

**UNDERSTANDING THE EXPERIENCES OF
PEOPLE RECOVERING FROM DRUG USE AT
THE ARCA REHABILITATION CENTRE IN
DURBAN**

BY:

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Declaration:

I, declare that this research thesis titled: **Understanding the experiences of people recovering from drug use at the ARCA (Assisted Recovering Centres of Africa) Rehabilitation Centre** is my original work except where otherwise stated. I declare that this thesis has not previously been submitted for any qualification at any other university. I have acknowledged all sources in the reference list.

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Firstly, all thanks to the Almighty God for helping me to complete this successfully.

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Dedication

To my mother, Marianne Hunsley and my father, Rowan Moses,

May you both rest in peace.

ABSTRACT

Background: Recently there has been a significant increase in treatment demand in South Africa for heroin (an opioid), a dangerous and extremely addictive drug that remains popular among different segments of the population, including Kwa-Zulu Natal. ARCA Durban is said to be one of the few rehabilitation centres that provide the drug naltrexone, which is an effective evidence-based treatment for heroin addiction.

Aim: This study aimed to understand the experiences of people recovering from drug use at ARCA Durban so as to add to literature on drug addiction and effective treatments for opioid/heroin addiction, especially in the South African context. The information generated by this study can be potentially useful for informing programmes in government run hospitals and rehabilitation centres.

Method: This study followed a qualitative research design and used a multiple case study approach. Qualitative data was obtained using semi-structured interviews using a small sample of participants (n=10). The research participants were chosen using convenience sampling and were suitable for this study as they were recovering from opioid/heroin addiction, were certified by ARCA as being clean of any substances and had completed or were at the end of ARCA's rehabilitation programme (i.e. six months +). This study was understood using the Transtheoretical Model of Stages of Change as a framework, which informed the interview questions asked in this qualitative evaluation of the ARCA programme. Thematic analysis was used to analyse the data.

Results: It could be suggested that ARCA Durban successfully assisted/guided all the participants in this study through the following stages of change: contemplation, preparation, action and maintenance. The participant's positive experience of ARCA and the anti-craving medication naltrexone were supported by previous and current literature. The underlying factor to their successful recovery was their personal choice to change, or as literature describes as their readiness to change.

Conclusion: ARCA Durban's approach in the treatment of opioid/heroin addiction is effective and relevant in the South African context, as all participants were of all races from the most popular areas where heroin is distributed, and these participants were able to reach the stage of Maintenance without any relapses at the end of the study.

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CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Substance abuse is one of the major public health concerns of the 20th century and poses a serious societal problem all across the world, including South Africa. It involves the excessive, improper, irresponsible or self-damaging use of addictive substances such as alcohol, illegal drugs and prescribed medications, which have negative effects not only for the individual but also to their immediate and extended families and society as a whole (Fisher and Roget, 2008; Reber and Reber, 2001). These substances have the potential to modify a person's perception, mood, cognition, behaviour or motor functioning if misused or abused (Routledge and Visser, 2007).

It was estimated that up to 1 in 3 teenagers in South Africa are addicted to alcohol and drug abuse (Dangar and Madonsela, 2011). These results were based on the number of young people who present themselves to treatment facilities (Dangar and Madonsela, 2011). Alcohol and drug abuse trends in South Africa are monitored by the South African Community Epidemiology Network on Drug Use (SACENDU) Project, which is a surveillance project looking at substance use trends by gathering data from substance treatment providers since 1996 (Dada, Burnhams, Johnson, Parry, Bhana, Timol, & Fourie, 2014). According to SACENDU's recent alcohol and drug abuse trends for the period of January – June 2014 (Phase 36), the primary drugs of abuse for all patients, including those under 20 years old was alcohol, cannabis, mandrax, cocaine, heroin and methamphetamine (Dada *et.al.*, 2014). Poly-substance abuse was also found to be high, with patients indicating more than one substance of abuse (Dada *et. al.*, 2014). Furthermore, the use of Nyaope (low grade heroin and other ingredients smoked with dagga) continues to pose a problem, especially for the younger population (Dada *et. al.*, 2014).

Over the years, there was a shift in the profile from white males who prefer to smoke the substance (Parry, Pluddemann & Bhana, 2009), to users becoming younger and injection use gaining significance (Parry, Pluddermann & Myers, 2005). This is supported by recent findings that indicate more Black African patients under 20 years of age have sought treatment for heroin addiction in 2014 (Dada *et al.*, 2014). In one study, it was reported that

substance prevalence for females could be higher but was underestimated because females were not seen in rehabilitation centres (Ramlagan, Peltzer & Matseke, 2010). In addition, SACENDU intends to monitor the increase in school referrals in Kwa-Zulu Natal (KZN) and the changing pattern in heroin use in KZN (Dada *et al.*, 2014). They also intend to continue to enlist treatment centres in the KZN region to ensure that the heroin data is representative, as their findings only represent 4 treatment centres in KZN (Dada *et al.*, 2014).

1.2 Statement of the problem

Although there has been a substantial amount of research conducted on substance abuse of legal substances, such as tobacco and alcohol, both in the American and South African contexts, more needs to be done on illicit drug-use and treatment in South Africa. One reason for the lack of research in this area could be that the behaviour under study involves using illicit substances, making studying this population extremely difficult and dangerous.

Another reason is said to be lack of funding for research on drug-related issues, which may be due to the many other priorities faced by the South African government, such as education, housing, health-care etc.; and unlike the American NIDA (National Institute on Drug Abuse), have no agency to provide sustained funding to specifically support research projects studying drug usage in South Africa (Peltzer *et al.*, 2010).

When it comes to treatment for alcohol and other drugs (AOD) in South Africa, especially in Cape Town, current treatment services struggle to effectively meet the demands for AOD-related services due to problems accessing treatment, service planning and service delivery issues (Myers, Louw & Pasche, 2010). Access to treatment is said to be hindered by geographical access barriers, awareness barriers, affordability, service availability, and the limited capacity to provide effective services (Myers, Louw & Pasche, 2010). The issues with service planning and delivery involve access to accurate and relevant information on AOD trends and evidence based treatment approaches, lack of intersectoral collaboration, capacity issues and leadership deficits (Myers, Louw & Pasche, 2010).

Recently there is significant increase in treatment demand in South Africa for heroin (an opioid); a dangerous and extremely addictive drug that remains popular among different segments of the population (Parry, Pluddemann & Myers, 2005; Peltzer *et al.*, 2010). Heroin

is the fourth most commonly abused substance in patients presenting for substance abuse treatment in South Africa (SA), with a recorded prevalence of 7.9% (Ramlagan, Peltzer & Matseke, 2010; Dada *et al.*, 2014). According to recent SACENDU findings, there has been a slight increase of treatment admissions for heroin as a primary drug of abuse in KZN; whereas in other sites it remained stable (Dada *et al.*, 2014). This could be as a result of the popular drugs “sugars”, “nyaope” or “whonga” by young Indian males south of Durban (Dada *et al.*, 2011). This indicates that heroin/opiate addiction is still on the increase as reflected in the number of people, especially young people, seeking treatment for the illicit drug. Heroin causes negative effects not to the individual alone, but to the entire country as a whole. In 2012, according to the National Survey on Drug Use and Health (NSDUH), approximately 669,000 Americans reported using heroin in the past year, which has been increasing since 2007 (NIDA, 2014). It was also found that “those individuals who use heroin are more likely to develop DSM-IV (The Diagnostic and Statistical Manual IV) dependence within two years of first use than individuals who initiate use of any other substance” (Mowbray, Perron, Bohnert, Krentzman & Vaughn, 2010: 306). It is also currently causing a state of alarm in America due to the rapid rise in deaths among young people who overdose on this drug, with one American State calling it an epidemic (ARCA Midwest, 2012; NIDA, 2014).

Furthermore, it is known that rehabilitation for heroin users can be a challenge, especially when alternatives, such as methadone (a common treatment for heroin), can be just as addictive (Fisher and Roget, 2008). Methadone is a fully synthetic opioid that has been designed as a legal substitute for heroin but unfortunately, a great number of people end up becoming addicted to methadone resulting in a higher prevalence of death rates related to methadone being reported over the years (Fisher and Roget, 2008). Therefore, there seems to be urgency, both in America and South Africa, with regards to the drug heroin, and the need for evidence-based treatment, as well as prevention interventions (ARCA Midwest, 2012; Parry, Pluddermann & Myers, 2005).

Some progress has been made with the formation of ARCA (Assisted Recovery Centers of America) in the USA in 2000, with their new approach in addiction therapy receiving positive reviews. One such approach is the use of naltrexone to treat heroin users (ARCA Midwest, 2012; NIDA, 2014). Due to their success in America, a division of ARCA America has opened in Durban called ARCA (Assisted Recovery Centres of Africa) Durban in 2006.

ARCA Durban was recently on Carte Blanche showing how effective the exclusive medical treatment was for two heroin addicts (although they do not only offer treatment for heroin but for many other addictions as well).

1.3 Purpose of the study

This study will attempt to understand the experiences of people recovering from drug use at the ARCA Rehabilitation Centre in Durban. Their experiences will add to literature around drug (opioid/heroin) addiction and treatment in South Africa in relation to understanding how recovery is affected by this programme. This study will be understood using the Transtheoretical Model of Stages of Change as a framework, which will inform the interview questions asked in this qualitative evaluation of the ARCA programme, tapping into the participant's experience of moving through the stages of recovery.

1.4 Acronyms

APA	American Psychology Association
ARCA	Assisted Recovery Centres of Africa
ARV	Anti- Retro-Viral
DSM-IV	The Diagnostic and Statistical Manual IV
FDA	Food and Drug Administration (United States)
HIV/AIDS	Human Immuno Virus/ Acquired Immune Deficiency Syndrome
NIDA	National Institute on Drug Abuse
NIH	National Institute of Health
NSDUH	National Survey on Drug Use and Health
SACENDU	South African Community Epidemiology Network on Drug Use
SANCA	South African National Council on Alcoholism and Drug Dependence
UNODC	United Nations Office for Drugs and Crime

WHO World Health Organisation

1.5 Definition of terms

The following definitions are provided to ensure consistency and understanding of these terms throughout the study.

Drug addiction: consists of intense, often uncontrollable drug cravings, together with compulsive drug seeking and use, which persists despite facing devastating consequences.

Naltrexone: is an anti-craving medication that is used to treat alcohol and heroin addiction.

Rehabilitation: an institute where recovering addicts receive treatment for their addiction.

Substance abuse: the excessive, improper, irresponsible or self-damaging use of addictive substances such as alcohol, illegal drugs and prescribed medications.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

There has been substantial amount of research done on substance abuse in both international and local contexts, however; more needs to be been done with regards to illicit drugs such as opiates, in South Africa.

What are opiates?

Opiates are a group of drugs that are used for treating pain and are derived from opium which comes from the poppy plant (Fisher and Roget, 2008). Opiates are referred to by a variety of names including opiates, opioids, and narcotics, and will be used interchangeably throughout this review (“Opiates (Narcotics)”, 2013). The term opiates is sometimes used for close relatives of opium such as codeine, morphine and heroin, while the term opioids is used for the entire class of drugs including synthetic opiates such as oxycontin, but the most commonly used term is opiates (“Opiates (Narcotics)”, 2013).

Heroin

Heroin is a semisynthetic opioid (also known as alkaloid analgesics), that occurs naturally in the opium poppy, *Papaver somniferum*), which was originally used as a cough remedy and for treatment of tuberculosis (Fisher and Roget, 2008). Heroin is usually a white or brownish powder, made synthetically by adding an acetyl group to morphine, and is usually snorted, smoked or injected into the body (Fisher and Roget, 2008; National Institutes of Health, 2013). Its popularity and abuse became prominent during the 20th century. Opioids are more commonly used in medications for their pain relief qualities (Quayle, 2013). An article by Kelly Quayle (2013), states: “...the most commonly abused opioids these days are obtained via prescription” (Pg.10). This is currently true in America with the finding that for most heroin addicts, their first contact with the drug was often through prescription medications (ARCA Midwest, 2012).

Heroin functions by rapidly filling the brain’s opioid receptors almost completely, stimulating feelings of well-being and pain relief at a high intensity (Fisher and Roget, 2008; NIDA, 2014). This could be a reason why it is so highly addictive. It is also found to be a

contributory factor in the high levels of property crime and crimes of violence (Parry, Pluddermann & Myers, 2005). It leads to impaired judgement and high rates of depression and causes major health problems such as miscarriages, heart infections, risk infectious diseases including HIV/AIDS and hepatitis and can lead to death from overdose (NIH, 2013; Quayle, 2013; NIDA, 2014). Continual use of heroin can lead to tolerance, which means that more and more of the drug is needed to have the same effect or to reach intoxication (often euphoria) (APA, 2000; NIH, 2013). Once dependent, if a person stops using it, they have intense withdrawal effects such as restlessness, muscle and bone pain, diarrhea, vomiting and cold flushes (NIH, 2013; Quayle, 2013). This usually means that a person has now become addicted to the substance.

2.2 South African Context

The widespread misuse of psychotropic drugs emerged in South Africa in the 1960's and 1970's, with globalisation facilitating the introduction of potent addictive drugs such as heroin, cocaine and ecstasy into the country (Peltzer, Ramlagan, Johnson, Phaswana-Mafuya, 2010). Heroin (an opioid) specifically was a relatively unknown drug in South Africa during the 1980's and was illegally imported (Peltzer *et al.*, 2010). According to Leggett (2002), cocaine and heroin were not readily available in society prior to 1994, therefore, marking the point of escalation to the period after apartheid and the liberation of most aspects of society following the 1994 democratic elections (Peltzer *et al.*, 2010). Some reasons for this escalation have been ascribed to “the opening up of the country's borders, a decrease in very restrictive internal controls, high levels of unemployment, and an increasing use of this country as a route for transshipment...”(Parry, Pluddermann & Myers, 2007:2). In South Africa, heroin users preferred smoking it with cannabis or inhaling the vapour, called ‘chasing the dragon’, however; in the mid-2000's, snorting and injection use appeared to be increasing in popularity (Peltzer *et al.*, 2010; Pluddermann and Perry, 2004).

It is important to note that there has not been much research into heroin's cheap derivatives such as sugars and whoonga. Many of the sources of information to be discussed have been taken from public discourses around heroin use that have not been supported by research, but are popular among those attending rehabilitation centres.

2.2.1 Sugars

Currently, “A recent emerging trend in a number of cities has been the sale of low quality heroin mixed with cannabis, known as ‘pinch’ in Mpumalanga and ‘sugars’ in Durban (where cocaine is also included in the mix)” (Parry, Pluddemann & Bhana, 2009:693).

‘Sugars’ is a heroin-derivative that is composed of a mixture of residual cocaine and heroin cut with any other drugs such as cannibus (marijuana, dagga), rat poison to household detergents and baby powder or it could be inhaled on its own (Pattundeen, 2008; Tolsi, 2006). It is sold cheaply (from R10-R35) and is a very addictive drug (only needing two ‘hits’ of sugars to become addictive) with a poor recovery rate, which has dominated and impacted negatively on the lives of many youth and their families, mainly in the Indian Community of Chatsworth situated South of Durban (Pattundeen, 2008, Tolsi, 2006).

This drug, which is said to have replaced the drug ‘mandrax’, has contributed to the increase in crime within this area, including the sex trade among teenagers and its enormity has even been compared to the ‘tik’ explosion that occurred in Cape Town townships and suburbs a few years ago (Pattundeen, 2008; Tolsi, 2006). Boys, it seems, are more likely to fall prey to this addictive lifestyle (‘sugars’ and drug abuse in general) (Brook *et al.*, 2006; Pattundeen, 2008; Sawyer-Kurian *et al.*, 2009), starting from as young as 11 years old (Tolsi, 2006). It was suggested that a holistic treatment is integral when one is looking at preventing relapse with reference to the drug ‘sugars’ (Tolsi, 2006).

2.2.2 Whoonga

Another recreational (street) drug that has become popular is whoonga or nyaope, that has allegedly come into widespread use in South Africa since 2006 (Hu, 2013), mostly in the impoverished townships of Durban, Pietermaritzburg and also appearing in the Western Cape (Mtolo, 2010; Sekkides, 2013). In an article by Mtolo (2010), Thokozani Sokhulu, an activist with *Project Whoonga*, an NGO fighting the use of the drug, states that one dose costs between R15 and R35 and is sold mostly from homes, and highlights the fact that addicted individuals can sell anything just to get high and the difficulty in spotting users.

This drug has also stirred massive media attention around the controversial problem of the alleged recreational use of the antiretroviral drugs in KwaZulu-Natal specifically because of its addictive potential, its association with criminal activity, and the challenge it posed to the rollout of antiretroviral therapy (Sekkides, 2013). It was originally believed to be made up of

a concoction of Antiretroviral (ARV) drugs which treat HIV patients, heroin, rat poison and dagga (Mtolo, 2010; Sekkides, 2013). Now after some studies and tests, researchers have found that whoonga more consists of heroin, dagga and rat poison – not ARV's as previously assumed and inaccurately informed by the media.

This finding is supported by a study done by Dr Thavendran Govender, of the University of KwaZulu-Natal's Chemistry department in which he tested samples of Whoonga and found that the drug was based on Heroin and rat poison (Strychnine), not ARV's (Sticky Scissors, 2011). Furthermore, specialists in the South African Police Service and drug rehabilitation centers say that Whoonga is essentially just a re-branding of older heroin based drugs like sugars, and has never been predominantly ARV based (Sticky Scissors, 2011). Even President Jacob Zuma was also reported to have spoken out against this misconception as these incidents run the risk of damaging treatment outcomes for the millions of HIV-positive South Africans who depend on ARVs to stay healthy (Hu, 2013).

Whoonga presents with many negative consequences and symptoms detrimental to a person's health and well-being. The article by Mtolo (2010) also quotes Carol du Toit, a director at the Durban alcohol and drug centres of the South African National Council on Alcoholism and Drug Dependence (SANCA), saying that "criminal, aggressive and violent behaviour has been associated with the use of whoonga. There is a very complex interplay between physical, emotional, psychological, social and environmental factors" (parag.8-9). She further warned that "the use of these ingredients can result in loss of short-term memory, lack of motivation, paranoia and dagga psychosis. In females, the menstrual cycle could be disrupted and foetal development impeded in pregnant women who use whoonga. In males, sperm development is affected with the number of abnormal sperm increasing or sperm production impaired. The plant [dagga] also contains a significant amount of tar which, when smoked, is very damaging to the lungs. There is a risk of accidents when a person is under the influence as perception is distorted. The use of heroin, another active ingredient in whoonga, can result in severe mental and physical deterioration, organ damage and convulsions. Heroin abuse could also lead to coma and death" (Mtolo, 2010: parag.11-15). This highlights the detrimental and even fatal effects of addiction.

2.3 Risk factors for substance use

2.3.1 Individual attributes:

There has only been one online newspaper article and journal article written on the drug 'sugars' (Pattundeen, 2007; Tolsi, 2006). According to the findings in that article, youth identified as most at risk were "introverted youth, who found it hard to communicate and express their feelings...such youth were shy, quiet and socially withdrawn" (Pattundeen, 2008, Pg. 63). However, Barnes *et al.* (2005) found in certain American adolescents exhibiting both high impulsivity (constructs such as thrill seeking, impatience, boredom etc), and moral disengagement (constructs such as deviant attitudes/tolerance of stealing or violence), these traits were expected to positively predict all problem behaviours.

Investigators in one study suggested that violence plays a role in adolescence and adult substance abuse as victims of assault may engage in behaviour that reduce negative emotions such as situational avoidance or drug abuse (Kilpatrick *et al.*, 2000). They conceptualized substance use as a strategy used to cope with stress produced by interpersonal aggression (Kilpatrick *et al.*, 2000). They used a Learning Theory model to understand this interaction, which was supported by studies that demonstrated the association between affect regulation and substance use (Kilpatrick *et al.*, 2000). There have been some studies that have found a relationship between depressive mood and substance abuse; whereas, other research did not find any associations with depressive mood and illegal drug use specifically (Brook *et al.*, 2006).

2.3.2 Parental factors:

Parents play a major role in their children's upbringing and much of the literature links parental factors with adolescent substance abuse. Brookes *et al.* (2006) identified two types of parental influences that have been incorporated by other investigators with reference to adolescent drug abuse, namely parental drug use and child rearing. In their study, parental drug use included parental smoking, alcohol and marijuana use. In their study, child-rearing included parental monitoring/supervision (which are protective against tobacco, alcohol and drug use) and the mutual attachment between parent and child, which has been found to predict less tobacco, alcohol and drug use among adolescents (Brook *et al.*, 2006). They conceptualized this according to a family-interactional perspective and found that "a weak parent-child mutual attachment relation is related to intra-psychic distress, and drug-using

peers, both of which predict drug use” (Brook *et al.*, 2006: Pg. 27). Involvement in delinquency would also be more likely. This is supported by Barnes *et al.* (2005) findings that substance abuse and delinquent behaviour influence one another, constituting what another author calls “a problem behaviour syndrome”. They also hypothesized that parental monitoring was related to lower levels of all problem behaviours (Barnes *et al.*, 2005). An online newspaper article by Niren Tolsi (2006) suggests that the youth that become addicted to ‘sugars’ may come from broken families with no role models.

2.3.3 Peer factors:

Barnes *et al.* (2005) identified that a key socialization agent during adolescence is the peer group. The results of their study supported the social learning/socialization theory that states: “young people learn problem behaviour by associations with significant others who engage in the same problem behaviour” (Barnes *et al.*, 2005: Pg. 166). Brooke *et al.* (2006) suggests that the peer group exerts its influence over the individual through modeling and social reinforcement of nonconforming behaviour (unconventional behaviors). In a South African study, it was also found that for many teens and adult men, the use of alcohol and other drugs helped them fit in with male peer groups, as well as improve their manhood i.e. “when some men are faced with challenges or changes related to their masculine gender role ideology, they experience significant stress or conflict and engage in traditional masculine behaviors, such as violence, to maintain a sense of power and control” (Sawyer-Kurian *et al.*, 2009). This would result in more young people being easily influenced to take drugs or become drug dealers because their peers are doing it and to fit in with their peers.

One possibility is that there could be an interaction between genetic and environmental factors that may explain the relationship between parental and adolescent drug use (Brook *et al.*, 2006). Another finding suggests that environmental stress e.g. discrimination, will affect the individual’s adjustment and in turn will affect the participation or non-participation of substance abuse (Brook *et al.*, 2006).

2.3.4 Environmental stressors:

Much evidence within the South African context has shown that environmental (a culturally-specific domain which may be associated with the adolescent’s frequency of drug abuse) and economic stressors have adverse consequences for families and children (Brook *et al.*, 2006).

These include such influences as “discrimination, victimization, and markers of poverty, such as lack of household amenities, and hunger” (Brook *et al.*, 2006: Pg. 27). Brook *et al.* (2006) hypothesized that high levels of environmental stress are related to adolescent drug use especially in South Africa. They state that some of the environmental stressors South Africans have been exposed to are, “a) major social changes associated with the transition from apartheid to equality; b) violence and crime; c) high rates of unemployment; d) technological changes; and e) an even-worsening AIDS epidemic”(Brook *et al.*, 2006: Pg. 27).

How good or bad a neighbourhood is perceived, may also contribute to the higher prevalence of adolescents participating in substance use. For example, in a South African study, participants talked about the combination of Alcohol and Other Drug (AOD) use with sexual behaviour, (Sawyer-Kurian *et al.*, 2009) such as gang rape which they regarded as a planned act i.e. “organize the drugs” to “get the girl” (Sawyer-Kurian *et al.*, 2009). However, some of the Black/African men participating in this study felt alcohol contributed to rape more than drugs (Sawyer-Kurian *et al.*, 2009). This study was done in Cape Town, in a deprived neighbourhood whereby the rate of rape, violence, forming gangs and substance abuse is high. In a study on “sugars” gangster rappers, celebrities and the media were identified as being a major influence with reference to using vulgar lyrics in the music arena to the explicit video’s and what message they portray, and making violence seem ‘acceptable’ (Pattundeen, 2008). These are socially constructed messages that the developing individual receives on a daily basis.

2.4 Addiction

Research into addiction by professionals or addiction researchers have only existed for a relatively short period of time in comparison to the length of time humans have actually been engaging in addictive behaviour (NIH, 2012). Towards the early 19th century, the term ‘addiction’, which is still controversial and heavily debated, came to be defined as “a disease of which personal *loss of control* was the major symptom...a ‘state’ that reduces the capacity for voluntary behaviour.” (Clark, 2011:56). Currently, it is not only attributed to a dependency on substances, but has shifted towards other behaviours that are potentially addictive, such as exercise, sex, gambling, video games, shopping and internet use (Griffith 2007, as cited in Clark 2011).

Although there are various types of addictions, the one of main concern in this review is drug addictions, such as heroin addiction. Drug addiction consists of intense, often uncontrollable drug cravings, together with compulsive drug seeking and use, which persists despite facing devastating consequences (NIH, 2012). It creates many problems for an individual as it affects various brain circuits, such as those involved in reward and motivation, learning and memory and inability to control one's own behaviour (NIH, 2012). This is the reason they call addiction a brain disease. Some people are more vulnerable of becoming addicted than others, but it may depend on a combination of factors, such as their genetic make-up, age of exposure to drugs and other environmental influences (NIH, 2012).

There are various conceptual models or constructs of addiction, but professionals have yet to agree on one model of what causes addiction and the best way to treat it (Fisher & Roget, 2008). The models to be discussed are the moral model, the medical model, addiction as a psychological construct, the sociological construct and the biopsychosocial model.

- The moral model is said to be an unscientific perspective rooted in religion (Clark, 2011). It views addiction as arising because the addict is morally weak, that those who fall into addiction do so out of choice, and so can overcome a compulsion to use with will power (Clark, 2011). It also implies that addicts should be punished (criminalizes the addict), not treated and therefore; has little therapeutic value (Clark, 2011).
- The medical model (disease model), “looks to an inescapable biological source for addiction” (Clark, 2011: 58) but also implies a genetic cause to it, although the evidence for this is currently inconclusive (Fisher & Roget, 2008). This model views addiction as a disease of the brain, as being just like any other disease or illness, and not a symptom or manifestation of any other underlying psychological or physical process, therefore; any problems that occur is as a result of the disease, and not caused by it (Fisher and Roget, 2008). The addict is seen as a victim of the disease and addiction can never be cured but the person can have a lifelong remission if they take certain steps e.g. the 12-step groups such as Alcoholics Anonymous. This is the official position held by NIDA, which funds majority of addiction research worldwide (Vrecko, 2010, as cited in Clark, 2011).
- As a psychological construct (psychodynamic model), addiction is viewed as self-medicating (Clark, 2011). Drug abuse is understood as a symptom of underlying

psychological problems and is used as a maladaptive psychological coping strategy (Fisher and Roget, 2008; Clark, 2011). Therefore, drug abusers need to resolve internal conflict and when they do, drug use will be unnecessary.

- As a sociological construct (social model) views drug use as a learned behaviour (Fisher and Roget, 2008). “The addiction behaviour is acquired through socialisation within family, the peer group, the media and subcultural affiliation and the adoption of a deviant role” (Clark, 2011: 60). Drug use, therefore; could be understood as a maladaptive relationship negotiation strategy.
- However, according to the bio-psycho-social model, each person’s drug use is a result of some aspects of some or all the other models (Fisher and Roget, 2008; Clark, 2011). Treatment and recovery require addressing the body, mind, social environment and spiritual/cultural needs of an individual and take on a developmental approach to recovery (Fisher and Roget, 2008).

When it comes to treatment, these models inform the interventions used.

2.5 Treatment

2.5.1 International context

Towards the late 1960’s, the federal government of America began to fund drug abuse programmes on a large scale due to the public concern over an impending drug abuse epidemic (Quinones, Doyle, Sheffet & Louria, 1979). There were three different types of treatment for drug abuse at that time, which included the residential therapeutic community, methadone maintenance and the outpatient drug-free treatment (Quinones, Doyle, Sheffet & Louria, 1979). Charles Dederich, an ex-alcoholic, was said to have started the therapeutic community in 1958 and also founded Synanon: “a residential structured milieu in which the addict was supposedly ‘restructured’ into a productive citizen through encounter groups and other forms of therapy” (Quinones, Doyle, Sheffet & Louria, 1979: 1164). Whereas; in 1964, Dr. Vincent Dole and Dr. Marie Nyswander of the Rockefeller University, funded by the Health Research Council of New York City, conducted experiments on maintaining addicts on the long-acting synthetic opiate, methadone, which in 1965, was reported to have been successful with 22 addicts; and by 1966, they were treating 750 addicts (Quinones, Doyle, Sheffet & Louria, 1979). “The theory behind methadone maintenance was

that, by providing and stabilizing an addict on a fairly large dose (80 to 120 mg per day) of methadone, the opiate receptors in the brain would become blocked, the craving for narcotics would vanish, and the addict would no longer commit crimes to pay for drugs but would be able to hold a job and normalize family and other social relationships”(Quinones, Doyle, Sheffet & Louria, 1979: 1164). Finally, the outpatient drug-free program came about in response to the need for non-residential centers, which addicts could approach, within their own communities should any “crisis” situations arise (Quinones, Doyle, Sheffet & Louria, 1979). These programs were developed into ongoing counselling centers, and usually, but not always, headed by former addicts from other indigenous communities (Quinones, Doyle, Sheffet & Louria, 1979). However; of all the treatments in that period of time, methadone maintenance was the type most systematically and thoroughly evaluated and the type of treatment in which professionals had to be employed (Quinones, Doyle, Sheffet & Louria, 1979). Methadone is still used today as a treatment option for opioid addiction, especially for those who do not respond well to other medication (NIDA, 2014). Due to the availability and increased use of methadone, there have been concerns in the past associated with risk of accidental overdose (Weich, Perkel, van Zyl, Rataemane & Naidoo, 2008) and that it could be just as addictive (Fisher and Roget, 2008).

Over the years, more research into addiction and treatment has been done, resulting in a number of evidence-based approaches to treating addiction. Drug treatment can include behavioural therapy (such as cognitive-behavioural therapy or contingency management); and pharmacological treatments involving medication such as buprenorphine (a partial opioid agonist), suboxone and naltrexone/vivitrol also used to treat opioid addiction (Weich et al., 2008; NIDA, 2014). According to the recent Cochrane Database of Systematic Reviews, methadone was reported to be superior to buprenorphine in retaining people in treatment, but both are equally effective in suppressing illicit opioid use (Mattick, Breen, Kimber & Divoli, 2014). They are both used for maintenance treatment of heroin dependence in programmes throughout the UK, Europe and Australia, but not yet in New Zealand (Mattick *et. al.*, 2014). In conclusion, combination of treatments will vary depending on the patient’s individual needs and, often, on the types of drugs they use.

2.5.1.1 Spirituality in the recovery process

Spiritual intervention was also found to be essential in the remediation of addictive diseases (DiLorenzo, Johnson, & Bussey, 2001). Many addiction counsellors were found to advocate

for a holistic approach in terms of treatment, integrating the spiritual, physiological (biological) and the psychosocial aspects of a person's life. Green, Fullilove & Fullilove (1999) reported the existence of evidence which supported the importance of spirituality in the treatment process and found that individuals who have participated in spiritually based programmes had experienced significant progress in their recovery from addiction. The article by DiLorenzo, Johnson and Bussey (2001), points out aspects of spirituality and the losses women in particular faced living an active addiction. They further described the emotional and physical deterioration of being an addict and how a lack of a spiritual self can impact on parenting, leading them to act irresponsibly, without a caring and nurturing manner, and its negative effects for their children's welfare (DiLorenzo, Johnson, & Bussey, 2001). They also explore the danger in waiting for a parent to "hit bottom" before implementing a meaningful treatment plan and propose for the inclusion of a spiritual aspect to their recovery process, because when individuals are reconnected to a positive spiritual momentum, they are more likely to take control of their lives (DiLorenzo, Johnson, & Bussey, 2001).

2.5.1.2 Recovery from opioid addiction without treatment

For many, there is a held notion that "once an opiate addict, always an addict", and national and international policies regarding illicit drugs encouraged abstinence, promoted methadone maintenance, and exercised extreme measures of drug control (Biernacki, 1990). However, the above-mentioned view of opiate use and addiction may not be fully supported by all scientific evidence. Charles Winick (1962), as cited by Biernacki (1990), in his "maturing out" hypothesis, was against this view and suggested that addiction might be a "self-limiting" phenomenon, and used a psychodynamic explanation why some addicts quit using after early adulthood i.e. to cope with problems encountered during that stage of the life cycle, and as the problems are resolved, the effects of the opioid drug is no longer desired (Biernacki, 1990). Therefore, in those cases, therapeutic interventions will not be needed, because the root cause of the problem is addressed and the drug no longer required.

Following Winick, Lee Robins (1973), as cited by Biernacki (1990), stated that in her classic studies of Vietnam veterans, showed that opioid addicts during the war could stop using without professional intervention after they returned from overseas. Robins offered documented evidence for the capacity of self-initiated recovery, but it was argued that they did not address social and psychological processes that may result in natural recovery

(Biernacki, 1990). A study to better understand opioid addiction used a qualitative life history study of 101 addicts who recovered on their own, without the help of any formal treatment programs (Biernacki, 1990). The study found that the so-called process of “spontaneous remission” may not be “spontaneous” nor a “remission” to some prior state; rather, it appears to be a rich social and psychological process that brings about dramatic life changes (Biernacki, 1990). Furthermore, there is a sequence to the changes, but they are not necessarily stages, because many were found to occur simultaneously (Biernacki, 1990). This study was able to show that there was a possibility for recovering opioid addicts to recover without treatment, but this was for a small percentage of the whole drug addiction population who may have been recreational users and should be considered on an individual case basis.

2.5.2 South African context

In a study which monitored alcohol and drug use trends from 1997-2006, it was found that over the years there seemed to be a higher demand for heroin treatment in South Africa, particularly in Cape Town, Gauteng and Mpumalanga (Parry, Pluddermann & Myers, 2005; Parry, Pluddermann & Bhana, 2009). Recently, the Western Cape, the Northern Region (Mpumalanga and Limpopo) and Kwa-Zulu Natal (KZN) seem to be the provinces with high treatment admissions for heroin, according to 2014 SACENDU findings (Dada et al., 2014). In terms of current treatment for heroin use, South Africa provides specialised treatment facilities i.e. those delivering one or more specialised substance abuse treatment services to people with alcohol and other drug problems (Ramlagan, Peltzer & Matseke, 2010; SANCA, 2007). A variety of treatment facilities provide medical management of opioid addiction such as detoxification; as well as rehabilitation, support groups e.g. Narcotics Anonymous, and psychological treatment, aiming at a more holistic approach to treatment (Ramlagan, Peltzer & Matseke, 2010; SANCA, 2007; Weich *et al.*, 2008). Furthermore, recent SACENDU findings have implications for policy and practice (Dada *et al.*, 2014). One implication was for policies to ensure that treatment options are available for people who cannot pay for treatment or can only pay partially; therefore more people, especially the unemployed or underprivileged can access treatment facilities (Dada *et al.*, 2014). According to a recent study, especially in the Cape Town area, access to treatment is said to be hindered by geographical access barriers; awareness barriers; affordability; service availability, and the limited capacity to provide effective services (Myers, Louw & Pasche, 2010). Another issue is with service planning and delivery, which involves access to accurate and relevant information on AOD trends and evidence based treatment approaches; lack of intersectoral

collaboration; capacity issues and leadership deficits (Myers, Louw & Pasche, 2010).

Although there is still much to do where substance abuse is concerned, it appears that South Africa is making efforts in this war against alcohol and drug use in the country.

2.5.2.1 ARCA Durban Treatment Approach:

ARCA (Assisted Recovery Centres of Africa) Durban was established in 2006 and is a division of ARCA America, which is now a licensed and registered Rehabilitation Centre with the Department of Social Development and Department of Health of South Africa (ARCA Durban, 2013). The license is said to cover in-patient Detoxification and in-patient care (ARCA Durban, 2013). Medical Aid providers associated with ARCA Durban may be used to cover their drug rehabilitation and alcohol rehabilitation and ARCA Durban provides a six month programme to achieve better outcomes (ARCA Durban, 2013).

ARCA Durban is advertised as one clinic in South Africa that offers a Rehabilitation Detox Medical Treatment Programme (ARCA Durban, 2013). They reportedly offer a superior, evidence-based, and medically cutting-edge approach to the treatment of addiction, going beyond 12-step programs, offering the latest medications to minimize withdrawal symptoms and control cravings as you enter recovery, including access to counselors, physicians and psychiatric services on an ongoing 24/7 basis (ARCA Durban, 2013). ARCA Durban is also said to provide flexible on-going group, family and individual counselling and Cognitive Behavioural therapy, which research supports as an effective treatment approach, as it allows long-term recovery with little or no disruption of work or family (ARCA Durban, 2013; NIDA, 2014; Weich *et al.*, 2008). ARCA Durban reports that this approach allows patients to return to work or school in 2-5 days and attend therapy sessions in the daytime, evenings and Saturdays. ARCA Durban state that they offer same day appointments for consultation or treatment, providing medical treatment programmes that are affordable, completely confidential and can be designed to suit individual needs without comprising the quality of the program (ARCA Durban, 2013).

ARCA Durban reports that they use anti-craving medications that can significantly improve treatment outcomes, namely, Vivitrol or Naltrexone, (ARCA Midwest, 2012). The United States federal government spent millions to develop Naltrexone about 30 years ago to prevent heroin relapses (ARCA Midwest, 2013; Byers, 2013). The FDA (Food and Drug

Administration) approved it to treat heroin addiction in 1984, and for alcoholism in 1994, but there was some controversy around practical difficulties in using a non-addictive medication, and other ideological barriers, which relegated this medication to a very narrow group of patients (Byers, 2013). By the 1990s, a federal nonprofit agency, the National Institute on Drug Abuse, funded research to develop an injectable form of the drug (Byers, 2013). A company ultimately developed Naltrexone/Vivitrol and was later bought by the drug's current manufacturer, Alkermes (Byers, 2013). The FDA approved its use in treating alcoholics in 2006, and followed with approval for opiate addiction in 2010 (Byers, 2013). It is now recognized and used to effectively treat both alcohol and opiate addiction.

Naltrexone is an opioid antagonist (i.e. blocks rewarding effects of opioids/other drugs) medication that comes in a pill form and should be used only after detoxification for a period of between one and two years (NIDA, 2014). The benefits of naltrexone is that it can be effectively used for relapse to opiate use; is not addictive or sedating, and does not lead to physical dependence (Dunn *et al.*, 2013; NIDA, 2014; UNODC/WHO, 2013). One critique is that it has resulted in poor compliance which limits its effectiveness (Dunn *et al.*, 2013). Therefore, Vivitrol, a new and long-acting form of naltrexone was developed as an alternative to avoid daily dosing and improve patient compliance (NIDA, 2014).

Vivitrol is a monthly intramuscular injection that blocks the brain's ability to get high (or drunk) (Byers, 2013). Therefore, should a heroin addict 'shoot up', he or she will feel nothing, as well as a prescription opiate addict won't get high if using this drug, and an alcoholic will lose muscle coordination without the pleasure of intoxication (Byers, 2013). In short, Vivitrol works to block endorphins, which stimulate surges of dopamine (Byers, 2013). Vivitrol gives the brain a chance to reboot by blocking endorphins altogether (Byers, 2013). However, Vivitrol must be coupled with therapy to work effectively (Byers, 2013). Therefore, ARCA Durban provides therapy and counseling and is licensed to provide naltrexone for the treatment of drug (opiate) addiction.

The aim of this study is to understand the experiences of people recovering from drug use at ARCA Rehabilitation Centre in Durban so as to understand the process of recovery for participants on the ARCA programme for opioid/heroin addiction. This is important as little research has been undertaken to understand this process in the South African context and

understanding the recovery process could help inform other rehabilitation programmes in South Africa.

2.6 Proposed Theoretical Framework

For the aims of this study to be possible, a Transtheoretical model of behavioural change, namely the Stages of Change will be used as a framework to understand how the ARCA programme helped the participants recover and progress through the six different stages of behavioural change. This model identifies that the stages of change is circular or spiral, and not linear (Prochaska, DiClemente & Norcross, 1992); therefore, people are thought to move back and forth along the continuum a number of times before reaching the final stage of change (Beinbauer & Maddeleno, 2005; DiClemente & Scott, 1997). These stages include: precontemplation (unaware of the problem, not thinking of or wanting to change in the next six months); contemplation (aware of the problem and thinking about taking action in the next six months); preparation (getting emotionally ready and intending to act in the next month); action (engaging in the new behaviour within the past six months); maintenance (keeping up the new behaviour and prevent relapse – six months to five years); and termination (ending at the appropriate point, experience no temptations and not becoming 'institutionalized') (Beinbauer & Maddeleno, 2005; DiClemente & Scott, 1997). The Stages of Change has been found to assist with health behaviour change for addiction to substances (Beinbauer & Maddeleno, 2005) and is also “an easy-to-use theoretical construct for evaluating the effectiveness of interventions” (Beinbauer & Maddeleno, 2005:55), such as those implemented at ARCA.

2.6.1 The Stages of Change

STAGES OF CHANGE

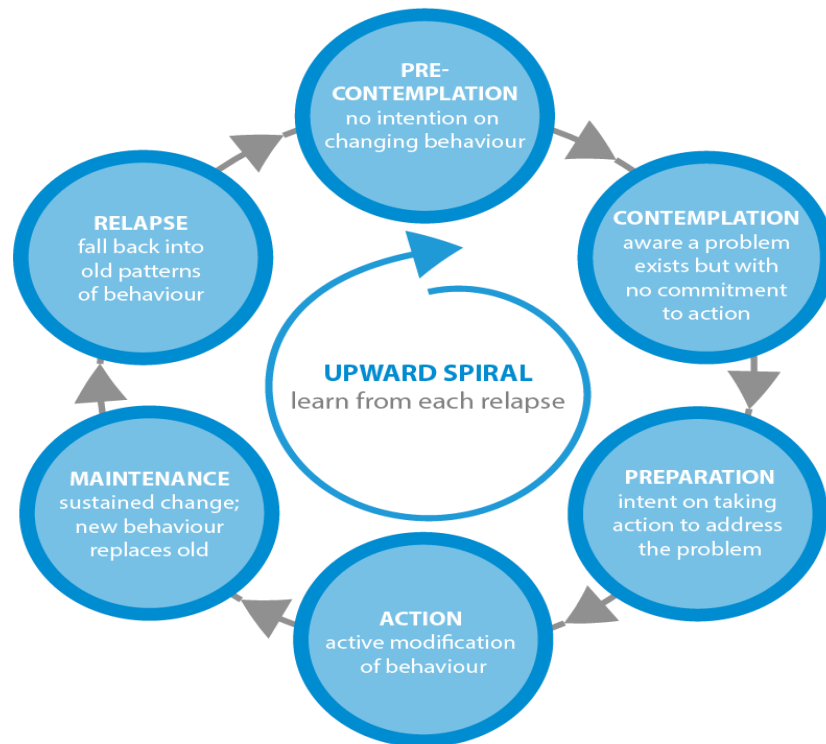


Figure 2.6.1.a) The Stages of Change Model.

2.6.1.1 Pre-contemplation

The process of recovery, according to the Stages of Change model, would begin with the pre-contemplation stage in which individuals are not willing, unable or fail to acknowledge drug use as a problem or to seriously consider changing their behaviour in the foreseeable future, i.e. in the next six months (DiClemente & Scott, 1997; Prochaska, DiClemente & Norcross, 1992). This stage is related to an individual's level of awareness of the consequences of their behaviour on others or towards themselves, while using drugs and could be described as being in denial. In addition, "People may be in this stage because they are uninformed or insufficiently informed about the consequences of their behaviour" (Breinbauer & Maddaleno, 2005: 55).

2.6.1.2 Contemplation

When individuals start to become aware that their addictive behaviour is a problem, and can consider the advantages and disadvantages of their behaviour, as well as come to the

realisation that change may be needed and they intend to change in the next six months, they enter the contemplation stage (Breinbauer & Maddaleno, 2005; DiClemente & Scott, 1997). They are basically ‘thinking’ of change, which can last up to a couple of weeks or even years; however, use of educational interventions that allows reflection about their bad habit could assist individuals to move into the next stage of change.

2.6.1.3 Preparation

The decision to take action and the intention to implement that decision moves an individual into the preparation stage (DiClemente & Scott, 1997). Preparation is when individuals make a commitment to modify the drug behaviour, planning to take action in the next month and have made some steps to change and are trying to change (Breinbauer & Maddaleno, 2005). The implementation of the plan initiates the action stage, which is the next process of change. According to Prochaska and DiClemente at the preparation stage, the individual needs encouragement to evaluate pros and cons of behaviour change (Breinbauer & Maddaleno, 2005). The therapist, then, needs to identify and promote new, positive outcome expectations in the individual and encourage small initial steps when the individual is in this stage of change.

2.6.1.4 Action

The next stage of change is called Action. This is when people have made significant modifications or adjustments in their lifestyles in the last six months (Breinbauer & Maddaleno, 2005). The tasks for behavioural change programme’s at this stage is to help the individual on restructuring cues and social support, enhance self-efficacy for dealing with obstacles and help to guard against feelings of loss and frustration (Breinbauer & Maddaleno, 2005).

2.6.1.5 Maintenance

Maintenance is the next stage of change. At this stage people are less tempted to relapse and increasingly more confident that they can continue their change and this usually lasts from six

months to five years (Breinbauer & Maddaleno, 2005:56). The tools required at this stage are to provide follow-up support, reinforce internal rewards, and discuss coping with relapse.

2.6.1.6 Termination

Beinbauer and Maddaleno (2005) included a sixth stage of change, called termination; whereby, the individual lacks temptations and enjoys complete self-efficacy. However, previous literature suggests that “the path of recovery requires movement from pre-contemplation through contemplation and preparation in order for an individual to take effective action and arrive at maintained abstinence from alcohol and drugs or maintained non-problematic drinking” (Diclemente & Scott, 1997: 139), and does not include this stage of change. Furthermore, many people hold the notion that “once an opiate addict, always an addict” (Biernacki, 1990), thus the term ‘recovering addicts’, which would suggest that termination is an ideal stage that many individuals aspire towards but may not be attainable.

2.6.1.7 Relapse

Many individuals relapse (return to older behaviours and abandoning the new changes) on their journey towards recovery and each time it becomes more difficult to start again. According to the Stages of Change model, relapse is considered normal and people are thought to move back and forth along the continuum a number of times before reaching the goal of maintenance (Breinbauer & Maddaleno, 2005). Breinbauer and Maddaleno (2005) state that “...they may have tried to change a number of times in the past and have become demoralised about their inability to do so” (Pg. 55), meaning that people who relapse will experience a strong sense of failure that can seriously breakdown their self-confidence. Some reasons that lead to relapse or make moving beyond relapse more difficult could be related to maladaptive cognitions, problems in beliefs or self-statements that may interfere with recovery (DiClemente & Scott, 1997); or a low level of readiness to change which refers to a “combination of the patient’s perceived importance of the problem and confidence in his or her ability to change” (DiClemente, Schlundt & Gemmell, 2004:104). However, DiClemente and Scott (1997) state that “relapse experiences contribute information and feedback that can facilitate or hinder subsequent progression through the stages of change. Individuals may learn that certain goals are unrealistic, certain strategies are ineffective, or certain environments are not conducive to successful change” (Pg. 139). Therefore, relapse can be an

opportunity for learning and growth and these individuals are encouraged to restart the process again at preparation, action or even the maintenance stages.

Previous research states that the high drop-out rates from treatment are probably related to clients being in the early-stage levels of change (Miller 1985). Therefore, DiClemente & Scott (1997) state that “it is important to understand not only the current stage of change for an individual but also to understand how often this individual has been through the cycle, either alone or with earlier treatment, to more accurately address his or her needs” (Pg. 140). This then supports the notion that for most individuals the path towards change is not straight and narrow but circular in nature, as indicated by previous literature (Breinbauer & Maddaleno, 2005; DiClemente & Scott; 1997; Prochaska, DiClemente & Norcross, 1992).

2.6.2 A conceptual framework for understanding the drug treatment process and outcomes

The Transtheoretical model provides us with six stages of change that an individual is likely to go through when engaged in behavioural change for addiction to substances. The focus of this study is with drug addiction, namely opioid/heroin addiction. Part of the Stages of Change model involves individuals seeking treatment for their addiction, and Simpson (2004) proposed a way to conceptualise the drug treatment process and outcomes, which in some aspects, is comparable to the Transtheoretical model of behavioural change. This proposed framework, in conjunction with the Transtheoretical model, adds a better understanding of the drug treatment process and outcomes in which the recovering addicts engage in.

Simpson (2004), in his conceptual framework, stated that when an individual enters the treatment process, emphasis is placed on creating a treatment plan to decrease or eliminate symptoms, increase quality of life and functioning, and promote recovery. The focus then moves to the essential role of establishing a therapeutic relationship necessary for patients to move successfully through an acute stage of treatment into phases of stabilization (Simpson, 2004). Simpson (2004) proposed that the main stages of the treatment process involve: a) *motivation/readiness to change* (i.e. readiness for personal change, for the treatment program, and for specific intervention activities and represents important patient attributes, including motivation, skills/resources, and confidence/self-efficacy); b) *early engagement* (i.e. the extent to which new admissions show up and actively engage in their role as patient, to

counselling sessions and within the therapeutic relationship); c) *early recovery* (i.e. a series of psychosocial and behavioural changes, signified by changes in thinking and acting, comparable in some ways to the transition from cognitive based contemplation to decision-based preparation and action stages of the Transtheoretical model); and lastly, d) *retention and transition* (i.e. helps stabilize recovery for transition out of primary treatment to sustain change over time and integrate that change into the lifestyle of the individual so that the new behaviour, abstinence from drugs, becomes the preferred habitual behaviour, and is comparable to the maintenance stage of the Transtheoretical model). Other issues Simpson (2004) addressed in his paper, involve co-occurring disorders, the possibility of multiple treatment episodes, and various options to consider in regard to treatment strategies and settings. He concludes by drawing our attention to new treatment guidelines that state: “Once a diagnosis has been established, it is critical to identify the targets of each treatment, to have outcome measures that gauge the effect of treatment, and to have realistic expectations about the degrees of improvement that constitute successful treatment” (Simpson, 2004: 113).

CHAPTER 3: RESEARCH METHODOLOGY

This chapter includes a detailed description of the research methodology that was utilised in the study. It is organised into several sections that provide structure within which to describe the research plan.

3.1 Aim

The aim of this research is to understand the experiences of people recovering from drug use at the ARCA Rehabilitation Centre in Durban. **The focus of this study is with drug addiction, namely opioid/heroin addiction.** This study will be understood using the Transtheoretical Model of Stages of Change as a framework, which informs the interview questions asked in this qualitative evaluation of the ARCA programme, tapping into the participant's experience of moving through the stages of recovery.

3.1.1 The objectives of this study are:

1. To understand how addiction was experienced by people recovering from drug use at the ARCA rehabilitation Centre
2. To understand how the ARCA programme helped the participants recover

3.1.2 Research Questions

- 1) What are participant's experiences of addiction?
- 2) What are participant's experiences of recovery as a result of being on the ARCA programme?

3.2 Research Methodology

3.2.1 Type of Design

A qualitative research design was used in this study. The qualitative method is said to be holistic, naturalistic and inductive (Terreblanche, Durrheim & Painter, 2006:47). According to Denzin and Lincoln (1994: 44), "qualitative research is a multi-perspective approach

(using different qualitative techniques and data collection methods) to study social interaction aimed at describing, interpreting, making sense of, or reconstructing the social interaction in terms of the meanings that the subjects attach to it". This basically means that it works from the viewpoints of the human beings themselves, called an insider's perspective, rather than that of an expert making assessments of the participant's experience. It studies a small number of participants (Sarantakos, 2003: 45). The qualitative researcher values the natural setting in order for him/her to better understand the participant's lived experiences (Ulin et al, 2002). Specifically a multiple case study approach was adopted which is a form of qualitative inquiry that understands a particular issue within a person's particular context (Yin, 2003). Further, using a multiple case study approach provides greater analytic benefits, according to Yin (2003), with multiple independent cases (10) being used in the study rather than a single case study.

A case study is an "empirical inquiry that investigates a contemporary phenomenon within its real-life context", according to Yin (2003:13), and becomes useful when contextual factors are believed to be of importance to the phenomenon being investigated. This means that the social contexts of participants are important. Researcher's need to be able to understand that behaviour is "socially situated, context related, context dependant and context rich" (Cohen, Manion & Morrison; 2000: 137); hence, the researcher ensured that situations (such as addiction) were not viewed in isolation but within the different stages of change the identified participants find themselves. This informed the theoretical framework that was used in this study: A Transtheoretical model of behavioural change, namely the Stages of Change, which informed the interview questions.

3.2.2 Data collection techniques

One of the key components of this approach is in-depth interviews; therefore, this form of data collection was used in this study, guided by an interview schedule (see the Interview Schedule attached to the appendix). All interviews were understood and conducted in English; therefore, no interpreters were needed. An audio recorder was used because it was not distracting e.g. while the interview is taking place, it allowed the interviewer to go back and listen to the interview to see if anything of importance was missed. It also gave the interviewer the opportunity to pay attention to body language, facial expressions, allowing the interviewer to observe the participants properly. The single interview sessions with each

participant took approximately 45 to 60 minutes in duration. Thereafter, there was a feedback meeting with all participants to discuss and ensure the validity of the results.

3.2.3 Recruitment Strategy

A list of recovering opioid/heroin users who have successfully completed or were at the end of the ARCA rehabilitation programme, were identified by the staff and interviewer using the inclusion criteria of the study. They each were contacted telephonically or personally approached by the interviewer to participate in the study. Ten participants received the consent forms explaining the full nature of the research. Dates were negotiated after receiving ethical clearance, and the interviews took place at ARCA Durban because it was a convenient setting in which the participants felt most comfortable.

3.2.4 Type of Sampling

The sample was a convenience sample because the sample was easily accessible, and there was no need to actively seek them out or provide incentives for participation as permission to proceed with the research project had already been obtained from the Director of the ARCA rehabilitation centre. The participants also fit the criteria to achieve the objectives for my research project as they were recovering from drug (opioid) addiction and have attended the ARCA rehabilitation centre throughout their journey of recovery.

3.2.5 Research Participants

One component of case study qualitative research is that it studies a small number of participants (Sarantakos; 2003: 45), which facilitates a thorough in-depth exploration of the data. Ten participants, both male and female, of different races and of ages ranging from 18-35 years of age participated in this research study. Ulin et al (2002: 57) states that, “the challenge for the qualitative researcher is, therefore, to select participants who will be able to provide the most meaningful information on the topic”. Thus, the research participants were recovering from opioid/heroin addiction that were certified by ARCA as being clean of any substances and have completed or at the end of ARCA’s rehabilitation programme. The

reason for a narrow focus was to investigate what works in terms of treating opioid/heroin addiction in the South African context, which can be incorporated into other rehabilitation programmes.

An outline of the participants' profiles is as follows:

3.2.5.1 Description of participants: Below follows brief descriptions of participants in the current study. These descriptions are aimed at introducing the reader to each participant and their background so as to better relate findings outlined in the subsequent chapter to participants' contexts.

1. Participant A, 17 May 2014

Participant A is a 23 year old Black African male. He was six months clean at the time of his interview. He reported living with his mother, his two brothers and his younger sister in Durban. He was 18 years old (2009) when he started smoking whoonga – heroin. Prior to drugs, he used to only smoke cigarettes. In 2009 he met his girlfriend and they had two daughters who are three and four years old. He reported that it took her three years to find out about his drug addiction. ARCA is the second rehab he has attended. The first rehab he attended was in 2011. At this rehab there wasn't a detox programme. He reported receiving tablets (suboxone and methadone) at night and in the morning and there was a social worker and psychologist there. After his first rehab, Participant A reported that he managed to stay clean for four months but reports relapsing because of his friends. He even dropped out of school due to his addiction. His family were angry because he got into crime and stole their personal belongings to sell for drugs. After his relapse, he reported smoking hard and his drug addiction became worse than before. His family noticed a change in him and spoke to him, but he didn't care at that point. He reported being scared to tell them he was back on drugs but he could feel he was addicted. He feared his siblings would tell his mother to kick him out the house or not give him money. In 2014 Participant A decided to go to his doctor and requested to go for detox because he wanted to quit smoking. As there were no beds available at the hospital, his doctor contacted the Director of ARCA and transferred him there. He was an inpatient for 21 days and he is now attending ARCA every Saturday with his family as an outpatient as part of their after-care programme. He reported that his mother

is his caregiver and gives him naltrexone, anti-craving medication, every morning at 7am before she goes to work. Participant A is unemployed and has a goal of completing his matric in the near future.

2. Participant B, 7 June 2014

Participant B is a 34 year old Coloured female and was 16 years married with two sons, aged ten and eighteen, at the time she was interviewed. She was born in Johannesburg and relocated to Durban with her family in 2009. She had started abusing opioids from a young age and reported that she was a very bitter young girl because of her parent's divorce and her mother remarrying someone she disliked. She also spent lots of time at her grandmother's house where they lacked proper supervision and used to drink a lot. She also had her first child when she was 15 years old and reported having to grow up very fast and not having time to be a child. After marriage and relocating to Durban, Participant B reported experiencing several challenges: she got retrenched from her job and was unemployed for two years; she developed anxiety and depression and experienced marital problems. The drugs helped her feel calm and confident as she was a person who did not like dealing with confrontation and would rather be quiet and keep it in. Participant B reported trying to stop two times in the past five years but she struggled and failed both times. Her 21 day stay as an inpatient at ARCA, which was her first experience of being at a rehab, was fully paid for. She reported only having to purchase the naltrexone every month now that she is an outpatient. Participant B reported that her family is still adjusting to her being sober and that she looks forward to attending marriage counselling with her husband. She is employed and attends ARCA every Saturday for the support sessions.

3. Participant C, 12 August 2014

Participant C is a 21 year old White female. She was two years clean at the time of her interview. She was adopted as a young child and started taking drugs at 19 years of age while taking a gap year after she matriculated. Her adopted family had a daughter who Participant C described as being popular, having lots of friends and as being an extrovert. Participant C

reported being a very insecure, withdrawn and a shy person growing up, and the drug helped boost her confidence, self-esteem and helped her make friends. She reported that she got involved in drugs through her friend who was a dealer. For one year six months she smoked her drug of choice and became dependent on it. She attempted to quit many times on her own but was unsuccessful. While at ARCA she realised that she needed help in order to recover from her addiction. She was met with overwhelming support from her parents, who helped her by sending her to ARCA. At that time, there was no 21 day inpatient programme at ARCA, so she only stayed for seven days where she underwent detox and received counselling and was put on naltrexone. After two years, Participant C still attends the Saturday support sessions with her sister, who is also recovering from drug addiction. Their relationship has since improved, she has learnt the importance of self-care and she is more family oriented.

4. Participant D, 24 January 2015

Participant D is a Black African male, who is 24 years old and was six months clean at the time of his interview. He was born in Johannesburg. He reported being an only child and at ten years of age, he relocated to Durban with his parents. He described being a shy, lonely person growing up. At age 20, his parents went through marital difficulties and almost got a divorce. He started feeling depressed and was unhappy at home. Participant D reported wanting to find his happiness elsewhere and because he was in his first year of varsity, began going to parties and spending more time away from home. He then got involved with drugs. He reported that he first started taking ecstasy, then cocaine and then heroin. He took drugs for three years. It became so bad. Participant D reported that he wasn't performing well at varsity or at work, he would be away from home for days and weeks at a time and then after one hectic weekend of drugging, he decided to quit and admitted himself into ARCA. His parents were notified by ARCA once he was admitted and they supported him throughout his journey at ARCA. He stayed at ARCA for 21 days and tries to attend the Saturday support sessions but sometimes cannot due to his job requirements.

5. Participant E, 3 February 2015

Participant E is a Black African male and was 21 years old at the time of his interview. He lives with his parents in Durban. He described being a kind, gentle person with a good

attitude before he got involved with drugs. At age 15, he began taking the drug whoonga. He began bunking school and dropped out of school in Grade 11. He reported engaging in crime (stealing, robberies) and was an aggressive, wild person with a bad attitude. Participant E was introduced to drugs by his friends and continued taking drugs to impress the group he was in. He reported being in jail many times. Participant E has been to six rehabs prior to ARCA. He reported that it was now his choice/decision to attend ARCA, previously it was to please his mother and to keep up the pretence. It took a painful experience to get him to make the choice to stop taking drugs. For Participant E, it was family rejection and being homeless. He reported that he had disappointed his mother and family so many times, that he had to beg and plead his mother to give him one last chance. They chose to send him to ARCA where he stayed for 21 days as an inpatient. He attends all after-care sessions during the week as well as the Saturday support session with his mother. At the time of the interview, he was unemployed and planning to complete his schooling.

6. Participant F, 24 February 2015

Participant F is a 24 year old white male, who was six months clean at the time of his interview. He reported being the only child and described that his father and grandfather were both alcoholics. He was born in Johannesburg and relocated to Durban because of work after High school. He is currently married with two daughters aged 8 months and 6 years old. Participant F began taking drugs at age 15 and it got worse when he was working and earning more money. He reported that he began neglecting his family and only thinking about his drug of choice. He described first taking ecstasy and smoking cannabis, and then started drinking alcohol and then two years ago taking heroin. His mother and the thought of losing his family - his daughters, motivated him to stop taking drugs. His mother told him about ARCA and he was placed on the 21 day inpatient programme. Participant F reported that being at ARCA gave him an opportunity to reflect on his life and the choices he made. He was employed at the time of the interview and was attending the weekly meetings and the Saturday support sessions with his mother and wife.

7. Participant G, 26 February 2015

Participant G is a 31 year old Indian male. He was six months clean at the time he was interviewed. He reported that he has one older brother who is married. Participant G is single and lives with his parents in Durban. He described being a happy person prior to taking drugs. He reported that from the time he was in school, his life revolved around having a girlfriend to be happy and needed that feeling of being loved, but alone he was sad and unhappy. Participant G reported experiencing many difficult periods in his life, which led him to take drugs. He reported being on drugs for 10 years before attending ARCA. He described having an addictive personality as he moved from one addiction to another e.g. gym to prescription medication, to cocaine and eventually heroin. He reported spending large amounts of money on drugs and as a result put himself in a lot of debt. Participant G became so depressed that one month before attending ARCA, he attempted suicide by overdose but was unsuccessful. His parents admitted him into ARCA and he stayed for the 21 day inpatient programme. As an outpatient, he attends the after-care programme at ARCA and reported having a more positive outlook on life. He was unemployed at the time of the interview but reported being supported by his parents during this whole process of recovery.

8. Participant H, 28 February 2015

Participant H is a 20 year old Indian male who was six months clean when he was interviewed for this study. He reported that he lives with his older sister and parents in Durban. Participant H began taking drugs in matric. He described being the 'cool kid' at school and very popular, so to uphold his reputation and maintain his status, he had to do things that the 'in-kids' were doing. He reported that had been using sugars for 3 years and had attended one rehab prior to ARCA. The longest he had been clean was 2 weeks in the 3 years of using drugs. While taking drugs, he reported losing weight, bunking school and eventually leaving school in the middle of his matric year. He found out about ARCA after he ran away from the first rehab from a friend of his fathers who had a son who attended ARCA and was clean for 3 years at that time. He began attending ARCA, but he reported he ran away after the 3rd day of detox. He felt after his 2nd day that he was okay now and didn't need to stay longer. However, after running away from ARCA, he experienced bad withdrawal symptoms and smoked as much as he could, but nothing happened because he was on naltrexone and realised it was pointless to smoke. He reported that his family had not quit on him, so he wasn't going to quit on himself, so he returned to ARCA, this time by his

own choice. He stayed for 21 days as an inpatient. As an outpatient, he is planning to complete his studies and helps his mother with the family business to keep himself busy. He also attends the after-care programme and support sessions on Saturdays at ARCA with his family.

9. Participant I, 28 February 2015

Participant I is a 24 year old Black African male who was eight months clean at the time he was interviewed for this study. He reported that he lives with his three sisters and his mother in Durban. Participant I began taking sugars in 2010, when he was still in school. He then dropped out of school in 2011 because of his addiction. He reported that a conflict with his mother led him to begin taking drugs and he started hanging out with the wrong group of friends who introduced him to drugs. He described causing hurt and pain to his parents and that is what motivated him to stop taking drugs. His parents found out about ARCA from the internet. After being discharged from ARCA after his 21 days as an inpatient, Participant I found out that he was going to be a father. At the time of the interview, he had returned to school to try and complete his studies, and was attending the after-programme at ARCA on Saturdays.

10. Participant J, 2 March 2014

Participant J is a 30 year old coloured male, who was six months clean at the time of his interview. He is married and has a son aged seven years. Participant J reported that after his mother's death in 2000, he struggled to cope with her loss and turned to drugs to numb the pain. This caused a lot of marital difficulties and affected his job. In 2014, his family approached him and confronted him about his drug addiction and he decided to try ARCA. ARCA is the first rehab that he attended and was in the 21 day inpatient programme. Participant J reported that his employer was very understanding and supportive, offering to pay for his stay at ARCA. As an outpatient, he continues to take naltrexone and tries to attend the Saturday support sessions when he can. At the time of the interview, he was employed under a different position and reported that his family was supportive of him throughout his journey towards recovery.

3.2.6 Ethical considerations

Ethical approval was granted by the UKZN Humanities and Social Sciences Research Ethics Committee, Reference number HSS/1503/013M, before the research was conducted (See the Ethical Approval Letter attached in the appendix). The participants were informed about the nature of the study undertaken. Informed consent forms were given to participants respectively stating, inter alia, the voluntary nature of participation in the study. Each participant had the right and freedom to leave or drop out or discontinue the study at any time and they were notified about this in the beginning of the study.

A letter from the Director of ARCA Durban in which the study took place, had already been received and permission granted. Anonymity and confidentiality were kept in the following ways: The participant's name was not used, but letters were allocated. The researcher and supervisor are the only people that have access to the data from the study. After the data had been collected and analyzed, the electronic and hard copies of the data have been stored in a locked cabinet in my supervisor's office and will subsequently be destroyed in 5 years. The interviewer had completed her internship as a Clinical Psychologist and had attended a course in trauma counselling, which equipped her with the necessary skills to notice when an individual is distressed or uncomfortable, at which point they would have been referred for counselling; however, none of the participants experienced much distress from the questions asked. The researcher also did not show any signs of vicarious trauma and therefore, continued with the data collection until its completion.

3.2.7 Reliability & Validity:

- a) "Reliability" implies that consistency in the research must be maintained and that if or when other researcher's attempt to replicate the study, they should arrive at the same conclusions (Hlengwa; 2003). The interviewer made an effort to make the steps to the research process as operational as possible and ensured that the research supervisor was fully informed at each step of the study to keep track of the proceedings of the research process. Each step was recorded to allow researchers intending to carry out research along the same lines, the opportunity to refer to the current study.

- b) Validity, on the other hand, aims to ensure the research findings reflect the truth and that the research project is investigating what it intended to investigate, so as to reduce the chances of making incorrect inferences. Validity was ensured in the following ways: the use of a representative thick descriptive data and quotes to substantiate the researchers findings ; and respondent validation, where the researcher held a feedback meeting with the participants to ensure that the researcher's findings and interpretations are valid and are true representations of the participant's experiences.

3.3 Data Analysis

Thematic analysis was used after the data was collected to attempt to understand the experiences of recovering addicts attending ARCA Durban. Yin (2003), states that it is a useful method of analysis, especially for case studies. Therefore, thematic analysis was a suitable method of analysis for a multiple case study approach as it provides a flexible tool to gain a detailed account of the data, according to Braun & Clarke (2006), as cited by Kathree (2010).

This form of analysis focuses on breaking down data that has been gathered into patterns/themes which are in relation to the research topic. These “themes are recurrent and distinct features of participant's and/or experiences, which the researcher sees as relevant to the research question” (King & Horvicks, 2011: 150). The basic system of thematic analysis is broken down into three stages; however, in reality, the process of analysis does not occur in a purely sequential manner (King & Horvicks, 2011). The first stage was descriptive coding, which includes: reading through a transcript, highlighting relevant material and attaching brief comments, defining descriptive codes, and repeating this process for each transcript and refining descriptive codes as you progress (King & Horvicks, 2011). The second stage was interpretive coding, which includes: clustering the descriptive codes together, interpreting the meaning of the clusters in relation to the research question and disciplinary position, and applying interpretive codes to the full data set (King & Horvicks, 2011). The third stage was identification of overarching themes, which were primarily informed by the guidelines set out in the interview schedule, but also includes deriving key themes for the whole data set, by considering interpretive themes from theoretical (in this case, the Stages of Change model) and/or practical stance of the project, and then constructing a diagram representing the relationships between the levels of coding in the analysis (King & Horvicks, 2011).

The interviewer used NVIVO as a qualitative aid to analyse the data.

CHAPTER FOUR: RESEARCH FINDINGS

This chapter presents the findings of this study. Based on the analysis of the data, several predominant themes were identified. Results were drawn from interviews with participants.

4.1 View of self before taking drugs

Before taking drugs, six participants expressed a “positive sense of self” and four participants described a “negative sense of self”, which formed the main themes for how they viewed themselves prior to taking drugs.

4.1.1 Positive sense of self

A positive sense of self was shown by words/descriptions of themselves that reflected “positive qualities”. This sub-theme was also expressed by their tone of voice during the interview, sounding almost as if they longed to be the person they were before they got involved with drugs. It seemed to be the happiest time in their lives, when compared to how they felt about themselves after taking drugs.

4.1.1.1 Positive qualities

Common phrases used among six of the participants were “kind person”, “happy person”, “good attitude”. Some even went on to describe positive qualities about themselves.

Participant A dropped out of school when he started taking drugs and referred to himself as being ‘a monster’ and ‘not a human being’ when reflecting on the type of person he was while on drugs. He seemed to have regrets and viewed himself before taking drugs in the following way:

“I was a good boy, I was schooling and I got respect for my parents. I was bright at school.”

(Participant A)

Participant E and I dropped out of school while taking drugs and also reflected on the good qualities they had before taking drugs, as seen in the following extracts:

“Before I got into drugs I was a kind person, who cared about others. Yeah, I was gentle to everyone. I had a good attitude.” (Participant E)

“I was a calm person actually...yeah, I was thinking about the future. What I can say, I was more responsible for my life...yeah.” (Participant I)

4.1.2 Negative sense of self

However, Participant B, C and D described having a negative sense of self before taking drugs. Their tone was also filled with regret but mostly anger because for some, life circumstances shaped them into the people they were.

4.1.2.1 Negative qualities

A negative sense of self was shown by words/descriptions of themselves that reflected “negative qualities”.

For Participant B, certain life circumstances resulted in her having a negative sense of self. She had a very good relationship with her mother when she was young and felt betrayed when her mother remarried. She had to fight for her mother’s attention and was often sent to her grandmother’s house where she was unsupervised. She grew up being a people pleaser and lacking in self-worth. This is supported by the following extract:

“I think I was a very bitter young girl, because my parents had divorced when I was very young, and my mom and I were quite close and she got remarried to a guy that I completely hated... I wasn’t confident, I was very insecure... I was a people pleaser for such a long time and I was addicted to making sure people were happy over and above myself” (Participant B)

For Participant C and D, they described being shy, alone and depressed prior to taking drugs. Participant D, similar to Participant B, attributed certain life circumstances as causing him to view himself in a negative light prior to taking drugs. For participant C, being adopted and trying to fit into her new life contributed to her negative self-image. This can be seen in the following extracts:

“I was a very insecure person. I didn’t like to socialise with anyone and uh... I was very shy and withdrawn...and my [adopted] sister was always like the popular one who would always get all the friends and I’d get lonely” (Participant C)

“I’m the only child and much of my family live in Johannesburg so there’s only three of us here: it’s me, my mom and my dad. I start off as a very shy person until I do get to know someone and then I can feel free... when you the only child you so alone, you know...how can I put it...you so alone most of the time...um...my parents went through like hard times you know, and there was a time when they nearly got divorced and whatever...and unconsciously I took a lot from it. I thought it was fine - I didn’t notice it at the time. I started feeling a bit depressed and whatever...” (Participant D)

4.2 Factors contributing to drug use

Participants described different factors that contributed to their drug use. The following sub-themes reflected the main factors that influenced the participant’s uptake of drugs: “factors allowing easy access of drugs” “benefits of taking drugs”;, and negative factors which included “peer influence”, “individual factors”, and “negative life circumstances”.

4.2.1 Factors allowing easy access of drugs

For Participant D, who was an only male child, one factor that contributed to his drug use was having too much freedom from his parents, which allowed him to engage in drugs during his first year of varsity. This was also around the same time that his parents were going through marital problems. This is supported by research into risk factors of substance use that states that child-rearing is one parental influence leading to adolescent drug use (Brookes et al., 2006).

“Even when you get too much freedom, you don’t worry anymore, so you don’t worry even if you not going to come home tonight. You take it for granted.” (Participant D)

For Participant F and G, another factor was having more money, which made it easy to get drugs, as they were working and earning large salaries. However, for all participant’s, one factor was that the drugs were easily accessible e.g. through friends who were drug dealers and in the areas they lived in, which were identified as being highly saturated in their drug of choice e.g. Chatsworth, Phoenix, Clairwood .

Some participants even included the “benefits” of drug use as being another factor contributing to their drug use.

4.2.2 Benefits of taking drugs

Some phrases used to describe the benefits of taking drugs were “boosted my confidence”, “numb my problems”, “needed an escape”, and “got more friends”.

For participant C, she made lots of comparisons between her and her adopted sister e.g. her sister was popular and had lots of friends, whereas, she was shy and was an introvert.

Therefore, the drugs helped her become more confident and make more friends, as illustrated in the following extract:

“It boosted me. I got this confidence...I could talk, you know? In a way it made me talk a lot and it made me express myself ...you know?” (Participant C)

For participant D, he was an only male child and felt depressed because of his parent’s possible divorce, and so the drugs helped him escape the unhappiness he felt at home, as seen in the following extract:

“I mean I always was so used of being around people outside so I wanted to find my happiness elsewhere when it wasn’t at home. Like an escape... I sort of found hey there’s something that actually makes me feel happy, you know...” (Participant D)

4.2.3 Negative factors that contributed to drug use

The majority of participants also described some negative factors that contributed to their drug use. These sub-themes included “peer influence (or peer pressure)”, “individual factors” and “negative life circumstances”.

4.2.3.1 Negative Peer influence

For half of the participants, one main negative factor that contributed to their drug use was peer influence, either friends at school, at home or at the clubs or parties they attended. These friends introduced them to the drugs and also made it easy for them to access the drugs. This is reflected by the following responses by Participant A, C and D:

“I started the beginning of 2009 at school. My friend L from Montclair introduced me. It’s easy to get the drugs because he stayed near by Clairewood.”* (Participants A)

“It was peers at the time and I had my friend who became a drug dealer because he was influenced by his friends, and always had it on him...” (Participant C)

“Okay peer influence came maybe from my side sort of how can I put it, not trying to fit in but I mean everyone is doing it so you know... and you know the company you keep sometimes will lead you into these things.” (Participant D)

Similarly, Participant E and F described being pressured by their peers to take drugs, either to impress their peers and uphold their reputation, or to maintain their status or popularity.

These are the responses:

“It started with the peer pressure, trying to impress the group I was with. It ended up as an addiction. It was one of my friends at Inanda. He was older than me. I think he was older by 6 years.” (Participant E)

“Uh it was just that at that point I was just too popular. I couldn’t not do what all the ‘in-kids’ were doing. I had to do it if I wanted to keep my status...that was basically it. It was a big reputation that I had to pull off.” (Participant H)

4.2.3.2 Individual factors

The individual factors that contributed to drug use were related to curiosity, and as one participant described as possibly having a heredity component to addiction or having an addictive personality.

Participant’s A and D attributed curiosity as a factor that led them to take drugs:

“...and another thing it’s like you want to try and explore things, you know growing up”
(Participant D)

“I heard about it before...I want to try it, how is it like. I did not know the negative side effects of taking the drug.” (Participant A)

Whereas, for Participant F, he had a generational influence as the male figures in his life, both his father and grandfather were addicted to substances, as seen in the following extract:

“Well, my father was an alcoholic, he died from drinking too much. But my mother never drank in her life and she’s always been very against it, so my addictive personality comes from him. His father also, so it’s been generations.” (Participant F)

Participant G expressed that he had an addictive personality and that was what contributed to his drug addiction. This is shown in the following extract:

“Because of my addictive personality it went from always needing to be in a relationship, to supplements, to steroids into gyming, into drugging. I was the biggest Indian in Toti. It was from one addiction to the next and it was really bad.” (Participant G)

4.2.3.3 Negative life circumstances

Participants also attributed specific negative life circumstances as contributing to their drug use. These were related to conflict within the family and loss in terms of jobs, divorce and relationships.

Participant B went through many negative life circumstances from a very young age. As an adult, a few factors that contributed to her drug use was the marital difficulties she was experiencing, being retrenched and being unemployed for 2 years, and her finding it difficult to adjust to Durban, as all her family and friends were in Johannesburg. She described this in the following extract:

“Going through difficult periods in my life and that was a way of keeping me going and also I experienced- we experienced lots of marital issues... I blamed my husband for a lot of things that had gone wrong. I lost my car, my retrenchment...so many things you know?”

(Participant B)

Similarly, participant D was dealing with his parent’s possible divorce:

“My parents went through like hard times you know, and there was a time when they nearly got divorced and whatever and unconsciously I took a lot from it. I thought it was fine, I didn’t notice it at the time... so if there’s something negative, it leads onto other things you know, and it adds up. So I think mostly that’s what happened.” (Participant D)

For two participants, conflict with loved ones contributed to their drug use, as seen in the following extracts from participant F and J:

“Um fighting with my spouse...that used to be the main cause.” (Participant F)

“I used to fight with my mum. Actually I liked...uh...at that stage I liked expensive clothes, so when I talked about things that I want, my mum would say no why you want expensive things and talking all the nonsense and then I end up smoking.” (Participant J)

4.3. Outlook on life while using drugs

Participants reported having a negative outlook on life while on drugs.

4.3.1 Negative outlook on life

All participants had a negative outlook on life while on drugs. Their lives revolved around the drugs only. This ‘negative outlook on life’ was identified as a sub-theme and included phrases such as “life was not a nice place”, “Life was no fun- only fun when you smoking”, “I was so depressed”, as described in the following extracts from the participants:

“When I started it was easy, everything is coming easy but when I’m addicted eish it’s hard. I did not see life as a nice place. It made me depressed. I only had my mum to talk to.”
(Participant A)

“I didn’t have an outlook, I was so depressed, I was so down I just thought...I couldn’t see the next week ...I couldn’t see...it was really just about today and making myself feel better about today, you know. I just didn’t have a positive outlook at all, I was negative, I was...nothing anyone said to me was good enough, nothing anybody did was good enough you know...it was me, my perception of myself. It was skewed and that’s the problem.”
(Participant B)

“My outlook?...let us be honest, if you are taking drugs what you can think of as accepted is committing crimes that’s all. Committing crimes, trying to find something that going to give you money, no interest in something that’s going to make your life better, not interested in anything that’s gonna bring peace in your life, sleep-you have to stay by crime...uh...no trust, uh always facing bad consequences of your life... It’s as if there’s no fun. The only fun you’ll get is if you start smoking. That’s the only fun that you have in life when you are still addicted to it, so it’s like everything that is around you that doesn’t conclude drugs in it, is like it’s useless to you. The only thing that’s gonna be meaningful it’s the only thing that’s gonna include drugs in it.” (Participant E)

4.4. Prior attempts to stop using drugs

The majority of the participants made previous attempts to stop using drugs. These participants tried to change and made some progress towards change, but relapsed or slipped back into prior stages of change.

4.4.1 Unsuccessful attempts to stop drug use

Most participants reported that they struggled, or failed because they were doing it for the wrong reasons, and most led to relapse.

For Participant B and C, they described trying to stop on their own, but struggling and being unable to, shown in the following extracts:

“Yes I tried to do it on my own. I obviously failed at it but it was um...people had spoken to me, and people reached out a lot. Yeah and it got ugly. So yeah I knew I had a problem I just didn’t have the courage to stop. ARCA was my first rehab. Twice in 5yrs I tried to stop.

Um...I tried to do that on my own but I battled.” (Participant B)

“I tried quite a lot of times. I kept on telling myself I’m going to stop and I tried but...um, I was so used to going out I was never at home and I couldn’t be at home anymore without using because I became so dependent, you know? There were 3 weeks where I did stop, but I couldn’t do it by myself.” (Participant C)

For Participants A and E, they had attempted to stop by attending other rehabilitation programmes prior to ARCA, but were unsuccessful. After each relapse their addiction had worse consequences. This can be illustrated in the following extracts:

“It’s my second time at a rehab. I stay clean for 4months and then I relapsed and I continue to smoke because of friends. I relapsed and smoked hard. I’m doing big things...like crime – everything that is going to give me money. It was worse afterwards. My family noticed again but I don’t care now.” (Participant A)

“Wow plenty of times, plenty of times. The reason why I say there were plenty of them is because I’ve been in rehab 6 times, this is my 7th time I came here, but this now, it was my choice to come here. In 2012...I think it was February...my mom thought I was about-I was going to change when I got to rehab, only to find that I wasn’t interested in getting any help, but I was doing it to satisfy her to get more money from her.” (Participant E)

However, Participant D, F, G and J, had not previously attempted to stop using drugs and ARCA was the first rehab they had attended.

PRE-CONTEMPLATION

4.5. Awareness of consequences of drug use

Participant D, F, G and J had not previously attempted to change on their own or been to a rehab before attending ARCA. This is related to their level of awareness of the consequences of their behaviour on others or towards themselves, while using drugs.

4.5.1 Unaware of consequences of drug use

Participant D, F, G and J described being unaware of the consequences of their behaviour while taking the drugs, and reported being in denial or having a false sense of being in control, as reflected in the following responses:

“I think when you start off you don’t really think of the consequences. You think everything is fine, you know...it doesn’t seem to be affecting anyone. You think those who it does affect are weak, and then you think me? Come on, really? It really doesn’t have to get to that stage. You thinking that this is nice, this is a small sort of thing, you know? It’s not like it’s going to hurt anyone.” (Participant D)

Participant I expressed being selfish and only seeking to satisfy his bad habits, as illustrated in the following extracts:

“Yeah, but I wasn’t thinking about that...because uh...I was thinking about myself only. I wasn’t thinking about what other people say or what my family say. I didn’t think about it.”
(Participant I)

However, Participant G did not see the consequences because the drug was free for him for a period of time, as described in the extract below:

“And there was a period in my life for the next 3 years I should smoke with these guys every day, so it’s free, you didn’t have to pay for drugs. Because it was free, there were no consequences. You are getting hooked on it for free.” (Participant G)

CONTEMPLATION

4.6. Factors that motivated change

Participants were able to discuss factors that precipitated change prior to attending ARCA. Some were positive and some were negative.

4.6.1 Negative factors that motivated change

The following themes were identified as negative factors that motivated them to seek change: “impact on family” and “drug losing usual its effect”.

4.6.1.1 Impact on family

One factor that motivated all of the participants to change was the negative impact their drug use was having on their family. This is illustrated in the following extracts:

“Yeah well, after I did it I used to sit back and think, listen...look what you’ve done, look what you doing to your family, look how you tearing them apart, you know? Even my mother and them, you know? They all knew about it. But the more people know the better.”

(Participant F)

“The destruction got too much, I mean there was the pros and cons of using, I mean I had to choose whether I wanna use or whether I want that family that stuck with me for 3 years, those 3 years of me using, because I was a pest. I was one of the worst people that you could meet.” (Participant H)

Participant B experienced losing her mother’s support and letting her family and children down by her drug use. She is also a pastor’s wife and so had a certain reputation to uphold. She also described the stigma of addiction especially among her church community, in the following extract:

“Look I think the damage that was being caused to my family...I think the major wake up was when my mum-because my mum and I are very close, I think when she came and said she is moving back to Johannesburg, she can't handle it, she can't...it had caused a major, major drift between her and my husband...and I was caught in the middle because she blamed him for not looking after me and yet I was very manipulative in doing whatever I needed to do to get the drug. So it had caused so much problems and then, I think with her moving back was an eye opener, it happened that she moved back and I was still continuing with it and so on. It wasn't like it was just one day this is what I...because my mother had heard of ARCA a few months back and I thought I need rehab... you must remember there's now a stigma to this. My husband is a pastor so you must understand that where I'm at is I'm the pastor's wife so you can imagine, like you don't do this in the church setting. It's just not heard of you know? How would they look at my family? So all of that you know...” (Participant B)

For Participant E, he had been to six rehabs prior to ARCA, so his family had been though a lot with him and he completely lost their trust. Both Participant E and Participant I described the damage that their addiction caused their family and the family rejection that resulted:

“Yoh! You want to know what made me think of wanting to drop out the drug industry? Like, my relative, my family, my family at Christmas time they rejected me. They didn't want me near them, so that was painful to me...and since I knew that I disappointed mum plenty of times, it was hard for her to uh...to like to believe me when I'm telling her I think I need to change, you see? So the thing that she did is that, when I asked her to put me to rehab she was like fed up, so she didn't exactly –she didn't exactly know what to do. So she couldn't believe me. I had to beg her for couple of weeks in order for her to give me the last chance.”
(Participant E)

“Actually my life was like breaking into pieces that's why I wanted to change...because my parents didn't – they were like not interested in me anymore. They told me that if I stopped drugs they will take me back at home because they were kicking me out of the house because I was taking drugs.” (Participant J)

4.6.1.2 Drug losing usual effect

For a few, a motivating factor was related to the drug losing its usual effect it had on the participants, as indicated in the following responses:

“There comes a time where you’ve had so much of your drug that you- it doesn’t have an effect on you. Once you start using so much and it just leaves you feeling horrible. When it comes to the morning you just so tired, you so drained, have withdrawals and you know? You neglect yourself. You don’t look after yourself at all.” (Participant C)

“Instead of going forward, I’m just taking steps back. It actually slowed me down...my performance, I wasn’t focused.” (Participant D)

4.6.2 Positive factors that motivated change

The following sub-themes were identified as positive factors that precipitated change: “support from others” and ‘spiritual intervention’.

4.6.2.1 Support from others

One motivating factor amongst some of the participant’s, was the support they received from others.

For Participant B, it was the unexpected emotional support from her best friend and the financial support from other church leaders. Similarly, for participant C, it was the emotional and financial support she received from her adopted parents and the support and encouragement from ARCA. This is illustrated in the following extracts:

“So what really happened was my best friend ‘cause she was always supportive of me with things, but this- she came to me and she said she investigated, she checked the place out and whatever and then she was prepared to come and book in with me. She was going to pay that money to come and book in with me just for me to be here and I think that was really the turning point for me...because for her to come from Welkom and say I’m prepared to do this with you, just do it...and it really did something for me. Everybody else said all those things but the fact that she would go to those lengths really touched me. And I thought you know what, let me give it a chance. Honestly it was like everybody is saying this is what we need to do, but the church also saying we are going to pay for you helped. I had the support...the fact that they were prepared to pay for me to come and I thought you know what let me try, let me do it.” (Participant B)

“I took up the courage to tell my parents. I didn’t think they would support me at all. It turned out to be the complete opposite. Yeah I felt relieved you know? My parents, they helped me. So I also got help from ARCA and I’m very thankful.” (Participant J)

4.6.2.2 Spiritual intervention

Some participants, who came from religious backgrounds, identified God as intervening and being one of the factors that motivated them to change their behaviour, as supported by the following responses:

“It was like keeping the façade for people and I was just dying inside anyway and I really think it was the definite intervention of God, because I mean, sitting back now and looking back, I can’t believe the things I did and I’m still paying for that like you know...um...so I wish I had done it sooner but it really was an intervention” (Participant B)

“Well, um my sister wasn’t there at the time, she moved away to stay with her friend, so it was me all by myself and that time when I went home from using, I lay in bed and thought about it...and I don’t know, it sounds weird, but God just came into my life in a way and I was just thinking you know, I thought, I just thought that God had made me want to tell my parents. I told my parents 2 years ago (Participant C)

PREPARATION & ACTION

4.7. Journey at ARCA

Each participant had an opportunity to share their experiences at ARCA as an inpatient and currently as an outpatient. They described what motivated them to continue in their recovery and the obstacles or temptations they faced and how they overcame them.

4.7.1 Experiences as an inpatient

All participants, except Participant C who stayed at ARCA for a 7-day programme two years ago, were on the 21-day inpatient programme. The following sub-themes were identified as common experiences the participants reported experiencing as inpatients at ARCA:

“emotional” and “feeling supported”.

4.7.1.1 Emotional

Participants described their first few days as being emotional; some were “scared”, “nervous”, and “moody”, and others were “stressed” with thoughts of loved ones back home. This is supported by the following responses:

“My first few days I was scared and nervous and I’m stressed about the things I leave outside...about my daughters – I have two (2) daughters. One is three years old, the other is 2 years...but all I need is to be better, to recover.” (Participant A)

“The process was...I was very, very drained, I hadn’t slept and I really wanted to feel fine again, and we came to ARCA – I began to feel very emotional. It hit me that I was going through this process and I was very scared.” (Participant C)

“I mean I thought about my family a lot. You think about things a lot...you backtrack...a lot of flashbacks... mmm, but most of the time you sleeping though. You are very tired and drowsy and grumpy and moody. I promise you, you are everything!” (Participant F)

4.7.1.2 Feeling supported

Despite the emotional journey participants were going through, they reported feeling supported and encouraged by the staff and other recovering addicts at ARCA.

Participants D and F described the support and encouragement they received at ARCA and that they didn’t feel judged. These are reflected in the two extracts:

“I got there at the reception and you know you could see they get many cases of people who arrive in such a state. I got there and I was high and everything. You could see the way they sort of handled it they used of that kind of situation. I mean you can tell when people know how to deal with certain types of things. Yeah, so they contacted my parents and whatever and that is when you get booked in. It was a welcoming sort of place. It wasn’t like you get there and you were interrogated like the headmaster waiting for you, saying ‘what did you do?’ You know? ‘This is wrong’ - that sort of thing. They were like ‘No, you gonna go through this, you gonna get better, it’s a big step you took to come here’ ...and it’s not supposed to be ‘well done you came because you using’ or whatever, but they make you feel actually happy about your decision. You know...and then you sort of look forward to change. It was like encouragement. It wasn’t like ‘you in rehab we gonna put you in a cell, you very naughty and we gonna punish you’ It was more like ‘come, relax, we gonna work through

this and this is probably like a new stage in your life so from the beginning, start again and lets work a way forward.” (Participant D)

“Um, the people here won’t judge you. They understand, they accept...and also the patients here are also very friendly. I don’t know if they always like that, but when I was here they were (chuckled). Well we all open books here, once I walk in those gates I feel free to say what I want to, I don’t hold anything back here.” (Participant F)

For Participant C, who described herself as a shy, withdrawn person, also highlighted the support she experienced from the staff at ARCA and the other recovering addicts. This is reflected in the following extract:

“It was very emotional for me...the tears...and then when I got into the door, I walked in and saw everybody, I felt – one person took me out for a cigarette and spoke to me. I just felt like I was going to get help. So we had a meeting with... I think it was the doctor or the doctor’s wife and then she explained the process and then my parents decided to go ahead with it. And then I went for my first detox. I was very scared and I remember Sister V took me by the hand and said everything is gonna be okay.” (Participant C)*

4.7.1.3 Positive detox experience

The participants mentioned that they all underwent 3 days of detox as soon as they arrived at ARCA, and it was a good experience because ‘the drugs were flushed out of their system’ while they were asleep.

For Participant A, it wasn’t his first detox but it was his first time experiencing it while being asleep. He describes his experience below:

“Not my first time but it was different at ARCA. I spent 3 days in detox. They put me on drips...uh...one needle...and then I’m feeling so dizzy I don’t know what they do before that...after that. I fall asleep and can’t remember when I woke up but I finished all the 3 drips and go out to sleep in the house” (Participant A)

Participants B, C and F underwent detox for their first time at ARCA and even though they were anxious and nervous, they described positive experiences in the extracts below:

“So obviously the first day I got here, it was my first time, I started on the detox but I was zoned out ‘cause I had taken so much drugs before that ‘cause I thought yeah look it’s my last let me just take whatever I can (giggles), so I was knocked out, I was out cold, cold. Um so the first night was nice (laughs) ‘cause I was sleeping through everything. I think the 2nd day argh it hit me, it hit me...I could feel it within my body like all the stuff - the drugs...it was like I could feel it being extracted from my body. There were 3 days of detox...and then the third day I was doing so much better. In fact, the 2nd day when I came out I could feel the difference. A major difference I have not felt in years (participant stressed this point). I could feel...I mean just being sober, not drugged up, being aware of my surroundings, being able to communicate. It was something else you don’t understand (giggles), ‘cause that’s how I was, that’s the person I’ve always been, and the drugs changed me, you know? For the first time I thought this is such a good feeling! I don’t know when last I felt like this it was such a good feeling. Feeling alive, present, there in the moment, you know...um, being able to speak to people without having to think now ‘wait let me just take something’ - what I did all the time. It was just amazing, it was amazing and the 3rd day, it was fine I knew what to expect and the next day I was absolutely fine ‘cause I could really feel like this is now the last being drawn out of me. After the 3rd day I was the only girl here but it was amazing, even the people here, we had a crazy bunch but they were so, they were just like my brothers so overprotective over me it was really nice.” (Participant B)

“The detox, the first day, I fell asleep. I remember them counting to 10 and all of a sudden I was asleep. Then um I just slept. And then the 2nd day of my detox I began to feel very emotional. I was on the detox I was feeling quite drowsy but I still can remember I had enjoyed it and I got – I began to know that I really had a problem, and it just made sense to me and I just knew I was ready. I personally think it helps when you ready to be in recovery. If you forced to be here, it can’t work, but I chose to be here. I did it for myself. My sister was still using but I managed to stay strong because I wanted her to also be in recovery and she also came here as well. (Participant C)

“First time detox...I’d say I was a bit anxious ‘cause I didn’t know what it was about. I just saw them put that drip in my arm and they said you going to sleep now. They put whatever they put in there and you have nice dreams. I won’t lie you have very nice dreams, and then you wake up and it’s finished. And that’s it. It’s very calming once you in the detox centre, but once you come out, that’s when the stuff starts, the cramps and everything, but obviously they do give you medication for it.”

(Participant F)

4.7.1.4 Positive counselling experience

After the 3 days of detox, participants mentioned attending first individual, then group counselling sessions. They described positive experiences, using words/phrases such as “helpful”, “informative”, “opened my mind”, “felt relieved”, “taught how to deal with problems”.

Participant C had a difficult childhood before being adopted and did not get an opportunity to deal with her past. For her, the counselling sessions were beneficial for the following reasons:

“After the detox we had a counselling session with one of the social workers and then before I left we had a meeting with my parents just to make a plan as to what to do when you out of ARCA, not work for 3 months and then get on your feet. it did help me um...I did speak a lot about my past and a lot of my childhood – just everything that happened, and it gave me a feeling like everything is going to be fine. Just speaking about it because I never used to speak about it to anyone and yeah. It taught me how to deal with my problems.”

(Participant C)

Participant D was an only male child and did not have anyone to talk to about how he felt lonely at home and how he was dealing with his parent’s marital problems, so ARCA offered an outlet, as he described in the following extract:

“I don’t know I felt sort of relieved, because...like I always felt like I needed someone to talk to, sort of a thing you know...like besides my mom or my dad, but someone which you can sort of trust in a way and tell all about whatever...and you know, I don’t know why but when you with someone whose counselling you or whatever you feel as though I can just talk about anything anyway, but I mean you do have close friends and stuff and you think why can’t I tell this to my close friend, you know? I probably trust her more than a stranger. But it’s a different thing, maybe because they counsellors, they studied about this thing, they know what they doing.” (Participant D)

For Participant E, he felt relief after his individual sessions and described his experiences attending the group sessions and the benefits of sharing his story with others. This can be seen in his response below:

“It felt like...you see, it felt like I was being relieved...from things that were bugging me you see. And like you start to gain your self-confidence, you like talking about your life and the things you’ve been through because of drugs, and start hearing other people telling you about what they’ve been through, you see. It’s like the way your’ll communicate it’s like you giving one another some confidence and motivation, yeah and support like: ‘you know what bro, I’ve been through a lot, more than you, so what you are telling me’ – like some of them when they hear my story and like ‘bro I’ve never been through what you’ve been through, I think my stories are much better than yours.’ You’ve been through so much there’s no need for you to go back you see.” (Participant E)

For participant F, the individual and group counselling sessions were informative, educational and non-judgemental, as described in the following extract:

“My first counselling session was with S. It went very well. Uh...she was very straight and to the point with me which was what I needed, and she was also my designated Social Worker which I didn’t know, but it was very good at the end of the day. I feel like she’s like- my mother is also like that, very to the point so she did get a lot out of me. Um, but I was very relaxed in the session. You know, you felt open. You not scared to say anything. The social worker’s here, even R* and K* as well are very nice people you know, you not scared to say anything they don’t judge you for anything. All the Social Worker’s here are very good. They are very informative, A* as well. He taught me about your brain, different parts of your brain and where the opiates affect you. I did learn about that as well and uh how your body works, also they showed us videos of after effects and how some people actually die from it and I’m just thankful I didn’t get to that stage. There’s some people that they 28 already and they dying and that’s just from drinking. Drugging does even worse things to you. It affects your brain. We saw a before and after photo and it didn’t look very nice. I used to have very heavy bags underneath my eyes, now I can see my face. I’m starting to put –get weight on my stomach too, which I never had before. I was always very, very skinny yeah. Since I came here I gained-I was 75 when I came here, when I left I 82kg’s, which was nice for me I did want to gain something, so it shows that drugs definitely eats up all your fat and whatever you have, everything inside your body.” (Participant F)*

Participant H, who had been to other rehabs and had experiences attending psychiatric wards, commented on the competency of the counsellors in dealing with their problems and that they were relatable, as seen below:

“Uh counselling was cool I mean uh...the counsellors you can relate to...I mean the three that are here and I won't mention names, but they good, they good. They know their stuff to speak quite honestly.” (Participant H)*

4.7.2 Experiences as an outpatient

The participants shared their experiences about leaving ARCA and returning home. The sub-themes were identified as “challenges after ARCA” and “overcoming challenges” as an outpatient.

4.7.2.1 Challenges after ARCA

Some of the challenges the participants described were the family adjustments to them being clean, financial challenges, exposure to their triggers (tempting situations), and going back to the same environment.

For participant A, the challenges he faced was regaining his family's trust, as seen in the following extract:

“After rehab they [his family] are still angry about me...for taking their clothes. The only person that's worried about me is my mom. Even today my brother and sisters are still angry. I didn't feel happy- I am trying to make things better.” (Participant A)

For participant B, one of her priorities after leaving ARCA was working on her marriage and proving to her family that she has changed and that she was fully invested in her recovery. She also described financial challenges and allowing her family to adjust to her being clean, which she was taking one day at a time. Her description is found below:

“The thing that I still need to do and see to is that my husband and I need to still go for counselling as a married couple 'cause obviously a lot of trust that's been broken and so on so we still have to fix that, you know. There are challenges, the financial challenges...um I'm not on medical aid so I gotta pay for my naltrexone and you know...its R800 pm. right now we gotta pay for it and see it myself I mean the church covered the cost for here and I gotta

sort of cover the cost for the medication on my own. But I mean it's a R800 worth spending for the fact that I can be sober and not feel for any medication. It was hard, it was hard because you must understand it's a new normal for my family, they had to adjust. Gosh it was difficult, I came with all the zeal, I was all fired up and I was like no this is what's gonna be done in my house and before I was a dead mother for a long time and now all of a sudden you all like here wanting to control things, and I understood that my family will take time to see that this is – coz obviously I tried and they saw and all of a sudden id slip back. They needed to see the consistency with me, you know type of thing, and I know like uh they need to see that I am really changed, I am a different person. So the first week was tough but then after that it's been going so well.” (Participant B)

Participant C only spent 7-days at ARCA because 2 years ago they did not have the 21-day inpatient programme in place. She described being prepared by the counsellors for the challenges she will face when she left ARCA. She also had to deal with temptation, her triggers and a change of lifestyle, which she described in the following extract:

“In the 2 years of my recovery, I was told I was going to have days when I feel down, and I had a lot of those days and um, there was a big time where I just isolate myself and is be in my room and id just be withdrawn and, um times when I was working and I had a disciplinary hearing –that really made me want to, never had something like that happen, so that really made me feel like using, and working with so much money, it can be a trigger. I didn't like to face them, I mean on the way back from ARCA there is a place where we used to go get the stuff from sometimes that to me was a trigger at the time and going to the pub as well. I really wanted to go back to the pub because I wanted to see my friends and thought they'd miss me but after I went there I realised it wasn't a good space for me. I thought let me give this a try, my outlook did change and my life became more meaningful when It never had much meaning before, so we became more family orientated and I found that I enjoy it, I actually enjoy not going out to clubs and to pubs and to places that I feel uncomfortable, because when I tried to, I have tried to go to pubs and while I'm not using and it did make me very uncomfortable. I think that's one of the main reasons why I haven't been back there. I don't like to.”

(Participant C)

For both participant H and participant I, their challenges were related to going back to their environment and dealing with their peers again. For participant I, it was also the new responsibility of being a father soon. This is illustrated in the two extracts:

“Yeah there is quite a bit. There’s going back to the same place and dealing with your peers and there’s pressure and stuff like that. There’s nothing that I didn’t learn here that’s not helping me out there ‘cause, yassis, I came in here with no skills on how to manage life. My only main skill in life was to use.” (Participant H)

“Yeah so many challenges...like my drug buddies coming to my house to go smoke. Yeah I don’t think about smoking now because I’m tired of being suffering. The problem is, I don’t want to because I’m going to have a baby in the end of June. So I don’t want to talk about drugs anymore and tell my child to not take drugs while I’m taking drugs. Yeah I want something I experience then get over it.” (Participant I)

4.7.2.2 Overcoming the challenges

The participants shared ways in which they overcame some of the challenges they faced after leaving ARCA. These included identifying and avoiding their triggers e.g. their old peers, changing their environment or lifestyle, using the equipment/tools that they learn at ARCA, setting goals for their life, attending the aftercare group sessions, taking their medication (naltrexone), getting the support from family and talking about their problems.

Participant H had been to other rehabs prior to ARCA and described receiving the tools at ARCA to deal with situations better. What also helped him overcome his challenges is his mind-set, because for the first time he reported taking charge and ownership of his recovery and that helped because it was his choice this time around. This is shown in the following extract:

“Yeah they gave me equipment, I know now when there are situations that I have to confront, I have steps that I follow which aren’t hard at all. A 3 year old can follow them, it’s just simple teachings, it’s like how a baby learns to walk in the beginning- that basically what ARCA does and the system did for me personally. They gave me my few steps again so I’m learning how to live life. I know I haven’t been out of treatment for that long, I haven’t been out very long but through all my relapses and through the treatments that I’ve been through,

this one is the one where I'm most willing, I mean, the others I just got out – used again, got out – used again, this one's the only one that I'm actually willing to do, take steps into the recovery process, to my sobriety, I'm actually willing to do it this time.” (Participant H)

Similarly, participant A also described receiving tools at ARCA to manage life better, as described below:

“They give me lots of things here in ARCA. ARCA has helped me to manage my life, to stay strong and control my anger. There are a lot of changes. I am changing too much. I see myself to achieve my goals.” (Participant A)

Participant C describes receiving support from her family and the other recovering addicts during the group support meetings as helping her overcome her challenges, seen in the following extract:

“The positive is I've got my sister, I've got my mom, I've got my dad and I also have ARCA. Coming to the meetings we all socialise outside. There's people that are going through similar things to what you did, and you feel so comfortable sharing in the meetings. And it's helped me a lot for my confidence because I can maybe talk in big groups, like for work experience maybe one day if I have to. I didn't think that ARCA was gonna work in the beginning, had doubts, but it actually turned out to be the opposite. I tried to be there like for my sister and that's how she came here, its 'cause I spoke to her and just let her know that she is gonna get help.” (Participant C)

Participant E is the only one who had been to six rehabs before attending ARCA and so had a lot to share when it came to overcoming his challenges. He reported avoiding triggers, changing his company, taking his medication and attending the aftercare programme, as helping him to overcome the challenges he faced. This is supported by the following extract:

“The only way to overcome them is to avoid them. There's no other way to overcome them. Just avoid everything you were doing before, you see...like, you can't change the environment but, if you are going to stay in that environment, change the routes you use. Even if I'm passing by the people who are smoking, I just turn my head around, and even if I'm driving my mum's car, even when I drive it on that road, I prefer to look the other way in order for me not to see the dealers house. Some of the dealer's houses are near my house. I have to pass there in order for me to go to the shops, like when I'm passing there I just prefer to call my girlfriend and say 'you know what come I just need to go to the shop'. When I'm

passing there I just look at my girlfriend, it helps me...if I'm going alone I don't wanna even look at the dealers house 'cause he gonna greet me, the negative thoughts come and then, although your craving are not physical, it's gonna be emotionally you see. And whenever my parents are going to work, I just decided to stay in my house. Call my girls to come visit me, most of the time I spend my time with my girlfriend. I got different girlfriends, I just call them and see which one is not at work and tell them you know what I just need someone to come and have some company with me. Most of them they don't smoke, they don't drink so, like when I'm sitting with them I don't even get a time to smoke cigarettes. Like today I only smoked one cigarette, and yesterday I only smoked one cigarette, now I'm decreasing the way I'm smoking cigarettes, I'm planning to quit everything now. Attending ARCA's aftercare service programmes, it helps a lot. Taking your medication it helps 'cause those are two things that are key for your life: the key of your recovery is your medication and attending aftercare sessions.” (Participant E)

For Participant F, his family, avoiding triggers, talking about his problems and taking naltrexone helped him overcome his challenges, as described below:

“Well definitely my family, I see them everyday. I look at my babies eyes everyday, my wife's eyes, and-but...in the same note you know, I had to make a lot of changes. Um, I had to cut all my triggers out, that's also another thing you learnt here, cut everything out and basically start afresh and learn. I know what I want in life and that is my family, so I had to prioritise everything, and that was how and that was the only way I did and obviously the medication they give us, naltrexone, I haven't had one craving since I've been out of here. And that's very good for me 'cause I was very heavy, I used to get cravings 3-6times a week. You know, and then as soon as I get my craving I go, now I don't even get a craving, I don't know maybe if I do get a craving, I will definitely say something about it, I've learn to talk about my problems, not just keep them up inside.” (Participant F)

Participant G reported that resigning from his job and ridding himself from stress helped, but also the support he received from his parents assisted him in overcoming the challenges he faced. This is described in the extract below:

“When I left here it was a decision with my parents, I decided to resign from my job. Um I thought it was still early days, it was my first time in rehab I don't wanna be in rehab again. I felt I rather take this time now, and get myself sorted out instead of getting myself in a stressful situation and obviously getting myself back into drugs again. We do it properly the

first time. It's nice. I'm spending more time with my parents, I don't go out much, so it's a different lifestyle but its better you know. Yeah there's a lot of financial stuff that I put myself into but if I go to work today, it can be sorted out so it can wait. My parents are here to support me so I'm lucky. Maybe not everyone has opportunities I have, you know I'm very grateful for having parents that can support me...but with that support I'm using it to the best of my ability to stay clean in my recovery.” (Participant G)*

MAINTENANCE

4.8. Current functioning as outpatients

Each participant had the opportunity to discuss their current functioning, now that they are outpatients. They described positive changes to self and to their outlook on life.

4.8.1 Change in outlook of life

All participants recognised a change in their outlook of life since attending ARCA. Their responses reflected a positive change.

4.8.1.1 Positive Outlook on life

This sub-theme included words/phrases that reflect these positive changes to life as: “life is more meaningful”, “family oriented”, “priorities are different”, “achieve my goals”, “think about consequences”, “take ownership”, “Hope”.

Participant A used to view life negatively, but now he has hope and determination:

“Yeah, there's a lot of changes...I am changing too much. I see myself to achieve my goals.”

(Participant A)

Similarly, participant E described being hopeful but also mentions the importance of setting boundaries in life, as seen in the following extract:

“Once you here, hope starts to rebuild in your mind and in your heart. Like you start being a different person when you in here, and when you think back about the journey you've been through, before creating the change in yourself, it's like you tell yourself this journey I'm gonna take now, the path I'ma take I have to make sure there's gonna be boundaries in it.

You see...those boundaries they are for your own good because you know if I had a

particular boundary in my path, I won't meet up with the drug addicts, I won't meet up with the drug users and the dealers. Those boundaries, they put for yourself they gonna help you, make sure the path that you are taking is gonna be straight. There won't be any relapse or any slips in it, you gonna make sure that everything – you can conquer anything that's gonna come in your way, like your drug use.” (Participant E)

Both participant E and F describe below that life is more meaningful because it is more family-oriented:

“My outlook did change and my life became more meaningful when it never had much meaning before, so we became more family orientated and I found that I enjoy it”

(Participant C)

“Yeah well, my priorities are different. Family is first even before work. Before it was work and drugging, so now I'd say I look at life from a different angle, you know. Yeah family, work, and then obviously the curriculum activities to keep me busy.” (Participant F)

Participant G has a completely different outlook on life compared to when he was taking drugs as he finds it more meaningful now and has a sense of regret in trying to commit suicide prior to attending ARCA. This is described in the following extract:

“Drastically...um...firstly in terms of the drug addiction I've learnt so much. Uh I know what I need to do to stay clean and to stay sober. Uh I've been given the tools here on how to face challenges and how to cope with it. And uh yes sometimes you get depressed and you worried about you know you not married and stuff like that, but also this place teaches you life skills, about how it's important to worry about yourself and be happy for yourself first. Life is hard where you can't always have what you want but you gotta be grateful for the things you do have. So yeah my outlook on life has changed because even now I can't even believe I attempted suicide. It's so stupid because what was I doing it for. How much of people I would of hurt that did love me, than getting love from people I didn't know.” (Participant G)

4.8.2 Type of person after rehab

Another factor related to a change in outlook on life, is the change in outlook they have towards themselves. This is seen in the type of people they are now that they are regarded as

“recovering addicts”. The participants used positive qualities to describe the person they are now.

4.8.2.1 Positive qualities

Many of the participants recognise that they will always be recovering addicts. However, they acknowledge that they are different from the people they were when they were taking drugs. ARCA is recognised as the main facilitator of this change. The participants described having positive qualities such as “a lot happier now”, “calm”, “increased confidence”, “improved self-esteem”, “proud of myself”, to name a few.

Participant A reported being clean for 4 months at his previous rehab but relapsed, but he was six months clean after attending ARCA and is still going strong. He described being proud of himself for doing so well and reported being a happy person now, with the help from ARCA and his parents. This is reflected in the following extract:

“I am trying to get back to being more normal. I am more happy and feeling better. I am getting help to those stressors that I have. Yeah I am stress free now. I am proud of myself. I want to say thanks to ARCA because now I am feeling better. Yeah...I am trying to manage myself, to control me...my life...and thanks to my parents who support me.” (Participant A)

Participant B was a people pleaser and an insecure person who lacked confidence and self-worth prior to and while taking drugs, but after attending ARCA, she describes being a new person. She described her positive sense of self in the following extract:

“No comparison, honestly no comparison...um... I’ve got my confidence back...uh I’ve got my mind back, I’m able to think straight, work efficiently, I’m productive, I’m a stronger willed person, I speak up for myself now, I am in control...um there’s no comparison. I’m the person I’m supposed to be, meant to be...but I’m still working on it. The challenges haven’t changed its still the same stuff when I came here, the stuff that we dealt with as a family is still there but I deal with all that stuff differently and that makes all the difference for me.” (Participant B)

Similarly, Participant H also described ‘feeling on top of the world’ in comparison to ‘the pest’ he mentioned he was while he was on drugs. This is shown in the following response:

“I’m actually loving it- I mean I’m enjoying life. I’m doing things that I would never have done before. It’s actually good that I don’t have to pay anymore to live, and I came to terms

to realise that hey you don't need to wake up and spend money to live, it's something that comes free everyday, so wake up in the morning and I'm feeling like I'm on top of the world. I'm actually bubblier than ever. Yeah I'm all excited. Yasis the drug gave me too much mood swings and too many downfalls but the truth is without it it's actually better though. I actually enjoy life without the drug.” (Participant H)

Participant F has become more cautious and thinks before he acts. He has changed his priorities and reported trying to be positive, as seen in the following extract:

“Well I'm relaxed. Um...I'm very cautious who I mix with. I think a lot more before I do and before I say, and I'm a lot more family orientated uh...I felt my memory has gotten a lot better now. My brain is recovering, you know, you can feel it. I try and be positive all the time, you know always look at the good things, the good side of things.” (Participant F)

For participant E, who has a long history of previous rehabs, crime and being in jail, has seen the most change. He described respecting his parents more and most importantly regaining the trust of his neighbours and his community is a big goal of his. He acknowledged how his behaviour has affected not only himself, but the wider community and can be shown in the following extract:

“I won't say I'm the person I was before, back to what I was, but slowly but surely I'm trying to get to the stage whereby I used to be the type of person where I was kind, respectful, and my mum can give me a lot of things to do at my house and she knows me that once I'm on drugs, you tell me something I snap out fast and I won't do that. But now she's like 'wash the windows, clean the yard' ...and I'm like 'okay mum I'll do everything you want me to do. Each and everything that I've been told by my parents to do, I do it...and for the neighbours and the community, I'm starting to respect them. I wanna gain everyone's trust by now. I don't wanna go out and walk in the streets and everyone is holding their bags, thinking 'hey there's this criminal'. I want you when you see me to tell yourself I'm secured around this person. There's nothing bad that's gonna happen to me.” (Participant E)

4.9. Evaluation of services provided at ARCA

The participants were given an opportunity to evaluate the services that ARCA provides.

4.9.1 Multidisciplinary team

All participants mentioned the multidisciplinary team that ARCA provides, which includes nurses, psychiatrists, psychologists, social workers, to name a few. Each participant reports being fully informed and having an individual treatment plan for his/her specific case. All participants provided positive feedback on the services rendered at ARCA and discuss the sub-theme of “good service” they received.

4.9.1.1 Good service

Some words used to describe the good service ARCA provided were “helpful”, “competent”, “friendly”, “encouraging”, “accommodating”, and “understanding”. Some of these are reflected in the following extracts from the participants:

For participant A, this was his second rehab and had a previous rehab to compare ARCA’s service to, as seen in the following extract:

“It’s a good service. It’s a good rehab. The only difference is the detox. The other rehab centre there is no detox but here there is a detox. The same day you on detox you do not feel any pain. The staff are good. They are friendly. They have care. They speak nicely and they take care of us.” (Participant A)

For participant C, who was clean for the longest period of time (2 years), was able to recall her experiences being at ARCA clearly and described their helpful service in the extract below:

“The service, the nurses are very helpful. Um, it was 2 years ago so...I found them very helpful. I felt safe um...I didn’t mind the food, the food was good and I found I was basically a holiday place but it was a rehab at the same time. So I got a bond with the other people that were there as well. There was like five (5) of us and there were some girls, I was happy because I could get along with the girls as well. So um, I thought the service was great, the doctor was helpful, and since then, I remember when I just came out I used to have nightmares and I went to speak to them and they prescribed some medication and it really did help. After that, the counsellors as well, if you needed counselling for any problems, they would help you and they’d always be there.” (Participant C)

Participant D commented on the medical treatment ARCA provided and the competencies of the staff in dealing with each case:

“Um...from the medical side you can't complain about anything, you got everything you needed, you know. The nurses over there, they were more friends. Everyone there knows how to deal with the patients there. I mean the staff there, you can see that they are trained and they know how to deal with the patients and they make sure that everyone gets their medication and whatever on time. Whoever is having a problem or a fit, they know how to deal with the situation.” (Participant D)

Participant E, who had attended six rehabs prior to ARCA, was able to describe the good service ARCA provided in detail, as reflected in the following extract:

“I won't lie to you, you see when I came here the treatment was good. For first three (3) days I had to go to detox, which they had to get rid of my drug in my system. After 3 days, and then I moved out of detox, then started attending programmes which teaches about the self-control, and the emotions control, to control your emotions, how to fight-face your triggers, how to face the environment that you are living in which is the biggest trigger for all of us as we are drug addicts, and how to gain your self-esteem. We had the group sessions and then one-on-one sessions, relaxation sessions-there are plenty of sessions and psychologists. They have it every day from Monday to Friday we having like a full programme, then Saturday it would be a family programme, where our parents come.”(Participant E)

Participant I was the only one who had a food critique, but still mentioned that overall, ARCA provided a good service, as seen below:

“We can understand each other. The food they giving us is not good but everything else was good. They provide food and if you want chips/chocolate. Don't allow you to have money, just leave at reception.”

However, Participant F was able to explain the reason behind the type of food that was provided at ARCA in the following extract:

“Um, the food I enjoyed some of the time. But I mean I've learnt after I got out that the diet that they give you is according to the medication that you get, so they give you a lot of fibre to make your body work and stuff. Because what they give you here [medication] it actually gives you cramps and I only found out once I went out 'cause I stopped eating fibre for 2 days and I actually had to go into hospital to have a drip on because the cramps were so bad and I couldn't go to the toilet at all. Yeah so whatever they did here they did do for a reason.”(Participant F)

Therefore, even though their diet was not as tasty or what Participant I was used to, Participant F was able to identify the benefits of that diet as complimenting the medication that they are prescribed as inpatients.

4.9.2 Most helpful service during the recovery process

According to the participants, the services which they found most helpful was the counselling, i.e. the individual and group sessions (as inpatient/outpatient), and the medical service they received i.e. the detox and naltrexone.

4.9.2.1 Counselling and medical services as most helpful

Many participants report that the counselling they received, and are still receiving, via their aftercare support sessions, have been very helpful. Others felt that the counselling, together with the medical services i.e. the detox and the medication, have assisted them the most during their journey of recovery at ARCA. This is supported by the following responses:

For Participant C, like the majority of the other participants, both counselling and the detox were identified as most helpful for the following reasons:

“I think the counselling was the most helpful because I’ve never had counselling and never used to talk about, problems with my childhood and I’ve learnt to deal with it, and the counselling for me was very helpful and also the detox because it takes everything out of your system. After a month, I started looking after myself and it made me feel better.”

(Participant C)

Participant E and G really benefitted from the aftercare programme and group counselling sessions, as well as the anti-craving medication, naltrexone. They indicate this in the following extracts:

“The sessions – all of them, from Mon-Saturday as an inpatient” (Participant E)

“The aftercare sessions: the Tuesdays, Thursdays, and Saturday sessions... I think...yes and the naltrexone the anti-craving drug” (Participant G)

4.10. Recommendations to other recovering addicts

The participant's recommendations to other recovering addicts included the use of naltrexone and attending the ARCA rehab centre.

4.10.1 Naltrexone is recommended

Participants support the use of naltrexone. They find it helpful and recommend that it be accompanied by counselling/aftercare support programme as well.

4.10.1.1 Naltrexone as helpful

They report that it is “helpful as an anti-craving medication”, “helps on your brain”, “helps with the negative thoughts”, and “helps to think of consequences”. This is reflected in the following extracts:

Participant F found naltrexone to be helpful as it had no side effects and helped his cravings to subside, as described in the extract below:

“I haven't had any side effects of it. The only thing that it's done very well is subside my craving, 'cause I haven't had a craving once. So I think it's very good 'cause that's what it's meant to do is to take your cravings away. I haven't had any hey. It really, really works for me. I have to be on it for a year, and then after that you can come off it but just buy some in case one day you might get that craving. So I will follow those rules yeah...anyone I know whose recovering the first question I'll ask them is 'are you taking naltrexone?'. Well 'cause it subsides your craving obviously...I mean 'cause that's the first problem to any druggie or alcoholics uh, that's the start to any of their problems is the craving, the first thing that you get.” (Participant F)

Participant H was able to test the anti-craving medication, naltrexone, and found that naltrexone does work. He was the participant who ran away after his 3 day detox and found that smoking was pointless while on naltrexone. He also reported that it stopped his cravings and helped prevent negative thoughts of using or getting the drug. He discussed his experience in the extract below:

“Like I said, naltrexone for me, I know it works because I tested the theory. I'ma test that theory and I did. The naltrexone actually works, I mean it blocks your receptors to the

ultimate because you know heroin is quite a strong drug and for it to block it, the naltrexone's good. And in terms of the anti-craving I mean, it works 'cause the thing is I would say I live in a drug den, we surrounded, the area I'm in, we surrounded by dealers and drugs on sale. I live in Phoenix, yeah unit 7, so it's a hub of drugs, but the thing is, um...in the morning if I get up, 'cause my routine, I'm still trying to get a normal routine because before as soon as you open your eyes you'd go and score. But the thing is with the naltrexone, I get up in the morning, the first thing I do is I pop a pill and within a few minutes you feel the ease, it takes about half an hour or so but you actually do feel that craving go away. Your mind is actually at ease, you no more plotting, scheming and deciding I'ma do this, I'ma do this. You just at ease, you come to terms with realisation.” (Participant H)

Participant C, who started taking naltrexone two years ago, also had positive experiences with naltrexone and described her experience in the following extract:

“Very positive experiences, that it really helped me. They give it to you while you in ARCA still and from there when I went home id take it every morning and it took off the...um...craving. So...and the naltrexone helped me, it really helped me a lot. I know there's a lot that they...suboxan or something like that, I heard it's not good for you. I think naltrexone is the best option to go with. And they can try it out. I prefer taking the tablet because it makes you get into a routine of taking your tablets and you feel like there's a safeguard.” (Participant C)

Participant E also had a positive experience using naltrexone, and was able to describe to the researcher how naltrexone works in full detail, as shown in the following extract:

“Naltrexone...it only helps- like you don't even get the negative thoughts, you don't get negative thoughts about having your craving. Yeah it helps with your craving, it doesn't even cross your mind that I used to even smoke this drug of choice so, I think I wanna try some because I'm no longer craving it. You can try them but what happens is that you won't enjoy them. First 'cause naltrexone doesn't help with the physical craving, it only helps for emotional craving. I wouldn't refer it for a drug addict that's still physically craving because if you are still physically craving, you gonna be having somebody effects, it will come like sort of pains, cramps, naltrexone doesn't help there...only helps on your brain and then like how you gonna think, how you gonna act. Before acting naltrexone makes sure that you think properly first, 'cause it comes with a lot of thoughts whenever you think about drugs...wow, you see when you think about drugs, a lot of thoughts just come in your mind...I've been

sober for this particular time, if I'm gonna smoke I'm like crashing everything, I have to start again from the bottom. Naltrexone helps sometimes to think of the consequences, although you use to enjoy the drug but wants you try naltrexone it turns it around and make you suffer in such a way that whenever you think of them you gonna feel as if you gonna hate your drug of choice. Yeah so that's where it's helping.” (Participant E)

Only one participant experienced some negative side effects from naltrexone but still recognised that it was a ‘healthy pill’.

“Ya naltrexone is uh...is a healthy pill, but I have a problem that every time I take it I have diarrhea.”(Participant I)

However, for two participants, the side-effects were as a result of them using other substances while on naltrexone e.g. alcohol and cannabis, as described by Participant C and E in the following extracts:

“Okay there was no negative side effects or anything but I went on holiday and my dad had a beer and I asked for a sip and that's what made me feel sick, drinking on the naltrexone. It could be different for everyone but a lot of people have said that it makes you feel sick when you drink, so I just stayed away and I didn't want to drink anymore. So... the naltrexone helped me, it really helped me a lot, but there's more positives than negatives.”

(Participant C)

“In order for you to enjoy them there's gonna be side effects that you gonna face. In order for you to go back to your drug of choice, you gonna have to stop taking naltrexone. Because I'm gonna be honest with you, I've tried dagga when I came out, but instead of enjoying it, it gave me a headache, a terrible headache I couldn't sleep the whole night. I only slept at around 4o'clock in the morning. When I wake up my mum gave me the naltrexone I told myself that hey naltrexone ay it don't wanna be mixed with any drug. You'll try even this pure Zol, it's gonna have its side effects on you, its best that you don't mix it with anything. When you are taking naltrexone tell yourself, 'cause you don't even crave for cigarettes, you only smoke cigarette's it's just something.” (Participant E)

Therefore suggesting that for some people side effects may occur, but for the majority of the participants in this study, no side effects occurred, only when used in conjunction with other substances.

4.10.1.2 Naltrexone best accompanied with counselling

For the majority of the participants, they recommended naltrexone be accompanied with counselling/support programme.

Participant G who had attempted suicide prior to ARCA and participant H who had been in a psychiatric ward before attending ARCA, strongly recommended that counselling/support programme be provided with the naltrexone, as reflected in the following extracts:

“Yes I would, but on the same note, naltrexone doesn’t work without the counselling. You need to have both. I think if you don’t come back to these after sessions I think it will be very easy to get back into using. Because this here keeps you in check you know. It’s a reminder, you speak to guys and it keeps you honest.” (Participant G)

“Nah definitely, definitely, but I also recommend that a programme comes with it though.”
(Participant H)

4.10.2 ARCA is recommended

ARCA was recommended by the participants for other addicts seeking recovery from their addictions.

4.10.2.1 Positive reviews of ARCA

All participants had positive reviews/feedback about the ARCA rehab centre and recommended it to other recovering addicts if they can afford it and if they are willing to change. Some of the reasons: ARCA is “practical, convenient and intimate”, “good support structure”, “like you on holiday”, “has a system that works”, “best recovery centre”. This can be reflected in the following responses:

For participant H who has been to other rehabs prior to ARCA and reported previously that it was his choice to return to ARCA after running away after detox and now being serious about his recovery, recommends ARCA for the following reasons:

“Yeah definitely recommend ARCA because to me it’s one of the best things to happen here. ARCA has a system that works. Like I said ARCA works but also you gotta be willing to do

the programme, if you willing there's like a thousand hands that's gonna stretch out to you, but if you not then it's pointless.” (Participant H)

For participant B, she recommended ARCA because of the atmosphere and environment it provided, as reflected in the extract below:

“Definitely. There is something for every addict, ARCA would be the answer. I mean I haven't been to other rehabs but even sitting here with the other guys I would say this has been something practical, so practical and convenient and it's not big – you don't feel it, it's intimate. I didn't feel that whole rehab vibe...it wasn't like that. It was like I am coming to get medical care and that was it. The environment, even the place how its setup, it's clean and you know, I didn't feel like something is wrong. It was chilled. In the evenings we would sit outside and laugh for hours. It was just fantastic. It was like we were on holiday – really – with a whole lot of our friends. It was very good.” (Participant B)

For participant D and E, they stressed that ARCA is a good rehab if the recovering addict is serious about change and their recovery. This is expressed in the following two extracts:

“Yeah I would recommend it to other people. If you serious about change or you serious about whatever you wanna do, that helpful hand, you know that little push, helps you. I mean they are a really good support structure, because that's what some people need just that support, helps them get through whatever they going through.” (Participant D)

“I recommend ARCA as the best recovery centre. Out of all the ones I've been to, I recommend it. Because here it all comes to you- you are the one that has to put yourself together in order to get better, 'cause the Doctor can't help you without your help. Unlike the other rehabs, they have to lock the gates and guide you. You are like in prison but its outside you see. Here, it's your choice, if you wanna go out it's up to you, you can go. But if you feel like you wanna recover, it's your choice.” (Participant E)

Participant G described his personal experience of being at ARCA and uses some negative descriptions of other rehabs given by other participants as a reason he recommends ARCA, in the following extract:

“Yes I would. Um...it's an amazing rehab centre to be honest with you. I have spoken to a lot of patients who have been to other rehabs who say how bad it is, compared to this...and from just what they say, but for me personally I felt it was a good experience and I learnt so much

and I don't see myself going- you know they say an addict can't say his never gonna relapse, you always recovering. But I still feel like as long as I'm here and always coming for sessions, I don't think I'm gonna slip." (Participant G)

One Participant actually recommended ARCA for sugar addicts, as reflected in the following extract:

"Yeah I recommend it for...for actually sugar addicts 'cause it's like, they have detox, flush out the system and give you some naltrexone with the cravings and things which helps."

(Participant J)

CHAPTER FIVE: DISCUSSION OF RESULTS

This chapter presents the discussion of research results with reference to previous literature.

As discussed earlier, there is a need for effective drug treatment facilities in South Africa, especially for the opioid drug, heroin. This study aimed to understand the experiences of individuals attending the ARCA (Assisted Recovery Centres of Africa) Rehabilitation Centre in Durban and how they helped recovering addicts move through the stages of recovery, using the Stages of Change model as a framework.

5.1 View of self before taking drugs

The Transtheoretical model of behavioural change is a model of intentional change. This model focuses on the decision making of the individual. Therefore, in order to start evaluating change, one needs to first look at the type of person the recovering addict was before participating in drugs. It is important to note that the participants were of both gender, of all races and different ages, and coming from different backgrounds and contexts.

Certain individual attributes such as an introverted personality type, has been found to be a risk factor for substance use/drug use (Pattundeen, 2008). The majority of the participants in this study were found to have a positive view of self before their involvement with drugs; however, Participants B, C and D had a negative view of self and presented with an introverted personality type, which has previously been suggested as a risk factor in one study (Pattundeen, 2008).

5.2 Factors contributing to drug use

The participants reported factors that contributed to their drug use. They all reported engaging in substance use/drug use as adolescents. Brookes et al. (2006) identified two types of parental influences related to adolescent drug abuse, namely parental drug use and child rearing. In their study, child-rearing included parental monitoring/supervision (which are protective against tobacco, alcohol and drug use) and the mutual attachment between parent and child, which has been found to predict less tobacco, alcohol and drug use among adolescents (Brook *et al.*, 2006). However, in this study, poor parental monitoring or supervision was identified as a factor promoting drug use, as a few participants reported that too much freedom from their parents at a young age contributed to their drug use. Thus,

indicating the importance of child-parent relationships in influencing adolescent substance use.

Other factors promoting drug use included more money, which was especially supported by Participant F and G, who reported receiving large salaries that helped to support their bad habits. Participants also reported that the drugs were easily accessible e.g. by living in specific areas such as Chatsworth, Phoenix and Inanda etc., which are areas saturated with their drug of choice

They also described the benefits of taking drugs. For some it helped those with a more introverted personality type to have more confidence and gain more friends. This was especially true in Participant C's case, as she was always shy and compared herself to her popular adopted sister who had many friends; so for her, the drug gave her confidence and helped her get friends. For others, the drugs helped numb their problems and offered them an escape from negative or difficult situations in their life, as seen in Participant D's case, who was an only child and the drugs helped him deal with his parents possible divorce This is supported by previous studies which found substance use as a strategy to cope with stress or stressful situations (Kilpatrick *et al.*, 2000).

Other risk factors for drug use by the participants included peer influence or peer pressure. This is supported by previous literature. Barnes *et al.* (2005) identified that a key socialization agent during adolescence is the peer group. The results of their study support the social learning/socialization theory that states: "young people learn problem behaviour by associations with significant others who engage in the same problem behaviour" (Barnes *et al.*, 2005:166). Some participants reported that friends had introduced them to the drug at school, at home, at clubs or parties, and helped make it easy to access the drugs. Participant E and F both described being pressured by their friends to take the drugs to impress their peers and uphold their reputation, or to maintain their status or popularity. Other reported factors contributing to drug use included curiosity, having a heredity component to addiction or having an addictive personality, as described by Participant F whose father and grandfather were alcoholic's, and Participant G who reported having an addictive personality. Others included negative life circumstances such as conflict within the family and loss in terms of jobs, divorce and relationships. This is supported by previous literature. DiClemente & Scott (1997), stated that for many individuals addicted to drugs or alcohol, interpersonal conflicts within an intimate relationship or conflict in other areas such as families, employment and

social systems, is problematic and can contribute to recovery or to continued drugging and drinking. In addition, some participants expressed patterns of sadness or depressed mood as a result of life circumstances prior to drug use, which supports previous research which identified that negative emotional states (depression, anxiety) and lack of constructive coping skills are risk factors for substance use (Hser, 2007).

5.3 Outlook on life while using drugs

All participants expressed having a negative outlook on life while using drugs. Participant B, who was diagnosed with depression and anxiety, reported that she was depressed at that point in her life. Participant E, who was on whoonga for six years and had been to six rehabilitation programmes prior to ARCA, reported that life was not fun or meaningful and only fun when it involved smoking drugs. This suggests that they were dependent on the drugs because their lives revolved around the drugs and everything else got neglected. This is supported by Mtolo (2010), where Thokozani Sokhulu, an activist with *Project Whoonga*, an NGO fighting the use of the drug, highlights the fact that addicted individuals can sell anything and do anything just to get high.

5.4 Prior attempts to stop drug use

Six participants in this study made previous attempts to stop using drugs. The Stages of Change model identifies that the stages of change are circular or spiral, and not linear (Prochaska, DiClemente & Norcross, 1992); therefore, people are thought to move back and forth along the continuum a number of times before reaching the goal of maintenance (Breinbauer & Maddaleno, 2005). Breinbauer & Maddaleno (2005) state that "...they may have tried to change a number of times in the past and have become demoralised about their inability to do so" (Pg. 55).

Some participants tried to stop on their own. Participant B reported that she tried to quit twice in five years on her own, but struggled. Participant C also reported trying to quit on her own many times but realised that she couldn't do it on her own as she was now dependent on the drug. For these participants, it appeared that assistance was required in the form of treatment, as shown in the participant's inability to quit on their own.

Other participants attended previous rehabs but relapsed. Participant A and H had attended one previous rehab before attending ARCA, as well as participant E, who reported attending six different rehabs before attending ARCA. These participants reported that they failed because of the influences of others, or because they were doing it for the wrong intentions e.g. to please their family, and this led to relapse. After each relapse, it becomes more difficult to begin the process of change and move through the stages of change. These participants suggested that when an individual chooses to engage in treatment, it has to be for the right reasons – not to please others, because it leads to failure. This could be related to maladaptive cognitions, problems in beliefs or self-statements that may interfere with recovery (DiClemente & Scott, 1997); or a low level of readiness to change which refers to a “combination of the patient’s perceived importance of the problem and confidence in his or her ability to change” (DiClemente, Schlundt & Gemmell, 2004:104). Research states that traditional health promotion programmes or interventions are often not designed for such individuals and are not matched to their needs (Velicer, 1998). This could be another reason why the participants were unsuccessful at the previous rehabs. Therefore, DiClemente & Scott (1997) state that “it is important to understand not only the current stage of change for an individual but also to understand how often this individual has been through the cycle, either alone or with earlier treatment, to more accurately address his or her needs” (Pg. 140).

Pre-contemplation

5.5 Awareness of consequences of drug use

When engaging in recovery from drug dependence, the process would start with the pre-contemplation stage in which individuals are not willing, unable or fail to acknowledge drug use as a problem or to seriously consider changing their behaviour in the foreseeable future, i.e. in the next six months (DiClemente & Scott, 1997; Prochaska, DiClemente & Norcross, 1992). Those participants that have made previous attempts to quit could be said to skip this stage as they have already reached it previously. The six stages of change suggests that those who have relapsed should start again with the preparation, action and maintenance stages of behaviour change (“Stages of change model”, 2015), which will be discussed later on in this chapter.

However, in this study, four participants were trying to quit for the first time and described being in the pre-contemplation stage. This stage is related to an individual's level of awareness of the consequences of their behaviour on others or towards themselves, while using drugs. "People may be in this stage because they are uninformed or insufficiently informed about the consequences of their behaviour" (Breinbauer & Maddaleno, 2005: 55). At this stage, these participants reported being unaware of the consequences of their drug use, but being in denial or having a false sense of being in control. Participant I, in particular, described being selfish and only seeking to satisfy his bad habits. This is supported by literature that states that continual use of heroin can lead to tolerance, which means that more and more of the drug is needed to have the same effect or to reach intoxication (often euphoria) (APA, 2000; NIH, 2013). For those participants, their only purpose or goal in life was to get the drug and satisfy their craving; therefore, lacking any intention to change their behaviour.

Contemplation

5.6. Factors that motivated change

When individuals start to become aware that their addictive behaviour is a problem, and can consider the advantages and disadvantages of their behaviour, as well as come to the realisation that change may be needed and they intend to change in the next six months, they enter the contemplation stage (Breinbauer & Maddaleno, 2005; DiClemente & Scott, 1997).

Participants in this study discussed factors that precipitated change. Some were positive and some were negative. The positive factors included support they received from loved ones, and for others it was in the form of a spiritual intervention. Many counsellors involved in addiction treatment believe that when individuals are reconnected to a positive spiritual momentum, they are more likely to take control of their lives (DiLorenzo, Johnson, & Bussey, 2001). This is supported by a small group of researchers that found that "spirituality is one of the essential foundations for the remediation of an addictive disease." (DiLorenzo, Johnson, & Bussey, 2001:158) This was evident for Participant B and C, who reported a strong positive motivating factor for change was their renewed spiritual connection with God.

Negative factors included the impact it was having on their family, as all participants described the damage that it caused the family and the family rejection that resulted for some

of the participants because of their drug use. This was especially relevant in Participant E's case, as he had been through six rehabs prior to ARCA and his family was on the brink of giving up on him. Participant B also described the stigma associated with addiction, especially as she was a Pastor's wife and the negative impact it would have for her husband and family, which further fuelled her decision to want to change. Another negative factor was that the drug was starting to lose its desirable effects and now causing detrimental harm to the body, such as bad withdrawal symptoms in the form of muscle and bone pain, diarrhea, and vomiting etc. Participant H even spoke about just needing to get the drug to stop the withdrawals he felt and not for the initial high the drug used to provide.

At this point, the participants were becoming aware of the consequences that their addiction was having on themselves and others.

Preparation and Action

5.7. Journey at ARCA

Each participant had an opportunity to share their experiences as an inpatient at ARCA and currently as an outpatient. The decision to take action and the intention to implement that decision moves an individual into the preparation stage (DiClemente & Scott, 1997).

Preparation is when individuals make a commitment to modify the drug behaviour, planning to take action in the next month and have made some steps to change and are trying to change (Breinbauer & Maddaleno, 2005). The implementation of the plan initiates the action stage, which is the next process of change.

Experiences as an inpatient

The participants made a decision to attend ARCA and described their first few days at ARCA as being very emotional. ARCA Durban offers same day appointments for consultation or treatment, providing medical treatment programmes that are affordable, completely confidential and can be designed to suit individual needs without comprising the quality of the programme (ARCA Durban, 2013). Research has found that major patient attributes for entering the drug treatment process includes motivation for change, readiness for treatment, and problem severity at intake (Simpson, 2004). They also found that motivational interviewing (Miller, 1996; Miller & Rollnick, 1991, 2002) is among the better-known approaches for raising patient commitment to ensure early engagement and retention.

Therefore, on arrival, they met with the Director of ARCA to discuss the procedure and the programme, where patients committed themselves to the treatment process and proceeded to the three day detox.

ARCA Durban offers a Rehabilitation Detox Medical Treatment Programme (ARCA Durban, 2013). For the majority of the participants, it was their first experience of detox. Some were scared, nervous and concerned about their loved ones back home; however, they mentioned being supported and encouraged by the staff and fellow recovering addicts at ARCA. The detox was pain-less, as they all described sleeping while the “drugs were flushed out their system” over the three days. After the third day, the participants reported feeling calmer, alive, sober, normal, aware of their surroundings and aware of the reasons for being in recovery. They all had a positive experience of the detox medical treatment and moved onto the next stage of their treatment, except participant H, who did not make a smooth transition to the next stage of the programme.

For Participant H, he had such a positive experience at the detox centre that he felt he did not need to further engage in the treatment process and he reported running away from ARCA after the third day of detox. Previous research states that the high drop-out rates from treatment are probably related to clients being in the early-stage levels of change (Miller 1985). One could suggest that his level of motivation for change was low, his readiness for treatment was low and his problem severity at intake was high (Simpson, 2004). Research found that clients must begin to see change as in their best interest before they can move from early stages toward action, and this is what happened with Participant H. From the information gathered from all the participants, it was clear that ARCA gives their patients freedom to leave and wants them to take responsibility for their own recovery, which was what eventually happened for participant H as he later made the choice to return to ARCA and take his recovery seriously. DiClemente & Scott (1997) state that “relapse experiences contribute information and feedback that can facilitate or hinder subsequent progression through the stages of change. Individuals may learn that certain goals are unrealistic, certain strategies are ineffective, or certain environments are not conducive to successful change” (Pg. 139). Therefore, for most individuals the path towards change is not straight and narrow but circular in nature, as indicated by previous literature (Breinbauer & Maddaleno, 2005; DiClemente & Scott; 1997; Prochaska, DiClemente & Norcross, 1992).

After the detox, participants reported attending first individual, then group counselling sessions. These are held every Tuesday, Thursday and Saturday, which also run in conjunction with a family support session every Saturday at ARCA. This is relevant as families have often been omitted from patient treatment plans (Simpson, 2004), which is a cause for concern as Miller (2003) argues that families can be part of the problem as well as the solution; they may themselves need psychosocial treatment to deal with drug use problems of a loved one, but they also can give effective support to recovery of the patient.

In relation to the counselling sessions, participants described positive experiences and for many it was their first time receiving counselling. Previous literature states that the success of counselling is consistently related to the quality of the therapeutic relationship, which is associated with participation in sessions that patients consider to be effective (Simpson, 2004). The participants reported attending all counselling sessions and described the counselling sessions as helpful, informative and that it opened their mind and taught them how to deal with their problems. The participants also highlighted that the benefits of the group sessions were to share their stories and learn from one another and to provide support, knowing that they were not alone in their recovery. This is supported by previous research that states “the first major step towards recovery in treatment settings is early engagement, which refers to the extent to which new admissions show up and actively engage in their role as patient” (Simpson, 2004: 106). The two major components of early engagement are participation (i.e. session attendance as inpatient/outpatient and psychological engagement in group sessions), and the therapeutic relationship which is at the core of effective treatment (Simpson, 2004).

According to Prochaska and DiClemente at this stage of change, the individual needs encouragement to evaluate pros and cons of behaviour change (Breinbauer & Maddaleno, 2005). The therapist needs to identify and promote new, positive outcome expectations in the individual and encourage small initial steps.

The participants shared their experiences of ending their 21-day inpatient programme and returning home. This represents the next stage of change called Action. This is when people have made significant modifications/adjustments in their lifestyles in the last six months (Breinbauer & Maddaleno, 2005). The tasks for behavioural change programme’s at this stage is to help the individual on restructuring cues and social support, enhance self-efficacy for dealing with obstacles and help to guard against feelings of loss and frustration

(Breinbauer & Maddaleno, 2005). The participants described some of the challenges they faced, and how they overcame their obstacles and temptations outside of ARCA.

Some of the challenges included family adjustments to them being clean, financial challenges, exposure to their triggers (tempting situations), and going back to the same environment. Research suggests that relapse prevention (Marlatt & Gordon, 1985) be utilised in substance abuse treatments to increase behavioural self-control to prevent relapse and build vigilance for high-risk situations that represent triggers. The goal is to establish new habit patterns for thinking and acting that can be maintained over time (Simpson, 2004).

Participants shared ways in which they overcame some of the challenges they faced after leaving ARCA. These included identifying and avoiding their triggers to substance use e.g. their old peers by forming new friendships with other recovering addicts at ARCA, changing their environment or lifestyle, using the equipment/tools that they learnt at ARCA, setting goals to achieve, attending the aftercare group sessions, taking their medication (naltrexone), and getting the support from family and talking about their problems. Previous literature states that the extent to which a patient has already engaged in participation and the therapeutic relationship will positively influence the effectiveness of relapse prevention and related strategies for strengthening recovery (Simpson, 2004). It appears that the participants, at the time of the interviews, have had a high level of participation and a very good therapeutic relationship with their counsellors as they have employed the strategies taught at ARCA and have progressed without relapsing to the stage of maintenance.

Maintenance

5.8. Current functioning as outpatients

The next stage of change is Maintenance. The focus here is on ongoing active work to sustain change over time to integrate that change into the lifestyle of the individual so that the new behaviour, abstinence from drugs, becomes the preferred habitual behaviour, and further prevent relapse (Simpson, 2004). At this stage people are less tempted to relapse and increasingly more confident that they can continue their change and this usually lasts from six months to five years (Breinbauer & Maddaleno, 2005:56). Most participants were between six months to two years clean when they were interviewed.

Each participant had the opportunity to discuss their current functioning as outpatients. They described positive changes to self and to their outlook on life. All participants reported a positive change to their outlook on life after attending ARCA. The participants found life to be more meaningful, they appreciated their family, their priorities were different, they were more hopeful, and believed they could achieve the goals they set for themselves. They also reported a change in how they viewed themselves; especially in Participant A's case because he viewed himself as a monster, as well as Participant B who reported having a skewed perception/view of herself while taking drugs. The participants also recognised that they will always be recovering addicts, but that they were different from the people they were before when they were taking drugs. Many attributed ARCA as the main facilitator of this inner change. Participants described more positive qualities such as being happier, calm, being proud of themselves for their achievement thus far, and gaining their confidence and self-esteem back.

The tools required at this stage are to provide follow-up support, reinforce internal rewards, and discuss coping with relapse. ARCA supports this by holding an after-care programme and Saturday support sessions for both outpatients and their families to attend and to address any problems or challenges that may arise, and provide follow-up individual and family counselling sessions to those who require it.

Beinbauer & Maddeleno (2005) included a sixth stage of change, called termination; whereby, the individual lacks temptations and enjoys complete self-efficacy. Most people strive to reach this ideal stage but for the participants in this study, they have not reached this stage of change yet, but are still in the maintenance stage. Previous literature suggests that "the path of recovery requires movement from pre-contemplation through contemplation and preparation in order for an individual to take effective action and arrive at maintained abstinence from alcohol and drugs or maintained non-problematic drinking" (Diclemente & Scott, 1997: 139). There is no mention of termination, so it therefore could be argued that they will not reach the stage of termination, but always be regarded as recovering addicts because of the nature of addiction and the circular process of the stages of change.

5.9. Evaluation of the services ARCA provides

All participants mentioned the multidisciplinary team that ARCA provides, which includes nurses, psychiatrists, psychologists, and social workers. Each participant reported being fully

informed and having an individual treatment plan for his/her specific case. Over the years, more research into addiction and treatment has been done, resulting in a number of evidence-based approaches to treating addiction. Today, drug treatment can include behavioural therapy (such as cognitive-behavioural therapy or contingency management), medications, and combination of treatments will vary depending on the patient's individual needs and, often, on the types of drugs they use. All participants provided positive feedback on the services rendered at ARCA and discussed the good service they received. According to the results of this study, ARCA provided services that were helpful and accommodating, the staff were competent, friendly, encouraging and understanding. According to the participants, especially those who had attended previous rehab centres, the services which they found most helpful was the counselling, i.e. the individual and group sessions (as inpatient/outpatient), and the medical service they received i.e. the detox and naltrexone.

5.10. Recommendations to other addicts

Participants recommended ARCA to other addicts seeking recovery for their addictions, who are really serious about change. Participant B, who is a pastor's wife, highlighted that ARCA is practical, convenient and intimate, and where close bonds are formed, much like a family. Participants also reported that it has a good support structure and does not feel like a rehab centre because you feel like you are on holiday there. Participant H, who had been to a previous rehab centre, reported that ARCA has a system that works, and in comparison to other rehab centres, it is the best recovery centre, especially for heroin addicts.

Another recommendation was the use of naltrexone for all recovering addicts. Participants recommended not taking other substances while on naltrexone to prevent negative side effects. The participants described naltrexone as helpful because it helped their cravings to subside, helped stop the damage to their brain caused by drugs, helped remove negative thoughts and enabled them to think more about the consequences of their actions. They also found naltrexone more helpful when accompanied by counselling or an aftercare programme. These results support previous literature which state that Naltrexone (aka. Vivitrol) blocks the brain's ability to get high, gives the brain a chance to reboot by blocking endorphins completely, and must be coupled with therapy to work effectively to treat both alcohol and opioid addiction (Byers, 2013).

5.11 Conclusion

This study aimed to understand the experiences of people recovering from drug use at the ARCA Rehabilitation centre in Durban, so as to add to literature on opioid/heroin addiction and effective treatments, especially in the South African context, as much research has been done in the American context. The information generated by this study can be potentially useful for informing programmes in government run hospitals and rehabilitation centres. This study attempted to understand their experiences of recovery using a Transtheoretical model of behavioural change, namely the Stages of Change model.

According to the study, all participants had a positive experience throughout their recovery at ARCA Durban, including the participant who absconded after his third day at ARCA. For the majority of the participants, it was not their first experience at a rehab centre and they were able to share some important insights. It was described as an emotional journey, but they all felt supported and encouraged because the staff at ARCA were described as empathic, transparent about the procedures, informative, helpful, fully trained and competent to assist them. The underlying factor to their successful recovery was their personal choice to change, or as literature describes as readiness to change (DiClemente, Schlundt & Gemmell; 2004, Simpson; 2004), because they all were serious about their recovery when they made the choice to attend ARCA.

The services which they identified as most helpful on their road to recovery was the counselling, i.e. the individual and group sessions/family support sessions (as inpatient/outpatient), and the medical service they received i.e. the detox and naltrexone. Participants recommended ARCA and naltrexone, in combination with therapy, to other recovering addicts because of their personal experiences attending ARCA, in comparison to other rehabilitation centres many of them previously attended. However, participants mentioned that individuals should be mindful when engaging in other substances while on naltrexone because it will result in negative side effects. All participants described having a positive view of self and a positive outlook on life after attending ARCA, reporting being more confident, having a boosted self-esteem and having hope for themselves and their future.

It could be suggested that ARCA Durban successfully assisted/guided all the participants in this study through the following stages of change: contemplation, preparation, action and maintenance. All participants were of all races from the most popular areas in Durban where

heroin is distributed, and these participants were able to reach the stage of Maintenance without any relapses at the end of the study. Therefore, the ARCA programme does show promise and there may be some lessons learnt in the treatment of opioid (heroin) addiction in the South African context i.e. a holistic model together with therapy in combination with medical management is more effective; access to treatment and resources, including affordability is a factor to consider; as well as the individual's readiness to change needs to be assessed first for better results.

CHAPTER SIX: LIMITATIONS AND RECOMMENDATIONS

6.1 Limitations

This qualitative study used a small sample of participants (n=10) and therefore, the results are not generalizable to the wider population. A limitation could be that the sample was skewed towards those who were successful and had positive experiences in order to show what is effective in the treatment of opioid/heroin addiction, and did not include those individuals who did not have a positive outcome. The majority of the participants had tried other drugs e.g. cannabis, in conjunction with heroin/sugars/whoonga, so this could be a limitation to the results. The expected time of completing my thesis had to be extended. The underestimation of the accessibility, commitment and availability of the participants was a limitation. The reality was that some participants failed to keep to time and to allocated dates, so interviews had to be rescheduled several times and required flexibility of time and venues at ARCA.

Another limitation was that the participants could not provide a lot of constructive criticism of the ARCA programme and may have given answers that they thought the researcher wanted to hear. Time constraints prevented this, as the researcher was unable to do more observations of the participants in the after-care sessions or with their family and friends and to take more time to get to know them better prior to interviewing them to earn more of their trust.

6.2 Recommendations

One recommendation would be to use a larger sample which would be beneficial to get more accurate results. Another recommendation for future research is to do a comparative study of ARCA and other rehabilitations in South Africa so as to be able to compare experiences of different rehabilitation programmes.

It is also important to be mindful of the nature of addiction and the circular stages of change and that this Transtheoretical Model of behavioural change is not without its critiques. Perhaps the study should have included more participants with a longer duration of their recovery/sobriety at ARCA, to understand this model better and to allow the researcher to address areas that were not able to be explored in this study. Therefore, one recommendation

would be to do a follow up study with the participants in one or two years to monitor their recovery and evaluate their progress.

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Appendix 1: Interview-schedule

General information:

1. Tell me about yourself. Probe for age, race and gender
2. What type/kind of person were you before you got involved with drugs? Probe about specific personality traits and qualities
3. Can you describe your experience of addiction?
Probe: When did you start taking drugs? (Duration)
What was your drug of choice?
What are the factors that contributed to your drug use?
Probe for specific factors:
 - a) Mainly peer influence?
 - b) Introduced by friends?
 - c) Other

Stages of Change:

A. Precontemplation

1. Were you ever aware at that time, of any consequences that your behaviour may have had on you or others?
2. Did you ever seek help in the past? If yes, how many times and why wasn't it successful?

B. Contemplation

1. What was your outlook on life when you started taking drugs?
2. What can you say caused you or made you to consider wanting to change your behaviour/ stop taking drugs (this time)?
3. Who or what motivated you to seek help? Probe for specific facts and how they responded.

C. Preparation

1. Who introduced you to ARCA?
2. What motivated you to approach ARCA for assistance?
3. Describe the process of entry into the ARCA programme

D. Action

1. When did you start attending ARCA?
2. What programme were you on at ARCA? Probe whether in-patient or out-patient
3. Can you comment on the service ARCA provides? Probe for information around the medical treatment, detox, the staff, counselling sessions etc.
4. Can you describe your first few days at ARCA
5. How did you feel after detox? Probe if this was their first time
6. How did you feel after your first counseling session?

E. Maintenance

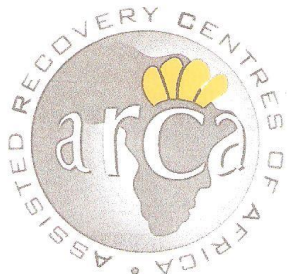
1. What kept you going, since many people relapse at this stage of their treatment?
2. Describe how you overcame any obstacles/temptations at this stage of your recovery

F. Termination

3. Tell me about your journey of recovery here at ARCA? (stages of change) Probe for negative and positive experiences
4. Did your outlook on life change while attending ARCA? Explain.
5. Which service do you feel helped you the most during your recovery process? Probe whether medication, detox or counseling support services
6. What were your experiences using the drug naltrexone throughout your recovery? Probe for negative and positive experiences
7. Would you recommend naltrexone to other recovering addicts and why?
8. Would you recommend ARCA to other recovering addicts and why?
9. I initially asked what person you were before you took drugs, so can you tell me what type/kind of person are you now? Probe about specific personality traits and what are the reasons they are the way they are presently.
10. If you have anything else to add or anything you feel is important that I may have left out, please share.

THANK YOU FOR SHARING YOUR EXPERIENCE WITH ME ☺

Appendix 2: Letter from Gatekeeper



Assisted Recovery Centre's of Africa

*1 Exmouth Avenue
Glenwood, Durban*

*Telephone: (031) 2615515 Fax: (031)2614595
Email: info@arcadurban.com*

To whom it may concern:

This is to confirm that I Dr C Naidoo has given Miss Row-Anne Hunsley permission to conduct interviews with my patients as part of her research on Understanding the experiences of recovering chemical substance abusers at the Assisted Recovery Centre Of Africa, Durban.

Researcher has to take prior consent from each patient individually to conduct the interview

Yours Sincerely

**Dr C Naidoo
MBCChB DA (SA) DOH (Natal)
Medical Director
Assisted Recovery Centres of Africa
(T) 031-3098911
(C) 0837775857
Email:
Web:**

Appendix 3: Ethical Clearance for the Study



17 January 2014

Ms Row-Anne Hunsley (208509640)
School of Applied Human Sciences - Psychology
Howard College Campus

Protocol reference number: HSS/1503/013M
Project title: Understanding the experiences of recovered substance abusers attending the ARCA Rehabilitation Centre

Dear Ms Hunsley,

Full Approval – Expedited


In response to your application dated 02 December 2013, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted FULL APPROVAL.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

Please note: Research data should be securely stored in the discipline/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully



.....
Dr Shrenuka Singh (Chair)
/ms

cc Supervisor: Professor Inge Petersen
cc Academic Leader Research: Professor D McCracken
cc School Administrator: Ms Ausie Luthuli

Humanities & Social Sciences Research Ethics Committee

Dr Shrenuka Singh (Chair)

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Appendix 4: Informed Consent Form

The Research Study

We are asking you to participate in a research study aimed at understanding experiences of individuals attending the ARCA (Assisted Recovery Centers of Africa) Rehabilitation Centre in Durban. Your participation is voluntary. The study will be conducted by a student completing her Master's degree in Clinical Psychology from the School of Psychology at the University of Kwa-Zulu Natal Howard College.

What are we trying to learn?

In this research we want to understand your personal experiences of attending the ARCA Rehabilitation Centre in Durban.

Why is it important/benefits of participating?

This study is important because there is a need for effective drug treatment facilities in South Africa especially for the opioid drug, heroin. ARCA Durban is said to be one of the few rehabilitation centres that provide the drug naltrexone, which is an effective evidence-based treatment for drug addiction. Therefore, the participant's experiences will either confer or add to literature around drug addiction and treatment in South Africa.

Who will be involved and how long will it last?

Ten (10) individuals, male and female, ages ranging from 18-35 years who attend the ARCA Rehabilitation Centre in Durban that have been certified as being clean and have completed or at the end of ARCA's rehabilitation programme, who are recovering from opioid addiction (such as heroin and its derivatives, e.g. 'sugars' and 'whoonga'), will participate in the study. The interviews will run once a week depending on your availability and as agreed upon by the Director of ARCA.

What will it mean if you participate in the study?

If you agree to participate in the study you will sit for a 40-minute long individual interview during which the researcher will ask questions about your experiences attending the ARCA Rehabilitation Centre and the use of the drug naltrexone throughout your journey towards recovery. This information will be used to add to the literature around current evidence-based treatments for addiction effective within the South African context.

Is there any disadvantage from participating in this study?

There are no known disadvantages/risks known to the researchers of participating in this study. However; there is the possibility that participation in the study may remind you of a time that you were depressed. If you get distressed by this, there is psychological help in place for participants of this study.

What if I change my mind later?

You are free not to take part or withdraw at any stage from participating in the study and your decision will not disadvantage you in any way. The last date for withdrawing will be in March 2015.

Who will see the information that we collected?

All records will be kept completely confidential. Your identity will be anonymous and following analysis of the data, the tapes and transcripts will be destroyed within a set period of time (5 years). The data will only be seen by the researcher and her supervisor, who will be assisting her throughout the completion of this research project.

Anticipated plans for publication

It is anticipated that the findings will be disseminated through scholarly journals as well as policy briefs.

Who to contact if you want to know more, or if you have a problem at any time?

If you want more information on the study before deciding whether or not to participate, or if you participate and later need help or have questions, please contact:

Prof I. Petersen

Row-Anne Hunsley

Department of Psychology

Student Psychologist

School of Applied Human Sciences

School of Applied Sciences

Howard College

Howard College

University of KwaZulu-Natal

University of Kwa-Zulu Natal

Tel: 031 260 7970

Tel: 031 209 4444/ 061 4800 157

If you wish to know more about your rights as a participant in this study you can contact:

MsPhumeleleXimba, Research Office, University of KwaZulu-Natal.

Tel: 031 2603587

Consent to Enroll

I, _____ agree to participate in the research study on understanding the experiences of participants attending the ARCA Rehabilitation Centre. I have received and understood the study information sheet. I have discussed the advantages and disadvantages of participating in the study and I agree to participate in the interviews as stated in the information sheet.

I know I can leave the research study at any time.

Declaration of Consent for Audio Recording

I, _____ hereby *consent/ do not consent* to have this interview recorded.

Signature: _____

Name: _____

Date: _____

You may keep the information sheet. The signed consent form will remain in our study files.