately, relapse can occur sooner than thought. In support of the above, Nelson (2012) supports this finding, that substance abusers in rehabilitation centers are protected from temptation. Moving back into real world, they will be once again faced with temptations. He suggested that treatment centers should take responsibility preparing discharged clients to aftercare services.

According to Doumas (2010), the membership standards for aftercare service should ensure that only clients who completed primary rehabilitation join aftercare groups. In this case it seemed to the researcher that aftercare services are for all substance abusers whether entering or not entering primary rehabilitation or completing rehabilitation. Although the definitions of aftercare services are explain appropriately by the participants, the researcher is however concerned about the membership of the aftercare groups. Aftercare refers to services provided to those who have completed rehabilitation programme.

Supported by Doumas (2010), aftercare services are not a pre–motivational stage for primary rehabilitation. Aftercare renders service to recovering substance abusers after primary
rehabilitation focusing on active support to recovering substance abusers with the association of successful ex-addicts role models progressing in recovery.

Previous studies have found that lack of sound training and strong foundation of therapeutic principles can be a risky path for unqualified counsellors. Aftercare services typically include a variety of clinical services. The recovering substance abuser should receive therapeutic services from a qualified counsellor including referrals to outside resources and agencies, continued monitoring of medications, one-on-one family therapy, and living sober resources (Davidson, 2007).

One of the essential aspects of aftercare service is the presence of professional involvement. Evidence for the important role that treatment professionals play in fostering engagement in aftercare services comes from an AA membership survey where one-half of respondents reported motivation being introduced to the fellowship by a treatment professional. Thus, professional involvement can powerfully influence recovering substance abuser’s level of affiliation with aftercare groups. When social workers are involve in aftercare services it increases the likelihood that recovering substance abuser will continue improving even after professional treatment has ended (Robertson, 2002).

The following recommendations were made based on the findings of the study:

5.3 RECOMMENDATION

1. Discharge / aftercare plan

The results of the study indicated that recovery from alcohol and drug abuse is a process of change and cannot be achieved in an inpatient treatment center. Once inpatient treatment is completed, the next step in the recovery process is aftercare service.
It is widely accepted that without strong aftercare services for at least a year or more, most clients would relapse into re-addiction, no matter what form of primary rehabilitation received (Marlatt, 2006).

All participants indicated that aftercare service is at least as important as inpatient rehabilitation. When the client is still fully involved in an inpatient treatment programme, it is recommended that the introduction to the aftercare programme should take place. The inpatient treatment programme should incorporate aftercare plans for clients prior to discharge. A discharge plan should be provided to refer clients to facilities that offer aftercare services in which they could meet some of the successful sober addicts in the aftercare programmes.

Inpatient treatment center should collaborate with local social workers to create a discharge / aftercare plan before recovering substance leaves the programme.

2. Cultural and gender sensitive spiritual programme

There is a need to introduce effective, cultural and gender sensitive spiritual programme in the aftercare service. The results of the study has shown that being part of a faith-based community, participating in religious activities, or associating with a network of individuals sharing similar beliefs, increases self-esteem, wellbeing, and a feeling of belonging.

It is recommended for aftercare services to promote an individualized inclusive and holistic approach to meet the needs of recovering substance abusers.

The Twelve-Step Treatment programme is a recommended cultural and gender sensitive spiritual programme that could provide a holistic approach for spiritual development recovery for substance abusers. Development of an easy to follow manual on the Twelve-Steps
Treatment Model to develop a spiritual orientation for recovering substance abuser is recommended.

3. Family therapy component

Families support contributed positively to recovery as it was identified in the study as one of the needs of recovering substance abuser.

The family therapy component should be introduced in the aftercare services, for effective support service-delivery for families, friends and the community, to help the recovering substance abuser to maintain sobriety. Families often need other forms of service and, even though the rehabilitation programme might not be able to meet those needs directly; the aftercare service should have the appropriate information about where support might best be obtained (Heather & Robertson, 2002).

4. Professional services in the aftercare service

The study indicated the important role treatment professionals play in fostering engagement in aftercare services. It concluded that professional involvement powerfully influences recovering substance abuser’s level of affiliation within aftercare groups. When social workers or related professionals are involved in aftercare services, it increases the likelihood that recovering substance abuser will continue improving (Robertson, 2002).

Thus, professional services are recommended as it will address clinical issues in recovering substance abuser, such as readiness for change and clients’ socio-environmental context on a case-by-case basis.

5. Relapse Prevention

Learning how to identify triggers was identified as the need of recovering substance abusers.
Relapse prevention is major components of substance abuse aftercare programmes in helping individuals who are newly recovered develop healthy and proactive ways to deal with the triggers that would lead to relapse (Roffman, 2000).

Relapse Prevention model is recommended to be part of the aftercare service to teach client to socialize without alcohol or drugs. Activities such as regular exercise routines, learning new hobbies and new interests could be introduce to the aftercare component to promote a healthy sense of self and a substance abuse free lifestyle.

6. Vocational education or job skills development

Employment or job-related training was identified as an essential part of recovery process in the study. Vocational education or job skills development is recommended to be provided for active aftercare group members to able them to support themselves through appropriate labour, which will assist them remaining drug or alcohol free.

7. Incentive for aftercare members

The finding of the study concluded that active members in aftercare groups should be awarded for their commitment. These awards could include allowance, transport, retreats, networking opportunities and accredited training such as counselling courses for aftercare group members.

8. Aftercare services guideline

The need for capacity building for social worker and aftercare members with regard to rendering effective aftercare services was also identified a service provision gap in the study. The social workers raised a common need for capacity building with regards to specialist training in addiction.
It is therefore recommended to develop an aftercare services guideline which could be helpful for professionals responsible for the creation and management of aftercare service.

Future research is also recommended on the development of evidence-based aftercare guidelines for social workers or related professionals.

5.5 CONTRIBUTION TO THE BODY OF PROFESSIONAL KNOWLEDGE

The results of the study contribute to the knowledge among social workers and related professionals on aftercare services. The results of the study will add value to knowledge gap in Namibia of understanding experiences of recovering substance abusers concerning their care in aftercare service. The literature review also brought a wide understanding about the overview on substance abuse and nature of aftercare services. Thus, the study enriched existing literature on the experiences of recovering substance abusers in aftercare service.

5.6 LIMITATIONS

The study covered aftercare groups in the regions of Namibia: Otjozondjupa Region, //Karas Region, Erongo Region, Kunene, Ohangwena Region, Oshikoto Region and Omaheke Region. Namibia is a vast country as a result distance was one of the limitations. The researcher had no funding and was unable to reach all the participants in their respective places. However, the MoHSS hosted a workshop in Okahandja (08 - 2 August 2011), which brought all the aftercare groups together. Therefore the researcher used this workshop opportunity as vehicle to reach aftercare groups.

The second limitation was the challenge that recovering substance abusers or families were not willing to reveal personal information as substance abuse comes with denial and stigmatization. In order to prevent this, the researcher emphasized the importance of the study
and guaranteed confidentiality. The researcher provides them with options that they have the right to withdraw from the study if needed.

The focus of the study was on aftercare services and excluded the investigation into the success of the treatment programme, or the appropriate preparation of recovering substance abusers during the treatment programme at ERRC. Limited literature review on treatment, specifically in Namibia was also obtained as some treatment center was not willing to share their information with the researcher.

The subjective nature of the qualitative data and its origins caused some doubts on standards of authenticity and trustworthiness. However, the researcher measured the authenticity and trustworthiness of the study through using different evaluator’s to clearly understand the viewpoints of the participants. The evaluators were the manager of the treatment centers, ERRC, stakeholders in the field of substance abuse, reports from the ERRC and aftercare groups and also researcher’s observations and prolonged engagement with the participants in group discussion held by MoHSS for all aftercare groups during 08 - 12 August 2011, in Okahandja. The researcher also explored personal feelings and experiences that might influence the study and integrated this understanding into the study to promote objectivity. The analysis of the researcher’s experience made the researcher aware of possible biases and preconceived ideas. Bracketing was implemented throughout the study and each phase of the research was carefully approached using bracketing (to lay aside what is known) and intuiting (looking at the phenomenon) to avoid bias and approach the phenomenon with an open mind.

Another limitation is that the study focused on the aftercare service delivery in Namibian context and therefore may not be generalized to other contexts. The strength of evidence of the study is also limited because of the small sampling size applied in the study. The
workshop participants sample represented the four identified groups including the recovering substance abusers, family members of recovering substance abuser, aftercare groups and key informants.

The research was conducted in English, which is the sole official language in Namibia. The sampling criteria of participants who were unable to express themselves in English were excluded, which limited other diverse views. Translators could have enhanced the results of the study.

5.7 FUTURE RESEARCH

The current study focused on the recovering substance abusers that are participating in the aftercare services. It is important to gain a greater understanding of why some substance users do not participate in aftercare groups. Additional research is greatly needed in this area. As a result, future research should be conducted on the development of evidence-based aftercare guidelines for social workers as the results of the study indicated that there is no guideline for aftercare services in Namibia.

5.8 CLOSING REMARK

The government of Namibia is developing a national alcohol policy to implement alcohol and drug prevention, treatment and aftercare services. The purpose of the alcohol policy is to minimise substance abuse related risk and potential harm in the country. Substance abusers are admitted in inpatient treatment programmes to resolve their alcohol problems. However, the question remains after the completion from inpatient treatment programme: Do these recovering substance abusers obtain sufficient aftercare services to ensure long term recovery? Are the aftercare services fulfilling the needs of recovering substance abusers?
A need has risen to evaluate the nature of aftercare services for recovering substance abusers. The purpose of the study was to investigate the nature of aftercare services through exploring the experience of individuals in the aftercare service, using the phenomenology approach.

Aftercare services should be viewed as an essential phase of the rehabilitation process of recovering substance abusers. Aftercare is a service in the community that assist recovering substance abuser accomplish specific goals such as reducing the frequency and severity of relapse; fostering social integration; helping families complete their recovery and ensuring the ex-addict’s adaptation to employment (Stevens, 2003).

The essential elements in aftercare services by means of the results of the study are adaptation to work and responsibilities; family involvement, and trained aftercare members to meet the needs of the recovering substance abusers.

The lived experiences shared by the participants in this study provided details and answers that create a greater understanding of the following aspects: the need of the recovering substance abusers to be supported by families, social workers and the community at large as the period following rehabilitation were identified as the most delicate and critical period for recovering substance abusers; and learning how to identify triggers as the need of recovering substance abusers.

This was an important study that has the potential to contribute to how people with addictions are treated in Namibia. The recommendations in terms of the findings are related to aftercare plan for discharge clients and their families; incentives for aftercare members; the involvement of treatment professionals in fostering engagement in aftercare services and the development of comprehensive aftercare service guideline which could be helpful for professionals responsible for the creation and management of aftercare group.
As a result, future research should be conducted on the development of evidence-based aftercare guidelines for social workers as the results of the study indicated that there is no guideline for aftercare services in Namibia.
REFERENCES


Diagnostic and Statistical Manual of Mental Disorders fourth edition (DSM–IV).


APPENDIX A

SEMI – STRUCTURED INTERVIEW SCHEDULE FOR RECOVERING SUBSTANCE ABUSER

1. AGE

<table>
<thead>
<tr>
<th>18 – 27</th>
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2. GENDER

<table>
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<tr>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
</tr>
</tbody>
</table>

3. KEY QUESTIONS

3.1 Tell me more about your life as a recovering substance abuse after inpatient treatment program.

3.2 Was it possible for you to stay sober after inpatient treatment program?

3.3 Have you ever had a relapse after inpatient treatment program? If yes or no please explain.

3.4 If you had a relapse, what were the reasons?

3.5 How did you enter the aftercare service?

3.6 What do you perceive to be positive and negative aspects of aftercare groups?

3.7 What types of aftercare services are you receiving?

3.8 Did the aftercare services fulfill your needs? If yes/no, in what ways?

4. RECOMMENDTION

4.1 Any recommendations or any comments on improvement of aftercare services.
APPENDIX B

SEMI – STRUCTURED INTERVIEW SCHEDULE FOR FAMILY MEMBER

1. KEY QUESTIONS

1.1 How do you as a family member experience the outcome of inpatient treatment programs?

1.2 What are the challenges of families in assisting recovering substance abusers?

1.3 Is the aftercare service fulfilling the needs of recovering substance abusers?

2. Any recommendations or any comments on improvement of aftercare services.
APPENDIX C

SEMI – STRUCTURED INTERVIEW SCHEDULE FOR AFTERCARE MEMBERS

1. Name of the aftercare group attending/ conducting


2. KEY QUESTIONS

2.1 Describe what is an aftercare service? What are the goals of aftercare services;

2.2 What are the activities in your aftercare group? Tick in the appropriate box

<table>
<thead>
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<tbody>
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<tr>
<td>Family therapy</td>
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<tr>
<td>Telephonic follow –ups</td>
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<tr>
<td>Home visits</td>
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<tr>
<td>Outings</td>
<td></td>
</tr>
<tr>
<td>Others</td>
<td></td>
</tr>
</tbody>
</table>

2.3 How many recovering substance abusers does your group have that comes from inpatient treatment centers?

2.4 Is the aftercare service reaching the appropriate target population?

2.5 What special role do you play in the aftercare service?

2.6 How is aftercare session conduct and by whom?

2.7 What are the challenges aftercare services are facing?

3. Any recommendations or any comments on improvement of aftercare services.
APPENDIX D

SEMI - STRUCTURED INTERVIEW SCHEDULE FOR KEY INFORMANTS

1. KEY QUESTIONS

1.1 What is an aftercare service?

1.2 What role should stakeholders play in rendering aftercare services to recovering substance abuser? And who are those stakeholders?

1.3 How should recovering substance abusers maintain sobriety after inpatient rehabilitation?

1.4 What would you attribute to reasons for the relapse after inpatient treatment program?

1.5 What do you think are the gaps in aftercare service provision?

2. Any recommendations or any comments on improvement of aftercare services.
Ms. A. Oaes is a registered student at the University of Namibia, studying her Master’s Degree in Social Work. The thesis topic selected is “A Social Work Investigation into the Nature of Aftercare Services for Recovering Substance Abusers”.

The purpose of the study is to investigate the nature of aftercare services for recovering substance abusers. Findings that would result from this study, would serve to guide social workers, related professionals and the Social Work Department at the University of Namibia, to teach and deliver effective aftercare services to recovering substance abusers.

An interview of approximately 45 minutes duration would form an intrinsic part of the research. The responses to the interview questions will be recorded using a mini-disc recorder.

Your participation in the research is entirely voluntary. You may choose to discontinue participation at any time, without prejudice. Information obtained would be treated with the utmost confidentiality. No direct benefit is due to you for participating in this research. However, what we discover as a result of this study would assist us in developing guidelines for providing effective aftercare services.

If there are any queries regarding the study, please contact Ms. Angela Oaes at the following telephone numbers: 2032037 or mobile number: 0813601296.

Should you agree to participate in this research, please complete the section below:
APPENDIX F

PERMISSION LETTER OBTAINED

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Enquiries: Mr. M. Simasiku  Ref.: 17/3/3

Tel: (061) 2032125
Fax: (061) 272286

E-mail: mhsoffice@minhso.gov.na

Date: 09 July 2013

OFFICE OF THE PERMANENT SECRETARY

Ms. Angela Oaes
P.O.Box 21558
Windhoek
Namibia

Dear Ms. Oaes

Re: A Social work investigation into the effectiveness of aftercare services for recovering substance abuse.

1. Reference is made to your application to conduct the above-mentioned study.
2. The request has been evaluated and found to have merit.
3. Kindly be informed that permission to conduct the study has been granted under the following conditions:
   3.1 The data collected must only be used for the purpose stated in the proposal and the permission requesting letter;
   3.2 No other data should be collected other than the data stated in the proposal;
   3.3 A quarterly report to be submitted to the Ministry’s Research Unit;
   3.4 Preliminary findings to be submitted upon completion of the study;
   3.5 Final report to be submitted upon completion of the study;
   3.6 Separate permission to be sought from the Ministry for the publication of the findings;
   3.7 Please forward the revised protocol to the Ministry upon addressing the raised concerns.

Yours sincerely,

Mr. Andrew Ndishishi
Permanent Secretary