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SUBSTANCE DEPENDENCY AND TREATMENT ISSUES IN SOUTH AFRICA: VOICES OF RELAPSED INVOLUNTARY SERVICE USERS

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ABSTRACT

South Africa like many countries across the globe is faced with a high prevalence of substance dependence among the youth. Drug treatment is a widely and generally accepted approach to curb substance dependence. Among users who are considered for treatment, the majority are treated on an involuntary basis, however, they relapse. This paper discusses the causes of relapse among in-patient and out-patient involuntary youth service users. The findings emanate from a qualitative study that was conducted in Uthungulu district, in KwaZulu Natal, South Africa. Findings revealed lack of personal motivation for behaviour change, stigmatisation and lack of reintegration of users, lack of aftercare programmes, socioeconomic conditions, poor social support, dual addiction implications and psychological factors as causes of relapse. The paper concludes that lack of effective aftercare programmes opened gaps through which socio-economic challenges and poor social support enabled post-treatment relapse. It is recommended that the social development sector must develop guidelines and treatment programmes designed for the treatment of involuntary service users in both in-patient and out-patient settings.

Keywords: Involuntary Service Users, Substance Dependence, Treatment, Relapse, Youth

INTRODUCTION

Substance abuse is an enormous social ill in South Africa and it keeps escalating (SANCA 2020). Alcohol, marijuana, cocaine, tik and heroin are usually the most abused substances in the country. The South African Community Epidemiology Network on Drug Use (SACENDU) (2018) reported that alcohol and cannabis were the most commonly abused drugs by youth of about 20 years old. Whereas the rate of substance dependence keeps increasing, a return to drugs after treatment is another critical issue that contribute grossly to the high prevalence (Ngoepe 2016). Usually, among the drug users who are considered for treatment, the majority are referred on an involuntary basis (Munirul 2012). Therefore, the aim of this paper is to establish the causes of relapse among the involuntary service users as narrated by the youth who were treated on an involuntary basis but have relapsed. The paper is significant in highlighting these causes from the service users' perspectives in order to clearly understand and help address current challenges in the treatment of involuntary users, and close gaps in treatment programmes and procedures that fail to mitigate the relapse problem.

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REVIEW OF LITERATURE

The Prevalence of Substance Abuse in South Africa

The abuse of drugs and drug dependency has been identified both internationally and locally as a mounting phenomenon (Voskuel 2015). Myers (2018) reports that there is an alarming rate of use and abuse of legal and illegal drugs among youth, and that this is of utmost great concern in South Africa. Substances used and abused in South Africa can be classified into three categories (Parry, 2015). In the first category, alcohol remains the most commonly abused drug in South Africa, followed by dagga (cannabis), woonga (nyaope) and the dagga-mandrax (white pipe) combination. Among the mostly abused drugs, there is also a considerable abuse of over-the counter and prescription medicines such as pain killers, tranquillisers (including the benzadiazepines), coughing mixtures (especially those made out of codaine), slimming tablets and solvents (especially glue). The second category includes drugs such as cocaine (both crack and cocaine powder), heroin, speed and ecstasy. In the latter category are the drugs such as opium, rohypnol, katramine and welconnal (Parry, 2015). Besides the classification of substances, many substance users in South Africa are poly-dependent users whereby one user misuses one common substance in combination with another type of illicit drug. For instance, combinations such as alcohol and dagga; dagga and mandrax; dagga and heroine; dagga and woonga and alcohol and cocaine (SACENDU 2018). According to Parry, Rich, Claire and Deluca (2012) South Africa is a hard-drinking country with a notable volume of about 5 billion litres of alcohol are consumed in the country on an annual basis.

In a national study conducted in 2016 on self-reported alcohol use and binge drinking, results showed that in 48 World Health Organization's member countries, South Africa presented with the highest per capita alcohol consumption by individuals of the age from 15 years and above. Amid heightening prevalence on the abuse of alcohol and other drugs, South Africa is faced with harmful patterns of drinking and the challenge of binge drinking among young people which has turned into a typical lifestyle (Vellis 2017; Vythilingum, Ross, Faure, Geerts and Stein 2018). These harmful patterns include heavy drinking in public spaces, leaving many households without parental supervision, substances induced social ills such as gender-based violence, spread of HIV and AIDS, school violence. The effects impact not on the user only but the families and the society at large. The financial costs associated with the treatment of substance-related disorders gives pressure on budgeting and other financial resources needed to treat dependency.

The South African Recovery Centre (2015) asserts that there is an alarming rate of substance dependency, and that the mounting of dependency rate is taking a heavy toll worsened by the unattended issues of relapse. Therefore, it is clear that the problem needs mitigation, perhaps using a multi-sectoral approach. Different findings about the nature and extent of drug abuse appear to be of common opinion that there is a lot that needs to be done in terms of harm reduction, supply reduction and demand reduction (The South African Recovery Centre 2015). Doing these might assist in alleviating relapse and other treatment problems.

Approaches to Treatment

There are two approaches to treatment in South Africa; these are inpatient and outpatient treatment avenues (Bernstein 2011). The outpatient treatment approach involves many

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

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

Post-treatment Relapse

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

In America, various studies conducted on youth perceptions, use and relapse established that depression is often a result of stress, and that there is strong links between stress, addiction and relapse (Anglin et al, 2014). Furthermore, a study conducted by Voskuil (2015) in South Africa, in Cape Town on identifying relapse indicators in state subsidised facilities; stress was identified as the leading precipitator of substance dependency and relapse. For instance, chronic stress contributes to periods of time between treatment completion and relapse, when compared to individuals with fewer stress (Wahler and Otis 2014). Chronic stress emanating from environmental factors such as unemployment, economic hardships, and discrimination has also been implicated as specific relapse risk factors. A social-psychological theory (developed by Berlin in 1981) outlines that stress is predominant among persons of low Socio-Economic Status (SES) and other socially disadvantaged groups.

Moreover, according to Anglin et al (2014) there is a close relationship between stress and relapse. Thus, stress varies with developmental differences, and environmental influences. Thus, adolescents, parental issues, peer pressure, school and learning problems were most dominant stressors, whereas for youth stress was mostly underpinned by life circumstances, emerging adult responsibilities, interpersonal and intimate relationships, these were leading to relapse. Eden (2016) postulates that stress and depression are crucial causes of relapse. Where there are lot of stressful events happening after treatment admission, many users prone into drugs use again for coping purposes. This appears to be in line with the findings of Wahler and Ottis (2015) who have proven that after treatment relapse is induced by stress.

Except stress and depression being determinants mostly provoking service users to relapse, a study conducted by Johnson (2012) found that insufficient rehabilitation outcome is

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a second core predictor of frequent relapse. Unemployable vocational skills, unsupportive employment model, ineffective rehabilitation, and unaltered behaviour are issues in the rehabilitation or correctional system that lead to high rates of relapse among delinquents (Clinical Treatment Models, 2009).

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

Research conducted by Keen (2015) on the prevalence of multi-addictions and current treatment by drug treatment centres in Durban, South Africa found that in-patient participants who had been treated for substance dependency before reported a poor response to it, with most relapsing soon after discharge (within one month). Another concern was that several participants in the study had used drugs whilst in treatment. Some had been introduced to or learned about other drugs, which they continued to use after they were discharged.

Reviewed literature in this paper mostly helped to increase understanding about the mounting scourge of substance dependency and relapse among voluntary service users. This review further outlined dynamics and shortcomings associated with substance dependency treatment. However, the available literature does not efficiently give insight on what could be the causes of substance dependency after treatment among involuntary service users. Hence, the significance of this paper lies in exploring the causes in this regard.

THEORETICAL FRAMEWORK

Numerous theories describe substance dependency and relapse problem by focusing mainly on the precipitatory factors, for instance, the bio-psychosocial theory considers factors such as the genetic inheritance, family, psychological variables, community, social pressure as the critical elements that can lead to substance dependency relapse if they are not adequately addressed during the treatment course (Mhlungu 2018). On the other hand, the psychodynamics intervention model considers substance dependence and relapse as a critical condition resulting from a futile attempt to compensate for inner emptiness (Mhlungu 2018). It regards substance dependence and relapse as a condition that can only be dealt through an effective treatment. The psychodynamics intervention model views treatment effective only when it firmly focuses on intervening to conscious contents of substance dependence in order to ease the psychological tensions brought by the inner emptiness that the user tries to compensate. This paper adopts the motive enhancement model and the cognitive behavioural theory as the conceptual and the theoretical lens in describing the problem of relapse in the context of involuntary treatment.

The motive enhancement model is generated from the Carl Rogers' person centred theory context (Miller and Rollnick 2013). The motive enhancement model has been used in the field of drug abuse, mostly in the area of alcoholism. It acknowledges substance dependency as a problem, and that service users relapse after treatment for a number of reasons. It views lack of motives as an epicentre of all these reasons for returning to drugs during and after treatment (Guydish 2012). The main thesis of the model is that the involuntary substance

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dependence service user is strongly controlled by ambivalence, whereby they are basically aware of the danger of abusing substances but they continue anyway.

The motive enhancement model affirms that lack of internalisation of motivation in a substance dependent causes relapse due to their inability to perceive discrepancy (Miller and Rollnick 2013). The theory enlightens the importance of separating behaviour from the service user and helps to explore how important personal goals are being undermined by current dependency patterns (Huang, Tang, Lin and Yen 2011). However, the model emphasises that without being enabled to develop internalised positive motives to change dependency behaviour, service users can not perceive and acknowledge discrepancy (Miller and Rollnick 2013). Apart from the ambivalence and discrepancy behavioural patterns, the motive enhancement model further regard resistance as a common critical behavioural element causing relapse among the involuntarily treated users (Garry 2010). The theory brings to light that service users tend to view their dependency condition differently, and finally this predicts poor treatment outcomes (Miller and Rollnick 2013). Motive enhancement theory proponents emphasise that relapse is also brought by the lack of a well-developed sense of self-efficacy, whereby service users find it difficult to believe that they can maintain behavioural change (McHugh 2012). In this light, the theory stresses that instilling motives will then improve self-efficacy, and that improving self-efficacy should insert hope, positivism, and feasibility of change achievement (Miller and Rollnick 2013).

Whereas substance dependency treatment is about facilitating behaviour change which in return brings about effective sobriety and abstinence after treatment, however, this is practically impossible for involuntary service users to achieve. On this note the researchers affirm that there is huge gap between the voluntary service users and involuntary service users, this gap has created means for a relapse to take place. The researchers further argue that in the involuntary context of substance abuse treatment, there is a lot missing in terms of research and literature, policy and treatment programmes. Therefore, there is a need to close the said gap by reconceptualising the involuntary service user and treatment thereof.

The researchers believe that in order to alleviate the probabilities of relapse internalised motives for behaviour change should be carefully instilled. This is in line with Apodaca and Longabaugh (2015) who affirm that, in order to alleviate relapse among the involuntarily treated service users, it is important to inject hope and need for change, so that service users take responsibility in the whole treatment process. Trotter (2011) on the other hand asserts that "when working with involuntary clients the building of self-esteem, self-efficacy and positive perceptions should be a prerequisite to avoid relapse". In order to obtain more views, and the redefining of the problem at hand the researchers looked at the cognitive behavioural theory.

Generally, the cognitive behavioural theory is based on the recognition that thoughts and feelings are closely related. An interpretation of ourselves, the future, and those around us affect the manner in which we feel and the manner we behave. Cognitive theory places greater emphasis that a person has power to make positive changes by actively working on modifying the destructive thoughts and behaviours. In light of this, the service users' behavioural attitudes associated with returning to substance dependency after treatment is stirred back by lack of cognitive empowerment (Otto 2012), as they lack cognitive empowerment, they automatically become powerless to deal with distortive thoughts, and ultimately become trapped in a circle of dependency behaviour wherein ability to detect triggers is impossible (McHugh 2012).

Cognitive behavioural theory stresses that the post treatment relapse is caused by service users' failure to face life realities. These fears about reality are perpetuated by lack of well-strengthened confidence and sense of self-determination, and ability to perceive future

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endeavours positively (Wax 2016). With specific reference to this context of posits by the theory, the researchers observe that the theory discovers that "the belief and assumptions that the person uphold can be interrupted and distorted by various effects (could it be childhood experiences, and learning experiences as an adult), as a result the person may have negative beliefs which may for instance predispose towards low self-esteem, depression, anxiety or continued abuse of substances. In this regard, the researchers find the context of theory clearly explaining that service users resort back to dependency behaviour due to failure to examine errors and distortions in thinking. It clarifies that relapse is caused by failure to learn to correct negatively biased attitudes and beliefs that are based on faulty assumptions and inability to learn to cope without drugs.

RESEARCH METHODOLOGY

The study was conducted in Uthungulu District, the North-Eastern part of the Province of Kwa-Zulu Natal in South Africa. A qualitative research method was adopted to explore and describe the experiences of involuntary service users. The target population for the study was the youth aged between eighteen to thirty-five years and social workers as key informants. A sample of eleven youth was selected through snowball sampling and four social workers. Data was collected using semi-structured interviews. Furthermore, the collected data were analysed using thematic analysis. This paper focuses only on the data obtained from the youth and one of the themes that emerged from the study which is the causes of relapse.

In terms of ethical considerations, firstly an ethical clearance certificate was obtained from the university to conduct the study. Much emphasis was made on the principle of voluntary participation in conducting the research. Informed consent was facilitated by social work practitioners to service users that they referred for participating in the study, this was done with intent to prevent the referred users from feeling compelled or coerced. The participants were protected from any harm in terms of stressful, anxiety inducing and emotional effects that could have emerged during the course of the study by ensuring anonymity and maintaining confidentiality. Arrangements were made for debriefing and counselling should any participant felt they needed such intervention. However, no participant needed to be referred for counselling.

Biographical Information of Participants

Among the eleven youths who were interviewed, eight were males and three were females. They were between twenty and thirty-one years of age. All the eleven participants were unemployed due to reasons such as retrenchment, suspension or dismissal from work, and dropping out from school. Table 1 below shows detailed biographical information of the participants.

Table 1: Biographical information of participants

Participant	Age	Race	Gender	Reason for unemployment
1	28	African	Male	Retrenched

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2	31	African	Male	Suspended
3	26	African	Male	Dropped out of school
4	23	African	Male	Dropped out of school
5	20	African	Female	Enrolling for grade 11
6	23	African	Male	Dropped out of school
7	21	African	Female	Enrolling for grade 11
8	28	African	Female	On work suspension
9	26	African	Male	Dropped out of school
10	18	African	Male	Enrolling for grade 9
11	31	African	Male	Work dismissal

RESEARCH FINDINGS AND DISCUSSION

Causes of Relapse among The Participants

The themes that emerged under causes of relapse among the youths in the study include; lack of personal motivation for behaviour change, stigmatisation and lack of reintegration of users, lack of aftercare programmes, socioeconomic conditions, poor social support, dual addiction implications and psychological factors. These are explained as follows:

Theme 1: Lack of personal motivation for behaviour change

The youth involuntary service users who participated in the study were asked if they had any internalised necessity to change their substance dependence behaviour. It was found out that all the participants were not motivated towards the treatment. Findings further asserted that, not having self-motivation made the involuntary service users to go on with the treatment process without willingness to stop substance dependence behaviour. All the participants mentioned that having treatment without willingness was on the basis that they lacked readiness and that this made them to have faulty compliance whereby their focus was with their referral sources than that of changing their substance dependence behaviour. The following quotes from some of the participants showed this lack of motivation:

> *I was not ready to quit drugs. Stress of being an unemployed graduate was among personal issues that made me to fear living without drugs. Then my little attempt to maintain abstinence was unsuccessful.*
>
> *I feel that I was forced to go for at Newlands Park Centre in Durban, I got this emotionally*

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draining, and as a result I was so looking forward to my discharge day at the treatment facility. It then took me about two weeks to return to drugs after I was discharged from the treatment facility.

My family became tired of my stealing behaviour, stealing household accessories my parents decided that I go for treatment; nonetheless, I feel like the whole plan for treatment was all behind me, and this caused me to feel intimidated.

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

Motive for a behaviour change play a prominent role even in alleviating resistance, and it could further restore positive perceptions about the treatment (Garry 2010). Lack of motivation for behavioural change among the involuntary service users perpetuates a return to non-rewarding behavioural attributes for different reasons (Trotter 2011). The motive enhancement theory regards relapse in the context of involuntary treatment as a result of lack of personal motivation and internalised insight about stopping drugs. The theory helps to explain how the involuntary treatment process can be facilitated in a manner that aid service users to develop sense of self-efficacy and be able to fight relapse triggers.

Theme 2: Stigmatisation and lack of reintegration of users

Participants were asked about how they experienced life after going through treatment. It was found in the study that the participants experienced forms of stigmatisation perpetuated by families and the society in general. Of the eleven interviewed participants, majority (ten) mentioned that the stigmatisation they experienced brought up some psychological elements of stress and withdrawals and this caused them to go back to using drugs. The findings of the study further make the assertion that stigmatisation, neglect and isolation by friends, families and the neighbourhood at large more or less common among involuntary service users. All these ten participants viewed stigmatisation, neglect and isolation as something that was perpetuated by that the treatment was not inclusive of families and significant others. Participants stressed that should the treatment process became inclusive of their families, they could be supportive accordingly, and that they could have felt accepted after treatment. They were also considerate that being accepted would have strengthened insights in their recovery process, and that even the judgemental attitudes from the society would have been alleviated. The following quotations from the participants attest to that:

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

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

Coping with life challenges after treatment was never easy, I felt so lonely; no one wanted to associate with me. I had no income, I then tried to sell perfumes and cleaning chemicals, people could not let me come to their houses as they would think that I was going to influence their children into drugs, I will never forget this experience.

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The findings of this study confirm what Bernstein (2011) argue that lack of reintegration with various systems of the society such as families, employment and the community, service users are likely to face stigmatisation in different ways, and ultimately relapse.

Theme 3: Lack of aftercare programmes

Study findings showed that it is not only the post-treatment stigmatisation that causes the relapse after the involuntary treatment, but revealed other post-treatment adjustment shortcomings such as lack of aftercare programmes, socio-economic conditions, poor social support as key challenges that easily set the ground for relapse among the participants. Lack of aftercare services was found to be a gross influence for the occurrence of these post-treatment shortcomings.

Aftercare has been described as the prominent phase in substance dependence treatment process. Aftercare services play a valuable role in strengthening human relations. Aftercare service fosters cohesion and social support among substance dependence service users. This study has found lack of aftercare as a prime cause of return to drugs among youth involuntarily treated for substance dependence as participants experienced exploitation, discrimination and stigmatisation after treatment. The following verbatims attest to that:

> *I had no idea why I was taken to rehab in the first place, but I ended up enjoying group sessions as I could hear others' stories and their wish to stop using drugs. Eventually I saw a need to change. Upon my discharge, life was difficult, I found myself battling with the triggers alone, I could not turn to my family, I had no body to go to, I could not return myself back to rehab at the time. It felt like I have reached the dread end of everything.*
>
> *Life is lonely after treatment. There is so much neglect. We battle with re-adjustments whilst faced with boredom.*
>
> *Besides, this knowledge is very powerful at the time it is shared by social workers during sessions, one becomes aware of his role thereof, but when you are now alone and you are supposed to apply what you were taught is not easy. I think if there was a way of supervising closely, maybe it could be figured out how I am doing, where I am failing and how much of support do I need.*

Due to lack of effective aftercare services, stigmatisation and poor reintegration become an obvious after treatment experience among the involuntary service users. It has a potential to cause relapse (Hellen 2015). Effective aftercare and reintegration are vital in the treatment of involuntary service users as also shown in the in the study conducted by the World Health Organization (WHO 2015) on substance abuse after treatment re-adjustment challenges. With the lack of aftercare, stigmatisation effects such as stress and negative self-regard are likely to take place. The cognitive behavioural theory states that the involuntary users' interpretation of themselves, the future ad those around them revolve within the scope of negative thoughts. In light of this, the users' behavioural attitudes and thoughts about returning to drugs become so strong. The motive enhancement theory argues that the treatment process must instil motivation in order to help the involuntary to be able to perceive discrepancy. This could help users to remain positive in the event of stigmatisation and lack of reintegration, thus alleviate post-treatment relapse.

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Theme 4: Socio-economic conditions

Participants in the study found it difficult to work on behaviour change successfully due to the difficulties they faced after treatment. These difficulties included socio-economic hardships; unemployment and lack of skills and boredom. These factors increased the likelihood of relapsing as participants found it difficult to survive the post-treatment phase.

> *Upon my return from treatment, I had no means to sustain living as a youth. I then decided to join a pyramid business where I was selling perfumes and getting paid on a commission basis. I battled even to have customers because almost everybody from my community was assuming that I was selling stolen products.*
>
> *Some could not allow me to enter their households when I was doing a door to door selling. They were saying I was not into selling instead I wanted to observe how I could break into their houses at night. I have found my life in a worse mess, I found myself with lot of stress which led to a loss of hope.*
>
> *I went for treatment on outpatient basis, the programme was good and was enjoying the group of other addicts I was placed in, I ended up stopping going for my sessions due to economic situations, I was unemployed at the time and I battled with money for transport to my sessions.*

Theme 5: Poor social support

Behavioural Health Research Institute (2015) postulates that social support plays a vital role in the recovery from the use of substances following treatment process. This is confirmed by Hellen (2015) who argues that social support enhances the probability that the individual will stay sober and well maintain sustainable recovery from drug abuse. The lack of social support among the participants was one of the themes that emerged in the study. The participants were cited as follows:

> *Upon my return home from the facility, many were avoiding me. I ended up socialising with the very same substance dependant peers, and finally I was back into a worse scenario of substance dependency.*
>
> *My family treated me as the very same person I was before treatment, they could not understand the process of change I was working on, I think they could not understand what could be their role thereof.*

In light of this, the researchers are of the opinion that motivation for behaviour change has to be facilitated with the inclusion of the users' families and significant others as support structures. This social support will play a valuable role in reducing post-treatment stigmatisation and strengthen human relations, at the end the service users will find a space of belonging as their systems of support are more likely to be reliable, and therefore relapse can be prevented among the involuntary service users.

Theme 6: Dual addictions implications

There are instances whereby the use of drugs connects to other behavioural addictions, these behavioural addictions that stimulate relapse after treatment (Williams 2017:103). One of the

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themes that emerged in the study was dual addictions. Out of the eleven interviewed participants, six mentioned that besides drugs addiction they had other addictions and that these other addictions were unnoticed during the treatment, as a result it stimulated relapse after the treatment process. Some of the participants shared the following:

> *I am partially a sex worker. Although sex work is not something permanent but I consider myself addicted to sex because I have multiple sex partners whom I am involving in sex with for financial gains. At the time I went for treatment I did not disclose my sex work story, even practitioners could not find this.*
>
> *I am convinced that after treatment I tried to stay away from drugs, while on the other hand I battled with sex work without taking drugs just to numb my conscience. Whenever I was to engage in a sexual activity automatically I would think about taking drugs. I am back to drugs as we speak. And I think I am fine regardless of consequences.*
>
> *Apart from drugs, I have a problem with gambling. It actually started with gambling which caused me financial problems, upon battling with stress of finances I ended up on heroin as I was trying to escape stress.*
>
> *My use of heroin worsened to an extent that I was recommended for treatment. But the treatment itself could not deal with gambling, yet for me drugs were not a problem at all, instead the big problem was gambling and I did not see it addressed in the course of treatment.*

The South African Depression and Anxiety Group (SADAG) (2014) asserts that there is a strong relationship between substance dependence and other addictions. The Substance Abuse Helpline of South Africa by SADAG (2014), and Mhlungu (2018:48) argue that the other behavioural addictions have a strong potential to cause relapse should they not get treated concurrently with drugs. These assertions were found aligning with the findings of this study where other behavioural addictions such as gambling and sex came out during the data collection. Herring (2011:100) argued that sometimes it is not drugging per se that are a primary need for treatment, instead, it is the other addictions that when they are not dealt with, they stimulate a return to drugs as a typical mechanism for coping. Therefore, the treatment itself must be relevant enough to go the extra mile to tackle other addictions.

In the face of other behavioural addictions intertwining with drug abuse treatment, the researchers consider the importance of quality of assessment form the onset of the treatment process. The researchers make appraisals on the role of effective assessment on the basis that when the assessment is well strengthened, it will be narrative enough to a point that it manages to probe elements of other addictions, and this can assist in mitigating the problem of relapse among the involuntary service users. This is supported in Goldberg (2014) findings which posit that a thorough assessment should identify the nature and the severity of the dependence problem, assess the consequences of dependence, and determine the service user's strengths and weaknesses. However, the researchers take to note of the issue of lack of assessment tools designed for involuntary service users in South Africa as one of the baseline challenges that compromises quality in treatment and ultimately open a gap for relapse.

Theme 7: Psychological factors

It was established from the findings that psychological factors such as trauma, stress and

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anxiety contributed towards the lack of willingness to quit substance dependency. These factors are likely to bring about resistance, and that the nature of resistance is so much close to unresolved stressors. Findings highlight that many users were deeply involved in drugs as a result of the general life events and experiences whereby drugs were chosen for coping with the reality of psychological factors associated with the life events. Therefore, when treatment was considered in this regard, it did not go deep to uproot the cause of these epic psychological factors since they are the underlying issues. Some of the participants mentioned that:

> *I had too much stressful life events, which led to depression and ultimately, I depended on substances for coping. When I went for treatment I feared that I would subject myself to worse stress. Nevertheless, I feel that my involvement in treatment did not address my needs. I am saying this because no professional assessment was done to establish that the cause of my dependency was a result of stress and the main cause of stress was not attended. As a result, it was easy for me to return to drugs after treatment.*
>
> *I was not ready to quit drugs. Stress of being an unemployed graduate was among personal issues that made me to fear living without drugs. Then my little attempt to maintain abstinence was unsuccessful.*
>
> *I feel that treatment was compelling and emotionally straining. I was so looking forward to my discharge day as I was coping at the treatment facility. It then took me about two weeks to return to drugs after I was discharged from New Lands Park Centre in Durban.*

In a theoretical point of view, the cognitive behavioural theory views relapse during or after treatment among the involuntarily treated users as the reality. The theory asserts that, it is the lack of cognitive empowerment that makes involuntarily treated users to battle with modifying destructive thoughts that reinforce a return to substances. Whilst the inability to handle the distorting thoughts strongly influence the return to drugs, the motive enhancement theory regards the cause of relapse among the involuntarily treated substance dependants as due to the epitome of ambivalence and the inability to perceive discrepancy.

CONCLUSION

Based on the causes of relapse among the youth involuntary service users in South Africa which this paper presented on, it can be concluded that; despite good psycho-education on substances, their effects and the emphasis on behaviour change, involuntary service users found it difficult to work on managing behaviour change due to the difficulties they face after treatment. The lack of personal motivation for behaviour change was the prime precipitant of post-treatment relapse that service users had indicated. Lack of motivation makes users to lack effective insight about the treatment. Ultimately, they lack cognitive power to maintain sobriety and abstinence after treatment. There are factors that contribute towards the lack of motives, for instance; post-treatment stigmatisation, socio-economic predicaments, neglect, and disconnection from social contacts. Many involuntary service users find stigmatisation and social exclusion perpetuated by treatment that is not inclusive of families and users' support cycles. Participants stressed that, should treatment involve families in the process, this would have secured them well equipped support system after treatment. Poor social support and socio-economic problems are among the epic difficulties that service users experience after treatment. The lack of effective aftercare programmes was found to have opened gaps through which

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socio-economic challenges and poor social support to occur. Effective aftercare could help strengthen human relations between service users and their close social connections. On this note, relapse could be prevented as users would have had good support system. It is through effective aftercare that service users are linked to needed resources; and this could help mitigate socio-economic hardships mostly experienced by many service users after treatment. Many service users have misused substances as a result of psychological factors, however; in the face of ineffective treatment, these factors become ignored and unaddressed. Consequently, users relapse as they find it difficult to cope.

RECOMMENDATIONS

Based on the conclusions, it is recommended that, in the face of all the factors that are found attributing to post-treatment relapse among youth involuntary users, the social development sector, mainly the department of social development at its macro level of policy making must consider developing standard operation procedures (SOPs) and guidelines, norms and standards, practice protocol and the treatment programmes designed for the treatment of involuntary service users in both in-patient and out-patient settings. The Department of Social Development together with all stakeholders in the social development sector must establish mechanisms that will enable effective case management systems, solution-focused and well managed aftercare programmes designed for service users inclusive of involuntary service users. The solution focused aftercare services must address concerns of boredom and unemployment; it must help integrate service users with their families and communities as this could play a valuable role in mitigating exploitation and stigmatisation faced by after treatment. There must be effective collaboration by the social development sector with the existing flagship programmes and other entities such as the Local Drug Action Committees at a local government sphere; this will strengthen social support mostly needed by involuntary service users after treatment.

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