Exploring experiences of substance-dependent employees in rehabilitation and their reintegration to the workplace: Case study of an alcohol and drug rehabilitation centre in Johannesburg, South Africa.

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DECLARATION

I declare this research report titled "Exploring experiences of substance-dependent employees in rehabilitation and their reintegration to the workplace: Case study of an alcohol and drug rehabilitation centre, Johannesburg" is my own work. It is submitted in fulfillment for the degree of Master of Arts in Occupational Social Work, at the University of Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

Signed this 19th Day of April 2020

Nicola Johnson

DEDICATION

I dedicate my work to:

My parents, thank you mom and dad for your sacrifices and endless support in making my dreams come true.

And

My research participants, your contribution in my research study has fueled my passion.

ACKNOWLEDGEMENT

This research study would not have been possible without:

Firstly, thank you Lord, all the glory, honour and praise go to you. What a faithful God! In all that I do I will continue to glorify and honour you.

To Dr. Francine Masson: Thank you for taking on the role of my supervisor and for all your efforts in assisting me in this journey. I have come out from this stronger, more knowledgeable and eager. You have played a significant role in my growth and for that I am thankful.

To the research participant: To those who have provided their time and willing participation, you are the heartbeat of this research, Thank you! Your resilience and bravery are admirable.

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ABSTRACT

Substance abuse and dependence is a prominent and demanding social problem emerging in the workplace. This challenge has brought about multiple negative costly effects and barriers in the workplace namely; poor productivity, absenteeism, distrust, stigma and relational conflict to name a few. Numerous global efforts have been made to alleviate substance abuse and dependency through prevention and treatment programmes. However, in the South African workplace context, very little is known about the experiences related to the rehabilitation and reintegration of employees with a substance dependency. Consequently, this research study embarked on a qualitative, exploratory case study, to identify employee's experiences of rehabilitation and reintegration to their workplace. eighteen participants were purposely selected for this study and face-to-face, semi-structured interviews were conducted on two occasions. The first interviews were conducted with eighteen participants and took place during their rehabilitation programme. This was done to explore motivating factors leading to rehabilitation and their experience of rehabilitation. The second interviews were conducted with eight participants when they returned to work upon completion of their rehabilitation programme. The latter interviews were conducted to identify their experiences of reintegrating to their workplaces. Thematic content analysis method was used to analyse the data from this study. The emerging thread of findings highlighted the daunting experiences of substance dependent employees in the workplace, and more specifically, the effects of their substance dependency on their personal and work life. A number of contributing factors were identified but the most predominant and common factor was their use of substance to cope with the demands of their personal and working life. The findings aim to provide knowledge pertaining to the experiences of rehabilitation and reintegration and the effects on the personal and work life of substance-dependent employees. As well as to create awareness and contribute to knowledge for occupational social workers, human resource practitioners and employers in managing substance dependence-related problems that arise in the workplace.

Keywords: Substance abuse, Substance dependence, Employees, Rehabilitation, Reintegration, Workplace, Occupational Social Work, South Africa

LIST OF ABBREVIATIONS

DSM-IV	Diagnostic and Statistical Manual of Mental Disorder, fourth edition
WHO	World Health Organization
EAP	Employee Assistance Programme
NDMP	National Drug Master Plan

PROLOGUE

I Think It's Brave

I think it's brave that you get up

In the morning even if your soul is weary

and your bones ache for a rest

I think it's brave that you keep on

living even if you don't know how to anymore.

I think it's brave that you push

away the waves rolling in every day

and you decide to fight

I know there are days when you

feel like giving up but I think it's brave

that you never do

-Lana Rafael

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CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION TO THE STUDY

Globally, the negative effects of substance abuse and dependency contribute to devastating and costly societal effects (Sullivan, 2015). The diagnosable abuse, dependency or other problematic use of substances is deemed to be a multifaceted phenomenon, as it involves, and is triggered by a number of circumstantial, relational and intrapersonal factors. These include the death of a loved one, financial stress, marital or family conflict, mental illness, and work-related stress, to name a few (Kassle, Waddle & Roberts, 2007).

The National Drug Master Plan (NDMP, 2013-2017) emphasizes the soaring rates of alcohol, drug abuse and dependence in South Africa. This indicates that South Africans are entangled in the worldwide drug problem which is being progressively destructive in the lives of individuals, their families, communities and workplaces.

Keneen (2010) indicates that the prevalence of illicit drug use is rated the highest in the unemployed and criminal populations. However, research reflects that the rates of individuals using substances in the workplace are soaring, as alcohol and drug abuse and dependency are growing among individuals in employment. Consequently, the workplace is identified as providing a unique opportunity to address and examine substance use and abuse problems (Cook & Schlenger, 2002; Sloboda & Bukoski, 2007)

People who are employed spend a significant part of their lives at work and their jobs often create significant meaning in constructing their individual identity. This can be described in terms of ways in which employment contributes towards an individual's economic stability and personal fulfillment. Employment also provides structure, productivity and a platform for positive social interaction (Conye, 2011; Quick, Tetrick & Association, 2011).

The dynamic and fast-paced nature of most workplaces however, makes them possible stress-inducing environments (Gatchel & Schults, 2012). In addition to personal stressors, employees are often exposed to numerous occupational stressors and unfavourable work conditions. This includes a lack of information provision, ineffective communication, unequal power distribution, role conflict, poor social relations, exposure to physically harsh environments, labour and salary disputes, a lack of job security, opportunities and general dissatisfaction (Csiernik, 2016); In addition to the aforementioned occupational stressors, the choice made by individuals to use substances is also triggered by internal factors such as the desire to "escape", "cope", or "forget about problems" that arise at home, socially or at work (Mogorosi, 2009).

There is a specialised field of practice called 'occupational social work' which advocates and provides support for employees social needs and problems, such as substance dependency that arise in the workplace. Mor Barak (2016, p.13) explains that occupational social work is "at the focal point between the realities of the workplace and the needs of the workplace." For example, substance dependency is described as a hidden disease in the workplace. This is often difficult to identify until employers or occupational and other health practitioners purposefully give attention to its existence (Burnhams & Parry, 2015).

Occupational social work practice exposes the reality that it is difficult, in fact almost impossible, for employees to keep their personal lives completely separate from their work lives. Employees with personal problems, such as substance dependence may well spill over into their work life (Du Plessis, 2001). The workplace is therefore acknowledged for its potential as an effective and successful place to address substance dependence, facilitate changes, as well as alleviate stigma (Cook & Schlenger, 2002).

This study therefore explored the experiences of substance dependent employees in rehabilitation and their re-integration to their workplaces. Specifically, the study focused on the perspectives and lived experiences of employees, their ability and inability to cope with substance dependency whilst working and their experiences of rehabilitation, returning to work and maintaining employment.

1.2 STATEMENT OF THE PROBLEM AND RATIONALE OF THE STUDY

Findings in the World Drug Report (2018) pointed out a number of threats and limitations that substance abuse and dependency posed to health, safety, sustainable development and the overall well-being of individuals globally. Firstly, the use of drugs and the drug markets are expanding more than ever before. Secondly, drug trafficking continues to grow rapidly regardless of efforts made to shut down trading platforms. Thirdly, drug treatment and health services continue to fall short as the number of people suffering from a substance use disorder receiving treatment remains low.

In South Africa, substance abuse and dependency remain a challenging health and social problem which negatively impacts and compromises the development outcomes of the nation (United Nations on Drugs & Crime 2013; World Health Organisation, 2011). A great deal of research, intervention strategies and government attention are focused on mitigating substance abuse among the youth and affected communities. However, in workplaces, substance dependence remains a fairly neglected concern. Therefore there is an urgent need for awareness, knowledge and interventions to assist employers to identify substance abuse more effectively and respond more supportively (Kilan, 2008; National Drug Masterplan 2013-2017).

Geldenhuys (2015), states that the existence and knowledge of substance abuse and dependency problems in the workplace is not a new occurrence. Substance abuse occurs across all sectors, so none will be excluded from this serious problem. Even though it is not a new occurrence in the workplace, managers, supervisors, unions and employee health and wellness practitioners continue to face challenges regarding substance dependence problems of employees. Employers are often afraid and reluctant to confront alcohol and drug-related problems at work (Mc Cann et al., 2011).

Substance abuse in the workplace is reported to be one of the most challenging tasks confronting employers. This could be due to the legal obligations of employers to provide safe, healthy and productive work environments (Dwoskin, Squire & Burdick, 2012). Additionally, substance abuse and dependence are said to have major negative impacts on the economy and has resulted in the decline in social and occupational functioning in the workplace. South African employers lose millions of Rands annually from increased absenteeism, decreased productivity, workplace

accidents, work errors, failure to meet deadlines, and criminal activities (Smook, Ubbink, Ryke & Strydom, 2018).

The alleviation and elimination of substance abuse and dependency is a highly desirable goal given that there are multiple approaches to its education, prevention and treatment. However, successfully achieving this goal is reported to be difficult (Thomas & Hersen, 2004). In the workplace, failure to address substance abuse was identified as the main contributing factor to its unsuccessful resolution. In addition, there are also other factors such as ignorance, lack of support, preference to conceal the problem rather than initiate treatment referrals, stigmatisation and also using unfeasible measures to address and mitigate substance dependency (Smook, Ubbink, Ryke & Strydom, 2018).

The motivation for the study was influenced by the researcher's interest that developed while working in the field of substance abuse. A large number of employed individuals reaching for assistance for their substance dependence challenges were not able to fully benefit from in-patient rehabilitation treatment. They feared dismissal, stigma, and discrimination should they disclose their substance dependence problems to their employers. There was also an observed growing trend within the in-patient treatment setting whereby employed individuals, who were referred by their employers, supervisors or managers, lacked support and follow-up of re-integration plans throughout the treatment program. The alienating and covert way employees affected by substance dependency were assisted, served as motivation to further explore the experiences of employees who depend on substances and who are in the process of rehabilitation and reintegration, particularly in the South African context.

1.3 PRE-UNDERSTANDINGS OF THE RESEARCH STUDY

• Problems relating to substance dependency may arise from personal, family, psychological and social influences, or from a combination of these factors. Such problems not only have an adverse effect on the health and well-being of employees but also contribute to difficulties at work, including deterioration in job performance (Mogorosi, 2009).

• Perceptions of substance use have changed over time due to growing awareness of the problem. However, there is still a stigma attached to drug dependency in the work environment and it continues to be perceived in a negative light. Furthermore, employers are reluctant to tackle the issue directly (Cook & Schlenger, 2002).

• Labour Relations Act, 1995 (No.66 of 1995) and The Constitution of the Republic of South Africa 108 of 1996 discuss that employees with a substance dependency should be treated in the same way as workers with health problems in terms of benefits. Employees that seek treatment and rehabilitation should not be discriminated against by the employer but rather be entitled to job security and support.

• An effective workplace policy has to be beneficial and constructive. It has to include prevention, treatment, rehabilitation, and follow-up measures. It should also maintain respect and confidentiality (Ghodse, 2005).

• Occupational social work equips the workplace with specialised skills and has a significant role to play, along with employee assistance programs, to assist companies in tackling substance dependency problems within the workplace (Straussner, 1990; Magorosi, 2009).

1.4 ANTICIPATED VALUE OF THE STUDY

Firstly, due to the problematic factors and negative effects resulting from substance dependence in the workplace. This research study provided awareness as well as a better understanding of the dynamics and the phenomenon of substance use in the workplace context. Secondly, given that there is a dearth of research evidence highlighting the perceptions of employees' experiences of rehabilitation and their reintegration into the workplace, this research study contributed towards the knowledge base. Thirdly, exploring substance use in the workplace and the reintegration processes of employees provided a better understanding of the experiences and possible challenges faced by employees with substance use-related problems. Lastly, this research study aimed to add value to the development of comprehensive guidelines and interventions to support and work towards alleviating substance dependence in the work environment. The findings were

derived from the lived experiences of service users and aimed to positively contribute to the amendment and improvement of workplace policies and employee assistance programmes.

1.5 RESEARCH AIMS AND OBJECTIVES

1.5.1 Primary aim

The primary aim of the research study was to explore the experiences of employees undergoing rehabilitation and their reintegration to the workplace.

1.5.2 Secondary Objectives

- To understand the experiences of substance-dependent employees after disclosing their substance dependency to line managers.
- To identify factors that motivated the employees to rehabilitate their lifestyle.
- To investigate and describe the support systems that existed within the workplace before, during and after rehabilitation.
- To understand the relationship between substance-dependent employees and their colleagues, employers, supervisors, and managers.
- To explore substance-dependent employees' experiences in their work life. (pertaining to work conditions, views of alcohol and drugs in their workplaces, experiences of disclosing or hindrance of disclosure, support structures in the workplace, knowledge of workplace substance abuse policies and fears of returning to work).
- To explore non work-related experiences of substance-dependent employees (pertaining to personal contributing factors motivating their substance use and effects of substance dependency on their personal lives).

1.6 BRIEF OVERVIEW OF RESEARCH DESIGN AND METHODOLOGY

The research focused on exploring the experiences of substance-dependent employees in rehabilitation and their reintegration into their workplace. The research design used for this study was an exploratory case study design. The research foundation stemmed from the use of a qualitative research design method using face-to-face semi-structured interviews. Rajen and

Rischa (2015) explain that qualitative research is a form of social science where the focus is on understanding peoples' worlds, interpreting their experiences and making sense of it.

Two separate face-to-face semi-structured interviews which unfolded in two phases were used as the method of data collection in the research study. The researcher had a set of predetermined questions on an interview schedule which were used to guide the interview and included open-ended questions. Sacks et al. (as cited in De Vos, 2011), asserts that active interviewing is not confined to asking questions and recording answers as one would in ordinary conversations, but rather relies on attentiveness, monitoring, and responsiveness.

The first face-to-face semi-structured interview were conducted with eighteen participants during their rehabilitation programme at an alcohol and drug rehabilitation centre in Johannesburg. This interview focused on exploring experiences relating to the disclosure of their substance dependence to management. Identifying their motivating factors for rehabilitation, investigating the support systems that existed before rehabilitation, their work-related experiences such as work conditions, workplace relationships, workplace culture and substance abuse policies, as well as their fears of returning to work were investigated. The second face-to-face semi-structured interview were conducted with eight participants who had returned to their workplaces after their rehabilitation programme. These interviews focused on exploring support systems that existed within the workplace during and after rehabilitation. The non-work-related experiences, such as personal contributing factors motivating their substance use and the impact of their substance dependency on their personal lives were also explored.

The participants that were involved in this research study were employees from workplaces situated in Gauteng and were service users of an in-patient alcohol and drug rehabilitation centre in Johannesburg. The participants were chosen using purposive sampling and there were eighteen participants in this research study. Creswell (2014) explains that this form of sampling is used in qualitative research and that participants and sites are selected that can purposefully inform an understanding of the research problem of the study. The participants chosen to participate in the study were existing service users. Participants were a consistent part of the research study unless they decided that they no longer wanted to take part in the study.

Creswell (2011) explains that qualitative data analysis is first and foremost a process of inductive reasoning, thinking and theorising which strays from structured, mechanical and technical procedures to make conclusions from empirical data of social life. According to Patton (2002), the qualitative analysis process involves transforming data into findings. This involves reducing the volume of raw data information, shifting significance from details, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. The qualitative data gathered from the interviews were analysed using thematic content analysis. Thematic content analysis was used to establish the research findings by identifying the relevant and main themes from the raw participant data (O' Leary, 2004). Making use of the thematic analysis process assisted the researcher to identify common themes and patterns. The researcher used steps outlined by Tesch (1990) as cited in (De Vos, 2011), as well as Braun and Clarke (2006) which provided a structural format for discussion and analysis of the findings in this research study.

1.7 THEORETICAL FRAMEWORK UNDERPINNING THE STUDY

Substance dependency is a multifaceted phenomenon and can therefore not be viewed in isolation. The theoretical framework that underpins this research study includes the coping and social learning model which views substance dependency as a result of poor or inadequate coping mechanisms, and also emphasises social and cognition influences (DiClemente, 2018). In addition to the coping and social learning model, this study made use of the social-ecological model. The social-ecological model focuses on the substance dependent individual and his/her environment (Duncan, Bowman, Pillay & Roose, 2007). The theoretical framework will be further elaborated on in Chapter 3.

1.8 LIMITATIONS OF THE STUDY

The limitations of this research included the following:

• Given the small sample size of eighteen participants, the findings obtained cannot be generalised to the broader South African workplace context and/or population.

• The research study focused on the experiences and perspectives of the employees who depend on substances. No contact was made with their employers or workplaces due to confidentiality preservation. Employers are identified as key stakeholders within the workplace. Therefore, not incorporating and having contact with them to find out about their perception of substance dependence is a barrier to developing holistic approaches to mitigate substance dependence in the workplace.

• The sensitive nature of the study may have possibly led to participants withholding or distorting crucial information to protect themselves. The researcher, however, ensured that all participation was voluntary and that participants were fully informed regarding the aim and the nature of the study before the interviews were conducted.

• The availability of participants was not consistent due to the reported experiences of relapse, disconnection with the rehabilitation centre after the completion of their treatment, failure to return to their workplace, as well as participants choosing to withdraw from the research study. The aforementioned factors, as well as the general nature of the study, resulted in the extension of the data collection period.

1.9 DEFINITION OF TERMS

Substance dependence: Refers to learned habits which, when developed, become difficult to stop despite the associated negative consequences (DiClemete, 2018). An individual is identified to be dependent on a substance when it becomes difficult or impossible for him/her to refrain from taking the substance without help, after having taken it frequently for a period of time. The dependence may be physical or psychological or a combination of both (National Drug Master Plan, 2013-2017).

Substance abuse: Refers to misuse and abuse of legal or licit substances such as alcohol, over-the-counter and prescription medication, nicotine, alcohol concoctions, inhalants, solvents, and indigenous plants, as well as the use of other illegal or illicit substances (National Drug Master Plan, 2013-2017)

Rehabilitation: Refers to “rehabilitation usually follows an initial phase of treatment in which detoxification, and if required, other medical or psychiatric treatment occurs. It encompasses a variety of approaches including group therapy, or specific behaviour therapies to prevent relapse.” (United Nations Office on Drugs & Crime, 2002).

Treatment: Refers to “a process aimed at promoting the quality of life of the drug dependent individual and his/her system (husband/wife, family members and other significant persons in his/her life) with the help of a multi-professional team” (National Drug Master Plan, 2013-2017).

Aftercare and reintegration: Refer to “on going professional support to a service user after a formal treatment episode has ended in order to enable him or her to maintain sobriety or abstinence, personal growth, and to enhance self-reliance and proper social functioning” (Prevention of and Treatment for Substance Abuse Act 70 of 2008).

Workplace: Refers to “A building or room where people perform their jobs” in *Cambridge Dictionary*. Retrieved from https://dictionary.cambridge.org/dictionary/english/workplace

Employees: Refers to “any person, excluding an independent contractor, who works for another person or for the State and who receives, or is entitled to receive, any remuneration; and any other person who in any manner assists in carrying on or conducting the business of an employer” (Labour Relations Act 66 of 1995).

Occupational social work: Refers to "a field of practice in which social workers attend to the human and social needs of the work community by designing and executing appropriate interventions to ensure healthier individuals and environment" (Googins & Godfrey, 1987, p.5).

1.10 OVERVIEW OF THE RESEARCH REPORT

The research report consists of six chapters:

Chapter 1: The first chapter of the research report provided an outline and introduction to the study. In the introductory chapter, the researcher highlighted the motivation for conducting the study. The problem statement was discussed whereby the nature of the problem is explained. The pre-understandings and the anticipated value of the study were also presented. This chapter

provided a brief description of the research design and methodology. The research aims and questions that the research study sought to explore were clarified as well as the limitations. The definitions of keywords were presented and finally, an overview of the research report was provided.

Chapter 2: This chapter presents the literature review, which goes on to provide an exploration into the understanding of substance abuse and dependency. Relevant literature is conceptualised and discussed. The overall aim of the literature review is to provide an overview of the theoretical framework and developments in research. Firstly, concepts of substance are defined and discussed, classification of substance abuse is provided. The processes, prevalence, aetiologies, and effects of substance abuse are discussed, as well as the theories and models of chemical dependency, stages of change, substance abuse treatment approaches and settings.

Chapter 3: In chapter three a literature review will be provided on the exploration of substance abuse and dependency in the workplace. The prevalence of substance abuse and dependency in the workplace as well as the effects will be discussed. Additionally, the impact of alcohol and drug dependency on co-workers will be explored. Employer's responses and workplace culture regarding substance abuse and dependency will be addressed. Workplace interventions to resolve substance abuse and dependency in the workplace will be presented. Lastly, relapse and reintegration, as well as workplace policies, programmes and guiding legislation and the theoretical framework underpinning the study, will be addressed.

Chapter 4: In this chapter, the methodology and research design underpinning the research study is explained, as well as the strengths, limitations, and rationale of the research design. The primary aims of the research study, research objectives and questions are then presented. Additionally, aspects such as the research population, criteria, and sampling procedure, research tools, instruments and methods of data collection and analysis are discussed. Lastly, the details regarding the trustworthiness and ethical considerations of the study are also explained.

Chapter 5: In chapter five a discussion on the results gathered from the research study is analysed on an exploratory level. The data collected through the use of face-to-face interviews is presented and discussed. The researcher demonstrates the qualitative data using themes and

quotations that reflect the insight and views provided the participants. This chapter will then discuss and compare the findings to existing literature, as well as reflections from the researcher's assumptions and thoughts. The aim of this chapter is to demonstrate the participants' experiences, and create awareness and understanding, and to respond to the research questions that the study sought to explore.

Chapter 6: In conclusion the final chapter of the research report will summarise the main findings and link them to the primary aims and objectives and the anticipated value of the research study. An overall evaluation of the strengths, limitations and concluding comments will be provided, as well as recommendations for future research, theory and practice will be discussed based on the research findings.

1.11 CONCLUSION

Russell Brand, (2007), a well-known drug and substance abuse activist stated that the mentality and behaviour of individuals who are dependent on substances is wholly irrational until you understand that they are completely powerless over their addiction and unless they have structured help, they have no hope. This chapter provides an overview of the study by introducing key aspects underpinning this research study. The problem statement and motivation of this study is discussed, followed by the pre-understandings and the anticipated value of the study is highlighted. Furthermore, the aim, objectives and research questions that guide this study were presented and lastly, a brief overview of the research design and methodology is provided, as well as the limitations of the study and definition of key terms.

CHAPTER TWO

LITERATURE REVIEW

UNDERSTANDING SUBSTANCE ABUSE AND DEPENDENCE

2.1 INTRODUCTION

Substance abuse and dependency are the cause of numerous devastating effects that have sparked an interest in research globally. The complexities of substance abuse and dependency have highlighted the very complex nature of substance dependency. The National Drug Master Plan (2013-2017) for example stated a number of such complexities resulting from the harmful use of alcohol and drugs. Firstly, it points out the negative impact on health due to increasing rates of alcohol fetal syndrome, premature mortality, the increase in communicable diseases such as HIV/AIDS, as well as the effect of cancer, heart disease, and psychological disorders. Secondly, the impact on safety and economic development, which includes issues such as the loss of employment, and risk of unemployment, individuals dropping out of school, violent crime, and conflict with the law. Thirdly, the growing impact of social costs resulting from the breakdown in the development and function of families, communities and workplaces, is further intensified by discrimination, stigma and exclusion. Consequently, findings in the World Drug Report 2018 signal the urgent need for the global community to improve its responses and efforts to mitigate this challenge.

In light of the of the complexities explored above, it could therefore be concluded that substance abuse and dependency is a phenomenon that cannot be studied, explored or understood in isolation in order to be thoroughly understood. This literature review provides an exploration into the understanding of substance abuse and dependency. Relevant literature is discussed in relation to a broad range of theories, approaches, diagnostic issues, aetiological perspectives and processes explaining and describing substance abuse and dependency phenomenon. This chapter aims to bring a general overview of substance abuse consisting of types of substances, effects, consequences and other debates inherent in substance abuse.

2.2 UNDERSTANDING OF SUBSTANCE USE DISORDERS

There are numerous understandings of substance use disorders, as well as various personal views, thoughts and experiences. Interestingly, the way in which substance dependency is perceived is said to have practical implications on the way individuals with an alcohol or drug dependency are treated by their families, professionals and the government (Van Wormer & Davis, 2013). Similarly, Robinson and Adinoff (2016) argued that influences such as religion, culture, work, social and political factors not only play a significant role in shaping ones perceptions and attitudes, but also impact and affect aspects such as funding towards treatment, the legal status, the criminalization and overall views and responses towards substance dependency.

2.2.1 Substance use disorders

The DSM-IV published by the American Psychiatric Association (APA, 2000), emphasises that the diagnosis of a substance use disorder is derived from "a collection of cognitive, psychological and behavioural symptoms, including that the individual continues the use, despite the significant substance-related problems." There is a pattern of self-administration that usually results in tolerance, withdrawal, and compulsive substance use behaviour. According to the DSM-5, the diagnosis of substance use disorder is based on pathological patterns of behaviours related to the use of substances. In further expanding from this definition the DSM-5 provided 11 substance dependency criteria which stem from four main categories: namely, impaired control, social impairment, risky use and pharmacological criteria. The 11 substance dependency diagnosis criteria include;

Table 2.1: The DSM-5 substance dependency diagnosis criteria

The DSM-5 substance dependency diagnosis criteria
1. The individual taking the substance in larger amounts or for longer time period than intended.
2. The individual spending a considerable amount of time expressing the desire to cut down, or control substance use and may report many unsuccessful attempts to decrease or discontinue use.

3. The individual may spend a considerable amount of time obtaining, using or recovering from the substance's effects.
4. Experiencing an intense desire or urge for the drug or substance that may occur at any time but is more likely in an environment where the drug was previously obtained or used.
5. The failure to fulfill role obligation at work, school or home.
6. The continuation of use despite the existence of persisting problems socially, or despite damage made worse by the effects of the substance.
7. The withdrawal from significant family, social, occupational or recreational activities or hobbies and instead prioritising of substance use.
8. The risky use of substances in situations where it is physically dangerous.
9. The continuation of the use of substances even with the knowledge of an existing physical or psychological problem that it likely to be caused by, or made worse by, the use of substances.
10. Requiring an increased amount of substances to achieve the desired effect, or the lack of satisfaction when the usual amount of substance is used.
11. The development of withdrawal symptoms which is relieved when consuming more of the substance.

In addition to the aforementioned substance dependency diagnosis criteria, the DSM-5 explains that substance use disorders occur in a board range of severity, ranging from mild to severe depending on the criteria identified. Mild substance use disorder is suggested as a result of the presence of two to three symptoms, moderate use by four to five symptoms and severe use by six or more symptoms (APA, 2000)

2.2.2 Substance induced disorder

The DSM-5 presents substance induced disorders which include three main categories namely, intoxication, withdrawal and other substance/medication-induced mental disorders, such as substance-induced psychotic disorder and substance-induced depressive disorder.

2.2.2.1 Intoxication

The essential features of intoxication include the development of a reversible substance specific syndrome due to the recent use of substances. The problematic behaviour or psychological changes associated with intoxication include violence, mood imbalances and impaired judgment.

2.2.2.2 Withdrawal

The essential features of withdrawal include the development of substance-specific problematic behavioral change, with psychological and cognitive associations due to the end of, or the reduction in, heavy and prolonged substance use. Withdrawals cause significant distress or impairment in social, occupational and other important areas of functioning. Therefore, most individuals with withdrawal have the urge to continue the use of substances to reduce the withdrawal symptoms.

2.2.2.3 Substance/medication-induced mental disorders

These are potentially severe, usually temporarily, but sometimes persisting central nervous system (CNS) syndromes that develop in the context of the effects of substance abuse, medications or several toxins. They are distinguished from the substance use disorders in which a cluster of cognitive, behavioral and psychological symptoms, which contribute to the continued use of a substance despite significant substance-related problems (Caphrina 2009)

2.3 THE UNDERSTANDING OF KEY TERMINOLOGY AND DEFINITIONS

2.3.1 Drug: In medicine, a drug is defined as any substance with the potential to prevent or cure disease or enhance physical or mental well-being. In pharmacology, it is referred to as any chemical agent that alters the biochemical or physiological process of tissue or organism. In general use, the term is used to refer to psychoactive or dependence producing substances and often more especially to those that are illicit (NDMP 2013-20117).

2.3.2 Illicit drug: Is defined as a psychoactive substance of which the production, sale or use is prohibited (NDMP 2013-2017).

2.3.3 Licit drug: Is defined as a drug that is legally available by medical prescription in the jurisdiction in question or, sometimes, a drug legally available without medical prescription (NDMP 2013-20117).

2.3.4 Psychoactive substances or drugs: Is defined as a substance that "when in use by a living organism, may modify its perception, mood, cognition, behaviour or motor function" (United Nations International Drug control Programme, 1997).

2.3.5 Misuse: The term misuse is the result of a psychoactive substance being consumed in a way that it was not intended for and which causes physical, social and psychological harm. It may take the form of a physical or psychological dependence or be part of a wider spectrum of problematic or harmful behaviour (Rassool, 2011).

2.3.6 Abuse: Abuse is about the bodily intake of drugs (legal and illegal) of natural or synthetic derivation that affect the central nervous system of the user. If used regularly, these drugs tend to be habit-forming and cause physical and psychological dependence (Mogorosi, 2009).

2.3.7 Dependence: A person is classified to be dependent on a substance when they experience difficulty or find it impossible to refrain from taking the substance without professional assistance, after having taken it for a period of time. The dependence may manifest physically or psychologically, or both (NDMP 2013-2017).

2.3.8 Physical dependence: Physical dependence is characterised by the need to use a psychoactive substance to avoid physical disturbances or withdrawal symptoms following the ending or reduction of use (Rassool, 2011).

2.3.9 Psychological dependence: Psychological dependence is described as a compulsion or an intense craving to continue to use the substance because of the need for stimulation or to relieve anxiety or depression (Rassool, 2011).

2.3.10 Addiction: Diclemente (2018, p.12) presents a definition of addiction that is understood as "learnt habits, that once established, become difficult to extinguish even in the face of

dramatic and, at times negative consequences." This definition is found to be more appropriate due to the negative connotations of addiction. This view is echoed in the use of the phrase "substance dependent" in the title of this research study.

2.3.11 Tolerance: According to Rasool (2011) tolerance refers to the way the body usually adapts to the repeated presence of a substance. Higher quantities or doses of the psychoactive substance are required to reproduce the desired or similar behavioural effects.

2.4 CLASSIFICATION OF DRUGS

Similarly, to the defining terms discussed above, literature provides a number of ways to classify drugs, some more complex than others. The National Drug Master plan, (2013-2017) states that drugs are commonly classified in three main groups, namely depressant, stimulant, and hallucinogens. In addition, Barlow & Durand (2011) present five main categories of substance abuse that include the three main groups - namely depressants, stimulants and hallucinogens, and also include opiates and other drugs of abuse. This classification comprises of the following;

2.4.1 Depressants: These substances result in behavioral sedation and can induce relaxation. Drugs that are included in the category of depressants include: alcohol, sedatives, hypnotics and anxiolytic drugs in the families of barbiturates and benzodiazepines (for example, Valium and Xanax).

2.4.2 Stimulants: These substances resulting in the increased activity, alertness and elevation of moods. Drugs included in the category of stimulants include cocaine, nicotine, and caffeine.

2.4.3 Hallucinogens: These substances result in the altering of sensory perceptions and can produce delusions, paranoia and hallucinations. Drugs included in the category of hallucinogens include marijuana and LSD.

2.4.4 Opiates: The major effects of these substances are to primarily produce analgesia (reduce pain) and euphoria. Drugs included in the category of opiates include Morphine, Codeine, heroin, opium. Marijuana and LSD is also included in this category.

2.4.5 Other drugs: substances in this category are abused but do not fit into one of the other categories. These include inhalants, anabolic steroids, and other over the counter medications.

These drugs produce a variety of psychoactive effects with characteristics described in the previous categories.

2.5 TYPES OF DRUGS AND THEIR PHYSICAL EFFECTS

Colligan (2011) explains that the human body is not designed to be in overdrive. Normally, the body maintains a state called homeostasis. This means that the brain's natural chemicals balance sleep-wake cycles, growth, alertness, moods, digestion, breathing, blood circulation, and much more. All drugs affect the body's homeostasis. In this section some of the common types of drugs and their physical effects will be discussed in relation to the drug classification and also present the effects of each drug.

2.5.1 Depressants

In contrast to the aforementioned stimulants discussed, depressants tend to slow a person down, decreasing behavioural activity and level of awareness. Regular use of depressants tends to lead to tolerance and discontinuing their use or cutting down on the dosage or frequency can produce withdrawal symptoms.

- **Alcohol**

Chronic drinking leads to tolerance and withdrawal hence the development of dependence. According to the national institute of alcohol abuse and alcoholism (2005), alcohol dependence is marked by four symptoms. These include; the craving, which is a strong need or urge to drink. The loss of control, which consists of not being able to stop drinking once drinking has begun. Physical dependence, which results in withdrawal symptoms, such as nausea, sweating, shakiness, and anxiety after drinking has stopped. Tolerance on the other hand causes a person to need to drink greater amounts of alcohol to feel intoxicated.

2.5.2 Sedative-hypnotic drugs

These drugs reduce pain and anxiety, relax the muscles, lower blood pressure, slow breathing and heart rate and induce sedation and sleep. The effects experienced include impaired physical co-ordination, impaired mental judgment and increased aggression. Although these psychoactive substances can lower inhibitions and bring a sense of well-being, they also cause memory

problems, confusion, poor concentration, fatigue and often respiratory arrest (NIDA, 2007). The drugs included in this class are barbiturates, benzodiazepines and methaqualone.

- **Barbiturates**

These include Amobarbital (Amytal), Pentobarbital (Nembutal) and Secobarbital (Seconal) and are usually prescribed to treat sleep problems. Although the use of barbiturates is legal with a prescription this type of medication is commonly abused by both those with a prescription and those who obtain the drug illegally. As with other depressants, repeated use of barbiturates leads to tolerance, so the person takes even larger doses in order to sleep or reduce anxiety. Withdrawal symptoms include agitation, restlessness, hallucinations, confusion and in some cases seizures (NIDA, 2005).

- **Methaqualone**

According to Kraemer & Maur (2008), Methaqualone is described as a powerful sedative, which has a high potential for addiction and was widely used. Consequently, it was therefore scheduled. Methaqualone is a sedative hypnotic drug with pharmacological effects similar to barbiturates. Methaqualone was reported to be have first been produced in 1955 and clinically introduced to the markets in the United States under the name Quaalude and mainly prescribed for insomnia but due to the high physical and psychological dependence it was discontinued. Methaqualone is known in South Africa as Mandrax and is considered to be a highly abused drug. The long-term effects associated with this drug include mood changes, feelings of relaxation, hallucinations, mental and emotional problems seizures, coma and death through overdose, to name a few.

- **Benzodiazepines**

These drugs are usually prescribed to alleviate muscle pain, to aid sleep or as a short-term treatment for anxiety. Examples of benzodiazepines include Lorazepam, Ativan, Tamazepam, (Halcion), Chlordiazepoxide lazepoxide (Xanax). In the case of dependence of benzodiazepines, it is recommended that users generally taper off the drug in consultation with a physician. Abruptly stopping can lead to seizures or psychosis.

2.5.3 Narcotic analgesics/ opiates

Narcotic analgesics are derived from the opium poppy plant or chemically related substance. Narcotic analgesics are sometimes referred to as opiates, or opioids, as well as exogenous opioids. Exogenous opioids include methadone, heroin, codeine, morphine, and synthetic derivatives found in prescription pain relief medications, such as oxycodone (Oxycontin), hydrocodone (Vicodin), meperidine hydrochloride (Dilaudid). These drugs can be injected, snorted, or taken by mouth. Legal, but restricted, narcotic analgesics are usually prescribed however some people abuse these medications, taking them not for their medical effects but instead for the "high" they produce (NIDA, 2008). The main function of this drug is to relieve pain and people who take analgesics for recreational purposes may experience temporary euphoria and pleasant relaxing effects which then fade into apathy, unhappiness, impaired judgment. This category is highly addictive and use can lead to tolerance and withdrawal and compulsive behaviours regarding obtaining and taking the drug (Keene, 2010)

- **Heroin**

Heroin is one of the stronger opioids and very addictive. Unfortunately, the contrast between the euphoria the drug induces, and the letdown that comes when its effects wear off, can drive some individuals to repeatedly crave the euphoria, and so they take the drug again and again which in turn leads to tolerance. Extraordinarily unpleasant withdrawal symptoms can arise within a few hours of the last dose and peak within 72 hours and take up to one week to subside. Symptoms include spells of chills and hot flushes, diarrhea, and extreme restlessness (NIDA, 2007)

2.5.4 Stimulants

According to Colligan (2011), stimulants, as mentioned in the aforementioned classification section, are named for their effects on the central nervous system. They stimulate it, increasing activity and arousal. Stimulants include nicotine, amphetamine, cocaine, crack and MDMA (ecstasy, or "e"). At low doses a stimulant can make the user feel alert, less hungry, and more energetic mentally and physically. The types of drugs that are categories as a stimulant include:

- **Cocaine and Crack**

Derived from the coca leaf, cocaine was a popular medicine for various ailments in the 18th century and it was declared illegal in the 19th century after the realisation that the quest for the drug was being abused and leading to dependence (Rebec, 2000). Cocaine is obtained in the form of a powder and is typically inhaled or "snorted", while crack, in a crystalline form, is smoked. The first few experiences of cocaine use may provide a heightened sense of wellbeing that can last up to one hour. This positive state may become increasingly harder to attain as tolerance develops (NIDA, 2007). Increased use of cocaine may result in the effects of paranoia, to the point of delusions, hallucinations, compulsive repetitive behaviours such as teeth grinding and increased heart rate, and high blood pressure, with the accompanied risk of heart attack and sudden death. Smoked crack acts more quickly than snorted cocaine, and has more intense effects. Like snorting cocaine, smoking crack leads to a sense of wellbeing, however this "high" only lasts a few minutes (NIDA, 2007). As with other stimulants when the crack evaporates, it leaves a sense of depression and intense craving for more of the drug.

- **Methamphetamine**

Another stimulant that is abused and leads to dependence is methamphetamine ("meth" or "speed") which is chemically similar to amphetamine, but has greater and longer lasting effects on the central nervous system. It can be inhaled, swallowed, smoked or injected. Methamphetamine can lead to an intense rush of pleasure and rapid use becomes abuse and then becomes dependence as a user becomes focused on obtaining and using the drug. Both the use of methamphetamine and the behaviours that are required to obtain it can impair functioning (NIDA, 2008). The injection of drugs and often sharing of needles increases the users' risk of contracting or spreading HIV/AIDS. Effects resulting from the use of this drug include irritability, heart problems, hallucinations, and paranoia at high doses of use (Ksir, 2000; NIDA, 2007), impaired memory, lack of emotional regulation, increased blood pressure, and risk of stroke (NIDA, 2007; Thompson, 2004).

- **MDMA (Ecstasy)**

Another stimulant that can be abused is methylenedioxymethamphetamine (MDMA), commonly called ecstasy, or simply “e”. MDMA is usually taken in tablet form. It is chemically similar to methamphetamine and the hallucinogen mescaline and has effects of distorted perceptions. With the first use people report heightened feelings of empathy towards others and greater sensitivity to touch. Additional effects include a sense of wellbeing and warmth towards others, reduced anxiety and distortions of time perception (NIDA, 2007). The abuse of this drug can result in poor mood and difficulty regulating emotions, as well as anxiety and aggression, and sleep problems. Additional side effects include increased blood pressure and heart rate, excessive sweating and acute dehydration.

- **Nicotine**

The active ingredient in tobacco is a stimulant that leads to abuse and dependence. Tobacco use is associated with cancer as nicotine is absorbed into the lungs. Nicotine causes increased alertness but also dizziness, increased blood pressure and irritability and for chronic smokers an increased risk of developing lung cancer and other breathing-related problems (NIDA, 2007). Nicotine withdrawal symptoms include insomnia, anxiety, irritability and concentration problems (Barker, Brandon & Chassin, 2004).

2.5.5 Hallucinogens

Hallucinogens are substances that induce sensory or perceptual distortions, although these drugs are less predictable in their effects. They lead users to think that they see, hear, taste or feel something that is not actually present or not present in the way it is perceived. Hallucinogens frequently taken for recreational purposes include LSD which is a hallucinogen because it alters the user’s visual or auditory sensations and perceptions. It also induces shifting emotions and users may experience synesthesia, which is the blending of senses. LSD normally has an effect within 20-40 minutes of being ingested and the effects last up to 12 hours (NIDA, 2001). LSD can induce a bad experience and result in adverse effects, including, intense fear, anxiety, and dread. A user may feel as though he or she is losing control, going crazy or dying. Recurrent LSD use can rapidly lead to tolerance, meaning that the user needs larger doses. LSD does not

cause withdrawal symptoms; however, LSD can induce enduring psychotic symptoms in a small number of people (NIDA, 2007).

- **Marijuana**

Marijuana consists of the dried leaves and flowers of the hemp plant, cannabis sativa. The resin of the hemp plants flowering top is made into another, more potent drug, hashish. The active ingredient of marijuana and hashish is tetrahydrocannabinol (THC). Marijuana's effects are more subtle than those of the other hallucinogens, resulting in minor perceptual distortions that lead a person to experience more vivid sensations and to feel that time has slowed down (NIDA, 2005). In addition, the user's cognitive abilities are also slowed or temporarily impaired (Ramaekers et al, 2006). THC ultimately activates the dopamine reward system (NIDA, 2000). Like the effects of LSD, marijuana effects depend on the user's mood, expectation and environment. These effects are detrimental to any user and may negatively impact on work, should these effects be known it will be easier to notice the use of marijuana in an individual.

2.6. THE PROCESS OF DRUG USE

Klosterman (2008) argues that the users of substances do not intend to become dependent. Therefore, it is often the case that individuals try a drug once or a number of times and stop. However, for some individuals drug dependence becomes a devastating and life-altering problem. This reveals that the development of dependency or addiction is indeed a unique process. Ross & Deverell (2010) explain that the addiction process occurs over a period of time and can be separated into four stages, which include:

Stage one: Use, most people will at some point in their lives use a psychoactive substance for medicinal purposes. At this stage a drug may be used socially and, or medicinally, with no destructive consequences.

Stage two: Misuse, at this stage the person starts to exceed the recommended dose, without the conscious intent of becoming intoxicated.

Stage three: Abuse, psychological dependency has developed when the user feels that he or she needs the drug to achieve a feeling of wellbeing, or to reach a maximum level of functioning. The person takes too much of the substance too often, which leads to some loss of control. The

consequences at this stage are severe enough to affect an individual's functioning at work, or home or adversely affect his or her health (Schuckit, 2002).

Stage four: Dependency or addiction, at this stage the person has lost complete physical and psychological control over his or her substance use. The individual's mental, physical and social functioning is affected and if intervention does not occur, the addiction becomes life threatening.

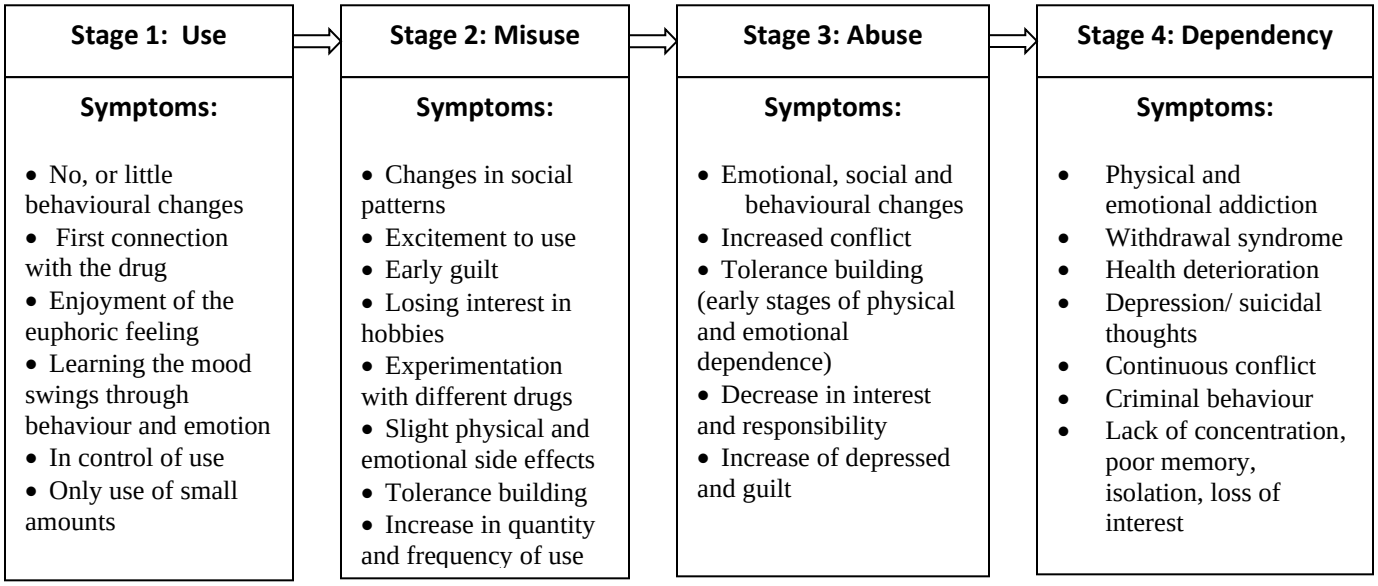

Figure 2.1: The process of drug use information adapted from Bennett &Lehman, (2001).

2.7 CAUSES AND THE PSYCHOSOCIAL EFFECTS OF SUBSTANCE ABUSE

There are many causes of substance abuse. Coomber, McElrath, Measham, and Moore, (2013) point out that there is a variety of theories that explain the substance abuse phenomenon. These explanations provide insight on a frequently asked question, "Why". Coomber et al. (2013) maintain that the reasons why people take drugs emanates from an individual's biological and psychological traits or stem from historical, environmental, economic, social and cultural context in which an individual or social group is situated.

- **Biological Explanations**

Research suggests that that one of the reasons people take drugs stems from a biologically inherited or, genetic predisposition to do so, as a result of a particular combination of genes (Muscat et al, 2009). In addition, research also reflects on a biological vulnerability, this involving an individual's biological makeup as well as environmental influences (Carson, Butcher & Mineka, 2002). Research stresses that in alcohol and drug dependency considerable evidence suggests that genetic factors influence the risk of dependence (Dick & Agrawal, 2008). In support, research also points to observations that highlight that family members often tend to have similar alcohol and drug use levels and therefore on that basis it is argued that heredity is a significant factor contributing to drug dependency (Coomber et al. 2013).

- **Environmental Explanations**

Environmental explanations include factors such as; a chaotic home life, family breakdown, child neglect or abuse, having a history in institutionalized care and educational underachievement. In addition, related problems such as truancy and exclusion from school, unemployment, underemployment and being of a lower socio-economic class. Other factors such as and having parents or siblings who condone drug use, or are dependent drug users themselves, have all been suggested as reasons why people use drugs (Coomber et al, 2013). Environmental factors are said to be a significant precursor in the development of alcohol and drug use, in addition to inherited factors. These include exposure to, or observation of parental attitudes and behaviours related to alcohol and drugs, which may influence the use of alcohol and drug use (Jung, 2001).

- **Psychological Explanation**

There are many questions that motivate research and exploration of psychological vulnerabilities. For example, is there an "alcoholic personality", or a type of character organisation that predisposes individuals to use alcohol or drugs rather than engaging in other defensive patterns to cope with stress" (Dick & Agrawal, 2008 p.386). Psychological explanations as to why people take drugs stem from certain personality characteristics which are typically seen as distinct from non-drug users, such as being more or less neurotic, extroverted, and impulsive or sensation seeking, (Muscat et al, 2009). In relation to psychological well-being it has been found that low

self-esteem, self-rejection, feelings of distress, powerlessness and hopelessness are also significant factors (Thio, 2004).

- **Sociological factors**

According to Milhorn (2017), sociological factors associated with substance dependency include family problems, financial problems, legal problems and isolation. The sociological factors also highlight the effects on intrapersonal, social and family relationships, effects on work and career prospects, finances and effects in relation to the law (Ross & Deverell, 2010).

With regards to family; substance dependence causes many problems in the family as individuals who are substance dependent often neglect children both physically and emotionally, they become violent to their family members, self-centered, and oblivious to other people's concerns (Milhorn, 2017). In addition, drug dependency is said to lead to progressive isolation with hobbies, relationships, and occupation greatly impacted and affected (Milhorn, 2017). Families dealing with a relative suffering from drug abuse experience significant pressure and may react to the issue by developing behaviors such as responsibility, acceptance, adoption of paternal approach, complete disconnection of the communication with the drug abuser, and withdrawal from the issue (Roskam, Zech & Nills, 2008).

Regarding financial problems, Milhorn (2017) characterised financial problems as the economic struggle of substance dependent individuals, which may result from missing work, losing their jobs, making poor financial decisions and spending large amounts of money on their drug use. Additionally, the history of substance use may also result in paying higher medical insurance premiums. Health risks, illness and physical injury associated with drug use can lead to higher medical expenses. And lastly, according to Milhorn (2017), using alcohol or other drugs slows the functioning in the brain, and may therefore lead to car accidents due to driving under the influence. In addition, the experience of intense drug cravings and withdrawal symptoms may result in drug dependent individuals committing crimes to get drugs or money to buy them, which leads to legal issues.

- **Taking drugs for fun and pleasure**

An additional explanation as to why people take drugs stems from the suggestion that drug users experience pleasure from drugs and from being intoxicated, or that specific drugs fulfill particular functions in people's lives - such as gaining confidence, feeling calmer, or relieving boredom (Coomber et al, 2013). In addition (Durrant and Thakker, 2003) also highlight social factors or rationale, such as "because they feel good", 'they help me remove stress", "in order to socialise". In an attempt to further explain the thrilling connotation to substance use, Shefor, and Horejsi (2010) explain that patterns of dependency are embedded in the learning process. In South Africa, many substance users and abusers use it mainly in the name of socializing before they are aware of dangers such as the possibility of addiction. Therefore, each time the experience of the individual's substance use provides the desired effect it increases the likelihood of the individual continuing to use. This includes the effects of substance use on one's emotions, and behaviour (Ross & Deverel, 2010).

- **Stress, emotions and addictive behavior**

Stress is identified to be a common risk factor in developing a substance dependency, as well as causing relapse. Stress has long been known to increase vulnerability to substance dependence (Sinha, 2008). The term stress refers to the process of involving perception and response to harmful, threatening or challenging events (Sinha, 2008). Examples of emotional stressors include interpersonal conflict, loss of a relationship, a death of a close family member, and loss of a child. The increased use of alcohol and drugs, both licit and illicit, is identified to be common methods used to numb the pain of bereavement (Csiernik, 2005). In addition, common psychological stressors include hunger, food deprivation, sleep deprivation or insomnia, extreme hyperthermia, and drug withdrawal states. Additionally, research explains that not only stress but also the individual's ability to effectively cope with stress, through effective problem solving, conflict resolution and behavioural and cognitive control, continues to affect the likelihood of substance use (Hyman & Sinha, 2009).

- **The experience of trauma and post-traumatic stress**

According to the APA (2000), the diagnosis of post-traumatic stress emanates from exposure to a traumatic event in which a person experiences, or witnesses an event, or events, that involves real or threatened bodily harm resulting in feelings of intense hopelessness or horror. Dass-Brailsford and Myrick (2010) point out that high rates of trauma exposure have been observed in both male and female substance-using populations and maintain that there is a growing body of literature that shows a strong association between post-traumatic distress (PTSD) and substance use disorder (SUD). In support, Najauts (2015) highlights a number of research studies and clinical observations showing the important linkages between substance use disorder and trauma, as well as trauma-related disorders such as post-traumatic stress. Najavits, Ruglass, Hien and Reid (2017) go on to explain that childhood trauma, and more broadly childhood maltreatment (physical, sexual and emotional abuse and neglect) shows important associations with substance use disorders. Trauma can affect the initiation of substance use disorder, including relapse following treatment. Although trauma can lead to dysfunction at any stage of development, childhood trauma is especially important in setting the stage for substance use disorder that is often chronic and severe. In fact, adverse events in childhood have been correlated with the onset of alcohol use at an early age (Bailey & Steward, 2014; Dube, et al, 2006).

2.8 DRUG USERS' PERSPECTIVES ON DRUG USE AND DEPENDENCE

To further expand on the causes and psychological effects a research study by Keene (2010) will be presented. The research study provides findings that describe drug users' views on their drug use and dependency. Firstly, Keene (2010) explains that findings pertaining to the individual's positive and negative reasons for starting to use substances indicate positive feelings associated with their initial use. In summary, the perceptions of the users included thrilling and positive feelings associated with the substance, such as:

The positive effects of starting drugs include what is described as "the rush", feeling happy and excited, being friendly and being confident and feeling that one is the best person around (Keene, 2010).

Van Wormer & Davis (2013) state that in order for one to understand the pain associated with substance dependency it is important to first understand the pleasure side of these activities. The

above-mentioned positive effects highlight different pressure and attractiveness which has sparked their use initially. In contrast to the above mentioned positive feelings, participants also shared their views on the negative effects of drug use. The main problems identified resulted from the downers experienced after using drugs are as follows, paranoia which is lack of sleep, feeling irritable and aggravated and physical exhaustion (Keene, 2010).

The research study as discussed by Keene (2010) explores the reasons for participants becoming dependent and points out that a common explanation for drug dependence resulted from the use as a form of coping and self-medicating. This included the use of drugs for coping and self-medicating purposes.

On further reasons why people take drugs, Volkow (2010) points out three major uses or attractions. He explains that initially individuals take drugs to feel good or to enhance their sense of pleasure. In this case, with stimulating drug use the euphoria is usually coupled by feelings of power, self-confidence and increased energy. The use of a depressant or sedative will lead to feeling relaxed and satisfied. Secondly, Volkow (2010) proceeds in explaining that people who suffer from anxiety and stress-related disorders may be attracted to the use of substances to feel better and in turn cope better. Lastly, Volkow (2010) states that the third reason that prompts substance use stems from the desire to do better. This includes enhancing one's performance when undertaking various tasks.

2.9 DRUG DEPENDENCY AND ITS IMPACT ON FAMILY RELATIONSHIPS

According Lander, Howsare and Byrne (2013), individuals with a substance dependency cannot be viewed, understood and treated effectively without considering the impact on the whole family. In support of that approach, Lander et al, (2013) point out that researchers have confirmed a reciprocal relationship between substance dependency and the environment. In this regard, it is acknowledged that individuals influence their social environments and as a result are also influenced by it.

Miller, Forcehimes and Zweben (2011) explain that embedded in the family is the pattern that is more than sum of its parts. This highlights that any change in behaviour of one of its members does not only affect the individual family member but instead, affects the entire family system.

Van Wormer and Davis (2013) maintain that in some instances the level of suffering is so extreme that the family unit barely functions.

2.10 CONSEQUENCES OF SUBSTANCE DEPENDENCY

- **Consequences on couple and marital relationships:**

Kuhn and Slabbert, (2017) present consequences of substance dependency on the couple or marital relationship, namely the fact that the nature of substance dependency often leads to dysfunction. For example, the female partner often attempts to maintain the homeostasis of the family system. This often results in the partners covering up for the maladaptive behaviour and this is described to be co-dependence (Kuhn & Slabbert, 2017). Co-dependency is characterised by the development of unhealthy patterns in efforts to deal with, or cope with his/ her companion's substance dependency (Fisher & Harrison, 2013). In addition, it is also identified that conflict in the couple or marital relationship may take on a violent form. Based on this, much evidence presents that often domestic violence results from substance use, but this is not always the case.

- **Consequences on parent-child relationship**

Kuhn and Slabbert (2017) point out that excessive substance use can have a negative effect and impair the functioning as a parent, as a partner, as well as a contributor to the family's well-being. Substance use requires time, which imposes on, and limits time that should be dedicated to family responsibility, or simply just spending quality time together (Kuhn & Slabbert, 2017).

- **Consequences on sibling roles and relationships**

According to Kuhn and Slabbert (2017), a major contribution of children's well-being depends on the trust and love from the people who take care of them. Therefore, children who are exposed to substance dependency disorders or behaviours may be exposed to the experience of various forms of neglect and feel a sense of abandonment. In addition, there can be a significant occurrence in sibling relationships called "parentification". According to family systems theory

this is defined as the process whereby children take on the role and responsibility of adults to compensate for the adults' neglect.

2.11 FAMILY INTERVENTION

Van Wormer and Davis (2013) argue that family-based interventions can be identified as an invaluable approach in preparing the family for necessary change. Furthermore, Van Wormer and Davis (2013) asserts that the emotions such as the anger and resentment that family members harbor should be addressed first before the substance-dependent relative returns home, in the cases of rehabilitation. Van Wormer and Davis (2013) also mentioned that often the family environment is toxic when there is active use of exposure to substance use or behaviors. In this regard, Van Wormer and Davis (2013) presents the view of family as a preventative resource; a system that is identified as both a risk and resilience.

2.12 BRIEF GLOBAL OVERVIEW OF SUBSTANCE ABUSE

Alcohol, tobacco and illicit drug use are described as global risk factors (Peacock et al. 2018). These harmful and negative risk factors are evident from the effects and impacts on communities, families and workplaces globally. Additionally, Geyer & Lambard (2014) explains that substance abuse including alcohol, illicit, psychotropic drugs and drug-related crime, such as drug manufacturing and trade to drug trafficking, is identified to be worldwide phenomenon that impacts negatively and hinders the achievement and outcome of development.

In research conducted by Peacock et al. (2018) it was found that globally, alcohol use and tobacco smoking is more prevalent than illicit drug use. Global estimates from the study highlighted that 1 in five adults report at least one occasional or heavy alcohol use, and one in seven adults were estimated to engage in daily smoking of tobacco, thus highlighting the acute harm, increased risk of cancer, repertory and cardiovascular diseases and exposure to a wide array of other chronic health conditions.

The most recent overview on the global status and trends of drug use and drug supply, as well as related effects and impacts presented by the World Drug Report, 2018, confirmed that more than a quarter of a billion people use drugs. With 31 million people suffering from drug use disorders this means that their drug use is harmful to the extent that treatment may be required. Additionally, the number of deaths resulting from the use of drugs remains high. Mortality rates

are said to include overdose and are indirectly caused from drug use through HIV and Hepatitis C, acquired from unsafe injecting practices. Furthermore, it is also reported that many countries fail to provide adequate drug treatment and health services. Only one in six people suffering from a substance abuse disorder received treatment for those disorders in 2016 and since then, rates have remained constant. Marijuana dominates globally, followed by an increase in cocaine-related substances and opiates. The latter is relevant to the South African context and may have increased due to the legalization of marijuana.

2.13 BRIEF OVERVIEW OF SUBSTANCE ABUSE IN SOUTH AFRICA

2.13.1 History of alcohol and drugs in South Africa

According to Ellis, Stein and Meintjies (2012), the issue with alcohol in South Africa can be traced back to the early years of the Dutch settlement. Dutch farmers come to the Cape and implemented the 'dop' system. In the early 1900's laws were established in an attempt to control the drinking of the "natives" and this resulted in the increase of illegal shebeens, resulting in further unmonitored drinking. In contrast in the 1990's to 1994 was characterised as a time of psychotropic substance use in South Africa, however heroin and cocaine was not widely used till late 1994.

In his opening address in 1994, the late president Nelson Mandela acknowledged alcohol and drug use to be a problem that warranted intervention (Ellis, Stein & Meintjies, 2012). Since then it has been confirmed that the end of apartheid resulted in an increase in South Africa's vulnerability to illicit drug trafficking (Ellis, Stein & Meintjies, 2012). South Africa is identified to be one of the main trans-shipment routes of illegal drugs, due to the air and sea travel connections passing through South Africa to many parts of the world, offering drug trafficking opportunities that did not exist before. Additionally, the country's geography, porous borders, and expanding international trade links have contributed to South Africa becoming an attractive and popular drug transit country (Ramlagon & Peltzer, 2012).

2.13.2 The use of substances in South Africa

Regarding the use of substances, South Africa is reported to have the highest lifetime prevalence of substance use disorders across the globe (Geyer & Lombard, 2014). Additionally, South

Africa follows worldwide trends in having alcohol as the major substance that is misused, with up to 6% of the population being classified as heavy drinkers. Parry estimates that one in four males and one in ten females in South Africa experience symptoms of abuse (Parry, 2005). Substance abuse treatment centers in South Africa report alcohol as a primary substance of abuse and over half of the patients having alcohol as a primary or secondary drug of abuse. The Central Drug Authority (CDA) estimated that 7.5% of the population engages in risky drinking over the weekend and 31.5% of the population aged between 25 and 45 years engages in "binge drinking." Additionally, the average person is said to consume 20 litres of alcohol in a month (Sacendu, 2018). Additionally, incidences of fetal alcohol syndrome (FAS) are reported to be the highest in the world (Stein, Ellis, Meintjies & Thomas, 2012). In addition to the high rates of alcohol misuse, Mogorosi (2009) states that the most widely illegal drug used in South Africa is marijuana. In fact, South Africa is identified to be the third largest producer of marijuana. After marijuana; mandrax is the second most popular illegal drug in South Africa (Peltzer & Ramlagan, 2007; Mogorosi, 2009).

A trend in South Africa regarding substance use that has been identified is that individuals with alcohol dependency rarely use other substances as well. Substance users are referred to rehabilitation centres through various routes. The most common of these being pressure by family and friends, resulting from work-related absenteeism, through legal and financial sources, due to non-payments of bills and maintenance, or the medical route resulting from accidents or referral by general practitioners and through self-referral (Sacendu, 2018).

2.13.3 Relevant debates related to substance abuse and dependence

Regarding relevant debates relating to substance abuse two aspects will be briefly discussed. Firstly, the legalisation of marijuana and secondly, the argument and debates around the advertisement of substances will be briefly discussed.

Larkin (2018) argues that what someone thinks of marijuana can determine who the person is, and their relation to substance. He further explains this by highlighting that to a botanist, user and narcotic official the substance will represent different meaning and regulations. Larkin (2018) asserts that at the center of that debate has been the issue of whether marijuana has legitimate medical use, its addictive qualities and physical and psychological harmful nature. He

maintains that numerous articles articulate and examine those issues uniquely, and from that powerful state laws were produced on marijuana in South Africa.

Furthermore, Larkin (2018) goes on to highlight arguments in favour of the reform of marijuana laws and legalisation, which include the argument that marijuana has legitimate medical use, particularly when smoked. The use of marijuana is said to treat chemotherapy-induced nausea, vomiting, increase appetite and decrease weight associated with HIV/AIDS, to address neuropathic pain and alleviate chronic pain and assist with sleep disturbances, to name a few. In addition, it was further argued that marijuana is no more harmful than tobacco and that there are no actual reports highlighting deaths from marijuana overdose in comparison to other drugs. It is identified to be beneficial due its uses in lieu of morphine (Larkin, 2018). And lastly, as a matter of social policy, the criminal justice system cannot discourage marijuana use at a cost society considers acceptable.

Aggressive enforcement of marijuana laws has not and cannot prevent the supply of an easily cultivated drug that can be grown almost anywhere. The pursuit of contemporary drug enforcement will only waste the criminal justice system's scarce resources. Larkin (2018) maintains that a society generally permits adults to make informed decisions - whether to knowingly engage in even dangerous activities and, lastly, marijuana use is not considered harmful.

In contrast to the aforementioned arguments on the reform of marijuana, Larkin (2018) presented the arguments that are against the reform of marijuana, which include the argument that there is no good reason to exempt marijuana use, which is also supported by the safety laws. Additionally, liberalised use of marijuana for medical or recreational purposes may result in increases in mortality and affect mobility due to the effects of THC, which can affect a driver's ability to quickly and effectively process and respond to unexpected situations while driving. Lastly, the legalisation of marijuana is said to eliminate the leverage that can be used to compel dependent users to seek treatment, which negatively compromises the nation's efforts to prevent or reduce physical, sexual and financial harm through drug use.

2.14. TREATMENT APPROACHES AND SETTINGS

Firstly, it is important to point out that there is a lot that takes place prior to, during and after the substance-dependent individuals make the decision to rehabilitate their lifestyles. To explain this process, DiClemente (2013) presents the stages of change which individuals undergo:

2.14.1 STAGES OF CHANGE

Pre-contemplation stage: An individual in the pre-contemplation stage is satisfied with, or at least unwilling to disrupt, a current behaviour pattern. Pre-contemplators are not considering a change in the foreseeable future - most often defined as a period of six months to a year (Diclemente, 2013).

Contemplation stage: An individual in the contemplation stage has begun thinking about changing his or her behaviour but has not made a firm decision to change and is not yet engaged in actual behaviour change strategies. Among substance abusers, contemplators are seriously pondering on quitting or reducing their substance use (DiClemente, 2013).

Preparation stage: Individuals in the preparation stage are planning to initiate change in the near future and in many cases have learnt valuable lessons from their past attempts at change and from failures associated with those efforts (Prochaska & DiClemente, 1992). The individual at this stage has resolved the decision making challenges faced during contemplation and has committed to a change plan soon to be implemented (DiClemente, 2013).

Action stage: Action is the stage in which individuals modify their behaviour, experiences or environments in order to overcome their problem. The two central features that characterise individuals in the action stage include, firstly, a firm and clear decision to change and the commitment to that change, secondly the appearance of active behavioural manifestations of the commitment to change and the initiation of the change plan.

Maintenance stage: The maintenance stage is characterised by two actions. Firstly, it involves sustaining and further incorporating changes achieved during the action stage into a lifestyle, and secondly is avoiding relapse. Persons in the maintenance stage have accomplished at least some minimal amount of change as a function of successful efforts exerted during the action stage and are on their way to developing a stable pattern of non-using behaviour.

Relapse: Relapse is a major challenge to sobriety and impedes treatment (Becker & Curry, 2008). They have cycled through the other stages, often more than once and achieved a period of maintenance through action. However, in substance abuse relapse is a common and normal occurrence (Denning, 2000).

2.15 TREATMENT PROGRAMMES

Early intervention programmes: According to Daley and Marlatt (2006), this level of intervention refers to "pre-treatment" approaches, which may or may not lead to the individual engaging in professional care. An example is driving under the influence programme, also referred to as a diversion programme or other services for the individual at risk for developing a substance abuse problem, or for whom there is not enough information to document a disorder at the current time.

Out-patient and aftercare programmes: According to Daley and Marlatt (2006), these programmes vary in length from several weeks to a month or longer. They may precede or follow rehabilitation programmes or be used as a sole treatment. The purpose of aftercare programmes is to help the client achieve and maintain abstinence or reduce harmful substance use, as well as to make personal changes to facilitate ongoing recovery and minimise relapse risk. Individual, group and family therapy and medical treatment may be included depending on the specific setting. Outpatient treatment is found to be suitable for clients who are not at risk of withdrawal complications, have a stable medical and mental condition, show a willingness to cooperate with treatment and are able to maintain abstinence with minimal support and have a supportive recovery environment.

In-patient treatment: In-patient treatment programs are almost exclusively abstinence-based and do not typically allows the option of harm reduction. Abstinence is a hallmark of in-patient programmes. Many things have to align to bring about a 28-30 day stay in a rehabilitation programme. Clinical wisdom implies an important advantage in providing a break from the daily grind that interrupts the usage pattern of alcohol or drugs, or both, over a long period of time. It provides the client with a break from work, and family responsibilities and allows complete focus on recovery. In-patient treatment provides a higher level of medical supervision than is available in the community and can help patients to increase the awareness of the trigger or

triggers that place them at risk of relapsing (Weiss, 1994). A month of in-patient treatment can provide the family with an important relief from the stress of living with an alcoholic or drug addict and offer the opportunity to learn more about addiction. Elements that can foster healthy coping skills for people in residential treatments include participation in 12-step, life skills training and cultivation of a network of supportive relationships (Forys, McKellar & Moos, 2007).

Detoxification: Detox services are designed to deal with the effects of alcohol and drugs and the potential for withdrawal symptoms, typically through the use of prescribed medications. Some substance abuse professionals consider detox a form of treatment; to others, it is an important entry into treatment (Mignon, Faiia, Meyers & Rubington, 2009, p. 260).

Individual therapy: According to Daley and Marlatt (2006), individual therapy may typically consist of meeting once a week for approximately 50 minutes to discuss the road to recovery and the addict's most pressing issues. Hamid, (2002) asserts that counselling entails assessing the specific needs of different patients and then providing or directing the patient to the services that meet those needs. Simply giving the patient time to talk about their problems can be, for some, a powerful technique in itself. Including the establishment of realistic goals, which may encompass not just drug taking but include work, leisure time activities and relationships with family and friends, providing practical help aimed at engaging the drug abuser in new ways of managing their time and developing alternative lifestyles. In a practical workplace situation, the feasibility of individual therapy needs to be considered, as workplace productivity is a major cause of hesitancy of employers in addressing substance dependency.

Group therapy: Group therapy has been the most frequently used treatment for substance abuse and has been considered more cost-effective individual treatment because many clients can be treated at the same time (Panas, Caspi, Fournier & McCarty, 2003). The underlying premise is that clients benefit from sharing with others in similar circumstances and the development of supportive relationships. Groups can break a cycle of isolation common among people with addiction problems.

Family therapy: It took some time for the family therapy approach to come to the field of substance treatment. Over time the field has made stronger efforts to incorporate the family into treatment. In-patient treatment rehabilitation programmes have supported the involvement because it improves communication and accountability and supports positive change within the family (Centre for substance abuse treatment, 2004).

Relapse Prevention: According to Leiper and Kent (2001), relapse implies not just a temporary setback but a scenario that efforts have been all in vain, leading to a sense of hopelessness. Its dictionary definition refers to "backsliding" and "failure following improvement" and implies disappointment and weakness. According to Marlott and Donovan (2005), based on a cognitive behavioural framework, relapse prevention seeks to identify high-risk situations in which an individual is vulnerable to relapse. As in most cognitive–behavioral treatments, relapse prevention incorporates a large educational component. This includes a cognitive restructuring of misperceptions and maladaptive thoughts, challenging myths related to positive outcome expectancy and discussing the psychological components of substance use and provides the client with opportunities to make more informed choices in high-risk situations. Relapse prevention also focuses on the implementation of global lifestyle self-management strategies. Lifestyle balance is a critical factor which includes the maintenance of goals following treatment and relapse prevention.

Motivation for treatment

The process of recovery from addiction can be a long road and can include relapse, and multiple treatment experiences. According to Dodes (2002), people who are successful in treatment need to have the capacity to be thoughtful of themselves. Mignon (2015) point out that historically, motivation has been conceived of as an all-or-nothing proposition and that a substance abuser either was motivated for treatment or was not. Today there is a more adaptable approach that reflects the abilities to encourage, support and perhaps even coerced motivation through family or legal intervention.

Motivation can work in ways other than solely quitting or reducing alcohol or drug use. It may be not just motivation for treatment, but also motivation for life changes that bring an employee

affected with an alcohol or drug addiction into treatment, such as desires for a better job and improved family relationships.

Intrinsic motivation: Internal factors, including cognitive and emotional factors, level of emotional distress, physical problems, and acknowledgment of the role substance abusers play in the individual's life, and the desire for a better life (Rosen et al, 2004).

Extrinsic motivation: Extrinsic motivation is attributed to external circumstances or other people who can bring about pressure for treatment (Fickenscher, Novins & Beals, 2006). External factors include consequences of substance abuse or addiction, including loss of profession or job, divorce, loss or restricted involvement with children, and legal factors such as driving under the influence arrest (Rosen et al, 2004).

2.16 COERCED TREATMENT

In contrast to the discussion on motivation, it is often the case that instead of facing the problem, individuals with a substance abuse dependency tend to justify and adopt various defense mechanisms (Mogorosi, 2009). These defense mechanisms include:

Denial and minimising: According to Conners, DiClemente, Velasquez and Donovan, (2013), denial is identified to be the most common defense mechanism, as well as the easiest to understand. It is defined as the act of refusing to recognise and accept the realities of a threatening thought or situation. If individuals deny their addiction and it remains untreated, it will continue to result in further anxiety – invoking consequences. In addition, Conners et al. (2013) explains that closely related to denial is the defense mechanism of minimising, which is when an individual accepts the problem but in a more diluted form, therefore not accepting the full extent of the problem. This defense is said to be especially common in cases of addiction.

Rationalising: According to Connors et al. (2013), it is the process whereby individuals seek a reason or an excuse for their behavior that they consider more socially and personally acceptable. This defense is said to work well at ridding the individual of guilt or responsibility for their behaviour and allows them to maintain their self-esteem, as well as tempts the individual to hide from reality.

Projection or blaming: According to Connors et al. (2013), projection occurs when an individual seeks relief from anxiety by attributing its cause to someone or something else. This defense typically arises when the anxiety-provoking situation involves an act that would typically cause guilt. The individual therefore attributes blame to an outside person or source instead of accepting responsibility for their actions.

Avoidance: According to Connors et al. (2013), the defense of avoidance is the act of avoiding any situation that may arouse unpleasant feelings, memories or impulses.

2.17 CONCLUSION

This chapter has shed light on the multifaceted subject of substance dependency. The overall aim was to provide an understanding of substance dependency. It is an attempt to provide an overview of the significant and linking literature to the findings. This chapter focused on providing answers to some questions, creating a foundation of understanding relating to the nature of substance dependency and its effects, impacts and consequences. The overview was of substance use disorders, key terminology and definitions, then the classifications of the drugs and some of the main, most common drugs used, as well as their effects, were highlighted. The stages of substance use were explained, and then matters regarding relevant current debates, the stages of change and treatment approaches were addressed in this chapter. The next chapter is literature review of substance abuse in relation to the workplace.

CHAPTER 3

LITERATURE REVIEW

SUBSTANCE ABUSE AND THE WORKPLACE

3.1 INTRODUCTION

Work represents a significant part of people's lives and a considerable amount of their time and energy is invested at work (Mor Borak, 2000). The significant role that work plays in human development is recognised due to the fact that it sustains, promotes survival and quality of life in a number of ways (Schreuder & Theron, 2001). In addition, employment contributes to the development and construction of self and identity and it influences how people are perceived and evaluated by themselves and others. Furthermore, work provides formal structures and context for relational and social interaction (Wetherell, 2009). Consequently, work becomes a meaningful mechanism that promotes and develops self-efficacy, self-esteem, purpose, and belongingness (Rosso, Dekas & Wrzesniewski, 2010).

Csiernik (2005) maintains that the workplace intensifies existing difficulties at the same time as it creates and supports its own problems. He goes on to explain that these problems that emerge in the workplace result from the nature of work, as well as the workers, home life and personal problems, all of which are entangled in their work life. This shows that the workplace indeed exposes personal and work-related problems and needs. Substance abuse and dependency in the workplace is recognised as one of the personal problems that are often exposed in the workplace (Development Services Group, Inc. 2013). In addition, the workplace is said to contribute to and impact substance use behaviour, either positively or negatively, and consequently, it is identified to be an environmental risk as well as a potentially beneficial platform from which to address substance dependency (Glatchel & Schultz, 2012).

This literature review is devoted to providing an overview of substance abuse and dependency in the workplace. Highlighting concerns and major concepts at the heart of the issue within the workplace context.

3.2 ALCOHOL AND DRUG USE PROBLEMS IN THE WORKPLACE

Mc Mann et al. (2011) describe employees with substance abuse or dependency problems as individuals whose dependency interferes with work, performance or the ability to do work and manage relationships at work. Additionally, Mc Mann et al. (2011) present problem substance use in the workplace in two categories; substance use that leads to incapacity, and substance use that which leads to misconduct. Mc Mann et al. (2011) goes on to explain that incapacity is defined as physical incapacity, resulting from physical damage or absence through sickness or deterioration of behaviour at work, resulting in employees unable to fulfill their work duties diligently and productively; and misconduct resulting from problem substance use that includes behavioural aspects rather than physical incapacity.

Csiernik (2005) explains that when demands from personal and work life exceed an ability to cope, or overwhelms existing coping mechanisms, a personalised psychological stress response occurs. This has been associated with the abuse of, and dependence on, alcohol or drugs. However, alcohol and drugs used by employees on-site or off-site impacts on work performance, resulting in decreased productivity, work errors, accidents, wasted materials, theft and other criminal activities, tardiness, absenteeism and the loss of skilled employees to name a few, resulting in very big losses to companies (Mc Cann et al. 2011). Issues arising due to the problematic use, abuse and dependency of drugs and alcohol by individuals in employment translate into an economic burden, raising socio-political interest concerning societal trends and beliefs, and can contribute to shaping the workplace culture that may either enable or discourage substance related work problems (Ghodse, 2005).

Lastly, due to the scale and pace of change in organisations and increased job demands, which include those physical, psychological, social or organisational aspects of the job that are associated with adverse health and well-being impairments. As a result, over the recent years, there has been a renewed interest in the issue of the quality of employees work lives (Kirby & Harter 2001, as cited in Kotze 2005).

3.3 THE PREVALENCE OF SUBSTANCE ABUSE AND DEPENDENCY IN THE WORKPLACE

Accurate estimates of the prevalence of substance abuse and dependency among the workforce is particularly difficult to obtain due to various limitations. For example, an inhibiting factor is the impact on the reputation of the employer or employee. The dearth of knowledge remains a major concern, even though it has gained some increased attention from the public health community, drug abuse researchers and theorists (Cook, 2002; 1991; Burnham & Parry, 2015).

The prevalence of substance abuse in the workplace highlights an increase in known substance use amongst employed individuals in South Africa (Grobler, Warnich, Carrel, Erbert & Hatfield, 2006; Mc Mann et al. 2011). To support this, a research study that Mc Mann et al. (2011) conducted focusing on mine workers found that alcohol and cannabis were the main substances used and was associated with coping, socializing and relaxation. This study estimated that 6% to 16% of the average labour force is likely to experience an alcohol-dependence problem and that 20% is likely to be affected by drug problems. Furthermore, a substantial amount of research suggests that significant financial implications are associated with employee alcohol and drug use. In fact, one employee's alcohol or drug dependency is found to have a significant impact not only on his or her own productivity and medical or legal costs, but also on their co-workers and the business operation as a whole (Bennet & Lehman, 2003).

3.4 THE IMPACT OF SUBSTANCE ABUSE AND DEPENDENCE IN THE WORKPLACE

Compared to alcohol dependency, substance abuse is identified to have greater cost implications for employers (Smook, Ubbink, Ryke & Strydom, 2014). This is due to productivity losses resulting from drug-related illnesses or deaths, work errors, accidents, wasted materials, tardiness, and absenteeism. Alcohol and drugs used by employees on-site or off-site impacts on the work performance resulting in decreased productivity, causing very big losses each year. It is estimated that over 50% of workplace accidents are substance-related, and the occurrence of theft and other criminal activities at work are increased as a result of substance abuse. In addition, undetected substance abusers cost the employer 25% of the employee's wages (Mc Cann et al. 2011; Kew 2008). There is also above average absenteeism, poor levels of

productivity and overall quality of performance of employees with substance abuse problems, which translates into actual cost to the company (Eberlein, 2010; Grobler et al. 2010).

The negative consequences linked between substance use and HIV and AIDS has repeatedly been pointed out (Mc Mann et al. 2011; Barnet & Whiteside, 2006; NDMP, 2013-2017; UNODC, 2012; World Drug Report 2018). High prevalence of HIV and AIDS is reported among individuals with a substance abuse problem due to their exposure in risky sexual behaviour, as well as the use of contaminated needles when using substances (Smook et al. 2014). This contributes to further effects within the workplace due to increased labour costs as a result of HIV-related absenteeism and resulting in additional pressure on the business sector (Whiteside, 2006).

The cost to the company is extensively highlighted in an array of literature, it is undoubtedly acknowledged as serious challenges due to the excessive losses. Very little has been said about the impact on the employee affected by an alcohol-drug related problem in the workplace, compared to the impact on the business sector. However, the NDMP 2013-2017 mentions occupational groups at risk. Only some groups are included due to the fact that they are regarded as high risk and exposed to considerable amounts of life-threatening danger. This includes factors such as shift or night work, traveling away from home, working in remote locations, unsatisfactory communication and job stress which may result from unequal rewards, role conflict, and excessive workload, job insecurity (Ghodse, 2005). These occupational groups include employees from sectors such as public transport, construction, engineering industry, security industry, financial institutions, artists and musicians (NDMP 2013-2017; Mc Mann et al. 2011).

An employee affected by substance abuse might earn less because of the deterioration in his or her ability to perform tasks. Promotion prospects might be reconsidered or the employee might be injured and suffer physical or mental ill health, perhaps leading to unemployment (Edwards et al., 1967). In addition, the impact on co-workers and employee's affected by alcohol-or drug-related problems vary. Ghodse (2005) asserts that substance abuse affects the workplace in many different ways, therefore making it difficult to pinpoint these effects in individual companies primarily due to the covert nature of this activity. Ghodse (2005), further highlights that there has

been noticeably more transparency from employees about alcohol abuse and dependency, however employees tend to keep any problem related to other substances to themselves due to the fact that dismissal has been the usual response of the employers. Ghodse (2005) notes that due to inconsistency, poor performance and absenteeism co-workers are left to carry out the increased workload. In addition, dealing with a drug- or alcohol-related problem in the workplace takes up valuable managerial time.

3.5 EMPLOYER'S RESPONSE TO SUBSTANCE ABUSE AND DEPENDENCE IN THE WORKPLACE

According to Dwoskin, Squire and Burdick (2012**),** substance use and abuse at work is said to be the one of the most challenging issues to confront as employers face pressure from the law which imposes the obligation to ensure safe, healthy and productive work environments for all, however employers are also required to accommodate the needs of substance-abusing employees.

Research conducted by Negura & Mararck (2008) explored the social representation of managers in order to better understand the attitudes and practices regarding drug dependency. Results of this research study revealed findings which highlighted the psychological vulnerabilities of drug-dependent employees, the company's vital role of productivity, the effects of work and the development of drug dependency and the company's duty to demonstrate social responsibility. Overall "closed-minded attitudes" were identified towards the idea of the integration of drug-dependent individuals back into employment. In addition, another prominent area in the research study were the social factors revealed, such as job insecurity, stress, high demands and awareness. The company's sense of social responsibility, and supportive attitude regarding the professional integration of substance-dependent individuals was mainly influenced by the company's production requirements and the fact that the company showed more tolerance towards drug-dependent employees who were already employees of the company. This further highlighted the biased attitude towards the hiring of substance-dependent employees.

According to Frone (2012) points out that proactive ways to challenge permissive workplace substance use culture are essential as the consequences are detrimental to the organisation and the employees. Innovative methods undertaken by employers include organizational policy,

supervision, awenesss campaigns and education programmes, drug testing and referrals for counselling and rehabilitation. In addition to drug testing, companies are beginning to see the value of rehabilitating substance dependent employees through implementing employee assistance programmes, rather than summarily discharging them and hiring replacements. In addition to creating bottom-line cost saving, EAP's positively impact employee morale by demonstrating genuine concern on the part of management. Increasing legal challenges by discharged employees also cause employers to be reluctant to terminate unless they have tried to rehabilitate the "troubled" employee.

Employer's policies around substance abuse reflect changes in attitude and knowledge over the last decade. This is evidenced by the drug testing consent forms, as well as stipulations of implications resulting from drug use. Dismissal of the substance dependent employees has a direct cost to the employer in terms of loss of a valuable worker and the cost to train and replace the worker who may have adequate experience and potential but is suffering from a drug- or alcohol-related problem (Ghodse, 2005).

3.6 WORKPLACE CULTURE REGARDING SUBSTANCE ABUSE AND DEPENDENCE

Research conducted by Forne and Brown (2010) suggest that workplace substance use norms may be important predictors of employee substance use. Employees need to make their stance clear on substance abuse, to address the unofficial practices that may be taking place within their organisations. Officially a blind eye may be turned to some employees' practices. At worst, some of these practices may have come to be accepted in some workplaces, for instance, drinking during breaks or participation in so-called liquid lunches (Becker and O'Hara, 1991). At times, the nature of the work itself may place very high demands on the workers, so that they may be tempted to use alcohol and or other drugs to absorb the pressure. The demand, for example, to maintain the required levels of productivity and constant deadlines, working night shifts, long shifts, constant long-distance driving, job complexities, and role conflicts may all play an important part in particular employees behaviour.

Workplace substance use climate can be defined broadly as employees' perceptions of the extent to which their work environments are supportive of alcohol and drug use at work. Workplace

substance use is comprised of three dimensions (Ames and Grube, 1999; Ames et al. 2000). The first dimension is perceived as the physical availability of alcohol and drugs at work. This dimension represents the ease of obtaining alcohol or other drugs at work and the ease of bringing them into the workplace or using them during work hours and during breaks. The second dimension represents the descriptive norm or the extent to which members of an individual's workplace social network use or work while impaired by alcohol or drugs at work. The third dimension represents injunctive norms or normative approval or disapproval of workplace substance use and impairment by members of one's workplace social network.

Lutchman and Liebenberg (2017) assert that before addressing drug abuse and the treatment of the individual employee, the treatment of the organization should be explored. Mc Mann et al. (2011) maintain that serious consideration should be given to changing the culture of the working environment if it allows, encourages or promotes alcohol or drug use. And in doing so Mc Mann et al. (2011) maintain that education is an important contribution, however, he emphasises that education is not enough to change behavior and highlights the importance of supporting education initiatives with other techniques and approaches. Mc Mann et al. (2011) further goes on to highlight the necessity to effect cultural changes in the social work environments in which people socialise and interact with one another after hours.

3.7 WORKPLACE FACTORS THAT ENABLE SUBSTANCE ABUSE

Although certain occupational groups are noted to have a higher risk of exposure to substance abuse, not all workplaces are at risk of enabling an employee's substance abuse. That being said, Mogorosi (2009) maintains that many workplace factors are also identified to unintentionally enable, induce or provide a “supportive” atmosphere for employee substance abuse due to the following workplace factors:

3.7.1 Work environment and occupational stress

According to Miller (2010), the traditional life cycles of human beings include infancy, childhood, adolescence, and adulthood. Transitions exist within each life cycle and such transitions produce stress. Life has many stressful events that mark the movement from one condition or cycle to another and they produce substantial challenges in the life of human beings. Coping with the workplace and job in relation to a transition is a common and stressful transition

of modern life. According to Fink (2010) in many individuals, drug use is a stress-driven behaviour. This is especially problematic because the life of a substance dependent individual is particularly stressful - even though many individuals initially turn to drugs in order to help them cope with stress, drug use by itself can generate or aggravate stress responses, which is a vicious circle.

Muloiwa (2008) states that a number of adverse work environmental factors can make even the best jobs stressful, which may contribute to employee problems such as substance abuse. Muloiwa (2008) defines occupational stress as poor mental well-being directly related to unpleasant work conditions, resulting from high work demand and a low amount of control over the situation. Occupational stress contributes towards employee absenteeism, diminished performance negativity and cynicism, a decline in commitment and creativity, decreased ability to concentrate and less interaction with other employees. Stressed workers can also develop a range of symptoms including insomnia, headaches, fatigue, anxiety, irritability, and depression. Some of these employees may end up abusing substances through an attempt to cope with their situations (Muloiwa, 2008).

Other stressful factors could include uncomfortable work settings, lack of safety, inadequate physical and financial resources, poor supervision and problems with co-workers, low pay, poor training and job preparation, job insecurity, and lack of opportunities for career advancement.

3.7.2 Denial of the existence of the problem

This factor involves organisations turning a blind eye to the use or abuse of substances as long as they are perceived and acknowledged to have no effect on work or work-related functions. The general attitude is that substance abuse is an employee's problem and in addition, the publicity resulting from an employee's substance use, abuse or dependency is not "good for business". The fear of losing customers and publicising the employee's substance-related problem is perceived to threaten the image or the survival of the organisation (Backer & O'Hara 1991 as cited in Mogorosi, 2009).

3.7.3 Availability of the substance in the environment

This factor relates to the organisation's geographical location and the availability of addicted substances in and around the workplace. According to Mennis, Stahler & Mason (2016), the most basic manner in which a risky environment can be considered to affect substance use behaviors is by facilitating access to substances of abuse. Ready access to substances lowers the barriers to acquiring, using, and abusing substances, thus facilitating substance use initiation and potential abuse. For those suffering from substance use disorders, environments with high accessibility to tobacco, alcohol, and illicit drugs can not only facilitate the acquisition of substances, but can also contain environmental cues that trigger substance craving. Such environmental cues can have substantial negative consequences for those in treatment for substance use disorders, as well as for those in long term recovery who are attempting to maintain abstinence from substance use (Canklin, Parkins & Salkeld, 2010).

3.7.4 Social control and peer pressure

This factor is also said to be an element of the work environment and atmosphere which fosters no freedom of independent individual behaviour. Another situation is the pressure of constant employee supervision, therefore, highlighting the existence of micro-management. In addition, the employees need to belong or be accepted, which may also lead to the employee succumbing to pressure and doing what they think is right in terms of that particular social or work groups norms (Johnson, 2007), such as participating in drinking and the use of substances to fit in.

3.7.5 Alienation and dissatisfaction

Some work environments isolate employees form their supportive networks when these are needed or in demand. This is especially experienced during stressful occasions, and dissatisfaction related to problems such as work overload, job complexities, unpleasant work environment, poor pay, feelings of powerlessness and personal issues in the employee's personal lives. Such employees may be more susceptible to the use of abuse alcohol or other substances.

3.8 WORKPLACE INTERVENTIONS

Csienik (2005) asserts that the provision of occupational-based assistance is not a new phenomenon. The well-being of employees is in the best interest of communities and organisations. Therefore, the workplace is identified to be a significant part of an individual

which affects not only the employee's life and well-being, but also that of the greater community and society (Harter, Schmidt & Keyes, 2003). Organisational supports intended to help employees improve their work-life balance has become increasingly prominent (Wood, Daniel & Ogobonnanya, 2018).

3.8.1 Drug testing as a workplace intervention

There seems to be an increase in employers making use of drug testing. Aside from the major motivation of reducing productivity losses, personnel turnover, and health insurance costs, this could also be due to public pressure and publicity about the dangers of drugs and the fact that politicians and the public are demanding a solution that is inexpensive and immediate (Greenblatt, 1987). The occurrence of numerous court challenges to drug testing, particularly for random, unannounced testing, due to the fact that they are considered to be invasive of privacy, defamation, a cause of intentional infliction of emotional distress, and discrimination against those “handicapped” by alcoholism or drug addiction means it is a difficult option for employers (Mc Mann, 2011).

3.8.1.1 Types and procedures

Drug tests are used to provide evidence that drugs have been used (Greenblatt, 1987). Drug tests can occur in four contexts: Pre-employment drug screening, testing for reasonable suspicion, randomly, and as part of an annual physical exam.

Pre-employment Drug Screening: This involves testing employee candidates during a medical pre-employment physical. In general, the purpose of the medical examination is to rule out the existence of any physical condition that might impair the candidate's ability to perform position being filled. Thus, the pre-employment drug testing is an effective way to screen out addicted workers (Masi and Burns, 1986).

Reasonable suspicion: This method involves testing employees when supervisory or managerial personnel have a reasonable belief or suspicion that an employee is under the influence of alcohol or drugs.

Random testing: This method involves choosing a sample of employees randomly for screening. Testing occurs intermittently, with all employees in specific areas eligible for testing

during these trials. This method is used to catch truly addicted workers, as well as to deter drug use as employees never know when testing will occur. This method stimulates heated debates because of privacy concerns and the lack of notice. (Masi and Burns, 1986).

Testing as part of an annual medical examination: This method is often used to avoid the legal pitfalls associated with random testing. It appears, however to target the more severely addicted or ignorant user.

In addition to the above mentioned testing procedure in the workplace, Straussner (1993) asserts that if the employer refers employees for drug tests based on performance and does not have an employee assistance programme (EAP) for rehabilitation, the goal of assisting employees with abuse problems is left unrealised. Drug testing solely for the purpose of labeling abusing employees and terminating them is clearly not in the interest of the employees and the company as a whole. The South African Labour Guide recommends, amongst other suggestions, that the policy on drug testing be a zero tolerance policy and must stipulate the method of testing and who is to be tested, as well as the consequences of a non-negative test. Importantly, the policy must make mention of the Occupational Health and Safety Act of South Africa (85 of 1993) which requires that employers provide a safe workplace that includes managing substance abuse in the workplace.

3.8.2 Limitations to treatment

In addition, treatment is said to depend on the willingness of the employee and requires participation. (Meier, Donmall. Mc Elduff, Brorrow Clough, & Heller, 2006). However, one may argue that this views treatment in a one-dimensional approach, as opposed to a holistic approach. Numerous obstacles to seeking help are identified in the workplace which includes aspects such as concerns for privacy - including confidentiality issues and potential for stigma (Tucker, Vuchinich & Rippens, 2004).

Additionally, denial, which is identified to be the hallmark of dependency, can keep employees dependent on alcohol or drugs, which further delays the process of acknowledging the problem. This can therefore delay entry into treatment. Another obstacle is the feelings of employees affected alcohol or drug addiction, such as perceptions that they can recover on their own, that their problem is not serious enough to warrant professional help, or treatment will not be helpful

(Mignon, 2004). Goerge (1996) found that those who entered treatment received feedback about the need for support from friends and family. Some substance abusers may not have the support and assistance from their family members.

3.9 Stigma

Green (2009) explains that the stigma or mark is seen as something in the person, rather than a designation or tag that others affix to a person. In this respect the term stigma is different to a term like discrimination. In contrast to stigma, discrimination focuses on the attention of research on the producers of rejection and exclusion – those who do the discrimination, rather than the people that are the recipients of these behaviours.

According to Link and Phelan (2001), people distinguish and label human differences, dominant cultural beliefs link a labeled person to undesirable characteristics and create negative stereotypes. Labeled persons are placed in distinct categories so as to accomplish some degree of separation of "us" from “them”. Labeled persons experience status loss and discrimination that leads to unequal outcomes. Finally, stigmatisation is entirely contingent on access to social, economic, and political power that allows the identification of differentness, the construction of stereotypes, the separation of labeled persons into distinct categories. The full execution of disapproval, rejection, exclusion, and discrimination thus we apply the term stigma, when elements of labeling, stereotyping, separation, status loss, and discrimination co-occur in a power situation that allows the components of stigma to unfold.

In addition to stigma, relapse is also identified to be a limitation of treatment. Relapse rates following treatment are high, and relapse should be identified as a “breakdown” in a person’s attempt to change or modify any target behavior. Marlaat & Donovan (2005) provide risk factors for relapse which include environmental risk factors, interpersonal risk factors, intrapersonal risk factors and lastly physical risk factors.

3.10 REINTEGRATION IN THE WORKPLACE AFTER REHABILITATION

Mc Mann (2011) asserts that the following precautionary measures should be taken after an employee has completed his/ her rehabilitation programme and when reintegrating or returning back to work:

- The rehabilitation centre should be consulted. This will include a proposed aftercare programme and recommendations to assist the employee to consolidate recovery. However, the employee must consent to this information being disclosed.

- If a residential treatment has been necessary, an employee assistance programme (EAP) counselor, human resource manager, or senior supervisor should have been in regular contact with the staff at the rehabilitation centre or clinic. The information gained during these discussions will prove useful when planning for the reintegration of the employee into the workplace.

- Baseline blood tests or urine screening should be available.

- Re-entry to the workplace may be facilitated by adjusting an employee's workload for a period of time or modifying his or her work environment. This would be effective especially if work-related stress was a factor in the development of their addiction or dependency.

Employment entry is commonly used as an important outcome indicating successful treatment (Magura, 2003). The focus of returning to work after the completion of rehabilitation centres not only around the provision of legal income, but also on the premise that work structures daily routines and discourages harmful drug use. There is therefore both a symbolic and real importance of returning or maintaining work for those who struggle with substance abuse (Margura, et al. 2004). In support of this, research focusing on the relationship between treatment and employment has observed colorations linking existing employment to improved treatment outcomes (Robins et al), such as long-term abstinence, lower relapse rates, and improved treatment duration. Post-treatment success rates in research studies vary but are generally very low among addiction treatment clients. There are no guarantees that individuals will not relapse or experience setbacks in their substance use management. There are also risks that an individual will take premature steps toward employment that may expose them to triggers or situations for which they are not ready.

3.11 OCCUPATIONAL SOCIAL WORK

Carapinha, (2009) asserts that occupational social work is "a specialized field of social work practice which addresses the human and social needs of the work community through a variety of interventions which aim to foster optimal adaptation between individuals and their environments”

Munn (2013), brings attention to an interesting term called work-life balance, where he highlights that individuals, organisations and the government is a primary force studied in the exploration of work-life balance. He notes that these forces are often studied independently when in fact they should be examined as a system. Munn (2011) defines how individuals choose to prioritise their work, family individual and community responsibilities. Furthermore, he maintains that how employees choose to prioritise their work, family, individual and community responsibility depends on work-life initiatives which include organisational programmes, practices, and policies available to help employees achieve balance and support. In light of Munn’s (2013) definition on work-life balance it could be argued that often employees have no control over how they want to prioritise their personal problems, such as substance dependence. This is especially due to the nature of substance dependency which could easily spill over into the employee’s work life involuntarily, and impinge on their job performance (Mogorosi, 2009).

Smith and Gould (1990) assert that occupational social work encompasses a broad range of activities, target systems, clients and auspices. Furthermore, Du Plessis (2001), states that attention should be given to the employee-as-person, where the concern is on the personal needs of employees as individuals, parents or community members. Secondly, attention should be given to the person-as-employee. Here the concern is on the occupational needs of employees as employees - such as their ability to cope with work-related stress, interpersonal conflict in the workplace and the negative spillover of work stress into the family. Thirdly, organisation-as-client; here the concern is on facilitating a working system or community that is characterised by justice, equality and human dignity. Lastly, employee-as-citizen; here the concern is on facilitating the social well-being of the communities in which employees live and in which organisations operate, through corporate social investment.

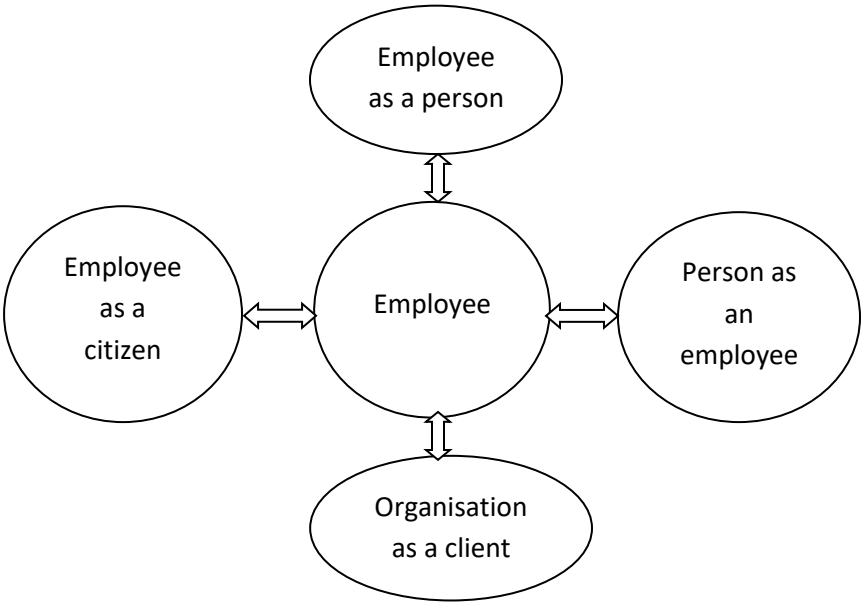

Figure 3.1 Client systems in occupational social work

3.12 EMPLOYEE ASSISTANCE PROGRAMMES

Occupational social workers often work within an employee assistance programme service or setting. Employee assistance programmes is a component in which occupational social workers work often and are identified to have a more curative approach. They are dependent on directives from management or employers as intervention is often prompted due to problems identified by management or supervisors, resulting from lack of productivity.

According to Mogorosi (2009), Employee Assistance Programmes refer to support services set up with the aim of helping employees deal with individual or collective problems of a personal, familial or work nature. These programmes are work-based services funded and operated by an employing organization, employees, union or both. Some of these programmes are external and contracted by either one or both these parties.

- **The rationale for employee assistance programmes**

There are various reasons for employee assistance programmes in the workplace. These can include efforts to humanize the workplace, meet the needs of a changing work environment and changing workforce, help improve an employee's work performance and contribute to reducing organisational costs. In relation to attending to employee challenges and problems such as absenteeism, discrimination and substance abuse, meeting employee health and general well-being needs, helping to increase employee work commitment and loyalty, improving general management-employee relations, meeting legal and social responsibilities of organisations.

- **Three basic principles of employee assistance programmes**

Principle 1: EAP is a job-based strategy for helping employees to solve their problems.

At some stage of their work life, it should be expected that employees, like everyone else will experience some problems – either personal or related to work. The very recognition of this would assist in developing harmonious relationships between management and employees. When an employee's problems affect their work performance, an organisation has an obligation to offer help. There are problems that may have an effect on, or spill over to, work performance (eg; absenteeism and addiction) and at that point the organisation can offer help. Balgopal and Patchner (1998), assert that "it is assumed that employee's problems are private unless they cause job performance to deteriorate. For when that happens, personal problems become a matter of concern for the company, as it is protecting its valuable asset - the trained employee".

Principle 2: Constructive confrontation is used to motivate employees to resolve their problems and overcome denial. The important duty of managers or supervisors is to ensure that work is done properly. Whenever managers and supervisors observe the deterioration of work performance, it is their duty to help the employee correct that. Organisations need to have disciplinary and grievance procedures through which supervisors and managers can confront their employees about their poor work performance should it continue.

Employees may either acknowledge their problems, deny the existence, or may be unaware of their performance problems.

Principle 3: Counseling is used to help employees solve their problems when it is clear that these problems are beyond the employees' control. When employee resources are exhausted, and the problems are beyond their control, outside help may be called upon (Daas-Brailsford &Myrick 2010)

In relation to the aforementioned discussion on employee assistance programmes, Soeker, Matimba, Machingura, Masimongo, Moswaane & Tom (2016), provided research which focused on exploring the challenges that employees experienced when returning to work after the completion of an employee assistance programme. This study was conducted in the Western Cape (SANCA) and included three participants and two key informants and conducted at South African National Council on alcoholism and drug dependency. Soeker et al. (2016) present interesting findings from their study which pointed out experiences of participants relating to the loss of role identity resulting from work routine disturbances, neglect of work responsibility and loss of concentration on work-related tasks. In addition, findings from this study highlighted barriers reported from participants that included workplace culture, poor support systems in their home and work lives.

3.13 EMPLOYEE WELLNESS

Csierik (2005) explains that the beginnings of health promotion and wellness programming began to emerge in the workplace, although the primary focus has essentially been on physical well-being. The majority of programming has remained focused upon individualisation the problem and seeing the worker as a troubled employee rather than taking a more ecological approach. Despite some progressive trends, it is still the individual employee who is considered "sick" and who requires reshaping to better fit the needs of the workplace environment. What is now required is a more comprehensive understanding of wellness and of the relationship between wellness and work.

3.14 WORKPLACE LEGISLATION

There is no single piece of legislation in South Africa that makes specific provisions for addressing substance abuse and related problems in the workplace. Workplace substance use

concerns are however reflected in sections of existing literature more especially the Labour Relations Act 66 of 1995, the Employment Equity Act 55 of 1998, and the Occupational Health and Safety Act 85 of 1993, which makes references to approaches for managing the problem through employee referrals to specialist care; and alcohol and drug testing protocols with little attention given to other intervention measures as it relates to substance abuse. The third National Drug Master Plan (2013-2017) for addressing substance abuse in the country and the legislative framework is provided by the Prevention and Treatment Act 70 of 2008.

- **The South African National Drug Master Plan (NDMP)**

The National Drug Master Plan (NDMP) was drafted in accordance with the provisions of the Prevention of and Treatment for Substance Abuse Act (No 70 of 2008). It highlights the country's responses to the substance abuse problem as set out by the United Nations Conventions and other international bodies. The South African National Drug Master Plan and labour legislation provide national directives to promote effective management of substance abuse in the workplace (NDMP, 2012-2016, p. 68). Several South African Acts stipulate labour requirements for dealing with substance abuse and dependence in the workplace and emphasise the obligations of employers and employees. The Constitution of the Republic of South Africa (108 of 1996) stipulates that no unfair discrimination directly or indirectly may be practiced on the grounds of disability, including substance abuse, which can be regarded as some kind of incapacity (RSA, 1996).

- **The Prevention of and Treatment for Substance Abuse Act 70 of 2008**

This act directs the implementation of comprehensive and integrated service delivery and promotes community based and early intervention programmes as well as the registration of substance abuse therapeutic interventions. McCann et al. (2011) points out that although The Prevention of and Treatment for Substance Abuse Act 70 of 2008 is not directly applicable to the workplace it reflects that substance abuse has become a significant problem in South Africa as a result of the global trade as well socio-economic factors such a poverty, inequality and unemployment and provides a comprehensive response to address the issue.

- **The Occupational Health and Safety Act 85 of 1993**

This act states that employers of large, as well as small, companies are liable for managing the negative impact of substance abuse in the workplace. This act further starts that employees have the right to safe work environments and that substance abuse can become an occupational hazard if not dealt with properly. Employees are legally bound to protocols governing substance abuse in the workplace (RSA 1993a).

- **Employment Equity Act 55 of 1995**

This act allows for medical examinations of the employees in the light of medical facts, employment conditions or inherent requirements of the job (RSA, 1995).

- **The Labour Relations Act 66 of 1995**

This act states that it is illegal to dismiss employees who are incapacitated or unable to work because of ill health resulting from substance abuse dependency (RSA, 1995).

3.15 GAPS AND AREAS IN NEED OF DEVELOPMENT IN THE SOUTH AFRICAN WORKPLACE

- **Substance abuse policies**

While policy development is encouraged within the workplace for tackling substance-related issues many companies still address substance abuse as a disciplinary issue. Substance abuse policy plays an important role in managing substance abuse in the workplace as substance abuse normally progress unexpectedly until a crisis occurs. Through the implementation of suitable policy and evidence-based interventions possible substance-related problems can be diverted or dealt with before such crisis points are reached. The gaps within workplace substance abuse policy are identified to be based on the fact that the emphasis on highlighting the legal obligations of employers and employees and drug testing protocols is clearly stipulated. Aspects such as early intervention and prevention and the use of evidence-practice should be more clearly outlined. A more holistic and participatory approach to drafting the policy is required. In doing

so more relevant and accurate information regarding the strengths, challenges, and problems that is unique to the workplace will be included. This is important as when dealing with substance abuse there is no one-size-fits-all approach.

Drug testing is best used as a part of a more comprehensive and integrated approach that incorporates aspects of policy, preventions and treatment. This suggests that drug testing should not be a stand-alone approach associated with mainly disciplinary measures and outcomes only.

- **Epidemiological studies**

Regarding epidemiological studies, there seems to be a need for accurate national estimates of substance abuse among the employed persons. Furthermore, more research is needed regarding the inappropriate use of over-the-counter or prescription medication. In addition, there is a need to further explore the nature and patterns of substance abuse in varying industries, as well as studies testing the efficacy of workplace intervention in South Africa.

- **Cost-effectiveness of workplace substance abuse programmes**

The major cost and economic burden that substance abuse and dependency pose on the workplace was clearly articulated and expressed in various literature sources. It is identified that there are a few studies conducted, highlighting cost-effectiveness of workplace substance abuse treatment programmes. Providing employers with some idea of the cost-effectiveness of a selected intervention will no doubt improve employer willingness to allocate resources to a tried and tested programme (World Health Organisation, 2010).

- **Strengthening prevention and treatment initiatives requires combined efforts from employers, researchers, and health practitioners**

Substance abuse problems can be addressed from the vantage point that substance use disorders commonly occur in a continuum from no use to occasional/ recreational use, misuse, abuse, with the end phase being dependence (Mc Mann, 2011). A well-balanced substance use strategy should therefore provide prevention, early intervention, treatment, reintegration, and aftercare services to deter the onset and mitigate the impact of substance abuse on employee's health and loss of productivity to the employer. There is a dearth of knowledge in the implementation of

evidence-based universal prevention practices in the workplace where there is a clear need for programmes that target the entire workforce. This will also assist in alleviating stigma and discrimination and increasing support.

3.16 THEORETICAL FRAMEWORK

Thompson (2009) explains that in exploring drug and alcohol abuse and dependency in the workplace it is necessary to acknowledge the many theoretical complexities as from a theoretical point of view how a social issue is defined and, indeed what counts as a social issue can change over time and across cultures. There is a variety of theories attempting to explain the complexity of substance abuse and dependency. Stevens and Smith (2001) point out various theories of substance abuse namely the moral theory; the disease theory; the genetic theory; the systems theory; the behavioural theory; the socio-cultural theory and lastly, the bio-psychosocial theory. Although there are many commonly models used to support substance abuse practice. The study will focus on the following models:

- **Coping/Social Learning Model**

According to Johnson & Thurlow (2004), Social Learning Theory suggests that addictive behaviour is a socially influenced, learned behaviour acquired and sustained through a social learning process. Learning occurs through imitation, trial and error, and other cognitive mental processes in social relationships with individuals. According to Maisto, Carey and Bradizza (1999), as cited in Johnson & Thurlow (2004), cultural and sub-cultural norms define whether alcohol use will be encouraged at all and if so, in what quantities and under what social conditions. These group norms are learned by observation of socialising agents such as the drinking behaviour of adults, and the presentation of alcohol use in the media.

Brandura (1969) and Akers (1992), as cited in Johnson & Thurlow, 2004) also explain that people learn attitudes and beliefs about drugs through the influence of their social groups and larger social systems, including the media. According to Johnson & Thurlow (2004), social learning theories focus primarily on the individual and how he or she learns to cope in everyday life. Social learning theory utilises macro- and mezzo-level analysis to explain an individual's

behaviour at a micro-level. Social learning theory informed many treatment strategies commonly used in substance abuse treatment programmes across the country.

In addition to the aforementioned information, social learning theory is applicable to the research study as it provides a viewpoint in understanding how substance abusers in the workplace are potentially vulnerable to substance abuse given their social influences and learned problem behaviours from other individuals.

Addictions often are considered the result of poor or inadequate coping mechanisms. Inability to cope with life stress leads addicts to turn to their addiction for escape or comfort. From these perspective individuals use substances as alternative coping mechanisms and rely on their addictions to manage situations, particularly those that provoke feelings of frustration, anger, anxiety, or depression. Social learning perspectives emphasise cognition and not simply coping. Social learning perspective also emphasises the role of peers and significant others as models. Coping and social learning perspectives have become popular among addiction researchers and clinicians. Coping responses are identified to be even more important as a way of remediating the consequences of an addiction than as a contributor to its development.

- **The social ecological model**

In addition to the above coping/ social learning model the social ecological model was employed as an additional theoretical framework. The social-ecological model by Mc Leroy et al. (1988) postulates five levels of interaction domains: The First interaction domain includes interpersonal factors, which entail biological and personal history factors, attitudes, education, and income. Secondly, interpersonal factors which involve formal and informal social networks, support systems like family, working groups and friendships. Thirdly, institutional factors which include social institutions with organisational characteristics, formal or informal rules and regulations. Fourthly, community factors, which entail relationships among organisations, informal networks and institutions. Lastly, the public policy level which involves local, state and national laws or policy. Additionally, Duncan, Bowman, Pillay and Roose (2007) highlight that the social ecological model also extracts from Bronfenbrenner's (1979) ecological system theory. In comparison to the many other theories, the coping/ social learning model the social ecological

model was identified to be more relevant for this research study as it reflects the interrelations among various personal, social and environmental factors.

Image of the social- ecological model

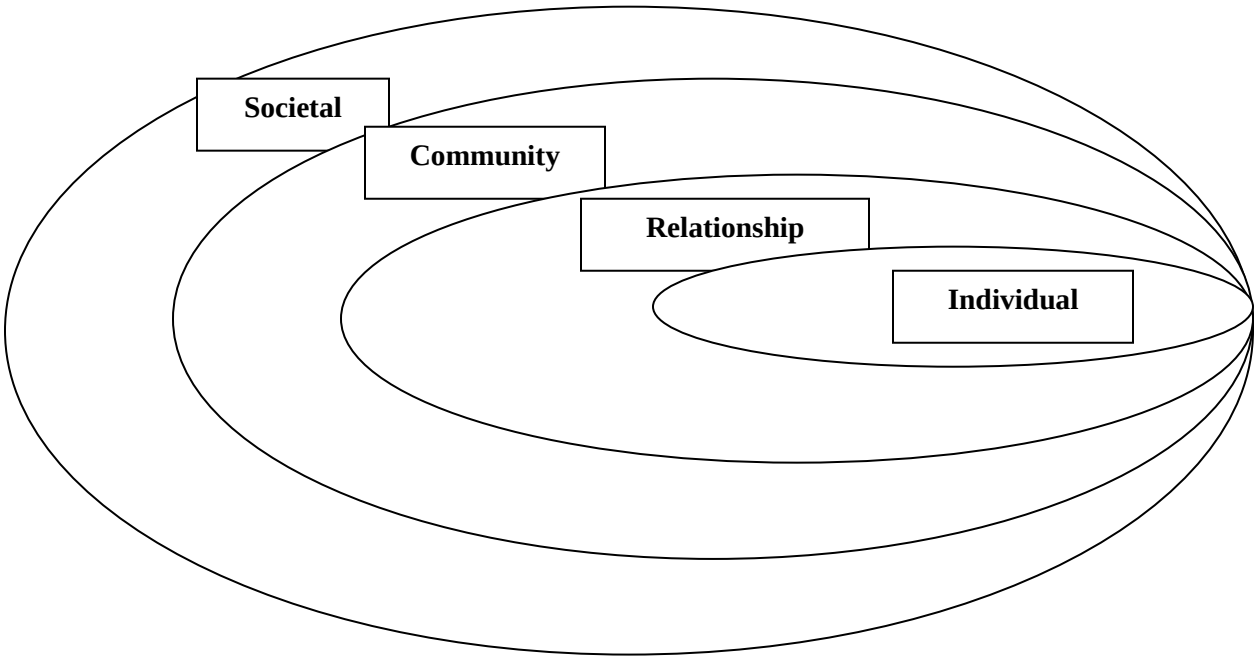

Figure 3.2: The social ecological model

3.17 CONCLUSION

This chapter focuses on the occurrence of substance abuse and dependency within the workplace. The alcohol and drug problem confronting the workplace was introduced. Then prevalence of substance abuse and dependency in the workplace was discussed. This was followed by the presentation of the impacts of substance dependency on the workplace. Employer's responses to substance abuse and dependency in the workplace were highlighted, as well as the workplace culture and interventions regarding substance abuse.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

The methodology and research design of a research study can be described as the blueprint or foundation on which the study is built (Braun & Clarke, 2013). A key aspect of a successful research study stems from the fact that it is systematic, meaning that it is planned, organised and has a specific goal (Goddard & Melville, 2007). In support, Yin (2016) maintains the importance of being “methodic" which entails following a set of orderly research procedures and steps in order to minimise careless work.

This chapter presents the details of the research design and methodology framework that was used in this research study. The research questions, aim and objectives underpinning this study will be provided to capture the intent of the researcher for conducting this research study. In addition, the research design used to conduct the study will be outlined and the strengths and limitations of the approach taken will be discussed. The sampling method that was used to select participants, as well as the research instruments, pretesting procedure, data collection and data analysis will be specified. Lastly, the researcher will explain how trustworthiness was ensured, as well as the ethical considerations and procedures that were followed in the research study will be addressed.

4.2 PRIMARY AIM OF THE RESEARCH STUDY

The primary aim of the research study was to explore experiences of substance-dependent employees undergoing rehabilitation and their reintegration into the workplace.

4.3 RESEARCH OBJECTIVES AND QUESTIONS

4.3.1 Research Objectives

The secondary objectives of the research study were:

- To understand the experiences of substance-dependent employees after disclosing their substance dependency to management.

- To identify factors that motivated the employees to rehabilitate their lifestyle.
- To investigate and describe the support systems that existed within the workplace before, during and after rehabilitation.
- To understand the relationship between the substance-dependent employees and their colleagues, employers, supervisors or managers.
- To explore work-related experiences of substance-dependent employees (pertaining to work conditions, views of alcohol and drugs in their workplaces, experiences of disclosing or hindrance of disclosure, support structures in the workplace, knowledge of workplace substance abuse policies and fears of returning to work).
- To explore non work-related experiences of substance-dependent employees (pertaining to personal contributing factors motivating their substance use and effects of substance dependency on their personal lives).

4.3.2 Research Question

The primary research question that guides this research study is;

- What is the experience of substance-dependent employees, rehabilitated and reintegrated to the workplace?

4.4 RESEARCH PARADIGM AND APPROACH

4.4.1 Explanation of research paradigm and approach

This research study aimed to explore the experiences of substance-dependent employees in rehabilitation and their reintegration to the workplace. The qualitative research approach was identified to be the most suitable approach to employ for this research study. Creswell (2014) describes qualitative research as an intricate fabric composed of tiny threads, many colours, different textures and various blends of material, thus highlighting its complex and detailed nature. In addition, Kothari (2004) asserts that qualitative research is concerned with the subjective assessment of attitudes, opinions and behaviours, as well as the function of the researcher's insights and impressions.

The suitability of the qualitative research approach was based on the fact that qualitative research is devoted to exploring and understanding meaning. This approach explores how individuals or groups make meaning of a social or human problem (Braun & Clarke, 2013; Creswell, 2014). The qualitative research approach was useful in that it assisted the researcher to explore and understand their experience as an employee with a substance dependency problem and the subsequent impact dependency had in their lives. In addition, qualitative research was used to assist the researcher to answer questions about the complex nature of the substance dependence phenomenon in the workplace, as well as to describe and understand the phenomena from the participant's perspective and lived experience (Creswell, 2009).

The researcher also had to take into consideration that the experiences of substance-dependent employees are often contradicted by accepted behaviours, beliefs, opinions, emotions and relationships of individuals (Rajen & Richa, 2015). The qualitative research approach was therefore valuable in this case as it captured the complexity and contradiction that characterises the real world, and allowed the researcher to make sense of patterns of meaning regarding the experiences of rehabilitation and reintegration of substance dependent employees (Braun & Clarke, 2013).

The researcher believed that it was important to select an approach that would be supportive and complimentary in efforts to explore the experiences of rehabilitation and reintegration substance-dependent employees. Creswell (2014) confirms the supportive nature of a qualitative research approach, especially when there is a need to explore a particular issue or problem as it results in the participant's experiences being heard. This was a particularly significant contributing factor to the researcher's choice to make use of a qualitative research approach, as well as for conducting this research study as the aim was not only to provide authentic knowledge to the field, but also to ensure that the voices of participants are heard.

The researcher also identified qualitative research to be a suitable approach based on the fact that it is not limiting or rigid. According to Creswell (2014), qualitative research provides a holistic and detailed understanding of the problem or area of interest. Exploring experiences of rehabilitation and reintegration of substance-dependent employees is complex and multifaceted, therefore it is important not to generalise but rather to individualise and treat each participant's

experience as unique. In conclusion, qualitative research approach was used to conduct the research study and its inductive and explorative qualities, as well as a qualitative approach, helped the researcher to empower the participants to share their stories and to provide a deeper understanding of the context or setting in which participants in a study address an issue or problem (Creswell, 2014).

Embedded in the qualitative approach, the research perspective and lens that guided the research study was the interpretive approach. This paradigm is described to be an approach that aspires to understand participants (Babbie & Mouton, 2001). The researcher found the paradigm has an empathic quality to understand participant's inner feelings and provides an ability to interpret individuals' daily experiences, deeper meaning, feelings and their personal reasons for their behaviour (Rubin & Babbie, 2010). This approach sheds light on the everyday lived experiences of the participants and supports the theory that human beings are involved in the process of making sense of their worlds and continuously interpret, create, give meaning, define, justify and rationalise their daily actions (Babbie & Mouton, 2001). The researcher found the interpretive paradigm to be suitable due to the fact that it upholds the notion that the participants are the experts in narrating their stories and experiences. Employing a qualitative research approach jointly with the interpretive research paradigm proved to be a complementary approach in this research study, ensuring that the lived experiences were captured (Leedy & Ormrod, 2005).

In conclusion, De Vos et al. (2011) maintain that qualitative research elicits participant accounts of meaning, experience and perception. It is therefore found to be valuable and appropriate for this research study as the aim was to explore the personal experiences of rehabilitation and reintegration of substance dependent employees.

4.4.2 Strengths and limitation of research approach

In considering the strengths and limitations of the qualitative research approach, the researcher found qualitative research easy to adapt to as it required establishing rapport with the participants and this skill was well developed in the researcher’s social work background. The researcher is also skilled at providing empathy which resulted in the participants feeling comfortable enough to openly share their experiences and introspection (Braun & Clarke, 2013).

The researcher identified an additional strength to be the fact that the approach assisted the researcher in providing a platform to explore their perspectives based on their lived experiences. Moreover, its ability to link and make reference to complex theoretical descriptions to further engage and analyse the participant's experience in the research context, provided a strong grounding and understanding. In contrast to the rich and exciting characteristics, the qualitative research approach was also challenging due to its time-consuming and demanding nature, in that it required the researcher to be present, actively listen and critically reflect throughout the research process (Braun & Clarke, 2013).

4.5 THE RESEARCH DESIGN

4.5.1. Explanation of research design

According to De Jong (2008), research design is a plan outlining how the researcher will conduct the study, as well as how observations will be made. This research study aimed to explore the experiences of substance-dependent employees undergoing rehabilitation and reintegration. Therefore, within the qualitative research approach, this research study made use of an exploratory case study research design.

An exploratory case study is described as a design of inquiry with the purpose of exploring a single individual, family, group, organisation, community, society or a phenomenon. Case studies are known for their exclusive focus on a particular case, or several cases in a multiple-case study (Rubin & Babbie, 2010; Creswell, 2014). Exploratory case studies are set to explore any phenomenon in the data which serve as a point of interest to the researcher (Zanal, 2007). In relation to the social sciences field, exploratory research is based on the notion of exploration whereby the researcher identified as an explorer and the exploration in this context will be the perceptions of the participants (Stebbins, 2001).

In conclusion, an exploratory case study design was employed for this study to assist the researcher to achieve an in-depth exploration and description of the participant's experiences of rehabilitation and reintegration into the workplace.

4.5.2 The rationale for research design

The researcher’s background in social work practice and interest in human behaviour and development was a motivating factor for the researcher to include exploratory and descriptive

elements to the research design. The role of case study methods in research becomes more prominent with regards to community-based problems (Zanal, 2007; Johnson, 2006). Through the use of case study research design, the researcher was able to go beyond quantitative statistical results and understand the behavioural conditions through the participant's perceptions (Zanal, 2007). Additionally, this was significant as this research study focuses on the holistic exploration of the substance dependency phenomenon.

Lastly, the case study design assisted the researcher to immerse herself in the activities of the participants to obtain an intimate familiarity with their social life and to identify patterns in the research participants' lives, words and actions in the context of the case as a whole (De Vos, 2011). This provided the researcher with the ability to explore the experiences of participants on a deeper level. Monette, Sullivan and Dejong (2011) highlight that the emphasis is on telling a story, as well as to gain an understanding through the depth and richness of detail provided.

4.5.3 Advantages of case study research design

The detailed qualitative accounts often produced in case studies not only help to explore or describe the data in the real-life environment, but also help to explain the complexities of real-life situations which may not be captured through experimental or survey research. The primary focus of case studies is a description, not a generalisation. The advantage of these methods is the rich and detailed descriptions they provide of people's lives, experiences, and circumstances. In addition, the ability of these methods to allow people to speak in their own voices makes them valuable sources of data (Monette, Sullivan & Dejong, 2011). Case studies are tailor-made for exploring new processes or behaviours, or ones that are little understood (Hartley, 1994). Lastly, an additional strength of a case study research design is that it proves to be a useful methodology in interpretive approaches as it allows the people being studied to play a big role in framing and providing meaning for their lives.

4.5.4 Limitations of a case study research design

Case studies are often accused of a lack of rigour. Yin (1984, p, 21) notes that "too many times, the case study investigator has been sloppy, and has allowed equivocal evidence or biased views to influence the direction of the findings and conclusions". Secondly, case studies provide very little basis for scientific generalisation since they use a small number of subjects, some

conducted with only one subject. The question commonly raised is “How can you generalise from a single case?” (Yin, 1984, p.21). This is a common criticism of a case study method as its dependency on a single case exploration makes it difficult to reach a generalising conclusion (Tellis, 1997). The researcher overcame these limitations by maintaining the focus on exploring and understanding, rather than making generalisations, as well as ensuring the use of self-reflection on thoughts and processes and taking field notes so as to be aware and avoid biased views.

4.6 METHODOLOGY

The research methodology is described as a way to systematically solve the research problem and is said to include many dimensions (Kothari, 2004). It is therefore of importance that the rationale of the research study guides the researcher to make use of effective and suitable methods (De Vos et al., 2011). This section presents the population and sampling, inclusion criteria, research instruments, pre-testing of the search instrument, and the data collection and data analysis methods.

4.6.1 Population and sampling

Paton (2002) asserts that there are no rules regarding sample size in qualitative research. The sample size is based on what the researcher wants to know, the purpose of inquiry, what will be useful and credible, as well as what can be done with the available time and resources. The population that was included in the research study were employees from various workplaces situated in Johannesburg and were service users of an inpatient alcohol and drug rehabilitation centre in Johannesburg. Some of these employees had voluntarily admitted themselves, while others were referred by their employer and were returning back to their workplaces after the completion of their rehabilitation programme. The participants were chosen using purposive sampling. According to Marlow (2005), purposive sampling is referred to as typical case sampling in qualitative research where cases are sought and selected for the study. Purposive sampling aims to generate insight and in-depth understanding of the topic of interest (Paton, 2002). In this research study, 18 participants were purposely selected for this study so that they could contribute purposefully, in order to inform and provide an understanding of the research problem and rationale of the study (Creswell, 2007).

4.6.2 Inclusion and exclusion criteria

The inclusion criteria for the study found participants to be eligible if they were employed individuals in the process of rehabilitation and re-integrating to the workplace. The participants had to be eighteen years or older, voluntarily participate in the study and be service users of the selected alcohol and drug rehabilitation centre in Johannesburg. The inclusion criteria were useful to the researcher when conducting the study as it provided clarity and assisted the researcher to easily refine the search for participants. Additionally, the participant selected based on the specific criteria could effectively contribute to the study which also assisted the researcher in minimising ineffective additions to the research study. The main aspect in the exclusion criteria was that if they did not return to work, they would be excluded. It was imperative that employees returned to work and experienced the reintegration process in order for that process to be effectively explored in the study. The exclusion criteria impacted the research study as some of the participants included in the first interview could not follow through to the second interview due to the fact that they did not return back to work.

4.6.3 Research Instruments

Two semi-structured interview schedules were the research tools used to collect data. According to De Vos et al. (2011), interviewing is the predominant mode of data collection in qualitative research and is particularly used by the researcher to attain a detailed picture of the participant's perceptions or experiences of a particular study.

The research study used two different semi-structured interview schedules for the participants (see Appendix B and C). The first face-to-face semi-structured interview was conducted during the participant's rehabilitation process at the selected alcohol and drug rehabilitation centre. This focused on understanding the participants experiences of disclosure of their substance dependence to management, identify motivating factors for rehabilitation, investigating the support systems that existed before rehabilitation, to explore the work-related experiences such as work conditions, workplace relationships, workplace culture and substance abuse policies, as well as fears of returning back to work. The second face-to-face semi-structured interview was administered when the participants returned and reintegrated to their workplaces and focused on exploring support systems that existed within the workplace during and after rehabilitation, as well as non-work-related experiences of substance-dependent employees, such as personal

contributing factors motivating their substance use and effects of substance dependency on their personal lives.

The research identified both advantages and limitations from the use of a semi-structured interview. The advantages experienced were that the semi-structured interviews were found to be flexible and allowed the researcher to probe and explore on a deeper level when an interesting contribution emerged from participants in the interview. The disadvantage was that once they returned to work it was difficult for them to avail themselves, therefore administering the second face-to-face semi-structured interview with the research participants was often difficult. This, however, also exposes work-related conditions in the study as a whole. Additionally, it was found to be time-consuming, as interviews took a considerable amount of time and produced rich data and this, therefore, extended the length of time needed to transcribe the interviews and proceed in the research process.

4.6.4 Pretesting the research instrument

An important part of the research study was to conduct a pre-test study. According to Yin (2016), pre-testing the research study helps the researcher to test and refine a number of aspects prior to the data collection process or the final study. Pre-testing the research instruments also helps the researcher to reflect and review on crucial aspects of the research study, such as the research design, fieldwork procedure, data collection instruments, sampling procedure, and analysis plans. Pre-testing the research tools benefits the researcher in the sense that mistakes and challenges can be prevented, and the necessary changes can then be made if the need is presented. Barker (1998) also emphasises the importance of pre-testing the instrument once the interview questions have been developed as it would assist the researcher to determine the duration of the interview, identify whether the questions are clear and understood by the participants, and also allows the researcher to identify whether there are areas or interests that have emerged which have not been included. As a result, the researcher of this study prioritised pre-testing the research instrument and the pre-test of the instrument took place at an alcohol and drug rehabilitation centre in Johannesburg and included two participants. These participants only participated in the pre-test of the study and were not included in the final research study. The feedback provided by the pre-test of the study participants reassured the researcher that no changes needed to be made as they felt that the questions were straightforward and understandable. It was determined that the semi-

structured interview schedule assisted in asking open-ended questions and providing clarity where it was needed. In the pre-test study participants understood the questions and purpose of the study and could relate fairly easily to the nature and focus of it, as it explored their lived experiences.

4.6.5 Methods and process of data collection

Two face-to-face semi-structured interviews were used as the method of data collection in the research study. When using semi-structured interviews, the researcher had a set of predetermined questions on an interview schedule, which was used to guide the interview and included open and closed-ended questions (De Vos et al., 2011). The researcher made use of active interviewing. Sacks et al. (as cited in De Vos et al., 2011), explain that active interviewing is not confined to asking questions and recording answers as one would in ordinary conversations, but rather relies on attentiveness, monitoring, and responsiveness.

Initially, appointments were arranged with the undisclosed alcohol and drug rehabilitation centre. The researcher telephonically contacted the rehabilitation centre to identify if there were potential research participants, making use of the inclusion criteria as guidance, and the researcher was then notified when participants were available. The participants were involved in group and individual sessions at the rehabilitation centre and it was therefore important for the researcher to ensure that their rehabilitation process and their programme was not negatively affected. Therefore, appointments were scheduled based on the availability of the participants. The researcher conducted individual interviews with the participants. This was prioritised to ensure that a safe setting and environment was provided for the research participants, as well as to uphold confidentiality as sensitive and confidential personal experiences were explored and discussed. During the first appointment, the researcher provided the participants with an information sheet and an introduction to the study (see Appendix A). Additionally, consent forms for participation were signed (see appendix D). Interviews were initially conducted at one location, which was the selected rehabilitation centre during their rehabilitation process. However, once the participants completed their 28-day rehabilitation programme and returned to work, interviews were conducted in different locations outside of the workplace environment in order to maintain anonymity and confidentiality. Lastly, during both interviews with the

participants the interviews were audio recorded and consent forms were provided and signed (see appendix E).

4.6.6 Analysis of Data

De Vos (2011) explains that qualitative data analysis is, first and foremost, a process of inductive reasoning, thinking and theorising which strays from structured, mechanical and technical procedures, to make conclusions from empirical data of social life. According to Patton (2002), the qualitative analysis process involves transforming data into findings. This involves reducing the volume of raw data information, shifting significance from details, identifying significant patterns and constructing a framework for communicating the essence of what the data reveals. The qualitative data gathered from the face-to-face semi-structured interviews were transcribed and analysed using thematic content analysis. This research study made use of thematic analysis which is defined by Braun and Clarke (2006) as a method for identifying, analysing and reporting themes within data.

The researcher made use of the steps outlined by Tesch (1990), as cited in De Vos (1998) which will provide a structural format for discussion and analysis:

- Transcribing and analysing the interview. Similar thoughts are grouped together and given labels.
- These labels are then reviewed and organised into condensed categories as summaries make data more manageable yet precise, as the original data is not lost (Babbie & Mouton, 2010). Groups of categories are headed under singular themes which mirror the researcher's objectives.
- Direct quotes were used when presenting the data to further clarify and illustrate the categories and themes which are linked to past research in the report's literature review.
- A discussion was presented, comparing past research and relevant theory and literature to the research study and the researcher 'critical opinions, was provided.

4.6.7 Strengths and limitations of the data analysis

The strengths of thematic analysis included the fact that it can be applied to data in different ways and can be used to develop a detailed descriptive account of a phenomenon. Additionally,

it was also identified to be flexible in terms of theoretical framework, research questions, methods of data collection and sample size, as well as the fact that it was relatively easy and quick to learn and to do, compared to other more labour intensive qualitative analytic methods (Braun & Clarke, 2013).

In contrast to the aforementioned strengths, the limitations of thematic analysis included the fact that thematic analysis lacks in providing analytical narratives. It mainly provides collections of extracts within the data and is, therefore, detailed, theoretical and technical knowledge, in comparison to other analysis approaches. Lastly, thematic analysis is identified (how did you overcome) to construct a weak and unconvincing analysis ((Braun & Clarke, 2006).

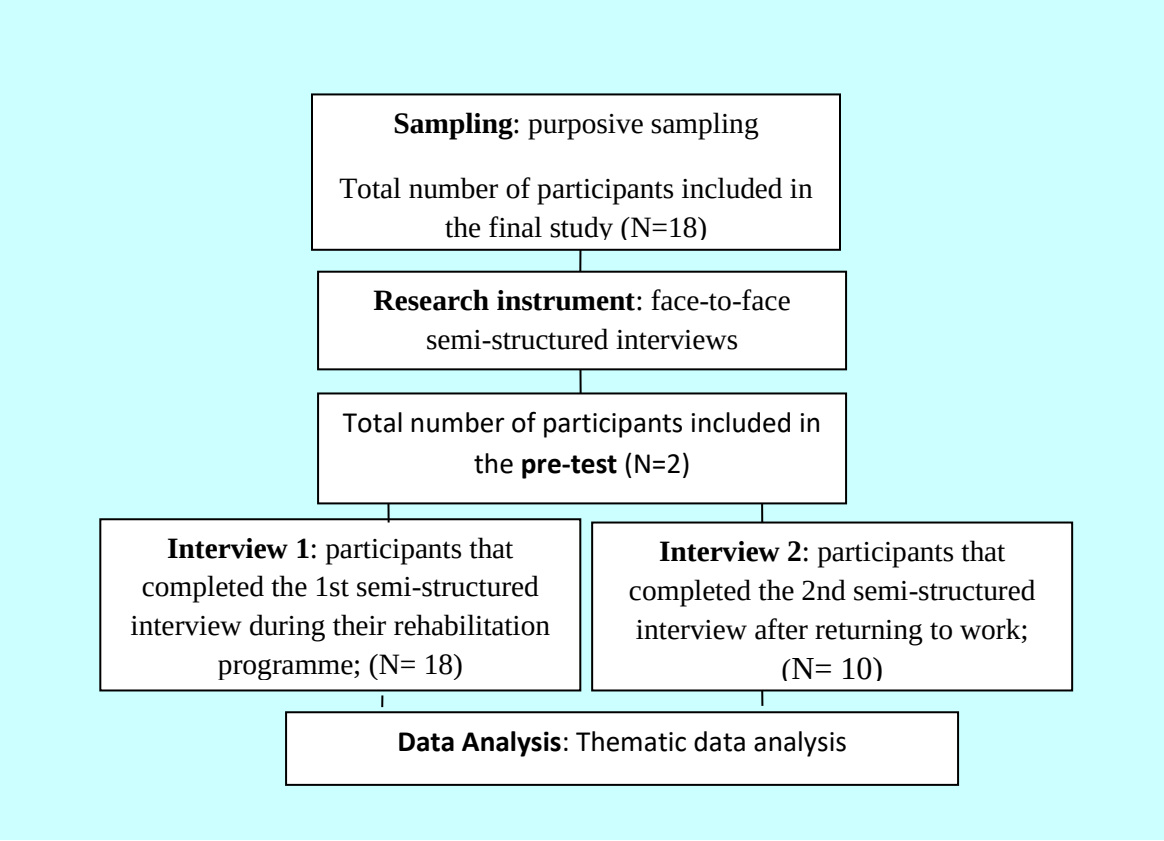

Figure 4.1: Research design methods of the study

The strengths of the methods of data collections and analysis were collected from relevant participants (purposive sampled participants), pretesting of the interview questions had been done meaning that questions were relevant and would be understood well. The analysed data was the relevant data that the researcher sought. The limitations were that some participants did not adhere to the second interview particularly those that had been re-integrated back to the workplace as they were not allowed time off from work. This limited the data saturation that was supposed to have been achieved.

4.7 ETHICAL CONSIDERATIONS

Ethics is a significant and core value which guides social science practitioners. Research ethics specifically has long been a heated topic for methodical reflection, and occasional intense discussion and disagreement among social scientists (Hammersley & Traiahou, 2012). There are various important ethical considerations that should be considered and adhered to throughout the research process. De Vos et al. (2011) highlight that research should be based on mutual trust, acceptance, cooperation, promises, and well-accepted conventions and expectations between all parties involved in a research study. Any research study is capable of raising ethical consideration, however due to the fact that human beings and their lived experiences are the core focus of this study, it presents unique ethical problems (De Vos et al., 2011). The following ethical care and considerations have therefore been taken into consideration for the research study:

4.7.1 Avoidance of harm

According to Creswell (2003), the researcher has an ethical obligation to protect participants within all possible reasonable limits from any form of discomfort and harm that may result from their participation in the research study. This may arise mostly due to the sensitive nature and topics of research studies which may expose painful memories or experiences which participants might disclose which they have perhaps rarely disclosed previously (Richie & Lewis, 2003). The researcher has therefore taken into consideration the importance of the avoidance of harm and has ensured that there is a plan of action to prevent discomfort, for example; the interview was conducted in a safe and confidential area and during and after the interview the participant was made aware of the possibility that they might experience feelings of emotional distress. They were provided with supportive counselling by the rehabilitation centre in Johannesburg where

the study was conducted. It was also considered to be a convenient and most suitable venue for the interviews.

4.7.2 Voluntary participation

A major ethical consideration is to ensure that participation is voluntary at all times. Participants should not feel forced to participate in the study. Additionally, all participants should be informed of the consequences of the study and provide consent to participate in the research study (Rubin and Babbie, 2010). The researcher took the ethical responsibility to promote the self-determination of participants by allowing the participants the right to make their own decisions regarding their participation in the research study. Participation remained voluntary throughout the research study. This was ensured from the initial contact with the participants where the consent form was provided and discussed. The researcher ensured that the participants were aware that their participation was completely voluntary and that they were free to withdraw from the study at any point.

4.7.3 Informed consent

According to Richie and Lewis (2003), it is imperative to obtain informed consent from participants who will be taking part in the research study, as well as informing them about the purpose of the research study, how the data will be used and what would be required of them during the study. The researcher obtained informed consent from the participants by firstly, building rapport with the participants during the initial contact and introduction to the research study. Background knowledge on the study that the researcher planned to conduct was provided, information regarding their participation in the study was provided verbally prior to the study being conducted. The informed consent form was signed on the conditions that the participants understood and were informed on what their participation in the study will involve, that they had the right to refuse to answer questions if they were not comfortable answering, they had the right to withdraw from the research study and lastly that confidential information will be shared in the study, but the researcher ensured that the personal information of the participants will not be revealed in the research study. Additionally, consent for audio recordings was also obtained and the researcher ensured that the audio recordings were kept safe.

4.7.4 Anonymity and Confidentiality

On the subject of anonymity and confidentiality Richie and Lewis (2003) assert that anonymity means that the identity of participants taking part in the research study is not made known outside of the research study. Confidentiality relates to refraining from referring directly to a participant's comments in the research study. The confidentiality of the participants was of importance to the researcher. By promising anonymity, the researcher ensured that research participants identifying details would not be made known. It is essential for the researcher to ensure that the conditions of confidentiality and anonymity was well thought of and considered, as well as thoroughly addressed with the participants and it was agreed that pseudonyms would be used. According to De Vos et al. (2011), every individual has the right to privacy and it is his or her right to decide when, where, to whom, and to what extent his or her attitudes, beliefs and behaviour will be revealed. The researcher has maintained the confidentiality of the participants in the research study through the use of pseudonyms for sharing information in order that the personal identification of the participant is not revealed and jeopardised. This was also done to uphold the agreement of consent between the researcher and participant.

2.8 RIGOUR AND TRUSTWORTHINESS OF THE RESEARCH STUDY

According to Guba and Lincoln (1985), as cited in Padgett (2005), a trustworthy study is one that is carried out fairly and ethically and whose findings represent as closely as possible the experiences and voices of the participants. Guba and Lincolin (1999) maintain that in order to ensure trustworthiness in qualitative research the following criteria must be established, namely credibility, transferability, dependability and conformability.

4.8.1 Credibility/authenticity

The first of the criteria is credibility, which is said to be the most significant. According to De Vos et al. (2011), the goal of credibility is to ensure that the subject has been accurately identified and described. The research finding should, therefore, present accurate findings where the research participant's views match the researcher's representation of them. To increase credibility, the researcher made use of member checking. This was done during the research interview to gain clarity, as well as afterwards. This was useful as it provided an opportunity for the participants to confirm that their views and experiences were accurately represented. In addition to the member check the researcher also made use of peer debriefing whereby a

colleague, that was not part of the research study, assisted in providing feedback and probing the researcher on the research process. Supervisory feedback was also helpful in this strategy.

4.8.2. Transferability

The criteria of transferability involved the researcher identifying whether the findings of the research study could be applicable or transferred from one situation or case to another (De Vos et al. 2011). The researcher understood that transferability was one of the key motives for conducting research therefore, in efforts to ensure transferability the researcher stated the theoretical parameters of the study, providing thick descriptions, as well as the use of various data sources, to support, elaborate and shed light on the research study.

4.8.3 Dependability

The dependability criteria assist the researcher in identifying whether the research process is logical, well documented and audited (De Vos et al. 2011). Furthermore, dependability is concerned with the stability of findings and involves the participant's evaluation of findings, interpretations, and recommendations of the study (Korstjens & Moser, 2018). To ensure dependability all interviews with the participants were recorded, once the consent was obtained. The audio recordings of the interviews assisted the research in the process of accurately transcribing the interview, as well as the analysing of the data. Additionally, the use of member checking also informed the involvement of the participants in the findings, interpretation, and recommendations of the study.

4.8.4 Confirmability

Lincoln and Guba (1999) emphasise the need to identify whether the findings of the study can be confirmed by another, to ensure the conformability criteria. Confirmability is said to be concerned with establishing that the data and interpretation of findings is not a fragment of the researcher's imagination, but clearly taken from data (Korstjens and Moser, 2018). To ensure dependability the researcher made use of an audit-trail in which the researcher and supervisor were involved, ensuring the accuracy of the research findings and reflexivity. The researcher ensured transparency of the research steps taken throughout the research process and reflectively recorded thoughts, feelings, and experiences throughout the data collection process.

4.8.5 Reflexivity

Reflexivity is a process of being self-aware whereby the researcher makes constant efforts to consider how her own thoughts and actions have shaped the research process. Reflexivity is the researcher's continual critique and critical reflection of her biases and assumptions and how this influenced the research study, as well as the continual evaluation of feelings, experiences, thoughts, and location of discoveries and meanings (Begoray & Banister, 2012). Reflexivity, therefore, assisted in ensuring that the researcher is conscious and present throughout the process. Begoray and Banister (2012) highlight that researchers are part of the world they study and therefore closely involved in the process and product of the study. There are numerous advantages of reflexivity, such as providing a positive contribution to the rigor of case study research and it assists the researcher and the reader in ascertaining the authenticity and validity of the study's results.

Being a researcher grounded in the profession of social work and with knowledge of occupational social work practice, was beneficial in conducting this research study. The social work skills that the researcher has acquired has especially played a crucial role in developing rapport with the research participants and contributed to the participants easily and openly disclosing their story, experiences, and perceptions. Although the researcher's social work experience has contributed to the researcher's ability to gather valuable data from the participant's narratives, it is also equally important to note the possibility that the researcher may over-identify with the research participants, which seemed to come naturally at times during the research study. However, the researcher made use of reflexivity to ensure self-awareness, as well as the ethical considerations, to remain focused on the role as a researcher and not a therapist. The researcher also understood the importance of remaining non-judgemental and unbiased and needing to use empathy in order to make the participant aware that they are understood and heard.

The researcher experienced no challenges with gaining entry. The researcher was warmly welcomed and assisted throughout the process of identifying potential participants in making use of the rehabilitation centre to conduct the research. The researcher, however, experienced delays in the process of finding employed substance dependent employees who are returning back to the workplace. In addition to the researcher's delay in obtaining participants who fit the research

study's inclusion criteria, the researcher experienced challenges when conducting the second part of the interview which focuses on the participant experiences of reintegration to the workplace. The researcher was able to reflect on the inconsistency and outcome and became aware of the fact that the nature of the research study was sensitive, as a recovery and re-integrating process affects every individual differently. Additionally, the fact that the participants came from various areas and workplaces and were often not able to meet the researcher for the second interview was prohibitive, and lastly the fact that the participants were expected to return to work and the nature of work does not always allow for flexibility and time to accommodate a research study. The fact that the research study was voluntary and the participant was aware of their right to withdraw from the study at any point meant that the researcher had to allow for self-determination.

4.9 LIMITATIONS OF THE RESEARCH STUDY

4.9.1 Participants

The researcher interviewed eighteen participants for the first section of the research study and only eight of the eighteen participants were interviewed for the second section of the research study. Most of the research participants were not able to commit to the second part of the interview due to work constraints and in some cases families and participants reported relapse. The research found a limitation of the study to be the unplanned withdrawal of participants.

4.9.2 Research design and data collection methods

The interview schedule that was administered on the second occasion when the participants had returned and reintegrated to their workplaces was identified to be limiting. The research had not gained the same participation at this stage compared to the use of the first semi-structured interview schedule and this was due to the fact that the participants were absorbed into the workplace and struggled with the availability to meet for the face-to-face interviews. Additionally, the nature of substance dependency means there is the chance of relapse, which disqualified those who had relapsed from the study. Also, for some participants the fact that they did not return to their workplaces after the completion of their rehabilitation programmes hindered the process of conducting the second interview, this affected the study as very little was contributed to the exploration of the reintegration process of these participants.

4.10 CONCLUSION

In conclusion, this chapter has presented the research design and methodological framework of the research study. The aims and research questions underpinning the study were provided, leading into other intricate details regarding the sampling methods, research instruments, pretesting procedure, data collection and data analysis procedure were specified. Lastly, the ethical considerations and how trustworthiness was ensured, was explained. The next chapter will focus on findings of the research.

CHAPTER 5

RESULTS AND DISCUSSIONS OF FINDINGS

5.1 INTRODUCTION

In this chapter, a discussion of the results and key findings collected and contextualized from the research study will be provided. The presentation of the results and key findings will be guided by the research questions, aims and objectives underpinning the study. The data collected will be discussed in accordance to the literature presented in chapters two and three. The results and key findings will be demonstrated through the use of tables, graphs, and verbatim quotations in the hope to shed light on the participants' experiences that the study sought to explore.

5.2 DEMOGRAPHIC INFORMATION

Table 5.1: The demographic profile of participants (N=18)

Demographic factor	Sub-category	N
Gender	Female	2
	Male	16
Race	Black	9
	White	3
	Coloured	6
	Indian	0
	Other	0
Age	18-25	1
	26-35	6
	36-44	9
	45-55	1
	56-65	1
Reported substance used upon admission	Alcohol	9
	Marijuana	5
	Cat	7
	Crystal Meth	3
	Cocaine	2
	Rocks	1
	Mandrax	1
Marital status	Single	10
	Married	7
	Divorced	1
	Widowed	0

The sample of the study comprised of eighteen participants (N=18). All eighteen participants were included in the first semi-structured interview and of the eighteen participants eight participated in the second semi-structured interview. Sixteen of the eighteen participants identified themselves as male, and two as female. Furthermore, of the eighteen participants, nine identified themselves as black, three as white and six as coloured. The age of the participants was categorised based on ages ranging from 18-65 years. The participants reported the use of alcohol, marijuana, cat, cocaine, rocks and Mandrax upon admission to the rehabilitation centre. Most of the participants reported use of alcohol while the least number of participants reported the use of rocks. And lastly regarding marital status, ten participants reported to be single, seven were married and one divorced.

5.2.1 The race and gender information of participants

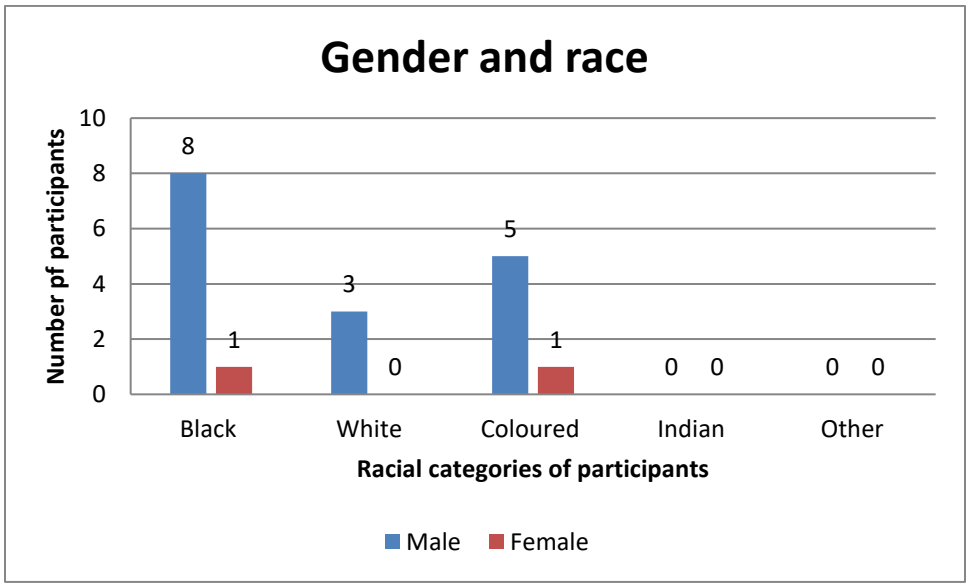

Figure 5.1: Gender and racial category (N=18)

The demographics of the research study illustrated in the figure above highlight the gender of the participants and their race. McHugh, Votaw, Sugarman &Greenfield (2017) state that gender defines the environmentally and socio-culturally-defined roles for men and women and also contributes to the initiation and course of substance use and substance use disorders. Of the eighteen participants, the majority were males. As displayed in the figure above, sixteen of the eighteen participants were male and only two of the eighteen participants were female.

Greenfield (2016) explains that compared to men, women are less likely to receive treatment for substance use disorders in the course of their lifetime. In addition, Greenfield (2016) also highlights specific barriers and obstacles hindering woman from seeking treatment. This includes stigma, lack of assistance with child care for those who are parenting, lack of support from partners and family, as well as insufficient financial resources for rehabilitation services, to name a few. The latter finding is evident in this research study with far more males than women. There is a clear major difference in the coping mechanisms of males and females. Help seeking behaviours are far more acceptable and established in women, who will approach mostly friends. By contrast, men are inclined to "act out" by using aggression and substances to cope with their difficulties. Afshari and Miri (2016) are psychologists that believe that men are inclined to act out their aggression, resulting in higher levels of substance abuse, crime and violence. The mechanism is reversed in women who turn their anger inwards, resulting in depression

This reversal of coping styles is evident from childhood where boys are more likely to present with ADD, ADHD and Oppositional Defiant Disorder. This is a result of the valorization of the Alpha males, and "Cowboys don't cry" stereotype in Western societies. In adulthood the disproportionate number of incarcerated males speaks to the gender differences in coping methods (Saraiya, Campbell & Hien 2019). Such cultural beliefs influence the different copying mechanisms based on gender.

Furthermore, the emerging changes in societal roles and attitudes toward women should also be mentioned. As well as the increase in the number of women entering the workplace in general, this may influence not only opportunities to drink but also a drinking culture (Bolton, 2011). Consequently, it is anticipated that the disparity between male and female statistics for drug use will begin to converge, as women move into working environments and begin to experience stressors that have been historically confined to males, particularly as breadwinners.

Regarding the race of the participants, nine of the eighteen participants racially identified themselves as "black", six of the participants identified themselves as "coloured" and only three of the eighteen participants identified themselves as" white".

5.2.2 The age of participants

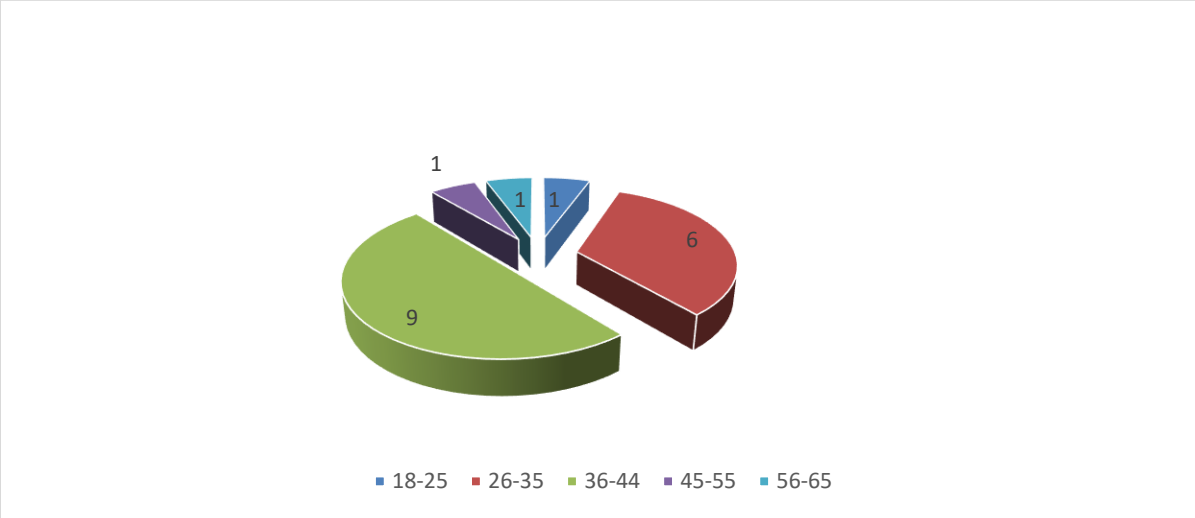

Figure 5.2: Age of Participants (N=18)

According to Koechl, Unger & Fisher (2012), research has shown that substance use, abuse and dependency is not limited to a specific age group. Regarding the age of the participants in the study, one of the eighteen participants was categorised in the 18-25 years age category, six respondents were categorised in the 26-35 years age category, and nine participants were categorised in the 36-44 years age category. Additionally, one participant was included in the 45-55 years age category and one participant was also included in the 56-65 years age category. Of all the participants, the youngest participant was 24 years old and the oldest participant was 56 years old.

The nature of alcohol and other drug use, abuse and dependency changes over the course of a person's life (SACENDU, 2018). This highlights role transitions that develop based on age, for example when individuals assume adult roles - they take on jobs and careers, enter into marriage and take on parental roles which influence the extent of their drug use. Strickland and Smith (2014) argues that alcohol and other drug use patterns and drug choices must be studied over a lifespan in order to understand and begin to control its impact on human behaviour and experience. Particularly as prescription and opioid abuse are largely found in older individuals, particularly women.

5.2.3 The substances participants reported to use upon admission

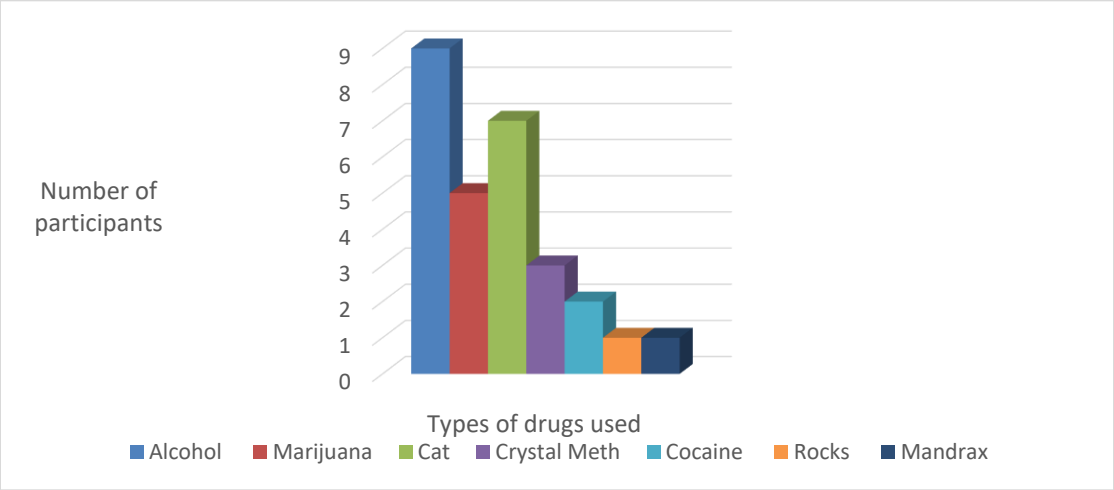

Figure 5.3: Substance used upon admission

The drugs that the participants reported using upon admission to the rehabilitation centre included alcohol, marijuana, cat, crystal meth, cocaine, rocks and mandrax. The most used substance was identified to be alcohol, as displayed in the figure above. Nine of the participants reported using alcohol. It is reported that alcohol remains a dominant substance in use and still causes the biggest burden of harm in terms of both communicated and non-communicated diseases (SACENDU, 2018). In the findings regarding substances used, six of the eighteen participants reported alcohol to be the primary substance. Participants that primarily used alcohol reported not to use any other substance at all. Smook, Ubbink, Ryke and Strydom (2014) point out that South Africa is facing an increase in substance use among employed people. The significantly higher use of alcohol as a drug of choice can be attributed to its availability and the fact that it is socially acceptable form of substance use. Furthermore, the increase in the number of alcohol abusers, including hazardous drinking patterns and marijuana use, is a major concern. Due to the recent legalization of marijuana for personal use in South Africa it is anticipated that the number of substance abusers in this category will increase.

In contrast, participants who use illicit drugs reported that they would also either use alcohol, marijuana or mandrax as their secondary drug of choice. This highlights trends of polydrug use as according to Ross, McElrath, Measham and Moore (2013. The motivation for polydrug use depends on the individual's drugs availability, the circumstances of usage and the effect desired

by the user and socio-economic resources. Polydrug use occurred when participants desire functions such as sleep, to gain appetite, to relax, to stay awake or to function productively at work.

5.2.4 The job titles of participants

The study focused on the experiences of employed substance dependent employees and therefore the participants included in the study were employed at various workplaces in Johannesburg. A representation of their job titles is displayed in the figure below.

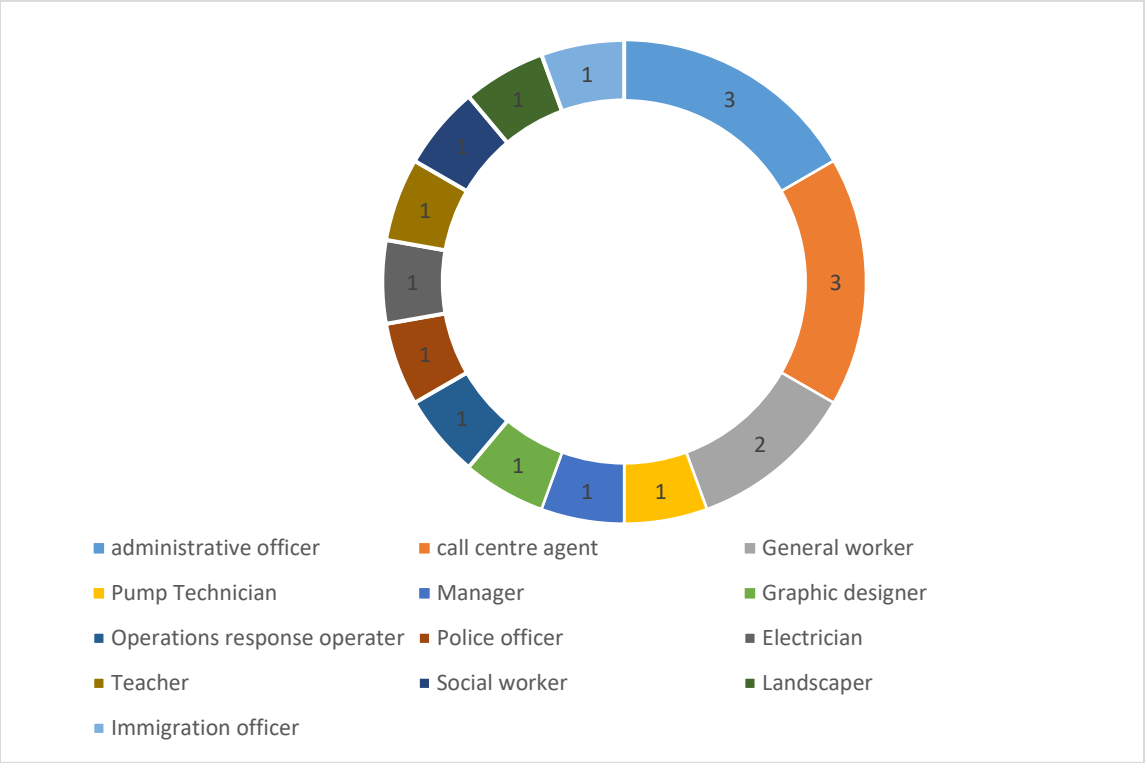

Figure 5.4: Job titles of participants (N=18)

5.2.5 Participants reasons for substance use

Various sources of literature and research speak of the effects and impacts of substance dependence in the workplace. However, very little is known about the actual experiences of the substance dependent employees. According to Mogorosi (2009), the use and abuse of substances occurs for a number of reasons, including individuals trying to forget about problems that arise at home, socially or at work. Therefore, in order to understand the experiences of substance dependent employees it would be important to understand the reason contributing to their use of

substances., Rooney, Harpworth and Stom-Gottfried (2013) highlight that understanding an individual's drug and alcohol use is essential for a number of reasons as problematic use of substances may be related to other problems in work, school, and family functioning.

Mc Mann et al. (2011), state that there are many diverse reasons that explain why individuals use substances. These reasons are said to stem from the individual and his/her interactions with their environment. In addition, two main views on the possible reasons for substance use in the workplace have evolved. Firstly, alcohol and drug problems are external to the workplace and are often carried into the workplace. Consequently, consideration is given to factors such as genetic susceptibility, environmental, cultural, and psychological as well as personality attributes. Secondly, conditions within the workplace contribute to employees' substance use, resulting from the organisation's culture and environment. The participants pointed out a number of reasons for their substance use which include social use, coping mechanism, stress, trauma, family influences, environmental and financial. The themes are discussed in detail below;

- **Social use**

Of the eighteen participants, three identified their reason for their substance use to be associated to the feeling and experience of pleasure from drugs and from being intoxicated. This highlights the connection of their drug use to their social environment and other drug users (Coomber et al, 2013). According to Strickland and Smith (2014), the social environment plays a crucial role in determining the likelihood that an individual will use drugs or develop a substance disorder. This reveals significant factors that social use contributes to substance dependence, as well as the risk factors that enable substance use. In addition, Mc Mann et al. (2011), state that there is a trend in some occupations where there is a culture for employee to drink or use drugs together as a means to unwind from stress and encourage social bonding, even though this form of bonding could be considered harmful. In that regard some participants mentioned that:

> *"Friday after work we would go to News café, have a few drinks and that's when I saw that they are using. I confided in them and told them I am also using and eventually it became a norm." (P2)*

> *"We would have casual drinks on Monday because of babalas, but I carry on using it."(P11)*

"Uhm and its very nice to be honest, it's that feeling that you get, especially certain places actually when you using ecstasy, E, it gets you in a zone, everyone in on that vibe so you feel the music you feel, your senses just come alive. It's like a party drug." (P4)

- **Coping mechanism**

Using substances in order to cope was common amongst the participants. Five of the participants explained that their drug use helps them to cope. Substance use is often considered a maladaptive or avoidant coping strategy and may be used as such by those who go on to develop a substance use disorder. Effective coping is consistently referred to as a key ingredient in relapse prevention, and it has often been used as a component of treatment interventions (Kuper, Gallop & Greenfield, 2011). According to Mc Mann et al. (2011), alcohol is considered to be the fastest acting, most effective and easily available tranquilizer. It is attractive for its immediate relaxing effects and means of providing a feeling of escape from reality or depression. Similarly, drug use provides an escape from the sometimes painful realities of life. Evidently participants had this to say:

"I saw that okay, it took quite a bit of pain I guess at the time away, uhm, two months ago I lost my dad, I was in a car accident, my daughter was extremely sick so I was going through quite a hectic time." (P 7)

"Emotions, something happened that pushed me to rather not be me." (P1)

"When we did it on Sunday, then on Monday I would need something to help me for my day at work and then it escalated to me absconding from work, not going to work, being late for work and so forth." (P4)

- **Stress**

Four of the participants' reasons for substance use stemmed from their attempts to decrease or alleviate stress. According to Sinha (2009), stress has long been known to increase vulnerability to dependency. In addition, stress experiences can be emotionally or physiologically challenging and activate stress responses and adaptive processes to regain balance. The participant's experience of stress seems to emanate more from emotional stress and in turn their use of substance is mainly to defuse or to conceal. In contrast, participants also use substances to aid their work-related stress. According to Mc Mann et al. (2011), stress at work whether real or

perceived, can produce a negative emotional state in individuals, rendering them vulnerable to alcohol or drug use.

"Personal strain and stress levels, I'd hit depression sometimes." (P18)

"To contain my stress and as a tool that I use to finish off my jobs, or for energy."(P12)

"I'm under a lot of stress." (P5)

- **Trauma**

According to Najavits et al. (2017), there is an important linkage between substance dependence and traumas as well as trauma related disorders such as post-traumatic stress disorder. Three of the participants shared that the reason for their use was associated with the death of a loved one. The experience of loss is therefore identified to be a contributing factor to their use. It was also identified that the loss experienced by all three of the participants was a loss of their parents. This points out that their loved ones were significant people in their lives and therefore this indicates severe emotional triggers to their substance use and may therefore prompt relapse.

"I started using just before my mother passed on, maybe at the age of twenty-one years old, but then I recovered by myself, I relapsed after my mother's death. It was like I felt like I had nothing left and after I got married, I relapsed after my mother's death it was an Easter, very painful, especially this time of the year of every year - very painful because her birthday is coming up at the end of the month." (P13)

"I lost my father and my wife and I have been fighting." (P5)

"My mom passed away, and I wasn't able to deal with that so I was drinking every single day." (P1)

- **Family influences**

  Mc Mann et al. (2011), states that family roles play an important part, in whether an individual will develop a substance dependency or not. In particular, the stability of family life at the age of onset of substance use is an important family or social risk factor.

"When I saw that everyone was using at home then I sort of fell into it." (P6).

- **Environmental**

Participants highlighted the exposure of the environment to be a contributing factor to their substance use. According to Jadidi and Nakhee (2014), environmental factors can be a significant precursor in the development of alcohol and drug use.

"*Where I live drugs are the in thing, everyone does it." (P9)*

"In Soweto, on weekends and at the end of the month we are at the shabeen." (P17)

- **Financial**

Financial challenges or abundance can lead to substance abuse; one may use substance due to the availability of funds to purchase yet on the other hand due to financial strain some may hope to forget their financial challenges through the use of substance (Mogorosi, 2014).

"We were going through a financial crash so other stressors that played a huge role. (P11)

"I used mostly when I had money." (P17)

"When it was payday I would stress because you know, my car payments and house payments. There were just a lot of expenses." (P9)

5.3. Objective 1: To understand the experiences of substance-dependent employees disclosing their substance dependency to management.

- ***Experiences of disclosure***

The participants were asked whether they had disclosed their substance dependency at work and fifteen of the eighteen participants reported that they had disclosed their substance dependency. Three of the eighteen participants shared that they have not yet disclosed their substance dependency at work. The participants that did not disclose his/her substance dependence, shared that their reasons hindering them from disclosing their substance dependency was due to the fact that they feared being judged, discriminated, victimised and losing their jobs. The participants who did disclose their substance dependence to their manager were already experiencing negative effects on their work and disclosed when changes in their behaviour in the workplace were identified or reprimanded.

"Fear of having to go through what I'm going through now, judgement, discrimination and victimization." (P4)

"Well obviously, I'm working in the banking sector, so drugs are not allowed and if I disclose it could probably cost me my job." (P13)

"I thought I would lose my job because I got so many chances at work, I signed so many warnings. This time I can't mess up, it's all up to me now."(P3)

"No, not at all. People were completely oblivious up until three weeks ago when I was sat down for an absenteeism review. So, he convinced me that either you raise your hand or we are declaring you incapacitated, so I then raised my hand and said 'okay, this is it', so then they decided to send me for rehabilitation."(P8)

It was evident that disclosing their substance dependency was not an easy experience for the participants. Mc Mann et al. (2011), points out that the failure of the employee to disclose to their employers may be sufficient cause of termination of employment. It could also be argued that the disclosure of substance dependency is generally sufficient grounding upon which employers could terminate the employment of substance dependent employees, regardless of the employee's disclosure. Hence a great amount of apprehension is experienced by the substance-dependent employees in this process.

The participants expressed their fear as a contributing factor that hindered them from disclosing. Participants mainly wanted to avoid the risk of losing their jobs. This highlights that their jobs presented as of significant value, so much so, that they would conceal their substance dependency.

In contrast, the employees who disclosed their substance dependency highlighted that they felt that it was wise and the best option for them to inform management as their substance dependency had resulted in concern, investigation, and grievance due to their late coming and absenteeism. Therefore, disclosing their drug use provided clarity as to their alarming behaviour and drastic changes observed in the workplace. This shows that the participants' decision to disclose their substance dependency to management was prompted by the effects of their substance dependency that emerged in their work-life. According to Dwoskin, Squire and

Burdick (2012), handling instances of substance use and abuse at work is a challenging issue confronting employers.

Additionally, based on the experiences shared by the participants, they seemed to disclose their substance dependency after participating in disciplinary measures and were on the verge of losing their jobs. For instance, a participant highlighted "*I ended up telling them because now I was in big shit*" (P1) Therefore, even the participant that had disclosed their substance abuse experienced a sense of fear and vulnerability in doing so. For example, one participant shared, *"I felt ashamed because now when I look at them, they don't look at me the same way". (11)*

It was also observed that participants would disclose their substance dependency when admitted into rehabilitation, as one who was admitted said: "*I think they know now. I sent them an email and told them about my problem."(P12)* This further highlights their fear and the avoidance of directly communicating and disclosing their substance dependency.

- ***Actions from management***

Participants who had disclosed their substance dependence were asked to share the reactions of their managers, supervisors or employers. From this, different experiences were shared. Fifteen participants shared positive reactions from management, highlighting that management was supportive and assisted them to seek rehabilitation or initiated a referral to employee assistance and wellness programmes as an attempt to assist.

> *"They said they going to find me help and he did, and then I went to see a social worker and she referred me here."(P7)*
>
> *"Oh, completely supportive, because of the nature of our relationship and he had also had experiences where in his capacity as a lawyer he had people previously he had to assist in this regard."(P9)*
>
> *"Uhm, they said yes, we are willing to help you, no problem. They were excited. But it was because they saw that I work hard." (P4)*

In the experiences of the participants on disclosing their substance dependency, reactions from management seemed to be supportive and they were willing to assist the employees to seek

assistance. One participant reflected and shared, "*I walked up to her and I said listen, I have an alcohol problem, I've booked myself into rehabilitation. And she said fine, you've had the strength to admit it, phone me when you done and you can start again." (P6)*And similarly another participant added, *"At the time they said it was a brave move and they were wishing me the best, and so forth."(P14)* This highlighted that some reactions from management were supportive but maintained a sense of withdrawal in this process once the participant has disclosed. Another participant shared, *"I feel I'm very fortunate. I've got a very helpful and caring environment so I feel it's actually a good place*." (P16)This highlighted the positive impact of a helpful and caring environment and in turn how this has contributed to the participant feeling embraced and understood in the process of disclosing. In addition, another participant shared, "*He also told me about his story, his addiction story of alcohol. He told me ways of getting better, like for instance he went to rehab, and he became a better man at the end of the day."* (P11)This reveals self-disclosure from the employer, which in turn contributed to the participant feeling understood and provided motivation for the participant to seek help.

In contrast three participants highlighted that management was not supportive in their reactions. One participant shared, "*I could notice that they became, like, very hostile towards me", (P1)* and another participant shared, "*they were a little bit taken aback" and "they knew about that, they were just waiting for me to disclose*". (P15)

Mc Mann et al. (2011), explains that often employers are unaware of substance dependency problems among the workforce until they start looking for them. Employers frequently avoid confronting the issue for many reasons, such as the fear of a situation that they know very little about, which prompts uncertainty about how to deal with it, respect for individuals' privacy and fear of confrontation, to name a few.

In conclusion, from both the positive and negative experiences and reactions that participants shared regarding the disclosure of their substance dependency, it was noted that all participants expressed a sense of value related to their jobs. This is clear as the disclosure of their substance dependence mainly stemmed from the fact that they did not want to lose their jobs, and as a result of that, they would rather seek assistance and attend rehabilitation than lose their jobs.

Therefore, we can see that their jobs were motivating factors in their decision to rehabilitate their lifestyles.

- ***Disclosing their substance dependence to colleagues and their reactions***

The participants were asked whether they had disclosed their substance dependence to their colleagues. Fourteen participants shared that they have disclosed their substance dependency to their colleagues.

> "*They were shocked, they never expected me to be one that was using." (P9)*
>
> *"One knew, that I know of, that saw me kind of, but he was not involved." (P18)*
>
> *"In the later stages you know, for every small thing that happens you'd find people looking at you weird." (P6)*

The participants that disclosed their substance dependence to their colleagues reported that they have good relationships with their colleagues. In this regard participants felt supported. It was also noted that some participants only disclosed to a few colleagues, which may highlight that they disclose to the colleagues they felt comfortable with, for example one participant shared: *"I told three teachers before, then I went to my boss. Then those three teachers - they told me as if they care, they advised me to go to church and seek help."*(P3)This highlighted the supportive and motivating role of these colleagues. In addition, one participant shared, *"They eventually ended up rebuking me and colleagues looking after colleagues, "ay, you need to stop it, this is not good enough, and it must come to an end."(P7)* This highlighted that colleagues of this participant began to confront the participant's negative behaviours. Mc Mann et al. (2011), points out that colleagues can either cover up for their fellow employees, or increase their frustrations. Additionally, among the participants who disclosed their substance dependence it was noted that the participant's colleagues would reprimand and provide suggestions that could limit the participant risk of exposure at work. For example, one participant shared, "*They tell me I must reduce, you must make sure when you are coming to work today stop at least at an early time, or don't drink at all when you know you coming to work."(P13)*

In addition, some participants shared their experience of challenges in their relationships with certain colleagues. They highlighted colleagues laughing and making fun of their problem and

their personal information being spread among the colleagues. Some participants shared that their colleagues would ask questions relating to their changes in weight and not know that it was due to their substance use until they disclosed. Interestingly, one participant also highlighted their introverted personality and their tendency to naturally isolate themselves and therefore focus more on work rather than on socialising with their colleagues.

Four of the participants stated that they did not disclose to their colleagues. One participant shared, *"No, they were completely oblivious, though I must say they went to my superior and they raised concern. But I don't think, in terms of them knowing as a fact, they didn't know, but they did raise concern regarding my temperament" (P5)* This highlighted that although the participant had not verbally disclosed to his colleagues, his colleague has observed changes in his behaviour and has resorted to reporting this behaviour. Additionally, one participant who had not disclosed her substance use to her colleagues shared, "*Not that I have said, uhm, but I know our division is a group of 12 woman, you know how that goes, and as much as they would say 'no let's just say to everyone she's on leave', I know how it goes, there is no confidentiality."(P10)* This highlighted challenges with regards to confidentiality, even towards these kinds of sensitive matters. The lack of confidentially is identified to negatively expose and affect the participant. In support, Akabas and Kurzman (2005) assert that confidentiality takes on a unique importance in the workplace when it comes to addiction.

5.4 Objective 2: To identify factors that motivated the employees to rehabilitate their lifestyle.

- ***Various motivational factors***

According to Gard (2013), motivation can be defined as anything that drives and sustains human behaviour. In addition, Rooney, Hepworth and Stom-Gottfried (2013) maintain that motivation is a dynamic force that is strongly influenced by ongoing interactions with the environment. Therefore, to assess motivation, one needs to understand the person, his or her perception of the environment, and the processes that he or she goes through in deciding to seek help.

Various motivational factors to rehabilitate their lifestyle were shared. Firstly, family played a huge role in motivating participants to rehabilitate their lifestyles. For the participants, family mainly represented their partners, mothers, children and siblings. In highlighting their family,

they also reflected on the negative impact and relationship conflict their substance dependence has caused. Their rehabilitation programme represented a sense of hope and change due to the fact that they didn't want to hurt, or cause further suffering or loss to their loved ones. According to Hepworth, Rooney and Stom-Gottfried (2013), family add to rich opportunities in which individuals experience a sense of belonging, loyalty, reciprocal care and interrelatedness.

Secondly, self-motivation was identified to be a common factor of motivation for the participants. Participants reflected their personal decision and need for change. The financial, physical and emotional challenges, turmoil and frustration that the participants experienced could also be identified as a contribution to their self-motivation and determination to seek help and rehabilitate their lifestyles. In addition, the need to improve, be a better person, take responsibility and rectify mistakes contributed to self-motivation. Rooney, Hepworth and Stom-Gottfried (2013) state that convictions, beliefs and ideas about the self, have been recognised as a crucial determinant of human behaviour.

"I have dreams and aspirations, not about saving my job." (P7)

"I didn't see myself in the mirror." (P3)

Thirdly, the experiences that the participants reflected on, such as the accidents, near death experiences, death of a loved one, relapsing - these alarming experiences were motivation to make a change in their lives and rehabilitate their lifestyle. Lastly, employment was a factor, as all of the participants were returning to their workplaces after the completion of their rehabilitation programmes. For most participants their jobs were a main motivational factor. Financial stability that their employment provided seemed to be of importance as it sustains their livelihoods and their families. Additionally, some wished to be promoted to a better position at work.

5.5 Objective 3: To explore substance dependent employees' experiences in their work-life.

- ***Working conditions***

The participants were able to share their experiences at work as a substance-dependent employee. Firstly, participants shared their experiences of working in stressful working conditions. One participant shared, *"Well it's a call centre, so I'd say there is a lot of pressure,*

and a lot of workload". (P5) This participant highlighted the stress that occurs due to the pressure to perform, achieve targets and manage the workload. According to Landy & Conte (2007, the demands of a given job, such as the pace of work, workload and the number of hours worked, can contribute to the experience of stress and result in subsequent strain. Another participant shared, "*It's intense, we are a reaction unit where we need to react at accidents, need to react to robberies, different occasions where we need to be on standby for any call from our supervisor. So stress levels are at its peak."(P9)* Stressful working environments were identified to be a common experience among the participants.

In contrast, one participant shared:

"It was shifts - I would know now that because this week I'm working from 9-5 or actually from 9-5:30. If it's a longer shift I would basically pre-plan more substance to help me survive throughout the day so I would have monster energy drinks, a full bag of Cat and know that okay this is going to need to last me through the day." (P13) According to Landy and Conte (2007), shift work has an important negative influence on the worker's satisfaction and performance. Additionally, Mann et al. (2011), highlights that shift workers identified to be an at risk group due to the stresses of their work, such as irregular hours and poor sleeping patterns.

In addition, participants also shared that they were passionate about their jobs. They expressed confidence in their efforts at work regarding tasks and accomplishments. Participants highlighted that, in fact, their work statistics revealed that they have excelled in their work targets and they have stressed their ability to master their tasks and ability in the workplace. It was also noted that participants would compare their work ability to that of their colleagues and highlight that they have reached more targets and that in fact, their drug use was performance enhancing. Participants compared themselves to colleagues who do not have a substance dependency, who do not arrive late, are not absent and have worked more consistently than they have. This revealed the participant's justification in asserting their value in the workplace regardless of their substance dependency. One participant also highlighted how he would share his target with his colleagues who had not reached theirs. In addition, this could show that in some cases where the participants are monitored based on performance and productivity, they may try to make up for

their behavioural challenges resulting from their substance dependence and ensure that they perform.

- ***Workplace culture***

Forne and Brown (2010) points out that workplace substance use culture is identified to be an important predictor of employee substance use. The workplace culture is important because it shapes employee's interaction in the workplace. For example, one participant shared their impression: "*It was government, everyone was drinking, and we used to drink all the time*", similarly another of the participants shared his experience of "*drinking and using substances with colleagues after work.*"(P2) This revealed the exposure to drinking culture as employees were accustomed and exposed to these workplace behaviours and attitudes. Mogorosi (2009) states that many workplace factors are also identified to unintentionally enable, induce or provide a "supportive" atmosphere for employee substance abuse. This is evident as participants shared that they did not initially use substances at work, however eventually they started to use at work when their drug use became excessive and they also used as a coping mechanism for work-related matters, such as to manage stress, and workload, to increase productivity and to stay awake.

One participant was of the opinion that, "*you can only really answer that question by bringing society into play, because it's a societal stigma that is placed on addiction, it's not necessarily workplace specific. I think society determines that more than the workplace.*" (P16) This perspective was relevant and speaks to the social–ecological model employed in the study as it highlights the impact, influence and interrelations between the participates immediate and social environment.

Additionally, with regards to workplace culture, the focus was on identifying the participant's perceptions on how drugs and alcohol are viewed in the workplace. The participants perceptions included: "*Obviously it's a bad thing, right. With alcohol, I wouldn't say it's as bad as, I would say, with the drugs". (P1)* This comment highlighted that the perception of substance use is generally negatively perceived, however the workplace is more accepting of the use of alcohol. Another participant added, "*I think obviously it is frowned upon in the workplace, my case specifically, but I do think there is a culminating spirit in terms of rehabilitation" (P18)* This

participant held a management role in the workplace and therefore, in sharing his perceptions on the views of alcohol and drugs in the workplace, it's seen that his association was of a more negative perception of alcohol and drugs, from a managerial perspective and experience. In addition, one participant added, "*as a form of being weak, a form of weakness not being able to say no*". (P7) This highlighted that the use of alcohol and drugs, and the inability to say 'no', was perceived as a sign of weakness, therefore indicating a negative connotation on the user.

Additionally, another interesting experience shared by the participants is their ability to recognise other users in the workplace. This enabled their drug use in the workplace. As some participants, whose nature of employment meant they did not have contact with clients, would drink whilst working, and during working hours, they would use with their colleagues. As a result, they ended up enabling one another's use and substances could be easily supplied and organised.

- ***Knowledge of substance abuse policy***

Smook, Ubbink, Ryke and Strydom, (2014) indicate that due to the negative impact of substance abuse in the workplace as well as the legal obligations employers are forced to develop workplace policies and practices. McCann et al. (2011, p.211) specifically refer to the importance of clear policies and procedures for dealing with substance abuse and dependence in the workplace. The participant's knowledge of substance abuse policy in their workplaces was investigated. The aim was to firstly explore the existence of substance abuse policies in the workplace, as well as to explore what the participants knew about the substance abuse policy. According to the findings eight of the eighteen participants did not know if there were substance abuse policies at their workplaces. One participant shared;

"some of the information is probably the information that we must dig for ourselves there is no chart where you can see it. I've never seen something like that I don't want to lie, if it is there maybe it is somewhere in the files in someone's office who has printed them but it was not presented properly even if it wasn't presented me know that we must not drink or take alcohol at work we are adults obviously but maybe put it there where we can see." (P14)

In contrast, ten of the eighteen participants confirmed the existence of substance abuse policy in their workplaces however, they conveyed a lack of awareness and knowledge of the substance abuse policy. For example, one participant shared;

"Yes, there is a policy but we actually know nothing because it has not been discussed, we just know it's there." (P1)

Of the ten participants who confirmed that there was a substance abuse policy at their workplaces the researcher explored what they knew about substance abuse policy. Participants' verbatim transcripts read as follows:

> *"Not much, well what I would have known about it is that if you get caught with alcohol or if you get caught taking other substances or if you get caught drinking on the job it's like an immediate dismissal something to that effect."*
>
> *"One of the policies is no drugs allowed, as well as no drug use during working hours and they have this thing of "pee in a cup" spot tests. So, if you are positive, chances are you could be fired." (P4)*
>
> *"If you get tested and test positive the tolerance is zero. But if you raise your hand and say listen, I have a problem, I need help and they are extremely accommodating and caring." (P16)*

It was evident form the above responses from the participants that they did not know much about the substance abuse policy. Major gaps were identified when exploring their knowledge of the substance abuse policies in their workplaces. Additionally, the participants responses also highlighted the gaps in the implementation of the substance abuse policy. For example, one participant shared;

> *"We would get emails to say we are going to test a few individuals uhm so of course you shouldn't be under the influence uhm, and I truly believe they've seen me a lot of times and they can see that "this guy is under the influence" uhm but I didn't see any action done or taken or anything like that."*

5.6 Objective 4: To explore non work-related experiences of substance-dependent employees

- ***Effects of their substance dependence on their personal life***

Regarding the participant's non-work-related experiences, the aim was to explore how their substance dependency affected their personal life. The findings highlighted a number of personal effects of their substance dependence. It was interesting to note how, compared to their work-related experiences, the personal lives of the participants were greatly affected.

> *"It almost cost me my marriage." (P8)*

> *"Personally, it messed up a lot of stuff. I have a daughter but now I'm not allowed to see her because I'm irresponsible. I also lost trust within the family because of the lies and the stuff you tell." (P7)*

> *"It affected my relationship with my ex-girlfriend, we argued a lot when I was drunk."(P17)*

Participants highlighted the negative effects on their marriages, to the extent where they highlighted divorce, breakups, separation, and constant arguments and conflict. Additionally, their family lives were affected - participants who have children highlighted the change and effect on their relationships with their children, the bond and the distance that developed as their use became excessive and prioritised. Mc Mann et al. (2011), states that common contributing factor to relapses is related to anger and frustration stemming from confrontations or arguments with marriage partners. In addition, the anticipated negative criticism was also a significant factor. The extended family unit was also affected due to family concern and their long-standing knowledge of the participants drug use. Factors that were highlighted included disappointment, distrust, lies, avoidance, neglect.

5.7 Objective 5: To explore the experiences of rehabilitation

- **Experiences of rehabilitation**

The participants experience of rehabilitation were explored, they shared different perspectives based on their unique experiences of the inpatient rehabilitation programme. Participants reflected on various positive and negative contributions to their rehabilitation experience.

Participants' verbatim transcripts read as follows:

> *"I think this is another, just beautiful institute, with no real rules and regulations and leaders and counsellors, but for me it's like coming to just rest." (P3)*

> *"Well the things you learn here is productive, it should help in the outside world, and I have also learnt that at the end of the day it is your choices. but the learning equipment and tools help you recognise that you are strong enough to survive out there, as well as the support, they have a support group for out-patients, I'm required to come every Monday or Thursday, just to have support and that kind of helps and motivates you." (P9)*

> *"My experience here, being sober for a long time is a thing that I've always wanted and I met mentors here, they are supportive and they know what they talking about."(P5)*

> *"I would say that I am here now for twenty four days and the first time I felt a little bit scared to come here and sometimes I make jokes with the guys and tell them it's prison, but ja, I did learn a lot."(P9)*

Based on the responses of the participants various gaps were identified with regards to the structure of the programme, this included rules and regulations, schedules within the programme. Goodman (2007, p. 83) points out that successful rehabilitation depends not only on the treatment but also on clients' willingness to actively engage and commit. In this regard, participants seemed to have benefited from the period in which they managed to focus on their sobriety. Participants also felt as though they benefited from an effective learning experience which further equipped them. The participants identified to have gained support and also reflected on the safe, and conducive environment whereby they could freely express their feelings and experiences. Participants also seemed to benefit from the fact that they could relate to the experiences shared by other participants, this assisted in providing participants with a non-judgmental environment and a sense of belonging.

5.8 Objective 6: To explore experiences of reintegration to the workplace

- ***Fears returning to work***

The participants were asked to share any fears that they might have regarding returning to the workplace after rehabilitation. Participants' verbatim transcripts read as follows:

> *"Ja, my supervisor is going to victimise me because she now knows she is part of the problem." (P11)*

> *"I wouldn't say that I am that afraid of the world outside but those doubts are there, more especially at work you see." (P8)*

> *"Yes, definitely, actually to be honest, I don't want to go back to the same place. I'd rather lose that job than to go back there because now I'm going to be judged even more you know and now, I'm going to be even more aware, because I'm planning on staying sober for quite some time, for a long time." (P2)*

> *'Well obviously, I have some fears you know, because it's a call centre and these things are there. I have friends that are currently doing it, so my fear right now is actually leaving this place. It's going to be difficult but I need to try and be strong for myself as well as for my family. I am worried because when I go there, I don't know if I will be able to maintain this clean and to resist temptation. In my team we are about eighteen, and maybe ten of the eighteen are drug users."(P2)*

Mc Mann et al. (2011), mentions that informal subcultures play a major role in continuing corporate substance abuse problems. Such subcultures are difficult to root out because of co-worker cover up and peer group pressure. Most of the participants did echo a negative feeling regarding going to work such as anticipated victimization, blaming superiors for be part of the problem, having doubts and were not motivated to go to the same negative work environment.

Additionally, some participants did not have fears of returning back to work but rather to their communities as their living environments seemed to be the main trigger to their use and explore them to high-risk situations. For example, two participants shared;

> *"No fears of returning to work, but to my community, yes."(P3)*

"No, I have no fears. Just environmental fears because where I live drugs are like the in thing, everyone does them." (P4)

Campos (2009, p.773) explains high-risk situations as those situations in which there is an increased desire to use, where the drug of choice may be readily available, or where social pressure to use drugs is increased. Other high-risk situations include particular environments, cognitive patterns, mood states or social situations. Some participants expressed only expressed a few doubts to their feelings of uncertainty at the time. This displayed the participant's ability to cope by virtue of individual characteristics as advised by Fischer and Niale (2008) who mention that inborn traits do influence copying mechanisms.

- ***Experiences of reintegration***

These were the participants' responses regarding their reintegration experiences and how the employment environment accepted them;

"Well, I feel good, it's a good thing but uh I'm not too happy about the environment that I'm in, but I feel good being myself again." (P4)

"It was nice, the embraces at first, the warm embraces, but then afterwards it gets back to the norm." (P9)

"Look it was not easy at first, but now I think I have gotten used to the routine." (P4)

"It's okay, my works better because obviously I'm fresher. My mind is clearer. There is that little bit of stigma still at work, you know, when the people walk past you, they like 'sniffing."(P13)

Based on the response above, participants reflected different experience and mixed feelings regarding their experiences of re-integrating back to the workplace. Some employees conveyed that they felt unhappy, some highlighted the lengthy and difficult of adapting to their work routine. others perceive it as a better environment to clear their minds, keep busy and they reflected on the positive response received initially upon their return however noted very little change that was maintained after in their working environments. Eberlein (2010, p.53) states that there is not an instant cure nor an instant treatment for dependence. This highlights that the treatment and the recovery of dependence is a long-term process and therefore, the re-integration process should be treated as an essential and supportive part of the recovery process.

- ***Support from management***

Kemper in Grobler et al., (2006 p.403) upholds that an appropriate belief system, supervisory practices and treatment facilities are significant factors in retaining employees, before dismissal is considered. Oganisations should offer appropriate assistance and engagement so that employees can feel supported and encouraged to take responsibility for seeking and accepting treatment. The participants were asked about their experiences of support from management in an attempt to determine and explore the support structures within the workplace. These were their verbatim responses;

"There was zero support. Instead they declined my leave, so I would say they have been part of it, but not in a positive way." (P12)

"No, not at all they just carried on as normal."(P10)

"I wouldn't say that they were involved on a larger scale. They were of the opinion that I have to go to rehabilitation, so it was my fight." (P2)

"My supervisor, my team leader is kind of my close friend now. I actually speak to him and it took a lot of weight off my shoulders. He knows the situation I'm going through and it is good because he checks up on me and would ask me "how's it going buddy", "are you coping" "are you alright." It keeps me motivated and it keeps me wanting to stay clean."(P7)

"Well they accepted me back, but they did not really discuss what happened you know, so it's kind of a "just get on with it" attitude." (P11)

Majority of the participants expressed that there was very little or no support at all form their managers. It can be concluded that managers did not support participants to a higher extent. However, the participants who has received support from management, felt more motivated, and positive about their rehabilitation and overall recovery. This highlighted not only the gaps within support structures in the workplace but also emphasised the crucial role of support from management in both the rehabilitation and reintegration process.

Support from colleagues

Colleagues spend most of time with the participants at workplaces and their involvement in the reintegration of the participants is of paramount importance. Regarding how participants blended with their colleagues these were the findings:

> *"My work colleagues called me every day." (P1)*

> *"My colleagues have definitely shown support because even when I was in that relapse stage some of them would tell me "my man, you starting again and you know what it cost and some of the absent days they would tell me "my man these people are like giving you unpaid leave so obviously its hitting on the pocket and so forth so they would be concerned more especially my team ja, they would do that and encourage me to come to work and mention "my man you following the same fate again, try to change" I didn't expect them to cover up for me."(P6)*

> *"Just one colleague, she is in the same situation with her husband who is in recovery and has been clean for four years now." (P7)*

> *"Yes, but they can only support me to a certain point because they have their own area of work that they have to focus on".(P 18)*

The overall results pointed out that half of the participants, reported on the positive support that their work colleagues offered them. The participants that did not receive support from their colleague did not formally disclose to their employees or share the full extent of their substance dependency. In comparison to the support received form management, it can be concluded that reintegrated employees are more supported by colleagues than management.

5.9. CONCLUSION

This chapter focused on the results and discussion of findings of the research study. Firstly, the demographic information of participants was presented. The results in relation to the objectives of the study were presented, whereby themes and subthemes were also derived and discussed. In addition, this chapter aimed to provide a detailed presentation of the participants' experiences of rehabilitated and reintegrated employees. The findings of the study provided insight into the unique journey of the participants rehabilitating their lifestyle and reintegrating back to work. The strengths of the research study emerged from the exploration of the effects of the

participants' substance dependency both in their personal life and work life. This highlighted that both rehabilitation and reintegration process is a vital area of study. The limitations of the study include the fact that most of the participants were not able to engage on their reintegration to their workplaces this provided a gap within the understanding of a broader perspective of the success of their reintegration after completing their rehabilitation programmes. The last section of this research report will elaborate on the key findings of the research study and present recommendations based on the findings of the research study.

CHAPTER SIX

MAIN FINDINGS, CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

The previous chapters of the research report provided an overview of the research study. This includes literature that has been presented and discussed. The aim of the literature was to provide an understanding of substance abuse and dependency and thereafter more specifically the focus was on substance abuse in the workplace. After literature had been explored, the methodology of the study was presented, that was followed by the analysis of data. Limitations of the study were outlined in the methodology of the study. Data analysis and finding were then discussed leading to this final chapter. This chapter provides a summary of the main findings of the study regarding the experiences of substance dependent employees of rehabilitation and reintegration to the workplace. In addition, this chapter will also provide recommendations and conclude the research study.

6.2 MAIN FINDINGS OF THE STUDY

The main aim of the research study was to explore the experiences of substance dependent employees that were in rehabilitation and their reintegration to the workplace. The study was guided by objectives which addressed the primary aim of the study. Each objective will be discussed and concluded in relation to the main findings.

6.2.1 To understand the experiences of substance dependent employees after disclosing their substance dependency to management.

The first objective of the study was to explore the experiences of substance dependent employees after disclosing their substance dependency to management. In addressing the first objective, participants shared both positive and negative experiences of disclosing their substance dependency to management. The majority of the participants did disclose their substance dependency to management however, it was noted that their disclosure was greatly reliant on the fact they did not want to lose their jobs. Additionally, they disclosed at a point where their dependency had greatly interfered and affected their work life. Some participants also reported to have experienced suspensions and participated in disciplinary hearings resulting from their

substance dependency. It is evident that the substance dependent employees seem to be trapped in an unmanageable cycle. The disclosure of their substance dependency to management is identified as a relief particularly when it is grossly affecting the employee. However, the disclosure process remains hindered due to the complex and sensitive nature of the challenge, risk of job loss, conflicting relationships with management or supervisors, and lack of confidentiality. The findings highlighted that the process of disclosing substance dependency is not an easy process for the employees and that their disclosure greatly depends on several factors. These factors include their experience of the employment and their satisfaction and connection with their workplaces. The relationship and attitude with management seemed to be a significant factor in the participants' decision to disclose. It is evident that it is also the self-awareness and eagerness that contributes much to rehabilitate their lifestyles. Lastly it seemed that the participants did not want to disclose because they did not want the negative attention associated with disclosing.

6.2.2 To identify factors that motivated the employees to rehabilitate their lifestyle.

The second objective in addressing the aim of the research study was to identify factors that motivated the employees to rehabilitate their lifestyle. Firstly, the participants motivating factors that related to the workplace mainly emanated from the fact that employees did not want to lose their jobs. Their jobs represented great value due to the fact that it provided them with a source of income that they are dependent on to support themselves and their families. In addition, the reintegrated employees valued their jobs as it provided them with some form of stability and structure in their lives that presented with vulnerabilities as a result of their substance dependency. The participants spoke of their jobs very passionately as well as the value that they contribute to their workplace. In addition to the work- related motivational factors majority of the participant's motivation for rehabilitation stemmed from their personal life, more especially the need to repair their lives, relationships with their spouses, children, families, with their loved ones. In addition, the desire of self-development and personal improvement was identified as motivation for the employees to rehabilitate their lifestyles. It was observed that the participants had been using substances for a long time therefore they shared numerous detrimental effects that their substances had on their lives. As a result, reintegrated employees felt exhausted by the process that impacted on them emotionally, financial, physically, socially and economically by

affecting their work. The latter factors being important in the substance users compel them to rehabilitate.

6.2.3 To investigate and describe the support systems that existed within the workplace

The third objective, in addressing the aims of the research study was to investigate and describe the support systems that existed within the workplace. Once again, some participants shared that they felt that there was support however others felt that there was no support. Participants mentioned support systems in terms of assisting them with the initiation of contact for their referral to the employee assistance programme. Regarding these referrals, participants also highlighted that processes took too long, as a result they ended up initiating their own entry into the rehabilitation because they felt that it was urgent. Additionally, some participants highlighted that their workplace will be covering half their medical aid costs for their inclusion in the rehabilitation programme. However, participants also felt that they did not receive support particularly regarding the shared experience of unpaid leave. In this case they felt that their workplaces were not accommodative. In addition, they shared that there was no support during their rehabilitation programme. Some participants shared that that they were supported when they reintegrated in the workplace by colleagues and managers, interestingly, the colleagues of the participants seemed to have taken on the primary supportive role. The colleagues of the participants have also seemed to play a motivating role to the participants, in that they were able to encourage, show care and concern as well as confront them when they noted the participants negative behaviours.

6.2.4 To explore substance dependent employees' experiences in their work-life.

The fourth objective, in addressing the aims of the research study was to explore substance dependent employee's experiences in their work-life. Some participants mentioned initially they did not consume substances at work, the problem intensified when they started using at work. Participants shared they would smell of alcohol, so they would hide and avoid people and therefore limiting interaction. Additionally, they mentioned frequent absenteeism, absconding, late coming, excuses, taking long and frequent breaks due to their drug use. However, some participants mentioned that they did not use at work and therefore did not have challenges at work. In addition, some participants mentioned that their workplaces would condone drinking,

due to the fact that their work-related duties were mainly office bond and administrative focused tasks which did not require face-to-face interaction with clients or customers. It was highlighted by the users that "you could hide it well and still perform your duties well". A lot of the efforts of the participants were focused on concealing their dependency.

6.2.5 To explore substance dependent employees' experiences in their personal life.

The fifth objective in addressing the aims of the research study was to explore substance dependent employee's experiences in their personal life. The participants mentioned major effects that affected their personal lives. For the participants that were married, they shared intense strain and effects on their relationships with their spouses. Due to the lies, deceit, changes in moods, and their absence in the home. Additionally, some participant highlighted that their substance use led to break ups with their partners and affected their relationships with their families and children. The participants mentioned that the trust in their relationships was affected and they mentioned continuous arguments. In addition, participants mentioned that they also drifted away from family and isolated themselves. Participants also mentioned financial strain that would affect their personal lives, this was intensified due to the fact that some participants are breadwinners and they would often use the money on sustaining their drug or alcohol use. There was a shared concern by participants regarding their communities and environments. They shared that they live in communities where substance use is prominent and easily accessible, their fears stemmed from their exposure to these environments whilst they were in rehabilitation. The participants' social life is also a challenge for them due to the fact that most of their friends and people they interacted with are also users and their relationships mainly focused on the use of substances through socialisation. Lastly, participants shared how the loss of loved ones had affected them and triggered their substance use, their use is often seen as self-medicating and in this regard drug use would be a coping mechanism. In addition to loss, the different overwhelming daily experiences and happenings in their lives of the participants seemed to be difficult to cope with and therefore drug use would be a mechanism for them to escape certain feelings, emotions and experiences.

6.3 RECOMMENDATIONS

The following recommendations were established from the findings and conclusion of the study;

6.3.1 Recommendations for further research

During the course of this research it has become apparent that the relationship between the workplace and the substance dependent individual is extremely complex. There is a need for further research on substance use, abuse, and dependency in the workplace. In particular, research with a more complex analysis of the workplace and the impact of substance abuse within the workplace context. Research to focus on the views and experiences of employers, management and colleagues who are exposed to employees with a substance use dependency. There remains a need for accurate national statistic on substance use, abuse and dependency in the workplace context. Research should become an integrated component in the workplace, so that evidence-based assessment and evaluation is provided and also tailored for the workplace and the workforce. Research studies will equip the workplaces with more innovative ideas and prompt solutions and guidance.

6.3.2 Recommendation to occupational social work

Occupational social workers need to provide creative interventions to address substance dependency in the workplace. Initiatives should target all levels of employees. Frequent awareness and psycho-education initiatives should be employed as early intervention programmes in the workplace. This would aid in alleviating, discrimination and stigma. Current substance abuse policies should be developed and employ a more integrative nature that include information that would benefit both the views of employees and employers. This would improve the participation of the workforce to abide with the policy, improve behaviour, educate and create an effective structure to address matters regarding substance use, abuse and dependency within the workplace. In turn, transitions to workplace culture and organisational development should be prioritised. To eliminate the exhaustive process of initiating the helping process, prompt debriefing and therapeutic intervention should be made available to employees with substance dependence. This will preserve the employee's motivation and promote progress in their decision to rehabilitate their lifestyle. Occupational social workers should focus on strengthening programmes on intervention, prevention and treatment level in the workplace. The latter should include work-life balance strategies to assist employees and equip them with healthier and more effective coping skills. Focus on the development and improvement of

workplace relationships and lastly provide effective and useful skills training on substance related matters to all levels of the workforce.

6.3.3 Recommendations to the practice of social work in the field of substance abuse

Firstly, it must be mentioned that the substance abuse field of practise is often very exhausting and labour intensive. Social workers should have intense supervision and debriefing should be prioritised. Teambuilding should also be prioritized to strengthen the team and create a positive and supportive environment. Additionally, social workers, working in the field of substance abuse should be more exposed to all the systems that the client is rooted in. This includes personal relationships, the community and the workplace. More efforts should be placed in having a more integrated approach rather than observing the service user in isolation. Social workers should provide creative ways in which substance related education, techniques, skills and knowledge is shared. In relation to that, social workers should also integrate practical transference of soft skills, and also focus more on the self-development of service users as the nature of substance dependency often robs individuals of these traits and these aspects needs to be relearned. In addition, research should be conducted on effective programmes and structure of therapeutic services. New theory and technological approaches should be reviewed and applied, more especially in in-patient rehabilitation centres towards avoidance of boredom, lack of participation and engagement in this period. Lastly, aftercare services should be prioritised with urgency. Creative programmes regarding aftercare and follow ups should be initiated. Due to service users' distance in location as well as work constraints often aftercare services are not used while depriving substance users of these support needs. This seems to be a great disadvantage as the reports provide evidence that the service user needs increased once they return to their communities and workplaces. In turn relapse will also be identified sooner if there is frequent contact and therefore immediate services could be provided.

6.3.4 Recommendations to employers

Employers should make a clear stance on views and practices regarding substance use, abuse and dependency in the workplace. Employers should be more active in the ensuring that practices and policies are functioning and implemented effectively. Employers should also ensure that services and approaches within the workplaces remain current and relevant. And lastly, employers should be equipped to supportive and proactive methods, rather than reactive in

addressing substance dependency in the workplace. There must also be adherence to ethical standards and policies in the workplace.

6.4 CONCLUSION

The experience of substance dependence should be viewed with a more humanistic approach. For far too long, substance dependency has been viewed with judgement, discrimination and stigma. People affected by substance dependency should be treated with respect and dignity as all human beings. It is evident that substance dependency is multifaceted and has detrimental effects on substance dependent employees, their family, social relationships, their community, their workplaces and society. This research explored the experiences of substance dependent employees of rehabilitation and reintegration. This research study also explored additional experiences in their work-life and their personal life and therefore presents a holistic view of the experiences of substance dependent employees. Furthermore, their experiences of coping with the demands of work and family, while also focusing on their recovery and reintegration to the workplace seemed overwhelming and highlighted the need for improved support structures. The resilience observed from the participants is admirable. Efforts within the workplace should be prioritised to ensure positive awareness, education programmes, research and policy within the workplace to address substance use, abuse and dependency. It may be argued that substance-related problems do not affect all employees in the workplace. However, the nature of substance dependency and the reality may be that employees are exposed to substance-related issues if not directly then perhaps indirectly due to their exposure with families, communities and the greater society. This may assist to limit the stigma and discrimination, ignorance and connect affected employees with the necessary services and resources. The workplace should prioritise the wellbeing of their employees and more attention should be placed on actively supporting substance dependant employees through their process of rehabilitation and reintegration.

"Hope is being able to see that there is light despite all of the darkness."

Desmond Tutu

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APPENDICES

Appendix A: Participant information sheet

Good Day,

My name is Nicola Johnson and I am a student registered for the Master's degree in Occupational Social Work at the University of the Witwatersrand. As part of the requirements for the degree, I am conducting a research study which aims to explore employees who use substances and their experiences of rehabilitation and reintegration in the workplace: Case study of West View Clinic. This study aims to explore the experiences and possible challenges that substance users from the workplace may experience during rehabilitation and reintegration to the workplace.

My interest in this research topic comes from the passion developed when working in the field of substance abuse, I am eager to understand and gain knowledge form the perceived experience that substance abusers face in the workplace settings. It is the hope that the knowledge gathered from the research study could positively contribute to the amendment and improvement of workplace policies and programmes. The Research study will also assist the effectiveness of workplace initiatives in assisting substance abusers from the workplace through the rehabilitation and reintegration process.

I therefore wish to invite you. Participation in this study is completely voluntary and refusal to participate will not be held against you in any way. If you agree to participate, I shall arrange to interview at a time and place that is suitable for you. The interview will last approximately one hour. You may withdraw from the study at any time and you may also refuse to answer any questions that you feel uncomfortable with answering. With your permission, the interview will be tape-recorded. No one other than my supervisor will have access to the tapes. The tapes and the interview schedule will be kept in a locked cabinet for two years following any publication or for six years if no publication emanate from the study. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report.

As the interview will include sensitive issues, there is a possibility that you may experience some feelings of emotional distress. Should you therefore feel the need for supportive counseling after having answered the questionnaire, I have arranged for this service to be provided free of charge by the West View Clinic.

Please feel free to contact me on 084 911 55999 or my supervisor Francine Masson on +27 11 717 4480 if you have any questions regarding the study. We shall answer them to the best of our ability. Should you wish to receive a summary of the result; an abstract will be made available on request.

Thank you for taking time to consider participating in the study

Yours sincerely

Nicola Johnson

Appendix B: Interview schedule 1

Interview schedule

Date of interview: _____

Venue: _____

Pseudonym: _____

Section A: Demographics

Age: _____

Gender: Male: _____

Female: _____

Job title: _____

Substance use history:

_____

_____

_____

_____

_____

_____

1. Broadly speaking, what was your experience like as a substance user in the workplace?

2. How has your substance abuse affected your personal and work life?

3. How is your relationship with your boss?

4. How is your relationship with your colleagues?

5. Have you disclosed your substance abuse problem at work?

a) If yes, what was your experience like when disclosing your substance abuse problem to your employer?

b) What was his or her reaction?

c) If no, what has hindered you from disclosing to your employer?

6. Did your colleagues know about your substance abuse problem?

a) If yes, how did your colleagues react?

7. What was the working conditions like at your workplace?

8. How was alcohol and drugs viewed at your workplace?

9. Was there a substance abuse policy in place at your workplace?

a) If yes, what do you know about the policy?

10. What has motivated you to rehabilitate your lifestyle?

11. Have you participated in a rehabilitation process before?

a) If yes, how was your previous experience of rehabilitation?

12. How was your current experience in the rehabilitation?

13. Do you have any concerns or fears of returning back to work?

Appendix C: Interview schedule 2

1. How do you feel since returning back to work after rehabilitation?

2. What was your experience of reintegrating back to the workplace?

3. Has your employer been involved in the rehabilitation and reintegration process?
   a) If yes, in what way?

4. Have your colleagues shown support since you have returned back to your workplace?

   a) If yes, in what way?

5. What contributed to the successful completion of your rehabilitation programme?

6. What recommendations would you make to West View Clinic to assist employees to reintegrate to the workplace?

Appendix D: Consent form for participation

CONSENT FOR PARTICIPATION

I, _____ (Full Name) have been informed on the research study Nicola Johnson is conducting on the rehabilitation and reintegration of substance abusers from the workplace; experiences and challenges.

I hereby confirm that:

- I understand and have been informed on what participation in this study will involve.
- I understand that my participation in the study is completely voluntary.
- I understand that I have the right to refuse to answer any questions that I am not comfortable answering.
- I understand that I have the right to withdraw my participation in this research study.
- I understand that any information I share will be confidential and that the researcher will not use any of my personal identification in the research study.

Name of participant: _____

Date: _____

Signature: _____

I, _____ (Name of Researcher) confirm that I have explained the purpose and procedures of the research study and the rights of the participants. I agree to adhere to the conditions mentioned in the information sheet and the consent form.

Name of researcher: _____

Date: _____

Signature: _____

Appendix E: Consent form for audio

Consent form for Audio of Interviews

I, _____(Full Name) have been informed about the research study that Nicola Johnson is conducting on the rehabilitation and reintegration of substance users from the workplace; experiences and challenges.

I hereby confirm that:

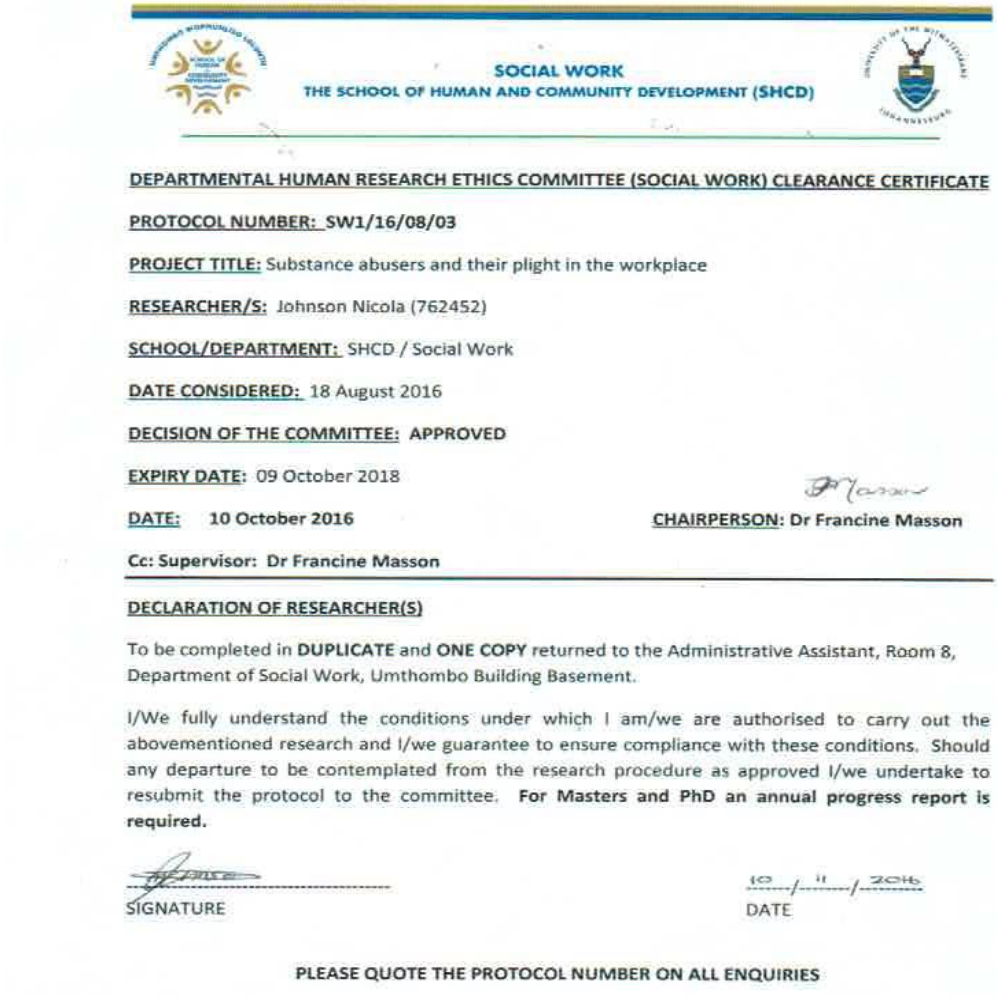
- I understand and have been informed on what participation in this study will involve.
- I understand that my participation in the study is completely voluntary.
- I understand that this interview will be audio taped and I give the researcher full consent to audio tape this interview.

Name of participant: _____

Date: _____

Signature: _____

Appendix F: Ethics clearance certificate



SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

DEPARTMENTAL HUMAN RESEARCH ETHICS COMMITTEE (SOCIAL WORK) CLEARANCE CERTIFICATE

PROTOCOL NUMBER: SW1/16/08/03

PROJECT TITLE: Substance abusers and their plight in the workplace

RESEARCHER/S: Johnson Nicola (762452)

SCHOOL/DEPARTMENT: SHCD / Social Work

DATE CONSIDERED: 18 August 2016

DECISION OF THE COMMITTEE: APPROVED

EXPIRY DATE: 09 October 2018

DATE: 10 October 2016 **CHAIRPERSON: Dr Francine Masson**

Cc: Supervisor: Dr Francine Masson

DECLARATION OF RESEARCHER(S)

To be completed in **DUPLICATE** and **ONE COPY** returned to the Administrative Assistant, Room 8, Department of Social Work, Umthombo Building Basement.

I/We fully understand the conditions under which I am/we are authorised to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the committee. **For Masters and PhD an annual progress report is required.**

SIGNATURE

10 / 11 / 2016
DATE

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix G: Permission Letter

27 July 2016

Confirmation of permission for research of Nicola Johnson

This serves to confirm that Westview Clinic grants Ms Johnson permission to conduct her research at our facility.

The student will receive supervision and interaction with our patients will be closely monitored.

Please contact the undersigned for any further queries.

Anthea Barriel
Public Relations Manager
011 472 7707
076 973 0135
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Appendix H: Turnitin Report