

DEFEATING THE DRAGON: HEROIN DEPENDENCE RECOVERY

by

MONIKA MARIA LUCIA FREITAS DOS SANTOS

submitted in fulfilment of the requirements for
the degree of

MASTER OF ARTS IN SOCIAL SCIENCE

in the subject

PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROFESSOR FJ VAN STADEN

CO-SUPERVISOR: PROFESSOR JL WEYERS

JUNE 2006

Student number: 3231-147-8

I declare that

DEFEATING THE DRAGON: HEROIN DEPENDENCE RECOVERY

is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference.

Ms MMLF dos Santos

Date

AKNOWLEDGEMENTS

The inspiration for the research study was born out of the epidemic of heroin dependants in South Africa from the mid 90's, specifically the heroin dependants who crossed my path during the course of my professional career within the substance abuse rehabilitation field. Each participants story has been one of deep magnificence, to them my humble gratitude.

From the academic world, I am especially fortunate to have been supervised and mentored by Professor Fred van Staden, Head of Psychology Department, UNISA.

Professor Leon Weyers, retired Vice Principal: Planning, UNISA, who has not only, as co-supervisor to the study, provided light along the phenomenological path, but has also proven that after fifty years of alcohol dependence, recovery is possible.

I am also indebted to another true academic for assistance in the statistical analysis of the data, Alheit du Toit, who I met at the right time in the most unlikely manner.

Alex Hamlyn, Director of the Houghton House Recovery Group, who unwittingly served as my mentor and inspiration over the years, especially at the outbreak of the heroin abuse epidemic. His expert input has proved to be invaluable.

Professor Charles Parry who heads the Medical Research Council's Alcohol and Drug Abuse Research Group SACENDU project, for his ongoing support and all the distinguished work he has undertaken in providing the substance abuse field with a sound scientific backing in South Africa.

Special gratitude to Andreas Plüddemann, Senior Scientist in the Medical Research Council's Alcohol and Drug Abuse Research Group and SACENDU co-ordinator.

Hennie Potgieter, Gauteng co-ordinator of SACENDU and former Superintendent of Elim Clinic, who supported me with so much warmth long before I ever dreamt of undertaking research.

Professor Rob Summers and Dr Beverly Summers, School of Pharmacy, MEDUNSA, for their unconditional support. Marlice Schoeman, Photobiology Laboratory, MEDUNSA, my research assistant who helped prepare the presentation of preliminary findings for the Medical Research Council. Neil Summers for the challenges he presented me along the way.

Professor Solomon Rateamane, Chairperson of the Central Drug Authority and Head of the Psychiatric Department, MEDUNSA. Johan van Velden, social worker from the Department of Social Development. Paula de Beer, social worker from Pretoria Academic Hospital. Sarah Fisher from 'Bridges' for her expert and 'insiders' participation. Tina Fysh, Chairperson of ToughLove South Africa for her specialised input over the years. Two medical sisters from Castle Carey Clinic, Sr Dorie Wilkens and Sr Marie Bredenkamp. All these individuals participated as experts, however, due to the extensiveness of this phase of the study, it is anticipated that these interviews will be carried over to a doctoral thesis.

SANCA National Directorate, Shamim Garda, National Executive Director and Judith Shopley, as well as the support from the SANCA Research Portfolio members. Also everything I learnt at Castle Carey Clinic/ Lapalamé Youth Drug Unit.

Department of Correctional Services, for granting permission to interview incarcerated heroin dependants, unfortunately this never realised due to the heroin dependants known to the researcher being released or transferred by the time access was granted. Also the Ahanang Prisons Project co-ordinators.

'Anthony' from Narcotics Anonymous, and all the unexpected support from other Narcotics Anonymous members.

Ted Leggett, whom I managed to trace in Vienna, previously of the Institute for Security Studies, now based at the United Nations Office for Drugs and Crime.

Senior Superintendent Kobus Jonker, formerly of the Occult-Related Crime Unit, SAPS, for the specialised knowledge that he exposed me to.

My gratitude also to the producers of 'Chasing the Dragon', Endemol SA, as well as the producers of Zola Seven, the counsellors at Drugwise as well as the Gauteng Substance Abuse Forum.

I wish to thank Jaco van der Bijl, clinical psychologist, friend and confidant, for his unconditional shelter and support in this process.

Erwin Lass, clinical psychologist and Head of the Reintegration Centre, Vista Clinic, for the hope that he has stood for and for saving me when I needed to be saved.

Also my thanks to Piet Botha, André Marais - clinical psychologist from Witrand Psychiatric Hospital, Antjie Haarhoff, Yvette Badenhorst - Sitara Clinic (SANCA Laudium), Michael & Jane Henning, Ruoall Chapman, Séamus Mac Róibín of UNICEF and André Peach.

I would like to thank my parents and family for providing me with what I needed in order for me to be in a place where I could commence and complete this study.

Far less obviously, the painting 'Beata Beatrix' by Dante Gabriel Rossetti, which has always been my favourite work of art. A copy of this painting has been in my office since I started working at Castle Carey Clinic in 1998 and moved along with me to Vista Clinic in 2006. It was only five years ago that I found out that the painting depicts the artists' wife who became addicted to Laudanum - an addictive medicine containing alcohol and opium.



DEFEATING THE DRAGON: HEROIN DEPENDENCE RECOVERY

KEY TERMS

Heroin, heroin addiction, heroin dependence, heroin addiction recovery, heroin dependence recovery, heroin use disorders, opioid addiction, opioid dependence, opioid addiction recovery, opioid dependence recovery, opioid use disorders, opioid use disorder recovery, substance use disorders, substance use disorder recovery.

SUMMARY

Heroin dependence, which is escalating within South Africa, has become a symbol of the social disorder of the times - associated with materialism, poverty, crime, the problems of a society in transition, the disadvantaged, and the inner cities. However, that is not to say that all those who misuse heroin develop a problem or become dependent. In reality, only a small minority of heroin users develop a dependence, but for those who do it can result in unpleasant and potentially terrifying experiences/consequences, that can often be extremely difficult to escape from. That is not to say that recovery from dependence to heroin is not possible. Indeed, contrary to the beliefs of many people, the reality is that many people do eventually recover. Despite the vast sums of money devoted to treatment intervention of heroin dependants in the South Africa and worldwide, the processes by which recovery occur remain fairly unclear. Moreover, relatively little is known about the contribution of interventions and processes in facilitating such recovery. The statistical and content analysis of the data revealed that one of the most important factors identified in allowing successful behaviour modification and promoting recovery was psychosocial and pharmacological intervention, which seemed to produce a range of positive effects that facilitated natural healing processes. However, a range of other factors alongside intervention were also important in promoting behaviour modification. This study has provided important information, from forty recovering heroin dependants themselves, on the many factors that are important in achieving abstinence, in allowing recovery to be maintained in the longer term, and in potentially allowing an eventual exit from heroin dependence. A number of difficulties encountered in intervention were also identified. The statistical findings of the study support the 'maturing out' hypothesis of heroin dependence ($\chi^2 = 16.841$; $p = 0.001$; $df = 3$). Ethnicity, highest level of education, employment status, marital status, biological parents' marital status or whether biological parents were deceased or not did not relate to any of the identified behavioural indices associated with heroin dependence recovery. A framework for the development of a contextual heroin dependence recovery model is also discussed.

CONTENTS

	Page
ACKNOWLEDGEMENTS	iii
KEY TERMS	iv
SUMMARY	iv
CONTENTS	v
TABLES	ix
FIGURES	x
GLOSSARY AND ABBREVIATIONS	xi
CHAPTER ONE: INTRODUCTION	
1.1 INTRODUCTION	1
1.2 OBJECTIVES OF THE STUDY	9
1.3 ANALYSIS OF KEY CONCEPTS	10
1.3.1 Substance dependence	10
1.3.2 Psychological dependence	11
1.3.3 Physiological dependence	11
1.3.4 Substance abuse	11
1.3.5 Substance intoxication	12
1.3.6 Substance withdrawal	12
1.3.7 Opioid dependence	13
1.3.8 Opioid abuse	14
1.3.9 Opioid intoxication	14
1.3.10 Opioid withdrawal	14
1.3.11 Psychoactive substance	15
1.3.12 Intervention and intervention efficacy	16
1.3.13 Relapse	16
1.3.14 Comorbidity	16
1.4 SUMMARY	18
CHAPTER TWO: HEROIN DEPENDENCE: HISTORICAL CONTEXT, PHARMACOLOGY, THEORY AND MAJOR INTERVENTION MODALITIES	
2.1 INTRODUCTION	19
2.2 THE HISTORICAL-LEGAL CONTEXT OF HEROIN DEPENDENCE	19
2.3 THE EMERGENCE OF HEROIN DEPENDENCE IN SOUTH AFRICA	39
2.4 HEROIN ADMINISTRATION, PHARMACOLOGY AND ADDICTIVE POTENTIAL	42
2.4.1 Heroin administration, addictive potential and health consequences	42
2.4.1.1 Heroin administration	42
2.4.1.2 Heroin addiction and dependence potential	43
2.4.1.3 Health consequences of heroin use and HIV/AIDS risk	49
2.4.2 Heroin pharmacology	50
2.5 PHARMACOLOGICAL INTERVENTION FOR HEROIN DEPENDENCE	53
2.5.1 Treatment of heroin withdrawal syndrome with opioids/substitute opioids	53
2.5.1.1 Heroin maintenance	53
2.5.1.2 Methadone	54
2.5.1.3 Buprenorphine	58
2.5.1.4 Methadone or buprenorphine?	59
2.5.1.5 Codeine-based drugs	61
2.5.1.6 Levo-alpha-acetylmethadol (LAAM)	61
2.5.1.7 Apomorphine	62
2.5.2 Treatment of heroin withdrawal syndrome with non-opioid substances	62
2.5.2.1 Naltrexone	62
2.5.2.2 Clonidine	63
2.5.2.3 Lofexidine	63
2.5.2.4 Psychotropic analgesic nitrous oxide (PAN)	64

2.5.2.5	Other medications	64
2.6	PSYCOSOCIAL THEORIES OF HEROIN DEPENDENCE	65
2.7	THERAPEUTIC INTERVENTION MODALITIES FOR HEROIN DEPENDENCE	70
2.7.1	Outpatient intervention/community based intervention	72
2.7.2	Residential intervention	73
2.7.3	Narcotics Anonymous	74
2.7.4	Minnesota Models and other 12-step variations	78
2.7.5	Coerced treatment intervention	79
2.7.6	Family intervention and social support	80
2.7.7	Relapse Prevention	81
2.7.8	Harm reduction and needle exchange programmes	81
2.8	DEFEATING THE DRAGON: HEROIN DEPENDENCE RECOVERY	83
2.8.1	Maturing out hypothesis	84
2.8.2	Phases/stages of recovery	85
2.8.3	Hitting rock bottom	87
2.8.4	Spoiled identity	87
2.8.5	Pharmacological effects	91
2.8.6	Natural healing experience	91
2.8.7	Psychosocial intervention	92
2.8.8	Relapse prevention	93
2.9	SUMMARY	94
CHAPTER THREE: METHODOLOGICAL PARADIGM AND RESEARCH DESIGN		
3.1	INTRODUCTION	95
3.2	RESEARCH DESIGN	96
3.2.1	Methodological paradigm	96
3.2.2	Measurement	96
3.2.2.1	Semi-structured interviews and analyses	96
3.2.2.2	Questionnaire	97
3.2.2.3	Sampling procedure and data collection	99
3.2.4	Data analysis	99
3.2.5	Statistical analyses	100
3.2.6	Data capturing	101
3.3	ETHICAL CONSIDERATIONS	101
3.4	SUMMARY	102
CHAPTER FOUR: RESULTS		
4.1	INTRODUCTION	103
4.2	BIOGRAPHIC AND SOCIODEMOGRAPHIC CHARACTERISTICS	103
4.2.1	Age	103
4.2.2	Gender	103
4.2.3	Ethnicity	103
4.2.4	Country/city/province of residence	103
4.2.5	Place of residence	104
4.2.6	Current legal status	104
4.2.7	Current educational status	104
4.2.8	Years schooling completed	104
4.2.9	Employment status	104
4.2.10	Reasons for unemployment	104
4.2.11	Marital status	105
4.3	PROFILE OF FAMILY BACKGROUND CHARACTERISTICS	105
4.3.1	Biological parents marital status	105
4.3.2	Biological father profile	105
4.3.3	Biological mother profile	107
4.3.4	Stepfather profile	109
4.3.5	Stepmother profile	110
4.4	HEROIN DEPENDENCE HISTORY	111
4.4.1	Substitution with other substances of abuse	112
4.5	DESCRIPTIVE STATISTICS OF BIOGRAPHIC AND DEMOGRAPHIC INDICES	113
4.6	STATISTICAL ANALYSES	114
4.6.1	Residing with family and/or friends over last year category	114
4.6.2	Legal status category	114
4.6.3	Years schooling completed category	115
4.6.4	Area of permanent residence: urban/rural category	115

4.6.5	Gender category	115
4.6.6	Ethnicity category	115
4.6.7	Age category	116
4.6.8	Education category	116
4.6.9	Employment category	116
4.6.10	Biological parents alive category	116
4.6.11	Parents ever divorced or separated category	116
4.6.12	Current marital status category	117
4.7	CONTENT ANALYSIS	117
4.7.1	Ways in: The formation and development of heroin addiction and dependence	118
4.7.2	Reasons/factors for heroin use	121
4.7.2.1	Initial heroin use	122
4.7.2.2	Continued/excessive heroin use	124
4.7.2.3	Lapse/relapse	126
4.7.3	Going deeper: The negative effects of heroin use	128
4.7.3.1	Physical effects	129
4.7.3.2	Emotional/psychological effects	131
4.7.3.3	Relationship effects	133
4.7.3.4	Social effects	133
4.7.3.5	Practical effects	135
4.7.4	Ways out: Realisation process	135
4.7.5	Taking action: Behaviour modification	137
4.7.5.1	Types of behaviour change	138
4.7.5.2	Factors influencing behaviour change	139
4.7.5.3	Spirituality	141
4.7.5.4	Decisional balances	142
4.7.5.5	Barriers to change	143
4.7.6	Perceived effects of intervention	143
4.7.6.1	Positive effects of intervention	145
4.7.6.2	Positive/important components of intervention	147
4.7.6.3	Accessing/commencing intervention	159
4.7.6.4	Pharmacological intervention	160
4.7.6.5	Difficulties of intervention	163
4.7.6.6	Negative/unsuccessful intervention	164
4.7.7	New labels: References to self in recovery	166
4.7.7.1	Factors/requirements for recovery	166
4.7.7.2	Aids to recovery	168
4.7.7.3	Changes in recovery	173
4.8	SUMMARY	174

CHAPTER FIVE: DISCUSSION AND CONCLUSION

5.1	INTRODUCTION	175
5.2	DISCUSSION OF BIOGRAPHIC, DEMOGRAPHIC, PARENT AND HEROIN DEPENDENCE PROFILE FINDINGS	175
5.2.1	Biographic and demographic findings	175
5.2.2	Parent profile findings	176
5.2.2.1	Biological father profile	176
5.2.2.2	Biological mother profile	177
5.2.2.3	Stepfather profile	177
5.2.2.4	Stepmother profile	178
5.2.3	Heroin dependence history profile findings	178
5.3	RESEARCH FINDINGS	178
5.3.1	Ways in: The formation and development of heroin addiction and dependence	178
5.3.2	Reasons/factors for heroin use	179
5.3.2.1	Initial heroin use	179
5.3.2.2	Continued/excessive heroin use	181
5.3.2.3	Lapse/relapse	181
5.3.3	Going deeper: The negative effects of heroin use	182
5.3.3.1	Physical effects	182
5.3.3.2	Emotional/psychological effects	182
5.3.3.3	Relationship effects	183
5.3.3.4	Social effects	183
5.3.3.5	Practical effects	183
5.3.4	Ways out: Realisation process	183
5.3.5	Taking action: Behaviour modification	185
5.3.5.1	Types of behaviour change	185

5.3.5.2	Decisional balances	185
5.3.5.3	Influencing changes	186
5.3.5.4	Spirituality	188
5.3.5.5	Barriers to change	188
5.3.6	Perceived effects of intervention	189
5.3.6.1	Positive effects of intervention	189
5.3.6.2	Positive/important components of intervention	189
5.3.6.3	Accessing/commencing intervention	191
5.3.6.4	Pharmacological intervention	192
5.3.6.5	Difficulties of intervention	192
5.3.6.6	Negative/unsuccessful intervention	192
5.3.7	New labels: References to self in recovery	193
5.3.7.1	Factors/requirements for recovery	193
5.3.7.2	Aids to recovery	194
5.3.7.3	Changes in recovery	194
5.4	FRAMEWORK FOR THE DEVELOPMENT OF A CONTEXTUAL HEROIN DEPENDANCE RECOVERY MODEL	195
5.5	STRENGTHS, CONSTRAINTS, LIMITATIONS AND RECOMMENDATIONS	197
	REFERENCES	201
	APPENDIX A	211
	APPENDIX B	215
	APPENDIX C	217
	APPENDIX D	222

TABLES

CHAPTER ONE: INTRODUCTION

		Page
TABLE 1.3.1.1	DSM-IV-TR CRITERIA FOR SUBSTANCE DEPENDENCE	10
TABLE 1.3.1.2	DSM-IV-TR CRITERIA FOR SUBSTANCE ABUSE	12
TABLE 1.3.1.3	DSM-IV-TR CRITERIA FOR SUBSTANCE INTOXICATION	12
TABLE 1.3.1.4	DSM-IV-TR CRITERIA FOR SUBSTANCE WITHDRAWAL	13
TABLE 1.3.1.5	DSM-IV-TR CRITERIA FOR OPIOID INTOXICATION	14
TABLE 1.3.1.6	DSM-IV-TR CRITERIA FOR OPIOID WITHDRAWAL	15

CHAPTER TWO: HEROIN DEPENDENCE: HISTORICAL CONTEXT, PHARMACOLOGY, THEORY AND MAJOR INTERVENTION MODALITIES

TABLE 2.7.3.1	The Twelve Steps of Narcotics Anonymous	75
TABLE 2.7.3.2	The Twelve Traditions of Narcotics Anonymous	76

CHAPTER FOUR: RESULTS

TABLE 4.4.1	Length of heroin dependence	111
TABLE 4.4.2	Frequency of heroin abuse	112
TABLE 4.4.3	Primary method of heroin ingestion	112
TABLE 4.4.4	Length abstinate from heroin (years)	112
TABLE 4.5.1	Descriptive statistics of biographic and demographic indices	114
TABLE 4.7.1.	Ways in: The formation and development of heroin addiction and dependence	118
TABLE 4.7.2	Reasons/factors for heroin use	121
TABLE 4.7.3	Going deeper: The negative effects of heroin use	128
TABLE 4.7.4	Ways out: Realisation process	135
TABLE 4.7.5	Taking action: Behaviour modification	138
TABLE 4.7.6	Perceived effects of intervention	144
TABLE 4.7.7	New labels: References to self in recovery	166

FIGURES

CHAPTER ONE

Figure 1.1	Adam & Eve	3
------------	------------	---

CHAPTER TWO

Figure 2.1	Papaver somniferum: opium poppy	21
Figure 2.2	Poppy Pod	22
Figure 2.3	Poppy Pod	22
Figure 2.4	Ripe Poppy pod	22
Figure 2.5	Opium farmer	23
Figure 2.6	Harvest time	23
Figure 2.7	Opium smoker	27
Figure 2.8	Opium smoker	27
Figure 2.9	Shanghai girl smoking her opium pipe	28
Figure 2.10	Manila opium den	28
Figure 2.11	Black opium	29
Figure 2.12	Heroin cough mixture	31
Figure 2.13	Bayer's Heroin Hydrochloride	31
Figure 2.14	Mrs Winslow's soothing syrup	32
Figure 2.15	Perry David's vegetable painkiller	32
Figure 2.16	Thai white heroin	44
Figure 2.17	China white heroin	44
Figure 2.18	Black tar heroin	44
Figure 2.19	Brown sugar Heroin	44
Figure 2.20	Opium smoker	45
Figure 2.21	Intravenous heroin use	45
Figure 2.22	Chasing the dragon	45
Figure 2.23	Heroin works	45
Figure 2.24	The chemical structure of heroin	51
Figure 2.25	The chemical structure of morphine	51
Figure 2.26	The effects of opioids on the brain and nervous system	52
Figure 2.27	The chemical structure of methadone	56
Figure 2.28	The chemical structure of codeine	61
Figure 2.30	The chemical structure of naltrexone	63

CHAPTER FIVE

Figure 5.1	Framework for a holistic model of heroin dependence recovery	196
------------	--	-----

GLOSSARY AND ABBREVIATIONS

Abuse:	Deliberately taking a substance for other than its intended purpose, and in a manner that can result in damage to the person's health or ability to function (http://heroinhelper.com).
Acid:	<i>l</i> -Lysergic acid <i>LSD</i> , (see below), a hallucinogen. Originally a white-street culture term (Gould, Walker, Crane & Lidz, 1974).
Acquirer:	Middle man between a <i>dealer</i> (see below), usually a <i>chipper</i> (see below) or someone on the outer edge of the heroin scene (http://heroinhelper.com).
Adulteration:	The process of diluting a drug (http://heroinhelper.com).
Agent Orange:	A herbicide used in the Vietnam War to defoliate forest areas (http://webster-dictionary.org/definition/Agent20Orange).
Agonist:	First, a compound that binds to a receptor to form a complex, which elicits a full pharmacological response, particular to the nature of the receptor involved. Second, any opioid that produces morphine or codeine-like effects on the body (http://heroinhelper.com).
Agonist-antagonist:	Any opioid which produces both agonist and antagonist activity at opioid receptor sites. The drug may be primarily one or the other, for example, butorphanol has more of an agonist than an antagonist effect (http://heroinhelper.com).
AIDS:	Acquired Immune Deficiency Syndrome.
Alcohol:	Drug acting as a central nerve depressant (Dawtry, 1968).
Alkaloid:	A molecule that contains nitrogen, carbon, oxygen, and hydrogen. All opioids are alkaloids (http://heroinhelper.com).
Amphetamines:	A group of chemically related synthetic stimulants. They have a structural resemblance to norepinephrine, a neurotransmitter that is produced naturally by the body. Amphetamines increase mental activity and physical energy as well as giving a euphoric feeling to the user (Dawtry, 1968).
Antabuse®:	The drug prevents the breakdown of acetaldehyde, a by-product of alcohol, and the build up of acetaldehyde causes feelings of illness. More specifically, if people drink while taking Antabuse, they will experience nausea, vomiting, elevated heart rate and respiration. Under ideal situations, the person takes Antabuse® each morning, before the desire to drink prevents the person from doing so. Unfortunately, non-compliance is a major concern with the use of this drug, and avoiding Antabuse® for a few days is sufficient for a person to be able to resume drinking (Barlow & Durand, 1995).
Antagonist:	A drug that blocks the effects of an opioid. They are used in cases of overdose, or to establish whether a user is an addict (http://heroinhelper.com).
Analgesic:	A drug that relieves pain without rendering the patient unconscious (http://heroinhelper.com).
Apomorphine:	A non-euphoric derivative of morphine without its acute addictive nature, used to induce vomiting. Sometimes used in heroin withdrawal treatment (http://heroinhelper.com).
Atropine:	A tropane alkaloid extracted from the deadly nightshade (<i>Atropa belladonna</i>) and other plants of the family Solanaceae. It is a secondary metabolite of these plants and serves as a drug with a wide variety of effects. Being potentially deadly, it derives its name from Atropos, one of the three Fates who, according to Greek mythology, chose how a person was to die (http://encyclopedia.thefreedictionary.com/atropine).
Back up:	<i>Pull-back</i> (see below).
Bag:	A dose of heroin, usually costing between R20.00-R50.00 (http://heroinhelper.com).
Balloon:	This often refers to a single dose of heroin - usually an eighth gram. Heroin is often distributed in small balloons so that it can be stored in the mouth and swallowed (without loss) should signs of law enforcement appear (http://heroinhelper.com).
Barbiturate:	A class of sedative, anti-convulsant, hypnotic drug, which depress the central nervous system. The kidneys remove the longer acting barbiturates; the liver removes the short acting ones. Barbiturates are widely used outside the realm of medical practice, with abuse of the substance reaching its zenith in the 1950s and 1960s in the United Kingdom and the United States (http://heroinhelper.com).

Barbs:	<i>Barbiturates</i> , (see above). With the shadowy social role that barbiturates took, this slang term developed (Gould <i>et al.</i> , 1974).
Belladonna:	First, a perennial Eurasian herb with reddish bell-shaped flowers and shining black berries; extensively grown in United States; roots and leaves yield atropine. Second, an alkaloidal extract or tincture of the poisonous belladonna herb that is used medicinally (http://www.words.universe.com/definition/belladonna).
Benzodiazepine:	A class of minor tranquillisers with lifetimes anywhere from a few hours to a few days (http://heroinhelper.com).
Black market:	Illicit market.
Black tar:	A crudely processed form of heroin illicitly manufactured in Mexico, uncommon to South Africa. It has the sticky consistency of roofing tar or can be as hard as coal, and is dark brown or black in colour. It is often sold on the street in its tar-like state, with the purity level ranging from 40% - 60%. This form of heroin is sometimes diluted by adding materials of similar consistency, such a burnt cornstarch, or by converting the tar heroin into a powder and adding dilutants such as quinine. It is most commonly used through intravenous administration (Alavi, Naicker & Cassim Peer, 2003).
Brown sugar:	Heroin mixed with adulterants, found in South Africa.
Buprenorphine:	A narcotic agonist-antagonist (trade name Subutex®) used in the treatment of heroin dependence (http://heroinhelper.com).
Bust:	To inform the police about drugs (Dawtry, 1968).
Business:	All the assorted things that a heroin dependent must do to maintain the habit. It is most commonly used in the phrase 'taking care of business' (http://heroinhelper.com).
Butorphanol®:	A narcotic agonist/antagonist used as an analgesic (http://heroinhelper.com).
Cannabis:	Flowering or fruiting tops of female plants of the genus <i>cannabis sativa</i> , from which the resin is extracted. An intoxicant containing tetrahydrocannabinol (THC) (Dawtry, 1968).
Cat:	<i>Methcathinone</i> , (see below).
CBT:	Cognitive Behavioural Therapy.
Chasing the dragon:	Method of heroin use. Powdered heroin is placed on aluminium foil and heated from below. The heroin is transformed into a sticky liquid and wriggles around like a Chinese dragon. The fumes given off are then inhaled, normally through a rolled up newspaper, magazine or tube (Alavi <i>et al.</i> , 2003).
China White:	White powder heroin from Asia, usually referring to heroin funnelled through France. Not commonly found in South Africa (http://heroinhelper.com).
Chipper:	An non-addicted or dependent, casual drug user (http://heroinhelper.com).
Chipping:	Occasional or recreational non-addictive or dependent heroin use (Pearson, 1987).
Clonidine:	A blood pressure medication that is regarded to be highly effective at modulating opioid withdrawal symptoms (http://heroinhelper.com).
Cocaine:	Product of coca leaves. Analgesic, temporary stimulant, highly toxic. Strong psychic but no physical dependence develops (Dawtry, 1968).
Cocktail:	A mixture of different drugs taken at once (http://heroinhelper.com).
Codeine:	Mild opioid used in cold cures and pain relieving mixtures (Dawtry, 1968).
Coke:	<i>Cocaine</i> , (see above).
Cold turkey:	To stop using or detox off of heroin abruptly and without the benefit of medication. The term has been part of the lexicon culture at least since the 1940s (Gould <i>et al.</i> , 1974).
Cold Shot:	Heroin dissolved in water without boiling it (http://heroinhelper.com).
Cold War:	First, a war with no direct fighting between counties involved. A cold war often involves countries with different ideologies, for example the United States capitalist and Soviet Union communist. Second, a war of mistrust, spying, propaganda and deception (http://webster-dictionary.org/definition/coldwar).

Come down:	Gradual descent from euphoric mood produced by the drug to the depressive aftermath (Dawtry, 1968).
Connection:	Middle man from whom drugs are obtained (Dawtry, 1968).
Cooker:	Spoon or other device used to cook heroin for injection (http://heroinhelper.com).
Crack cocaine:	Crack is the most potent and the most addictive form of cocaine. It is made by adding an alkaline substance to cocaine powder, resulting in a product that is about 90% pure (http://heroinhelper.com).
Cut:	The act of diluting a drug. Also the substance with which a drug is diluted (http://heroinhelper.com).
CIA:	Central Intelligence Agency.
CNS:	Central Nervous System: the brain and spinal cord (http://heroinhelper.com).
Dagga:	The Afrikaans word for <i>cannabis</i> , (see above) (Dawtry, 1968).
Darvon®:	An analgesic soup containing <i>propoxyphene</i> , (see below) (http://heroinhelper.com).
Dealer:	A person who sells any drug on a regular basis (Gould <i>et al.</i> , 1974).
Demerol®:	Brand name for <i>Meperidine</i> , (see below), a synthetic opioid similar to morphine but only about as potent as codeine. American trade name for <i>pethidine</i> , (see below) (http://heroinhelper.com).
Depressant:	Substance which depresses activity of the higher centres of the brain, thus relieving tension, anxiety and inhibition (Dawtry, 1968).
DEA:	Drug Enforcement Administration.
Detox:	Detoxification. Detoxification is the controlled withdrawal from a substance such as heroin. It is a procedure that aims to alleviate signs and subjective discomfort, and prevent the risks inherent to suddenly stopping use of a substance that has resulted in dependence. However, it is not a distinct form of treatment for chemical dependence in its own right. Detoxification (or detox) needs to be supported by a period of aftercare for the person to produce long-lasting changes in behaviour (Hopkins & Clark, 2005).
Diacetyl-morphine:	Heroin.
Dihydro-codeine:	A semi-synthetic opioid similar to codeine (http://heroinhelper.com).
Dihydro-morphinone:	<i>Dilaudid</i> ® (see below) (http://heroinhelper.com).
Dilaudid®:	A semi-synthetic opioid, about three times as potent as heroin (http://heroinhelper.com).
Disulfiram:	<i>Antabuse</i> ® (see above).
Dirty urine:	A urine specimen that has been found by drug testing to contain traces of illegal drugs or substances of abuse (Gould <i>et al.</i> , 1974).
Dixarit®:	South African brand name for <i>Clonidine</i> (see above).
Dope:	Any narcotic. In this study it refers to heroin only (Gould <i>et al.</i> , 1974).
Downer:	A class of opioid, barbiturate or tranquilliser-based drugs; originally a white street-culture term (Gould <i>et al.</i> , 1974).
DPN:	Diphosphopyridine nucleotide.
Druglord:	A person who controls an organisation dealing in illegal drugs (\">http://www.webster-dictionary.org).
Dysphoria:	A withdrawal symptom that distinguished by feelings of uneasiness and malaise (http://heroinhelper.com).
Ecstasy:	A designer drug that is a stimulant. It is an amphetamine derivative with the scientific name of methylenedioxy-methamphetamine (MDMA) (<i>Oxford Advanced Learner's Dictionary</i> , 2000).

EMIT:	An acronym for 'enzyme multiplied immunoassay technique.' It is a common system used for detecting drug use from urine samples (http://heroinhelper.com).
Endorphins:	Compounds produced by the body that are used to regulate pain and create a sense of well being. Endorphins are very similar to, and act in the same way as opioids (http://heroinhelper.com).
Enkephalins:	Short chain amino acids that act as opioids and are a form of endorphins (http://heroinhelper.com).
Ephedrine:	Stimulant tablet prescribed among other things for asthma and shock (Dawtry, 1968).
Encounter group:	A small group that focuses on intensive interpersonal interactions, or 'encounters'. The group usually has as its goals the removal of psychological barriers and defences, achieving openness, honesty and the willingness to deal with 'here-and-now' and to eschew intellectualisation and personal history. Encounter groups and their use in psychotherapy began with the human potential movement (Reber, 1985).
FDA:	Food and Drug Administration.
Fentanyl:	An extremely potent opioid, roughly 100 times as powerful as morphine (http://heroinhelper.com).
Fix:	Injection of a narcotic or the quantity of a drug needed (Dawtry, 1968).
GC/MS:	Gas chromatography/mass spectrometry. This is a device that is used for many valid applications and can also be used as a drug screening tests. These tests are expensive, so employers and bureaucracies don't like to use them but they are the only tests that are reasonably accurate (99.98%). They are also the only tests that can distinguish between morphine and a poppy-seed bun (http://heroinhelper.com).
Golden Crescent:	An important area in the production of opium. It encompasses Pakistan, Iran, and Afghanistan (http://heroinhelper.com).
Golden Triangle:	An important area in the production of opium. It encompassing Thailand, Northern Laos, and Eastern Burma (http://heroinhelper.com).
H:	Heroin.
HSRC:	Human Sciences Research Council.
Half-life:	The amount of time it takes for half of the amount of a drug in the body to be removed (http://heroinhelper.com).
Hallucinogens:	Drugs such as cannabis and LSD, taken primarily for their hallucinogenic properties (Dawtry, 1968).
Hard core:	Term usually applied to an addict with a chronic history of drug abuse.
Hard drugs:	Term usually applied only to opioids, cocaine and certain synthetics (Dawtry, 1968).
Hardness:	A mostly meaningless measure of a drug's dangerousness. Drugs like caffeine are considered 'soft' while drugs like heroin and cocaine are considered 'hard' (http://heroinhelper.com).
Heroin slang:	First, the most common terms are: brown sugar, black tar, brown, brown sugar, China white, dope, dragon, H, horse, junk, scag, scar, shit, smack, tar, Tai, Tai white, white. In addition, these are a collection a number of slang terms from personal experience and literature studies, some of which are so silly that maybe a playful junkie was just pulling some clueless sociologist's leg: big H, blanco, blanks, boy, brother, caballo, ca-ca (counterfeit), cat, chick, Chinese red, cobics, chiva, crap, cura, dogie, doojee (duji), flea powder, goods, hard stuff, Harry (hairy), Henry, joy powder, ka-ka, Mexican, Mexican mud, poison, red chicken, schmeck, snow, stuff sugar, tecata, thing, white stuff. One can find localised references to heroin in just about any word starting with the letter 'H' (http://heroinhelper.com).
Hepatitis:	Inflammation of the liver (http://heroinhelper.com).
High:	In a state of euphoria, as an effect of drugs (Dawtry, 1968).
Hit:	To inject (http://heroinhelper.com).
Hooked:	Dependent on drugs (Dawtry, 1968).
Hypnotic:	Sleep-inducing drugs (Dawtry, 1968).

Hypodermic:	Syringe (http://heroinhelper.com).
Ice:	<i>Speed</i> , (see below).
IDU:	Injection drug user.
Imipramine:	<i>Tofranil</i> ®, (see below) (Dawtry, 1968).
Immodium:	The antidiarrhetic medication <i>Loperamid</i> ® (http://heroinhelper.com).
IM:	Intramuscular (http://heroinhelper.com).
Inhalants:	A group of volatile substances that are rarely produced for their psychoactive properties but can be abused for such purposes. Glue, petrol or gasoline, carpet cleaners, paint thinners, fire extinguisher fluids, correction fluids, aerosol fluids, ether, chloroform and nitrous oxide (Rudgley, 1999).
ISS:	Institute for Security Studies.
IV:	Intravenous (http://heroinhelper.com).
Joint:	First, cannabis cigarette, this is largely white street-culture. Second, prison or jail (<i>Gould et al.</i> , 1974).
Junk:	Heroin or a narcotic drug. American slang term dating back to the 1940s (Dawtry, 1968).
Junky:	Drug user, in this study the term specifically refers to a heroin dependent (Dawtry, 1968).
Kat:	<i>Methcathinone</i> , (see below).
Khat:	Substance derived from the leaves of the African tree <i>Catha Edulis</i> , chewed or drunk as an infusion to produce euphoric effect. Similar to amphetamine in active principle (Dawtry, 1968).
Kicking down:	Using less than your normal dose of heroin to reduce your tolerance; a limited form of withdrawal (http://heroinhelper.com).
Kick the habit:	Stop taking drugs or to withdraw from a drug (Dawtry, 1968, http://heroinhelper.com).
LAAM:	Levo-alpha-acetylmethadol. It is a synthetic opioid with a three-day half-life, which has been used instead of <i>methadone</i> (see below) in maintenance programmes (http://heroinhelper.com).
Laudanum:	Tincture of opium, popular tranquilliser of the 19 th century (Dawtry, 1968).
Librium®:	Chlordiazeposide. A tranquilliser often used in psychoneuroses, epilepsy and to relax muscles of psychotic patients. Mild anti-depressant (Dawtry, 1968).
LSD:	Lysergic Acid Diethylamide. A colourless, odourless, hallucinogenic drug from the ergot of rye (Dawtry, 1968).
Magic dragon:	Heroin.
Mandrax®:	Sleeping tablet. Contains methaqualone and diphrenhydramine. Dangerous particularly in combination with alcohol (Dawtry, 1968).
MAO inhibitor:	Monoamine oxidase inhibitors are prescription medications that block the action of monoamine oxidase in the brain. They relieve certain types of mood disorders such as depression and anxiety, as well as phobias, and panic attacks (http://www.advancedpaintreatment.com).
Mainline:	Intravenous injection (http://heroinhelper.com).
Mafia:	A secret organisation of criminals or a group of people within a community who use their power to get advantages for themselves (<i>Oxford Advanced Learner's Dictionary</i> , 2000).
MEDUNSA:	Medical University of South Africa.
Mescaline:	Product of a Mexican cactus, Peyote, similar in effect to LSD. Related to adrenaline (Dawtry, 1968).
Meperidine:	A synthetic opioid commonly known as <i>Demerol</i> ®, (see above) (http://heroinhelper.com).
Methamphetamine:	A white crystalline powder first synthesised in the 1800's and later adopted as a drug during World War II by the Axis Empire and the Alliance, to aid in keeping troops alert,

which it is still used today. Methamphetamine, commonly known as speed, crank, crystal, glass, is d-desoxymethylamphetamine synthetic in nature, but can be derived from the extract of ephedra from mau huang, a nearly illicit plant. Methamphetamine is extremely potent, and addiction is rapid, especially if used intravenously (<http://www.urbandictionary.com/define.php?terms=methamphetamine>).

Methadone:	<i>Physeptone</i> ®, (see below). A synthetic opioid, morphine substitute, narcotic, analgesic, addictive, but used to blockade heroin craving during withdrawal. Reduces physical pain for up to 48 hours (Dawtry, 1968).
Methcathinone:	A strong synthetic powder made from over the counter ingredients. The street names for methcathinone in South Africa are Kat and Cat (www.ravesafe.org).
Methedrine®:	Methylamphetamine hydrochloride. Employed to counter circulatory collapse. Form of amphetamine now often abused and usually self-administered intravenously (Dawtry, 1968).
Mexican mud:	A crudely processed form of heroin illicitly manufactured in Mexico, not found in South Africa at present (Dawtry, 1968).
Morphine:	Alkaloid derived from opium in 1803 for analgesic purposes (Dawtry, 1968).
MMPI:	Minnesota Multiphasic Personality Inventory. One of the most widely used self-report inventory for the assessment of personality (Barlow & Burand, 1995).
MMTP:	Methadone Maintenance Treatment Programmes.
MRC:	Medical Research Council.
Majahideen:	Literally means 'struggler', someone who engages in jihad, or 'struggle', but is often translated in the West as 'holy warrior'. In the late twentieth century, the term became popular in the Western media to describe various armed fighters who subscribe to militant Islamic ideologies, although there is not always an explicit 'holy' or 'warrior' meaning within the word (<i>Wikipedia: The Free Encyclopaedia</i> , 2006).
Naloxone:	A potent narcotic antagonist (trade name Narcan®) (http://webster-dicdicdictionary.org/definition/naloxone).
Naltrexone:	A narcotic antagonist (trade name Revia®) that blocks or counteracts the effect of opioids. It is given to a person who is dependent on opioids and produces immediate withdrawal symptoms, an extremely unpleasant effect. A person must be withdrawn completely from the opioid before starting naltrexone, and because it removes the euphoric effects of opioids, the user must be highly motivated to continue treatment (Barlow & Durand, 1995).
Narcosis:	Unconsciousness produced by a drug (Dawtry, 1968).
Narcotics:	First, strictly speaking, a distinct class of psychoactive substances that causes states of stupor, sleep and calm. Opium and its derivatives, such as heroin and morphine, is the narcotics par excellence. Narcotics may be seen as a sub-division of the hypnotics. Second, to drug enforcement organisations narcotics refers to various 'hard drugs', particularly heroin and cocaine. However, cocaine is, in terms of its psychoactive effects, a stimulant rather than a narcotic. Third, many older generation researchers have used the term as a general all-encompassing rubric for all psychoactive substances (Rudgley, 1985).
NA:	Narcotics Anonymous.
Nar-Anon:	International anonymous support group for significant others of narcotic dependants.
NAADAC:	National Association of Alcoholism and Drug Abuse Counsellors, this association is United Kingdom based.
NEP:	Needle Exchange Programmes.
Needle:	Hypodermic syringe (Dawtry, 1968).
Neuro-transmitter:	Any endogenous compound that plays a role in synaptic nervous transmission (http://heroinhelper.com).
NIU:	Non-injection user.
Nyeope:	Heroin smoked with cannabis. A South African township-culture term.
OD:	Overdose. To take too much of any drug. Can be used to suggest fatality, more often either advances narcolepsy or simply overindulgence (Gould <i>et al.</i> , 1974).

Opium:	The opium poppy (<i>Papaver somniferum</i>), being the source of both the indispensable painkiller morphine and the most notorious of all street drugs, heroin. The word 'opium' is thrown around very loosely but the definition is very specific (http://heroinhelper.com).
Opiate:	The word opiate has been used to refer to the naturally occurring chemicals in the poppy that have a narcotic effect (relieving pain and inducing sleep) (Barlow & Burand, 1995). Also review <i>Opioid</i> , (see below).
Opioid:	First, opioids is used to refer to the family of substances that include <i>opiates</i> (see above) as well synthetic variations created by chemists (for example, methadone) and pethidine and similar-acting substances that occur naturally in the brain (for instance, enkephalins, beta-endorphins and dynorphins) (Barlow & Durand, 1995). Second, the naturally occurring opioids, all of which are derived from the opium poppy such as morphine and codeine. Third, the semi-synthetic opioids including heroin and various other preparations such as dihydromorphinone. Fourth, the synthetic opioids including methadone, and meperidine, all of which are wholly synthetic compounds with a morphine-like pharmacological profile. Fifth, the narcotic antagonist which when used in conjunction with an opioid block its effects but when used alone have opioid-like properties. Sixth, the endogenous opioids that occur naturally in the brain such as endorphins. As a class the opioids all have both analgesic and narcotic effects; they also produce (often rapidly) both drug tolerance and drug dependence (Reber, 1995).
OPT:	Outpatient therapy (Gould, <i>et al.</i> , 1974).
OxyContin®:	Oxycodone hydrochloride. The drug is indicated for moderate to severe pain where use of an opioid analgesic is appropriate for more than a few days. Oxycontin is a semi synthetic morphine derivative, about half as potent as morphine (http://oxycodone/prescribe/html).
Paregoric:	Camphorated tincture of opium in cough mixtures has a high alcohol content (Dawtry, 1968, http://heroinhelper.com).
Parenteral:	Injection in any of its many forms (http://heroinhelper.com).
Paraphernalia:	<i>Works</i> , (see below) (http://heroinhelper.com).
Partial agonist:	A compound which possesses affinity for a receptor, but unlike a full agonist, will elicit only a small degree of the pharmacological response peculiar to the nature of the receptor involved, even if a high proportion of receptors are occupied by the compound (http://www.advancedpaintreatment.com).
Pethidine:	Synthetic narcotic of opiate group. If misused it is highly addictive (Dawtry, 1968).
Peyote:	Mexican plant producing <i>mescaline</i> , (see above) (Dawtry, 1968).
Physeptone®:	<i>Methadone</i> , (see above) (Dawtry, 1968).
Propoxyphene:	A weak synthetic opiate (~1/10 as strong as morphine) which is the primary ingredient of <i>Darvon®</i> , (see above) (http://heroinhelper.com).
Psilocybin:	Hallucinogenic drug similar to LSD derived from the mushroom Teonanacatl (Dawtry, 1968).
Psychedelics:	Substances administered specifically for their hallucinogenic side effects, such as LSD, mescaline, psilocybin and cannabis (Reber, 1985).
Pull-back:	Pulling the syringe plunger back so that the syringe will fill with blood if the needle is inside of a vein (http://heroinhelper.com).
Poly-substance:	A variety of psychoactive substances.
Pusher:	Drug dealer (Dawtry, 1968).
PCP:	Phencyclidine. In low to moderate doses it acts as a stimulant, whilst in higher doses it acts as a depressant. As an anaesthetic agent it was relegated to the realm of veterinary sciences (Dawtry, 1968).
Quinine:	A bitter tasting alkaloid commonly used to cut heroin, it has also been used in the past to treat malaria (http://heroinhelper.com ; <i>Oxford Advanced Learner's Dictionary</i> , 2000).
Rave:	A large party normally held outside or in a large empty building, at which people dance to fast electronic music and often take illegal drugs (<i>Oxford Advanced Learner's Dictionary</i> , 2000).
RIA:	Radioimmunoassay. It is common system used for detecting drug use from urine samples (http://heroinhelper.com).

Ritalin®:	A form of amphetamine used paradoxically to treat hyperactive children (http://heroinhelper.com).
Rip-off:	Steal, exploit. The term probably originated in the radical politics of the 1960s meaning exploitation or counter-exploitation and gradually coming to its present meaning of overindulgence (Gould, <i>et al.</i> , 1974).
Rocks:	A South African term for <i>crack cocaine</i> , (see above).
Run:	First, a period of constant use. With heroin this is generally a period of time dependant (http://heroinhelper.com). Second, to bring or take drugs into a country illegally and secretly (<i>Oxford Advanced Learner's Dictionary</i> , 2000).
SACENDU:	South African Community Epidemiology Network on Drug Use. This is the alcohol and drug research group of the Medical Research Council, which monitors alcohol and drug abuse trends in the cities of Cape Town, Durban, Port Elizabeth, Gauteng and Mpumalanga province.
SANAB:	South African Narcotics Bureau.
SANCA:	South African National Council on Alcoholism and Drug Dependence.
Script:	A prescription (http://heroinhelper.com).
Scene:	Environment where drugs circulate (Dawtry, 1968).
Score:	Obtain drugs illegally (Dawtry, 1968).
Seconal®:	Sedative. Used as a sleeping tablet (Dawtry, 1968).
Sedative:	A drug that depresses the central nervous system and causes drowsiness (http://heroinhelper.com).
Semi-synthetic opiate/opioid:	A compound with some opioid receptor affinity, synthesised by functional modification of a product extracted from opium (Dawtry, 1968).
Shooting up:	Administration of heroin intravenously (http://heroinhelper.com).
Shot:	Injection (Dawtry, 1968).
Skin-popping:	Subcutaneous (under skin) injection (http://heroinhelper.com).
Slam:	To inject, especially intravenously (http://heroinhelper.com).
SLORC:	State Law and Order Restoration Council.
Smack:	Heroin. A term used more in the white sub-street-culture than in the addict subculture (Gould <i>et al.</i> , 1974).
Snatch:	A South African term, 0.1g-1g of heroin wrapped in a plastic bag of 5cm x 5cm, rolled up and knotted with the ends and burnt together (Alavi, <i>et al.</i> , 2003).
Sniff:	To inhale a liquid or solid through the nose (http://heroinhelper.com).
Snort:	To inhale a liquid or solid through the nose (http://heroinhelper.com).
Speed:	A class of amphetamine-based drugs; originally a white street-culture term (Gould <i>et al.</i> , 1974).
Speedball:	Heroin-cocaine combined (http://heroinhelper.com).
Spiking:	Intravenous use of a substance, within the context of this study the terms refers to intravenous heroin use.
Split:	A term used at least since the 1950s, it implies that another addict's habit or doings is made known to others and/or to law enforcement officials (Gould <i>et al.</i> , 1974).
SSRIs:	Selective serotonergic reuptake inhibitors, a type of antidepressant medication, perhaps the best known being fluoxetine (brand name Prozac®) (Barlow & Durand, 1995).
Stimulants:	Substances that act on the higher centres of the brain, increasing cerebral activity, resistance to sleep and fatigue. Depression may follow when effects wear off (Dawtry, 1968).

Strychnine:	A poisonous substance used in very small amounts as a medicine (<i>Oxford Advanced Learner's Dictionary</i> , 2000)
Stoned:	Drugged to an almost paralytic state (Dawtry, 1968).
Straight:	A non-drug using person (http://heroinhelper.com).
Strung Out:	Addicted to heroin (http://heroinhelper.com).
Subutex®:	<i>Buprenorphine</i> , (see above).
Suboxone®:	<i>Buprenorphine</i> , (see above).
Synthetic opiate/opioid:	A compound with some opioid receptor affinity, synthesised using no products extracted from opium (Dawtry, 1968).
Syringe slang:	Fit, gimmick, hypodermic, outfit, rig, works (http://heroinhelper.com).
Taliban	A fascist Islamist nationalist Movement which dominated most of Afghanistan from 1996 until 2001, having diplomatic recognition from only four countries: the United Arab Emirates, Pakistan, Saudi Arabia, as well as the Chechen Republic of Ichkeria (<i>Wikipedia: The Free Encyclopaedia</i> , 2006).
Thai white:	A more pure form of heroin, often used intravenously and commonly found in South Africa.
Tofranil®:	<i>Imipramine</i> hydrochloride, (see above). Mood-changing drug, sometimes used with Librium, as calmative or anti-depressant (Dawtry, 1968).
Tolerance:	The capacity of the body to become less responsive to a substance with repeated use; the necessity to ingest more of a drug on subsequent episodes to achieve the same effect (http://heroinhelper.com).
Tough/love:	International support group programme designed in the United States for parents in crisis. It is a structured support group for those who feel entirely helpless in the face of their teenager's behaviour (Schauffer, 1998).
Tracks:	Repeated needle entry scars along a vein (http://heroinhelper.com).
Trafficker:	An unlicensed dealer in illegal drugs (http://www.webser-dictionary.org).
Tranquilliser:	A drug bringing calm by reducing cerebral activity without loss of consciousness or sleep (Dawtry, 1968).
Tricyclics:	A group of anti-depressant drugs that function by preventing the re-uptake of amines in the cholinergic synapse. Side-effects are relatively minor and there is little tolerance or dependence (Reber, 1985).
Upper:	A class of either cocaine, amphetamine or methamphetamine; originally a white street-culture term. The term is used for any substance that is a central nerve stimulant (Gould, <i>et al.</i> , 1974).
UNODC:	United Nations Office of Drugs and Crime.
UKPCBADc:	The United Kingdom Professional Certification Board of Alcohol and Drug Counsellors.
Valium®:	Diazepam. Tranquillising drug (Dawtry, 1968).
Warlords:	Supreme drug leader exercising power in a region (http://www.webser-dictionary.org),
Weed:	<i>Cannabis</i> , (see above) (Dawtry, 1968).
Wellconol®:	A synthetic opioid composed of dipipanone hydrochloride, a synthetic opioid, and cyclizine hydrochloride, an antihistamine. Wellconol is dissolved and injected in South Africa, and was the only drug abused intravenously during the apartheid era. Often referred to as <i>pinks</i> within the South African context (Leggett, 2001).
WHO:	World Health Organisation.
Works:	The equipment necessary to prepare and inject heroin. Usually an eyedropper and hypodermic needle, but can be a syringe (Gould <i>et al.</i> , 1974).
Zol:	White-culture Afrikaans South African slang term for <i>cannabis</i> , (see above).
Xanax®:	<i>Benzodiazepine</i> , (see above). Anti-anxiety; sedative-hypnotic; anti-panic agent, known also as Alprazolam (http://what-definition.com/xanax).

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

Drug abuse and dependence, having evolved into a global problem, has broken out of well-defined localised addict communities, infiltrating all strata of society. This is true for developed countries, and is particularly conspicuous in developing countries struggling with the instability and vulnerability of transition, such as South Africa (James, 1998), where traditional use of drugs for therapeutic, ritual or religious reasons has been replaced by socially detrimental abuse and drug dependence (Boone, 2001). It is such emerging and developing democracies that are especially prone to destabilisation forces such as drug and alcohol abuse resulting in complex ramifications. The problems of illiteracy, high unemployment rates, AIDS, poverty and crime exacerbate the problem in South Africa. Furthermore, some treatment procedures such as detoxification and rehabilitation can be especially expensive, and a large disparity between the services of the private and public health and welfare sector prevails (James, 1998).

Heroin manufacturing in the Golden Crescent and in the Golden Triangle is regarded to be the second largest industry in the world, which involves links with the United States' CIA, the Majahideen and Pakistan's nuclear weapons programme. The United States involvement in Vietnam, for example, boosted the opium trade in south-east Asia. It is claimed that the CIA encouraged, or even created this trade and opium farming due to the assistance required during the Vietnam War of the highland tribesman near North Vietnam (Kenny, 1999).

The 2002 UNODC report on Global Illicit Drug Trends estimated that globally about 13 million people abuse opioids. About 70% of opioid abuse relate to heroin. Of 63 countries reporting trend data (1999-2000), 71% reported an increasing trend in heroin abuse. In Asia, Europe and Oceania, which together have 73% of the world's total population, between two thirds and three-quarters of substance abuse treatment demand is related to opioid abuse (cited in Plüddemann, Parry & Flisher, 2004).

Although prevalence rates for heroin consumption are generally low in Africa, UN reports point to a steady increase in heroin use in a number of African countries, especially countries located along the primary drug trafficking routes, such as Ghana, Nigeria, and South Africa. According to the UNODC's report for 2004, South Africa is estimated to have one of the highest prevalence rates of heroin use in Africa, and is regarded as the smuggling capital of southern Africa (*United Nations Office for Drugs & Crime*, 2004).

The opening up of the borders in South Africa since the mid 1990's has brought with it an influx of imported drugs, most notably cocaine, ecstasy and LSD from Europe, and perhaps most worryingly, heroin (Boone, 2001; Leggett, 2001; Rocha-Silva, 1998). While heroin has always found its way into South Africa, it started making its presence felt in 1995 (Dugmore, 1999). When the country's borders opened in 1995, the Nigerian drug cartels arrived and suddenly an influx of cheap crack-cocaine flooded the market. This was viewed as a 'sophisticated' drug, which made it socially more acceptable. Once people were hooked on this, the dealers quickly brought in 'brown sugar' and 'Thai white', riding on the wave of their previous success (Scher, 2000).

The trend data presented by SACENDU has also highlighted the changing nature of drug abuse in South Africa toward so-called 'harder' drugs, such as cocaine and heroin, as well as an emerging trend toward intravenous heroin use (Plüddemann, Hon, Parry, Bhana, Matthysen, Potgieter, Cerff & Gerber, 2002).

According to SACENDU statistics, heroin was the third most abused illicit substance with those individuals presenting for treatment in Gauteng in 2003 (cannabis was predominant followed by the 'white-pipe' combination of mandrax and cannabis). In 1998, 52 patients were treated at registered rehabilitation centres for heroin dependence in Gauteng (it was at that stage the least abused substance presenting for treatment); this escalated to 347 heroin patients treated in 2003 in Gauteng alone (Plüddemann, Hon, Bhana, Harker, Potgieter, Gerber & Parry, 2004; Plüddemann *et al.*, 2002). This trend is very similar to that witnessed in other countries, particular the United States, where heroin use has increased among middle-class youth. In other countries, heroin addiction and dependence adversely affects public health and public disorder disproportionately to the number of people who abuse the drug (Boone, 2001). In Cape Town only 2% of all patients ($n = 2\ 301$) in substance abuse treatment during the first half of 1998 had heroin as a primary substance of abuse. However, in the second half of 2003, 7% of all patients ($n = 1\ 659$) were in treatment for heroin abuse. The trend in Gauteng has followed the same pattern, with 8% of 2 617 patients treated for heroin during the first half of 2003, although decreasing to 6% in the second half of that year. In both these sites a further 2% of all patients reported heroin as a secondary substance of abuse in the second half of 2003. Most patients are white and relatively young. Since January 1997, the mean age at which patients present for heroin dependence treatment has decreased from 29 to 24 years in Gauteng and 27 to 24 years in Cape Town. From 1997 to 2003, between 22% and 34% of persons seeking treatment for heroin abuse in Cape Town and between 24% and 43% in Gauteng, were female. This contrasts with drugs like cannabis and mandrax, where over 90% of patients are male (Plüddemann, *et al.*, 2004).

A national survey conducted amongst 10-21 year olds in black communities in 1994 by the HSRC found that 0.9% of the 1 378 participants reported lifetime, past twelve-month and neighbours use of heroin respectively (Rocha-Silva, de Miranda & Erasmus, 1996). Anecdotal information from professionals working in substance abuse treatment and prevention also suggests a possible increase in heroin use in certain township areas, such as Hammanskraal in Pretoria and Langa in Cape Town (Plüddemann, *et al.*, 2004). In a survey conducted by the Pretoria branch of SANAB in the schools in the Pretoria area, it was found that 35% of school's drug-users had tried heroin (Smillie, 2001).

An increase in injection heroin use has also been noted, with the proportion of patients reporting injection drug use increasing from 29% in the second half of 1999 to 51% in the second half of 2001 in Cape Town, however decreasing again to 44% in the second half of 2003. In Gauteng the proportion of heroin patients reporting injection has increased steadily from 36% in the second half of 2001 to 49% in the second half of 2003. Heroin was also the third most common primary drug of abuse amongst patients who are younger than 20 years in Cape Town in the second half of 2003 (Plüddemann, *et al.*, 2004).

If heroin use, in particular, continues to increase, we are likely to see even greater levels of drug-related crime than we have to date (Boone, 2001). This researcher was implicated on a professional level in 2002 with the so-called 'Adam & Eve' case, concerning a Pretoria teenage couple who murdered a family member while both were heroin intoxicated (see Figure 1.1,p.3). The ISS 'Three-Metro's' study showed that

approximately half of the arrestees surveyed in Gauteng, Cape Town and Durban, tested positive for illicit substances (Parry & Louw, 2001). Results across the three sites and for each of the three phases of the survey showed that between 0.2% and 2.5% of the arrestees reported having used heroin at least once. Johannesburg and Cape Town had slightly higher levels than Durban (Plüddemann *et al.*, 2002). However, a national survey of 1 143 arrestees conducted by the HSRC during 2000 did not report any use of heroin (Plüddemann, *et al.*, 2004).

Currently purity testing of heroin samples seized by police is not routinely conducted, however statistics on heroin seizures and arrests made by police are available. On a national average an increase in heroin seizures has been reported by SANAB over the past few years. SANAB reports that in 1996 only 800g of heroin was seized nationally. This increased steadily to 13.5kg by 2000, with a slight decline from this figure being recorded in 2001 (9.5kg) and 2002 (9.5kg). The number of arrests made nationally for either the possession of or dealing in heroin has also increased steadily from 12 in 1996 to 284 in 2002. Seizures of heroin reported by the Forensic Science Laboratories in Cape Town and Pretoria also increased drastically in the second half of 2002, with over 73kg reported by the Pretoria lab in the second half of 2002, compared to no more than about 6kg in previous periods (cited Plüddemann, *et al.*, 2004).

Outside the expanding subculture of heroin dependants in South Africa, many people still picture back-street junkies - images from movies such as *Trainspotting* or *Basketball Diaries* where despondent youth seek refuge in the drug. Yet many heroin dependants in South Africa come from a middle-class background. South Africa has advanced to a situation where unnatural diseases such as alcoholism, drug dependence, child abuse, automobile accidents, sexual abuse and violent crime has become pervasive (Dugmore, 1999). People are being forced to live in a society that they often cannot understand. The suburbs are likely to be emotionally alienated jungles just as any squatter camp, township or slum in which the individual must fight to survive (Densen-Gerber, 1973).

William Burroughs (1977, xv-xvi), who is regarded as an iconic figure within the heroin sub-culture, died at the age of eighty-three after a lifelong dependence on heroin. In the prologue to his novel *Junky*, he conveys his own account of heroin dependence;

'The question, of course, could be asked: Why did you ever try narcotics? Why did you continue using it long enough to become an addict? You become a narcotics addict because you do not have strong motivations in any other direction. Junk wins by default. I tried it as a matter of curiosity. I drifted along taking shots when I could score. I ended up hooked. Most addicts I have talked to report a similar experience. They did not start using drugs for any reason they can remember. They just drifted along until they got hooked... You don't decide to be an addict. One morning you wake up sick and you're an addict... Junk is not, like alcohol or weed, a means of increased enjoyment of life. Junk is not a kick. It is a way of life.'

Heroin dependence can begin at any age, but problems associated with the dependence are most commonly observed in the late teens or early 20's (*American Psychiatric Association*, 2005; Kenny, 1999; Richardson, 1989; Parker; Bakx & Newcombe, 1988). In a study conducted by Hunt and Chambers (1976) regarding epidemiological biographic information regarding the heroin-use epidemic in the United States from 1965-1975, the suggestion is made that first heroin use follows a distinctive age pattern, unlike cannabis (and perhaps other drugs) and is unaffected by other potential substitutes. First use typically occurs between the ages of fifteen and twenty-one. Family members of individuals with a heroin dependence are also more likely to have higher levels of psychopathology, especially an increased likelihood of other substance related disorders and antisocial personality disorder. Once heroin dependence

develops, it usually continues over a period of many years, even though brief periods of abstinence are frequent. During the first twelve months after the onset of remission/abstinence, the individual is most vulnerable to relapse. Increasing age is associated with a decrease in prevalence. Literature suggests that the majority of new users will give up. The tendency for remission generally begins after thirty years and has been phrased 'maturing out' (*American Psychiatric Association*, 2000). However, documented cases of persons who have remained heroin dependent for fifty years or longer is in existence (Plant, 1999).

The point at which a heroin dependent comes to the decision to 'kick the habit' is determined by a variety of factors: personal, social and environmental (Parker *et al.*, 1988). According to Burroughs (1977:151);

'When you give up junk, you give up a way of life. Why does a junky quit junk of his own will? You never know the answer to that question... The decision to quit junk is a cellular decision, and once you have decided to quit you cannot go back to junk permanently any more that you could stay away from it before.'

Most heroin dependants discover the motivation, for whatever reason, to try to abstain from the drug. It might be simply that the dependent has become tired of the heroin lifestyle, fear of being arrested, or they are afraid of harming themselves if they do not stop. A change of friends can be an important consideration, or damage to family relationships might weigh heavily on their minds. Sometimes it is an enforced decision such as a disruption in local supply. Or, not uncommonly, it is because the heroin dependent is facing a court appearance, in which case they might hope that it would influence the decision of the court if they are seen to be making an effort to change their lifestyle. The heroin dependant's motivation to abstain from heroin can also be influenced by the complexities and inadequacies of treatment resources (see Chapter 2, 2.7, p.70). Nevertheless, it is probably true to say that all self-motivated attempts to abstain from heroin takes place within one form or another of subtle compulsion: from family, mental health professionals or the cost-benefit calculations of being caught up in a criminal case (Pearson, 1987).

It has been emphasised by many recovering heroin dependants that it has to be the dependants' decision to quit heroin. Until the dependent is genuinely ready to make the commitment, he or she is likely to emerge from the most comprehensive and expensive treatment intervention, and go back straight into addiction or dependence. Yet there are documented cases of epiphanies, opportunities, lucky breaks and good timing when some kind of intervention helps (Terry, 1999; Kenny, 1999).

According to Barlow and Durand (1995), most research indicates a need for some level of social support or therapeutic intervention for heroin dependants and a number of models and programmes have been developed in order to help them. Unfortunately, in no other area of psychology have invalidated and untested methods of treatment been so widely accepted (Barlow & Durand, 1995). Given the lack of baseline data and systematic monitoring of the drug abuse and dependence situation, most interventions remain input orientated and little has been done to measure their impact and effectiveness (Boone, 2001). However, just because a programme has not been subjected to the scrutiny of research does not mean it doesn't work, but the sheer number of people receiving services of unknown value for heroin dependence is cause for concern.

Rocha-Silva (1998) theorises that matters are further complicated by the lack of integrated information needed for the effective treatment of substance abuse and dependence in South Africa. One reason according to this researcher is the lack of 'infrastructure' in developing countries that generally facilitate long-

term comprehensive and integrated information gathering. There exist a number of epidemiological studies regarding the social, psychological and clinical aspects of heroin dependence. Less is known of the long-term course and outcome of the condition, or the effectiveness of treatment intervention. Many follow-up studies suffer from methodological deficiencies, in particular, inadequate length of follow-up, inadequate surveillance during follow-up, lack of comprehensiveness of assessment and lack of specification of criteria of outcome, which make prognosis and evaluation of intervention problematic (Singer, 1975).

The processes by which such a recovery comes about, thus remains fairly unclear. Moreover, relatively little is known about the contribution of treatment interventions, both psychosocial and pharmacological, in facilitating such recovery. This is ironic given the vast sums of money devoted to the treatment of drug and alcohol problems. If improvement in the provision of treatment services for people who are suffering from heroin dependence is to occur, then it is essential that the process underlying recovery from heroin dependence be better understood.

According to *The National Drug Master Plan* (1999), further research is required to make closer and better matches between substance dependants and specific treatment programmes, taking into account factors such as age, gender, culture, social experience, geographic location, level of education and type of drug, and to make appropriate modifications (where necessary) to treatment models.

The need for further research is reinforced by Prins (1995), who points to the need to examine, for example, how and why people get into and out of drug addiction and dependence, since studies like Winick's (1962) failed to provide any hints as to the factors/circumstances involved in 'maturing out' (see Chapter 2, 2.8.1, p. 84). The need for more research is further highlighted by McIntosh and McKeganey (2002), who point out that even though it is commonplace within health and social care services to obtain the views of clients, and to include these views in the planning and delivery of services, this remains a rarity within the substance abuse field. Clearly this reinforces the need for more research, which aims to explore the views of dependants regarding their experiences of addiction, dependence and recovery. McIntosh and McKeganey's (2002) study demonstrates that recovering addicts are capable of providing a considered and informative account of their recovery and the factors that have helped them.

Thus, treating people who are dependent on heroin is a difficult task, perhaps because of the many ways people can come to use these substances and because of the combination of influences that work together to keep them 'hooked'. For some, according to Barlow and Durand (1995), the best-case scenario is sometimes just trading one dependence (heroin) for another (methadone). Even for those who successfully manage to cease taking heroin, the urges and craving to resume their drug use may last a lifetime.

Heroin addiction and dependence is not always a continuous, permanent condition. Despite what many believe, the view of '*once an addict, always an addict*' is misleading. It was once the conventional belief that, without treatment, heroin dependence was a permanent condition. Indeed, in more recent years an even more gloomy view has become widespread: that even with treatment, virtually all heroin dependants relapse (Kaplan, 1983).

Although relapses do occur, and while some mortality rates have been reported to be as high as 2% per year, about 20%-30% of individuals who are dependent on heroin achieve long-term abstinence. An

exception to the chronic course of heroin dependence was witnessed in service personnel who became addicted to opioids in Vietnam. Less than 10% of those who had been dependent of opioids relapsed on their return to the United States of America, however, many of them substituted with alcohol and amphetamines (*American Psychiatric Association, 2000*). This compares with a number as high as 90% in the rest of society, indicating how important a role social context can play, both in the development of heroin dependence and in its reduction and elimination (www.substancemisuse.net).

According to results published from a 24-year follow up study conducted on 500 opioid dependants undergoing medical and psychosocial intervention in California, the life of an addict, dependent on opioids, is bleak. At a follow up in 1985-1986, 27.7% of those individuals had died, the mean age being 40. Approximately half of the deaths had been as a result of homicide, suicide, or accident, and a third were from drug overdose (Barlow & Durand, 1995). Despite this, the implications of intervention programmes that serve the needs of heroin dependent is one step toward not only reducing drug use, but also reducing the health and crime problems associated with heroin dependence. It has been found, for example, in the United Kingdom, that two years after completing a treatment programme, weekly heroin use was down by two-thirds one year after the end of treatment (Boone, 2001).

In research undertaken by Stimson & Oppenheimer (1982), one group of heroin dependants treated in British clinics in 1969 underwent a follow-up study in 1979. Of the sampled population, 15% had died from causes related to their drug use. This level of deaths is much lower than either the heroin dependants or doctors might have foreseen in 1969. However, it could be considered a high death rate for a young population under medical treatment. The majority of survivors (47%) were no longer attending clinics. If those who were in prison were excluded, an estimated 38% of the original sample was abstinent from opioids ten years later, and that on the whole experienced few problems in their lives. This result is certainly a much more optimistic result than what most would expect, for whatever reasons, and by whatever routes; these people managed to stop their dependence. Heroin addiction and dependence then, is not necessarily irredeemable.

Cheaper heroin is also becoming more widely available to the residents in disadvantaged communities (*United Nations Office on Drugs and Crime, 2002*). Media articles suggest that of all dependants in South Africa, most of them from disadvantaged communities, only an estimated 3% undergo treatment. Apart from the nightmare of addiction and dependence itself, heroin dependants are in danger of falling into the hands of a new breed of drug rehabilitation centres, normally created by owners of a plot of land, good sales and marketing, and a guaranteed influx of cheap labour which enhance profit margins. These facilities are able to fall into the ambit of the Mental Health Act by calling themselves 'care centres'. Numerous unregistered examples of such centres are still prevalent in South Africa (Friedman, 2002). Most of these so-called 'care-centres' are unlicensed, partly due a moratorium on the granting of licenses by the Department of Social Development to addiction centres until more stringent criteria are in place, and by calling themselves 'care centres'. This situation has arisen due to the state closing down several long-established treatment centres and reduced subsidies for organisations such as SANCA (Donaldson, 2001; Friedman, 2002).

1.2 OBJECTIVES OF THE STUDY

The objectives of this study are as follows:

- * To explore heroin abuse and dependence, a relatively new subject of study in South Africa.
- * To explore the biographic and socio-demographic background of the heroin dependent.
- * To gain a greater understanding of the heroin dependants' perspectives regarding intervention efficacy within the recovery process.
- * To explore the heroin dependants intervention expectations.
- * To determine treatment method outcome according to the heroin dependants expectations.
- * The formulation of tentative suggestions for the restructuring of heroin dependence intervention programmes.
- * To determine new priorities for future research regarding heroin dependence recovery.
- * To identify new research questions and hypothesis about the existing heroin phenomenon.

To date, limited studies regarding psychosocial and/or medical interventions for heroin addiction and dependence have been published in South Africa. A study is presently being conducted by SACENDU regarding heroin abuse epidemiology in Cape Town. Preliminary findings of the study have indicated that a lack of affordable treatment services is problematic, an increase in heroin use amongst previously disadvantaged communities, a lack of affordable detoxification services, and problems/issues regarding methadone. Findings also suggest that changes are taking place in the profile of users with increasing use among females, Afrikaans speakers and lower socio-economic status populations on the Cape Flats. The time between taking other drugs and experimenting with heroin is also declining (Plüddemann, 2004). This researcher also assisted with an unpublished study undertaken by honours students from the School of Pharmacy, MEDUNSA, regarding needle exchange programmes for drug addicts in Centurion (Alavi *et al.*, 2003). Notwithstanding, the heroin phenomenon and problem in Gauteng and South Africa is a new one, and treatment facilities and professionals were, and perhaps are still, not fully equipped to treat such dependencies. Prior to commencing this study, the project co-ordinators of SACENDU were consulted for advice with regards to an area within the substance abuse field that remains under-researched. The SACENDU project co-ordinators identified the need for research regarding treatment efficacy for substance use disorders in general (Parry & Potgieter, personal communication, February 28, 2003). Dr Richard Rawson, who is the Adjunct Associate Professor and associate director of University of California's Integrated Substance Abuse Programs and has been conducting research and developing systems for treating individuals with substance use disorders since 1974. He was also of the opinion that a lack of research regarding intervention efficacy for heroin addiction and dependence also exists in the United States, and was of the view that this is a global problem area (personal communication, February, 17, 2003).

1.3 ANALYSIS OF KEY CONCEPTS

1.3.1 Substance Dependence

According to the DSM-IV-TR (*American Psychiatric Association, 2000*), the essential feature of substance dependence is a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues use of the substance despite significant substance-related problems. There is a pattern of repeated self-administration that can result in tolerance, withdrawal and compulsive drugging behaviour.

Reber (1985) notes that the term 'substance dependence' has come to be favoured over the terms *addiction* and *habituation* in scientific writing. An individual is said to have developed dependence when there is a strong, compelling desire to continue taking it. This desire may derive from a wish either to experience its effects and/or to avoid or escape the aversive experiences produced by its absence. Dependence on a substance may in origin be largely psychological or physiological. Barlow and Durand (1995) define substance dependence as physiological dependence on the drug or drugs, the requirement of greater and greater amounts of the drug (tolerance), and responding physically in a negative manner when the substance is no longer taken (withdrawal).

Another view of substance dependence concentrates on 'drug-seeking behaviours' as a measure of an individual's dependence on a drug or drugs, such as repeated use of the drug, a desperate need to ingest more of the substance and the likelihood of resuming the drug after a period of abstinence. This reaction is different to *physiological addiction* (see 1.3.2, p. 11), and is sometimes referred to as *psychological addiction* (see 1.3.3, p. 11) (Barlow & Durand, 1995). The DSM-IV-TR definition of substance dependence, as shown in Table 1.3.1.1, combines the physiological aspects of tolerance and withdrawal with the behavioural and psychological aspects (*American Psychiatric Association, 2000*).

TABLE 1.3.1.1 DSM-IV-TR CRITERIA FOR SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- (1) tolerance as defined by either of the following:
 - (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - (b) markedly diminished effect with continued use of the same amount of the substance
- (2) withdrawal, as manifested by either of the following
 - (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal from the specific substances)
 - (b) the same (or closely related) substance is taken to relieve or avoid withdrawal symptoms
- (3) the substance is often taken in larger amounts or over a longer period than intended
- (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use
- (5) a great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects
- (6) important social, occupational, or recreational activities are given up or reduced because of substance use
- (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either Item 1 or 2 is present)

Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither Item 1 nor 2 is present)

Course specifiers:

Sustained Full Remission specifier is used if none of the criteria for Dependence or Abuse have been met at any time during the period of 12 months or longer.

Early Partial Remission specifier is used if, for at least 1 month, but less than 12 months, one or more criteria for Dependence or Abuse have been met (but the full criteria for Dependence have not been met).

Sustained Partial Remission specifier is used if full criteria for Dependence have not been met for a period of 12 months or longer; however, one or more criteria for Dependence or Abuse have been met.

The following specifiers apply if the individual is on agonist therapy or in a controlled environment:

On Agonist Therapy: this specifier is used if the individual is on a prescribed medication such as methadone. This category applies to those being treated for Dependence using a partial agonist or an agonist/antagonist.

In a Controlled Environment: this specifier is used if the individual is in an environment where the use of controlled substances is restricted, and no criteria for Dependence or Abuse has been met for at least the past month. Examples of these environments are closely supervised and substance-free jails, therapeutic communities, or locked hospital units.

Source: *American Psychiatric Association, 2000.*

1.3.2 Psychological dependence

The term refers to a phenomenon that can vary in intensity from a mild involvement with a behaviour to an addiction that seriously restricts the individual's other behavioural options. It can centre on any situation, person or object, although particular forms of it may be more acceptable than others. The dependent behaviour is maintained by the degree of reinforcement it provides, and this in turn depends on the individual's perception of his or her need hierarchy and the likelihood that this course of action will meet the most important needs better than other available options (Krivanek, 1988).

The term is thus used to describe a rather pervasive drive to obtain and take the substance. The term is usually defined by exclusion, i.e. it is used for dependencies on drugs whose action does not produce fundamental biochemical changes such that continued doses of the drug are required for normal functioning. Drugs such as cannabis are commonly cited as ones likely to produce psychological dependence with habitual use. The term is preferred over the term *drug habituation* (Reber, 1985).

1.3.3 Physiological dependence

Physiological dependence, also sometimes referred to as *physical addiction*, refers to drug dependence produced by alterations in physiological states resulting from repeated administration of the drug. The characteristic that differentiates it from *psychological dependence* is that severe physiological dysfunctions emerge if the drug is suddenly discontinued or if an antagonist is administered. The opioids and the barbiturates both produce such dependence with prolonged use. The term is preferred over the previously used *addiction* and *drug addiction* (Reber, 1985). Most authorities agree that at a purely physiological level, after six months of daily heroin use someone would have developed a physical dependence on the drug (Pearson, 1987).

1.3.4 Substance Abuse

DSM-IV-TR addresses the concept of substance abuse by defining it by how significantly the use of the substance interferes with a person's life (*American Psychiatric Association, 2000*). Defining substance abuse solely by how much of a substance is ingested can be problematic according to Barlow & Durand (1995); for example, it would be hard to determine by itself if taking one injection of heroin is considered abuse.

Although a diagnosis of substance abuse is more likely in individuals who have only recently started taking the substance, some individuals continue to have substance-related adverse social consequences over a long period of time without developing evidence of substance dependence (*American Psychiatric*

Association, 2000). Reber (1985) states that substance abuse is used only for cases in which there has been relatively long-term abuse (i.e. longer than a month), leading to impaired social and/or occupational functioning.

TABLE 1.3.1.2 DSM-IV-TR CRITERIA FOR SUBSTANCE ABUSE

A.	A maladaptive pattern or substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:
(1)	recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance related absences, suspensions, or expulsions from school; neglect of children or household)
(2)	recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use)
(3)	recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)
(4)	continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights)
B.	The symptoms have never met the criteria for Substance Dependence for this class of substances.

Source: *American Psychiatric Association*, 2000.

1.3.5 Substance Intoxication

Substance intoxication is often associated with substance abuse or dependence. Evidence for recent intake of the substance can be obtained from the history, physical examination (e.g., smell of alcohol on the breath), or toxicological analysis of the body fluids (e.g., urine or blood). Any possible maladaptive behaviour change induced by a substance, depends on the social and behavioural context, and may place the individual at significant risk for adverse effects, for example, legal problems, disruption in social and family relationships and financial difficulties (*American Psychiatric Association*, 2000).

TABLE 1.3.1.3 DSM-IV-TR CRITERIA FOR SUBSTANCE INTOXICATION

A.	The development of a reversible substance-specific syndrome due to recent ingestion of (or exposure to) a substance. Note: Different substances may produce similar or identical syndromes.
B.	Clinically significant maladaptive behavioural or psychological changes that are due to the effect of the substance on the central nervous system (e.g., belligerence, mood lability, cognitive impairment, impaired judgement, impaired social or occupational functioning) and develop during or shortly after use of the substance.
C.	The symptoms are not due to a general medical condition and are not better accounted for by another medical condition.

Source: *American Psychiatric Association*, 2000.

1.3.6 Substance Withdrawal

Most individuals with substance withdrawal have a craving to re-administer the substance in order to reduce the adverse symptoms. The dose and duration of use and other factors such as the presence or absence of additional illnesses also affect withdrawal symptoms. Withdrawal develops when doses are reduced or stopped, whereas signs and symptoms of intoxication decrease, in some cases gradually, after dosing stops (*American Psychiatric Association*, 2000).

TABLE 1.3.1.4 DSM-IV-TR CRITERIA FOR SUBSTANCE WITHDRAWAL

A.	The development of a substance-specific syndrome due to the cessation of (or reduction in) substance use that has been heavy and prolonged.
B.	The substance-specific syndrome causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Source: *American Psychiatric Association, 2000.*

1.3.7 Opioid Dependence¹

Most individuals with opioid dependence have significant levels of tolerance and will experience withdrawal on abrupt discontinuation of opioid substances, including heroin. Opioid dependence includes signs and symptoms that reflect compulsive prolonged self-administration of opioid substances that are used for no legitimate medical purpose. Persons with opioid dependence tend to develop such regular patterns of compulsive drug use that daily activities are typically planned around obtaining and administering opioids (*American Psychiatric Association, 2000*).

For several reasons, the term 'addiction' is in growing disrepute among drug authorities today, however, its use is probably most defensible with respect to opioids. Opioid dependence was the first such phenomenon discovered and described. Pharmacologists have argued that it is too emotion-laden, and that 'physical dependence' - the presence of physical symptoms on cessation of substance use - means the same thing while being free of the emotional content. For opioid users, this continued use could be explained by the fact that cessation of use causes physical withdrawal symptoms, in other words, the users were addicted - physically dependent. Since no known withdrawal took place among the users of other substances, they had to be suffering from a different kind of drug dependence, equally real but psychological rather than physiological in nature (Kaplan, 1983; Richardson, 1987).

Experts have noted another problem with relying on addiction as the cause for drug dependence. Some opioid and alcohol users, who are clearly not addicted to these addiction-producing drugs, nonetheless seemed dependent on them. Often opioid addicts who have gone through withdrawal and seemed completely free of any addiction relapse into use again. As a result, substances have been categorised between those producing physical dependence and those that merely produce psychological dependence. Opioids have been placed in both categories. Although the presence of gross physical symptoms on cessation of use does differentiate some abused substances from others, more careful measurements of users of substances thought to cause only psychological dependence, have revealed clear physical withdrawal symptoms. Consequently, the dichotomy and distinction between physical and psychological dependence is often blurred (Kaplan, 1983).

¹ The DSM-IV-TR (*American Psychiatric Association, 2000*) classification of the various opioid diagnostic criteria has been utilised due to its international recognition and reliability. All forms of heroin abuse, intoxication, dependence, tolerance etc. reside under the various opioid classification categories due to heroin being categorised as an opiate.

1.3.8 Opioid Abuse²

Legal difficulties may arise as a result of behaviour while intoxicated with opioids or because an individual has resorted to illegal sources of supply. Persons who abuse opioids typically use these substances much less often than do those with dependence and do not develop significant withdrawal symptoms. When problems related to opioid use are accompanied by evidence of withdrawal or compulsive behaviour related to the use of opioids, further information should be gathered to see if a diagnosis of *Opioid Dependence*, rather than opioid abuse is more appropriate (*American Psychiatric Association, 2000*).

1.3.9 Opioid Intoxication³

The magnitude of behavioural and physiological changes that result from opioid use depends on the dose as well as the characteristics of the individual, such as tolerance, rate of absorption and chronicity of use. Symptoms of opioid intoxication last for several hours. Severe intoxication following an opioid overdose can lead to coma, respiratory depression, pupillary dilation, unconsciousness and death (*American Psychiatric Association, 2000*).

TABLE 1.3.1.5 DSM-IV-TR CRITERIA FOR OPIOID INTOXICATION

A.	Recent use of an opioid.
B.	Clinically significant maladaptive behavioural or psychological changes (e.g., initial euphoria followed by apathy, dysphoria, psychomotor agitation or retardation, impaired judgement, or impaired social or occupational functioning) that developed during, or shortly after, opioid use.
C.	Pupillary constriction (or pupillary dilation to anoxia from severe overdose) and one (or more) of the following signs, developing during, or shortly after, opioid use: <ul style="list-style-type: none"> (1) drowsiness or coma (2) slurred speech (3) impairment in attention or memory
D.	The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.
	<i>Specify if:</i> With Perceptual Disturbances

Source: *American Psychiatric Association, 2000*.

1.3.10 Opioid Withdrawal⁴

In most individuals who are dependent on heroin, withdrawal symptoms begin within 6-12 hours after the last dose, eyes begin to tear, yawning and perspiration occurs and pupils dilate. Gradually, sneezing, weakness, depression, muscle cramps, nausea, vomiting and diarrhoea appear. Without pharmacological treatment, the observable symptoms peak in two to three days and are over in a week to ten days. Biochemical and subclinical differences, generally unnoticed by the addict, last up to twelve additional months. The contraction of muscles just beneath the skin, so those waves of 'goose flesh' are prominent, gave rise to the expression 'cold turkey' to signify abrupt withdrawal from opioids. In addition, the muscle spasms in the long muscles of the leg produce involuntary kicking movements, which may be the basis for the expression 'kicking the habit'. Opioid withdrawal, unlike alcohol or barbiturate withdrawal, very rarely

² The diagnosis of heroin abuse resides under this DSM-IV-TR classification category (*American Psychiatric Association, 2000*).

³ The diagnosis of heroin intoxication resides under this DSM-IV-TR classification category (*American Psychiatric Association, 2000*).

⁴ The diagnosis of heroin withdrawal resides under this DSM-IV-TR classification category (*American Psychiatric Association, 2000*).

causes death (Kaplan, 1983; Kenny, 1999; Burroughs, 1977). However, according to Sadock and Sadock (2003) and Erwin Lass, clinical psychologist and Head of Vista Reintegration Centre, Centurion (Coetzee, 2006), between 8% and 14% of people die while in withdrawal of heroin.

In Detzers' (1998: 9-10) personal account of opioid withdrawal, he recalls;

'If you go about twenty-four hours without stuff you enter the House of Mirrors. In this house all you can do is sit around and think about yourself. You see a reflection within a reflection within a reflection within a reflection. Senses begin to return, smells are overpowering, sounds echo in your head. You become aware of your body: your legs are down there, your arms are out there. As you progress from Stage One through Stage Four, that awareness changes to pain. Junkies talk a lot about the physical discomfort of withdrawal, but in fact that's not the worst of it. The House of Mirrors is primarily a feeling of fear and despair. As you turn ever more into yourself, the feeling of despair becomes overwhelming and the Fear (a terror without object) causes your resolve to evaporate. A junkie will do anything to escape it. It's a terrible feeling. During the House of Mirrors it's very difficult to sleep. You lie there in bed and your muscles begin to tense. As the tension builds you crave a way to release it. Eventually you get this semivoluntary motion where your body twists and your legs kick (it's the symptom that gave rise to the expression "kicking the habit"). You get a momentary release and then it starts building again. If you somehow manage to fall asleep, you're liable to wake up kicking and ejaculating at the same time. It's weird. I call it "doing the jerk". Doctors call it "clonus". After about five to seven days you enter the House of Blue. The fear and despair have begun to wane; they are replaced by a pervasive fatigue and sense of discontent. The House of Blue Lights is a frustrating feeling. You don't feel good and you don't feel bad. You feel blah and bored, and it goes on and on and on. It becomes difficult to remember why you decided to stop using. You quickly forget the horrors of the House of Mirrors and start trying (often unsuccessfully) to convince yourself that one more hit wouldn't hurt. Everything seems grey. If you have to do something, anything, the effort involved seems monumental, impossible. You don't talk much because, try as you may, you can't think of anything to say. I tend to sit on one spot and stare at (not through) the window.'

Symptoms may take 2-4 days to emerge in the case of longer-acting drugs such as methadone or LAAM. Acute withdrawal symptoms for a short-acting opioid such as heroin usually peak within 1-3 days and gradually subside over a period of 5-7 days. Less acute withdrawal symptoms can last for weeks to months. The more chronic symptoms include anxiety, dysphoria, insomnia, and drug craving. Almost all individuals with opioid dependence report a physiological component, including 50% who experience acute withdrawal symptoms. The withdrawal syndrome can be also precipitated by administration of an opioid antagonist (e.g., naltrexone) after a period of opioid use (American Psychiatric Association, 2000).

TABLE 1.3.1.6 DSM-IV-TR CRITERIA FOR OPIOID WITHDRAWAL

A.	Either of the following:
(1)	cessation of (or the reduction of) opioid use that has been heavy and prolonged (several weeks or longer)
(2)	administration of an opioid antagonist after a period of opioid use
B.	Three (or more) of the following, developing within minutes to several days after Criterion A:
(1)	dysphoric mood
(2)	nausea or vomiting
(3)	muscle aches
(4)	lacrimation or rhinorrhea
(5)	pupillary dilation, piloerection, or sweating
(6)	diarrhoea
(7)	yawning
(8)	fever
(9)	insomnia
C.	The symptoms in Criterion B cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D.	The symptoms are not due to a general medical condition and are not better accounted for by another mental disorder.

Source: American Psychiatric Association, 2000.

1.3.11 Psychoactive substance

A psychoactive substance is defined as a drug that alters the state of consciousness of the user (Rudgley, 1998). Reber (1985) characterises *psychoactive substances* as a generic term for any drug that affects the consciousness, mood and awareness. At one time or another all of the antipsychotics, antidepressants, anti-anxiety drugs, stimulants, sedatives, psychedelics and hallucinogens have been classified as such.

Reber further argues that essentially any drug can be placed in this group; aspirin, when it relieves a headache, can change one's consciousness and awareness. However, Reber contends that its use should be restricted to substances that produce a marked psychological effect.

1.3.12 Intervention and intervention efficacy

According to *The National Drug Master Plan* (1999), intervention is a process aimed at promoting the quality of life of the drug dependant and his/her system (husband/wife, family members and significant important persons in his/her life) often with the help of a multi-professional team.

Intervention efficacy refers to the success, or lack thereof, of any specific procedure designed to cure or lessen the severity of a disease or other abnormal condition (Reber, 1985). This meaning is used to cover medical, pharmacological or psychosocial procedures and interventions.

1.3.13 Relapse

The idea of relapse - the return to drug use after a period of abstinence - is as problematic as the idea of addiction and dependence. One understanding of relapse is the breaking of a commitment to abstinence, by even a single use of the drug of choice. Another understanding is that relapse is the use of any drug whatsoever, including alcohol, after a period of abstinence. Relapse can also be understood as a breakdown in abstinent thinking and lifestyle, long before the actual breaking of the commitment to abstinence (Friday, 1992).

Determinants of relapse are identified as psychological (emotional) or physical (urges and cravings) events, interpersonal factors such as social pressure or interpersonal conflict, and non-personal environmental events such as financial loss, accidents and unemployment (Marlatt & Gordon, 1985). Relapse is also often seen as stemming from a character flaw in the addict, such as lack of motivation to change, or as not having 'hit rock bottom' yet (Friday, 1992).

Heroin dependants over 30 years of age reportedly have a lower relapse rate after treatment (*American Psychiatric Association*, 2000; Friday, 1992). There is a higher abstinence rate after treatment among middle and upper class individuals. Heroin dependants with four or more years of tertiary education, have dependants and are employed after discharge from treatment, are also reputed to have lower relapse rates than do the disadvantaged, uneducated or unemployed individuals (Friday, 1992). It is evident that heroin dependants who begin their addiction at an earlier age, or who have been addicted/dependent for longer than three years are more likely to relapse. Furthermore, the earlier the heroin dependence process is interrupted, the better the prognosis is for continued abstinence (Hamlyn, personal communication, 2 September, 2004; Friday, 1992).

1.3.14 Comorbidity

Epidemiological studies have shown that between 30% and 60% of all drug dependants have a concurrent mental health diagnoses, including personality disorders, major depression, schizophrenia and bipolar disorder. Personality disorders are also common, including antisocial personality disorder, borderline personality disorder, and anxiety disorders including PTSD and depression. Some evidence suggests that men who use drugs are more likely to have antisocial personality disorder, while woman and minorities in

the United States are more likely to suffer from depression or PTSD. While people with schizophrenia do not constitute a large proportion of the drug-abusing population that seeks treatment, a high percentage of people with this disease abuse psychoactive substances (Hertzman, 2000; Leshner, 1999; Barlow & Durand, 1995).

Heroin dependants with mental illness co-morbidity are more likely to engage in behaviours that increase the risk of HIV/AIDS, for example, injecting heroin dependants with antisocial personality disorder more frequently share needles (Leshner, 1999). A concurrent mental disorder can complicate substance abuse treatment in a multitude of ways. For example, clinically depressed individuals have an exceptionally hard time resisting environmental cues to relapse. Misuse of opioids alone was associated with a 14-fold increase in risk of suicide, the same order of increase that is found in severe mental illness. Due to suicide being such a risk factor, its assessment and management by all professional staff with whom heroin dependants have contact with, should be regarded as central to general mental health care (Appleby, 2000; Neale, 2000). Another significant challenge to the study of depression in heroin dependants is that heroin and opioid use may induce transient symptoms that are difficult to distinguish from organic mood disorders (Brienza, Stein, Chen, Gogineni, Sobota, Maksad, Hu & Clarke, 2000).

Heroin dependants with anxiety disorders are considered poor candidates for standard treatment drugs of the benzodiazepine class due to potential secondary dependence. In a study conducted by Nunes (1991), depressed heroin dependants responded positively when treated with the anti-depressant *imipramine*, with improvements in mood and reduced heroin use among more than 53% of the treated sample in the study (cited in Gossop, 2003). The prescription of SSRIs also appears to be safer (Leshner, 1999). The prescription of tricyclics to heroin dependants would appear to increase their risk of overdose (Darke & Ross, 2000). Treatment intervention has to be tailored for patients with a dual diagnosis, for example, heroin dependants presenting with antisocial personality disorder, responded better when standard contingency management therapy was modified, treatment professionals giving rewards for desirable behaviours, such as attending scheduled counselling sessions and testing negative for substances, more frequently (Leshner, 1999).

Though there exists ample evidence of psychological deviance among heroin dependants in drug treatment programmes, there is insufficient evidence to define the majority of heroin dependants as dysfunctionally psychotic or neurotic. Weissman (cited in Hunt & Chambers, 1976), utilising the MMPI, found that male heroin dependants have significantly higher scores on depression and psychopathy but were not significantly different from normal males on hypomanic, hypochondriasis and schizophrenic scores. Psychiatric interviewing of the same subjects suggested that only 3% were psychotic. However, heroin dependants seen in mental hospital settings are more typically psychotic. Keup (cited in Hunt & Chambers, 1976) found psychosis as a problem in almost half of his study population of 160 heroin dependants at the Downstate Medical Center in Brooklyn, New York. He recorded that 15% of the dependants suffered from psychosis as a primary problem, and that 31% suffered from psychosis as a correlate problem.

1.4 SUMMARY

Heroin dependence is unique among contemporary problems in the breadth of its social impact: no other condition has mobilised such a range of institutional responses, involved so many professions and disciplines - medicine, public health, education, legislature, judicial, law enforcement and foreign affairs - nor, unfortunately, inspired such irrational fear in the general public. This dual response has an easy explanation. Heroin dependence has become a symbol of the social disorder of the times, associated with materialism, poverty, crime, the problems of a society in transition, the disadvantaged and the inner cities. Since the problem of heroin dependence recovery is everyone's property, heroin dependence recovery research reflects the preconceptions of the variety of researchers who have studied it. The clinical psychologist may view heroin dependence as a character disorder that may be addressed by the facilitation of the identity restructuring of the personality. The economist may see heroin as a commodity and studies its marketing systems in terms of supply and demand measured by cost and purity of street heroin. In a similar way the pharmacologists, the sociologist and other specialists bring their own skills and special points of view to heroin addiction, dependence and recovery. Because the particular aspects regarding heroin dependence recovery are intrinsically complex and difficult, each of these approaches is incomplete and their narrow focus denies a wider perspective. This study explores the factors, which are important in achieving abstinence, in allowing recovery to be maintained in the longer term and in potentially allowing an eventual exit from heroin dependence, from recovering heroin dependants themselves.

CHAPTER TWO

HEROIN DEPENDENCE: HISTORICAL CONTEXT, PHARMACOLOGY, THEORY AND MAJOR INTERVENTION MODALITIES

2.1 INTRODUCTION

Heroin dependence is attributed as being a destroyer of countless lives and a major cause of urban crime. Heroin dependants are notorious for wallowing in the role of the outlaw, the illegality, the separation from the rest of society is part of the attraction in its use and, by some theories, an attraction that surpasses the appeal of the high itself (Friedman, 1992). Others recognise the existence of a social problem, which has been aggravated by a relatively benign vice forcing heroin dependants to steal to meet the grossly inflated cost of their drug habits, and do not accept that the glamour of vice plays an important role (Legget, 2001).

Magic dragon, smack, H, dope, junk, like the pursuit of physicists and other sciences who investigate the invisible, the heroin experience is inferred more often that it is captured. Supposition and hearsay are what detect heroin dependencies elusive surge. It is said to be rooted in social depravity and also to span the classes. Assertion and anxiety are reputed to be at the heart of the heroin problem. Heroin withstands being pinned down (Kohn, 1987). After all, if the problem of overcoming dependence to heroin - the 'hardest' drug, were an easy task, we probably would have solved it by now.

It is also not clear why heroin should be regarded as the 'hardest' drug. It is, after all, a white powder indistinguishable to the eye from cocaine, mescaline, amphetamines and barbiturates. It is true that heroin is addictive, but many other drugs that are not considered to be 'hard' share this complex property. In all probability, the 'hardness' of heroin, in the public view, stems from a combination of factors: the condition of those users who come to the public's attention; the public attitude toward the kinds of people who use the drug; the criminal penalties for its sale and use; the strong social disapproval it evokes; and the enormous social costs attributed to its use. Regardless of heroin's 'hardness' - whatever that may mean - there is no doubt that its use does constitute a social problem (Kaplan, 1983).

2.2 THE HISTORICAL-LEGAL CONTEXT OF HEROIN DEPENDENCE

1400 BC

The use of heroin is inextricably linked to the use of morphine and other opioids. Opium has historically been used for medicinal and recreational purposes, with the first signs of the drug's existence dating back to 4000 BC, being used by the Sumerian and Assyrian civilisations. In 3400 BC, the opium poppy was cultivated in lower Mesopotamia. The Sumerians referred to it as *Hul Gil*, the 'joy plant'. The Sumerians soon passed along the plant and its euphoric effects to the Assyrians. The art of opium poppy culling continued from the Assyrians to the Babylonians who in turn passed their knowledge onto the Egyptians. In the capital city of Thebes, 1300 BC, Egyptians begin cultivation of *opium thebaicum*, grown in their famous poppy fields. The opium trade flourished during the reign of Thutmose IV, Akhenaton and King Tutankhamen. The trade route included the Phoenicians and Minoans who moved the profitable item across the Mediterranean Sea into Greece, Carthage, and Europe (Booth, 1996).

Greek and Roman physicians also made use of medicinal opium. In 1100 BC on the island of Cyprus, the 'Peoples the Sea' crafted surgical-quality culling knives to harvest opium, which they cultivated, traded and smoked before the fall of Troy. In 460 BC Hippocrates, 'the father of medicine', dismissed the magical attributes of opium but acknowledged its usefulness as a narcotic and styptic in treating internal diseases, diseases of women and epidemics. Alexander the Great introduced opium to the people of Persia and India in 330 BC (Booth, 1996).

1000 AD

Opium thebaicum, from the Egyptian fields at Thebes, was first introduced to China by Arab traders in 400 AD. Use of opium spread from the Middle East with the expansion of the Islamic religion, while the Koran forbade the use of alcohol and other intoxicants, opium was not banned. In 1020 Avicenna of Persia taught that opium was 'the most powerful of stupeficients' (<http://www.substancemisuse.net>).

1200 AD

Ancient Indian medical treatises *The Shodal Gadanigrah* and *Sharangdhar Samahita* described the use of opium in 1200, for diarrhoea and sexual debility. The *Dhanvantri Nighantu* also described the medical properties of opium (Booth, 1996).

1300 AD

From 1300 opium disappeared for two hundred years from European historical record. Opium had become a taboo subject for those in circles of learning during the Holy Inquisition. In the eyes of the Inquisition, anything from the East was linked to the devil (Booth, 1996).

1500 AD

In 1500 the Portuguese, while trading along the East China Sea, initiated the smoking of opium. The effects were instantaneous as they discovered, but it was a practice the Chinese considered barbaric and subversive. During the height of the Reformation, 1527, opium was reintroduced into European medical literature by Paracelsus as laudanum. These black pills or 'Stones of Immortality' were made of opium thebaicum, citrus juice and quintessence of gold and prescribed as painkillers (Booth, 1996).

1600 AD

Residents of Persia and India began eating and drinking opium mixtures in the 1600s for recreational use. Portuguese merchants carried cargoes of Indian opium through Macao and directed its trade flow into China. In 1601 ships chartered by Elizabeth I were instructed to purchase the finest Indian opium and transport it back to England (Booth, 1996).

From the 1620s - 1670s Rajput troops fighting for the Mughals introduced the habit of taking opium to Assam. Opium was given daily to Rajput soldiers. From 1637 onwards opium became the main commodity of British trade with China (Booth, 1996).



Figure 2.1 *Papaver somniferum*: opium poppy
Source: <http://opioids.com/images/index.html>



Figure 2.2 Poppy pod
Source: <http://opioids.com/images/index.html>



Figure 2.3 Poppy pod
Source: <http://opioids.com/images/index.html>



Figure 2.4 Ripe opium pod
Source: <http://opioids.com/images/index.html>



Figure 2.5 Opium farmer
Source: <http://opioids.com/images/index.html>



Figure 2.6 Harvest time
Source: <http://herointimes.com>

1600 AD

Residents of Persia and India begin eating and drinking opium mixtures in the 1600s for recreational use. Portuguese merchants carried cargoes of Indian opium through Macao and directed its trade flow into China. In 1601 ships chartered by Elizabeth I were instructed to purchase the finest Indian opium and transport it back to England (Booth, 1996).

From the 1620s - 1670s Rajput troops fighting for the Mughals introduced the habit of taking opium to Assam. Opium was given daily to Rajput soldiers. From 1637 onwards opium became the main commodity of British trade with China (Booth, 1996).

In 1680, English apothecary, Thomas Sydenham, introduced Sydenham's Laudanum, a compound of opium, sherry wine and herbs. His pills along with others of the time become popular remedies for numerous ailments (Booth, 1996).

1700 AD

China had long exercised the upper hand in economic relations with the West. Silks, tea, fine pottery and other items flowed to the West from China. Throughout the 18th century, the British East India Company had a monopoly where they brought opium from farmers, particularly from India, and then sold it to independent wholesalers. Exports to China earned hard currency, reducing the trade imbalance. Monopolising opium buying in India provided revenue for hard-pressed colonial administrators. Official China considered opium smoking a moral vice and an economic threat (Kohn, 1987; <http://www.substancemisuse.net>).

In 1700, the Dutch exported shipments of Indian opium to China and the islands of Southeast Asia; the Dutch introduced the practice of smoking opium in a tobacco pipe to the Chinese. Chinese emperor, Yung Cheng, issued the Imperial Edict in 1729 prohibiting the smoking of opium and its domestic sale, except under license for use as medicine. In 1750 the British East India Company assumed control of Bengal and Bihar, opium-growing districts of India. British shipping dominated the opium trade out of Calcutta to China (Booth, 1996).

Linnaeus, the father of botany, first classified the poppy in 1753, *Papaver somniferum* - 'sleep-inducing', in his book *Genera Plantarum* (Booth, 1996).

The British East India Company's import of opium to China reached a staggering two thousand chests of opium per year in 1767. The British East India Company assumed monopoly over all the opium produced in Bengal, Bihar and Orissa in 1773. Warren Hastings introduced a system of contracts that stipulated that dealings in opium were awarded through auction. In 1793 the British East India Company established a monopoly on the opium trade. All poppy growers in India were forbidden to sell opium to competitor trading companies. The imports of opium into China become a contraband trade in 1796. Silver was smuggled out to pay for smuggling opium in. East India Company introduced Bengal Regulation IV in 1797 to enable the appointment of Opium Agents for purchase of opium from cultivators and its processing at factories owned by the company at Patna and Ghazipur. In 1799, China's emperor, Kia King, banned opium completely, making trade and poppy cultivation illegal. In 1800, the British Levant Company purchased nearly half of all

of the opium coming out of Smyrna and Turkey, strictly for importation to Europe and the United States. (Booth, 1996).

1800 AD

Within the modern period, in the early 19th century, the first appearance of a narcotic drug arrived in Europe in the form of opium and its use increased dramatically in the United Kingdom in the 19th century. The Fens area of Eastern England became specifically known for its opium production (<http://www.substancemisuse.net>). Opium could be purchased anywhere as a legal substance. This legality, coupled with the fact that the drug proved to be inexpensive and plentiful, provided no reason for a black market. Hence it was not necessary to steal or commit acts of violence in order to obtain enough opium to sustain their dependency. In addition, usage did not warrant social concern. Thus, people who consumed the drug lived with their addiction without being ostracised from the community. Although there was no stigma attached to opium at the time, it was still considered to be a highly addictive drug by the medical community (Elgie, 1998).

Friedrich Sertürner of Paderborn, Germany discovered the active ingredient of opium in 1803, by dissolving it in acid then neutralizing it with ammonia. The result: alkaloids - *Principium somniferum*: morphine, named after Morpheus, the God of sleep and dreams. Physicians believed that opium had finally been perfected and tamed. Morphine was lauded as 'God's own medicine' for its reliability, long-lasting effects and safety. Morphine remained more under the control of the medical profession and was not sold in shops like opium. Morphine was more commonly used by upper and middle classes, since the lower classes seldom saw a doctor (<http://www.substancemisuse.net>; Plant, 1999).

In 1805 a smuggler from Boston, Massachusetts, Charles Cabot, attempted to purchase opium from the British, he then smuggled it into China under the auspices of British smugglers. American John Cushing, under the employment of his uncles' business, James and Thomas H. Perkins Company of Boston acquired his wealth from smuggling Turkish opium to Canton in 1812. John Jacob Astor of New York City joined the opium smuggling trade in 1816. His American Fur Company purchased ten tons of Turkish opium, and then shipped the contraband item to Canton on the Macedonian. Astor later left the China opium trade and sold solely to England (Booth, 1996).

Writer John Keats and other English literary personalities experimented with opium in 1819, intended for strict recreational use - simply for the high and taken at extended, non-addictive intervals (Booth, 1996). Thomas De Quincey's '*Confessions of an Opium Eater*' (1966), an autobiographical account of his opium addiction was first published in 1821, was reputed to have paved the way for the Western world to realise a new concept, that of drug addiction.

In the mid-19th century, most United States addicts were affluent women addicted to opioids, which were legally accessible. Laudanum was sought out to remedy pain (Kaplan, 1983; Elgie, 1998). Notably, it now seems remarkable that opium was ever regarded as such a simple fact of daily life, given that even mild, medicinal doses can dramatically affect perceptions and states of mind (Plant, 1999).

The German company, E. Merck & Company of Darmstad, began commercial manufacturing of morphine in 1827. In 1830 the British dependence on opium for medicinal and recreational use reached an all time high as 22 000 pounds of opium is imported from Turkey and India. Jardine-Matheson & Company of London inherited India and its opium from the British East India Company once the mandate to rule and dictate the trade policies of British India were no longer in effect (Booth, 1996).

In 1838, a new Imperial Commissioner tried to control trafficking in Canton. This precipitated the Opium War with the United Kingdom and an embarrassing defeat for China. In subsequent years, the Imperial government was unable to enforce dictates against the drug. By the turn of the century, opium permeated all aspects of society and economy in China. Despite decades of efforts and substantial funding, British and American missionaries gained few converts in China. Missionaries had to provide a defence, and they claimed that opium was a major impediment to their work (Kohn, 1987; <http://www.substancemisuse.net>).

On the 18 March 1839, Lin Tse-Hsu, imperial Chinese commissioner in charge of suppressing the opium traffic, ordered all foreign traders to surrender their opium. In response, the British sent expeditionary warships to the coast of China, beginning The First Opium War. New Englanders brought 24 000 pounds of opium into the United States in 1840. This caught the attention of United States Customs which promptly placed a duty fee on the import (Booth, 1996).

The Chinese were defeated by the British in the First Opium War in 1841. Along with paying a large indemnity, Hong Kong was ceded to the British. The Treaty of Nanking between the Queen of Great Britain and the Emperor of China was signed in 1842 (Booth, 1996).

In 1853 Dr Alexander Wood of Edinburgh discovered a new technique of administering morphine, injection with a syringe. He found the effects of morphine on his patients to be instantaneous and three times more potent (Booth, 1996).

In the United States, the cultural impact of Chinese opium smoking was important. The Californian gold rush of 1848 created a high demand for Chinese mine workers. Some Chinese workers had smoked opium before leaving for the United States, but their new harsh working circumstances were conducive to addiction. Fears about the opium den's effect upon young white men and women fed resentment against the Chinese (Plant, 1999; <http://www.substancemisuse.net>). In San Francisco, smoking opium in the city limits was banned and is confined to neighbouring Chinatowns and their opium dens (see Figure 2.7 & 2.8, p.27; Figures 2.9 & 2.10, p.28) (Booth, 1996).

'There were opium dens where one could buy oblivion, dens of horror where the memory of old sins could be destroyed by the madness of sins that were new'

Oscar Wilde
The Picture of Dorian Gray (1891)

The British arrived in lower Burma in 1852, importing large quantities of opium from India and selling it through a government-controlled opium monopoly. The British and French renewed their hostilities against China in the Second Opium War in 1856. In the aftermath of the struggle, China was forced to pay another indemnity. The importation of opium was legalised. Opium production increased along the highlands of Southeast Asia (Booth, 1996).



Figure 2.7 Opium smoker

Source: <http://opioids.com/images/index.html>



Figure 2.8 Opium smoker

Source: <http://opioids.com/images/index.html>



Figure 2.9 Shanghai girl smoking her opium pipe
Source: <http://opioids.com/images/index.html>



Figure 2.10 Manila opium den
Source: <http://opioids.com/images/index.html>



Figure 2.11 Black opium
Source: <http://opioids.com/images/index.html>

One of the side effects of the invention of the hypodermic syringe in 1853 was inadvertently addicting those who were too liberally injected with morphine on medical grounds. Troops returning home from the American Civil War were coming back into civilian life as addicts who had become used to regular shots of morphine (Rudgley, 1998; Robertson, 1987; Kohn, 1987).

British public, influenced by the temperance movement, directed concern over opioid use by the lower classes. It was believed that working women in the industrial towns doped their babies when they went to work. In 1868, British Parliament passed the Pharmacy Act, which restricted the sale of drugs to pharmacies. It was thus harder for the masses to get morphine, however, use by the upper classes did not change (<http://www.substancemisuse.net>; Plant, 1999).

The United States was fascinated with technology and the influence of the Industrial Revolution led to the widespread use of the hypodermic needle, although it was morphine that popularised its use (Plant, 1999). The syringe was regarded as cleaner, safer and more clinical than any earlier means of inserting drugs into the body. Both morphine and the syringe were promoted as sophisticated medical aids. Authorities mistakenly surmised that the invention of the hypodermic needle would remedy opium dependence; however, the opposite was true, and potential dependence to both opium and morphine increased substantially. Hypodermic morphine became so popular that, by 1874, there were increasing fears that morphine might itself become a problem. However, usage was limited to Chinese labourers, intellectuals, artists and sex workers (Elgie, 1998).

In 1874, English chemist, CR Wright first synthesised diacetylmorphine, a synthesis of morphine and acetic anhydride. He considered its effects too powerful and unpleasant to be pursued. In 1895 Heinrich Dreser working for The Bayer Pharmaceutical Company of Elberfeld, Germany, found that diluting morphine with acetyls produced a drug without the common morphine side effects. Bayer Pharmaceutical began production of diacetylmorphine and coined the name 'heroin'. Heroin would not be introduced commercially for another three years (Booth, 1996).

By the end of the century Bayer Pharmaceutical marketed diacetylmorphine as 'heroin'. Heroin was thought at the time to be useful in treating morphine dependence. Bayer Pharmaceutical also produced a cough medicine that contained diacetylmorphine and gave the name heroin to this substance, it was called heroin because of its *heroic* possibilities for treatment (see Figure 2.12 & 2.13, p.31) (Plant, 1999). Similar to the hypodermic needle's misguided palliative effect on opium dependence, Bayer Pharmaceutical initially marketed heroin as a more effective pain analgesic than morphine and, paradoxically, as a medical cure for morphine dependence (Elgie, 1998).

In 1878 Britain passed the Opium Act with the hope of reducing opium consumption. Under the new regulation, the selling of opium was restricted to registered Chinese opium smokers and Indian opium eaters while the Burmese are strictly prohibited from smoking opium. The British acquired Burma's north-east region, the Shan state in 1886. Production and smuggling of opium along the lower region of Burma thrived despite British efforts to maintain a strict monopoly on the opium trade (Booth, 1996).

COUGH

The Best of Clinical Experience Designates Glyco-Heroin (Smith) as a Respiratory Sedative Superior in All Respects to the Preparations of Opium, Morphine, Codeine and Other Narcotics and without derived of the toxic or depressing effects which characterize the latter when given in doses sufficient to reduce the reflex irritability of the larynx, trachea and laryngeal mucous membrane.

THE PROBLEM
of establishing a cough in such form as will give the desired relief of the most distressing cough of the most obstinate kind.

HAS BEEN SOLVED BY
the pharmaceutical compound known as

GLYCO-HEROIN (Smith)

The results obtained with Glyco-Heroin (Smith) in the alleviation and cure of cough are attested by numerous clinical studies that have appeared in the medical journals within the past few years.

Scientifically Compounded, Scientifically Conceived, GLYCO-HEROIN (SMITH) simply stands upon its merits before the profession, ready to prove its efficacy to those who are interested in the advancement of the art of medicine.

Figure 2.12 Heroin cough mixture

Source: <http://opioids.com/images/index.html>

Am. J. Ph.]

7

[December, 1901

BAYER Pharmaceutical Products

HEROIN—HYDROCHLORIDE

is pre-eminently adapted for the manufacture of cough elixirs, cough balsams, cough drops, cough lozenges, and cough medicines of any kind. Price in 1 oz. packages, \$4.85 per ounce; less in larger quantities. The efficient dose being very small (1-48 to 1-24 gr.), it is

The Cheapest Specific for the Relief of Coughs

(In bronchitis, phthisis, whooping cough, etc., etc.)

WRITE FOR LITERATURE TO

FARBENFABRIKEN OF ELBERFELD COMPANY

SELLING AGENTS

P. O. Box 2160

40 Stone Street, NEW YORK

Figure 2.13 Bayer's Heroin Hydrochloride

Source: <http://opioids.com/images/index.html>



Figure 2.14 Mrs Winslow's soothing syrup
 Source: <http://opioids.com/images/index.htm>



Figure 2.15 Perry David vegetable pain killer
 Source: <http://opioids.com/images/index.html>

The United States Congress, in its earliest law-enforcement legislation on narcotics in 1890, imposed a tax on opium and morphine. Tabloids owned by William Randolph Hearst published stories of white women being seduced by Chinese men and their opium to invoke fear of the 'Yellow Peril', disguised as an 'anti-drug' campaign (Booth, 1996).

1900 AD

In the early 1900s, the philanthropic Saint James Society in the United States mounted a campaign to supply free samples of heroin through the mail to morphine dependants who were trying give up their habits. Efforts by the British and French to control opium production in Southeast Asia were successful. Nevertheless, this Southeast region, referred to as the 'Golden Triangle', eventually becomes a major player in the profitable opium trade during the 1940s (Booth, 1996).

In various medical journals in 1902, physicians discussed the side effects of using heroin as a morphine step-down cure. Several physicians argued that their patients suffered from heroin withdrawal symptoms equal to morphine dependence. In 1903 heroin dependence rose to alarming rates. The United States Congress banned opium in 1905 (Booth, 1996).

China and England finally enacted a treaty in 1906 restricting the Sino-Indian opium trade. Several physicians experimented with treatments for heroin dependence. Dr Alexander Lambert and Charles Towns touted their popular cure as the most 'advanced, effective and compassionate cure' for heroin dependence. The cure consisted of a 7-day regimen, which included a five-day purge of heroin from the addict's system with doses of belladonna delirium. In the same year, The United State Congress passed the Pure Food and Drug Act requiring content labelling on patent medicines by pharmaceutical companies. As a result, the availability and consumers of opioids significantly declined (Booth, 1996).

The first federal drug prohibition passed in the United States in 1909 outlawed the importation of opium. It was passed in preparation for the Shanghai Conference, at which the United States pressed for legislation aimed at suppressing the sale of opium to China. The International Opium Commission convened in Shanghai on the 1 February 1909. Heading the United States delegation was Dr Hamilton Wright and Episcopal Bishop Henry Brent. Both tried to convince the international delegation of the immoral and evil effects of opium. In 1919, after 150 years of failed attempts to rid the country of opium, the Chinese were finally successful in convincing the British to dismantle the India-China opium trade (Booth, 1996).

At first heroin's addictive qualities went by unrecognised and when United States legislation, just before the First World War, effectively reduced the distribution of other opiates and of cocaine, heroin slipped through the net. In 1914, the Harrison Narcotic Act in the United States effectively banned the use of opium, morphine and cocaine. However there was one major omission - heroin (<http://www.substancemisuse.net>). Consequently, many of those who were addicted to opium, morphine and other opioids switched to heroin, as it was not considered addictive for some time. Only in 1924 was a federal law passed making heroin an illegal substance and subsequently prohibited. Having now become criminals, heroin users were pursued with considerable gusto by the authorities, and medical doctors were prosecuted if found to be supplying addicts' needs. In the wake of the first federal ban on opium, a thriving black market opened up in New York's Chinatown in 1925 (Booth, 1996). Much of the anti-heroin rhetoric of the time foreshadowed the 'War

on *Drugs*' that has dominated late twentieth-century official thinking (Szasz, 1990). Heroin dependants were portrayed as intertwined with politically destabilising forces such as anarchism and Bolshevism (Rudgley, 1998).

Due to the fact that the drug was synthesised by the Germans, American propagandists further fuelled the anti-German feeling during the First World War. The Temperance mentality was evident throughout the Western World, but was most visible in the United States. Americans were warned of a fiendish plan to introduce habit-forming drugs into German toothpaste and patent medicines that were to be exported to the United States before World War I. Temperance supporters also showed a great enthusiasm for warlike propaganda, unsupported claims, half-truths and bold-faced lies were propagated as divine writ or scientific fact (<http://www.substancemisuse.net>).

After the war, attempts were made in the United States to give heroin dependants the opportunity to get detoxification treatment, but due to pressure from puritanical groups, this policy was viewed as condoning or even propagating heroin use and clinics were soon closed down. This attitude must be seen in the light of contemporary events, particularly the Prohibition Era in 1919. Under Prohibition, the highly profitable drug trade (largely the dealing of alcohol which was then an illegal substance) built the criminal foundation for the later, even more profitable, narcotics business (Rudgley, 1998).

In the United States, the Supreme Court overturned itself in 1925 by entitling drug dependants to medical care. The Rolleston Report in 1926 provided British doctors with consent to provide maintenance therapy to addicts to relieve 'morbid and overpowering craving' (<http://www.substancemisuse.net>). However, the stigma attached to drug dependence was such that physicians were unwilling to treat drug dependants under any circumstances, thereby further marginalising this population and fostering an emergent illegal drug market catering to the needs of a drug dependant population. Although heroin itself was finally outlawed in 1926, the new laws did encourage some dependants to refrain from using heroin and discouraged general experimentation, these new laws and regulations forced addicts who would not or could not change their habits into a more clandestine lifestyle (Elgie, 1998). In the 1930s, the majority of illegal heroin smuggled into the United States come from China and was refined in Shanghai and Tietsin (Booth, 1996).

In the United Kingdom the perception of heroin dependants was completely different and, until the 1960s, heroin users were generally seen as medical patients whose problems were to be dealt with by doctors who could provide them with morphine and related drugs to monitor, and hopefully, ease their condition as part of maintenance therapy (Rudgley, 1998). The Dangerous Drugs Act of 1920 and Dangerous Drug Regulations of 1921 made it illegal to possess opioids and cocaine. It had been argued that the high proportion of medical doctors who were drug dependants influenced the Rolleston Committee's decision to avoid the Harrison Act's punitive approach. The Rolleston report concluded that morphine and heroin dependence were rare in the United Kingdom (<http://www.substancemisuse.net>). At the official professional level, contemporary civil servants and the medical profession were in general agreement on the disease concept of addiction. When the United Kingdom ratified the Hague Convention of 1912, this consensus became the basis for the formal policy on opioids. The Dangerous Drugs Act was amended in 1967 to restrict heroin prescriptions by doctors to those in special clinics (Krivaneck, 1988; <http://www.substancemisuse.net>).

During World War II in the early 1940s, opium trade routes were blocked and the flow of opium from India and Persia was cut off. Fearful of losing their opium monopoly, the French encouraged Hmong farmers to expand their opium production. Burma gained its independence from Britain at the end of World War II in 1947. Opium cultivation and trade flourished in the Shan states (Booth, 1996).

From 1948-1972 Corsican gangsters dominated the United States heroin market through their connection with Mafia drug distributors. After refining the raw Turkish opium in Marseilles laboratories, heroin was made easily available for purchase by junkies on New York City streets. In the 1950s, United States efforts to contain the spread of Communism in Asia involved forging alliances with tribes and warlords inhabiting the areas of the Golden Triangle, thus providing accessibility and protection along the south-east border of China. In order to maintain their relationship with the warlords while continuing to fund the struggle against communism, the United States and France supplied the drug warlords and their armies with ammunition, arms and air transport for the production and sale of opium. The result: an explosion occurred in the availability and illegal flow of heroin into the United States and into the hands of drug dealers and drug dependants (Booth, 1996).

Heroin had become the most contentious feature in the global exchange of addictive substances. A variety of international gatherings were held during the 20th century which led to the development of drug laws and drug control institutions, these involved not just drug issues, but also issues such as trade policy, national security concerns, the Cold War and medical considerations. In 1961, the UN collated all previous illicit drug conventions into one convention known as the Single Convention. By that time the conventional wisdom had developed (led by the United States) that certain substances were socially unacceptable, that 'bad' people using these substances were morally corrupt or helpless (or both), and that societies had little choice but to regard those who consumed certain substances primarily as delinquent and criminal (<http://www.substancemisuse.net>; Kohn, 1987; Plant, 1999).

Burma outlawed opium in 1962. The United States involvement in Vietnam from 1965-1970 was blamed for the surge in illegal heroin being smuggled into the States. To aid the United States allies, the CIA set up a charter airline, Air America, to transport raw opium from Burma and Laos. Some of the opium was transported to Marseilles by Corsican gangsters who refined it into heroin and shipped the heroin to the United States via France. The number of heroin dependants in the United States reached an estimated 750 000 (Booth, 1996).

In October 1970, legendary singer, Janis Joplin, was found dead at Hollywood's Landmark Hotel, a victim of an 'accidental heroin overdose' (Friedman, 1992), while in 1982 comedian John Belushi, died of a 'speedball' overdose (Barlow & Durand, 1985).

Heroin exportation from Southeast Asia's Golden Triangle, controlled by Shan warlord, Khun Sa, became a major source for raw opium in the profitable drug trade in 1972. In the same year, Solomon Snyder and Candace Pert discovered opioid receptors in the brain. President Nixon created the DEA on the 1 July 1973, under the Justice Department to consolidate virtually all federal powers of drug enforcement in a single agency. In the mid 1980's Saigon fell, the heroin epidemic subsided. The search for a new source of

raw opium yielded Mexico's Sierra Madre, 'Mexican mud' temporarily replaced 'China white' heroin until 1978 (Booth, 1996).

Hans Kosterlitz and his colleagues, in 1975, isolated and purified an endogenous opioid in the brain, enkephalin. In 1978 the United States and Mexican governments found a means to eliminate the source of raw opium - by spraying poppy fields with Agent Orange. The eradication plan was termed a success as the amount of 'Mexican mud' in the United States drug market declined (Booth, 1996). In response to the decrease in availability of 'Mexican mud', another source of heroin was found in the Golden Crescent area - Iran (Oliver, 2004), Afghanistan (Dixon, 2003) and Pakistan (Whitaker, 2001), creating a dramatic upsurge in the production and trade of illegal heroin.

United States State Department officials concluded on the 13 September 1984, after more than a decade of crop substitution programmes for Third World growers of cannabis, coca or opium poppies, that the tactic could not work without eradication of the plants and criminal enforcement. Poor results were reported from eradication programmes in Burma, Pakistan, Mexico and Peru.

In 1988 opium production in Burma increased under the rule of the SLORC (State Law and Order Restoration Council), the Burmese junta regime. The single largest heroin seizure was made in Bangkok within the same year. The United States suspected that the 2 400-pound shipment of heroin, en route to New York City, originated from the Golden Triangle region, controlled by drug warlord, Khun Sa. In 1990, a United States Court indicted Khun Sa, leader of the Shan United Army and reputed drug warlord, on heroin trafficking charges. The United States Attorney General's office charged Khun Sa with importing 3 500 pounds of heroin into New York City over the course of eighteen months, as well as held him responsible for the source of the heroin seized in Bangkok. In 1992 Colombia's druglords were said to be introducing a high-grade form of heroin into the United States (Booth, 1996).

Society witnessed a new resurgence of heroin use and more powerful forms of the drug emerged. The mean purity level for heroin was 6% in 1987 and 37% in 1997, reaching 60% in New York in the same year (<http://www.substancemisuse.net>). These forms can be smoked, with a similar effect as intravenous injection. These methods are also regarded as less invasive and as a result have attracted different types of people (Elgie, 1998).

In 1993 the Thai army with support from the United States DEA launched its operation to destroy thousands of acres of opium poppies from the fields of the Golden Triangle region. An effort to eradicate opium at its source remained unsuccessful. In January 1994 the Clinton Administration ordered a shift in policy away from the anti-drug campaigns of previous administrations. Instead the focus included 'institution building' with the hope that by strengthening democratic governments abroad, it would foster law-abiding behaviour and promote legitimate economic opportunity. By 1995 the Golden Triangle region of Southeast Asia was the leader in opium production, yielding 2 500 tons annually. According to United States drug experts, there were new drug trafficking routes from Burma through Laos, to southern China, Cambodia and Vietnam (Booth, 1996).

Khun Sa 'surrendered' to SLORC in January 1996. The United States was suspicious and feared that the agreement between the ruling junta regime and Khun Sa included a deal allowing 'the opium king' to retain

control of his opium trade but in exchange end his 30-year-old revolutionary war against the government. In November 1996 international drug trafficking organisations, including China, Nigeria, Colombia and Mexico were said to be aggressively marketing heroin in the United States and Europe. A bumper opium crop of 4 600 tons was yielded in Afghanistan in 1999. UN Drug Control Program estimated that around 75% of world's heroin production was of Afghan origin. In 2000 the Taliban leader Mullah Omar banned poppy cultivation in Afghanistan; United Nations Drug Control Program confirmed that opium production was eradicated. In July 2001, Portugal decriminalised all drugs for personal consumption (Booth, 1996).

Within the last ten years, the presence of heroin in media culture rose dramatically and has contributed toward a more casual attitude regarding the drug (Krivaneck, 1988; Kohn, 1987). The music industry played a role in popularising and glamorising the use of heroin. With musicians such as Kurt Cobain, who was reputed to have committed suicide in April 1994 while battling with a heroin dependence, the notion of heroin use had become more glorified. The film industry has also been implicated, movies such as *Trainspotting*, *Basketball Diaries*, *Pulp Fiction* and *Requiem for a Dream*, brought heroin into the collective psyches of this era.

'Choose life. Choose a job. Choose a career. Choose a family. Choose a big fucking television, choose washing machines, cars, compact disk players and electrical tin openers...choose DIY and wondering who the fuck you are on a Sunday morning. Choose sitting on the couch, watching mind-numbing, spirit-crushing game shows, stuffing junk food into your mouth. Choose rotting away at the end of it all, pishing your last in a miserable home, nothing more than an embarrassment to the selfish, fucked-up brats you spawned to replace yourself. Choose your future. Choose life. But why would I want to do a thing like that? I chose not to choose life. I chose something else. And the reasons? There are no reasons. Who needs reasons when you've got heroin?'

Irvine Welsh
TRAINSPOTTING (1996)

Furthermore, 'heroin chic' became a fashion statement from the 1990's through to the new millennium, with the pale, thin, blank look being promoted (Elgie, 1998). President Bill Clinton, former president of the United States, decried 'heroin chic' fashion photography for sending a message that using the once-feared drug is 'glamorous' and 'sexy.' Clinton commented on the admissions by magazine editors that the 'wasted addict' look in some fashion layouts has glamorised heroin use (<http://opioids.com/heroin/heroinchic/html>).

'In the press in recent days, we've seen reports that many of our fashion leaders are now admitting - and I honour them for doing this - they're admitting flat-out that images projected in fashion photos in the last few years have made heroin addiction seem glamorous and sexy and cool, and as some of those people in those images start to die now... you do not need to glamorise addiction to sell clothes' (<http://opioids.com/heroin/heroinchic/html>).

Clinton further stated that when he was growing up, heroin was feared as the worst drug imaginable;

'There were these horrible images associated with it - strung-out junkies lying on street corners in decidedly unglamorous ways' (<http://opioids.com/heroin/heroinchic/html>).

Clinton attributed heroin use increase, and cocaine use decline partly due to 'images that are finding their way to our young people'. Clinton's remarks were prompted by a *New York Times* story about the fatal drug overdose of Davide Sorrenti, 20, a fashion photographer, and the use of models in drugged stupor-like poses in some fashion magazines (<http://opioids.com/heroin/heroinchic/html>).

2000 AD

During the war in Afghanistan in the autumn of 2001 heroin flooded the Pakistan market. The Taliban was regime overthrown (Whitaker, 2001). In October 2002 UN Drug Control and Crime Prevention Agency announced that Afghanistan had regained its position as the world's largest opium producer. In December

the United Kingdom Government health plan made heroin available free on National Health Service 'to all those with a clinical need for it'. Consumers were sceptical (Booth, 1996).

In April 2003 Korea's attempt to penetrate the Australian heroin market hit rocky waters. The United States FDA and DEA launched a special task force in October 2003 to curb a surge in net-based sales of narcotics from online pharmacies. Consumer groups filed a lawsuit against Oxycontin maker Purdue Pharma in January 2004. The company was alleged to have used fraudulent patents and deceptive trade practices to block the prescription of cheap generic medications for patients in pain (Booth, 1996).

In September 2004 Singapore announced plans to execute a self-medicating heroin user, Chew Seow Leng. Under Singapore law, chronic heroin users with a high physiological tolerance to the drug are deemed to be 'traffickers'. Consumers faced a mandatory death sentence if more than 15 grams (0.5 ounces) of heroin is taken a day. In the same month, a Tasmanian company published details of its genetically engineered opium poppies. Top1 (thebaine oripavine poppy 1) mutants do not produce morphine or codeine (Booth, 1996).

Tasmania is the source of some 40% of the world's legal opioids; its native crop of poppies is already being re-engineered with the mutant stain. Conversely, some investigators expect that the development of genetically engineered plants and microorganisms to manufacture potent psychoactive compounds will become widespread later in the 21st century. Research into transgenic psychotropic botanicals and microbes is controversial; genes from mutants have a habit of spreading into the wild population by accident as well as design (Booth, 1996).

In September 2003 the FDA granted a product license to Purdue's pain medication Palladone: high dose, extended-release hydromorphone capsules. Palladone is designed to provide 'around-the-clock' pain-relief for opioid-tolerant users. An unannounced withdrawal of newly issued DEA guidelines to pain specialists occurred in October 2004. The guidelines had pledged that physicians wouldn't be arrested for providing adequate pain-relief to their patients. DEA drug-diversion chief Patricia Good earlier stated that the new rules were meant to eliminate an 'aura of fear' that stopped doctors treating pain aggressively. In December 2004 pain-treatment specialist Dr William Hurwitz was sent to prison for allegedly 'excessive' prescription of opioid painkillers to chronic pain patients. Testifying in court, Dr Hurwitz described the abrupt stoppage of prescriptions as 'tantamount to torture' (Moore, 2004).

Researchers at Ernest Gallo Clinic and Research Center in Emeryville, California, inhibited the expression of the AG3 gene in the core of nucleus accumbens in May 2005; experimentally blocking the AGS3 gene curbs the desire for heroin in addicted rodents. By contrast, activation of the reward centres of the nucleus accumbens is immensely pleasurable and addictive. The possible effects of over-expression and gene amplification of AGS3 remain unexplored (Viega, 2005).

2.3 THE EMERGENCE OF HEROIN DEPENDENCE IN SOUTH AFRICA

While heroin and cocaine have been present in South Africa for some time, these drugs were not widely used until after the 1994 elections. One explanation of this course of events is that these drugs, which have to be imported, were difficult to smuggle in during the years of apartheid. However, the borders were hardly impenetrable during the latter years of the struggle, as mandrax was imported in great quantities. This delayed proliferation could perhaps be attributed to a lack of drug dealers, rather than a lack of supply (Leggett, 2001). According to the UNODC's Country Profile on Drugs and Crime (*UNODC, 2002*) heroin is sourced from markets in Southeast and Southwest Asia, couriered principally via Johannesburg International Airport. Other sources include seaport entry via Mombasa and Dar es Salaam. The heroin is then transported down East Africa's main arterial road networks toward South Africa. Most of the heroin available in South Africa is 'Thai white'.

With the coming of democracy in South Africa, the borders were opened to immigrants from the rest of the continent, especially countries that assisted in the struggle against apartheid. Nigeria in particular played an important part in assisting with the birth of democracy in South Africa. Due to political turmoil of its own, Nigerian immigrants could make a *prima facie* case for refugee status (Leggett, 2001).

Unfortunately, Nigerian syndicates are renowned internationally for their involvement in heroin and cocaine trafficking (Kruger, 1996; Leggett, 2001; Smille, 2000; Baynham, 1998). It is generally agreed that the present wave of Nigerian immigrants first made their appearance in Johannesburg since the early 1990s, peaking in 1996, particularly in the inner-city neighbourhood residential hotels of Hillbrow, Yeoville and Berea (Leggett, 2001; Kruger, 1996). Hillbrow's sleazy hotels are notorious crime hotspots. A general victim survey of the Hillbrow police station area conducted by the ISS uncovered startling frankness about the prevalence of drugs, sex work, and corruption in Johannesburg's inner city. The Mimosa International on Clarendon Street, allegedly a virtual drive-in drug market, has been seized under the assets forfeiture provisions of the 1996 Prevention of Organised Crime Act. The Sands Hotel on O'Reilly Street has been shut down by court order, as the hotel is in default to the city for payment of services and is in violation of building codes. The Sands, and other nearby hotels, however, have been the sites of countless drug arrests (Leggett, 2002). A study commissioned by the UNODC of drug markets in Johannesburg, using mainly key informant interviews reported that use of heroin is used by some sex workers in Hillbrow and surrounding areas (Leggett, 2000). However, research conducted by the same author amongst over 50 sex workers in Durban did not report any use of heroin (Leggett, 2001).

On arrival many Nigerians applied for political refugee status under Section 41 of the Immigration Act. The visa they received pending their hearing allows them to work legally in South Africa, and prohibits repatriation even if convicted of a criminal offence. Other East African nationals, including Kenyans and Tanzanians are involved in retailing heroin in Cape Town and Pretoria (Leggett, 2001).

Leggett (2001) identifies two reasons as to why one specific ethnic group in Nigeria, namely the Ibo, has become notorious in the international drug economy, namely, the Biafran War, and the rise and fall of the oil economy. After Nigerian independence in 1960, Muslim groups from the north that controlled the military dominated national politics. The Ibo, joined with others speaking a similar language, seceded from the union to form an independent 'Biafra' in the south-east corner of the country. Nigeria laid siege to the elitist

nation immediately, and over a million Biafrans starved to death prior to their leaders surrendering. Therefore, the Ibo claimed continuing persecution, stating that job discrimination was rife.

Within the informal sector, such as the street trade in South Africa for example, the Nigerians and other West Africans take up limited vendor opportunities, evoking resentment from local vendors. A single successful 'run' can net the courier approximately forty times the monthly salary of a typical Nigerian (Baynham, 1998).

It is reputed that the Nigerians became directly involved in drug dealing when Nigerian naval officers, stationed in India in the 1970s, supplemented their incomes by involving themselves in heroin trafficking. Nevertheless, when Nigeria's oil price dropped, the economy crashed, this left well-educated youth jobless, stranded outside their homeland, and unwilling to settle for lifestyles below that to which they were accustomed. Many, being familiar with the drug habits of western youth, tapped into the Nigerian communities' resident in Bangkok and Rio. They were allegedly responsible for importing 40% of the heroin to the United States, and a large part to Europe of the heroin and cocaine supply (Leggett, 2001). The Ibo are regarded to be essentially businessmen and have little interest in violence (Kruger, 1996). Through the recruitment of corrupt police assistance, it is possible to minimise violent competition and resolve disputes quickly. Perversely, this has led to the Nigerian dealers being attributed by some as bringing order to inner-city areas similar to Hillbrow (Leggett, 2001).

Many Nigerian dealers never get past street dealing in Hillbrow, owing to the saturation of the market. Market saturation creates considerable pressure for mid-level dealers to branch out into other areas of South Africa and claim new territory. Outside of Hillbrow, street dealers of all ethnic groups are common, but most source their drug supply from Nigerian dealers (Leggett, 2001). The 'flat' rather than 'hierarchical' structure favoured by the Nigerian dealers, who work together on the basis of highly personalised relationships, makes it very difficult for the anti-drug agencies to penetrate their organisations. The job of the authorities was also made more onerous due to the extent of corruption in the police and customs services, a source of acute concern at the highest levels of the South African administration. Tempted by large bribes or commissions, enforcement officials in substantial numbers throughout South Africa are believed to be supplementing their meagre salaries by collaborating with local and foreign agents of international drug trafficking syndicates. Many of these syndicates trace their roots back to Lagos and its environs (Baynham, 1998).

According to Smillie (2000), part of the reason for heroin infiltrating the urban middle class strata of society can be attributed to the Nigerian drug pushers infiltrating the rave drug culture. Traditionally the white Mafia bouncer, which made it initially difficult for the Nigerians to infiltrate clubs and sell drugs, controlled this drug scene. However, the Nigerian dealers offer cheaper forms of ecstasy from outside the clubs and from there introduce the ravers, or others attending clubs, to heroin. Another reason as to why heroin could be becoming more popular is because it is becoming cheaper with drug pushers selling a less pure form in quarter-gram sachets for R50, which means it competes with other illicit addictive substances such as mandrax.

Although heroin is regarded to be a white, middle class drug, increasing numbers of black youth are reportedly taking the substance as well, increasingly it is smoked with cannabis, this the black township youth refer to as '*nyeope*' (Hosken, 2005). In the second half of 2000 there was no record of black heroin dependants undergoing treatment in South Africa (Plüddemann, Hon, Parry, Bhana, Matthysen, Potgieter, Cerff & Gerber, 2001). In the second half of 2004, SACENDU statistics reflected that 12% of the heroin dependant population ($n = 197$) in treatment facilities in Gauteng were black (Plüddemann, Hon, Bhana, Harker, Potgieter, Gerber, & Parry, 2004). According to Hennie Potgieter, Gauteng co-ordinator of SACENU, heroin use in the second half of 2005 was 7.7% out of a total population in Gauteng of 2 848 patients. The number of black patients in treatment for heroin dependence in Gauteng was 20.1% in comparison to white, Asian and coloured patients (Potgieter, personal communication, February, 13, 2006). Black heroin and drug dependants are also less likely than their white counterparts to afford residential rehabilitation and many are unaware of the dangers of the drug (Smetherham, 2002).

In the course of working therapeutically with incarcerated heroin dependants at Emthonjeni Juvenile Prison (Baviaanspoort), this researcher was confronted by a significant number of young incarcerated black heroin dependants. During discussions with them, it became evident that none had attended any sort of drug rehabilitation programme, except for those offered by the newly initiated Ahanang Prison Project initiative (see 2.7.5, p. 80). This specific group of heroin dependants were mostly living and dealing drugs in the Hillbrow and Soweto area prior to their incarceration. All the offenders were incarcerated for severe criminal offences such as sexual offences, murder, housebreaking and assault; and all reported socially and economically deprived backgrounds. The 'Adam & Eve' case (see Chapter 1, Figure 1.1, p.3) also highlighted the level of violent crime that can occur while intoxicated with heroin.

There are three types of crime that might be linked to heroin use. *Systemic crimes* are those that occur because heroin use is illegal and illicit drugs are brought and sold in black markets. The second type of crime is *economic crime*; some addicts need money to pay for their heroin use. Economic crime is likely to be strongly linked to prohibition. Heroin would be much cheaper under decriminalisation, some have estimated that it could be bought and sold at 2% of current prices. If the estimates were roughly accurate, there would be a drastic reduction in economic crime. The third type of drug-related crime that may be identified is *psychopharmacological crime*, arising from the effects of heroin and other drugs, for example, a drug may relieve inhibitions, affect judgement and perception. However, the drug that most likely causes psychopharmacological crime is alcohol. In 1998, it was reported that 21% of persons in United States jails for violent crime were under the influence of alcohol alone at the time of the committed crime. Only 1% was under the influence of heroin alone. One final connection between drugs and crime is related to the fact that drug use and crime both occur in poor communities. Both occur, or are influenced, by poverty (<http://www.substancemisuse.net>).

Heroin abuse, addiction and dependence is also starting to take a hold within the coloured population, rapidly replacing the old mandrax culture on the Cape Flats, notorious for its involvement in gangsterism and crime. The consequences of heroin, however, far exceed those of mandrax because heroin is far more dependence producing. Should heroin become properly established there, to quote Smetherham (2002:1), '*all hell is going to break loose*'. The problems of gangsterism go far beyond drugs though, being rooted within the

adversity of a disenfranchised poor community, and violence is an essential part of the gang life, with or without chemical assistance. No one can say for certain how many lives have been lost in turf wars over drug territory and vigilante reaction to these crimes. The problem of gangsterism in the Cape Flats is thus deep and longstanding. While drugs may have aggravated the problem, gang members continue to engage in a range of criminal activities and forms of violence unrelated to drugs (Leggett, 2001). A heroin epidemic in these areas could evoke nostalgia for the days when heroin was only available to middle class suburbans.

2.4 HEROIN ADMINISTRATION, PHARMACOLOGY AND PHARMACOLOGICAL INTERVENTIONS

2.4.1 Heroin administration, addictive potential and health consequences

2.4.1.1 Heroin administration

Heroin can be smoked (*chasing the dragon*), snorted, or injected with the use of a hypodermic needle. Chewing heroin gum is not in common use, except in the Golden Triangle. The needle can be put into the skin (*skin-popping*) or intravenously (*spiking* or *mainlining*) into one of the main veins. Intravenous administration is regarded as the most practical and efficient manner to administer low-purity heroin. Heroin is mixed with water and citric acid in a spoon and heated until it becomes a clean brown solution. The solution is then drawn up in a syringe and a cigarette filter is often used to filter out impurities (Alavi *et al.*, 2003).

The injecting of heroin results in near-instantaneous analgesic and euphoric effects. The user experiences a state of well being and tranquillity and this accompanies a general depressing of the central nervous system, with a slowing of pulse and breathing rate and a drop in blood pressure (Rudgley, 1998). The effects of heroin generally last three to four hours. The different effects produced by heroin do not show tolerance development at the same rate. There is a high level of tolerance for the analgesic, sedative, euphoric and emetic effects, as well as for respiratory depression. However, there is a lower level of tolerance for the ability of heroin to reduce pupil size and induce constipation. The withdrawal syndrome occurs after discontinuation of the use of heroin, which consists of physical, subjective and behavioural signs or symptoms. The prevalence and intensity of these withdrawal signs depends on the dose, the time the dose is postponed, the duration of use and the state of health of the user. The onset of withdrawal generally occurs at the time of the next habitual dose, which ranges from four to six hours for heroin, and 24 hours for methadone. The protracted phase of physiological changes, such as mild increases in blood pressure, temperature, respiration and pupil size can last for four to ten weeks or even longer (<http://www.substancemisuse.net>). Burroughs (1977: xv) recounted his process to heroin dependence by asking the question;

'Why does a man become a drug addict? The answer is that he usually does not intend to become an addict. You don't wake up one morning and decide to be a drug addict. It takes at least three months' shooting twice a day to get any habit at all. And you don't know what junk sickness is until you have several habits. It took me almost six months to get my first habit, and then the withdrawal symptoms were mild. I think it is no exaggeration to say it takes about a year and several hundred injections to make an addict.'

Heroin in South Africa can be found in two types, namely brown sugar (often simply referred to as 'heroin') and Thai white. Brown sugar is usually associated with America and Central Asia. It was regarded as the standard drug of injection in the West until the 1990s, when Thai white, a purer form of white heroin

appeared from the Far East. Thai white can be smoked, which makes it a far more marketable drug. In South Africa, brown heroin appeared after 1994, and dropped in quality, and then the far more potent Thai white was introduced. In some areas, according to Leggett (2001), the quality of Thai white has also decreased; heroin users are divided as to which variety is presently better. Brown sugar has been found to be cut with a variety of psychoactive substances, including benzodiazepines, barbiturates, caffeine, quinine, strychnine and inert substances such as 'Bisto' (a powdered gravy mix), starch, colouring agents, cocoa, brown sugar, powdered milk, glucose, flour and talcum powder. The ratio of dilutants ranges from 9 to 1, to as much as 99 to 1. Both varieties are cheap by international standards - selling for as little as R100 a gram. The purity of each individual batch or as is known in South Africa, snatch, of heroin is unknown and buyers depend on the reputation of the dealer (Alavi *et al.*, 2003).

The availability of high purity heroin, in the form of Thai white, has meant that users now snort it like cocaine. When smokable heroin was rediscovered in the 1980s, a dramatic increase in heroin use occurred, because it was no longer necessary to inject the drug in order to use it. Smoking or 'chasing' appeals to newcomers because of the HIV/AIDS risks involved in intravenous use, and due to the historical stigma attached to intravenous heroin use. It has promoted heroin from being a 'ghetto' drug, to a middle class drug, with a much larger target market (Smetherham, 2001).

Black tar and Mexican mud are crudely processed forms of heroin illicitly manufactured in Mexico. Black tar has the sticky consistency of roofing tar or can be as hard as coal, and is dark brown or black in colour. Black tar is often sold on the street in its tar-like state, with the purity level ranging from 40% - 60%. This form of heroin is sometimes diluted by adding materials of similar consistency, such as burnt cornstarch, or by converting the tar heroin into a powder and adding dilutants such as quinine, and is most commonly used through intravenous administration. White powder heroin, or China white from Asia, usually refers to heroin funnelled through France. Black tar, Mexican mud and China white are uncommon in South Africa (Alavi *et al.*, 2003).

Drug analogues are chemical compounds that are similar to other drugs in their effects but differ slightly in their chemical structure. Pharmaceutical companies, for legitimate medical reasons, produce some analogues. Other analogues sometimes referred to as 'designer' drugs, can be produced in illegal laboratories and are often more dangerous and potent than the original drug. Two of the most commonly known opioid analogues are fentanyl and meperidine (marketed under the brand name Demerol®). Fentanyl was introduced in 1968 by a Belgian pharmaceutical company as a synthetic narcotic to be used as an analgesic in surgical procedures because of its minimal effects on the heart. Fentanyl is particularly dangerous because it is fifty times more potent than heroin and can rapidly stop respiration. On the street in the United States, users have been found dead with the needle used to inject still in their arms (*National Institute on Drug Abuse*, 2000).

2.4.1.2 Heroin addiction and dependence potential

Heroin is extremely addictive and regular users find that they need much higher doses to get the same feeling than novices do. However, while heroin addiction is a 'terrible thing', it is not as easy to become a heroin dependant as most people believe. Many novices become violently ill the first time that they try the



Figure 2.16 Thai white heroin
Source: <http://opioids.com/images/index.html>



Figure 2.17 China white heroin
Source: <http://opioids.com/images/index.html>



Figure 2.18 Black tar heroin
Source: <http://opioids.com/images/index.html>



Figure 2.19 Brown sugar heroin
Source: <http://opioids.com/images/index.html>



Figure 2.20 Opium smoker
Source: <http://opioids.com/images/index.html>



Figure 2.22 Chasing the dragon
Source: <http://opioids.com/images/index.html>



Figure 2.23 Heroin 'works'
Source: <http://opioids.com/images/index.html>

drug (Leggett, 2001; Kenny, 1999; Pearson, 1987; Kaplan, 1983). Heroin dependants can, however, inject extraordinary amounts of the drug that would kill an inexperienced user. The widespread notion that smoking or snorting the drug means that the user side steps the danger of becoming addicted is false (Rudgley, 1998; Pearson, 1987). Furthermore, heroin overdose deaths are not restricted to the injection of heroin. While intravenous use may constitute a greater risk-factor, there is no safe, overdose-free way to use heroin. This reality was brought to light in a study conducted in New South Wales, Australia, which compared the toxicology between non-injecting routes of administration with injection fatalities. For each route of administration there is a risk of overdose that may increase with polydrug use (Darke & Ross, 2000).

A study regarding the quality (or purity) of heroin and heroin-related deaths from 1987 to 1995 in Vienna, failed to substantiate the widely held belief that increases in heroin-related deaths could be explained by an increase in the quality of heroin. The population of pure-heroin related deaths represented a third of the heroin-related deaths. Pure heroin-related deaths were significantly younger than polydrug heroin-related deaths. Based on these findings, the suggestion was made that a proportion of the deaths were due to novice heroin use and potentially users returning to heroin use after a period of abstinence, heroin taken in combination with other central nerve system depressant drugs (Risser, Uhl, Stichenwirth, Höningschnabl, Stellwag-Carion, Klupp, Vycudilik & Bauer, 2000).

The heroin experience may be influenced by biological makeup, previous experience with the drug, expectations about the drug's effect, personality, clinical condition, age and gender (<http://www.substancemisuse.net>). The strength of a drug habit may also depend on the mode of administration. Addictive behaviours may also be produced and maintained by operant conditioning. Numerous variables determine the persistence of behaviour shaped by operant conditioning, for example, the length of time between the behaviour and the reward. Intravenous injection habits have been related in part to the short time between use of the drug and its effect. The whole injection ritual, for example, is subject to operant conditioning as well. As a result, the dependant attempting to stop use misses not only the effect of heroin, but also the whole process of shooting up - heating the water-filled spoon to dissolve the heroin, tying off the vein, drawing up some blood into the needle, and finally, pressing home the plunger. Some heroin dependants are known to go through the motions of shooting up when no heroin is available and even inject water (Kaplan, 1983). Finnegan (1995) studied the cognitive structures underlying heroin injecting behaviours, and concluded that drug injection and its related consequences are complex, and questioning the assumption that people take drugs because of some personal inadequacy, that some reasons were positive. Some heroin dependants regard giving up usage of the hypodermic needle as more difficult than that of quitting heroin (Pearson, 1987; Friedman, 1992). Two other important variables also determine an individual's reaction to a drug. These are normally referred to as the user's 'set' and the 'setting' of use. The drug user's set includes, amongst other things, biochemical and genetic makeup, and the user's expectation of the drug's effect (Kaplan, 1983).

According to Burroughs (1977, 22-23);

...the actual changes are difficult to specify and they do not show up in the mirror. That is, the addict himself has a special blind spot as far as the progress of his habit is concerned. He generally does not realise that he is getting a habit at all. He says there is no need to get a habit if you are careful and observe these rules like shooting every other day. Actually, he does not observe these rules, but every shot is

regarded as exceptional. I have talked to many addicts and they all say they were surprised when they discovered they actually had the first habit. Many of them attributed their symptoms to something else... of course; junkies don't as a rule die from the withdrawal of junk. But in a very literal sense, kicking a habit involves the death of junk-dependent cells and their replacement with cells that do not need junk.'

In Freedman's (1992) biography of Janis Joplin, the sixties bohemian singer who died of a heroin overdose, the author argues that a heroin dependant, given his or her fix, can function better than an alcoholic can. A heroin dependant, freed from the circumstances that produce dirty needles that lead the dependant not to eat, is unendangered of organic damage, whereas alcohol can damage the brain, liver, heart, the gastrointestinal tract, the pancreas, and the entire central nervous system structure. Former theories that malnutrition was the cause of such damage have been abandoned; sufficient quantities of ethyl alcohol alone are the source of the damage, proper nutrition notwithstanding. Withdrawal from heroin is not as hazardous as from alcohol as the former rarely causes death; the latter, frequently. Moreover, there is the strange phenomenon of 'ageing' or 'maturing' out (see 2.8.1, p. 84). For some reason, a noticeable percentage of heroin dependants stop their heroin use around their mid- or late-thirties. No such process occurs with the alcoholic. Due to the pharmacology of alcohol, the problem progresses, not get better.

Heroin dependence is also not always a continues and permanent condition. It is now clear that many heroin dependants permanently give up heroin at an early age and after a relatively brief period of addiction. In a study conducted by O'Donnell (cited in Kaplan, 1983), of those in a cross section of American young men who had at one time used heroin on a daily basis, only 4% had used heroin in the twenty-four hours before their interview. This study is quite unusual among investigations of heroin users and addicts because it involves 'normal samples', unlike most samples collected from court or treatment records, which heavily over-represent the most intractable cases, these samples consisted of those who had not been selected for any quality correlated with the difficulty of cure.

However, Burroughs' (1977:116-117) warned that;

'An addict may be ten years off the junk, but he can get a new habit in less that a week; whereas someone who has never been addicted would have to take two shots a day for two months to get a habit at all. I took a shot daily for four months before I could notice withdrawal symptoms... why does an addict get a new habit so much quicker that a junk virgin, even after the addict has been clean for years? I do not accept the theory that junk is lurking in the body all that time - the spine is where it supposedly holes up - and I disagree with all psychological answers. I think the use of junk causes permanent cellular alteration. Once a junky, always a junky. You can stop using junk, but you are never off after the first habit.'

Genetic predisposition has also been identified as a contributing factor toward heroin dependence (Barlow & Durand, 1995). Several scientists have postulated a biochemical mechanism to explain the 'craving' phenomenon. According to this theory, heroin use causes a permanent change in the biochemistry of the addict, which persists long after withdrawal symptoms have dissipated. This results in periods of tension, depression, anxiety and craving for heroin - all of which make it virtually impossible to effect a permanent cure. It has been noted that heroin tolerance seems to build up faster in a former dependant than in a neophyte. The impression is also held that becoming dependent is much easier the second time around. However, a substantial number of heroin dependants have been 'cured' despite these alleged changes (Kaplan, 1983; Burroughs, 1977).

Neurobiologists have long known that the euphoria induced by heroin activates the brain's reward system. New research indicates that chronic heroin use can induce changes in the structure and function of the system's neurons that last for weeks, months or years after the last 'hit'. These adaptations, can perversely, dampen the pleasurable effects of a chronically abused substance such as heroin, and also increase the

cravings that trap the addict in a destructive downward spiral. During prolonged heroin use, and shortly after use ceases, changes in the concentrations of cyclic AMP and the activity of cAMP response element-binding protein (CREB) (a protein that regulates the expression of genes and overall behaviour of nerve cells), in neurons in the reward pathway predominate. These alterations cause tolerance and dependence, reducing sensitivity to the drug and rendering the dependant depressed and lacking motivation. The more prolonged abstinence changes the delta FosB (a protein) activity and glutamate signalling predominance. These actions seem to be the ones that draw a drug dependant back for more, by increasing sensitivity to the drug's effects if it is used again after a lapse, and by eliciting powerful responses to memories of past highs and to cues that bring those memories to mind (Nestler & Malenka, 2002).

Many medical scientists believe that the root of addiction and dependence lies in the way the brain processes dopamine and serotonin, two neurotransmitters in the brain. Both trigger sensations of pleasure, happiness and serenity that produce a natural high. In addictive personalities, these scientists say, dopamine and serotonin are too rapidly re-absorbed by the brain after release. This means the high is short-lived. Desperate to redeem it, addicts turn to artificial substances such as heroin. It's regarded as a biochemical compulsion, the cure for which is to locate the biochemical key that slows down the re-absorption or uptake rate. Despite progress into all sorts of plants and potions that facilitate this process, no cure for addiction has been found (Dugmore, 2005).

In contrast to mainstream views, Kaplan (1983) argues that even in its classic form (i.e. a high purity level), heroin withdrawal is not *that* serious. Pharmacologists compare it to a bad case of the one-week flu. The person will experience considerable pain and discomfort, but not so serious that it cannot be borne by someone with considerable determination, especially if the person knows that the pain will be tolerable. Many heroin dependants go through withdrawal with no pharmacological help at all. They simply go to bed, telling their friends and family that they have flu, and suffer in relative silence.

Although there are reports of nonaddicted and nondependent, weekend users who have used heroin for years, they are often regarded merely as on their way to addiction and dependence. Though this certainly does happen, it is now known that it is by no means inevitable. In fact, occasional recreational use, known as *chipping*, is much more common than compulsive, addicted and dependent use. These 'successful', nonaddicted/nondependent users tend to abide by rigid rules that control their drug use. Some individuals use only on weekends and in groups of other such users who provide support to each other in limiting intake (Pearson, 1987; Kaplan, 1983). An almost universal rule among such groups is to shun addicts as they attract the attention of the police and because they threaten the values of the controlled user (Kaplan, 1983). For controlled use of heroin to be sustained over any length of time there must be other commitments in the person's life which compete with the demands of heroin (Pearson, 1983). Thus, in an area of mass unemployment, it might be expected that heroin misuse would quickly assume a pattern of epidemic growth once it becomes available in a locality simply because in the absence of any realistic promise of work commitments, which provide a major means by which people fashion self-esteem, meaningful identity and constructive routine time-structures, controlled use becomes more difficult. In the absence of constructive routines and structures of meaning and identity, such as might be supplied by work commitments, it is more difficult to 'stay clean' and 'come clean' from heroin. Studies have indicated that heroin dependant has to

break out of the heroin dependant routines and replace them with alternative patterns of daily activity (Pearson, 1987; McIntosh & McKeganey, 2002).

2.4.1.3 Health consequences of heroin use and HIV/AIDS risk

Heroin use holds a number of implications for the health and well-being of the user. The depressant action of heroin on the CNS places the user at risk for an overdose and pulmonary complications, such as pneumonia and tuberculosis. Research commissioned by the WHO estimated that globally for the year 2000 a median estimate of 69 152 deaths could be attributed to opioid overdose (Plüddemann, *et al.*, 2004).

According to Garrick, Sheedy, Abernthy, Hodda & Harper (2002) data from the Australian Bureau of Statistics indicates that in 2000, a total of 737 deaths attributed to opioid overdose occurred among persons aged 15 to 44 years (*National Drug and Alcohol Research Centre*, 2000). A review of all forensic cases from July 1995-February 1997 in Sydney, Australia, found that 4% of all cases were related to drug overdose and 80% of these were related to heroin (cited in Plüddemann, *et al.*, 2004). A retrospective analysis of the deaths of over 2 700 heroin injecting drug users (1985-1998) in Italy showed that 37% were due to overdose and a further 33% were due to AIDS (Plüddemann, *et al.*, 2004). Non-fatal overdose may also have consequences including paralysis, seizures, nerve palsy, peripheral neuropathy and cardiac arrhythmia, many of which result in a lifelong compromise of health and well-being (Strang, 2002).

For years heroin users have been aware of the many and varied dangers of intravenous heroin use, and amongst these have been infectious diseases. Intravenous drug use, through the direct and indirect sharing of injection equipment, is a well-known risk factor for the transmission of blood-borne viral infections, such as HIV, hepatitis B, C and G. Also bloodborne viral transmission of hepatitis has been noticed in close communities of IDUs (injection drug users) but its consequences are less severe than AIDS and most recover. During minor epidemics of hepatitis, people are often more careful about sharing needles and syringes and confine themselves to a restricted circle of apparently safe individuals. The primary mode of spread of the AIDS virus in intravenous heroin users is the use of contaminated equipment. In drug using circles, sterile needles and syringes can be in short supply. There is, however, considerable variation from country to country, and from city to city (Robertson, 1987; Pearson, 1987).

The use of heroin also holds important implications for public health. The United States Centers for Disease Control reported that in 1999, 5 932 AIDS-related deaths occurred in the United States that were attributed to IDU. NIUs (non-injection users) are also at increased risk for contracting HIV and hepatitis due to the high risk sexual behaviours associated with patterns of drug dependence and the possibility of NIUs becoming IDUs as heroin dependence develops and users seek a more efficient means of administering the drug (Plüddemann *et al.*, 2004).

Another factor that makes the presence of AIDS in this population group in South Africa difficult to verify is the fact that the presence of intravenous heroin use and AIDS in this community is relatively new (Plüddemann *et al.*, 2004). The limited evidence available suggests a transition from smoking to injecting as a route of administration among some heroin users. SACENDU findings report that intravenous use by patients with heroin as their primary drug of abuse seems to be increasing, with the proportion of patients reporting injection drug use increasing from 29% in the second half of 1999 to 51% in the second half of

2001 in Cape Town, however decreasing again to 44% in the second half of 2003. In Gauteng the proportion of heroin patients reporting injection has increased steadily from 36% in the second half of 2001 to 49% in the second half of 2003 (Plüddemann *et al.*, 2004). The long incubation period between acquisition of the virus and the onset of symptoms also makes detection and prevention extremely difficult. An infected person may remain symptomless for four or more years, depending on other factors, before developing symptoms of the illness. During this period, intravenous drugs may still be used and needles shared, thus spreading the infection rapidly. Such a group may have many contacts with other smaller or larger groups in the immediate vicinity, or in fact at any distance, and distribution of the virus could be rapid (Robertson, 1987).

In a study conducted by Robertson and Bucknall (cited in Robertson, 1987), retrospective testing of samples taken to look for evidence of hepatitis, showed that the AIDS virus was introduced into the Edinburgh community of intravenous drug users in or around August 1983. By March 1985, 50% of over 150 intravenous drug users were known to be infected. In addition, some had no recent blood sample available for testing, so if all these were positive, then the total would be 84% positive. Robertson estimated an 85% prevalence rate for HIV amongst intravenous drug users in Edinburgh in 1986. This rapidity of spread is likely to occur in any group sharing equipment in a similar way. In neighbouring Glasgow, the rate was less than 4%. The major difference between the two cities was the availability of needles and syringes. With the improved availability of treatment and the access to clean injecting equipment the prevalence of HIV in Edinburgh has dropped dramatically (<http://www.substancemisuse.net>).

The spread of HIV/AIDS in heroin dependants is not only attributed to intravenous use. Infected users, particularly the young and single, are likely to spread the virus to the wider population through sexual contacts. The tendency of some heroin users, particularly females, to finance the habit through prostitution, further enhances the likelihood of HIV spreading to the wider community through this transmission group (Parker, Bakx & Newcombe, 1988).

At present, the prognosis for those infected with HIV is highly uncertain. It may not be that all infected will develop full-blown AIDS. It is, however, also possible that all those infected will eventually become ill. Much remains to be learnt about what causes the infection to lead to illness, and there is reason to believe that the reduction of stress and of further challenges to the immune system may do much to defend an infected person's health. However, intravenous heroin users are poor candidates of such palliatives. The heroin dependants self-neglect is likely to diminish survival chances (Kohn, 1987; Robertson, 1987).

2.4.2 Heroin pharmacology

The production of heroin begins when raw opium is dissolved in heated water 'purified' by the addition of lime salts, which precipitate out organic waste leaving a suspension of morphine. Following filtration and re-heating, ammonia is added as a precipitant, and the morphine is re-filtered. The synthesis of heroin from the morphine base involves many steps, requires a laboratory, and may take up to 24 hours to complete. The morphine base is treated with acetic anhydride in equal amounts and heated for six hours with subsequent conversion to heroin (diacetylmorphine). Treatment with chloroform to remove impurities is followed by precipitation of heroin with sodium carbonate; this step is repeated several times until the

desired purity is achieved. The resulting substance is cocoa in colour and is bleached with activated carbon and alcohol, then neutralised with hydrochloric acid with conversion to hydrochloride. The heroin is then baked and sifted, and may be ninety percent free from impurities. Alternatively, the morphine base may be initially treated with acetone, bleached and purified prior to the addition of acetic anhydride to produce heroin (Stimmel, 1975).

If injected, heroin is rapidly diacetylated at the 3 position to 6-monoacetyl morphine (MAM), which in turn is 6-diacetylated to morphine at a slower rate. Levels of MAM are detected within minutes after injection and are followed shortly thereafter by the appearance of morphine in increasing concentrations. This indicates that diacetylation of heroin probably precedes its specific pharmacologic effect with MAM and morphine becoming subsequently responsible for most of its pharmacologic effect. Within a short period of time, cerebral levels of heroin are not present although the pharmacologic action of the drug continues unabated. Heroin appears to have a greater lethal effect than morphine when used parenterally. This may be due to the greater ability of MAM to transverse the blood-brain barrier due to its increased lipid solubility (Stimmel, 1975). When injected, heroin reaches the brain before it is converted into morphine, and it is this fraction that accounts for heroin's greater power (Kaplan, 1983).

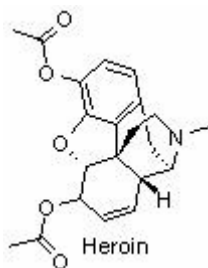


Figure 2.24 The chemical structure of heroin

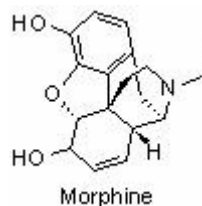


Figure 2.25 The chemical structure of morphine

Source: <http://www.chemicalforums.com/index.php?page=molecules>

Opioid receptors have been demonstrated in all the vertebrates. This alone suggests that they have some important role in the normal functioning of organisms. Research has identified opioid-like peptides, such as enkephalins and endorphins. Both enkephalins and endorphins have opioid-like effects. These substances are critically important in modulating pain and in the mechanisms of reward. Given the crucial role of reward, motivation and emotion in learning and information processing generally, it therefore seems likely that the endogenous opioids affect even the highest cognitive functions. Under natural conditions, the releasing stimuli for the endogenous opioid system are probably emotional. Exogenous opioids like morphine and heroin presumably operate by taking the place of endogenous opioids at the opioid receptors. Such unnatural ligands cannot match the fine tuning that the system shows when it operates under natural conditions, using its own endogenous chemicals. The effect of exogenous opioids is gross and inflexible. Since their administration is under external rather than situational control, opportunities for 'misuse' is much greater (Krivanek, 1988).

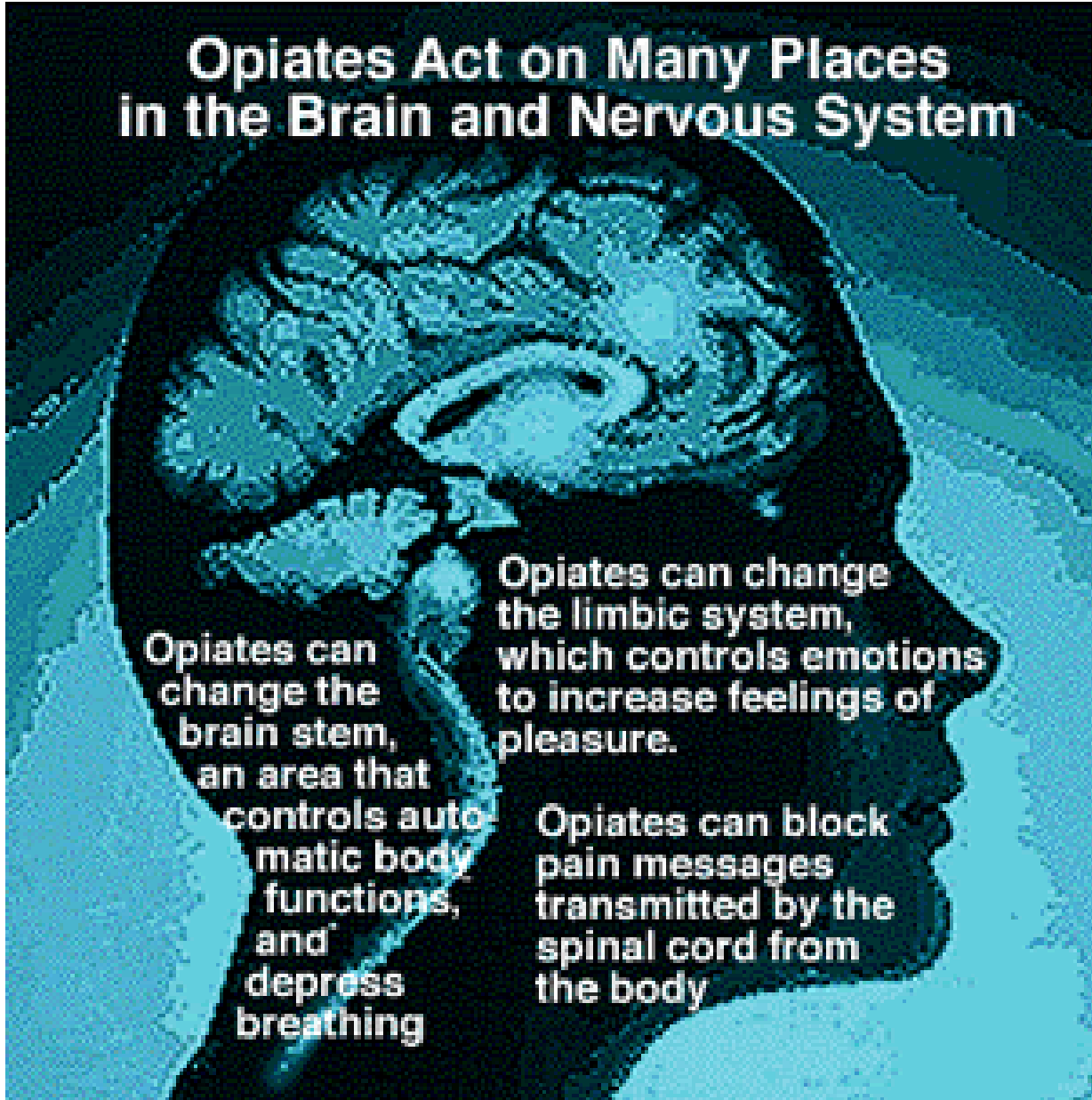


Figure 2.26 The effect of opioids on the brain and nervous system

Source: <http://opioids.com/images/index.html>

2.5 PHARMACOLOGICAL INTERVENTION FOR HEROIN DEPENDENCE

For some individuals, general support, encouragement and understanding of the symptomatology may suffice, enabling symptomatic relief of heroin withdrawal without medication. As indicated, studies of self-recovery by heroin dependants' show that shifts in identity and lifestyle, together with changes in the individual's environment, are important in the pathway out of dependence. For others, however, a history of serious withdrawal complications, a lack of social support or other problems, may make substitute prescribing a viable option. Withdrawal symptoms may also differ depending on the pharmacological profile of the heroin dependant. The severity of heroin withdrawal symptoms are also not clearly related to the quantity of heroin taken. When assessing withdrawal, for the purposes of dose titration, it is better to place greater weight on observable signs rather than subjective symptoms. Untreated heroin withdrawal typically reaches its peak 36-72 hours after the last dose and symptoms will have subsided substantially after five days (*Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland, 1999*).

2.5.1 Treatment of heroin withdrawal syndrome with opioids/substitute opioids

2.5.1.1 Heroin maintenance

Legally sanctioned clinics dispensing narcotics existed in the United States and in the United Kingdom. With the United States' Harrison Act of 1914, the Department of the Treasury moved to eliminate suppliers of narcotics. Realising that the sudden confiscation of large amounts of opioids would create an extreme hardship and panic among opioid dependent persons, the Department urged the creation of special clinics to detoxify those individuals who could no longer obtain narcotics from their usual source. A maximum of 15 grains of morphine or heroin was usually prescribed. The initial dose was then decreased by a half-grain every other day until some discomfort was experienced. The patient would then be offered the choice of hospitalisation for the remainder of the detoxification or completely withdrawn on an ambulatory basis (Stimmel, 1975).

In the United Kingdom, guidelines were subsequently established under which specially licensed physicians could detoxify heroin dependants or provide long-term treatment in instances where narcotic use or provide long-term treatment in instances where narcotic use enabled continued functioning and previous detoxification and all other treatment was unsuccessful (Kenny, 1999). Physicians prescribing narcotics notify the Home Office, which then enters the heroin dependant individual's name in a central index or register. This register is a means of recording the number of heroin dependent persons undergoing treatment in the United Kingdom and has continued to do so up to the present time; returns are submitted to the WHO. With the Dangerous Drug Act of 1967, clinics were established for dispensing of prescriptions for heroin and other narcotics, as well as rehabilitative services. Those who enrolled in the clinics were reported to the central register. There is no specific system; each clinic differs with respect to approach, staffing and effectiveness in rehabilitation (Stimmel, 1975).

The first clinical trial in Switzerland, of prescribing heroin to chronic, long-term heroin dependants, began in 1994 and ended in 1996, it reputed to have reduced by half the number of drug-related deaths in Switzerland. Deaths from AIDS-related illness also began to fall substantially from 1994 (Kenny, 1999).

Almost all of the major medical complications of heroin use relate either to drug impurities or unsterile techniques of injection. Pharmacologically, pure heroin, used clinically, has no more harmful effect than any other opioid; heroin can be used in similar conditions for which morphine or other synthetic narcotics are administered. However, heroin does display certain distinct advantages over morphine - it is more potent and can provide relief of pain more rapidly with minimal emetic sequelae; it has been used as an antitussive, in terminal cancer patients, in acute myocardial infarction, and in pulmonary edema as well as in general analgesia. The reason for this is individual variability - both between the drugs, with respect to the several effects they as a class have in common, and between the patients, with respect to each one's unique physiology and psychology. While there is evidence that some patients respond better to heroin than to other opioids, there is no way to predict who these will be (Krivanek, 1988).

However, as discussed previously, with continued administration heroin does produce increasing tolerance and marked physiologic dependence. Although maintenance on a fixed level of heroin is possible, if euphoria is the desired goal, increasing doses must be prescribed. In addition, injections must be taken at least two to three times a day to prevent withdrawal symptoms. This necessitates the user either having to return frequently to the dispensing clinic for injections, or the writing of prescriptions for outside administration. Once heroin is self-administered, debilitate complications are likely to begin to appear such as hepatic cellular damage as determined by liver function, septicaemia and abscesses at injection sites, these conditions can be attributed to unsterile injection techniques. The reason for this is not likely to be of ignorance of sterile techniques when injecting, but rather the presence of underlying personality disturbances associated with strong feeling of self-destruction seen in most heroin dependants. However, it can be argued that there are a number of persons dependent on heroin that has rejected all forms of available therapy (Krivanek, 1988; Stimmel, 1975). These individuals might well benefit from heroin maintenance if only to free them from the legal hazards associated with illicit heroin use and it is possible that the heroin offered may serve as the initial step in reaching such people.

Heroin maintenance would also eliminate a black market in drugs that reaps huge profit for underworld organisations (Stimmel, 1975). The problem of diversion (heroin leaking into the black market) would be real but not necessarily that significant. In the United Kingdom, where heroin may be legally prescribed, physicians use approximately 3kg of heroin for every 7kg of morphine for pain management. Assuming that United States doctors were to prescribe similarly, in 1982 they would have used a hypothetical 228kg of heroin, since their actual morphine use for that year was 533kg. In 1982, the estimated consumption of illicit heroin in the United States was 228kg of legal heroin to be somehow diverted into the black market and this would amount to only 2.9 per cent of what was already being consumed illegally (Krivanek, 1988).

2.5.1.2 Methadone

Methadone, sometimes called by its trade name *Physeptone*, administered in descending doses of a reduction programme, has been used to reduce the degree of tolerance to and dependence on heroin. For

some people it can work, and they are able to 'come off' heroin without any of the distressing symptoms associated with cold turkey. However, it can also lead to a recurring cycle of abstinence and relapse, because although a methadone-reduction course solves the problem of 'coming off' heroin, it does nothing to address the more difficult accomplishment of 'staying off' heroin (Pearson, 1987). After either cold turkey or detoxified withdrawal has been completed and all the marked physiologic features of acute abstinence have abated, physiologic features of prolonged or secondary abstinence persist. These features may or may not be related to the yet undefined biochemical or physiologic/metabolic abnormalities that underlie the state of craving in the abstinent individual (Stimmel, 1975).

In Eric Detzers' *Poppies: Odyssey of an Opium Eater* (1988), the author, who practised as a psychiatric social worker, recounts his personal eighteen-year dependence on opium. Detzer reports that during World War II, the Germans cut themselves off from the Turkish poppy fields, just when they needed morphine for their fallen soldiers. Malkinckrodt Laboratories synthesised methadone hydrochloride and named it 'dolophine' after Adolf Hitler, but it is also said to be derived from 'dolor', the Latin word for grief (Kenny, 1999). In the 1960's, during a heroin abuse epidemic in the United States, Dr Nyswander and Dr Dole resurrected methadone. They discovered that if they gave opioid dependants enough methadone (dolophine), they stopped taking heroin, and to quote Denzer (1988: 34);

'They'd line them up at their clinic and pump 150 to 200 milligrams apiece into them - roughly enough to kill the entire French Foreign Legion. When these junkies tried to shooting a little of the six percent street dope into their opiate-saturated bodies, nothing would happen. Nyswander and Dole heralded their treatment as a "cure" for narcotic addiction, as moronic medical history repeated itself. When methadone inevitably turned up for sale on 125th and Lexington, Drs Nyswander and Dole quietly retired to New England.'

The basic concept developed by Dr Dole (and which underlies the use of pharmacologic maintenance for heroin dependence) is that heroin craving is due to an as yet undefined biochemical abnormality caused by the drugs themselves and is independent of rehabilitation. The primary effect of methadone as used in chronic maintenance treatment is the ablation of drug craving and the establishment of a sustained normal state during which rehabilitation may be carried out (Stimmel, 1975). Not only may it replace heroin use so long as the dependant stays in this treatment, but it may also be part of a longer and more difficult process whereby the dependant eventually ceases all opioid use (Kaplan, 1983). A second effect of high-dose methadone treatment is to blockade any euphoric effects that might otherwise occur from the self-administration of heroin or similar short-term narcotics. Moderate doses of methadone, 40-60mg per day, are needed to achieve the primary effect. However, the specific dose will vary according to the degree of dependence that exists. The blockading effect is assured only by higher doses of 80-100mg per day, this higher dosage has been found to be more effective in reducing heroin use than treatment with a moderate dose of 40 to 50mg per day (Zickler, 1999). According to Kaplan (1983), methadone does not in fact 'block' the euphoric effects of heroin. The belief probably gained currency because many of the early methadone patients attempted to get high on heroin but failed in their attempts. Their use of relatively large quantities of methadone had probably caused them to develop an increased tolerance to the euphoric effects of heroin, and the relatively low dosage of heroin that they used was insufficient to overcome their tolerance. Simply using a larger dosage of heroin could surmount what was thought to be a 'blockade'. A heroin dependant maintained on methadone knows that he or she can gain an euphoric effect from heroin provided that a large dosage is used.

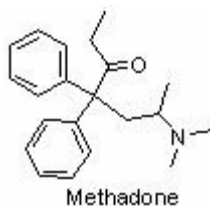


Figure 2.27 The chemical structure of methadone

Source: <http://www.chemicalforums.com/index.php?page=molecules>

Methadone becomes effective within 30 minutes after oral ingestion, and its duration of action in a tolerant individual is 24-36 hours (Zickler, 1999). No euphoria or narcotic effect is experienced after the oral ingestion of a dose of methadone, unless the dose administered exceeds the degree of tolerance of the individual. Thus methadone can be administered orally, has a long duration of action, its effects last for a little over twenty-four hours - about four to six times as long as that of heroin (Kaplan, 1983) and is pharmacologically quite different from heroin when used in a tolerant individual (Stimmel, 1975). The requirement that methadone must be taken orally can free the addict from his dependence upon intravenous use by removing the temptation to take the drug by a more euphoric, though less therapeutic, route (Kaplan, 1983). In the non-tolerant individual, methadone has acute effects similar to those of all short-acting narcotics such as heroin and morphine (Stimmel, 1975).

The methadone maintenance programme was particularly effective in treating United States soldiers who had become dependant on heroin during the Vietnam War. Within a year, over eighty per cent of these Vietnam veterans were clean of heroin use as a result of the methadone maintenance treatment. However, the Vietnam veterans who had become heroin dependent were not necessarily representative of the heroin dependants as exists at present. Soldiers in Vietnam took heroin as a psychological shield against the experiences of that war. Most veterans were keen and motivated to get back to normal life on returning home. The Vietnam veteran heroin dependants' recovery story shows how important a role social context play, both in the development of heroin misuse and in its reduction and elimination. The heroin dependant of society today is someone who has chosen due to personal or chemical vulnerability (Kenny, 1999).

Indeed, there has been increasingly international concern about the safety of methadone maintenance programmes. In addition to high rates of psychiatric morbidity, methadone maintenance patients also show cognitive deficits compared to matched controls. A history of alcohol dependence and repeated exposure to overdose, increases the likelihood of cognitive impairment (Darke, Sims, McDonald & Wicks, 2000). Zandor and Sunjic (2000) undertook a study regarding deaths in methadone maintenance treatment in Australia, they concluded that the first seven days of methadone maintenance treatment is a high-risk period and that inadequate clinical review of subjects' tolerance to methadone and/or subjects' use of other central nervous system depressant drugs probably contributed to most of these cases of deaths during induction. The findings from this study reinforce the importance of a thorough drug and alcohol assessment, cautious prescribing of methadone, frequent clinical review of patients' tolerance to methadone during induction and education about the dangers of additional drug use during this period. Disulfiram (Antabuse®) treatment may be an effective pharmacotherapy for cocaine abuse in methadone-maintained heroin addicts, even in heroin dependants without co-morbid alcohol abuse. Disulfiram inhibits dopamine β -hydroxylase resulting in

an excess of dopamine and decreased synthesis of norepinephrine. Since cocaine is a potent catecholamine re-uptake inhibitor, disulfiram may blunt cocaine craving or alter the 'high', resulting in a decreased desire for cocaine (Petrakis, Carroll, Nich, Gordon, McCance-Katz, Frankfurter & Rounsaville, 2000).

In a study conducted by Dr Raymond Byrne (cited in Kenny, 1999), it was demonstrated that the mortality rate of methadone in Dublin in 1998 was twice that of heroin. Many, such as the late Dr Judianne Densen-Gerber, a psychiatrist and lawyer who used to practice in the field of heroin dependence rehabilitation, stressed some serious criticisms against methadone. Dr Densen-Gerber (1973:186-187) stated in her recount of the 'Odyssey House' story that;

'It is my view that it (methadone) is useful in only a small percentages of cases and is far from the panacea that many believe it to be. In 1804 morphine was heralded as a cure for opium smoking. In 1904 heroin was heralded as a cure for morphine addiction. And now, we have methadone, another narcotic, which is heralded as a cure for heroin addiction. We are behaving like addicts, who never learn from experience. Already there are drug dealers who sell illegal methadone and people addicted to and overdosing from it. One wonders what is next. Another narcotic to cure methadone addiction? There are more than three thousand drugs of abuse. Do we intend to find a substitute for each? And then substitutes for substitutes?'

Regardless of political or moral issues that methadone provokes; a treatment of involving maintenance on an addicting drug does have several practical advantages. It places the heroin dependant under strong pressures to appear on a fixed schedule for their dose - which in itself adds a degree of stability in an often chaotic life (Pearson, 1987). It also appears that heroin use by those in methadone maintenance programmes does gradually decrease so long as they remain in their programme. Moreover, at each appearance of the heroin dependant, programme staff may monitor progress, in terms of work progress, urinalysis, assistance in finding employment, talking about the heroin dependants' problems etc. Since many heroin dependants in maintenance are willing to modify their behaviour to gain a methadone supply more easily and to secure other rewards, such treatment can have a major impact on behaviour modification. Often those in methadone programmes gradually lose their friends and contacts in the heroin-using community and their more regular lives tend to leave less place for heroin use (Kaplan, 1983). In an Amsterdam study, steadily increasing the methadone dosage in a harm reduction setting was useful in supporting intravenous drug users in the process of cessation of injecting and reducing the spread of the HIV infection (Langendam, van Brussel, Coutinho & van Ameijden, 2000). Furthermore, heroin dependants recruited on the street and offered free methadone maintenance treatment were more likely to enter and remain in treatment, even if they have never been in treatment before or claim not to want treatment (Kwiatkowski, Booth & Lloyd, 2000).

The fact that methadone is an opioid cross-tolerant with heroin also gives methadone the property of preventing the withdrawal symptoms of heroin dependence. As long as heroin dependants stay on methadone, they are in little danger of developing a compulsive run of heroin use. Since it is during such 'runs' that criminality of the heroin dependant is most likely to skyrocket, methadone is of importance in reducing the number of crimes perpetrated by heroin dependants. Furthermore, the increased tolerance to heroin that methadone maintenance produces can be viewed as a mixed blessing - the greater amount of heroin a dependant on methadone requires to get high, raises the price that must be paid per 'fix' and this factor could avert or lower the number of times the use of illegal heroin occurs. On the other hand, if the

dependant is going to use heroin occasionally, there is no social good accomplished by forcing the heroin dependant to raise more money than necessary in order to indulge their dependence (Kaplan, 1983).

2.5.1.3 Buprenorphine

Buprenorphine was first shown to have potential for use in the treatment of opioid dependence in 1978 (*Subutex®: Buprenorphine GP Product Brochure, 2002*). Buprenorphine is a mixed agonist-antagonist with unique properties that differentiate it from full opioid agonist such as heroin or methadone. Antagonists occupy a receptor but do not activate it. Antagonists may displace agonists in a dependent heroin user and provoke an immediate withdrawal syndrome. Buprenorphine acts as a partial agonist at the μ opioid receptor sites. There are several advantages to buprenorphine's partial agonist effects. Because its agonist effect at very high doses is less than that of a full agonist, an overdose with buprenorphine produces less severe respiratory depression than an overdose of a full-agonist opioid. A further potential advantage of buprenorphine is that, at least in principle, its mixed agonist/antagonist action may lead to less severe withdrawal syndrome than that associated with pure agonists such as heroin or methadone (Gossop, 2003), and has a reduced potential for dependence, tolerance and euphoria (*Subutex®: Buprenorphine GP Product Brochure, 2002*).

Buprenorphine has an effective duration of at least 24 hours. It is available as an 8mg sublingual tablet, and can be taken daily. In well-controlled studies it has been reported to be equivalent to 30mg of methadone. It is reported to have low euphoric effects at higher doses. There is interest in its use as an alternative to methadone maintenance and also in the management of opioid withdrawal as its mixed agonist/antagonist properties make it a potentially good agent for the management of heroin withdrawal. It is also reported to have lower overdose withdrawal since there is a 'ceiling effect' on the level of respiratory depression that it can cause (*Subutex®: Buprenorphine GP Product Brochure, 2002*). Buprenorphine is also reputed to have lower levels of physical dependence, so patients who discontinue the medication generally have fewer withdrawal symptoms than do those who stop taking methadone (*Practitioner, 2003*).

In the late 1980s, a wave of buprenorphine misuse in the form of injecting was reported in several parts of the United Kingdom, especially in Glasgow and the North of England (Sakol, Stark & Sykes, 1989). The ready solubility and injectability of buprenorphine makes it a substance that requires longer term supervised dispensing (*Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland, 1999*).

Buprenorphine is absorbed via the sublingual route, which means that patients have to be supervised for several minutes to prevent abuse of the drug. This process is not only time-consuming, but is expensive to maintain on a large scale. To circumvent the issue of the abuse of buprenorphine, a new combination of substitute drug has been devised, which combines buprenorphine and naloxone. Naloxone is an opioid antagonist that causes immediate and severe withdrawal symptoms when taken intravenously. However, it is inactive when taken orally. Clinical trials are currently being conducted to determine the most effective ratio of buprenorphine to naloxone, and are likely to result in a take home product with characteristics of low abuse liability, low diversion potential and diminished risk of overdose in non-tolerant patients (Gossop, 2003).

2.5.1.4 Methadone or buprenorphine?

For people dependent on heroin, the prescribing of substitute drugs is a very significant, albeit controversial, aspect of harm reduction that has become an integral part of many drug treatment strategies. Although abstinence remains the ultimate goal of substitute prescribing programmes, where this is not achievable interventions now focus on risk reduction, harm minimisation and intermediate service aims. The value of substitute prescribing has been argued that harm reduction initiatives, including substitute prescribing, lessen the social, medical and economic cost of illegal drug use to users and to society at large. Methadone remains the most common substitute drug used for the treatment of opioid dependence. Methadone has proved to be an effective substitute drug for opioid dependence for a number of reasons, including its long half-life resulting in it only having to be consumed on a daily basis, unlike heroin which has a short half-life thus having to be consumed numerous times a day to prevent withdrawal symptoms. As methadone is also available in liquid form it deters injecting behaviours, thus reducing the risk of disease transmission. Numerous researchers have produced compelling evidence that methadone programmes reduce the rates of illicit drug use, injecting behaviour, criminal behaviour, other HIV risk behaviours, overdose and death among treatment participants (James & Clark, 2006; Langendam *et al.*, 2000)).

Although methadone does have many positive attributes, over the years a number of negative factors have emerged. As mentioned earlier (see 2.5.1.2, p.56-57), one major problem associated with methadone programmes is the ease of which the methadone can be abused and in particular the ease of using it intravenously and methadone leaked from prescriptions has been reported to be heavily implicated in drug deaths (Kenny, 1999; Densen-Gerber, 1973). Methadone maintenance programmes have been associated with a number of problems including limited community and patient acceptance, and in general patients possess negative views of methadone and methadone programmes based on their own personal experiences as well as what is heard from others. Many studies have noted that among heroin users methadone has a bad reputation for greater addictiveness, side effects and overdose risk than heroin (James & Clark, 2006).

Alternative pharmacotherapies, such as buprenorphine, have been proposed to be more effective than methadone, and also cause less limiting hypotensive side effects and adverse events for the heroin user (*Practitioner*, 2003). Buprenorphine exerts sufficient opioid effects to prevent or alleviate opioid withdrawal symptoms, but produces a milder, less euphoric and less sedating effect than high doses of heroin or methadone. Buprenorphine has unusual properties in that it is a partial opioid agonist and a partial opioid antagonist; thus, there is a lower risk of overdose and an easier withdrawal process than methadone. Buprenorphine is also a safer substitute drug as it does not depress the central nervous system as severely as methadone; thus, death from buprenorphine alone is extremely rare (James & Clark, 2006). Auriacombe's (2001) (cited in James & Clark, 2006) study in France noted that the death rate per patient treated with methadone was 0.0007 compared with 0.0002 for buprenorphine. When put into context, these results show that if all of the patients receiving substitute prescriptions were on methadone then the death rate would have been 288 whereas if they had all been on buprenorphine the death rate would have been 46.

Buprenorphine also has a longer half-life than methadone so, potentially, dosing could be given three times a week as opposed to daily with methadone. Thrice weekly dosing reduces the costs of maintaining a heroin dependent person, as well as reduce the disruption caused to the life of the heroin dependent individual. Daily dosing of buprenorphine seems to combine effectiveness with patient convenience, and may carry some cost savings for the patient and the health system by reducing the frequency of attending for dosing and increasing the capacity of the treatment service. Research has established that buprenorphine blocks the effects of exogenous opioid administration, suppresses heroin self-administration and reduces the severity of withdrawing from opioids. The use of buprenorphine for medical withdrawal from opioids can serve to initiate and engage patients into continuing addiction treatment due to its shorter term medical withdrawal in comparison to longer term treatments such as methadone programmes (James & Clark, 2006). Furthermore, buprenorphine is reputed to be well accepted by pregnant women, and is associated with a low incidence of neonatal abstinence syndrome (Fischer, Johnson, Eder, Jagsch, Peternell, Weninger, Langer & Aschauer, 2000).

There have been numerous studies comparing the effectiveness of buprenorphine against methadone. However, the results are varied and in many cases inconclusive. Johnson (1992) (cited in James & Clark, 2006), compared doses of 8mgs of buprenorphine against 20mgs and 60mgs of methadone. It was reported that 8mgs of buprenorphine was superior to 20mgs of methadone and equal to 60mgs of methadone with regard to retention in treatment. Subjects in the buprenorphine and high dose methadone groups were noted to have similar numbers of opioid negative urine samples, and both were superior to low dose methadone. However, studies using higher doses of methadone (80mgs) have reported that methadone is superior to buprenorphine (8mgs). A number of randomised clinical trials have reported that buprenorphine and methadone are equally effective in the treatment of opioid dependent patients (James & Clark, 2006).

Ahmadi (2003) (cited in James & Clark, 2006) reported that the retention rate in treatment of patients on 8mgs of buprenorphine was 68.3% which was superior to the retention rate for patients on 30mgs of methadone which was 61%. However, an equivalent number of studies have reported inferior results for buprenorphine with regard to retention in treatment and opioid negative urinalysis (James & Clark, 2006; Schottenfeld *et al.*, 2000). Eder and colleagues (1998) noted that subjects on buprenorphine provided a greater proportion of negative urine samples. However, retention in the buprenorphine group was significantly lower than that of the methadone group. Interestingly, it was noted that buprenorphine was clearly more effective in the more motivated individuals in the study. The inferiority of buprenorphine reported in the aforementioned studies has been attributed to the dose of buprenorphine being too low, or a too slow induction onto low doses of buprenorphine. Meta-analyses studies have reported that there was relative equality in buprenorphine and methadone efficacy, although the participants on methadone were less likely to have opioid positive urine samples. It was also noted that those participants who had had past experiences with methadone were more likely to be drug free on the buprenorphine treatment (cited in James & Clark, 2006).

Meta-analysis of thirteen studies concluded that buprenorphine in flexible doses was less effective than methadone in retention rates in treatment. It was also reported that high dose buprenorphine does not retain in treatment more patients than low dose methadone, although it was found to suppress heroin use more effectively (James & Clark, 2006).

Buprenorphine treatment, as opposed to methadone, as a substitute drug takes less time to complete than methadone, and can be effectively administered thrice weekly, thus reducing the restrictions imposed by prescription collection (Gossop, 2000). As the time taken to complete buprenorphine treatment programmes is far shorter, heroin users may be more likely to engage and remain in buprenorphine treatment, in comparison to longer term treatments such as methadone programmes. The issue regarding the abuse of buprenorphine can also be overcome by the use of a combination of buprenorphine and naloxone which has properties that prevent intravenous use. The combination of buprenorphine and naloxone appears to provide the solution to the majority of the negative aspects of buprenorphine (James & Clark, 2006). However, variations between individuals in their specific pharmacotherapy requirements needs to be taken into consideration, and methadone treatment programmes (together with other pharmacotherapy interventions) could play an important part in treatment for some individuals.

2.5.1.5 Codeine-based drugs

Though there is little published literature, some medical practitioners use codeine-based substitute medications, including dihydrocodeine, either as the principle drug in treating heroin withdrawal (for persons already stabilised on a prescription of dihydrocodeine) or as an adjunct to a methadone withdrawal programme, where it may be used to counter withdrawal symptoms towards the end of a reducing methadone regime, usually when the methadone dose reaches around 15mg.

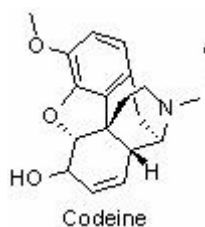


Figure 2.28 The chemical structure of codeine

Source: <http://www.chemicalforums.com/index.php?page=molecules>

However, there is concern regarding its widespread use abroad, and repeated tablet-taking, which is necessary due to the drug's short half-life, may reinforce patterns of drug-taking behaviour and prohibit change. Those with severe heroin dependence may require large quantities of tablets, which may give rise to concern over diversion (*Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland, 1999*).

2.5.1.4 Levo-alpha-acetylmethadol (LAAM)

Levo-alpha-acetylmethadol (LAAM), in an oral preparation, is a congener of methadone and is a longer-acting alternative which can be given once every two to three days, thus it has the advantage that it can be taken less frequently than methadone. The long-term effectiveness of LAAM with respect to reducing illegal drug misuse, criminality, HIV status and risk behaviours, appears to be comparable to methadone (Rawson, Hasson, Huber, McCann, & Ling, 1998). Consequently the discussion under 2.5.1.2, p.54 is also relevant in this case.

Due to a lack of funding, little research was carried out during the 1980s. The reasons for the lack of funding are in themselves interesting. In general, pharmaceutical companies tend to show little interest in the development of anti-addiction medications. There are virtually no market incentives and several disincentives for pharmaceutical companies to develop such medications. The cost of bringing any new drug to market can be very great, and only a few of the potential medications eventually appear on the market. Pharmaceutical companies may also be hesitant to develop addiction medications because of the stigma that many attach to them or their drugs, especially if the drug has other medical uses (Gossop, 2003).

2.5.1.6 Apomorphine

Apomorphine is obtained from morphine boiled in hydrochloric acid; it is regarded as a non-addictive metabolic regulator. For many years the only use for apomorphine, which has no narcotic or pain-killing properties, was as an emetic to induce vomiting in cases of poisoning. According to Burroughs, who underwent apomorphine treatment himself (<http://www.artdamage.com/wsb/testimony.htm>: 4);

'Apomorphine acts on the back brain to regulate the metabolism and normalise the blood stream in such a way that the enzyme system of addiction is destroyed over a period of four or five days. Once the back brain is regulated apomorphine can be discontinued and only used in case of relapse. No case of apomorphine addiction has ever been recorded.'

Toxic effects induced by heroin are associated with a decrease in intracellular dopamine (Oliveira, Rego, Morgadinho, Macedo & Oliveira, 2002) and a chronic deficiency in endorphins (Lotringer, 2001). Accordingly, those who suffer from a deficiency of these substances are prone to dependence in order to cover their metabolic requirement (Lotringer, 2001). In a study undertaken by Battaglia, Gesi, Lenzi, Busceti, Soldani, Orzi, Rampello, Nicoletti, Ruggieri and Fornai (2002), administration of apomorphine rescued damaged striatal dopaminergic terminals, and according to Lotringer (2001), also stimulates the production of endorphins. To date, only limited research by pharmaceutical companies has been undertaken regarding the use of apomorphine to treat the heroin withdrawal syndrome. Burroughs was of the opinion that a deliberate attempt had been made in the United States to mislead medical opinion and to minimise research and the value of this treatment (Lotringer, 2001).

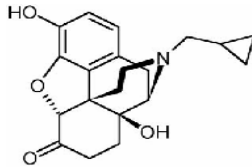
2.5.2 Treatment of heroin withdrawal syndrome with non-opioid substances

2.5.2.1 Naltrexone

Naltrexone is a non-addicting opioid antagonist. The opioid receptor blockade cannot be overcome even by four or five times the average daily heroin dose of most dependants. It is the only treatment for heroin abuse for which it is possible to give patients a virtual guarantee that if they take it regularly in the prescribed dose, they cannot become dependant on heroin (Kenny, 1999).

If the patient is not opioid-free, naltrexone will reverse the 'high', causing withdrawal symptoms. Any attempt to overcome the antagonism by taking opioids is very dangerous and can lead to fatal overdose. Naltrexone does not cause euphoria, therefore abuse potential is negligible, and is not associated with the development of tolerance. Naltrexone is also associated with reduced craving for heroin. At a twelve-month follow-up, significantly more patients, 64%, who received naltrexone than those who did not, 39% were opioid-free

(Gonzalez & Brogden, 1988). In a study conducted by Rothman, Gorelick, Heishman, Eichmiller, Hill, Norbeck & Liberto (2000), of heroin dependants facing a hypothesised 'protracted abstinence syndrome', characterised by dysphoric mood and produce by a physiologic abnormality, a combination of buprenorphine and naltrexone treatment improved the retention rate to 33%, as opposed to 10% retention generally reported for treatment with naltrexone alone.



Naltrexone

Figure 2.29 The chemical structure of naltrexone

Source: <http://www.chemicalforums.com/index.php?page=molecules>

Naltrexone can be given orally or as an implant. Naltrexone blocks opioid effects for up to 72 hours, thus it needs to be ingested only three times per week. 'Rapid' detoxification over 5 to 7 days utilising naltrexone to precipitate withdrawal symptoms can also be undertaken. It can also be administered as a general anaesthesia, or what is sometimes termed a 'sleep cure' (Kenny, 1999). However, the effectiveness and safety of rapid anaesthetic-antagonist detoxification as a treatment has not yet been established (*Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland, 1999*).

Naltrexone has been found to work well with highly motivated patients and when used under supervision. Studies have found heroin dependants with good social integration and social resources tend to respond well to treatment with naltrexone (Gossop, 2003).

2.5.2.2 Clonidine

Clonidine was originally developed for the management of high blood pressure and is an anihypertensive medication; still its primary use is to control high blood pressure. For this reason there is a need to monitor blood pressure and to modify or withdraw the treatment if symptomatic hypotension occurs. An internist happened to prescribe it to a narcotics addict who also had hypertension, within a few days it became clear that not only did it stop high blood pressure, but it also eased narcotic withdrawal (Detzer, 1988).

2.5.2.3 Lofexidine

Lofexidine is a non-opioid treatment for opioid dependence. Lofexidine hydrochloride is similar in action to clonidine, but causes much less hypotension. It can be used with supervision in residential and community settings. There is evidence to suggest that it is equally as efficacious as methadone in treating withdrawal symptoms (Bearn, Gossop, & Strang, 1996; Brown & Flemming, 1998; Carnwath & Hardman, 1998). Some medical practitioners use lofexidine prior to and during initial assessment, to control symptoms of opioid withdrawal and enable a full assessment to take place. It is also sometimes useful to control symptoms when a patient claims to have lost a prescription of methadone, instead of reissuing the methadone

prescription or refusing to prescribe. The treatment course is between 7-10 days. It is probably most likely to be successful for patients with an average daily heroin use (up to 1g per day of 50mg of methadone equivalent), non poly-drug users and those with shorter drug and treatment histories (*Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland, 1999*).

2.5.2.4 Psychotropic analgesic nitrous oxide (PAN)

Nitrous oxide has become well known as laughing gas, and is often used in dentistry as an anaesthetic and analgesic. Nitrous oxide treatment is regarded as a safe, rapid and effective treatment for opioid withdrawal. It works by stimulating the endorphin system, which is at the lowest ebb during withdrawal. The gas also stimulates other under-active systems, while depressing over-active systems. It has also been found that oxygen alone seems to have a beneficial effect, and in some cases the nitrous oxide is not needed. Anaesthesia is always avoided, when the correct technique and equipment is used - the nitrous oxide is given via a specialised unit that discontinues the nitrous oxide if the oxygen concentration in the mixture falls below thirty percent (Gillman & Lichtigfeld, 2004; James, 1998).

The administration of the gas can be given on an in-patient or outpatient basis. Generally, improvement with regards to withdrawal states is seen within minutes. The use of dependence forming medications are reduced by about 90% with negates the danger of secondary dependence and reduces the amount of costly medicines. Furthermore, the rapidity of recovery is reputed to enable physicians to distinguish those patients requiring intensive therapy from those who do not, since the majority of patients respond positively to one administration of the gas, usually on admission. Although rare, the only significant side effect is slight headache and nausea. The rapidity of the response enables the patient to abandon the sick role speedily and enter the essential next phase of the rehabilitation process, namely psychosocial intervention (Gillman & Lichtigfeld, 2004; James, 1998).

2.5.2.5 Other medications

There is a range of medications, some available over the counter, which can be used to reduce the physical effects of heroin withdrawal, for example:

Loperamide hydrochloride (Imodium), Co-Phenotrope (Lomotil) - used in standard doses for the treatment of diarrhoea.

Metoclopramide hydrochloride - used to treat nausea and vomiting, it may also be useful in the treatment of stomach cramps.

Non-steroidal anti-inflammatory drugs (NSAIDS) - used to alleviate muscular pains and headaches (*Department of Health, The Scottish Office Department of Health, Welsh Office, Department of Health and Social Services, Northern Ireland, 1999*).

2.6 PSYCHOSOCIAL THEORIES OF HEROIN DEPENDENCE

Although much of the relevant research emphasises various aspects in the recovery process, it seems that in order to fully understand the recovery process, one first needs to develop an understanding and appreciation of the nature of heroin dependence and how it develops. This need is highlighted by McIntosh and McKeganey (2002), who begin their work by examining the processes of becoming addicted and dependant, since they believe that an appreciation of the conditions and circumstances under which participants became addicted and dependant, is essential to gaining an understanding of the place of drugs in peoples lives, and some of the significant issues they had to address in giving them up.

The stereo-typical image of the modern user of opioids is that of the back-alley junkie. Although many heroin users are forced by their habit and 'criminal status' into such lifestyles, this is too narrow a view. Each person undoubtedly has his or her own path to abuse and dependence. Bateson (1972:314) theorised that;

'The individual's beliefs about what sort of world it is will determine how he sees it and acts within it, and his ways of perceiving and acting will determine his beliefs about its nature. The living man is thus bound within a net of epistemological and ontological premises which - regardless of ultimate truth or falsity - becomes partially self-validating for him.'

What kind of person becomes a heroin dependent? In my encounters, it has repeatedly struck me that these were among the most sensitive, intuitive and reflective individuals in our midst. They seem often to be people who feel the pain and suffering of humanity, and unable to bear what they feel, try to block it off. Kenny (1999:77) reflects that *'heroin is a sane reaction to an insane world'*. Certainly, the reasons for heroin use as a widespread phenomenon are varied, with the orgasmic totality of the rush, the over-all placid euphoria, peer pressure, availability, the hideous conditions of the inner-city, and a host of other factors coming into play, not to mention that once dependence is established, reasons may take a secondary place (Friedman, 1992).

The popular view is that people take heroin when unhappy, to flee from anxiety or to compensate for a permanent or temporary inability to cope with the real world. In reality, the first experimentation is usually an unplanned venture. Heroin is made available normally through a friend or a group, and on the spur of the moment an offer is accepted (Pearson, 1987; Krivanek, 1988).

Exactly why one person should copy the behaviour of another, and voluntarily adopt his/her attitudes and practices, is no clearer for heroin use than for religious conversions, but both are empirical facts. The evidence for friendship or peer group spread is now so overwhelming that it is no longer debated among serious researchers, but in spite of this certitude, there are still people who believe that new heroin use is the result of some deliberate marketing strategy, in which the dealers sell unwary innocents the idea of use as well as the drug itself. First and most directly, this phenomenon is known from the accounts of heroin dependants themselves (Hunt & Chambers, 1976; Elgie, 1998). Many never take it again. For those who do, the reasons for the second time are typically as normal and social as for the first (Krivanek, 1988).

A common view is that the pre-addict slips gradually into a level of use where he or she can no longer take it or leave it. *Physical dependence* develops, and it is the threat of withdrawal that maintains the behaviour from then on (Krivanek, 1988). Such a drift into addiction and dependence is observed in many individuals, but the importance of withdrawal is arguable. There are innumerable instances of physically dependent

persons who do not see themselves as drug dependants and who do not behave like conventional drug dependants (Kohn, 1987; Krivanek, 1988; Plant, 1999).

According to Krivanek (1988), there are three basic requirements for the development of heroin addiction and dependence. Firstly, the prospective heroin dependant is one who lacks sufficient reasons for abstaining. People can avoid conventional commitments by growing up outside conventional society. They can also do it by having nothing staked on continuing to appear conventional, that is, by having no job, reputation and so forth to lose. Or they may deliberately set out to appear unconventional. Heroin addicts and dependants of all three types exist. The second basic requirement for the development of an addiction and dependence is that the addict must be able to associate certain effects with the use of heroin. And finally, these effects must be highly positive, that is, they must fill a perceived need better or more conveniently and other readily alternatives. With all these three basics in place, the stage may be set for *psychological addiction*, and it is on this foundation that a chronic dependence on heroin may develop.

Heroin, as compared to cannabis, psychedelics and amphetamines, are affect diminishes. Heroin provides a blunting of affects and the chronic user is usually someone who will go to any lengths to turn himself off and avoid coming to terms with any psychological disequilibrium (Smith & Grey, 1972). Burroughs (1977: xvi) claimed that;

'Junk is not, like alcohol and weed, a means to increased enjoyment in life. Junk is not a kick. It is a way of life.'

It has already been suggested that a person's potential for heroin addiction and dependence is a function of susceptibility and exposure. Whether the behaviour continues will depend on the association of that behaviour with certain effects that are personally positive in the sense that they fill or remove an existing need. Susceptibility factors are therefore relatively more important in the maintenance of the addictive behaviour, because once the person decides that he or she wants heroin, exposure can usually be actively altered to make it possible. The degree of psychological dependence develops, that is, the movement toward addictive levels of heroin use, depends on the status of the need to use heroin being filled or removed and on the relative effectiveness of the behaviour in achieving this (Krivanek, 1988).

Friday (1992) presupposes that some people are by nature more contemplative, passive (White, 1999) and receptive. Such individuals are prone to heroin dependence when they have experienced serious frustration early in life and become one-sidedly receptive, passive, and closed off to their own potential for mastery and engagement in projects and tasks, resulting in the need to find fulfilment in passive, effortless ways. In the rejection of life as a task or challenge, the heroin dependent is not fully present in his or her life-world. Semi-presence or 'poor presence' narrows the heroin dependants perception such that the ultimate concern it to satisfy the dependence.

'As a habit takes hold, other interests lose importance to the user. Life telescopes down to junk, one fix and looking forward to the next, "stashies" and "scripts", "spikes" and "droppers." The addict himself often feels that he is leading a normal life and that junk is incidental. He does not realise that he is just going through the motions in his non-junk activities. It is not until his supply is cut off that he realises what junk means to him.' (Burroughs, 1977: 22-23)

Many heroin dependants clearly indicate their narrowed perception of the world when talking about how, for them, there is no interest, no desire to work at anything that does not provide an avenue to narcotics. No desire to travel and to see places outside the main drug capitals, no desire to have relationships with people

who are not heroin or drug dependants and/or a heroin source, and no desire for conversation outside the realm of heroin trafficking and heroin use (Friday, 1992).

The heroin dependants' goal is frequently a state of nothingness - the best feeling is no feeling. Heroin's ability to neutralise emotions, to relieve feelings of isolation, and to make the user feel that they can manage life is underlined again and again (Kenny, 1999). People seeking an increase in affective states, on the other hand, more often abuse cannabis, psychedelics and even amphetamines. These people are more interested in exploring the meaning behind their drug fantasies (Smith & Grey, 1972).

However, this view of heroin misuse as a passive, escapist activity has subsequently been challenged and a more active view of heroin user's life-style has been developed both in terms of the pursuit of pleasure and status. Narcotics could serve as a means by which 'action-seeking' youth can demonstrate their claims to manhood, or be seen as a resourceful entrepreneur (Pearson, 1987)

The experiences of heroin seem to be remembered in a similar way, particularly in the early days of use. The warm bath, the removal of all emotional pain, embarrassment, guilt and rejection. To be sure, recovering heroin dependants emphasise that this period only lasts a short time, and that after dependence sets in, the pattern of dependence, secretiveness, boredom, marginalised living and criminal activity is established. The elusive first hit is pursued repeatedly, even when there are no veins left, and the chronic heroin dependent (if he/she survives) knows well that the ultimate high can never be experienced again. Heroin becomes more like a dose of insulin to a diabetic - something the body begins to crave just to stay in a state of normality (Kenny, 1999).

In terms of the development of heroin addiction and dependence, McIntosh and McKeganey's (2002) findings echo those of other research, reporting a typical finding of experimentation with softer drugs in early teens followed by a progression to more powerful drugs, such as heroin, and regular use in later teens/early twenties. The main reasons for participants' initial drug and later heroin use were curiosity and a desire to comply with the expectations of others, especially peers, although taking drugs, and specifically heroin, in order to cope with problems in their life was also a factor for a small minority. In terms of the progression to regular heroin use, participants offered a combination of explanations/factors influencing this transition including an unconscious 'drift' rather than as a result of a deliberate decision, the influence of relationships or peer groups who provided opportunity and encouragement to use heroin more regularly, boredom resulting from unemployment or poor recreational activities, to cope with life problems and escape from reality, or to overcome feelings of personal inadequacy such as shyness or lack of confidence. In contrast, participants' escalating heroin use was driven by a continuing desire to experiment and find new 'highs', as well as the need to satisfy heightened tolerance thresholds (McIntosh & McKeganey, 2002).

According to McIntosh and McKeganey (2002), recognition by individuals that they were dependent could take anything from a few weeks to several months, depending on the heroin dependants ability to support their habit. Recognition usually came with the experience of withdrawal symptoms and the realisation that they needed heroin to function normally, which often came when they were deprived of them for some reasons, such as a lack of money. Occasionally, family/friends would inform the heroin dependant that they thought they had a problem, although this was less common than one might expect. It is also clear from the

study, that once heroin addicts became dependent their lives became dominated by the need to feed their habit, with the need to obtain money becoming their overriding preoccupation. Often this led to lives involving manipulation and deception of others, and engaging in crime such as theft/shoplifting. Much of the sample also ended up spending a period in prison, and experiencing deterioration in health as a consequence of their use.

Els and Jonker (2000) identify a dysfunctional family system or serious traumas as usually the starting point for possible involvement in drug dependence. There is also mounting evidence that children reared in chemically dependent families are more likely to develop substance abuse problems themselves, suggesting the potential for continuation of substance abuse patterns into successive generations (Sheridan, 1995; *American Psychiatric Association*, 2000).

In a study conducted by Aloni and Balconi (2002), communication organisation of speech and the mental representations of the attachment experience in fathers with a heroin dependent young son, reveals the possible contribution of discourses, such as affective deprivation, resulting in relational neglect. Initially heroin offers the dependent hope that they have found the perfect parent who will meet needs that the user has had for many years, resulting in a symbiotic relationship. Clinical observation seems to show such a pattern with some types of heroin use – those, in which there tends to be exclusive heroin use, rather than poly drug use, and those in which the drug use is symptomatic and dependent use rather than experimental use. Heroin ultimately neglects the dependant, because it fails to provide long-term physical and emotional support (White, 1999). However, Pearson (1987) affirms that modern day users are much more likely to come from intact families, with whom they have retained close links, even if these links have become strained. Indeed, this signifies one of the most significant differences between the new heroin users and the former generation, when heroin use was associated more with the bohemian and counter-culture.

People are also influenced by curiosity, the desire to fit in and for acceptance, boredom, societal tendencies, negative self-concept, physical and/or emotional abuse (Els & Jonker, 2000). However, socialisation variables can be culture dependent, for example, Anglo youth are more likely to group into close-knit peer clusters where very similar attitudes toward drugs and similar levels of use are likely to emerge. In contrast, American Indian youth may use drugs in more varied contexts and in more heterogeneous groupings (Swain, Oetting, Thurman, Beauvais & Edwards, 1993).

Els and Jonker (2000: 174) identify the cycle of addiction and dependence as follows:

- * *A person experiences a major life trauma; experiences ongoing emotional pain from unresolved family issues, or any combination of these.*
- * *Old negative messages repeatedly passed on during childhood are recalled.*
- * *The negative messages provide the fuel for establishing a base of shame.*
- * *The shame leads to a low self-concept.*
- * *The continual sense of a low self-concept leads to emotional pain.*
- * *A way to resolve this pain is sought; thus an addictive agent is sought.*

- * *The addictive agent is found to bring relief from the emotional pain.*
- * *The addictive agent carries with it negative consequences or fallout.*
- * *Frequently this fallout involves the violation of the person's value system.*

Louw (1992: 341-391) distinguishes the addiction process progress as follows:

Experimental use

The user learns that:

- * *Chemicals can provide a temporary mood swing in the direction of euphoria.*
- * *Chemicals ensure this mood swing with every intake.*
- * *The mood swing can be regulated by the intake of this chemical.*

Taking control of use

The user:

- * *Applies what he or she has learnt during the experimental phase, in all social and life situations.*
- * *Develops self-imposed rules about the use of chemicals and adheres to them.*
- * *May sporadically suffer from a hangover, as a result of the overuse of chemicals, but experiences no significant emotional pain.*
- * *Is a classic 'social user'.*

Beginning to lose ground

A user becomes an abuser when the chemical is employed to relieve tension, stress and fears or to boost self-confidence. The abuser starts to rely on the chemical in order to handle situations in life, which in turn heightens the importance and the value thereof in his/her life. The increasing dependence to cope leads the person, when under the influence, saying or doing things that are not in line with his/her fundamental value system. When this happens, the person cannot turn back to the normal situation, but experiences pain such as remorse, embarrassment or hurt. To ease this emotional pain, he increases his intake of the chemical. This is the start of the downward spiral.

The following symptoms are indicative of dependence:

- * *Uses the chemical too fast.*
- * *Is deceptive with regard to use.*
- * *Uses chemicals in advance to events involving using.*
- * *Experiences memory blanks or blackouts.*
- * *Rationalises.*
- * *Denies any problem.*
- * *Avoids talking about any use.*
- * *Minimises use.*
- * *Behaves in a grandiose manner.*
- * *Displays erratic behaviour/rapid mood changes.*

- * *Experiences that others disapprove of use.*
- * *Experiences loss of control over limiting use.*
- * *An attempt to prove that no problem exists.*
- * *Displays decreased interest in work, hobbies, friends or school.*

Using drugs to feel normal

As the individual continues with behaviour such as blaming, rationalising, lying and minimising to justify conduct and ease emotional pain, all relationships are affected and damaged. This in turn leads to further emotional pain. What is usually seen as 'normal' is reduced to the level where the person has to use the chemical to survive emotionally as opposed to euphoria.

Symptoms include:

- * *Same symptoms as early phase, only increased and intensified.*
- * *Change in personal relationships.*
- * *Promises to cut down or change.*
- * *The shame leads to a low self-concept.*
- * *Self-pity.*
- * *Employment or school problems.*
- * *Physical deterioration.*
- * *Hopelessness.*

Furthermore, some couples use heroin as an important part of the structure of their relationship, sometimes referred to as a 'shared substance abuse disorder'. The prognosis for shared substance abuse disorder is good for the pre-relationship nondependent person once the relationship ends. One of the treatment goals could be for the addict(s) to see that the relationship only leads to further heroin use. However, if parties are married, have been together for some time, or there are children, then there are problems if the therapist suggests ending the relationship. If neither person wants to end the relationship, then the prognosis is worse than that for the single heroin dependant. If the couple detoxify together, it usually only takes one to relapse and then they are both using again in a short time (White, 1999).

2.7 THERAPEUTIC INTERVENTION MODALITIES FOR HEROIN DEPENDENCE

Human needs are broadly similar, but the benefits to be derived for a particular dependence must ultimately be assessed in terms of each individual's own perceptions. Almost any behaviour between total indulgence, total asceticism and total self-destruction can become a reinforcer. Similarly, the movement from use to addiction and dependence occurs in not one but several ways, and different forces maintain the state once it is established. Situations can maintain a dependence, dependants themselves can maintain it, more or less willingly, and in some cases several people have a stake in the process, with the actual dependant being only one member of the culpable group. All these situations require different therapeutic approaches if the problem is to be managed successfully (Krivanek, 1988).

Heroin treatment programmes are intended to achieve several goals. Firstly, the reduction of the level of heroin use among patients. In addition, since heroin dependence is believed to lead to increased criminal activity and decreased capacity for legitimate employment, treatment programmes could be expected to improve clients' performance in those two areas. In practice, little data is available regarding the attainment of these three goals (*Illinois Economic and Fiscal Commission*, 1977; Terry, 1999; Louw, 2004). Several behavioural therapies, such as contingency management therapy and cognitive-behavioural interventions, show particular promise as treatments for heroin dependence (*Practitioner*, 2003; Schottenfeld, Pantalon, Chawarski & Pakes, 1999). Thus, changing a specific behaviour is viewed, primarily, as changing the underlying cognitive structure of the behaviour in question (Finnigan, 1995).

The idea that the dependant could alter their behaviour by abstaining from the use of substances gained acceptance by many, including dependants themselves, during the 1960s. A milestone that assisted in reinforcing the view can be traced back to a therapeutic, residential drug treatment called Synanon, created by Charles Dederich (himself a recovering alcoholic) in 1958. Synanon was grassroots, non-law enforcement programme for heroin dependants that became a popular model for treatment facilities in the 1960 and 1970. These facilities were normally situated in an old house or converted building. Participation was voluntary and free from the usual figures of authority making it more desirable to those addicts who had an aversion to formal treatment. Unfortunately, success rates from these programmes have not been better than any other method of 'curing' dependants. Once leaving these facilities, rates of relapse have been high (Terry, 1999).

Other therapeutic communities, such as Phoenix House, Daytop Village, Odyssey House and Gateway Foundation followed Synanon in the 1960s. These were set up by 'graduates' of one of the 'parent programmes', and carried forward many common elements of the philosophy, social organisation and practices from the original programmes (Gossop, 2003).

According to Burroughs (1977), the longer a person remains in residential treatment, the better the chance is that the person will statistically stay off heroin. This view is supported by the *Illinois Economic and Fiscal Commission* (1975) and Gossop (2003), who reiterate that patients who receive residential care are more likely to succeed than those who do not, and probability of success rises with the length of stay in residential treatment. However, addicts do not have equal access to residential care (Friedman, 2002; Louw, 2004). Apart from this factor, it is increasingly obvious that there is an important interaction between the characteristics of the client and the characteristics of the intervention and that therapeutic success depends on matching client and therapy (Krivanek, 1988; *National Drug Master Plan*, 1999; Louw, 2004). The time lag between young heroin dependants taking heroin and engaging with intervention is often several years, by which time their successful treatment is far more problematic (<http://www.sustancemisuse.net>).

It is, however, one thing to say that different heroin dependants need different treatment interventions, and quite another to put this into practice. While the assessment of each client's needs, strengths and lifestyles is necessary, it is often sketchy at best. The reasons for this are various. There is the obvious cost involved of interventions, the lack of general training on the part of programme personnel - this of course makes assessment and intervention redundant (Gossop, 2003; Krivanek, 1988). There is also the question of

ideological bias - the feeling that one's particular treatment is the only solution for all dependants, and that all other programmes are inadequate (Krivanek, 1988; Louw, 2004). However, probably the single most compelling reason for redundancy of adequate interventions in South Africa, is the lack of affordable treatment centres to which clients may actually be directed. People with the means to book into a clinic can do so, whereas poorer heroin dependants and other drug dependants do not have that choice (Kenny, 1999), though there is a trend to open up state subsidised beds.

An even more basic problem to intervention is the question of what we are actually trying to achieve. With a legal drug like alcohol, there are two options: the goal can be to help a problem drinker give up alcohol altogether, or a return to social, safe levels of drinking. However, with an illicit substance like heroin, the situation is very different. Any use is by definition misuse. Controlled use is not acceptable, even though there is evidence that some proportion of users - perhaps a substantial number - are able to manage this without particular difficulty (Krivanek, 1988; Kaplan, 1983).

Krivanek (1988) asserts that some of the factors that seem to facilitate controlled use of heroin seem similar to the data concerning the resumption of controlled drinking by ex-problem drinkers. The data suggests that if heroin were as freely available as alcohol is now, a significant proportion of high-risk groups would develop serious problems with it. However, such serious problems would be by no means normative, and their incidence might well be drastically reduced by attending to factors that place these groups at high risk on the one hand, and by providing adequate help and encouraging its use on the other. On balance, heroin use under such conditions might well be less than we now experience. It is unlikely that they would be greater - though problems there would certainly be.

At the moment, though, abstinence is the only permissible goal for heroin dependants. Paradoxically, maintenance of the dependence is also acceptable, provided that the responsibility for this is taken out of the dependants' hands. In a methadone or buprenorphine maintenance programme, the client is obviously still dependent. Success is therefore measured by abstinence from illicit substances (Krivanek, 1988).

Another problem presents itself when focusing on therapeutic intervention programmes for the treatment of substance dependence. As stated previously, in no other area of psychology have invalidated and untested methods of intervention been so widely accepted (Chapter 1, p. 6) (Barlow & Durand, 1995).

2.7.1 Outpatient intervention / community based intervention

Outpatient intervention, also referred to as community based intervention, is more extensively utilised world-wide than any other drug dependence intervention modality (Gruber, Chutuape & Stitzer, 1999). Outpatient intervention normally involves the client remaining in their environment - allowing dependants to continue with daily duties and work obligations, detoxification if necessary, counselling sessions, and a number of other means of helping and giving psychological support to the dependant or user who desires not to return to heroin use. This type of more natural intervention can also be used as an effective tool in reaching the unmotivated heroin dependent (de Beer, 2004). It has two main advantages, firstly is its cost, it is by far the least expensive of the methods of treatment. Secondly, even if it is enforced by court order, this kind of treatment exerts far less control over the user's life than does other treatments. Not only does it restrict less

the freedom and autonomy of the user, but it lessens the likelihood that the user will be labelled a dope fiend and forced into associations deeper than themselves in the heroin culture (Kaplan, 1983; de Beer, 2004).

In a study conducted by Gruber, Chutuape and Stitzer (1999), inner-city heroin dependants enrolled for reinforcement-based intensive outpatient treatment (RBT) short-term efficacy in treatment intervention was reported. The therapy provided abstinence-contingent partial support of housing, food and recreational activities, abstinence-contingent access to social skills and employment finding group and non-contingent individual counselling, within the context of a day treatment programme. One month after detoxification, RBT clients were significantly less likely than controls to have returned to drug use. Fifty percent of RBT clients versus 21% of controls reported thirty days of abstinence from heroin and cocaine with confirmatory negative urine results. RBT clients also had significantly lower scores on the Beck Depression Inventory at one month and showed evidence of less alcohol use and higher rates of employment.

Coerced outpatient intervention is similar to standard probation - with medical personnel and counsellors replacing probation officers. Like probation in practice, it often exerts little supervision, and as a result, outpatient drug-free treatment may not be at all drug-free, however, urinalysis can tell reliably whether someone has used heroin within the past seventy-two hours. The ability to check on whether someone is using heroin is extremely important - not only for behaviour control but also because if the pressure to avoid heroin use succeeds, the values, associations, and other satisfactions which the user may develop can make his/her return to heroin less likely and actually effect a 'cure' (Kaplan, 1983). RIA (radioimmunoassay) tests can be used to detect heroin from a urine sample or GC/MS (gas chromatography/mass spectrometry) can be used as a drug screening tests and are reputed to have an accuracy rate of 99.98% (<http://heroinhelper.com>).

It is; however, not to say that urinalysis addresses the problem of coercing the heroin dependent or user into abstinence. Resourceful heroin dependants are often able to outsmart clinicians and rig tests so as to produce a negative result. Even with urine testing, outpatient treatment has limited success. It seems singularly unable to affect the behaviour of the long-time or 'hard core' heroin dependant, and whatever success outpatient treatment does have most often pertains to younger and less established heroin users, who typically find it easier to give up the drug anyway (Kaplan, 1983).

2.7.2 Residential intervention

The establishment of specialised facilities to care for people with substance abuse problems dates back to 1935 with the first federal narcotic 'farm' built in Lexington, Kentucky. Now mostly privately run, facilities such as these are designed to help people get through the initial withdrawal period and to provide supportive therapy to go back to their communities (Barlow & Durand, 1995).

Residential care can be extremely expensive (Kaplan, 1983). The question arises, then, as to how effective this type of care is compared to outpatient therapy that can cost 90% less (Barlow & Durand, 1995). Residential treatment also exerts more control over the users life. Usually this takes place in what is called a 'therapeutic community'. Typically dependence is regarded primarily as a symptom of a more basic underlying disorder. The drug-free residential treatment programme aims to make fundamental changes to the user's personality, values and ways of coping with the world. It makes use of group processes and a

highly structured environment (de Klerk, 2001). The basic idea common to most drug rehabilitation programmes is that a person will not be able to stay off drugs unless he or she changes in some fundamental manner, and that such change is best brought about by becoming a member of a close-knit group. Rehabilitation communities have clear and explicit rules, and in some facilities residents and staff take part in 'encounter groups' in which any departures from the rules are discussed as examples of the individuals' immaturity, lack of responsibility and inability to be honest with themselves (Dorn & South, 1987). Often discipline is severe (de Klerk, 2001) and the interactions are confrontations aimed at 'rebuilding' that can be demeaning to the patient (de Klerk & Versluis, 2001; Brits, 2001; Kaplan, 1983). This 'rebuilding' often continues after cure - indeed, in some cases, cure is promised only while the former patient remains in the therapeutic community - usually treating other drug dependants. (Kaplan, 1983; Densen-Gerber, 1973; Friedman & Oelofse, 2001; de Klerk & Versluis, 2001; Louw, 2004).

Residents may stay in the facility for a few weeks to several months, though it is common for them to leave without completing the programme, finding the situation over-demanding and sometimes oppressive. Some users develop a pattern of returning and then splitting again several times over a period of years, though some residential facilities are reluctant to take 'splittees' back (Dorn & South, 1987). Criticisms against the use of confrontational interventions has come to the fore, and that the use of strong confrontational methods such as those used in therapeutic community encounter groups would be regarded as ludicrous and unprofessional if used in the treatment of other psychological or medical problems. Confrontational strategies have also not been supported by clinical outcome studies, and that therapist behaviours associated with this approach have been shown to predict treatment failures, whereas empathic approaches are more likely to be therapeutically effective. However, the role of confrontation should not be completely denied. In a general sense, the purpose of confrontation can be used to help clients alter perspectives and to facilitate change (Gossop, 2003).

A number of therapeutic community programmes raise serious moral issues. Often a charismatic leader with extremely authoritarian values directs them. Such leaders tend to demand absolute obedience, and harshly punish the slightest infractions (Kaplan, 1983; Friedman & Oelofse, 2001; de Klerk & Versluis, 2001; Gossop, 2003). Some drug rehabilitation programmes have developed into cults, very much like those religious groups where members completely surrender their autonomy (Kaplan, 1983). This is; however, not to say that residential treatment is useless. Data suggests that it is about as effective as methadone maintenance in securing a long-term lowering of heroin use (Kaplan, 1983).

2.7.3 Narcotics Anonymous

The beginning of Narcotics Anonymous (NA) dates back to the 1940's and the efforts of a few drug dependants who were struggling to learn how to stay clean without the help of 'experts'. Borrowing from Alcoholics Anonymous (AA), they commenced weekly meetings called 'Addicts Anonymous'. These first meetings began in Lexington hospital in 1947 and continued until its close in 1966. A different version of the same story involves a group of heroin dependants being acrimoniously ejected from their local AA meeting (Gossop, 2003). Those who participated in these early meetings are credited with the development of Narcotics Anonymous (Terry, 1999). Narcotics Anonymous advocates the shared experience of many

recovering dependants in dealing with dependence, recovery and relapse. The 'Twelve Steps' of Narcotics Anonymous, as adapted from Alcoholics Anonymous, forms the basis of the recovery programme. It is a non-profit society and has no dues or fees of any kind (*Narcotics Anonymous World Service, 2003*).

The only requirement for membership is the desire to stop using. The primary purpose of the fellowship is to stay clean and to carry the message of identification, hope and sharing to the addict who still suffers. Closed meetings are for drug dependants or those who think they might have a drug problem. Open meetings welcome anyone wishing to join the fellowship (*Narcotics Anonymous World Service, 2003*).

The principles of the 'Twelve Steps' is stipulated below (*Narcotics Anonymous World Service, 2003:17*).

TABLE 2.7.3.1 The Twelve Steps of Narcotics Anonymous

- | |
|--|
| <ol style="list-style-type: none"> 1. <i>We admitted that we were powerless over our addiction, that our lives had become unmanageable.</i> 2. <i>We came to believe in a Power greater than ourselves could restore us to sanity.</i> 3. <i>We made a decision to turn our will and our lives over to the care of God as we understood Him.</i> 4. <i>We made a searching and fearless moral inventory of ourselves.</i> 5. <i>We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.</i> 6. <i>We were entirely ready to have God remove all these defects of character.</i> 7. <i>We humbly asked Him to remove our shortcomings.</i> 8. <i>We made a list of all persons we had harmed, and became willing to make amends to them all.</i> 9. <i>We made direct amends to such people wherever possible, except when to do so would injure them or others.</i> 10. <i>We continued to take personal inventory and when we were wrong promptly admitted it.</i> 11. <i>We sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry it out.</i> 12. <i>Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.</i> |
|--|

The twelve steps (Table 2.7.3.1, p.75) are the essential principles and ingredients of the recovery process. Progression through the steps is seen as essential for achieving and maintaining abstinence. It is the responsibility of NA members to involve themselves in 'working the steps'. This involves studying the written materials made available through the fellowship, monitoring their own functioning, praying for guidance and support, and trying to stay abstinent one day at a time. This leads from an initial recognition of helplessness in the face of their dependence, through a personal commitment to change with the help of the Higher Power, and ultimately to a responsibility for positively influencing the lives of others (Gossop, 2003).

The steps emphasise two general themes, spirituality - belief in the 'Higher Power', which is defined by each individual and which represents faith and hope of recovery. Secondly, pragmatism - belief in doing 'whatever works' for the individual, meaning doing whatever it takes in order to avoid taking the first drug (Gossop, 2006).

The group meetings are one of the best known aspects of NA. Meeting, which may be 'open' or 'closed', are held weekly and normally last for an hour. The 'closed' meetings are only for those members who are willing to describe themselves as 'addicts', and in these groups members are encouraged to share their experiences, achievements, fears and failures with peers who provide support. In 'open' meetings, non-addicts and outsiders with concerns about friends or family are permitted to attend. Step meetings are usually closed and consist of a discussion of the meaning and ramifications of the twelve steps (Gossop, 2003).

The twelve steps are the central element for the NA groups. These differ from the twelve traditions. The traditions define the policy and regulations that govern each fellowship, emphasise the responsibility of the fellowship to the individual member, and proscribe financial, political, or any other associations with other organisations (Gossop, 2003).

The welfare of the Fellowship is protected by the 'Twelve Traditions' (*Narcotics Anonymous World Service*; 2003: 57-58).

TABLE 2.7.3.2 The Twelve Traditions of Narcotics Anonymous

- | |
|--|
| <ol style="list-style-type: none"> 1. <i>Our common welfare should come first; personal recovery depends on NA unity.</i> 2. <i>For our group purpose there is but one ultimate authority - a loving God as He may express Himself in our group conscience. Our leaders are but trusted servants; they do not govern.</i> 3. <i>The only requirement for membership is a desire to stop using.</i> 4. <i>Each group should be autonomous except in matters affecting other groups or NA as a whole.</i> 5. <i>Each group has but one primary purpose - to carry the message to the addict who still suffers.</i> 6. <i>An NA group ought never endorse, finance, or lend the NA name to any related facility or outside enterprise, lest problems of money, property or prestige divert us from our primary purpose.</i> 7. <i>Every NA group should be fully self-supporting, declining outside contributions.</i> 8. <i>Narcotics Anonymous should remain forever non-professional, but our service centres may employ special workers.</i> 9. <i>NA, as such, ought never be organised, but we may create service boards or committees directly responsible to those they serve.</i> 10. <i>NA has no opinion on outside issues; hence the NA name ought never be drawn into public controversy.</i> 11. <i>Our public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio, and films.</i> 12. <i>Anonymity is the spiritual foundation of all our Traditions, ever reminding us to place principles before personalities.</i> |
|--|

There is evidence that following the Narcotics Anonymous programme has proved to be *the* solution for many dependants, if and when they can or do follow it (Friday, 1992). However, according to Terry (1999), the diffusion of the 'success' of 12-step programmes into the popular culture has perhaps created yet more pressure for people who use illegal substances to alter their behaviour. For those who want to quit it may provide hope. For those who want to continue using, it may add to the likelihood that they see themselves as somehow flawed. Furthermore, there is no 'proof' that NA 'works', but its tremendous growth can be seen as a testimony of its popularity.

Kohn (1987) argues that the main problem with spiritually based programmes is that they tend to be addictive. The pressure on their members to substitute the group for their former peers often leads to a simple transfer between enclosed subcultures. Former heroin dependants may warm to the new rituals and closeness of the NA groups, and will be spared the consequences of their former way of life. This may, of course, save their lives. Kenny (1999) disputes that no one ever died from going to too many (NA) meetings. Research has indicated that 'spirituality' to inner-city HIV-positive drug users has been of use in reducing craving and HIV risk behaviour, following medical recommendations and increasing hopefulness. Higher levels of religious faith and spirituality predicted a more optimistic life orientation, greater perceived social support, higher resilience to stress and lower levels of anxiety (Arnold, Avants, Margolin & Marcotte, 2002). According to Rabbi Abraham Twerski, professor of psychiatry at the University of Pittsburgh School of Medicine and medical director of the Gateway Rehabilitation Centre in Pittsburgh, the source of substance dependence is a spiritual deficiency. Irrespective of whether the person is religious or atheist, he regards all human beings as spiritual and that spirituality is the cornerstone of recovery (Dugmore, 2005).

Furthermore, the fundamental principle that the dependant is suffering from an incurable disease could place a burden on the persons' life. In accepting their 'incurability', dependants condemn themselves to a

permanent state of dependence (Kohn, 1987). The disease model as applied to heroin dependence has several consequences, depending on the view taken, can be good or bad. Once something is considered to be a disease, the sufferer is no longer punished, but is rather helped (Kaplan, 1983; Krivanek, 1988). Displacing responsibility from the sufferer onto those who are treating them may also make the sufferer more willing to accept treatment. After all, it is easier to say 'I'm sick, treat me,' than to say, 'I have a destructive behaviour pattern, stop me.' In addition, dependants who feel they have a disease may be better able to cope with the guilt over prior behaviour. A disadvantage of the disease model is that addicts may not take personal responsibility for their actions (Kaplan, 1983). This view is strongly rebutted by NA. Paradoxically, the NA disease concept is used to emphasise the need for dependants to take responsibility for their own behaviour and to participate actively in their own recovery. Although dependants are seen as not responsible for their illness, they are seen as fully responsible for their recovery (Gossop, 2003).

If heroin dependence is indeed a 'disease', it is not a typical one. A disease seems, at base, to have three characteristics. First, it is something, which is bad to have, and would be good to have go way, or be cured of. Second, it must be a condition over which the sufferer has no control at the time - even though some diseases, such as gonorrhoea or syphilis, may have been originally brought on by the sufferer's own 'misbehaviour'. Finally, a disease is a condition which is regarded primarily within the domain of the medical profession to try to cure or alleviate (Kaplan, 1983).

It remains unclear as to whether or not heroin dependence meets the first criterion of a disease. Although it is often taken for granted that sufferers wish to be cured, this is not always the case with the heroin dependent, however, many want to have the circumstances surrounding their life - such as police harassment, changed. The second of the criteria for a disease is that the condition, regardless of what brought it on, once established, is beyond the control of the sufferer. With respect to heroin dependence, this also raises problems. Certainly some heroin dependants act as if they cannot control themselves, but as previously mentioned, others manage quite well, once they decide they want to. Nor does the third criterion for a disease seem to be any more applicable to heroin dependence. It is hard to see any intrinsic reason why the medical profession should be charged with the primary responsibility for cure or alleviation of heroin dependence (Kaplan, 1983).

Indeed, the whole attitude to what might be called 'excessive behaviours' is illogical. While many regard heroin dependence or alcoholism as a disease, few think the same of habitual cigarette smoking or eating too much - though it is by no means easy to articulate any meaningful differences among these (Kaplan, 1983; Wistosky, 1990).

Furthermore, the disease model of substance dependence rests on three major assumptions: predisposition, loss of control over use and progression. Over the years, all these assumptions have been challenged. As discussed earlier, there are addicts who do appear to be able to control their intake, and the permanency of addiction and dependence has also been challenged. Similarly, dependence does not necessarily progress; this is highlighted by the 'maturing out' phenomenon at about the age of forty. As far as predisposition to substance dependence is concerned, in no case has it been possible to demonstrate a consistent physical

or psychological factor that would distinguish the dependant from the non-dependant (Winick, 1962; Krivanek, 1988; Barlow & Durand, 1995; Dugmore, 2005).

Several essential characteristics of NA differentiate it from other interventions. Firstly, NA involves the individual acting in collaboration with others who share the same problems, to provide mutual support for each other's recovery. The element of mutual support is seen a key dynamic for change. The twelfth step can involve sponsoring another member, and sponsorship is also seen as an important component of recovery. A sponsor is expected to be someone who has achieved a substantial period of abstinence and who has studied and worked the twelve steps, this can also serve as part of the sponsor's own recovery (Gossop, 2003).

NA has sometimes been non-professional or even anti-professional in its attitude and style. More recently, however, many groups have moved toward a greater willingness to work in alliance with professionals, and many groups are currently linked to or operate with close working links with professional organisations (Gossop, 2003).

2.7.4 Minnesota models and other 12-step variations

The Minnesota Model was developed at a time when alcoholics were treated in locked wards with other mentally ill patient. Reduced to their common denominations, all Minnesota Models share four basic beliefs: First, understanding alcoholism and drug dependence as an illness. Second, understanding drug and alcohol dependence to be an incurable condition. Third, seeing the 12-step fellowship of Alcoholics Anonymous and Narcotics Anonymous as the vehicle for ongoing recovery. Fourth, the use of recovering substance dependent counsellors as part of the multidisciplinary team (Hamlyn, 2004).

This model is sometimes regarded as a *physical-psycho-spiritual model*. Patients first receive needed medical care, immediate attention to the often severe physical consequences of substance dependence, as well as medical assessments and detoxification. Secondly, people who experience the Minnesota Model are armed with a new set of ideas about the nature of substance dependence. Accordingly, they learn new strategies for changing their mental habits. Lastly, the necessity of living life on a spiritual level is emphasised. Learning to live a spiritual life involves acknowledging one's personal limitations and relationship with a Higher Power that is individually defined and learning about spiritual principles (Hamlyn, 2004).

According to Hamlyn (2004) the approach today has several key components;

- * *Treatment professionals and patients collaborate in defining the path of recovery.* Their relationship goes beyond the usual patient-professional, and a give-and-take quality to the relationship is encouraged. Underlying this is the expectation that people will take an active role in their own recovery.
- * *Changes in lifestyle habits become the focus of treatment.* This can involve both cognitive and behavioural strategies.

- * *Treatment focuses on the long-term.* It is asserted that the disease of substance dependence cannot be cured and therefore working through and dealing with persist problems directly is encouraged. It is accepted that substance dependence is progressive, incurable and fatal, focus is therefore placed on managing the condition and living well with it.
- * *Treatment is multidisciplinary.* The complexity of substance dependence demands the expertise of professionals in medicine and mental health, along with the wisdom and practical expertise of recovering addicts.
- * *Rehabilitation relies on natural support systems.* Family members, friends and self-help groups including the 12-step fellowships all participate in the recovery process.

The greatest challenge in developing the model within the South African context has been the training and accreditation of 'lay counsellors' that work in centres following the Minnesota Model. Most of the centres have looked overseas for the necessary training and accreditation of their counsellors. NAADAC (National Association of Alcoholism and Drug Abuse Counsellors) and UKPCBADDC (The United Kingdom Professional Certification Board of Alcohol and Drug Counsellors) have been widely used. Today the centres are co-operating in the long and complex process of setting up an accreditation board in South Africa to service this need (Hamlyn, 2000).

2.7.5 Coerced treatment intervention

The greater cost effectiveness of treatment intervention over imprisonment remains, even in situations where the dependant is coerced into treatment intervention by the threat of imminent incarceration. Though probably not as effective as with purely voluntary patients, coerced intervention may nonetheless make major changes in the life of the heroin dependent. Often the heroin dependent will cooperate in treatment, to their and societies benefit, even though the heroin dependent would not have entered voluntarily (Kaplan, 1983).

As compared with imprisonment, treatment intervention is both economical and effective - not so much because treatment interventions are so enormously successful and cheap, but rather because, as applied to heroin dependants, the usual processes of the criminal law seem to be singularly costly and ineffective. Even residential intervention, the most expensive form of heroin dependence treatment, costs considerably less than the cost of imprisonment. Furthermore, treatment intervention has several advantages over imprisonment. Heroin dependants could be treated for a considerably longer time than what they would be incarcerated. Treatment intervention also interferes less with their autonomy and inflicts less pain upon them; and treatment intervention is more likely than incarceration to encourage life-styles and values which make both heroin use and crime less likely after the legal or medical intervention has ceased (Kaplan, 1983).

The existing evidence indicates that incarceration does not alter drug use upon release. Very large proportions of cases that pass through the courts are recidivists. Moreover, incarceration can teach users some things that society would prefer them not to learn. Limited, if any rehabilitation services exist within

prisons in South Africa, and the majority of interventions are provided by voluntary bodies or other agencies, not by the Department of Correctional Services. The Ahanang Prisons Project was the first initiative launched in 2003 on a national level in South Africa, initiated by SANCA in collaboration with the Department of Correctional Service (DCS), which targeting incarcerated youth in youth prisons and DCS throughout South Africa. According to researched undertaken by the HSRC (1996) (cited in *SANCA: Ahanang Correctional Services Project*, 2004), on sentenced prisoners, 76% were engaged in either alcohol or drug abuse during the period of committing the crime for which they were sentenced. The Ahanang Prison Project has strived to fill the voids within this sector by targeting the incarcerated dependent, and promoting skills transfer to DCS staff (*SANCA: Ahanang Correctional Services Project*, 2004),

A *restorative* approach is currently being used in South Africa. Restorative justice holds that criminal behaviour is primarily a violation of one individual by another. According to Howard Zehr (cited in *The Restorative Justice Centre: an introduction*, 2005), considered the 'grandfather' of the international restorative justice movement;

'When a crime is committed, it is the victim who is harmed, not the state. Instead of the offender owing a debt to society, which must be 'paid back' by the offender being subjected to some form of state imposed punishment, the offender owes a specific debt to the victim - which can only be repaid by making good the damage caused.'

This model is basically an extension of the rehabilitative paradigm. Heroin dependants facing criminal charges are diverted from criminal justice system to a means of making suitable restitution to specific victims and society in general (Krivanek, 1988). That is to say, they are effectively given a choice between incarceration and rehabilitation (Dorn & South, 1987).

2.7.6 Family intervention and social support

Heroin dependants experience isolation and decreased support as the dependence worsens. One of the strongest predictors of recovery, even for those who recover without formal treatment, is often fear of losing significant relationships, such as family members or friends. In research about recovery from substance dependence, social support, especially from families, has been found to be especially beneficial (Sayre, Cornille, Rohrer & Hicks, 1992). Furthermore, research suggests that greater engagement in non-drug related recreational, social, vocational and parenting activities is associated with improved outcome in terms of abstinence from heroin (Schottenfeld, Pantaloni, Chawarski & Pakes, 1999)

According to White (1999), initially heroin use offers the user hope that he or she has found the perfect parent who will meet needs that the user has had for many years. Heroin dependence is also reputed to balance patterns of distance, closeness and loyalties within families, with most cases coming from families described as highly enmeshed. It has been noted that heroin users, even when not living at home, are in frequent, often daily, contact with their mothers. A death theme is also usually apparent, frequently linked to the death of a significant other. Symptomatic behaviour is often linked with, and supported by, overt and covert disturbance in the marital sub-system. This threatens family fragmentation, and often occurs at a threshold of development both in the life of the family and in the heroin dependant (Gleeson, 1991).

The initial shock and sense of stigma experienced by parents and families' is often followed by a period of grief and mourning at the loss of the child as they had envisaged he/she could become. Simultaneously,

fears with imminent loss of the dependant in a tangible sense and initial recriminations against themselves and/or the heroin dependent. When these initial reactions begin to be replaced by exploration of ways in which parents try to regain contact with their child and to find new ways of caring, there may be bewilderment as to how this should be expressed (Donoghoe, Dorn, James, Jones, Ribbens & South, 1997).

One answer to these parental dilemmas is given by parent support groups such as *ToughLove* and *Nar-anon*. The key idea behind these support groups is normally that care needs to be redirected from too tight a focus upon the heroin dependant, to a reevaluation of the parents themselves (Donoghoe *et al.*, 1997)

The dynamics of parental interaction with the heroin dependant has thus profound and long lasting effects on the dependants' emotional maturity and growth throughout the recovery period. Therapists involved in treatment and aftercare programmes that address family of origin issues, should be aware of this. Making room for growth is an issue for all involved in the recovery process, for adult children of dependants, children and their parents (Sandoz, 1991).

2.7.7 Relapse Prevention

Marlatt and Gordon's relapse prevention treatment model (1985) focuses on the learned aspects of dependence and sees relapse as a failure of a person's cognitive and behaviour coping skills (Friday, 1992).

Relapse prevention is a self-management programme designed to enhance the maintenance stage of the habit-change process. The goal of relapse prevention is to teach individuals who are trying to change their behaviour how to anticipate and cope with the problem of relapse. Based on the principles of social-learning theory, relapse prevention is a self-control programme that combines behavioural skill training, cognitive interventions and lifestyle change procedures. The relapse prevention model includes both behavioural and cognitive components that are similar to other cognitive-behavioural approaches that have been developed in recent years as an outgrowth and extension of more traditional behaviour therapy programmes (Marlatt & Gordon, 1985).

Intervention involves helping dependants remove any ambivalence with regard to quitting substances of abuse, and by examining their belief systems regarding the positive aspects of the substance and confronting the negative consequences of its use. High-risk situations are identified and strategies are developed to deal with the potentially problematic situations as well as craving that may arise after abstinence. Incidents of relapse are dealt with as occurrences from which the person recover and learn from, in other words, people in treatment are encouraged to see relapses as episodes brought on by some temporary stress or situation that can be changed by the development of coping skills (Barlow & Durand, 1985).

2.7.8 Harm reduction and needle exchange programmes

Some dependants may not want to, or feel able to, give up heroin or other drugs completely. They might just want to reduce the harm that heroin can cause, for example they might change from injecting heroin to smoking it. Harm reduction (or harm minimisation) is a model of working that has been associated with drug

use since the mid 1980's. It was a response to the need to try and minimise the harm caused by injecting drug use and the beginning of the HIV epidemic. The harm reduction model recognises that people will continue to use drugs despite the risks and sometimes prohibition, and works on the principle that some of the risks of drug use can be reduced and minimised. Prevention measures and education are important, however if they are unsuccessful, then the consequences of drug use must still be dealt with. The effects of injecting heroin include not only the pharmacological actions of heroin, but also possible infection and damage caused by the process of injecting. Harm reduction focuses on educating heroin and other drug users about the risks of drug taking and helping them to take responsibility for themselves. With this information, people are able to make choices about the level of risk to which they will expose themselves. Harm reduction is a process and not a treatment and should be integrated with other forms of intervention (<http://www.substancemisuse.net>).

An important harm reduction intervention is the development of the NEP (needle exchange programmes) which targets intravenous heroin users by providing them with clean needles, a bleach kit and education, in exchange for used or dirty needles. NEP is an approach that has been introduced in certain countries, with the goal of decreasing the negative consequences of addictive drug use. The primary focus of the approach is to reduce the spread of HIV/AIDS and other infectious diseases, such as Hepatitis B, C and G, among people who inject substances. Although NEP may make referral to treatment, they recapitulate that many intravenous drug users, including some in treatment programmes, continue to inject drugs and share injection equipment. NEP therefore seeks to reduce the harm associated with these practices, a philosophy sometimes referred to as harm reduction or harm minimisation. The essential arguments in favour of NEP are that such interventions could decrease the transmission of HIV by increasing the probability that intravenous heroin dependants use uninfected syringes and produce reductions in HIV risk behaviour. Such programmes also provide heroin dependants with a referral to therapeutic and medical intervention and provide risk reduction information (Alavi *et al.*, 2003; *Minnesota AIDS Project*, 1995).

In a study conducted by Alavi *et al.* (2003) in the Pretoria/Centurion area in South Africa of seventeen intravenous users, 53% of the participants reported some use of 'dirty' needles. Of the studied population, 29.4% did not consider it necessary to use clean needles, while 47% stated that their reason for not using clean needles was due to a lack of accessibility to clean needles.

Furthermore, in a study comparing the prevalence of major depression between intravenous heroin dependants enrolled in Rhode Island Methadone Maintenance Treatment Program (MMTP) and Rhode Island Needle Exchange Program, higher rates of depression were found among NEP attendees than those enrolled in the methadone maintenance programme. Many factors may contribute to the higher rate of major depression in the NEP cohort compared to the MMTP cohort. It is possible that those enrolled in a multidisciplinary methadone treatment programme for at least six months feel less isolation, less helplessness and more hopeful than persons in NEP. In addition, many heroin dependants drop out of MMTP early; this could be associated with depression and could have reduced the relative rate of depression in the MMTP group. Stress related to obtaining drugs on the street and financial problems may have contributed to depression among NEP attendees. The higher rate of depression in the NEP cohort may also be partially explained by the higher rates of alcohol abuse/dependence and the daily use of opioids

within this group. These findings indicate a need for psychosocial intervention in needle exchange programmes (Brienza, Stein, Chen, Gogineni, Sobota, Maksad, Hu & Clarke, 2000).

Cities where needle exchange policies were introduced at the beginning of the HIV epidemic have much lower prevalence rates than those who did not introduce these measures for either political or economic reasons, with some cities citing a prevalence rate in at-risk groups increasing from 0 to 50% in a very few years. Counties without harm reduction strategies have experienced catastrophic rates of HIV among their drug using population (<http://www.substancemisuse.net>).

Germany is reported to have facilities called 'injecting rooms', in some cities, where health officials have provided special rooms for chronic heroin dependants. These rooms are reputed to be bare, clinical, spotlessly clean and well maintained. The user is provided with a clean set of 'works' on entering: syringe, ampoule of heroin and a swab all laid out neatly in a kidney dish. The user enters the room, takes possession of the allocated 'works', and injects heroin. Reports of deaths from overdose in the cities involved have reportedly been reduced (Kenny, 1999). Paradoxically, the Swiss had a celebrated, or notorious, 'needle-park' in Zurich, an area in which heroin dependants were free to use without supervision. It was later regarded as a social disaster, and created a heroin slum. Furthermore, it acted as a direct enabler to heroin dependants (Kenny, 1999).

Opponents of NEP argue that the method is an inadequate substitute for drug treatment and is not a preferred means of entry into drug treatment. NEP can also raise important ethical issues as people are morally compelled to support a lesser harm (drug abuse) in order to overcome a greater harm (AIDS). It is also argued that public health risks outweigh the potential for NEP, and that there are better ways of addressing the spread of HIV/AIDS. Giving formal sanction to a project that facilitates drug use could be sending a mixed message, and in fact enabling heroin dependence, that threatens to undermine the credibility of all other preventative efforts (van Eden, 2001; Kenny, 1999). Non-injecting users might be tempted to begin injecting and existing intravenous users encouraged to continue doing so (Dorn & South, 1997). However, it is argued that in very chronic cases, where a heroin dependant is likely to die from street use, or from heroin-and-methadone cocktails, it might be worth considering (Kenny, 1999). Generally speaking, there needs to be a lot more debate concerning harm reduction policies, world-wide and as well as in South Africa (Plüddemann *et al.*, 2004).

2.8 DEFEATING THE DRAGON: HEROIN DEPENDENCE RECOVERY

Recovery from heroin dependence is complex and researchers from various disciplines have sought to understand the nature and dynamics of the process involved. Some heroin dependants recover from their dependence with the help of treatment agencies, whilst others recover 'naturally' and without pharmacological or other interventions. Some researchers argue that the numbers recovering spontaneously may be as high as those who recover following treatment intervention (Terry, 1999; www.substancemisuse.net).

2.8.1 Maturing out hypothesis

One of the earliest and most widely quoted account of giving up heroin is the 'maturing out' hypothesis of Winick (1962). Winick advanced the theory that heroin dependence is a self-limiting process and that most heroin dependants mature out of their dependence naturally by the time they reach their mid-thirties. Based on a study of arrestee records of heroin dependants in the United States, which showed that as age increased, the number of people being arrested for drug-related offences decreased, he concluded that two-thirds of heroin dependants 'mature out' of their heroin dependence in their mid-thirties.

Winick studied the age and duration of dependence of 7 234 heroin dependants originally reported to the Federal Bureau of Narcotics in 1955, but not reported again during a five-year period through 1960. These persons were called 'inactive addicts.' According to Winick, experience had shown that it was almost impossible for a regular narcotic/heroin user to avoid coming to the attention of authorities during a two-year period. Therefore, inactive status seemed equivalent to cessation of drug use, with the exception of an uncertain number of subjects who died (Maddux & Desmond, 1980).

Winick speculated that maturing out of heroin dependence might be a function not only of age, but also of length of heroin dependence. The mean length of heroin dependence in the inactive group was 8.6 years. Using the same database, he reported that the age at onset of heroin dependence and length of heroin dependence was inversely correlated. That is to say, the earlier the heroin dependence started, the longer it lasted, and the later it started, the shorter it lasted. Thus age rather than length of heroin dependence seemed to predict cessation of heroin use. His speculation with respect to length of heroin dependence was not confirmed (Maddux & Desmond, 1980).

The maturing out hypothesis consisted of more than a trend to cessation of heroin use within a specified age group. Winick proposed a psychodynamic explanation. He speculated that the dependants begin taking heroin as a method of coping with the challenges and problems of early adulthood. Then, some years later, as a result of some process of emotional homeostasis, the stresses and strains of life become sufficiently stabilised so that the dependant can face them without the support provided by narcotics. Winick did not have information about the emotional experience of his subjects (Maddux & Desmond, 1980).

Winick also addressed the question of the frequency of maturing out. Of 16 725 heroin dependants originally reported during 1953 and 1954, 65% were not reported again by 1959. Without citing his source of information, Winick stated that some 60% of the patients admitted to the former Public Health Service Hospitals at Lexington, Kentucky, and Fort Worth, Texas, never returned. Perhaps he knew of Lowry's report, which stated that 64% of 17 741 patients admitted to the Lexington hospital during the years 1935 through 1952 had not been readmitted by 1955. From these data he speculated that two-thirds of heroin dependants matured out of their dependence (Maddux & Desmond, 1980).

According to Winick (1962) 'maturing out' is a process by which dependants' stops taking heroin, as the problems for which he/she originally began taking heroin, become less salient and less urgent. Winick's (1962) proposition was clearly important as it went against the dominant opinion at the time that heroin and substance dependence was a destructive and lifetime affair, with the only end being death (Prins, 1995; Robertson, 1998). Instead, it provided a more hopeful and optimistic view, suggesting that for some at least,

heroin dependence is a reversible process, and the natural ageing and maturing process aids recovery. It is clear that Winick's (1962) contribution was fundamental in stimulating a considerable amount of research on heroin and substance dependence, work that was primarily aimed at proving or refuting his thesis (Prins, 1995).

Despite this contribution, and the fact that the maturing out thesis has been widely quoted in substance dependence literature, Winick's (1962) work has been heavily criticised for failing to provide much information regarding the factors/circumstances under which such a process of maturing out would take place. Prins (1995) argues that in order to gain such details more qualitative research is needed, for example, focusing on why and how people get into and out of substance dependence. Furthermore, although many subsequent studies have confirmed that a high proportion of narcotic dependants do stop using from their thirties (e.g. Waldorf, 1983; Biernacki, 1986; Prins, 1995), many disagree that the maturing out hypothesis provides the only explanation. In particular, a study by Swiestra (1987) provided an overview of 19 follow-up studies in the Netherlands. Although evidence was found to demonstrate classic 'maturing out' patterns under certain conditions, Swiestra did not agree with the theoretical explanations of Winick, and instead sided more with the views of Waldorf (1983), who identified numerous different routes out of substance dependence (cited in Salter, Davies, & Clark, 2006). Whilst other researchers and academic sources have shown that a high proportion of heroin dependants do stop using in their mid-thirties, the maturation process is only one way that heroin dependants overcome their dependence. Several other reasons could account for the apparently less prevalence in older people - more experience in the concealment of drugs, imprisonment and the substitutive use of alcohol and other drugs.

According to Singer (1975), there is evidence that the prevalence in the older age groups remains lower. The nature of the maturing-out process, assuming it to exist, remains unknown. It could be due to an actual maturing of the personality which enables the individual to tackle problems without the support of heroin, or to a lessening of psycho-social stresses and problems faced in earlier years, or to a lessening of the euphoric action of heroin on an ageing nervous system. In a study conducted by the same author regarding the prognosis of male heroin dependants in 270 participants in Hong Kong, a detailed analysis was undertaken with regards to other factors leading to relapse and then correlating them with a good or poor prognosis. It is noteworthy that there was no evidence to support the hypothesis that a maturing out process occurs among heroin dependants (Singer, 1975).

As well as 'maturing out' of narcotic dependence, Waldorf (1983) argued that, apart from death, individuals can also 'drift' out of dependence; become alcoholic or mentally ill; give up due to religious/political conversion; 'retire' by giving up the drug while retaining certain aspects of the lifestyle; or change because their situation or environment has changed. Clearly, as the work of Waldorf demonstrates, the maturation thesis is increasingly seen as being only one of several explanations of how individuals may overcome their dependence (McIntosh & McKeganey, 2002).

2.8.2 Phases/stages of recovery

Another common approach in the substance misuse field involves describing addiction, dependence and recovery in terms of a series of stages or phases. For example, Frykholm (1985) proposed three phases of

addiction referred to as experimental, adaptation, and compulsive, and three phases of de-addiction, where the process of becoming addicted is reversed. According to Frykholm, the first phase of de-addiction involves a period of ambivalence; where the negative effects of drug use are increasingly felt resulting in a gradual desire to stop using drugs, which is generally offset by a continuation of pleasurable effects of drugs and a physical dependence on drugs. In contrast, in the treatment phase, attempts at detoxification become more sustained and drug-free periods grow longer. In this phase, the dependent perceives a need for 'external control and support' and so seeks help, and also undergoes a radical reorientation in which he/she suddenly experiences a desire to fulfil the role of ex-addict. The final stage is referred to as emancipatory, and involves the period following detoxification when the dependent effectively becomes an ex-dependant and can remain 'clean' without external assistance (Frykholm, 1985).

Although Frykholm (1985) provided a useful model of substance dependence, his work has been criticised for not allowing for spontaneous recovery from addiction and dependence. Other stage-based models, such as that of Waldorf's (1983) six-stage model, do allow for spontaneous recovery, as recovery is said to occur with or without treatment intervention. In Waldorf's model, the three phases of becoming addicted are referred to as experimentation, escalation and maintaining, and the corresponding three stages of de-addiction are referred to as the dysfunctional or 'going through changes' phase, the recovery phase, and the ex-addict phase. In the first phase, the negative effects of drug use begin to be felt and the user may make forced or voluntary attempts to stop, which usually end in relapse. In contrast, in the recovery phase, the user makes a concerted effort to give up drugs, and recovery to the ex-addict phase is said to occur with or without treatment.

Several studies have also shown that the influence of significant others, such as partners or children can be important in the decision to quit (Waldorf, 1983; Frykholm, 1985; Simpson, Joe, Lehman & Sells, 1986; Smart, 1994). For example, Simpson *et al.* (1986) reported that more than half of their sample stated 'family responsibilities' were important in their decision to stop, while about a third cited pressure from family members as important. Another important factor reported to be influential in the decision to stop is deteriorating health or the fear of health problems (Waldorf, 1983; Valliant, 1983; Simpson *et al.*, 1986), as well as the occurrence of more general negative events such as a period in prison or the overdose or death of drug-using friends/associates (Shaffer, 1992; Edwards, Oppenheimer & Taylor 1992).

Many heroin dependants site how their heroin use lifestyle had affected their children negatively. This guilt feeling could be so strong that they act as a catalyst to stopping heroin use. Children can be so important because they provide such an uncompromising image of the person the dependent had become as a result of his or her heroin use lifestyle (Schottenfeld *et al.*, 1999). The decision to quit is often precipitated by certain trigger events. However, these trigger events often come at the end of a period of reflection and review that has been going on for some time.

Prochaska, DiClemente, & Norcross (1992), who propose that there are five stages in the process of change involved in recovery, developed one of the most popular stage models of recovery. According to this 'stages of change' model, individuals' progress through a series of stages, beginning with 'pre-contemplation', which is the period before the user has considered stopping. Individuals then progress to the 'contemplation' stage, where the user begins to think about stopping and on to the 'preparation' stage where the decision to

stop occurs and efforts are made to prepare for stopping. Subsequently in the 'action' phase specific steps are taken to reduce drug use, and finally in the 'maintenance' stage non-using behaviour is consolidated and the individual becomes an ex-addict. According to the model, individuals can move back and forth stages or even skip stages, which fits in with the notion of substance dependence as a relapsing disorder. Despite its popularity, like the other models, this account has been questioned, for example, regarding whether addictive and dependant behaviour does actually involve movement through a series of stages. Nevertheless, it is clear that this model has much intuitive appeal, and has been influential in the development of various techniques for dealing with dependencies, particularly Motivational Interviewing (Miller & Rollnick, 1991).

2.8.3 Hitting rock bottom

The fact that a number of conflicting stage/phase models exist, means that there is necessarily some disagreement regarding the precise number of stages which individuals may pass through in order to overcome addiction and dependence. However, according to McIntosh and McKeganey (2002), one of the features common to many of these models is the importance of a specific 'turning point', at which the decision to give up drugs is taken and/or consolidated (Prins, 1994; Simpson *et al.*, 1986; Shaffer & Jones, 1989). Such a turning point has been variously described as an 'existential crisis', an 'epistemological shift' or as hitting 'rock bottom', but whatever the terminology used, it refers to the dependent reaching a point in their drug-using career beyond which they are not prepared to go, and is often accompanied by some experience or event which stimulates/triggers change. For some, this turning point is an essential step on the road to recovery from heroin dependence. Some event may trigger the decision, such as an adverse drug effect, prospect of going to prison or losing a child or partner. The heroin dependent has deteriorated to such an extent physically, socially and psychologically that there are only three possibilities open to them, firstly to continue - but this could lead to total degradation of identity and likely physical damage as well. Secondly, exit through suicide - often given serious consideration by many heroin dependants at this stage, and tried by some. Lastly, to try and break dependants and thereby exit drug-using career decision (McIntosh & McKeganey, 2002). According to research undertaken by Terry (1999), who himself was an incarcerated heroin dependent, heroin dependants looking for a 'way out' benefit by developing new relationships and re-defining self-concepts that either exclude or depreciate their old values. Simultaneously, they need to be accepted within new social worlds and not be condemned for past actions.

According to McIntosh and McKeganey (2002) another common area of substance dependence research focuses on identifying the factors and circumstances which promote or impede the process of recovery. Although the reasons given by dependants can vary considerably from study to study, McIntosh and McKeganey (2002) identify some of the more common and prominent themes. In particular, 'burn out' is reported to be one of the most frequent precursors to recovery, as it seems that sustaining a habit can become an exceptionally difficult and demanding task associated with many problems. This is demonstrated in numerous studies, like that of Frykholm (1985) and Simpson *et al.* (1986), where dependants' main reason for stopping was that they were 'tired of the life' or words to that effect. McIntosh and McKeganey (2002) point out the similarity of the 'burn out' explanation and Winick's (1962) 'maturing

out' hypothesis, since both are products of changes, which could be said to occur naturally with the passage of time.

2.8.4 Spoiled identity

McIntosh and McKeganey (2002) believe that their study helps enhance the understanding of the process of the 'maturing out' of heroin dependence. According to these researchers, the 'maturing out' phenomenon is closely related to what Goffman (1963) described as the recognition of a 'spoiled identity' and to the temporality of the factors which promote this recognition and that encourage and facilitate the decision to change. One element in this process is that heroin dependants develop close relationships with others over time and acquire a sense of responsibility for them (Sayre, Cornille, Rohrer, & Hicks, 1992; Schottenfeld *et al.*, 1999). A second element may be a product of the natural history of heroin and drug-taking and the changing effect of the drug. Heroin loses the ability to produce pleasure and the use thereof could increasingly be viewed as troublesome.

Clearly the various research described has been influential in increasing our understanding of the various stages involved in addiction, dependence as well as the various factors which correlate with recovery. However, according to McIntosh and McKeganey (2002), with the exception of the work of Biernacki and Waldorf (Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981), relatively little is known about the cognitive processes through which the decision to stop using drugs occurs. McIntosh and McKeganey (2002) believe that the work of Waldorf and Biernacki is distinctive, since they have sought to explain the process of recovery in terms of the management of a spoiled identity. According to Biernacki, (1986) the decision to stop taking heroin comes about when the user's addict identity conflicts with, and creates problems for, other identities that are unrelated to heroin and other drug use, such as those of a partner, parent or employee, in ways that are unacceptable to them. The key to the recovery process lies in the realisation by the heroin dependent that their damaged sense of self has to be restored with a reawakening of their old identities and the establishment of new ones. Recovery is facilitated by a process through which a new calculus or arrangement of identities and perspectives emerges and becomes stabilised. This process entails a different articulation of identities in which the identities of an addict becomes de-emphasised (symbolically and socially) relative to the other identities existing or emerging as part of the person's overall life arrangement (Kellogg, 1993).

Biernacki (1986) proposed that in order to change their lives successfully, heroin dependants must fashion new identities, perspectives and social world involvement and adjustment wherein the heroin dependent is excluded or dramatically depreciated. However, we have no way of assessing social adjustment objectively nor does there an accepted standard by which it can be measured. What, for instance, constitutes 'satisfactory' social adjustment? The concept of mental health remains an obscure ideal that can be variously interpreted (Singer, 1975; Szasz, 1990).

Heavily influenced by the work of Biernacki and Waldorf, McIntosh and McKeganey (2002) conducted their own qualitative research on addiction, dependence and recovery, interviewing 70 ex-addicts. Without doubt, this detailed work has built on earlier substance dependence research, providing a number of much needed detailed insights, which clearly portray the views of ex-addicts. McIntosh and McKeganey (2002) found that

a similar range of factors/reasons to those already identified in the literature were influential in interviewees attempts to stop using. These reasons/factors included the impact of their drug use on family/significant others, the threat to ones health, to keep/get their partners of their back, to prevent their children being removed from them, a sense of weariness with the routine and demands involved in maintaining their drug use, the death of someone close due to drugs, and the threat of prison as a result of criminal activities engaged in to support their habit. These researchers point out that what is lacking is an understanding of the process of recovery as seen from the users' perspective.

A variety of reasons have been cited for attempts to quit heroin; a sense of weariness of demands of maintaining the habit, death of someone close or threat of incarceration. Importantly, these reasons given do not necessarily differ for successful and unsuccessful attempts to stop. However, like Biernacki and Waldorf, McIntosh and McKeganey (2002) strongly believe that the factor, which distinguishes apparently successful attempts from earlier attempts, has to do with the drug dependants' sense of identity. They argue that their research demonstrates that drug dependants are stimulated by a desire to restore a 'spoiled identity', as they realise that they exhibit characteristics that are unacceptable to themselves and significant others.

McIntosh and McKeganey (2002) believe that what distinguishes successful attempts is that they have at their core a concern with the person's sense of self or identity. The central feature of a 'spoiled identity' is the realisation of an individual that he or she exhibits characteristics that are unacceptable both to themselves and to significant others. The process of recognising and acknowledging a 'spoiled identity' and the subsequent decision to give up drugs were usually the result of a gradual process of realisation, while negative and positive experiences prompted a review of personal identities. The circumstances that can force heroin dependants to review their identities can be single events, ongoing experiences, or usually both. Often it is the impact that their heroin use has on those that are significant that forces the heroin dependent to confront what they have become.

McIntosh and McKeganey (2002) suggest that these factors were seldom sufficient in themselves to promote permanent exit from drug misuse, arguing that their potential effect was mediated by the meaning which individuals ascribed to them and the implications that these interpretations had for their sense of self. These factors act as a mirror to the self, by revealing to the dependants the nature and extent of their spoiled identity and by forcing them to review what they had become.

McIntosh and McKeganey (2002) suggest further that one of the reasons why the process of deciding to give up drugs is a gradual and evolving one is because it involves the individual accepting a negative definition of themselves. It is believed that this will be resisted for as long as possible, due to the potential implications for the individual's sense of self worth. The individual must have a desire for a new identity and a different style of life. Positive occurrences, such as marriage or birth of a child, could re-awaken a heroin dependant's perspective on the future and show that it can be better than the present and worth striving for. Heroin dependants have to believe that it is feasible to develop a new identity and life. Failed attempts at recovery are not necessarily a waste of time as they may play a significant role in the process of recovery. A period of abstinence could clarify and highlight the extent that their identities have been damaged. During abstinence, heroin dependants can examine their heroin-using lifestyle from the perspective of the non-user.

Also, the heroin dependants' non-using, or residual, identity can re-emerge and comparisons can be made between it and the heroin-induced identity. This view is supported by Kellogg (1993) who suggested that the key to successful recovery from heroin dependence is the construction by the heroin dependant of a new identity incorporating non-using values and perspectives of a non-dependant lifestyle.

The restoration of a 'spoiled identity' cannot be achieved by the simple act of the heroin dependant declaring that he or she has stopped taking heroin and other drugs; a renewed sense of self has to be built and constantly defended against a variety of often powerful opposing factors. One of the reasons why the transition is so difficult is because the individual has to get used to an almost entirely different way of life. The heroin using lifestyle has provided much of the meaning, structure and content of the person's life, often for many years, then all of a sudden it is gone and something has to take its place (McIntosh & McKeganey, 2002).

Re-entering conventional life is, for most heroin dependants, far from easy and at first many feel strange, incompetent and lacking in important practical and social skills as they have been detached from mainstream activities and culture for a long time. The second aspect that makes managing the transition out of heroin so difficult for many dependants is the unrelenting nature of the task of ensuring that they retain an abstinate lifestyle (McIntosh & McKeganey, 2002).

According to McIntosh and McKeganey (2002), the most clear reference to identity was in terms of giving up 'for yourself', as many participants made it was clear that you would be unlikely to succeed if you sought to stop for the sake of others, the implication being that success would only come if you did it for yourself, i.e. for the sake of your own identity.

McIntosh and McKeganey (2002) believe that one of the problems with stopping for reasons other than the self, is that the drug is frequently considered more powerful than a whole range of very good reasons for stopping, and so the only realistic prospect of overcoming this power comes when the drug-using identity is being rejected. According to McIntosh and McKeganey (2002), the majority of participants referred to identity in terms of the negative impact that their lives as dependants had on their sense of self, which was generally reported in the form of a deep unhappiness at the person they had become. Sometimes the dependants sense of revulsion at what they had become was associated with a belief that they had become a 'different' person during their dependence, although a memory of their former drug-free selves sometimes remained. Indeed the presence of this residual memory sometimes played a vital role in the decision to quit, as it enabled dependants to recognise the extent to which their identities had been damaged by their dependence, and provided seeds of hope for the future because this memory enshrined within it the belief that they did not have to be the people they had become (McIntosh & McKeganey, 2002). Although McIntosh and McKeganey (2002) strongly emphasise the importance of the recognition of a spoiled identity, they do concede that this is insufficient on its own to achieve recovery, and that it went hand in hand with a desire for a new identity and different lifestyle, as well as the need to believe that change was feasible, since without this, any inclination to alter behaviour would simply disappear (McIntosh & McKeganey, 2002).

Unlike other literature, the experience of rock bottom-like experiences was not a universal or necessary condition for successful recovery in McIntosh and McKeganey's (2002) study. Like Biernacki (1986),

McIntosh and McKeganey (2002) identified two principal routes out of drug use, the rock bottom type or exit via rational decisions, the main difference being, having to stop in the former and wanting to stop in the latter. As is the case in other studies (Prins, 1994; Biernacki, 1986), deciding to give up drugs was surrounded by a great deal of ambivalence for the participants in McIntosh and McKeganey's (2002) sample. There was a clear conflict between a desire to change and a reluctance to give up the drug. Indeed, it seems that ambivalence is endemic to the lives of heroin and drug dependants and is present for a large part of their drug-using career. Overall, McIntosh and McKeganey (2002) believe that the findings from their detailed study have helped to enhance the understanding of the process by which dependants appear to 'mature out' of dependence, arguing that it is closely related to the recognition of a spoiled identity, and the factors, which promote this recognition and encourage/facilitate the decision to change.

2.8.5 Pharmacological effects

In terms of recovery, McIntosh and McKeganey (2002) found that alongside cognitive and perceptual shifts, important changes in the pharmacological effects of drugs play a major part in the dependants' decision to stop using. It seems that the realisation that the drug is no longer a positive part of a dependants life represents an important turning point, a view that is backed up by numerous researchers (Stimson & Oppenheimer, 1982; Frykholm, 1985; Prins, 1994). The heroin dependant just feels normal, rather than gain pleasurable effects. Also, a stage is reached when the process of getting and taking heroin comes to be regarded as tedious and unpleasurable. The realisation that heroin is no longer a positive presence in the users life could be an important turning point. However, the physiological dependence can remain a barrier for recovery (Burroughs, 1977; Singer, 1975; <http://www.substancemisuse.net>).

2.8.6 Natural healing experience

Further important insights into the nature of the recovery process come from George Vaillant, who followed alcoholics for forty years, and looked at how those who have pulled out of their difficulties have succeeded. Unlike some, Vaillant (1996) does not believe there is a specific age where dependants recover, arguing that the notion of 'burnout' in middle life is a misinterpretation of the relatively smooth attrition among drug-dependent individuals. According to Vaillant (1996), the critical factors in achieving abstinence do not seem to be maturation, treatment intervention or even a stable pre-morbid personality or social adjustment, but instead recovery seems to depend on the severity of dependence, and on the individual encountering the right kind of natural healing experience. Vaillant (1996) argues that there are three general factors contributing to stable remission, which can operate at any stage in the life cycle. The first factor is when there is mild substance abuse, which lasts only for a short period, and a simple change in life circumstances may lead to complete remission. This is illustrated in Robins' (1993) research, which shows that a change in environment for many servicemen returning from the Vietnam War, resulted in remission, indicating the important role that social context may play in addiction and recovery. The second factor is very severe dependence, which seems paradoxical, but evidence suggests that severity i.e. getting tired/hitting rock bottom may be favourable for recovery (Vaillant, 1996). The third factor is the fortuitous occurrence of life experiences, which disrupt entrenched habits, and minimise relapse. These experiences include acquiring a substitute behaviour that competes with the dependence, encountering compulsory supervision, discovering new sources of hope and self-esteem, and finding new people to love to whom the dependant is not 'in

debt'. According to Vaillant these experiences are mutually reinforcing circumstances, found most reliably in CBT (Cognitive Behavioural Therapy) programmes and in groups like NA. Literature reviews of remission from various addictions by Brownell, Marlatt, Lichtenstein and Wilson (1986), Stall and Biernacki (1986), and Miller (1993) confirm these life experiences to be important.

2.8.7 Psychosocial intervention

It seems that the potential role of psychosocial intervention within the recovery process has been downplayed in a sense, with findings such as those of Waldorf and Biernacki (1979), Stall and Biernacki (1986), and Cunningham (1999), suggesting that the proportion of dependants who manage to overcome dependence without formal psychosocial intervention may be even greater than or equal to the proportion who recover following treatment intervention for their dependence. However, the importance of psychosocial intervention continues to be demonstrated in studies like that of McIntosh and McKeganey (2002), where the interviewees expressed a deep appreciation of various treatment services, such as counselling and support, and detoxification and rehabilitation services. There is also evidence to suggest that psychosocial interventions of different kinds can produce various benefits (see Edwards, 2000), as well as evidence to suggest that many years later patients will remember the intervention of some treatment/professional as being significantly related to their recovery (Edwards *et al.*, 1987).

However, since research demonstrates that a range of competently applied psychosocial interventions with different theoretical underpinnings are likely to give roughly the same kinds of success rates, it is somewhat difficult to establish what aspects of intervention are particularly effective. Even though the positive components of psychosocial intervention remain unclear, it is possible that positive interventions may have in common the capacity to catalyse and support natural processes of recovery (Edwards, 2000). Although 'maturing out' has traditionally been applied to the process by which some dependants give up drugs 'naturally' without the aid of psychosocial intervention (Winick, 1962; Biernacki, 1986; Prins, 1994), researchers like McIntosh and McKeganey (2002) believe that this is too narrow a view of the processes going on. They argue that it is possible for the 'maturing process' to apply as much to those dependants who overcome their dependence with the assistance of psychosocial intervention, since it is the decision to stop that is important, and whether this occurs with or without intervention is of secondary importance (McIntosh and McKeganey, 2002).

Even though research suggests that there are people that recover without the need for psychosocial intervention, there is still a significant proportion who require treatment, which has led to the conclusion by some that treatment is a modest but worthwhile facilitator of natural recovery. According to Edwards, Marshall and Cook (1997), although psychosocial intervention is one of a number of interactive influences that can play a part in recovery, it can be helpful in many ways, for example it can help to nudge the person towards a more constructive way of seeing things or enhance self-efficacy. Edwards (2000) has drawn together relevant research to provide a useful summary of how people usually get better from drinking problems, and some of the ways that psychosocial interventions can support recovery. Firstly, dependants have to believe that change is feasible, and skilled therapists can be helpful in enhancing self-efficacy. Dependants need to be motivated, and specific treatments such as Motivational Interviewing can be used here, with much emphasis being placed on the need to be ready to change, due to the growing popularity of

Prochaska and DiClemente's (1992) model of change. Since recovery involves movement towards a goal, therapists can also be helpful in clarifying appropriate goals. It is clear that successful recovery involves avoiding relapse, which can be done through learning various psychological skills, e.g. CBT, and with building of supportive networks, which can be achieved through groups like NA and after-care. Finally, since change must feel good for it to be held, a major part of treatment often involves helping people to find rewarding substitutes for their use. Treatment research also points to the reality of between-person variation, in the sense that what one person gains from therapy may be different to someone else's gain (Edwards *et al.*, 1997).

2.8.8 Relapse prevention

A fundamental problem that has to be addressed by all recovering heroin dependants is that the desire for heroin remains for a long time, and in many cases is never completely eradicated. Substitution with other drugs, most commonly alcohol and cannabis can occur. This can result in new problems, although often the substitution is a short-term strategy. Some use distraction, namely trying to concentrate activities and mind on matters other than heroin. Others use 'negative contexting' or the reminding of themselves of the negative side of using heroin (<http://www.substancemisuse.net>). Friday (1982) presupposes that individuals who return to heroin use after a period of abstinence are people, for whom the abstinence is marked by ambivalent feelings, wanting and not wanting the drug.

Relapsing on heroin can occur when the strategies which recovering heroin dependants adopt to maintain their abstinence fail. To help prevent this, the recovering dependant should avoid people who use heroin and other drugs, establish a set of non-heroin and other drug related activities and relationships, develop a new positive sense of self, find constructive and satisfying ways of occupying time and avoid becoming lonely, isolated and bored (<http://www.substancemisuse.net>).

Two related processes, according to McIntosh and McKegany (2002), are important for establishing a new identity and preventing relapse. First, heroin dependants have to distance themselves from their past lives and their drug-using networks. Second, they have to develop a range of new activities and relationships both to replace those that they have given up and to reinforce and sustain their new identities. Heroin dependants have to dissociate themselves completely from their drug-using friends and from the drug sub-culture. However, success in avoiding heroin-using friends could lead to other problems such as initial social isolation. This situation could also be compounded by the fact that heroin dependants have often become detached from their own families as a result of their dependence. The fact that social isolation can lead to relapse demonstrates the importance of the recovering heroin dependants establishing an alternative set of social relationships as soon as possible. The constructive occupation of time when giving up heroin is crucial as the heroin-using routine - getting the money, acquiring and then taking the drug - took up a major part of the day. However, simply occupying time is not necessarily sufficient, doing something that provides a sense of purpose and gives their lives meaning, is necessary.

If the new life of a recovering heroin dependant has been established, with its new activities and relationships, is seriously threatened or damaged, the person's resolve can be seriously undermined and the temptation to start using heroin again can become irresistible. Trigger events can be loss of employment,

ending of a relationship, other personal crisis and traumas. The risk of relapse may increase when the dependant is feeling emotionally fragile or hurt. However, many recovering heroin dependants are capable or withstanding difficulties in their lives. While relapse is a very real and ever-present danger to the recovering heroin dependant, it is certainly not inevitable and strategies for preventing it can be effective (<http://www.substancemisuse.net>).

Often the ideal solution is paid employment. Employment keeps the recovering heroin dependant occupied and out of the way of temptation. Also, it provides an alternative network of non-users to whom the person could relate and who could provide reinforcement for their claim to a new identity. Employment strengthens ties to conventional society by providing recovering heroin dependants with a stake in the future along with the means by which he or she could maintain a heroin-free life-style. It also encourages a positive sense of self-based on the satisfaction that the former heroin dependant derives from holding down a job. New activities and relationships impart a sense of normality and progress and help to reinforce faith in both the desirability and in the probable success of rehabilitation (Sayre, *et al.*, 1992; Schottenfeld, *et al.*, 1999; Pearson, 1987).

2.9 SUMMARY

It can be concluded that while heroin has been used to meet physiological, mental and spiritual needs since earliest times, it seems particularly compatible with the special needs generated by modern society. The current orientation toward heroin use did not simply happen, and it was not created by the pushers. The problem lies in the users. Heroin can be all things to all people. Heroin can reduce a psychological or physical pain, fill a spiritual void, confer an identity or kill time - up to a point and at a price. In all cases, the heroin dependant perceives use of the substance as providing the most convenient and effective means of filling a dominant need, and has no sufficiently strong disincentives against filling it in this way.

This has been a long chapter, perhaps because the process of 'coming off' heroin can be a long process. But whether or not someone approaches the question of 'coming off' gradually, with or without methadone or other pharmacological intervention, or as a swift self-administered withdrawal, each heroin dependant is eventually faced with the problem of 'staying off'. Repeatedly heroin dependants say that this is much more difficult to accomplish. It would be wrong to think of this difficulty, however, as arising from heroin's awesome addictive powers. It is perhaps more a question of the way in which, in order to support heroin dependence, addicts must structure their lives around the effort to secure a continuous supply. Staying off heroin seems to be as much about rebuilding new routines, new motivations, new identities and new friendships as it is about avoiding the temptations of the drug itself. This is, of course, easier said than done. Factors such as unemployment undoubtedly make it more difficult for people to stay off heroin because of their inability to replace heroin's rigid daily routine with any other meaningful time-structure.

Clearly heroin dependence and recovery are contentious and complex issues, and there is great variation between individuals and no one single pathway to recovery. Despite this variation, there is no doubt that the increased interest in this area of research can significantly improve the understanding of some of the process involved in recovery.

CHAPTER 3

METHODOLOGICAL PARADIGM AND RESEARCH DESIGN

3.1 INTRODUCTION

This analysis, at the purely descriptive level, primarily concerns itself with the reality that is experienced by the research participants. However, it also includes any reference to heroin that the researcher has had exposure to, whether it be occupational, media, books and so forth. It is important to include the researcher's own experience and imagination of possible experience within the collective experience. The researcher's view is an important element as the variations on the themes are always compared and contrasted with the researcher's experience in order to establish clarity within the meaning of heroin dependants' recovery.

In terms of the researcher's involvement and exposure to heroin dependants and the rehabilitation of heroin dependants, it started in 1998 with one addict, Pieter, who was sixteen and had been admitted for his first residential treatment for heroin dependence. Pieter had been an intravenous heroin dependent for a year and was the first heroin dependent I ever had as a patient. Indeed, he was probably the first heroin dependent admitted to that specific rehabilitation centre ever. I instantly had a sense of recognition with heroin dependants.

There was limited specialised care and knowledge concerning heroin dependence at that time in South Africa. The common sentiment amongst professionals whom I consulted with advised me that heroin dependants did not respond to intervention. They were viewed as very dissident, and if they were admitted for residential care, they were normally isolated from other patients. It was during long hours of guarding these individuals that I came to understand the nuances specific to the heroin sub-culture. This was a unique and strange opportunity. Unique in that I had spent a considerable amount of time in their presence over the course of eight years and due to this fact I came to understand these dependants on a meaningful level. Strange in that there was a lack of specialised knowledge and skills within many treatment facilities regarding the phenomenon of heroin dependence. Due to urban legend, *inter alia*, the notion that they were the 'hardest' patients to deal with, I imagine I was one of few at the time to have spent a so a great deal time with heroin dependants in isolation. I couldn't imagine, being an idealistic, enthusiastic young therapist, why this group of patients should be different from any other patient and not respond to therapy. Many of them were very charming. They were young, they were intelligent, they were gifted, and they were sensitive - as well as being scheming, manipulative and difficult. In the years since, it has been demonstrated that heroin dependants can recover. Pieter is six years clean from intravenous heroin dependence, this I know as we contact each other at least once a year as our birthdays fall on the same day.

Heroin dependants not only crossed my path in rehabilitation and psychiatric facilities, but also those incarcerated, involvement in media productions concerning heroin dependence as well as being subpoenaed for a heroin-related murder trial (see Chapter 1, Figure 1.1, p.3). Instinctively I knew that from these heroin dependants ultimately something unique and distinctive would come out of the situation. Many of these ex-heroin dependants have indeed been interviewed for this study, and I accredit them with any specialised knowledge that I might have acquired.

3.2. RESEACH DESIGN

3.2.1 Methodological Paradigm

McKeganey (cited in Neale, 2000), argues that there is a strong case for linking qualitative and quantitative techniques when investigating the addictions in order to improve the explanatory power. Such a combination of methods is not, however, without limitations. In this study, the analysis of material from the qualitative part of the study is potentially subject to more researcher bias than the quantitative analysis. The small sample size, meanwhile, increases the danger of Type II errors (the null hypothesis is not rejected when it is actually false). Additionally, the representativeness of the study population is not certain given that data relating to the total number of recovering heroin dependants in South Africa is unavailable. Ultimately, however, the aim of the study is not to provide a basis for substantial generalisation or the formulation of scientific laws or rules. The objective is rather to provide an explorative and descriptive account of the recovery process from active heroin addiction and dependence from the vantage point of recovering heroin dependants themselves. To this end, because the participants discussed their thoughts and feelings in their own words, the information collected seems likely to offer a high level of validity, and degree of insight into events, circumstances and interventions that lead to their recover.

A qualitative descriptive research approach has been used for the participant interviews. An attempt has been made to study heroin dependants perceptions concerning intervention efficacy from the 'emic' or 'insiders' perspective. The goal of the research can thus be defined as describing and understanding rather than explaining and predicting human behaviour. The chief shortcoming of the chosen qualitative research methodology is that it may not provide conclusive answers to the research question, but may allude to the answer and could provide insights into the research methods that could provide more definitive answers.

Data relating to the population and samples' socio-demographic and biographic information has been analysed in order to gain a systematic impression.

3.2.2 Measurement

In order to explore the background of the heroin population in Gauteng over the course of the last six years, data was obtained from the SACENDU. This served at the pre-study of the research. The SACENDU data has also been utilised for comparison purposes with this study's socio-demographic data.

3.2.2.1 Semi-structured interviews and analyses

Semi-structured interviews were conducted in order to gain a detailed picture of participants' experiences of heroin dependence and what is needed to achieve recovery. According to Babbie & Mouton (2001), this method provides much more flexibility than the more conventional structured interview, questionnaire or survey, as the participant gives a fuller picture and the researcher is free to follow up interesting avenues that emerge in the interview. Babbie & Mouton (2001) also describe the 'natural fit' that exists between semi-structured interviewing and qualitative analysis. By employing qualitative analysis an attempt is made to capture the richness of the emerging themes rather than reducing the responses to quantitative categories, and wasting the opportunity provided by the detail of the verbatim interview data (Babbie & Mouton, 2001). The inductive nature of this approach is unique in

that it assumes an openness and flexibility of approach and allows a conceptual framework to emerge from the data.

The semi-structured interviews with the recovering heroin dependants were tape-recorded, transcribed and the interview contents subjected to content analysis. The interview between the researcher and respondent had a general plan of enquiry, and an interview schedule with relevant 'probes' was utilised. The participants were asked the following question;

'Describe to the fullest your process in coming 'clean' from heroin, and to the extent that counselling and/or medical intervention was able to assist you.'

Various 'probes' were utilised in order to further investigate the participants recovery process such as whether or not the participant still experienced cravings and how they dealt with them, the role of support systems, significant others and societies perceptions towards someone with a history of heroin dependence, whether or not the participant found it hard to remain abstinent from heroin - and if so, how they overcame these difficult period. Participants were also asked whether or not they thought treating heroin dependence was different to the treatment intervention of other forms of substance dependence, as well as their perception with regards to the necessary length (if any) of intervention. Participants who used heroin intravenously were additionally asked if they or their friends had ever shared needles, and if they had ever felt apprehensive with regard to contracting HIV/AIDS. Many participants spontaneously spoke of how they became dependent on heroin, as well as the contributory factors that lead to their heroin dependence.

3.2.2.2 Questionnaire

A mixed design was adopted; using semi-structured interviews as well as a questionnaire (see Appendix C). The questionnaire was adapted from the 'Intake' TCU Methadone Outpatient Forms questionnaire (<http://www.drugtext.org/library/bookmenu.htm>), and was used to obtain the biographic and sociodemographic particulars of the recovering heroin dependants. The 'Intake' TCU Methadone Outpatient Forms questionnaire was adopted due to its content appropriateness. Information contained in the 'Intake' TCU Methadone Outpatient Forms questionnaire regarding the participants relationships with spouse/primary partner/children in the last six months, hours spent per day in leisure or social activities, significant others' alcohol and drug histories, religious background, detailed relationships with family members in the last six months, acculturation, peer relations, detailed criminal history, health and psychological status, detailed alcohol and other drug use, gambling history and aids risk assessment, was not adopted in the ammended questionnaire as the information gathering would have proved to have been too extensive. However, should the present study ever be expanded on, such detailed data gathering could enhance the overall understanding of the profile the participants, and could prove to be useful in terms of assessing high risk factors and planning intervention strategies accordingly.

The biographic/sociodemographic variables obtained from the adapted questionnaire included the following

- * *Age* - no restrictions were placed on age.
- * *Gender* - both males and females were interviewed.
- * *Race/Ethnicity* - no restrictions were placed on race or ethnicity.
- * *Area of Permanent Residence*.
- * *Residing Place for Most of the Time in the Last Year* - whether the participant was living with family or other relatives, with a group of friend(s) or non-family members (non-institutional),

alone in own dwelling, homeless, hospital, rehabilitation facility or nursing home, jail/prison or the correctional facility or any other dwelling, for most of the time in the last year preceding the interview.

- * *Current Legal Status* - this included information of any incarcerations or probation, parole, probation and parole, awaiting charge, trial or sentence, outstanding warrant, case pending and any other legal implications.
- * *Current Level of Education* - schooling /qualifications and special interest.
- * *Number of Completed Years of Schooling* - information was gathered with regards to standards/grades failed or repeated and reasons as to why this occurred.
- * *Employment Status* - whether the participant was currently unemployed, undertook occasional or irregular work, were part-time or full-time employed.
- * *Reason/s for Unemployment* - whether the participant did not try to find work, tried but couldn't find work, was unable to work due to alcohol and drug problems, was unable to work due to other health problems, was needed at home or any other reasons.
- * *Family Background* - marital status of biological parents was obtained, together with information regarding whether or not biological parents were still alive.
 - This section also included a Likert scale which was used to explore parental relationship domains during the course of the participants life-worlds, such as whether or not biological parent(s) and/or stepparent(s) were employed, supported the participants family financially, spent enough time with the participant, yelled or had loud arguments with the participant (verbal abuse), hit the participant very hard (physical abuse), made the participant engage in sexual acts against their will (sexual abuse), got drunk (alcoholism), used other psychoactive substance (drug dependence), did things against the law, spent time in prison, was a good parent, and really loved the participant.
- * *Current Legal Marital Status* - whether or not the participant had ever been married, was legally married, living as married (including common law marriage), separated, divorced or widowed. The participants' marital status history was also elaborated on.
- * *Type of Psychosocial Intervention Undertaken* - this information gathering included all types of in-patient short term interventions, in-patient long term interventions, halfway houses, Narcotics Anonymous, other self-help group interventions and Correctional Service interventions. The chronological order, together with dates and duration of each intervention, was obtained from each participant.
- * *Type of Medical Intervention Undertaken* - information was gathered regarding all medications used within the recovery process for both withdrawal and subsequent to withdrawal. Medication used was recorded in chronological order together with dates and duration of use. The number of 'cold turkey' episodes was also documented (with and without withdrawal symptoms).
- * *Substance Abuse History* - the information gathered included the length of heroin dependence, modes of ingestion (smoking, intravenous, intramuscular, snorted, swallowed or other), primary mode of ingestion, how regularly the participant was using heroin and dosage (daily, weekly, monthly), how many times the participant tried to quit heroin on their own ('cold turkey'), in a treatment intervention programme, in prison or some other way. The participant was also asked as to how many times they had quit heroin for a year or longer (together with dates and duration), and how many times they had quit heroin for less than a year (together with dates and duration). Abuse of any other psychoactive substance during heroin abstinent periods was

also documented, as well as psychosocial and medical/pharmacological interventions undertaken during heroin abstinence periods.

3.2.2.3 Sampling procedure and data collection

Data was collected from 40 participants, 31 of which had remained abstinent from heroin for over a year. The majority of the participants had undergone some type of psychosocial and/or medical/pharmacological intervention in an effort to overcome their heroin dependence. No restrictions were placed on age, gender, and area of residence or ethnicity. Interviews were conducted from April 2004 to June 2005.

The snowball non-probability technique was utilised. According to Breakwell, Hammond and Fife-Shaw (1995), this type of sampling technique is particularly useful for difficult-to-get-to populations such as drug users. The main sources of participants were acquired through the process of accumulation as each located participant suggested another participant, and also through various intervention networks familiar to the researcher, such as NA, registered and unregistered short-term and long-term residential facilities, state residential facilities, psychologists and social workers in private practices, as well as word-of-mouth. Due to the nature of the researcher's employment, some of the participants were familiar to the researcher. Correctional Services granted consent to interview incarcerated recovering heroin dependants at Emthonjeni Juvenile Prison (Baviaanspoort), unfortunately all the offenders known to the researcher had been either released or transferred to other prisons by the time consent was granted for the interviews. Furthermore, Correctional Services at present does not keep record of the type of substance that an offender might have abused prior (and often during) incarceration, so no incarcerated heroin dependent unknown to the researcher could have been identified or approached. A built in bias of this type of sampling technique is that heroin dependants in other networks or in no networks at all were not sampled. Another bias called researcher/ experimenter effects (Breakwell *et al.*, 1995) might have occurred if participants familiar to the researcher might have tried to 'please' the researcher in their responses.

No incentive was offered to the participants during recruitment. Before the interview commenced, a standardised plan of the interview was read out to each participant, and they were assured of confidentiality and anonymity. Participants were also informed that they were under no obligation to answer any questions that they were uncomfortable with, and that they were free to pause for a break or terminate the interview at any time. Each participant was then asked to sign and date a standardised consent form. The questionnaire focusing on the biographic and demographic particulars of the participants was completed by the researcher, after which an interview with each participant was tape recorded.

3.2.4 Data Analysis

The interview recordings, which ranged from 14 to 42 minutes, were subsequently transcribed. The interviews were recorded for several reasons. Firstly, this avoided the need to make extensive notes during the interview, which allowed the researcher to give participants their full attention in order to maintain rapport and to follow up any interesting areas not already stipulated within the interview guidelines. Secondly, this avoided the potential difficulties of relying on the interviewer's memory, since memory can often be a selective and inaccurate. Finally, this allowed for subsequent transcription verbatim, which provided a rich source of data on which to conduct the analysis. Generally, the digital recorders provided high quality recordings, which were imperative for successful transcription and

analysis of the data. Although the process of transcribing the semi-structured interviews for analyses was labour intensive, it was deemed necessary in order to achieve sources of data that were detailed and rich enough to successfully conduct the analysis on.

Content analysis was employed to analyse the interview data. Content analysis is different from other methods in the sense that it allows the generation of theory that closely approximates the reality it represents, rather than the testing of theory. The inductive nature of this method assumes an openness and flexibility of approach, which is advantageous since it allows the researcher to follow the leads gained from the data (Gould *et al.*, 1974). This approach can also help the analyst break through the biases and assumptions that can be brought to or developed during the research process. This was especially important considering the lack of research within the substance misuse field exploring the views of substance dependants themselves, and including these views in the planning and delivery of services.

Transcribed interviews were read, subjected to content analysis, and discussed by the study's supervisor, co-supervisor and research student in order to determine the usability of the material and the categorising of themes within the interviews, this increased the inter-rater reliability of the study. Interviews were then purged of all connecting words in order to separate out words containing meaning versus words lacking significance (Elgie, 1998). To authenticate interpretations, interview conclusions were taken back to a sub-set of participants (Breakwell *et al.*, 1995).

The interview was comprised of separate meaning units. Meaning units were determined by phrases or paragraphs that were able to stand on their own and generate meaning. The translation of interviews to meaning units involved using the participants own language in order to best generate a true meaning of their language (Elgie, 1988).

Categories were established by removing the meaning units from the rest of the interview and applying phrases that would encompass several of the meaning units at once in their totality. These categories were coded in order to identify the regularities. Categories that were clustered together became themes (Elgie, 1998).

The discussion of the findings was organised in the following way:

- * The themes that were derived from the interviews of the 40 participants was explored in order to find the explicit meaning behind the heroin dependants perception with regard to the important factors that facilitated their eventual exit from heroin dependence.
- * The presumption of themes is discussed and compared to the actual data that was derived from interviews.
- * The themes and their meanings were compared with the existing literature regarding this subject.

3.2.5 Statistical analyses

The biographic and demographic details of the study lent itself to statistical analyses. The statistical distributions of many variables that were addressed in this study were unknown and unpredictable; thus non-parametric statistical techniques were primarily utilised.

3.2.6 Data capturing

After the biographic and demographic data was collected, it was converted into computer readable format, which included assigning numerical values to information, e.g. male = 1; female = 2. Nominal variables such as gender were assigned '1' or '2'; this did not hold any significance other than to identify it. Ordinal variables, where there was some degree of order in the assignment of a number, for example the variable education level, A-1 assigned to grade 12 is less than A-2 assigned to a university degree, this implied, in contrast to the nominal variables, actual numerical values.

After entry, the data was 'cleaned'. This involved ensuring that no invalid responses were captured. The inspection of the data in this manner was part of ensuring high quality research data. The statistical package SPSS was used to analyse the data.

3.3 ETHICAL CONSIDERATIONS

While conducting the research, there were several important ethical issues taken into consideration. During the undertaking of interviews, particularly on topics as sensitive as addiction, dependence and recovery, it was essential that trust be established early in the interview so that a good rapport with the participant could be established. To assist this, participants were reminded of their anonymity in the research, and the interviews were conducted as informally as possible, on a one-to-one basis, so as to ensure that a conversational style of interview developed. Since the study covered a sensitive subject certain ethical considerations needed to be addressed, it was possible that the interview might raise particularly upsetting or uncomfortable emotions for the participants. In order to avoid potential problems, participants were reminded that they did not have to answer any questions that they were uncomfortable with, and that they were free to terminate the interview at any time.

As a result, the interviews were successful in the sense that for the most part participants seemed to be at ease during the interviews, and were generally happy to be involved in the research. The accounts therefore were taken to be truthful and accurate, since participants had agreed to participate in the study and realistically participants were unlikely to gain anything from being untruthful.

- * The welfare of the participants in the study was addressed at all times. The harm to someone who participated in the study was not greater than the risk that the participant would normally have encountered (Breakwell *et al.*, 1995). Due to the explorative nature of the research, it is not anticipated that this ethical code has been breached.
- * The principle of informed consent was adhered to in the study. Participants were fully informed with regards to all aspects in the research that might reasonably be expected to have influenced their willingness to participate in the study (Zechmeister & Shaughnessy, 1992).
- * Understandable language was utilised when obtaining the appropriate informed consent. Each participants consent was appropriately documented (*The Professional Board of Psychology, Health Professions Council of South Africa, Ethical Code of Professional Conduct*, 2002).
- * For participants who were legally incapable of giving informed consent, appropriate permission was granted and documented from a legally authorised person, together with the participants consent (*The Professional Board of Psychology, Health Professions Council of South Africa, Ethical Code of Professional Conduct*, 2002).

- * Informed consent was obtained from each participant and legally authorised person (when appropriate) for the recording of the interviews (*The Professional Board of Psychology, Health Professions Council of South Africa, Ethical Code of Professional Conduct, 2002*).
- * All participants input were treated in confidence, although due to the nature of the method of data collection (questionnaires and interviews), participants cannot be considered to be anonymous since the interviewer collected the information from an identifiable participant (Babbie & Mouton, 2001).
- * The 'Confidentiality Statement' (see Appendix B) stated that all information disclosed during participation in this study was protected within the limits of the law. However, it was also stipulated that a report to the police department or the appropriate protective agency would be required in the following cases:
 - if in the judgement of the researcher, a research participant became dangerous to himself or herself or others (or their property), and that the revealing the information would be necessary to prevent danger;
 - if there was suspected child abuse, in other words if the child was under 18 and had been a victim of crime or neglect;
 - if there was suspected elder abuse, in other words was a male or female aged 60 or older had been a victim of crime or neglect.

If a report was required, the researcher would have discussed its contents and possible consequences with the research participant, however, no such infringement occurred (Miller, 1999).
- * No form of deception was utilised within the study. Due to the explorative nature of the study, all participants were fully informed with regards to the nature of the study (Babbie & Mouton, 2001).
- * From the outset of the study, it was made clear to the participants that they had the right to withdraw from the study at any time without any negative effects to them (*The Professional Board of Psychology, Health Professions Council of South Africa, Ethical Code of Professional Conduct, 2002; Breakwell et al., 1995*).
- * All participants were debriefed with regards to the exact nature of the study. The researcher discussed with all the participants their subjective experience of the research process, so that any unintentional effects of the research process could be monitored and intervention recommended or arranged if necessary (*The Professional Board of Psychology, Health Professions Council of South Africa, Ethical Code of Professional Conduct, 2002; Breakwell et al, 1995*).
- * It was made clear that to the participants that there was no form of direct benefit from participating in the study.
- * All findings have been reported and will be made known to the scientific community. Technical shortcomings have been indicated; limitations of the study and methodological restraints that determine the validity of the study has also been specified (Babbie & Mouton, 2001).

3.4 SUMMARY

The overall aim of the study was to conduct qualitative/quantitative research, exploring in detail the views of recovering heroin dependants regarding their addiction, dependence and recovery process. The variation between the findings of quantitative and qualitative research draws attention to the importance of applying both types of research to obtain a more complete picture of heroin users' perspectives of recovery. The findings of this study have subsequently been recorded in the following two chapters.

CHAPTER 4

RESULTS

4.1 INTRODUCTION

A detailed recording of the sample characteristics made it possible to build a composite impression of the recovering heroin dependants' biographic and demographic life-worlds. This formed the wider social, cultural, economic and situational context within which the content analytic data unfolded.

4.2 BIOGRAPHIC AND SOCIO DEMOGRAPHIC CHARACTERISTICS

4.2.1 Age

Participants ranged between the ages 16-49. The mean age is 23.98 and the standard deviation 7.721. The highest proportion of heroin dependants interviewed ranged between the ages 20-24 years, 40% ($n = 16$), and the second highest proportion of participants interviewed ranged between the ages 16-19 years, 30% ($n = 12$). This tendency correlates distinctly with the SACENDU Gauteng data for the first half of 2003 which indicates that the highest proportion of 196 heroin dependants in treatment, 47.9% ($n = 94$ of 196), ranged in the age category 20-24 years, and that the second highest proportion of heroin dependants in treatment, 19.4% ($n = 38$ of 196), ranged between 15-19 years (Plüddemann, personal communication, October, 28, 2003).

4.2.2 Gender

Of the participants, 20% ($n = 8$) were females and 80% ($n = 32$) males. Similarly, the SACENDU Gauteng data for the first half of 2003 indicates that of 196 heroin dependants in treatment, 26% were females and 74% males (Plüddemann *et al.*, 2004).

4.2.3 Ethnicity

The majority of participants, 92.5% ($n = 37$), were white¹. The only other population group represented in this study were black African participants at 7.5% ($n = 3$). The reason for this result may be that heroin use and dependence only started to appear within the black African culture and other population groups towards the commencement of this study. However, the ethnic representation of this study correlates distinctly with the SACENDU statistics for 196 heroin dependants in Gauteng during the first half of 2003, with only 2% ($n = 4$ of 196) of heroin dependants in treatment being black African, 2.6% ($n = 5$ of 196) Asian, 2% ($n = 4$ of 196) coloured, and the majority, 93.4% ($n = 183$ of 196), white (Plüddemann, personal communication, October, 28, 2003).

4.2.4 Country/province/city of residence

Of the participants sampled, 77.5% ($n = 31$) resided within the Pretoria area, this included the areas of Centurion, Akasia, Mamelodi and Soshanguve, while 7.5% ($n = 3$) participants lived in Johannesburg. In Cape Town and the Northern Province (Pietersburg and Tzaneen) 5% ($n = 2$) of

¹ The terms 'white, black, and coloured' refer to demographic markers and do not signify inherent characteristics. These markers were chosen for their historical significance. The demographic characteristics of substance users are important in identifying vulnerable sections of the population and in planning effective prevention and intervention programmes (Plüddemann *et al.*, 2004).

participants resided respectively. A further 2.5% ($n = 1$) of participants resided in Mpumalanga (Evander), while 2.5% ($n = 1$) participants lived in the United Kingdom.

4.2.5 Place of residence

Of the sampled population, 87.5% ($n = 35$) participants lived with a significant other, while 12.5% ($n = 5$) resided on their own.

4.2.6 Current legal status

Only 15% ($n = 6$) of participants had undergone some type of legal intervention during the course of their recovery, such as a court order to a rehabilitation centre or incarceration. The majority of participants, 85% ($n = 34$), had never been arrested or incarcerated.

4.2.7 Current educational status

The majority of participants were well educated, 35% ($n = 14$), having completed some form of tertiary education, 30% ($n = 12$) matriculated, while 35% ($n = 14$) ranged between Grade 7-Grade 11 as highest level of education completed. Many of the participants who ranged in the Grade 7-Grade 11 category were of a school attending age at the time of participation in the study. The participants tended to be better educated than the heroin dependants represented in the Gauteng SACENDU statistics for the first half of 2003, which reflects that only 6.1% ($n = 12$ of 196) heroin dependants undergoing treatment were in possession of a tertiary qualification (Plüddemann, personal communication, October, 28, 2003).

4.2.8 Years schooling completed

The majority of participants, 62.5% ($n = 25$), completed twelve or more years of schooling, while 37.5% ($n = 15$) completed 7-11 years of schooling. Most of those who had completed more than twelve years of schooling failed at least one grade due to their heroin dependence.

4.2.9 Employment status

In terms of employment status, 50% ($n = 20$) were employed full-time and 12.5% ($n = 5$) worked part-time, 22.5% ($n = 9$) were unemployed at the time of the interview, and 15% ($n = 6$) of the participants were scholars. The employment status of the participants sampled seemed to be better than that of those heroin dependants undergoing treatment during the first half of 2003 in Gauteng, according to SACENDU statistics, the majority of participants, 60.7% ($n = 119$ of 196), were unemployed, while only 23% ($n = 45$ of 196) worked full time. A further 5.1% ($n = 10$ of 196) were employed part-time (Plüddemann, personal communication, October, 28, 2003). The findings reflected in the SACENDU data may be due to the fact the most of the SACENDU participants at the time of participation in the SACENDU project had remained abstinate from heroin for a very short time, while the participants in this study had been substantially longer heroin abstinent and consequently had more time to stabilise various domains, such as employment, of their life-worlds.

4.2.10 Reasons for unemployment

Of the 22.5% ($n = 5$) of participants who were unemployed at the time of participation in the study, 10% ($n = 4$) stated that they tried but could not find work, 5% ($n = 2$) reported that they could not work due to alcohol and/or drug problems, while a further 7.5% ($n = 3$) stated that they could not work due to reasons such as raising children etc. A further 10% ($n = 4$) reported that there were

other reasons (such as a lack of a work permit) as to why they were unemployed at the time of the interview.

4.2.11 Marital status

The majority of participants, 82.5% ($n = 33$), had never been married, while 15% ($n = 6$) were married and 2.5% ($n = 1$) were divorced. The findings of this study in terms of marital status of the participants correlates quite prominently with the Gauteng SACENDU data of 196 heroin dependants undergoing treatment during the first half of 2006, with the majority of SACENDU participants, 80.1% ($n = 157$ of 196), reporting that they had never been married, 6.6% ($n = 13$ of 196) married and 6.2% ($n = 12$ of 196) divorced (Plüddemann, personal communication, October, 28, 2003). The high percentage of single participants in both this study and in the SACENDU project might be attributed to the majority of participants ranging in the young adult age category of 20-24 years old.

4.3 PROFILE OF FAMILY BACKGROUND CHARACTERISTICS

A Likert scale was used to evaluate varies relationship domains during the course of the participants' life-worlds between them and their biological and stepparents.

4.3.1 Biological parents marital status

Of the samples population 62.5% ($n = 25$) of participants biological parents had never been divorced, while 30% ($n = 12$) of participants stated that their biological parents were divorced, and 7.5% ($n = 3$) had never, or no longer had contact with their biological parents up until the time of being interviewed.

4.3.2 Biological father profile

Of the forty participants in the study, thirty-three participants responded on the biological father profile. The standard deviation was calculated to be 5.59999 and the mean 54.7879.

In terms of participants biological fathers being alive, 77.5% ($n = 31$ of 33) stated that their biological fathers were still alive at the time of being interviewed, 12.5% ($n = 5$ of 33) of participants stated that their biological fathers had died, while 10% ($n = 4$ of 33) of participants had either never known their biological fathers, or no longer had any form of contact with their biological fathers.

Of the sampled population, 90.9% ($n = 30$ of 33), evaluated that their biological fathers worked consistently throughout the course of their life-worlds. A further 9.1% ($n = 3$ of 33) of participants reported that their biological fathers had not to varying degrees been consistently employed during the course of raising them. None of the thirty-three participants evaluated that their biological fathers had never been employed. Of the responses provided, 90.9% ($n = 30$ of 33) stated that their biological fathers contributed financially consistently and adequately during the course of their lives, while 3% ($n = 1$ of 33) of participants stated that their biological father had never financially supported the family during the course of their life-worlds. A further 6% ($n = 2$ of 33) of participants reported that their biological fathers had supported their family financially to varying degrees during the course of their life-worlds.

Of the sampled population, 21.2% ($n = 7$ of 33) participants were of the opinion that their biological fathers had always had loud arguments or were verbally abusive towards them, while 66% ($n = 20$

of 33) participants reported varying degrees of verbal abuse/loud arguments during the course of their life-worlds between them and their biological fathers. A further 18.2% ($n = 6$ of 33) participants stated that their biological fathers had never had loud or abusive arguments with them. Only 9.1% ($n = 3$ of 33) of participants reported that their biological fathers had hit them hard/had been physically abusive on a consistent basis during the course of their life-worlds, however, a further 36.4% ($n = 12$ of 33) of participants reported varying degree of aggressive physical contact between them and their biological fathers. Just over half of the sample, 54.5% ($n = 18$ of 33), of participants reported no form of physical abuse between them and their biological fathers. The majority of participants, 97% ($n = 32$ of 33), reported no form of sexual abuse conducted by their fathers, while 3% ($n = 1$ of 33) participants reported having been sexually abused by her father.

In terms of substance dependence histories, 18.2% ($n = 6$ of 33) participants reported that their biological fathers had been full-blown alcoholics during the course of their life-worlds. A further 33.4% ($n = 11$ of 33) of participants evaluated that their biological fathers had abused alcohol to varying degrees during the course of their life-worlds. However, 48.5% ($n = 16$ of 33) of participants stated that their biological fathers had never abused alcohol, while only 3% ($n = 1$ of 33) of participants reported that their biological fathers had been chronic illicit drug addicts. A further 6.1% ($n = 4$ of 33) of participants reported that their biological father abused illicit drugs inconsistently. The majority of participants, 90.9% ($n = 30$ of 33), reported that their biological fathers had never abused any form of psychoactive or illicit substance.

Of the sampled population, 87.9% ($n = 29$ of 33) participants reported that their biological fathers had never committed anything against the law, however, 6.1% ($n = 2$ of 33) participants reported that their biological fathers had had some clashing with the law. None of the thirty-three participants reported that their biological fathers had a pervasive pattern of breaking the law. Only 9.1% ($n = 3$ of 33) of participants stated that their biological fathers had spent brief periods of time incarcerated. The majority of participants, 90.9% ($n = 30$ of 33), stated that their biological fathers had never spent any time incarcerated.

Only 12.1% ($n = 4$ of 33) participants were of the opinion that their biological fathers had spent enough and quality time with them during the course of their life-worlds, while a further 12.1% ($n = 4$ of 33) participants stated that their biological fathers had spent an adequate amount of time with them, and 48.5% ($n = 16$ of 33) participants were of the opinion that their biological fathers had spent an average amount of time with them. Only 12.1% ($n = 4$ of 33) of participants were of the opinion that their biological father had spent an inadequate amount of time with them during the course of their life-worlds, while 6.1% ($n = 2$ of 33) of participants were of the opinion that their biological fathers had never spent enough time with them while they were being raised.

Regarding levels of strictness, 36.4% ($n = 12$ of 33) of participants were of the opinion that their biological fathers had been extremely strict during the course of their upbringing. A further 36.4% ($n = 12$ of 33) were of the opinion that their biological fathers had been strict most of the time during the course of their life-worlds, while 12.1% ($n = 4$ of 33) of participants were of the opinion that their biological fathers had been average in terms of strictness. A further 6.1% ($n = 2$ of 33) of participants were of the opinion that their biological fathers had not been strict, while another 6.1% ($n = 2$ of 33) of participants stated that their biological fathers had been extremely lenient during the course of their life-worlds.

Only 33.3% ($n = 11$ of 33) of participants were of the opinion that their biological fathers were really good parents. A further 42.4% ($n = 14$ of 33) of participants were of the opinion that their biological fathers had been a reasonably good parent, while 12.1% ($n = 4$ of 33) of participants were of the opinion that their biological fathers had been an average parent. A further 9.1% ($n = 3$ of 33) of participants were of the opinion that their biological fathers had been a poor parent, and 3% ($n = 1$ of 33) of participants were of the opinion that their biological father had been a really bad parent.

The majority of the participants, 75.8% ($n = 25$ of 33), were of the opinion that their biological fathers had always loved them during the course of their lives, while 18.2% ($n = 6$ of 33) of participants were of the opinion that their biological fathers loved them to varying degrees. Only 6.1% ($n = 1$ of 33) of participants stated that their biological father had never loved them.

4.3.3 Biological mother profile

Thirty-seven of the forty participants responded on the biological mother profile. The standard deviation is 6.48699 and the mean 54.4054.

The majority of participants, 90% ($n = 36$ of 37), verbalised that their biological mothers were currently alive, 7.5% ($n = 3$) of participants biological mothers were deceased, while 2.5% ($n = 36$ of 37) of participants had been adopted and had never had any form of contact with their biological mother.

In terms of mothers employment history, 48.6% ($n = 18$ of 37) of participants stated that their biological mothers had always been employed full-time during the course of their life-worlds, while 12.5% ($n = 5$ of 37) reported that their biological mothers had been housewives and therefore had never been employed. Of the sampled population, 35% ($n = 14$ of 37) of participants reported that their biological mothers had been employed to varying degrees during the course of their life-worlds. Over half of the sample, 56.8% ($n = 21$ of 37), evaluated that their biological mothers had always contributed financially to the family upkeep, while 41.4% ($n = 12$ of 37) of participants reported that their biological mothers had contributed financially to their family's upkeep to varying degrees during the course of their life-worlds. Only 10.8% ($n = 4$ of 37) of participants stated that their biological mothers had never contributed financially to their family's upkeep as they had been house-wives for the duration of their married live.

Loud or abusive arguments with biological mothers failed to feature prominently within this category, however, 24.3% ($n = 9$ of 37) evaluated that their biological mothers had almost always severely verbally abused them during the course of their life-worlds, while 21.6% ($n = 8$ of 37) of participants reported that their biological mothers had verbally abused them on a regular basis. A further 35.1% ($n = 13$ of 37) of participants reported some verbal abuse from their biological mothers during the course of being raised. Only 2.7% ($n = 1$ of 37) of participants reported severe physical abuse from their biological mother on a consistent basis, however, a further 22.2% ($n = 9$ of 37) of participants stated that some level of physical abuse to varying degrees during the course of being raised by their biological mothers. The majority of participants, 73% ($n = 27$ of 37), experienced no form of physical abuse during the course of their upbringing. No cases of sexual abuse from the side of biological mothers were captured.

Full-blown alcoholic biological mothers were reported by 10.8% ($n = 4$ of 37) of participants, with a further 10.8% ($n = 4$ of 37) of participants reporting that their biological mothers had been problem

drinkers during the course of their life-worlds. The majority of participants, 67.6% ($n = 25$ of 37), stated that their biological mothers had never abused alcohol. Furthermore, the majority of participants, 81.1% ($n = 30$ of 37), reported that their biological mothers had never abused any form of illicit or other psychoactive substances. Only 5.4% ($n = 2$ of 37) of participants reported that their biological mothers had chronic substance (mostly prescription and other the counter medication) dependence problems, while 13.5% ($n = 5$ of 37) participants stated that their biological mothers had abused psychoactive substances to varying degrees.

The majority of participants, 91.9% ($n = 34$ of 37), stated that their biological mothers had never had any form of conflict with the law. Only 2.7% ($n = 1$ of 37) of participants reported that their biological mother had had serious conflict with the law, while 5.4% ($n = 2$ of 37) participants stated that their biological mothers had been in some conflict with the law to varying degrees during the course of their life-worlds. Only 2.7% ($n = 1$ of 37) of participants reported that their biological mother had been incarcerated for an extended period. The majority of participants, 94.6% ($n = 35$ of 37) indicated that their biological mothers had never been incarcerated.

Only 16.2% ($n = 6$ of 37) of participants were of the opinion that their biological mothers had been very strict during the course of life-worlds. This category tended to be diffuse, and no prominent tendency is apparent.

In terms of quality time that biological mothers had spent with the participants, 40.5% ($n = 15$ of 37) of participants evaluated total stability on this factor, however, only 2.7% ($n = 1$ of 37) of participants evaluated that their biological mother had been totally absent in terms of time spent with them during the course of being raised. A further 40.5% ($n = 12$ of 37) of participants were of the opinion that their biological mothers had spent adequate quality time with them, while 18.9% ($n = 7$ of 37) were of the opinion that their biological mothers had spent an average amount of quality time with them. Only 5.4% ($n = 2$ of 37) participants stated that their biological mothers had spent an inadequate amount of time with them during the course of their life-worlds.

Approximately half of the participants, 56.8% ($n = 21$ of 37) were of the opinion that their biological mothers had been a very good parent. A further 27% ($n = 10$ of 37) were of the opinion that their biological mothers had been an adequate parent, while 10.8% ($n = 4$ of 37) participants were of the opinion that their biological mothers had been average in terms of their parenting. Only 5.4% ($n = 2$ of 37) of participants were of the opinion that their biological mothers had been poor in terms of their parenting skills. None of the thirty-seven participants reported that their biological mothers had been an extremely bad parent during the course of their life-worlds.

The majority of participants, 78.4% ($n = 29$ of 37), felt that their biological mothers completely loved them, this may be an indication of affection warmth within the family environment, while 13.5% ($n = 5$ of 37) of participants felt that their biological mothers loved them adequately. Only 5.4% ($n = 2$ of 37) participants were of the opinion that their biological mothers loved them to varying degrees ranging from average to poor. A minority of participants, 2.7% ($n = 1$ of 37), were of the opinion that their biological mother completely failed to love them whilst they were being raised.

4.3.4 Stepfather profile

Eight of the forty participants responded on the stepfather profile. The standard deviation was calculated to be 7.54865 and the mean 53.8750.

The majority of participants, 87.5% ($n = 7$ of 9), stated that their stepfathers worked consistently throughout the course of their upbringing. None of the eight participants evaluated that their stepfathers had never been employed. This profile is similar to that of biological fathers, and appears to be a stable factor. Of the responses provided, 62.5% ($n = 5$ of 9) stated that their stepfathers contributed financially consistently and adequately during the course of their live-worlds.

Only 12.5% ($n = 1$ of 9) of participants were of the opinion that their stepfather always had loud arguments or were verbally abusive toward them during the course of being raised. Half of the participants, 50% ($n = 4$ of 8), reported varying degrees of verbal abuse/loud arguments during the course of their life-worlds between them and their stepfathers. A further 37.5% ($n = 3$ of 9) participants stated that their stepfathers had never had loud arguments with them. None of the eight participants reported that their stepfathers had hit them hard/had been physically abusive on a consistent basis during the course of their lives, however, 25% ($n = 2$ of 8) of participants reported varying degree of aggressive physical contact between them and their stepfathers. In terms of physical abuse incurred on the participants by their stepfathers, 75% ($n = 6$ of 9) participants evaluated that their was no form of physical abuse incurred by their stepfathers during the course of their life-worlds. None of the eight participants reported any form of sexual abuse conducted by their stepfathers.

Regarding substance dependence, 25% ($n = 2$ of 9) of participants evaluated that their stepfathers had been full-blown alcoholics during the course of their life-worlds. A further 50% ($n = 4$ of 8) of participants evaluated that their stepfathers had abused alcohol to varying degrees during the course of their upbringing. Only 5% ($n = 2$ of 9) of participants reported that their stepfathers had never abused alcohol. None of the eight participants stated that their stepfathers had chronic drug problems. The majority of participants, 87.5% ($n = 7$ of 8), stated that their stepfathers had never abused any form of licit or illicit psychoactive substances. While 12.5% ($n = 1$ of 9) of participants reported some drug abuse by their stepfather.

The majority of the participants, 87.5% ($n = 7$ of 9), evaluated that their stepfathers had never done anything against the law. Only 12.5% ($n = 1$ of 9) of participants reported that their stepfathers had had some conflict with the law. None of the eight participants reported that their stepfathers had a pervasive pattern of breaking the law. Only 12.5% ($n = 1$ of 9) of participants reported that their stepfathers had spent brief periods of time incarcerated. The majority of participants, 87.5% ($n = 7$ of 8), reported that their stepfathers had never spent any time incarcerated. These findings almost mirror those of the biological father profile, with 87.9% ($n = 29$ of 33) of participants reporting that their biological fathers had never done anything against the law and a further 6.1% ($n = 2$ of 33) of participants stating that their biological fathers had had some clashing with the law. None of the thirty-three participants reported that their biological fathers had a pervasive pattern of breaking the law.

In terms of the level of strictness, 37.5% ($n = 3$ of 9) of participants were of the opinion that their stepfathers were extremely strict during the course of their upbringings. A further 37.5% ($n = 3$ of 8) were of the opinion that their stepfathers had been strict to varying degrees during the course of

their upbringing, while 25% ($n = 2$ of 9) of participants were of the opinion that their stepfathers had never been strict during the course of their upbringing.

Only 12.5% ($n = 1$ of 8) of participants were of the opinion that their stepfathers had spent enough quality time with them, while 25% ($n = 2$ of 9) of participants were of the opinion that their stepfathers had never spent enough time with them. Only 35.7% ($n = 3$ of 8) of participants were of the opinion that their stepfathers had really been a good parent. Half, or 50% ($n = 4$ of 9), of the participants were of the opinion that their stepfathers were to varying degrees a good parent, while 12.5% ($n = 1$ of 9) of participants evaluated that their stepfather had never been a good parent. As with the father profile, the responses tended to be diffuse and no clear trend is apparent.

Half, 50% ($n = 4$ of 9), of participants were of the opinion that their stepfathers had always loved them during the course of their lives. The remaining participants, 50% ($n = 4$ of 9), were of the opinion that their stepfathers loved them moderately. None of the participants were of the opinion that their stepfathers had never loved them during the course of their life-worlds.

4.3.5 Stepmother profile

Five of the forty participants responded on the stepmother profile. The standard deviation is 10.35374 and the mean 50.8000.

In terms of stepmothers employment history, 60% ($n = 3$ of 5) of participants evaluated that their stepmothers were employed full-time during the course of their upbringing. While 20% ($n = 1$ of 5) reported that their stepmothers had been employed most of the time. A further 20% ($n = 1$ of 5) participants stated that their stepmothers had never been employed during the course of their upbringing. The majority of the sample, 80% ($n = 4$ of 5), evaluated that their stepmothers contributed financially to the family upkeep on a consistent basis, while 20% ($n = 2$ of 5) of participants evaluated that their stepmothers had sometimes contributed financially during the course of their life-worlds.

Loud or abusive arguments with stepmothers featured more prominently compared to biological mothers within this category, with 40% ($n = 2$ of 5) of participants evaluating that their stepmothers verbally abused them during the course of their life-worlds. A further 40% ($n = 2$ of 5) reported some verbal abuse, while 20% ($n = 1$ of 5) of participants stated that their stepmother had never verbally abused them. None of the five participants reported severe chronic physical abuse from their stepmothers during the course of their life-worlds, however, 40% ($n = 2$ of 5) of participants reported some level of physical abuse to varying degrees during the course of their upbringing. The majority of participants, 60% ($n = 3$ of 5), experienced no form of physical abuse. This is a similar tendency as with that analysed with the biological mother profile which indicated that 22.2% ($n = 9$ of 37) of participants reported some level of physical abuse to varying degrees during the course of being raised by their biological mothers. The majority of participants on the biological mother profile, 73% ($n = 27$ of 37), experienced no form of physical abuse during the course of their upbringing. As with the biological mother profile, no cases of sexual abuse were reported.

No cases of full-blown alcoholic stepmothers were either reported, however, the participants reported that 40% ($n = 2$ of 5) of their stepmothers abused alcohol to varying degrees. However, 60% ($n = 3$ of 5) of participants reported that their stepmothers had never abused alcohol during the course of their life-worlds. The majority of participants, 60% ($n = 3$ of 5), reported that their

stepmothers had never abused any form of licit or illicit psychoactive substances, while 40% ($n = 2$ of 5) of participants evaluated that their stepmothers had abused psychoactive substances to varying degrees.

None of the five participants' stepmothers had ever had any form of conflict with the law or had been incarcerated.

None of the participants were of the opinion that their stepmothers had been very strict during the course of the upbringing. However, 60% ($n = 3$ of 5) of participants were of the opinion that their stepmothers had been reasonably strict in raising them. A further 20% ($n = 1$ of 5) of participants were of the opinion that their stepmother had been extremely lenient in raising them, and another one participant, 20% ($n = 1$ of 5), was of the opinion that their stepmother was moderate in terms of being strict during the course of their life-worlds.

In terms of quality time stepmothers spent with the participants, only 20% ($n = 1$ of 5) evaluated complete stability on this factor, however, only 2.5% ($n = 1$ of 5) of participants evaluated that their stepmother was completely absent in terms of time spent with them. A further 60% ($n = 3$ of 5) evaluated that their stepmothers had spent adequate to poor time with them during the course of being raised.

Only 20% ($n = 1$ of 5) of participants were of the opinion that their stepmother was a very good parent. The majority of participants, 80% ($n = 3$ of 5), were of the opinion that their stepmothers had been a good parent to varying degrees during the course of raising them.

Of the sampled population, 40% ($n = 2$ of 5) of participants felt that their stepmothers really loved them, a further 40% ($n = 2$ of 5) were of the opinion that their stepmothers loved them to varying degrees. This may be an indication of reasonable affection warmth within the family environment during the course of participants' life-worlds. Only 20% ($n = 1$ of 5) of participants was of the opinion that their stepmother did not love them at all.

4.4 HEROIN DEPENDENCE HISTORY

TABLE 4.4.1 Length of heroin dependence (years)

Years dependent	Frequency	Percent	Cumulative Percent
0	9	22.5	22.5
1	5	12.5	35.0
2	5	12.5	47.5
3	12	30.0	77.5
4	4	10.0	87.5
5	1	2.5	90.0
6	2	5.0	95.0
10	1	2.5	97.0
12	1	2.5	100.0
Total	40	100.00	

The duration of heroin dependence varied from less than a year to twelve years of heroin dependence. The mean average of duration of heroin abuse is 2.64 years and the standard deviation 2.568.

TABLE 4.4.2 Frequency of heroin abuse

Frequency of heroin abuse	Frequency	Percent	Cumulative Percent
Daily	38	95.0	95.0
Weekly	2	5.0	100.0
Total	40	100.0	

The majority of participants, 95% ($n = 38$), abused heroin on a daily basis at the peak of their dependence.

TABLE 4.4.3 Primary method of heroin ingestion

Primary method of ingestion	Frequency	Percent	Cumulative Percent
Smoked	15	37.5	95.0
Intravenous	22	55.0	100.0
Snorted	3	7.5	
Total	40	100.0	

The predominant primary mode of ingestion was reported to be intravenous injection, 55% ($n = 22$), while 37.5% ($n = 15$) of participants reported primarily smoking heroin and a further 7.5% ($n = 3$) snorted heroin as their primary mode of ingestion.

TABLE 4.4.4 Length abstinate from heroin

Length abstinate	Frequency	Percent	Cumulative Percent
0	9	22.5	22.5
1	7	17.5	40.0
2	7	17.5	57.5
3	5	12.5	70.5
4	8	20.0	90.0
5	2	5.0	95.0
10	1	2.5	97.5
27	1	2.5	100.0
Total	40	100.00	

The duration of remaining abstinate from heroin ranged from less than a year, 22% ($n = 9$), to 27 years of abstinence, 2.5% ($n = 9$). The mean length of abstinence from heroin is 2.88 years.

4.4.1 Substitution with other substances of abuse

Thirty-one of the participants, or 77.5%, had abstained for longer than a year from heroin at the time of involvement in the study. Of this percent, 47.5% ($n = 19$ of 31) had substituted with other substances of abuse during the heroin abstinate period, most commonly alcohol, 45% ($n = 18$ of

31), followed by cannabis, 27.5% ($n = 11$ of 31). The third most common substance that participants substituted with was crack cocaine 7.5% ($n = 3$ of 31), cocaine 7.5% ($n = 3$ of 31), hallucinogens 7.5% ($n = 3$ of 31) and methcathinone 7.5% ($n = 3$ of 31). Inhalants 5% ($n = 2$ of 31) and mandrax 5% ($n = 2$ of 31) was reportedly the fourth substance that participants had substituted with. Of the sample, 12.5% ($n = 5$ of 31) of participants abused methamphetamine as a substitute, 2.5% ($n = 1$ of 31) of participants abused other opioids and benzodiazepines respectively. No abuse or substitution with methadone, amphetamines, barbiturates or sedatives was reported. From the analysis it is evident that 60% ($n = 24$ of 31) of participants who had abstained for longer than a year from heroin had undergone therapeutic intervention and 27.5% ($n = 11$ of 31) underwent pharmacological intervention during this time period.

Of the forty participants, twenty-two, or 55%, responded on the category of substitution with other substances during their first year of remaining abstinate from heroin, although thirteen of the twenty-two who responded, had in fact remained abstinate from heroin for longer than a year. Nine, 22.5% ($n = 9$) of the participants had not yet abstained from heroin for longer than year at the time of participation in the study.

Regarding the twenty-two participants who responded in this category, 40% ($n = 16$ of 22) underwent therapeutic intervention and 27.5% ($n = 11$ of 22) underwent medical intervention during their heroin abstinate period. Alcohol was the most prevalent substance abused at 40% ($n = 16$ of 22), followed by cannabis 32.5% ($n = 13$ of 22) and crack cocaine 30% ($n = 12$ of 22). Substitution with the following substances of abuse was less prevalent; cocaine, hallucinogens and methamphetamine respectively at 15% ($n = 6$ of 22), sedatives 12.5% ($n = 5$ of 22), benzodiazepines 10% ($n = 16$ of 22), and methadone and other opiates both at 12.5% ($n = 5$ of 22). Barbiturates, inhalants, mandrax and amphetamines were respectively abused by 5% ($n = 2$) of the participants. Only 2.5% ($n = 1$ of 22) reported abuse and brief dependence on methcathinone.

4.5 DESCRIPTIVE STATISTICS OF BIOGRAPHIC AND DEMOGRAPHIC INDICES

Table 4.5.1 (see below) summarises the descriptive statistical characteristics of the biographic and demographic contexts of the sample groups' process of heroin dependence and recovery. Primary quantitative indicators of this process have been identified as:

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

TABLE 4.5.1 Descriptive statistics of biographic and demographic indices

	N	Minimum	Maximum	Mean	Standard Deviation
Age (years)	40	16	50	23.98	7.721
Years schooling completed	40	7	14	11.18	1.448
Index 1: General Profile of Mother	37	2.46	4.85	4.1850	.49900
Index 2: General Profile of Father	33	2.77	4.85	4.2145	.43077
Index 3: General Profile of Stepmother	5	2.69	4.92	3.9077	.79644
Index 4: General Profile of Stepfather	8	3.00	4.92	4.1442	.58067
Psychosocial intervention: Residential, long-term (frequency)	11	1	12	4.00	2.898
How long using heroin (years)	40	0	12	2.65	2.568
Times quit heroin: On your own 'cold turkey': withdrawal (frequency)	40	1	2	1.80	.405
Times quit heroin: On your own: 'cold turkey': no withdrawal (frequency)	10	2	30	10.50	8.031
Times quit heroin: In a residential treatment programme (frequency)	38	1	29	2.58	4.296
Times quit heroin: In an out-patient treatment programme (frequency)	13	1	12	3.77	3.004
Times quit heroin: In prison (frequency)	2	2	2	2.00	.000
Times quit heroin: Some other way (frequency)	40	1	2	1.20	.405
Length clean from heroin	40	0	27	2.88	4.404

4.6 STATISTICAL ANALYSES

Non-parametric test such as the Mann-Whitney *U*-test and Kruskal-Wallis test was used for the data analysis, as well as parametric tests such as the chi-square. Regrettably, chi-square cross-tabulations could not be performed on most of the data since the chi-square expected cell counts were too low for interpretations. A larger sample with a more even spread in the data collection would have been necessary in order to calculate chi-square analysis. Using chi-square with small expected frequencies runs the risk of Type II errors (Aron & Aron, 2004).

4.6.1 Residing with family and/or friends over last year category

The participants who have lived without family and/or friends over the last year

- * Tended to have been dependent on heroin for longer (Mann-Whitney $U = 38.5$; $\rho = 0.041$; $z = 2.048$; $\alpha < 0.05$).
- * Tended to recover from heroin dependence in ways other than 'cold turkey' (such as self-administered detox's, pharmacological intervention and substitute maintenance programmes), in a treatment programme or when incarcerated (Mann-Whitney $U = 47.5$; $\rho = 0.018$; $z = 2.360$; $\alpha < 0.05$).

4.6.2 Legal status category

Participants who at the time of the interview had never had any form of legal intervention were more likely to have quit heroin 'some other way' (such as pharmacotherapy substitution/maintenance programmes) than those who had undergone legal intervention (Mann-Whitney $U = 66.00$; $\rho = 0.45$; $z = 1.96$; $\alpha < 0.05$).

Current legal status does not relate to

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * length of recovery.

4.6.3 Years schooling completed category

Participants with a schooling of 12 or more years had stopped using heroin significantly longer than those with a schooling of 7-11 years (Mann-Whitney $U = 120.00$; $p = 0.055$; $z = 1.916$; $\alpha < 0.05$).

Years of schooling made no difference to

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome.

4.6.4 Area of permanent residence: urban/rural category

Place of residence does not relate to any of the identified behavioral indices. No significant differences could be identified between urban/rural category regarding

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.5 Gender category

Gender does not discriminate between any of the measures except

- * Men in this sample have quit more times on their own than woman (Mann-Whitney $U = 80.00$; $p = 0.019$; $z = -2.342$; $\alpha < 0.05$).

No significant differences could be identified between the gender categories regarding

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.6 Ethnicity category

Ethnicity does not relate to any of the identified behavioral indices. No significant differences could be identified between the ethnicity categories regarding

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;

- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.7 Age category

The older participants were, the longer they had reportedly remained abstinate from heroin ($\chi^2 = 16.841$; $p = 0.001$; $df = 3$).

No significant differences could be identified between the age categories regarding

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome.

4.6.8 Education category

Successful recovery is not affected by the level of education, no significant differences could be identified between the education category regarding

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.8 Employment category

Present employment status does not have a bearing on

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.9 Biological parents alive category

The biological parent alive category did not relate to any of the identified behavioral indices. No significant differences could be identified between the biological parent alive categories regarding

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.10 Parents ever divorced or separated category

Whether the participants' parents had ever been divorced/separated or not does not relate to

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;

- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.6.11 Current marital status category

Current marital does not relate to any of the identified behavioral indices. Current marital status does not have a bearing on

- * length of heroin dependence;
- * length and frequency of psychosocial interventions;
- * frequency of ways in which heroin dependence was overcome;
- * length of recovery.

4.7 CONTENT ANALYSIS

It is the study's concern to provide information about the heroin addiction and dependence recovery problem and phenomenon in such a fashion that the reader can form their own impression and conclusions. It follows then that the goal of this analysis would be to reduce the distance between the reader and the phenomenon itself. Most readers are denied direct access to the world of heroin use and recovery, and their ways of finding out about that world are limited to channels that provide only abstractions, not representations. In other words, the events of heroin dependence and recovery occur in shooting galleries, alleyways, patrol cars, criminal court, treatment facilities, and other places that most people never see. The public has to rely on newspaper articles, books by experts, word-of-mouth and often other haphazard sources. The specific information presented by these sources may more or less be true, but each step in generating and transmitting places more distance between the reader and subject matter, and consequently diminishes descriptive value. The goal of reducing the distance between the reader and the recovering heroin dependent aims to bypass this process and provide information the reader might gather if the systems itself was directly accessible. Needless to say, complete elimination of the reader-phenomenon distance is impossible, as the researcher stands between them. Since it is impossible for the researcher to act as a mere windowpane, as real, tangible, living situations must be transformed into sequences of words, which is not a passive transmission of information, but an active creative process. The researcher has tried to reduce the distortion and information loss that would be introduced through interpretation and analysis (Gould *et al.*, 1974).

A number of significant themes emerged from the content analysis of the interview data. Each theme is made up of a series of concepts, and in many cases these concepts have been grouped together into sub-themes, which exist within the given theme. To avoid any ambiguity the themes are presented in separate sections, with each section beginning with an overview of the concepts, and if applicable the sub-themes, contained within the overall theme. Following a brief definition/explanation of the overall theme, there is a more detailed interpretation of the data, where each of the concepts and the sub-themes are examined in depth. This analysis is frequently exemplified by extracts from the interviews.

The analysis of the data revealed seven main themes:

1. Ways in: The nature and development of heroin addiction
2. Reasons/factors for heroin use
3. Going deeper: Negative effects of heroin use
4. Ways out: Realisation process
5. Taking action: Behaviour modification
6. Perceived effects of intervention
7. New labels: References to self in recovery

The results of this study have been integrated to form guidelines for the development of a heroin dependence recovery model (see Chapter 5, p, 197), which aims to provide a picture of the processes involved in behaviour modification, the role of psychosocial and pharmacological intervention, as well as the potential path to recovery from heroin dependence. The dependence recovery models of McIntosh & McKegany (2002) and Salter, Davies & Clark (2006) were in particular used as a basis for the formulation of this study's heroin dependence recovery model.

4.7.1 Ways in: The formation and development of heroin addiction and dependence

Although each participant's account of their heroin addiction and dependence was very individualistic, a number of common concepts emerged in relation to the nature of the heroin addiction/dependence, and the way in which it developed.

TABLE 4.7.1 Ways in: The formation and development of heroin addiction and dependence

<ul style="list-style-type: none"> * Powerful nature of heroin addiction * Heroin dependence recovery harder/ more intense than other forms of substance dependencies * Differences/ similarities between heroin and other forms of substance dependence * Difference in heroin addiction due to physiological dependence and withdrawal symptoms * Propagation of heroin 'hardness' by media * Biological and environmental factors related to heroin addiction/dependence * Preoccupation with heroin addiction * Gradual progression of the heroin addiction problem to dependence * Rapid escalation of heroin use and deterioration * Rapid progression and deterioration from lapse to relapse * Changing person

The majority of participants referred in some way to the **powerful nature of their heroin addiction**. They used various descriptions such as feeling that the heroin addiction 'took hold' of them in some way, that they lacked any control over it, or they felt 'trapped' by the heroin addiction. The following quotation provides an illustration of the intensity of heroin addiction.

'Ja (yes), I mean I actually wanted to stop, 'cause like I... it's just that the heroin stuff wore me out. I could feel that I was getting a high, but then I wasn't being myself anymore. I was starting to be someone else, and I never used to have time for my girlfriend. I really missed my old life. That's why. I'd become like a Barbarian, 'cause like heroin... when I used to smoke heroin I... my face became gaunt and down. I was always sleeping you know.' (Participant 40)

As the previous quote demonstrates, for many participants' their heroin misuse seemed to take over their life, particularly in the later stages of their problem as their life tended to revolve more and more around using. They reached a stage where they were dictated to by their heroin addiction,

rather than having any sense of control or choice. The following quote typifies how the participants' heroin abuse become an integral part of their lives.

'The whole thing is a habit pattern. You fall and you use and use and use. They say it takes 42 days to change a habit - for those neuron bonds to regenerate or whatever the case is.' (Participant 21)

Half of participants, 50% ($n = 20$), were of the opinion that heroin dependence was different to other forms of chemical substance, and that **recovery from heroin addiction and dependence was harder or different** in terms of recovery.

'Yip, absolutely, yes. I think heroin is basically one of the worst chemical addictions one can get, that and basically Wellconol as well... I did that as well. You can't compare alcohol with heroin, or dagga with heroin.' (Participant 35)

'With heroin, it's not a "high", it's a neutral - you feel just fine. Where as coke and crack, which was also a huge problem for me, that is actually why I used heroin. That "high" was actually more what I was looking for. But then I used heroin to come down - to just feel "normal", not "normal", but to feel stable. So, because it is physically addictive, I think, I think it is just completely different. I've seen too many people that was with us in rehab, that were on other drugs, and those that were on heroin, there is definitely a difference.' (Participant 20)

'Yes. The drugs are not the same. The physical addiction, your body is addicted. That's what makes it so bad. I used other drugs before I got addicted to heroin. I smoked rocks; I was not addicted to it. I used cat, it wasn't nice, so I used it once and if someone offered it to me again I said no. I used coke, if people approach me now I'll still say "no thank you", but give me heroin, I will not be able to say no.' (Participant 34)

'Other people, like, I've been to Cocaine Anonymous meetings and the crack addicts and cocaine addicts are much different. Um, and I know that's why they have separate meetings for it. And people who just smoke weed are different. Are much different.' (Participant 10)

Various participants were also of the opinion that **heroin addiction was different** compared to other substances of abuse due to **physiological dependence and heroin withdrawal symptoms**, and that subsequently intervention should be specialised and individualised in order to treat such dependencies.

'Hectic. Hectically. It's like day and night. Like you can't treat every person the same, so you can't treat every drug the same. If you on, lets say cocaine, basically you end up... maybe steal and scheme and do stuff to get that drug. But, more likely, it's the upper class people that use coke, but not necessarily. The upper class people also use heroin. I know lots of computer guys who earn a lot of money, that use heroin. I just think that as the drugs differ - treatment is different. Because the effect of the heroin, the, actually the negative effect that heroin gives you, like the withdrawals. If you go down on crack, you're confused in your head. Coke and all the rest is more mentally. Heroin is physically, you know you can die of withdrawals, physically withdrawals of heroin.' (Participant 25)

'Yes, definitely. Heroin makes every cell, everything in your body, every muscle, it makes everything addicted. The moment you quit, then it feels as if your muscles get life and you get cramps and yes, mentally, that addiction is also severe because it keeps you in a constant depression basically. It's not a high, it's a downer, and the moment you start coming clean, and you stop smoking, you start craving severely. Yes, there's definitely a difference.' (Participant 37)

'Ja (yes), I think it's a whole lot different 'cause like with dagga you don't get, you don't get like those stomach cramps, I mean. I used to, I used to like, um, my stomach would get knots, that's how bad, immediately when you let go then like bad gasses, like you feel you're really dying, ja (yes). Do, I mean like, even in a rehab if a person had to get that, I think it would really hurt.' (Participant 40)

'It is very, very hard. It's a 24 hour a day addiction that you have. An hour passes and you must use otherwise your muscles are sore and it feels as though you literally want to die from the pain of withdrawal. And it's a matter of an hour, two hours then you can start...' (Participant 13)

'The advantage, you're probably going to think it's crazy, the advantage that a heroin addict has is that you realise how addicted you were to a drug. While acid and coke and those type of drugs, you don't click it always. So you realise what drugs do to you, how it damages and that type of thing.' (Participant 21)

Four participants (10%), however, were of the opinion that all forms of substance dependence are intrinsically similar.

'No, at all. There is no difference at all. The alcoholic, the heroin addict, there is no difference. It's all the same really. Whether the individual needs some form of chemical to get by in the day - whether it's heroin or whatever. My mum is on prescription stuff from the doctor, from the pharmacists, and she understands there is not much difference between me having to prescribe myself heroin to get through the day, and the doctor prescribing her anti-depressants and so forth to help her get through the day. There's not much difference. You know, someone was prescribing her - I was prescribing myself basically at the end of the day... to get through the day.' (Participant 31)

'I don't really think so. I don't think there's really much of a difference between any addiction, whether it's alcoholism or heroin. I don't think there's much of a difference. It's still the same. The perception... you're still like, how can I say? The addiction itself is... how can I say? The actual problem itself is not using the heroin, or using alcohol, there's other issues that are involved. So I basically see them all as the same, whether it's ecstasy, or LSD, or heroin, or coke. Whether it's physiologically addictive or how can you say? Psychologically addictive or whatever, it's all the same thing really.' (Participant 32)

'I think there is a difference, but I think it all comes down onto the same thing. I think that heroin just grips you different, it brings you down. It makes you physically... you need it just everyday. Because I smoked crack as well, and I didn't need that every day, but that took all my money away. But heroin was just every day, and it was non-stop, that's all I was thinking about.' (Participant 38)

'I don't know. It depends from person to person. It depends totally, I mean, many people take heroin to sort of... other drugs is an escape route from reality. I believe so. I don't believe... all addicts have the same motive, and that's it. That's what I believe. But also people need to be treated individually - we are not all the same, but we have the same motive.' (Participant 22)

Some participants seemed **uncertain** with regards to **heroin's** so-called **'hardness'** as compared to other drugs, and the common held idea that heroin dependants are destined to die from their dependence was questioned by one (2.5%) of the participants. The following quotes illustrate the uncertainty expressed by participants. One participant (2.5%) however, emphasised the fact that heroin dependants often believe that their addiction is the **'hardest'** and that this belief is **propagated by the media**. The link between **biological and environmental factors** is also highlighted in the following extract.

'I think you've got it. I think it's both nature, I think it's probably nature and nurture... For sure, I think that the pharmacotherapy for heroin addiction needs different treatment. I don't believe that that... heroin addicts always think they're different, or special, that they're the worst addicts - the best addicts, the worst addicts. I think that's got a lot to do with media... society thinks that heroin addicts are hopeless, everybody that uses heroin dies, and it's just not true. Studies show that, and I know people who used for twenty years and not died. You don't die.' (Participant 27)

'I'm not sure. I don't know how to answer this question 'cause it has come up before. I've asked a person, and he, the psychologist, actually she said to me you can't actually compare 'cause it's a, sometimes it gets psychologically involved... involves a person psychologically, so you can't actually compare. But if you can talk about physical, I'd say heroin is the hardest part to get off, but I can't compare other drugs and other people. Addiction is addiction.' (Participant 15)

In terms of the way the heroin addiction and dependence developed, participants described a **gradual progression** to more excessive and problematic use, developing slowly over a relatively long period. Thirty-three (95%) participants eventually ended up using heroin on a daily basis.

'Well for me it was like a slow gradual slide down and I got to a point where I would just spend hours in the bathroom trying to get one hit. I would be standing with a needle in my neck, I would just be covered in blood with holes, and this went on for a few years and I was abusing friends, family through my addiction... aunts, uncles who wouldn't speak to me in the street. Friends, friends who... police knocking at my door, police knocked at my door saying "can we interview you 'cause we need to know you're whereabouts 'cause so and so was found dead in a crackhouse", or whatever, "and we need to know if you used with him when he died." Over the last few years it was really like that. Most of my friends are in jail or died. And my sister threatened me. A few friends, who are clean, close friends and my mother, over a couple of years I saw what I was doing to them. I saw what I was doing to myself. This was the thing, I never really look what I was doing to myself, and it was going to be just a matter of time before I'd probably over-dosed myself or something stupid because my mind was so messed up. I'd probably have ended up killing myself physically and then over a few months or so I thought about it quite a lot. I didn't want that. I really needed to get help, so I did.' (Participant 31)

Participants generally described later periods (usually at the **peak** of their habit) as involving **rapid changes** both in terms of their use spiralling out of control and in terms of a general deterioration.

'I realised that my life had totally deteriorated and my body too, and I went to speak to my mother. I told her what I was doing and what I was using, "I want to stop; I cannot carry on like this." And from Thursday on they... I told them, they kept my car keys in the safe so that I could not drive to the city.' (Participant 37)

Similarly, periods of lapse were also described as involving **rapid progressions from lapse to relapse**. This again was in terms of the participants use and deterioration in the participant 'in themselves', as a result of the negative effects of their use (for examples of the negative effects see Theme 4.7.3, p. 128).

I learnt pretty much and I got my head sort of together from all my friends and other stuff and I went home and I had a fall-back. I don't know. Ja (yes), it opened my eyes a bit, it made me look a bit further that just to a front wall.' (Participant 7)

With regard to the implications of heroin addiction and dependence, it was clear that for many participants their heroin misuse problem led to a significant **changing of the person**, in terms of their life, lifestyle, perspective, identity etc. This was demonstrated by the fact that participants often noted the differences between themselves as a 'using' and 'clean'² person, implying that the heroin misuse had changed them in some way.

'You take your moms car and you ride it into the wall. Or you throw your appliances out the window or you become agitated, scream and shout at family and friends. You become a completely different person. You're not yourself. You would never in your normal mind, no matter how intoxicated you were with alcohol, you would not perform such, or do any such harmful things to somebody else, even a close friend, who you'd verbally abuse because of the fact that you are withdrawing, and not to do with anything else.' (Participant 24)

'They're emotionless. They only live for heroin. They worry about nothing or anybody. They don't care about themselves. All they're looking for is their drugs, and that's it. They don't care who they hurt and how much they're hurting themselves. They're only looking for their drugs - that's why I say - they are the dead walking. They don't have a soul.' (Participant 26)

*'Oneday I was all spiked up and I was drunk with it as well. I got home very late one night and I came to my room and as I walked into my room there's a mirror, and I caught a glimpse of myself in the mirror and when I looked at my blood eyes I was so shocked. You know, well I can't really explain what I see... what I saw and how I felt. I saw the inner demon, the hate, all the bad things on the outside, and I got a fright of myself you know. This is how people see me know, they don't see *****, they see this thing, because you become heroin. Basically you... okay, ja (yes) okay figuratively speaking, but once you're... heroin is like different bits and pieces of a demon or something bad that your building a demon or something bad, and it takes over your body and you do things that you never thought you would ever do, say things you don't mean and you're in that first stage, you have no hope, heroin controls you. Heroin is your God - it tells you what to do.'* (Participant 30)

4.7.2 Reasons/factors for heroin use

There were numerous reasons and/or factors influencing participants' use of heroin. Although these factors were highly individualistic, a number of common factors emerged from the data, which were sub-categorised into reasons/factors influencing **initial use**, influencing **continued or excessive use**, and influencing **lapse/relapse**. Although each reason/factor is presented as a separate concept, in reality it was often a combination of these concepts that influenced participants use.

TABLE 4.7.2 Reasons/factors for heroin use

<p>4.7.2.1 Initial heroin use</p> <ul style="list-style-type: none"> * Experimentation * High availability * Direct experimentation with heroin

² With respect to the terminology used in this dissertation, being clean refers to abstaining from heroin.

- * Trend toward 'chasing the dragon'
- * Continued use after experimentation
- * Enjoyment

- * Negative feelings
- * False sense of confidence
- * Life problems
- * Background factors

4.7.2.2 Continued/excessive heroin use

- * High availability, enjoyment, negative feelings, life problems
- * Physical dependence and increasing physical tolerance levels
- * Withdrawal symptoms
- * Escapism from heroin misuse problem, financial and employment problems
- * Barriers to behaviour change
- * Fear of withdrawal
- * Shared heroin abuse disorders
- * Preconception that heroin dependence recovery an impossibility

4.7.2.3 Lapse/relapse

- * High availability, negative feelings, life problems
- * Failure to cope with cravings
- * Withdrawal of substitute prescriptions too quickly/substitute withdrawal
- * Substitute medication leading to relapse
- * Complacency
- * Substitution, lack of effort, justification and self-destruction
- * Long process of recovery, daily battle and practical implications

4.7.2.1 Initial heroin use

A range of factors emerged as influential in determining when and why participants **initially** came into contact with various substances, including heroin, the most common of which being **experimentation**. For the majority of participants this involved teenage experimentation with peers of a range of different substances. This was generally, although not always, due to choice and peer pressure rather than force.

'Okay, my addiction in my eyes, is a choice, in short, it's your choice to start - no-one makes that decision for you. But because you use heroin and you then stop one day - your body gets sore and it feels like you're going to die.' (Participant 20)

'Then you know you have to get it. So that's why I think it's initially a choice with heroin.' (Participant 20)

'Depends on the environment you're in. If you're in an environment with lots of friends and all of them in a partying mood... you find yourself - you want to be with them, be in the group - that's where peer pressure comes in. You have to sometimes, you have to make decisions, to turn your back. Sometimes it's not "lekker" (nice); to do that, but on your own, if you think about it, you realise it's the right thing to do. After awhile you get into the mood of saying "no".' (Participant 8)

'I don't know how I got into it, it's the whole thing with the rock 'n roll thing, you meet people with drugs and stuff so, so that's how I got into drugs.' (Participant 19)

'I was so deep in the drug culture, understand? Dealing, and it was difficult... friends.' (Participant 39)

Another common factor influencing initial use was the **high availability** of heroin. This referred to a wide range of reasons, such as mixing within heroin using circles, being in close contact with dealers, friends and/or significant others and being offered heroin and other substances by them, having lots of money, and therefore increasing the potential availability of heroin and various substances.

'I saw this coming, years ago. Because this thing is easily available on every street corner in Pretoria, almost you know. Only in the old days we had to go to Johannesburg, to Hillbrow. Now then, a year, even a year or two later, we've found a dealer here in town. People don't, once again, people don't understand. Poor parents, they go to work and come home. They don't realise their kid's an addict now, until it becomes bad. Then they think, oh well, this is just something... they send him to rehab, and then you'll be fine after three weeks. It's not that, it's a long-term thing.' (Participant 19)

Participants also mentioned that in the past most heroin dependants first consumed a spectrum of drugs before they start to experiment with and abuse heroin, and how this trend may be changing to **direct experimentation with heroin** prior to using any other substances of abuse. This was attributed mainly to the high availability of heroin.

'Yes, that's why I think it's more psychological, I don't know. I don't know exactly how to describe it to you. But if you are there amongst the people, then you know there's a difference between a heroin junky and another junky. Even between coke and party drugs. Party drugs you find more amongst young people. You're cool and you're happening and cocaine - older or business people, anyone. Heroin I think is someone who has gradually done everything. I don't think you get someone who's just a heroin "junkie", eventually, in the long run, only heroin. But they've first been through the spectrum to get to heroin. Although when we used... it was so... but I don't know if today the kids at school get just heroin. Then they're not going to bother with the rest. I don't know how it is so, but in our time it was so.' (Participant 20)

One participant (2.5%) also highlighted the **trend toward 'chasing the dragon'** as opposed to intravenous heroin use, he alluded to the long history of opioids.

'Even its milder forms, any opiate is a, is a physically addictive thing, you know. So if it's opium or morphine or heroin, you know, it's the same thing, it's the same evil basically. The history of opiate addiction goes back centuries. There was a time when it seemed to ease off, because the thing with the needles, but then it became very fashionable again when they started smoking it and "chasing the dragon".' (Participant 19)

The aspect of **continued use after experimentation**, despite the fact that initial heroin use is an unpleasant experience for most persons, is highlighted in the following extract.

'Lots of people I know use heroin once and hate it, and lots of people love it. Using heroin for the first time is not actually a lovely experience. The first few times you're nauseous or throw up and itching. But why did I carry on using you know? Lots of people are put off by that, but why did I; it's like starting to smoke. In the beginning it's not nice, you're coughing and whatever. But why did I keep on smoking until it almost got better, until it was nice to smoke. Until it was nice to use heroin, even though that nice period lasts for a very short time and the horrible period lasts for a long, long time. Why could I never stop using? Also being physically addicted to it, having to use all the time. Ja (yes), I think there's a big difference.' (Participant 10)

Another factor, which was influential in many participants' heroin use, was **enjoyment**, whether it was enjoyment of the taste or the effects of heroin.

'I had a 'poncho' for drugs you know - from an early age, I always wanted to use drugs. I had always enjoyed using drugs. It was really difficult to get my head around the idea that I had to stop using all together, and eventually I kind of knew, and when I knew that that was what I needed to do, I knew exactly what help I needed in order to achieve that.' (Participant 18)

Many participants also reported that part of the reason for their initial use was a response to various **negative feelings**, such as stress, anxiety, loneliness, depression, boredom and insecurity. Often the use was reasoned as their way of coping, suppressing or escaping from these negative feelings. One of the clearest examples of this involved participants using heroin as a way of coping with their insecurity and building their confidence to better cope in social situations.

'Sometimes I am judgmental on myself feeling like I don't fit in and I don't belong and there is something wrong with that and me. But, with time that is also getting less and less. So, I wouldn't be the person today if it wasn't for the road I walked, and it's the way I am living my life.' (Participant 10)

'Yes. Heroin you withdraw more and also I think psychologically one gets addicted to it. You like that high. Heroin people take heroin because you want to be relaxed, and then you get addicted.' (Participant 23)

'I think the big thing was I realised that my family and my parents, and the people that I had hurt long ago, what they meant to me. It's not nice being alone. The last four/five months I was alone. It was me, there were those who smoked with me, but they were strangers, you wouldn't tell them anything. I think that's the thing, I'm scared of being alone again. I know that if I smoke again I'm going to lose my parents, I'm going to lose the few friends I've made now, and yes, that's the big thing.' (Participant 37)

'So, sometimes I really feel like relapsing, at that time I often feel like I don't care in myself, because I am still struggling with my self-confidence.' (Participant 10)

The following quotes exemplify the **false sense of confidence** that heroin evoked for a few participants.

'Once you've mainlined, it's just whoa... it felt to me everytime that I mainlined I felt like a God, understand, anything could come my way. I don't really thing so; it's just an illusion that's given to you. Yes.' (Participant 39)

'Ja (yes) it did hold me back you know. I just thought that like why would, I mean, if someone treated me bad, then I just thought that it was worthless, and all that, so I would just carry on using.' (Participant 9)

Participants also expressed that their initial use was influenced by various **life problems**, such as bereavement, relationship and family problems, and work stress. Again the use was often viewed as a coping mechanism or escapism from various life problems.

'From my parents I felt a bit of resentment. I don't know. I felt like they were getting back at me the whole time. Maybe it was because I was very young, so it felt like they were trying to block me the whole time with everything. With other people, I felt like they wanted to help me... my parents I felt were different. I was angry with them. I was letting them down, so maybe they resented me. I felt like resentment from them, but it changed with time. Time heals all wounds.' (Participant 7)

'With life pressure, I'd say that's also like getting me down. I do kind of manage to get out of it.' (Participant 3)

A final factor that was viewed as potentially influential in several participants' initial use was termed **background factors**, and mostly included difficulties experienced by participants in their childhood, such as abuse, or the death of a parent. Generally, these were viewed more as contributing factors rather than actual reasons for using.

'I believe each druggies drug problem came about due to something that happened in his life. Understand, whether it was peer pressure or sexual abuse as a child, whatever, I believe every druggie had a problem and that's why he shifted to drugs, there must have been something, something big that triggered the child to decide let me move onto drugs, let me experiment with it, understand? I believe you must face your problem. So long as you run away, and the problem runs behind you, you know what I'm speaking about, the problem becomes bigger, so you won't be able to just leave it and think that you can mainline it away. You must face it, you must just stop and actually face your problems, because what heroin does it's a short-term pain reliever in terms of your bodily pain and your emotional pain, understand?' (Participant 39)

4.7.2.2 Continued/excessive heroin use

In terms of the factors and reasons for participants' continued/excessive use of heroin, a number of concepts reported as reasons/factors for initial use continued to be influential. These were **negative feelings, enjoyment** and continued search for a 'high', **high availability**, and **life problems**. A number of other concepts also emerged as important, specifically in relation to participants' reasons/factors for their continued/excessive use. The clearest factor that was reported by the majority of participants was **physical dependence** on heroin. Generally, participants continued to use so as to avoid experiencing **withdrawal effects** and feeling physically bad, and in order to function normally.

'I didn't use because I wanted to. I just used like I needed to, my body needed it and I needed it in order to do anything. So I didn't want to use heroin at all basically.' (Participant 38)

'If you can just get a place were you cannot just get the stuff, then your body automatically tells you that is doesn't need it. After a few couple of days, then your body it fine. So heroin, you need it every day to survive or your body can't even walk.' (Participant 8)

'Ja (yes) there is a big difference because of that physical need and that physical want. It's very different to pills for example, ecstasy, it's not like you have to have your daily fix of it, with heroin you do otherwise you become sick. It's a big thing.' (Participant 11)

Furthermore, participants often reported using more excessively due to **increasing physical tolerance levels**, as they became more dependent on heroin.

'Heroin is something your body gets used to so quickly and without it your body is weak. Compared to dagga, dagga you just get "rustig" (relaxed) if you smoke dagga. Compared to heroin - your body needs it to function, so if you use dagga or buttons - it's not that addictive. You can get addicted to it, but it's not that addictive that you need it every day.' (Participant 8)

'You can't, you know I think addiction is a physical addiction, much more than it's a psychological thing. You can become a heroin addict by accident, you know, after a few times that you've used it, that for me is the worst thing, that physical dependence. Because that's what it is. They always seem to go straight for the psychological things, you know... fill in this questionnaire, unhappy childhood whatever, I think that's a load of rubbish. A lot of people become heroin addict wilfully. Well not wilfully, but they start using heroin. I did, I tried it and then liked it, for the first few months you know, until the lions' nest starts.' (Participant 19)

The following extract illustrates that although heroin dependants speak of the horrors of physical withdrawal, **withdrawal symptoms are not always life threatening**. Two participants (5%) referred to withdrawal as not as intense as what many make it out to be and that **withdrawal symptoms are similar to 'bad flu' symptoms**.

'In retrospect, it was like having a bad flu, because I became dependent again on morphine in 1999. I don't know - because it was medically administered after an accident. It could have made it... it could have made it more comfortable, as long as it was monitored. Had I been given medication to do it on my own - I would have abused it. I wouldn't have been able to not use heroin. It would have definitely helped.' (Participant 27)

'I went "cold turkey", so there was no medical assistance, there was no psychological assistance. My parents didn't even know that I stopped using heroin. So they weren't aware of the fact that I had, or that I was withdrawing. Basically stayed in my room all day or stayed in the garden all day, and steered clear from their attention, because I didn't want them to know that I was using heroin, even though they did know that I was. They had found syringes and they had found, you know, foil and all that. So they were aware that I was taking. They did try and stop me from further abusing it.' (Participant 24)

Another reason for continued/excessive use for many participants was as an attempt to **escape from the heroin misuse problem** itself, and/or the various negative consequences of it. For example, the following extracts shows how a **lack of employment and financial problems**, which occurred as a result of the dependence on heroin.

'So I didn't have any choice... I was told by my father "what about my job? I can't loose my job"... If it didn't give you financial problems. Yes, I believe that no addict wants to quit. You'll want to use forever. But the money runs out.' (Participant 2)

'I have all these problems... where am I going to get money?' (Participant 39)

For many participants, a final factor, which significantly impacted on their continued use of heroin, was various **barriers to behaviour change**, such as a lack of awareness/denial of the problem.

'I felt like naked as I was walking down the street... naked 'cause I was so used to from when I was young having one thing or another as a barrier, drugs is a barrier to keep me away from reality.' (Participant 31)

'You've got to get people to understand that they are addicts' and they must get some sort of help.' (Participant 3)

The latter factor obviously acted as a barrier to immediate behaviour change, but also seemed to have been influential in deterring some participants from committing to behaviour change earlier.

The following extracts also highlight the **fear of experiencing withdrawal symptoms** as a significant barrier to behaviour change.

'I basically just decided that fear of heroin, it can't carry on, because heroin was always to me "the fear" - you never knew where it is, it always comes and it teases you and follows you, you understand? I went to Castle Carey, and the withdrawal symptoms that I experienced there was heavy. It was my severest withdrawal ever. I think it was because I knew it would be my last time. Um, muscle pain, stomach pain; um later it felt like DT's - those DT hallucinations that you get. The pain got so bad that it felt like I was in a dream world, understand? Just to try and stop the pain, understand? Because the pain was intense for me, it was as if my body was saying to me "kry vir jou" (spite yourself), understand?' (Participant 39)

'In the beginning stages - yes. Because you've got cramps. When I was on heroin before I came here. My mom didn't know what to do, and you know you can't sleep you're screaming, you're going... my mom had to lock me in my room. I went crazy - banging the doors, scratching the door, I had cramps. Feels like your body wants to burst from the inside. You can't like die you know. Yes, so... I was permanently biting my face, my eyes looked like they were popping out. You're so vulnerable... you just go crazy, become like a wild animal.' (Participant 30)

The difficulty of heroin withdrawal and the impact it can have on couples with a **shared heroin abuse disorders** in terms of the mutual influence a relapse precipitated by withdrawal symptoms can pose as a high risk to each other, is highlighted in the following extract.

'Well, when I decided that's it and no further, he decided... we basically decided together. But for both of us the withdrawal was too bad, that's why we tried many times to quit, but, the withdrawal was too bad, and, and then you drive and go buy again. If he relapses he's out the door, out of my life. Yes, if he takes again, or if he associates with anything, except for his friends, or if he uses not heroin, but something else... that's why we don't go visit there, and they must come visit us.' (Participant 34)

Another apparent barrier to behaviour change for several participants was a feeling of being unable to see a way out of the heroin misuse problem. Therefore, although participants may have recognised that they had a problem and accepted the need to change their behaviour, they may not have felt able to stop using due to their apparent lack of control over it. The following quote highlights the **preconception** of many heroin users **that heroin dependence recovery is impossibility**.

'In using circles there is kind of, there's a message "no-one gets out of this alive", and that's what I believed. I'm not talking about, I mean this is really going back to my sick thinking, but I thought like, there's people who are kind of, people who are not serious about their addictions, they have been using a couple of years. They kind of part-time addicts, do you know what I mean? There's a bunch of people, quite a considerable bunch of people who've been shooting heroin for more than five years or more than ten years and they're like committed to it. None of those people get well ever, that's what I thought. Like us, we never get better. Do you know what I mean? So, that was the attitude that permeated the circles that I was... yea people would go to rehab, come back and they'd use again. Everybody seemed to. Obviously well if I didn't see them, if I never saw them again it didn't mean they were using, in fact if I ever saw them again it was because they would be using. So it kind of reinforced itself. But it was certainly the inclination I was in, that I won't get better, it's a life sentence.' (Participant 18)

'Using heroin is like the forbidden territory almost. I remember when I started using it, and I know a lot of other people also like that, I think it's okay to smoke weed and it's okay to use ecstasy and acid and coke and all these things, but I used to say to myself; "I am never going to use heroin", because it's, even in the circle of using drugs it's like, a dangerous thing to do because heroin addicts die and that's it. And heroin addicts get AIDS, and heroin addicts throw their lives away and become prostitutes and live with the Nigerians. Even between junkies, there's like this stigma attached to heroin addicts.' (Participant 10)

'I must say, the first while it was difficult. The biggest thing is the fear. The fear of falling or if it doesn't work, or what then? That's the biggest thing. Then the devil rides you. He rides you because he says to you, um, "you aren't going to make it", or "there isn't a way of getting out". The recovery rate is what, one or two percent for heroin?' (Participant 21)

Therefore, although participants may have recognised that they had a problem and accepted the need to change their behaviour, they may not have felt able to stop using due to their apparent **lack of control** over it.

4.7.2.3 Lapse/relapse

Many of the same concepts highlighted as reasons for initial and continued use were influential in participants experiencing a lapse/relapse. Such factors included lapsing/relapsing as a result of **high availability, negative feelings** and various **life problems**, for example, due to still mixing with heroin and other drug users and the resultant temptation of people using in close proximity. However, several additional factors also emerged from the data that were specifically related to lapse/relapse. For some participants, a major reason for lapsing was a **failure to cope adequately with the heroin addiction and the associated cravings**.

'A few incidents had happened but I wasn't really equipped to really deal with it at that stage, and then I started using again. Now the last time it really became bad because I was back on the streets and I didn't really have cash or a place to stay or anything. I was literally on the streets. It was like before when I had money and I could stay somewhere, or get around and the last time I was going to use, I don't know what it was... it definitely wasn't heroin. Everything was lame. I couldn't walk. I couldn't do anything and for the first time. And I can honestly say this, something that I'm not really ashamed to say about it that I cried out to God. That was my saving grace.' (Participant 32)

Another important reason for relapse for some participants was **complacency**. Participants often falsely believed that using a small amount would not result in a full-blown relapse, or they used again because they quickly forgot about the negative effects of use. Other (less common) factors influencing relapse included **a lack of effort/commitment to behaviour change, substitution with another substance** (most commonly alcohol) that later lead to heroin use, **the justification of use as a reward for being clean**, and **self-destruction**, since some participants' felt that they did not deserve the success that came with being clean. An illustration of this self-destruction is given in the following extract.

'When I came out I didn't do the basic things correctly. I used alcohol; as a result I relapsed on ecstasy, one time with coke and a few times with crack - every time I used alcohol. It's been a process over the last three years until now, for me to use nothing. The period of the relapse were short, were periods of... my first was for a month, two weeks, two weeks, two weeks. December - then the college confronted me, then again I was right. Then I used three times on my second and once the end of last year. Every time I used alcohol - that's were I ended up. I never used heroin again and it was during this year that I made the final decision - no alcohol. My biggest thing... I view it almost the same as alcohol. I don't want to... because it is chemicals at the end of the day! You understand.' (Participant 21)

For several participants another factor influencing their lapse/relapse was the fact that **substitute prescriptions were withdrawn too quickly**, or that they were **unable to cope with the substitute withdraw** as it was withdrawn and as a result, they used. Some participants were of the opinion that **substitution medication lead to relapsing on heroin**.

'I went into rehab - four different rehabs, twelve months - then I was totally clean off methadone and heroin and all medications, but when I came out I felt at the time worse than when I went in. I was totally bedridden, and I felt like I couldn't stand up. I felt worse when I came out, and I started using again because I felt worse.' (Participant 31)

'The whole thing is that if you take medication you're replacing one thing with another thing, and the thing is also, for me that really helped because previously I tried to come off drugs I always replaced one thing with another thing. In that way it is easier to relapse because you never have a clear mind, you always want to replace the one thing with something else.' (Participant 22)

The often **long process of recovery and decision making** was mentioned by many participants. The following quotes highlight the **daily battle that occurs during early recovery** and that the first year of recovery is often regarded as the hardest adaptation period. Participants also had to deal with the **practical implications** of their previous heroin use. When an individual stopped using heroin, they found that everyday situations and their past inevitably caught up with them.

'It's very, very hard to stay clean. Initially, I mean. I think for the first nine months that I was clean it was the first thing I thought every morning as I woke up - was about heroin, and it was a daily decision. Then I managed not

to use. It's not enough to just wake up in the morning and saying "I'm not going to use", you are presented with situations during the day where you have to continue making decisions and I think a lot of that was habit, but a lot of it was kind of was, was biochemical. I was just so used to being "stoned" that everything reminded me of heroin. Everything reminded me of using. Everyday situations, my natural response to everything was to get "stoned", and I think that was really hard, part of that psychologically, part of that as I say I think is really physical... I remember waking up nine months or ten months after the last time I used and drug, and like getting to that 12 o'clock in the day, and like fuck, I haven't used heroin once today - profound, do you know what I mean - like 12 o'clock, and then eight, four hours I hadn't thought about heroin at all, and it just slowly got better from there but I think the first year was really, really difficult. I think one of the things about, because I, there were really seriously, serious improvements in my life within that year. I think that helped me to see that what I was doing in my work.' (Participant 18)

4.7.3 Going deeper: The negative effects of heroin use

It is clear that for all participants their substance misuse resulted in numerous **negative effects**. These have been sub-categorised into **physical effects**, **emotional and psychological effects**, **social effects**, **impact on relationships** and the **practical impact**. Many of these negative effects were extremely serious and for several participants some of these effects clearly persisted for considerable time following abstinence.

TABLE 4.7.3 Going deeper: Negative effects of heroin use

<p>4.7.3.1 Physical effects</p> <ul style="list-style-type: none"> * General deterioration * Use-related illness/problems * Needle sharing * Inadequate methods of needle sterilisation * Needle exchange programmes * Risk of contracting HIV/AIDS, hepatitis and other blood borne diseases * Overdose/death * Death due to violence * Personal consequences/self-care <p>4.7.3.2 Emotional/psychological effects</p> <ul style="list-style-type: none"> * Negative feelings/emotions * Numbness * Suicidal/didn't care if dead * General emotional effects * Psychological consequences * Co-morbid psychological disorders * Operant conditioning <p>4.7.3.3 Relationship effects</p> <ul style="list-style-type: none"> * General negative effects * Break-ups/loss of relationships <p>4.7.3.4 Social effects</p> <ul style="list-style-type: none"> * Isolation * Negativity from society * Stigmatisation * Less socially active
--

* Changing social circles

4.7.3.5 Practical effects

* Employment/jobs

* Neglect practicalities

* Lack of responsibility

* Criminal activity

* Practical consequences

4.7.3.1 Physical effects

In terms of **physical effects**, most participants described a **general deterioration** in their physical health/state as a result of their use, and that the progression to intravenous heroin use is particularly difficult to deal with in terms both physical and mental dependence. The vast majority of participants also described experiencing more specific **use-related illnesses** or **physical problems**, such as impotence, muscular pain, weight loss, headaches and sleeping disorders.

'Heroin - the withdrawals physically are quite strenuous on your body and you find it goes into... one cannot perform or function as a normal human being. You get muscular pains, you get headaches and migraines. Whereas alcohol you might just feel that you do need a beer, and your body might say "listen, have a 'dop'." You might feel queasy. I think with ecstasy as well, I think ecstasy is more of a mental addiction than a physical addiction. But, once one used heroin intravenously and you are addicted to it, to go clean is extremely, extremely difficult. One experiences a hell of a lot of physical pain and suffering to try and come clean, which lasts between three and five days, before one starts being able to function as a normal... or even stand up to go to the bathroom.' (Participant 24)

'You deteriorate and you get to a point that you have to stop.' (Participant 2)

'Your physical, your body starts taking a lot of strain. You become very pale, you can't urinate properly, you loose a hell of a lot of weight. A friend of mine, same height as me, almost two metres tall, weighed 53kg when he went to rehab the first time. You get dark rings under your eyes, you become, you look as if you're an AIDS victim. You look as if you got some type of terminal disease. You feel like that too. That stops me mainly.' (Participant 24)

'Certain things that don't function like your sexuality, just goes zero, you know, no interest in that. But that's things that other people wouldn't actually know, for the nodding off all the time, falling asleep in the middle of the day.' (Participant 19)

'Then, I was clean, I didn't use anything from that Thursday until the Sunday one o'clock, and for those four days I hardly slept. I experienced badly withdrawal throughout. That Sunday afternoon I thought that after three days it would be better, compared to the previous time, and it did not get at all better, it only got worse.' (Participant 37)

Collapsed veins due to needle use, re-use of needles and **needle sharing** were reported by seven (17.5%) of the participants who had used heroin intravenously.

'Later it became... you buy one needle, four people would use it. Afterwards it would become so blunt and everything. When you force it into your skin, your skin becomes taught, it's sore. It becomes physically painful and then you begin to miss inject because you can't find a vein, and the thing is so blunt that it presses on your vein. Yes, we shared needles, like mad hey, so... not with so many people. I shared with eight different people during my entire heroin career - girlfriends that I had.' (Participant 39)

'You end up like... two friends in a car and the needles' actually got mixed up, and they're so certain, this is mine and this is mine, this is mine - and I can be certain by certain marks that this is mine, but of course it's touched the other guys' needles. I don't know how or who had it... but I took it anyway. I had withdrawals, "cold turkey", so I learn - you can get your fix, my fix will be better because I waited longer. No one, never ever. Yes, but only with certain people. But the thing is, how I thought is... Koosie only shares with Jannie needles, but Jannie shares only with Sunny and Koosie needles. You know it's like a sick thing that will end up. Not even AIDS, any disease, like yellow fever, or anything, anything. That's also like, my friends would say; "you can share with me I don't have AIDS you know." I usually told them; "no listen here, I'm not scared of AIDS, I'm scared of a cold", or something like that, that's a small disease, a germ. They actually fell for it.' (Participant 25)

'I wasn't bothered. As long as I got heroin I was happy. Often I was close and then the needle would get stuck, jis, and then I'd need, and I see a guy in a parking lot, and he would give me. I just didn't care. Yes. Three, four guys in a room, all three/four would share one needle. When I think about it now, I get frightened - I can't believe I did it. It's really bad.' (Participant 26)

'I shared three times the entire time I was using it. Well, I was pretty careful with that sort of issue. I knew the people that I was sharing with, we were always together. I knew their lifestyle. Although it wasn't a very smart choice to make, you don't always know everything about them, but it was... then it was like I was desperate - the only thing to do at that stage, and that's why I did it. Other than that, no, I wouldn't share.' (Participant 32)

'I was... once or twice, actually when I had no choice, but you just go to the hospital; "can I have the needles please?" No problem. I'm not racist, but usually the black people don't think like that... you know, they just give. Give needles. Okay, I can only get needles, but I'd use the same needle over and over.' (Participant 30)

'No. I would always buy needles. No I never. We were in groups and stuff but never... I used my own needles; I made a point of it. It's like using a condom. It's just something, you don't use somebody else's needles. Yea, they shared needles. No, it was the same needles over and over and over. I used to steal my needles, new needles... I never had a problem with that.' (Participant 29)

It is of major concern that many of the participants, who had in fact shared needles or seen other intravenous users share needles, had used **inadequate methods in an attempt to sterilise needles**. Some participants stated that this was due lack of knowledge with regards to sterilisation, or due to haste and desperation.

'Yes, yes. I only shared with a few guys once or twice like I said. I shared, when heroin is calling, it's calling. All that we did was just burn the needles with a lighter - and then you sterilise it. I don't have AIDS. When I was at Family Outreach that was my biggest worry, but I had an AIDS test when I was at Family Outreach, to my relief it came out negative. In that aspect, like I said, when heroin is calling, it's calling - like I shared that needle, and actually I was going downhill - down a cliff.' (Participant 30)

'We always made sure that we used our own syringes. Before we even left Tzaneen to ride to Jo'burg to pick up our heroin, we always stopped at the chemist to buy. Each person would buy their own syringe, at a stage we had a big packet and every time we'd use, we'd just help ourselves, and maybe use your own syringe more than once, boil it in water if you didn't have another syringe. Boil it in water and then use it again on your own, but we'd never share, we never shared. We were very, very holy about not sharing, because of HIV, and there's quite a few others. Hepatitis, yea. Not really. I've actually seen people share needles. They would use a needle, and then rinse the needle in normal tap water, and then give it to another person, they would also use it. It all depends from person to person I'd say. The majority of the people who do use intravenously, I would presume or I would assume, I actually think that they do not share their needles with other people, unless they're in dire straits and they really need a hit, and there is only one needle - they most likely share it, um, after thoroughly disinfecting it, boiling it in water. I'd say the majority of users are very careful with regard to their own clean use.' (Participant 24)

'I haven't yet picked up AIDS, so I was lucky. I only shared needles with people I knew, like my girlfriends, for example, my sister and my sister's boyfriend that she had. Only with people that I knew. But I do go regularly, every six months, for HIV tests because I'm scared of that disease. I've used dirty needles, needles that I dug out of rubbish bins and that's for me... you're looking for it now. When I came home my needles were gone, my mom threw them away in the dustbin - it's a backyard rubbish bin. I climbed halfway into that rubbish bin to get that needle; I didn't even clean it. When I started with heroin five years ago, I always bought a pack of ten, and then after I used a clean needle I would throw it away. If I maybe used it a second time, I would first dip it in boiling water.' (Participant 39)

Participants who used heroin intravenously and had shared needles were asked to share their thoughts with regards to **needle exchange programmes**. The participants highlighted uncertainty, ambivalence and moral dilemmas with regards to such programmes on the one hand, and on the other hand the crucial role the NEP could play in the face of the HIV/AIDS epidemic.

'With friends yea. The only reason that I've been in that situation was where I've been going through serious withdrawal and there's just one needle in the house and it's been like... well I worry about the consequences. I didn't always think about the consequences you know. Definitely, you need them. They are very good yea. You go to a pharmacist, hand in your old ones and pick up new ones - clean ones, and I reckon it stops the spread of Hepatitis C and... HIV, yea. Definitely. No, not at all. I think that people who are going to use their needle and they're heroin addicts, aren't going to go... if they're handing out free needles, they're not going to go and use heroin you know. People don't know about it until they're in that situation, then they find out you can get clean needles. Nobody who's using - it's definitely not where they start. I think it's a very good thing that they do needle exchange. The needle exchange in the UK, you get um, little pads... antiseptic pads to clean your wound... yea, you get everything you need. You get a "sharps bin" to put your needles in so as not to leave needles around.' (Participant 31)

'Like in Amsterdam - if you use needles you can give your old needles and get new ones? I think it will keep heroin people on heroin. Places overseas where it already is for people on heroin, yes, it's a good thing. Yes, because you avoid HIV in the first place. Not really actually, two people can still share that needle, understand? But needle exchange is a good thing because you can always get clean needles, and I think it's for free. So it's a good thing in a way, but it's also a bad thing when it comes to the aspect of heroin junkies, understand? Let me try and explain it to you. In a good way it's... okay, if you don't have money for needles, then I can go and give in my old needles, understand? In a bad way, you will always continue using heroin; the problem will always be there. I don't think you will then make it. Basically, yes. It won't work. It's two negatives together.' (Participant 39)

Some participants discussed the risk of contracting **HIV/AIDS, Hepatitis and other blood borne diseases**, although none spoke of being tested positive for HIV/AIDS or any other blood borne illness. Participants also reported having known others whom had **died or overdosed as a direct cause of heroin dependence or death due to drug related violence**.

*'You end up in jail and from there on it can't go well with you - it's just downward. Otherwise you share needles with people who have AIDS and you die. So there isn't another path except for... and that's the seriousness of it. Since **** and I have been out, now three years, sixteen people who were with us have died, and I always say that - it's not a joke. All of them, or many of them that we know, they did not think it was so serious. Sixteen is not a little, and that's the few that we know. Sixteen in three years out of the 160 of the people that were there. Okay, you do not know of everyone, but we were close to some of the people and some of our friends, here in Pretoria North, two specifically are dead. If people come speak to me, I give them the harsh reality. I know a person mustn't say fuck it up, no - the only reason why I say it is out of experience. I don't know where **** and I could have ended up, do you understand? Yes definitely, nothing out of my own accord.'* (Participant 20)

'A friend came over and he OD in my house. Nobody was there except me and my cousin and luckily we got to call the emergency, the ambulance, and they got there just in time, but they had to work on him in our house. It gave me such a fright that I flushed down my, I think it was 200 grams worth of heroin, down the toilet. I did like sort of quit, I went "cold turkey" for four days.' (Participant 28)

A final physical factor alluded to by most participants was in terms of the **personal consequences** of their use, which essentially related to the participants inability to look after themselves properly. For instance, many participants described a **lack of self-care** regarding their health, for example by not exercising/eating properly. Many participants also described a lack of hygiene or care for their appearance.

'With regard to family and friends, I personally feel your friends don't really give a damn. They might, they suggest to you; "you look like shit - stop taking heroin." But if you're a heroin addict you don't really care what you look like.' (Participant 24)

4.7.3.2 Emotional/psychological effects

The emotional and psychological effects of heroin use related to a range of concepts, the most common of which was a variety of **negative feelings/emotions**, which were experienced by all of the participants. In particular, many participants reported that their using left them feeling depressed or low, with other common feelings including guilt, shame, desperation, fear, anxiety and numbness/lack of feeling. The desire to negate all feeling and to enter into a state of feeling **numbness** was in particular a recurring theme.

'I got to a point in my life were I just didn't care about living, and I had no self-respect left and dignity and... using heroin was like an inevitable option almost. And I know that the first time I used it was like the drug I've been looking for all along, the high, but also... being completely comfortably numb, feeling nothing and that's the one thing I miss of using heroin. I like being numb. I like not having to feel my emotions, reality and stress, and anxiety and all these things that I am always prone to. So, I think there is a big difference... Almost now when I meet an addict, you can like almost know the difference, who's a heroin addict and who's not... I've found like a certain type of person uses heroin. Like I want to numb the pain of living. You can't cope with life... It's not often that I pity myself, but sometimes I feel unhappy with the choices I've made and guilty and ashamed.' (Participant 10)

For many of the participants, these negative feelings became so extreme that they reported experiencing times where they **didn't care if they died**, or were consciously **suicidal**, either experiencing suicidal thoughts or actually attempting suicide.

'To be quite honest, you're not actually proud of who you are. You, you're scheming, you're stealing, you're doing everything wrong in the book. You're loosing all you friends, your dear friends, and you're breaking relationships. You're not proud of who you are. Then, all this advice is coming to your side, you actually go and you think about it. You actually start knowing what's right and wrong, but, you're trapped in this hellhole and you can't get out. Afterwards, you know exactly what you're doing, you know it's wrong, and then on your mission to Sunnyside, you actually start hating yourself and want to die, and it's just a bad thing.' (Participant 25)

'I decided that I could not do it on my own - because I started thinking that it would be easier to die.' (Participant 37)

Many participants also reported more **general emotional effects** such as feeling emotionally fragile or experiencing emotional breakdowns, which was a likely consequence of the negative emotions, such as anger and passive-aggression feelings that they were experiencing. Some participants involved themselves in related destructive behaviour such as prostitution and violence.

'There were reasons; there were things in my life that were already there long before I used drugs. I think it was almost like inevitable that I would use, like my low self-esteem, and my depression and feeling I don't belong and feeling I'm not good enough, being so perfectionistic and judgmental and critical and always setting myself up to be a victim and my inner anger and all that stuff.' (Participant 10)

'No. I do think that heroin addicts tend to be angrier than most people, because it's such a big downer... to take such a major downer - heroin addicts are generally angry with parents, with life, they're angry people - and it's passive anger, but it comes out in like rage.' (Participant 27)

'I was prostituting myself to get heroin, and I don't want to go back there, and I was stealing, and I just... got raped once on heroin, and, just don't want to go back to that life. I lived on the street for a few weeks. I lived in a crack house for four weeks, ja (yes)... just never want to go back there. I think that all that stuff builds up powerlessness, and that happened and stuff. I think that's when everything started to click. I really saw what I did and happened to me and that... ja (yes), anyway, ja (yes). Heroin is just bad for... I didn't work with heroin, it's not like... we say we still love our drug, but we can't use it, but I don't like heroin, not at all.' (Participant 38)

A final negative effect reported by several participants was in terms of various **comorbid psychological disorders** resulting specifically from their use, such as anxiety and panic attacks, mood disorders, eating disorders, self-mutilation, anti-social and asocial behaviour, agoraphobia, paranoia and psychosis.

'I can't tell you, when I was in the girls' house, bulimia and anorexia is a huge problem in girls' mind with heroin. Because they want to be heroin thin. You know, say about 50% of the girls that were with me in the house had an eating disorder and all of them who had an eating disorder, say about 90%, relapsed in order to be thin. That's what's scary. Then it says to me that it forms more part of a psychological problem, because I don't have a concept of an eating disorder, but that which I saw there showed to a large extent that the two can go hand in hand. The girl that I shared a room with, she would... over there if they catch you you're in trouble. She would binge 3 o'clock in the morning. She would set her alarm to eat, and binge 5 o'clock in the morning. She would set her alarm to vomit, and throw it outside in a packet. So, so bad is it. There I experienced it for the first time and I could not believe it.' (Participant 20)

'It was all the... don't know what it was, but it - they started, I think they sort of tell you all the stuff when you're still a little bit psychotic and it just stayed in my brain. So, it's like, I'm gonna die and all that... the stuff that happened.' (Participant 38)

'I got taken out of society... about six months later I cut myself. I cut my arms... I harmed myself... I got put on an "at risk" list, so I had to then go see a counsellor every week, and then ah, my life deteriorated.' (Participant 31)

'Cause I saw from my friends, some of them, like my other friend got killed - 'cause we used to do a lot of things together check, but then I quit, I just quit. After my friends' death I just quit straight. Yes, we were close; we were really very close friends. You know, when you see your friend dying... because he died next to me, we were like brothers together, and like, he just died there - he was shot in the head. Not really, we were actually making money for drugs.' (Participant 40)

'You're very antisocial; you just want to be by yourself, in a dark place.' (Participant 19)

'Ja (yes), I think that depression, the depression that I get from heroin was intense.' (Participant 9)

'Because they know its killing them and they know how bad it is. They have to, some things you have to live through to um, understand it, you know. So, if it's somebody. Most heroin addicts are depressed I believe, so if it's somebody I'll just tell them you know, get clean because it's worthless, you're screwing up your life. What else, you know? I can tell my own story and... ja (yes).' (Participant 17)

'Also my problem now with staying clean is I can't be in a group with a lot of people, let's say thirty people, or twenty people, I get... I feel like I'm going crazy. I don't know why, not that I'm claustrophobic, or... it's just with a lot of people.' (Participant 12)

One participant who used to use heroin intravenously identified **operant conditioning thought process** in terms of the actual process and ritual of intravenous use. In the following extract he described becoming 'addicted to the needle', and how he had to recover from the ritual of 'shooting up'. This particular participant also substituted at interim periods with intravenous buprenorphine administration.

'No, 'cause like I said earlier, it's actually all in the head, all in your mind. My problem wasn't actually drugs actually, my problem was the needle. Just the routine of spoon, something in the spoon, cook up, slurp, tie up, hit. The routine, that's actually how I discovered to mainline Subutex, 'cause Subutex wasn't the first thing, other than heroin, that I mainlined. I experimented with anything 'cause it's fun to mainline. You get an all different effect. Thank God I didn't reach to Wellconol. Because, I promise you, I would have mainlined it as well.' (Participant 25)

4.7.3.3 Relationship effects

The vast majority of participants reported various **general negative effects on relationships**, such as increased family arguments, a general bad atmosphere within the family and increased worrying by the family about participants. Many participants also reported that their substance misuse resulted in the **break-up or loss of many relationships**, resulting in either a loss of support from family and friends or a loss of contact.

'Once you're addicted to heroin and you use it intravenously, you become detached with normal reality, day-to-day life. Things that you would perceive as normal, other people would perceive as completely crazy. People still ask me today, "aren't you scared of a needle?" or "didn't it hurt?" And it doesn't, because you block yourself off from that physical pain, and even mental pain from you family and friends, who might verbally abuse you because you don't listen to anyone else. They can't talk to you nicely and say "listen, stop using heroin", because you won't listen to them. Which eventually lands up in arguments and fights and physically abusing each other, to an extent that you, you know, you both just detach yourself from each other. So, it's quite sad.' (Participant 24)

'When my girlfriend used to come over I'd always be scared of her you know, because she always used to tell me that my heroin will kill me. I was like scared of her, and how can I be scared of somebody who loves me? If there are people who love me, they don't trust me anymore, you know, because of the heroin, so then, I had to stop you know. I had to draw a line there because I would have lost my entire life.' (Participant 40)

'When I finally decided what had happened, my wife kicked me out of the house, you know. Can't go on like this because I mean it does destroy everything around you. You spend all your money on it. I was fortunate in that I was always earning enough to support the habit and to provide for the family. But your whole family goes to bits because you're not even interested in them. You know, heroin becomes your God, your one and only thing. Then when I realised how bad I was, in the gutter, that's where you've got to make that decision so you've got to kick, beat this thing.... Well, my wife always helped me, until she was really desperate and said "get out", which I can't blame her for. That actually, that turned me around, because I was going to lose my family. The rest of my family doesn't want to know me because... you know what happens... So that for me was also the help to realise I'm going to lose, you know, people close to me because of this, this white powder.' (Participant 19)

'Yes, especially the support from my mother. The nights I make her cry due to heroin. It's not nice to see that. The other days that I made her laugh due to my cleanness - it's another feeling, it's great. They don't need to lock their things away, it can now lie around and everything. It's something else, that I can actually now feel love that comes from my parents, especially my father and I. The past few years walked a very hard path, him and I. We always physically took each other on. I attacked him with knives, and he, I can't say he tempted me to do it, he said to me; "if you want to hit me, come, let us do it and get it over with, and then I will show you that you're a junky, you can't hit." But it's totally different now. It's great. I have a nice relationship with my mother and everyone. It's friendly. I can't remember how long ago that we fought. I can't remember, it's nice.' (Participant 39)

4.7.3.4 Social effects

The most commonly reported negative consequence was in terms of the **isolation and negativity from society and significant others** experienced by 35% ($n = 14$) of participants. An example of this isolation and perceived **stigmatisation** is provided in the following extracts.

'It's hard for me, because, especially the idea of society of the drug addict it like a horrible thing. You know, I feel like that no matter how long I stay clean, it's always going to be with me kind of. I am still an alcoholic. It doesn't go away. And I mean, sometimes I go to parties, and the people don't understand why I don't drink and I say to them; "I choose not do drink." I've gotten to a point in my life were I feel that I don't need to explain myself all the time and say "I can't drink because of this and this and this..." and sometimes people aren't supportive and think I'm strange and it's not easy. (Participant 10)

'Start with my family. My sisters' were very supportive. I didn't really involve my mum in my recovery, and my dad just looks at me as a, you know, junky, a waste of space. But over the years of me being clean, they tried hard to slowly come to understand a bit more. People look down on me you know, and I've lost jobs, because someone said to someone, said to someone "he's a junky", or whatever, "he's not clean", and I've been looked at as scum, I've had that a lot. But since I've been in South Africa no-one knows you know, it's only my girlfriend and her immediate family that know... Her brothers, her older brother I'm not sure. They say to me that they're supportive, but I don't know really what they think. Her mum and dad's very supportive, they're like Christians, Afrikaans Christians, and I think that even though they don't like black people... which I find really strange, they can tolerate me in there house! I find it difficult you know, it's very difficult... hard for me to understand how they can be like that if they're Christian, as Christians they go to church every Sunday.' (Participant 31)

'I want to say it's as if there's a board around your neck that you wear for the rest of your life. It never goes away. They are always scared and they don't trust you because you did it. Yes, and they keep throwing it back in your face. I regret telling the people that I told. I should have just kept quiet. Yes, family. People outside of your family, they... how can I say... they are not... they know about it, but they don't judge you the whole time. It's not them that hang a board around your neck.' (Participant 34)

'I think they're very judgmental. I don't think they know what's going on, what's really happening and the whole drug addiction world, because, it's not like I want to hurt anyone, it just happened while I'm doing it, it's so selfish. I don't think they know what happens in your head. I don't even know what happens in my head. But my family is supportive now, but when they didn't know what was going on, they didn't know what to do. I don't think society will ever really fully understand.' (Participant 38)

'I think they're two-faced people, the society people, because they see a drug addict as a person who has a habit, they get confused between those two. It's not a bad person who uses drugs, it's a bad habit.' (Participant 35)

'Yes... it's a combination of both. Some people look down on you firstly and they feel sorry for you. They think you, there's something wrong with you or you're weaker than they are, while at the end of the day you only have issues in one area, and they have issues in another area. So, if it's drugs or pornography or medication or alcoholism... and I would say... even now if you asked me to take someone in who is addicted to heroin, I would probably do it, but I would probably watch him carefully for two years! A person goes through that, and in the long run they don't trust you, even if your intentions are right.' (Participant 21)

'You can't every time... you can't put your trust in other people and so on. The people around you will always, you know, disappoint you - it doesn't help placing your trust in other people, or in my case, it is so - that's what I've learnt. Sometimes person's expectations are too great and um, it doesn't happen that way, it is also a dangerous place to be in if you begin to place your trust in your family because usually disappointment is a reality. In a way people are supportive, but as I said, it doesn't help you going to look for people the whole time for reassurance. That's my opinion.' (Participant 22)

*'Let's say, I've had mixed feelings from society, you don't mind me swearing? I don't give a fuck about society, because society neglected me. They all turned their backs on me and walked away. Some of society treated me like glass. I can't speak to people without them "oh, aren't you *****, the one on drugs? You're the ***** that was in rehab." You know, or like when I speak to a girl, and when I hear someone warning "he was on drugs, he was on heroin, stay away for him." You know that really affects me as I have no confidence, just going up to somebody... look, everybody knows I was on drugs. But the world's perception of drugs is totally fucked because they can't see the life of a recovering person through their eyes.' (Participant 30)*

Often this isolation was due to the users isolating themselves from others for various reasons including shame of use or hiding use. Isolation also occurred for other reasons such as loss of contact with family/friends due to their heroin misuse. Some of the participants also reported that their heroin dependence resulted in them being **less socially active**, or a reduced ability to mix with others, for example due to feeling lethargic, or unable to function socially without their 'fix'.

'Because that's I think again, because of the social - heroin is a very antisocial drug. You spend a lot of time on your own and in toilets.' (Participant 4)

'Heroin is more... you don't want to do much.' (Participant 4)

This lack of social activity is likely to be associated with the isolation experienced by participants. The final social effect reported by many participants was a **change in social circles**, as a result of their increased use. Basically, this involved an increase in contact with users and often a decrease/conscious avoidance of non-users, i.e. old friends and family. Again, it is possible that changing circles may have implications for the isolation experienced, as participants became more isolated from nonusers.

4.7.3.5 Practical effects

Finally, with regard to the **practical effects**, one of the clearest consequences of use was in terms of **employment/jobs**. Virtually all of the participants reported that their heroin use affected their ability to work effectively, as well as increased the time that they took off work, both of which often resulted in the participants being fired or resigning from their jobs. Furthermore, many participants described their inability to find further work or work at all during periods of very heavy use. Another difficulty that resulted from participants' heavy heroin use was a **neglect of practicalities**, such as paying bills and saving money.

'I did work during that time but I lost my work due to heroin. I lost my flat that I had, my girlfriend, everything... my car, everything that I possessed. I sold everything, cellphones.' (Participant 39)

'...and I've lost jobs, because someone said to someone, said to someone "he's a junky", or whatever, "he's not clean", and I've been looked at as scum, I've had that a lot.' (Participant 31)

It seemed that many participants **lacked a sense of responsibility**, with most participants describing themselves by using negative attributes such as being unreliable or irresponsible. Other common examples of irresponsible/negative behaviour included criminal activity including stealing, the manipulation of others, lying to or lacking respect for others, and violent/aggressive behaviours. Most of these behaviours were often reported to be an attempt to fund their habit. Often this lack of responsibility combined with a neglect of responsibilities resulted in various **practical consequences** for participants, such as financial problems, losing houses or possessions, criminal offences, violence, as well as inhibiting potential life achievements.

'I think if it were... if using drugs were legal I don't think it would make addicts not criminals. I think the process of addiction make people criminal or make people indulge in criminal behaviour in order to maintain an addiction. Money wise, but also in other ways you know, alcohol people, most alcoholics break the law, they drink and drive, they, you know, and that's illegal. I think that a lot of alcohol impairs judgement. I mean if you are wasted all day, every day you're not going to make good decisions about what to do next. I think add to that desperation and a lack of unmanageability and people are going to indulge in criminal behaviour. I don't think that making drugs illegal will reduce criminal behaviour in people with addiction problems.' (Participant 18)

'You get caught for possession. Or stealing, or whatever, to get it in your hands.' (Participant 20)

'So I thought to myself it is actually time because now it's me and the law, and if I'm going to be against the law for the rest of my life I'm not going to get anywhere, so I might as well take the programme and see if it works this time and really be dedicated to do my side as well.' (Participant 35)

'We had stolen something, then like, apparently... when they came they started shooting and they shot the guy and I guess I was lucky.' (Participant 40)

4.7.4 Ways out: Realisation Process

TABLE 4.7.4 Ways out: Realisation Process

* Unaware of problem

- * Factors influencing realisation
- * Series of realisations
- * Difficulty in accepting heroin use problem and admitting it to others
- * Sudden realisation of problem
- * Factors influencing acceptance of heroin misuse problem
- * Clearer awareness
- * Maturing out phenomenon
- * Continued use despite awareness

Many of the participants reported being **unaware of their heroin misuse problem** in the earlier stages of their dependence and that others around them often being aware of the problem before they were. Not only were participants unaware of their escalating heroin use and developing dependence, but many were also **unaware of the increasing negative effects of their heroin use** and that these effects were a consequence of their heroin use. For example, some participants were unaware that certain illnesses/physical problems were use-related or the symptoms of withdrawal. This lack of awareness was often reported to be due to denial of the problem or more simply to a lack of awareness, education or understanding of themselves and their addiction/dependence. One participant used/substituted alcohol as a means of dealing with heroin withdrawal; this was largely due to a total lack of education and resources within the African township in which he lived in.

'I mean I got off because of the alcohol that I was using by then, because whenever I used to get those cramps I used to drink alcohol, so then, I wouldn't wish other people to use that - but then it helped me out at the end. On the long-run I came out the winner. I don't know. Ja (yes), 'cause I didn't have like a facility like a rehab. I didn't even know of this place. Maybe if I had I would have asked my parents to bring me here.' (Participant 40)

Another factor which inhibited/delayed several participants' awareness of the problem was the fact that they had a continued supply or used continuously for a period of time, which masked the signs of their developing heroin dependence. Several participants described the realisation of their problem as resulting from a **series of realisations**, often occurring later in their dependence. As well as starting to recognise the heroin misuse problem, participants also tended to experience realisations regarding the negative effects of heroin use and the connection between these effects and the heroin misuse, the need to change their behaviour, and of the need to seek help/treatment in order to do this.

'I went to Castle Carey, rehab, because I decided myself that I can't carry on the way it was. I was on heroin for five years. It's five years of my life that I lost, understand?' (Participant 39)

For some participants the initial realisation/awareness of the problem did not automatically result in a full recognition/acceptance of the problem. For several participants it was often **difficult to accept the problem and to admit it to others**.

'Well, you don't really share your addiction or you don't tell many people about you addiction, because you don't want people to know you are using heroin, or any other drug for that matter... I think one has to have a very close bond within a family, a strong family, a strong relationship within your family, for one to start taking advice from them.' (Participant 24)

Due to these difficulties, it sometimes took considerable time for this acceptance to occur and so it was generally a gradual process. However, for a minority of participants, **the process involved a sudden realisation of the problem**, often this was facilitated by a 'rock-bottom' experience. This highlights marked individual differences between people, in terms of how they experience and recognise their heroin dependence.

'I was using heroin and then one day I went to go buy heroin and then the police busted me and I was taken to my parents house, my dad's house. The police talked to him about it and stuff and that was the first time he found out that I was using. Yes, because that was like a sign to me you know. That was like, you know, the whole thing, you know, I was locked up and everything in the holding cell. So I mean that experience proved to me that I had another chance because I didn't, I got off of it you know without anything, without a criminal record.' (Participant 17)

A variety of **factors influencing the realisation/recognition/acceptance of the problem** and the need for behaviour change were revealed. The following extract highlights how the experience of withdrawal and craving were important factors in helping participants' to realise their developing heroin dependence.

'I didn't want anymore. It was when I saw it became a big problem... couldn't get rid of it. Couldn't, had to use it as part of my day.' (Participant 36)

The increasing negative effects of participants using, particularly on their families/children was also reported to have been influential in participants realisation that they had a substance misuse problem and the need for intervention and change. Other less common contributors included the transition to heavier heroin use/increased tolerance and the impact of a clean period. Several participants also pointed out that for them it was a combination of such factors rather than a specific factor/event that influenced them seeking intervention and their realisation of the problem.

'It's a long story really, but I'll try and cut it down. I went to see a doctor who my mother, my mother who was searching one day and pulled her hand out with a needle stuck through it - and had to have a HIV test and everything, and my Dad made me go see a doctor, who set me up the counsellor.' (Participant 31)

Despite earlier realisations of their problems many participants also described a **clearer awareness** of their heroin misuse problem and its negative effects, later on in their heroin dependence. For many participants this seemed to be influenced by the passage of time, which resulted in a clearer perspective of the problem and associated events. One participant alluded to the **'maturing out' phenomenon** as a reality in heroin dependence recovery. Many participants also reported that the experience of intervention was extremely important in facilitating a clearer outlook. The following extract provides an example of the role that intervention played in facilitating the realisation of the negative effects of use on family relationships.

'A lot of people I used with 'matured out'. I'm not saying that they didn't cross-addict to alcohol.' (Participant 27)

'But I mean, once you're in there, you start learning all this then you realise once you're clean your mind can focus much more on the bigger parts of the story, and not just the getting high, and just getting through the day.' (Participant 5)

Finally it should be noted that **in spite of a realisation** of the problem and the need for behaviour change, many of the participants' **heroin misuse continued for some time after this**. Although this is likely to have been influenced by a variety of factors, including the various reasons for continued use and barriers to behaviour change noted previously, several participants described a number of factors which were particularly influential including, feeling helpless/unsure of how to go about stopping their heroin use, experiencing a lack/very little negative effects at the time therefore not fully questioning the problem; a lack of support/intervention which was needed in order to change behaviour. Also, the following extracts demonstrate how some participants justified their continued use as a result of recognising that they had a problem.

'Then after my rehab I was totally clean, but I was a "dry drunk", do you know what I mean? Then I started using again. I was more mixed up in my head that ever because I had been to rehab, and if that couldn't keep me clean, then what's going to help?' (Participant 21)

'When I came out of SANCA I knew I was going to use again, same as Magaliesoord, same as the first time when I came out of Noupport... also I knew I was going to use again. Then the last time I came out of Noupport I was really determined to stay clean.' (Participant 21)

4.7.5 Taking action: Behaviour modification

The theme of behaviour change is broad in the sense that it refers to any kind of behaviour change that was performed in an attempt to control/stop the heroin misuse problem. It included behaviours such as independently cutting down in an attempt to control use, going 'cold turkey' in an attempt to achieve abstinence and accessing treatment intervention, whether it be substitute prescriptions, meetings, counselling, rehab etc. Nearly all participants described experiencing numerous/successive unsuccessful attempts to change their heroin using (and associated) behaviour, illustrating the high degree of difficulty involved in this. The theme is sub-categorised into **types of behaviour change**, **factors influencing behaviour change**, **spirituality**, **decisional balances involved in behaviour change** and **barriers to behaviour change**.

TABLE 4.7.5 Taking action: Behaviour modification

<p>4.7.5.1 Types of behaviour change</p> <ul style="list-style-type: none"> * Serious attempts * Non-serious/temporary attempts <p>4.7.5.2 Factors influencing behaviour change</p> <ul style="list-style-type: none"> * Realisation of problem * Belief in oneself * Importance of family/children * Negative effects of heroin use * Access treatment as cannot change independently * Unable to detox independently * Process of behaviour modification * Practical and geographic constraints <p>4.7.5.3 Spirituality</p> <ul style="list-style-type: none"> * Heroin dependence influence on a spiritual level * Spirituality in broad sense * Spirituality as crucial factor in recovery * Spiritual conversions <p>4.7.5.4 Decisional balances</p> <ul style="list-style-type: none"> * Continued use rather than change * Tired, sick and almost dead * Change rather than continued use <p>4.7.5.5 Barriers</p> <ul style="list-style-type: none"> * Barriers to change

4.7.5.1 Types of behaviour change

The **types of attempted behaviour change** have been divided into **serious** and **nonserious/temporary** behaviour change. Basically, serious attempts referred to a real commitment to behaviour change following a 'rock bottom' - like experience. Participants described themselves as being in a very bad state, being completely fed up with their situation and feeling it was necessary to do something to change it. This type of experience tended to occur later in their heroin dependence.

'I think the person must really be at a point where they want to change and want to stop using. I think that's the bottom line. They must get to that point, no matter if they think they've hit rock bottom, and if they think it's horrible to use and they can't do it anymore. They must really get to that point of surrender and giving up and willingness of wanting to change and wanting to stop using forever.' (Participant 10)

Conversely, several participants described having experienced **non-serious/temporary behaviour change**, which referred to a less committed attempt to change behaviour with participants sometimes sabotaging intervention, and tended to occur earlier in addiction. For example, several participants described temporary changes in their early use, for example, when they were pregnant, having a family, or in order to support their denial. Several participants also described how substitute prescriptions were used as a security/safety net to support continued use, or how earlier treatment experiences were treated as a respite from use rather than a serious attempt to change behaviour.

For each person it is different. I'm certain that if I got the right person that could work with me - then it could have worked. But, I am not very easy to work with, I think. I either "click" with someone and I'm open, or start playing mind games with the therapist. And 99% of the time I played games with them. And actually I fooled myself. I wasted my parent's money. Pretty much, I was so "moerse" (very) clever, so "slim vang sy baas" (clever catches its boss).' (Participant 25)

'It's been like a four year process, for years I didn't really do too much, it was in and out programmes, followed rules, except for Magaliesoord which I left, all the other ones I completed - never ran away. But then I came out and I stayed clean for a certain period after that, then I was back to the heroin. It was like a planned thing - then I knew I was going to use.' (Participant 21)

'I actually got engaged. I always fought against it, and then I decided that I wanted to stop because there are other things to live for. Eventually you start getting withdrawal symptoms, then your head tells you; "your mind is right, it is now over, you accept it". The withdrawal is bad.' (Participant 34)

Finally, for a minority of participants, some aspects of their behaviour change were non-serious in the sense that it represented a forced change rather than a positive decision to change their behaviour. These related to an inability to use due to a lack of money or contact with a dealer, geographical difficulties, or attempting to change behaviour through coerced treatment.

'Well, treatment didn't really help me... I wasn't really ready and I was rebelling. Later I was more open towards treatment.' (Participant 12)

'I arrived at Castle Carey. I was clean for a month. When I came I came for counselling and I explained my situation. They tried to get me to realise what my situation was. At that time I don't think I was quite open enough to counsellors to listen to them to what they really say.' (Participant 7)

'Then I went into a rehab, Staanvas, where they also gave me methadone and sleeping tablets and vitamins and all kinds of things like that. Also counselling, group therapy and psychologists and that. But at that stage I didn't really co-operate and I don't think I was really open to change and co-operating. So that was not really successful.' (Participant 10)

4.7.5.2 Factors influencing behaviour change

In terms of the factors influencing behaviour change, the most common influencing factors that facilitated behaviour change occurred following a **realisation and acceptance of the problem** and

the need to change their behaviour. Understandably, this recognition of the problem was an essential factor for successful behaviour change.

'I think, it's like coming to admit that you have a drug problem. I think that is where my mind-set changed. Once I accepted that I had a problem, a drug problem, then that's when I opened up to recovery.' (Participant 9)

'And to know that I am an addict for the rest of my life and I have this disease of addiction and I'm responsible for my recovery, and I can do something about it and I'm not helpless, and that really helps me.' (Participant 10)

'I needed to come clean.' (Participant 4)

Belief in oneself was also identified as a factor that facilitated behaviour change.

'I would tell them, just get your mind set. Just get your mindset and what you want to be in life.' (Participant 16)

'Believing in myself, and co-operating with you guys.' (Participant 33)

'Ja (yes) the first time it was, but when I started believing in myself and saying to myself that I can make it, it wasn't that much hard.' (Participant 33)

'Just believe in yourself and that you can do it, and stop using drugs. That's all.' (Participant 33)

Another important factor for some participants was the **importance of family/children** in motivating their behaviour change. Some participants reported wanting to achieve stability for the sake of their children and the fear of losing contact with their children.

'And image. You don't want to be associated with someone using heroin, and I've got a baby daughter, so... to recovery... she was a motivation. A big motivation.' (Participant 36)

'And the fact that we have a child - then you no longer go out. You don't go party anymore, you don't go looking for those things anymore... I think with us it was a bit of a different situation, you have a child to keep clean for, and how do you explain that to her? It is still something we will have to resolve when she's older. I still don't know how. Yes, support systems, I would say is a key factor.' (Participant 20)

For several participants, another major reason for behaviour change was the need for relief from the increasing **negative effects of their heroin misuse**. Participants expressed that the need for behaviour change was influenced by a desire for some kind of normality that was free from such negative effects. Many also reported that another reason for **accessing treatment intervention** was influenced by the fact that they **felt unable to achieve behaviour change independently**. Some participants were **unable to detox independently** due to physical dependence or being unable to cope without help/support.

'No, in-patient. In-patient is necessary, I mean, because if you're an out-patient the dangers of the temptations are so much more than what... you've got a little bit of enclosure on the in-patient. I think if you can just get to the feel of it on the inside, you're a lot... you just come out a lot stronger than what you ever get outside. Do you understand what I'm saying? I wasn't there six weeks. I was there I think seven or eight. That's stretching it a bit, places like Noupoot... it's stretching it a little bit... a hell of a lot actually. Because the period you spend in rehab... you owe it to yourself to come right. You know it's either make or brake. If you brake then you know... the steps should be taken. But if it doesn't brake you know it was successful.' (Participant 29)

Various participants also highlighted the **process** it takes for behaviour modification to take place.

'50/50 I'd say. I know that it is very easy for me to jump back in to the whole behaviour and using again. I also know where I've been. Luckily with the rehab where I have gone to the tools that they provide you with I now put in practice to prevent myself from going off the track, or going back to bad behaviour or doing certain things that I know will put me back on the wrong path. Time takes time, time takes time.' (Participant 11)

Geographical constraints in obtaining heroin or other drugs was highlighted by a number of participants as contributing to behaviour change.

'The only reason I stopped is because you can't afford it anymore and it wasn't available. The lack of availability and the lack of finance... I stay 400 km away from a dealer, so that stopped me from using, but I didn't have money to get in the car and drive all the way to Jo'burg to pick it up.' (Participant 24)

'There was no medical intervention on any level. My process was - I did a geographical. I made a decision that I wouldn't go on and I couldn't die. I just overdosed again, and that brought me round, and I - in the end that I could see of getting clean was to remove myself to another country - so I did a geographical to a place where I knew I couldn't get the stuff. To a very remote island, and I went "turkey", so I was very, I was quite ill.' (Participant 27)

'Thinking of consequences. For me, being in South Africa - ignorance, 'cause I don't know where to go in South Africa and in the city I don't know where to go to score, and I try to make sure that I don't. That's why I don't go to NA, because I don't want to meet someone who might point me to the wrong direction. So I try to keep myself ignorant while I'm here, and that's why I've never used while I've been in South Africa.' (Participant 31)

'Well, book yourself into a decent rehab, if you're using it intravenously and if you're using it longer than a month. Otherwise, go home, tell your parents about it, discuss it with them. See if they can assist you, maybe send you on a holiday somewhere or go with them away somewhere, where you're not in touch with your crowd of friends that you would be taking heroin with, or not living close to a dealer or never even close to a telephone, because you're most likely to pick up the phone and get hold of the dealer and make a plan to get hold of heroin.' (Participant 24)

4.7.5.3 Spirituality

Sixteen participants (40%) were of the opinion that **spiritually** played a decisive and **crucial factor within their recovery process**. Some participants referred to spirituality in a broad sense, and not to a specific religion or denomination.

'When man is frail or threatened or close to death, then he finds God very quickly - to suit him you see. But I must admit that I'm not really this religious kind of guy. I have always believed in God, but not the way that structured religion portrays it. But I did pray very heavily and I did read the Bible, to look for guidelines, and I'm sure that helped me, because imagining doesn't matter - as long as it helps. If you're a Buddhist, or Islam, I don't know if Muslims ever get involved with stuff like this. Very interesting. They actually use it as a weapon against the infidels, you know. I think for this question you want to know - I think spirituality can be a very powerful force to a pure addict as well. And if it works, then it's wonderful. If he becomes a re-born Christian it doesn't matter, then, I mean, if it helps him to recover then it's wonderful. If they become Buddhists, even better, I think the Buddhists have a much better way of dealing with stuff like this as well, the Zen way.' (Participant 19)

'Ja (yes), definitely. I read about that rehab somewhere in the mountains were the Buddhist monks get these people and there is a lot of places like that, and whether it is Hinduism, or whatever the situation, everybody that gets into some religion, it's like they get addicted to it. There is a definite power in each of those religions. In the end you have to replace what you've had with something else. If you leave that void, it's going to fail and that's what happens with the guys. They have that void, and they go back to heroin and keep on relapsing. They don't have something else to fall back on.' (Participant 2)

'I thought I was happy while I was on drugs, but my subtle instinct, it's not actually you... it's believing in something that doesn't exist... you see, I don't know like, you know, I say personally every kind of drug, the... from the Higher Power out there, he gives it and um, or he will.' (Participant 12)

'Then also then, my relationship with God and I pray, and when I feel like I want to use then I just think... I just take it for like an hour or half an hour at a time, and then think, okay just until 12 o'clock, and then until 3 o'clock and that, it really helps me get through the day. But these days, as the longer I stay clean, the less they become.' (Participant 10)

One participant (2.5%) was of the opinion that heroin dependence had **affected him on a spiritual level**, but not necessarily that spirituality had played a role in his recovery.

'Yes. On a spiritual level - yes definitely. 'Cause it's like taking heroin is THE DRUG - you know there is nothing that can compare to the heroin anywhere... you know not even a beautiful woman. If you had to put heroin or a model... the perfect woman... you will take heroin, because nothing can give you what heroin can give you - or nothing - that's what I thought at that time. On a spiritual level yea - it's more the thinking, you feel on top of the world, you feel like a God. You feel so much more powerful. So much more confident. So it definitely affects you in a spiritual way as well, definitely.' (Participant 30)

Numerous participants had undergone **spiritual conversions**, many of which occurred during their rehabilitation programmes at various Christian based centres. Some of these participants concurrently believed that medication was taboo; this often tended to reflect the opinion of the treatment facility that they attended.

'They taught me from the Bible, I relied on God's strength to pull through the withdrawal. Medication for me is a substitute for drugs, for heroin. You can survive without medication and rely on Gods strength. You can rely on God's strength to give you strength to go through the tribulations in your life and just, if you look down, don't look down, don't fall back to drugs to replace that void in your life. Just look forward, take each day as it is, never look back, and remember how life was before you used drugs. Rely on God to prepare your day for you. That's the main thing.' (Participant 8)

'The only option that I had was to walk there, and I couldn't really walk, and, like I said, I cried to God and I walked all the way there, I walked the whole night, managed to get there. When I got there he offered me a cup of coffee. It was probably the best cup of coffee I've ever had, and then, since that day I've been clean up until now, and my only saving grace was, was God, Christ, that's all.' (Participant 32)

'Get his Christianity right, because I believe that without God you won't make it. I became a Christian in Castle Carey. I was involved with Satanism. It's scary you understand? Everyone's always said to me that without Christianity you won't get it right. So that's my number two point.' (Participant 39)

'Noupoorts programme also helps you in that rather to replace your addiction with another addiction form such as with another medication and so on, it helps you to get another addiction... to take God into your life, to take that as a replacement, and in my case it really helped. There was a stage, all addicts feel so, you feel empty - you have to fill that gap with something and why can't you give it a go to, you know, fill it with Christianity?' (Participant 22)

'I must say, it helped me a great deal. The thing that I learnt in Noupoort is you must place all your trust in God, and he will help you it doesn't matter what. And God will really, if you have enough faith, you can overcome anything. It is just so, and I believe in that. For me it's so much easier, because I can give all my things to God. It is only through Him that I am clean today, through no one else.' (Participant 22)

'It helped me now. Now that I am out of Noupoort, that I am out of that place, I have something to fall back on I believe that if you... Christianity - if you have that discipline of the Bible, the rules of life - if you keep to that, then you will prosper and you have something to fall back on.' (Participant 23)

'Noupoort is a Christian programme, I came to repentance through the Bible and Christian principles.' (Participant 6)

'But everything is from above. It's the only chance you have to recover. That is my opinion as I've seen it. God has really blessed me. In March/April I met a girl that God blessed me with, and I believe it's all blessings for the decision that I've made. Amazing girl. I can't believe that He loves me so much that He gave such a girl to me. But the process you mustn't fear. It's human to fall, and love, if you fall you're not going to hell and it's all over and whatever the case. People can fall, and God forgives you and it's a process and you carry on. To grasp this type of thing it's... it's the truth. The only thing, and it's my opinion - I feel very strongly about it... and I'm certain once you've completed your research you will see that these are the things that mostly come out. It's just hope, it's only God. Yes, it was faith in something that you cannot see. In something that is not possible... Since I've made a decision not to use it, more once again, it's only mercy from above. I'd say that's the biggest void that we now have, a lack of discipleship. Discipleship work from that which you've been through. You can help others through it so that they in turn can help others. It's a discipleship network that's not applied. They get treatment and come clean, and everything is positive.' (Participant 21)

'The only advice that I would give to people is to, is just to give God a chance. 'Cause that's... many people don't believe in God you know, in what He can do, but, just let other people... just give it a chance, you know what I mean? If it's not real, nothing will happen, but if it is real, then it will change your life. At least be prepared to just give it a chance. Okay, that's the only thing I really think can save you and actually set you free from it completely.' (Participant 32)

4.7.5.4 Decisional balances

In terms of the decisional balances involved in behaviour change, it became apparent that at different times in their lives participants experienced various balances/choices, which had to be weighed up. These included the benefits of staying clean versus the benefits of continued use, the continued enjoyment of use versus the feeling that use was wrong/dangerous, and the difficulties of treatment intervention versus the difficulties of continued use. As the heroin dependence progressed, the decisional balances generally seemed to shift from favouring **continued use rather than changing behaviour** in the early stages, to **favouring change rather than continued use** in the later stages, displayed by more responsible decision making. Regarding the former, factors such as continued enjoyment and desire for heroin tended to outweigh the negative effects of use, or any feelings of wanting to change.

'The thing is, if you've made the decision out of your own to another year, the chances that you are going to go back on your decision again and start using after that, is very much smaller than when you were forced. So, it comes from yourself in the end. I always tell parents; you keep him in rehab until he starts making the right decisions. After a year, if he doesn't decide to stay for half a year, you make the decision for him and when it comes to that end and he is still not making the decisions for himself - you make the decisions for them, until he learns to make the right decisions himself. An then when he comes out, he is going to make the right decisions.' (Participant 2)

An additional factor that seemed to favour continued heroin use was a necessity to use and dependence on heroin, which again seemed to far outweigh other factors, which may have motivated the user to change their behaviour.

'Heroin is your God - it tells you what to do.' (Participant 30)

Participants often described a transitory period where the balance began to tip in favour of change.

'I think once you get that link, that when you think of heroin you think of bad things then you are really on the road to recovery. But up until that time, I always just think of heroin as my best friend.' (Participant 19)

In many cases it took some time for this shift in opinions to translate into actual behaviour change. Nevertheless, for many participants the balance seemed to tip in favour of behaviour change rather than continued use when the negatives of use began to outweigh the positives and/or reasons and factors for continued use. The following participant, who had injected himself with a poisonous substance and then called his father desperately for help, illustrates an example of this.

'I managed to get to a telephone, and I phoned my parents and my dad said to me "okay, just hang on", he'll be there now, I was in Sunnyside. After an hour, he wasn't there yet, so I phoned him again, said to him "are you going to come and pick me up or not?" I said I wasn't really feeling very well. I didn't want to tell him what happened. He knew I had used, but I didn't want to tell him about how I was feeling... with like what I had injected myself, 'cause I didn't know myself. My dad said to me, no, he's not going to come pick me up, I must get myself to Mike if I really want to get back here. So, to get to Mike is 41km from Sunnyside to his place.' (Participant 32)

More specifically, some of the participants described wanting behaviour change as a result of being completely fed up with the negative effects of their heroin use or, of being too ill not to go to treatment and change their behaviour.

'Well I tried to get off heroin by myself, but I couldn't. I can describe it as... feeling lost, like trying to get off it; you don't know what to do. Just going through the "cold turkeys" and the cold sweats, I just couldn't stand that.' (Participant 9)

The participants' **downward spirals** were affected unexpected contingencies. Their narratives frequently revealed times when they endured great degrees of pain, fear and inner turmoil from situations and events they did not anticipate and could not control. Their experiences that followed often propelled them towards unprecedented depths of desperation and despair and greatly affected their self-evaluations and behaviour. In this phase, examples of various decisional balances included choosing the dignity of being clean rather than heroin, choosing to have a job rather than heroin, choosing a life rather than a life dictated by heroin, or quite simply choosing life rather than heroin and potential death.

'If you can get the patient to understand there are only two ways. With heroin you will die eventually, there is no other way out. They've got to get this thing that's it's the devil, or it's bad you know. Connect it with evil, or bad things, then it will be easier for them to beat it. Until they've reached that point, it's always going to be their best friend.' (Participant 19)

An additional major factor that was influential in tipping the balance in favour of behaviour change rather than continued use was the **changing effect of heroin**. This went from being positive to becoming more and more negative.

4.7.5.5 Barriers to change

A final concept that emerged in relation to behaviour change was the existence of various **barriers to behaviour change**, which prevented successful change. These factors are considered within other themes (see 'continued/excessive use' in theme 4.7.2.2, p.124; and 'potential barriers to intervention' in Theme 4.7.6.5, p.164 & 4.7.6.6, p.164).

4.7.6 Perceived effects of intervention

Intervention was of great importance to the participants, and this was illustrated by many of the participants who described their relief at receiving some form of intervention. Several participants felt that they may have died if they had not received intervention when they did.

'Four or five years later ah, I got to a low point were I had to go seek help otherwise I would have been dead. I would have died within months. I had friends around me who died regularly or go to jail.' (Participant 31)

'When you see what happens... it's a very dangerous game, heroin addiction, you can die easily. I must have OD'd, I don't know, many times. I was just lucky.' (Participant 19)

'I always say, because a lot of parents come see me, either one of three paths, and that's precisely what the doctor said to me that time... you die because you OD, you die because... all the paths end up there.' (Participant 20)

'With regard to someone else who has obviously been using for longer than a month, I'd say, go to rehab because it's the only way you're going to stop.' (Participant 27)

This theme has been sub-categorised into **positive effects of intervention, positive/important components for successful intervention, accessing/commencing treatment, difficulties of intervention, and negative/unsuccessful intervention.**

Recovery is a crucial theme, and has been sub-categorised into various **factors/requirements necessary to achieve current/future recovery, various aids to help/facilitate recovery, and various changes that occur in recovery.**

TABLE 4.7.6 Perceived effects of intervention

<p>4.7.6.1 Positive effects of intervention</p> <ul style="list-style-type: none"> * Various improvements * Improved coping mechanisms and self efficacy * Altering person/perspective/life * Special needs in terms of intervention * High level early interventions * Cumulative effect of intervention <p>4.7.6.2 Positive/important components of intervention</p> <ul style="list-style-type: none"> * Common experience * Safe/protected environment * Specialised intervention/treatment structure * Long-term residential intervention * Sufficient time to facilitate change * Difficulty in reintegration * Long-term care * Medium/short term residential intervention

- * Chronicity of heroin dependence linked to duration of intervention
- * Out-patient intervention
- * Heroin abstinence without formal intervention
- * Intervention success determined by individual choice
- * Life-long commitment to recovery
- * Personal factors
- * High level early interventions preventing chronic heroin dependence
- * Empathetic/ understanding environment
- * Hope
- * Counseling
- * Co-dependent recovery
- * Medical sector facilitating de-stigmatisation
- * Support

- * Education regarding heroin dependence
- * Holistic approach
- * Alternative therapies/activities

4.7.6.3 Accessing/commencing intervention

- * Accessed at rock bottom
- * Feeling nervous/scared at start
- * Uncertainty of expectations
- * False belief in a miracle cure
- * Barriers to accessing treatment

4.7.6.4 Pharmacological intervention

- * Medication for withdrawal during recovery process
- * Methadone
- * Buprenorphine
- * Clonidine
- * Tranquillisers/sedatives
- * Anti-depressant medication
- * Ambivalence toward substitute prescribing
- * Medication only for acute withdrawal

4.7.6.5 Difficulties of intervention

- * Acceptance of complete abstinence
- * Substitution

4.7.6.6 Negative/unsuccessful intervention

- * Negative /unsuccessful experiences
- * Contradictions within treatment services
- * Intervention not intense or long enough
- * Lack of alternative activities or education
- * Inadequate therapeutic skills
- * Lack of individualistic intervention
- * Evasive attitude toward addiction/dependence
- * Contradictions within treatment intervention services
- * Substitute medication prolongs or postpones withdrawal symptoms

- * View of medication as substitution
- * Pharmacological intervention of no use
- * Lack of medical intervention
- * Negative experiences re-emphasise the importance of appropriate structure of intervention

4.7.6.1 Positive effects of intervention

The majority of participants reported **numerous improvements** relating to various factors, one of the clearest of which was in terms of their understanding/awareness of themselves, their behaviour and their heroin dependence. This improved understanding is described in the following extract.

'My whole perception about life. I don't know. Before when I was on drugs I didn't feel motivated about life so, like were I was going, what am I going to do oneday. I had dreams that I wanted to do, but I didn't really make commitments to do it. I didn't really know what to do to do it. So then, when I cleared my mind, I know sort-of were I was going and I was starting to find "rigting" (direction).' (Participant 7)

Other common improvements were in terms of physical health, confidence (as alluded to in the previous quote), reducing feelings of guilt/shame, and a reduction in the feeling of isolation. Another major **improvement** was in terms of learning **coping methods and self-efficacy**.

'Sometimes I am also glad that I maybe went through this, made me feel like a strange person. Feel like I can, feel like I can cope and handle more than your average normal person will be able to handle. Not... you get strong people I feel, I feel my perception to handle certain situations will be more... will be more careful than the average guy, girl, granddad. Definitely heroin is not an option, it's an ongoing battle, but the enemy is falling one by one. Slowly but surely I am battling through the enemy line. I'm not on the defend now, I'm on the attack.' (Participant 30)

Other less common improvements were in terms of relationships, self-care, maturity, and anger management.

'You stay in a clean home, and you keep your room clean and you understand why it must be so.' (Participant 23)

Another clear positive effect of treatment was an **altering of the person** in terms of their life/lifestyle/perspective/identity.

'No, I don't think it did. I don't think societies perceptions had anything really to do with whether I cleaned up or not. I think my perception had much to do with it. To a really larger extent the only people, the only people that I tell ever, that I tell about my addiction are people that I think will be supportive of it. I've been patronised a few times, but I've never had a negative response, do you know what I mean? Patronising is not a negative response. Like people, like a bit... patronising, but friendly and supportive - but in quite a patronising way. Mostly though, I've only ever had yea, active support. People think it's good, and "well done", do you know what I mean?' (Participant 18)

'That was a crucial factor. Whether it's family of just anybody else whose prepared to stand in and actually just give you the support that you need, but the real support, not the little nursing you on, you know, "don't worry about it, it's okay, I'll get hold of you sometime". That's the thing, you know what I mean. People, I've seen it in Noupport plenty, the people get like, they say it's a hard place, but that's because they've always been nursed, and always been spoon fed everything there entire life, want to be treated like a five-star hotel. They're not prepared to make their beds. It's a whole life-style you've got to change. You've got to completely change you're life-style. It's not just to just stop using, or "clean time" - because that's what NA teaches you. How many days you been clean, how many weeks you've been clean, it's not about that. It's an entire lifestyle change that's what it is.' (Participant 32)

'Heroin addicts have actually sold their soul.' (Participant 24)

As the previous example suggests, most participants reported some kind of actual and/or desired changes in their life or in their perspective of life, including a new optimism for life, and a desire to and/or actual rebuilding of their life with better/new relationships or college/job placements, etc.

'Not any more. No, not at all... it's amazing, when I think of heroin, I just think of how stupid I was. I wasted a lot of time and money on this stupid white powder. Life is much better without it.' (Participant 19)

'And then I went to my sister. There I got a contract to work, and I think that was a motivation for me, every day I just worked harder and harder. In the end it payed off.' (Participant 15)

'My advice to people would be just to realise you can't live with a thing that substitutes life, so you can't fulfil your life with a drug, you have to enjoy life as it is.' (Participant 8)

'You see the other side of life that you know but never experience. So I think the big thing for me was long-term and spiritual orientation and being able to see the better side of life.' (Participant 13)

'There was another factor, I mean, I met a girl last year and the last time I saw her she... when I looked into her face, the tears. I mean, I've seen it in my parents' face before, but it didn't really bug me and she basically told me to just choose joy and just to choose, you know, like a better life. I mean, she was in Noupoot for a year as well and after that night, that's when I make up my mind, I said, 'to here and no more, and no more'. I didn't want anything more to do with it at all. And that was just a choice that I made. Basically it came down to a choice, either I was going to use, or I wasn't going to use anymore, and that was it.' (Participant 32)

One participant (2.5%) verbalised concern with regards to her career, and the ensuing stereotypes that could permeate in a new work environment.

'It's sometimes difficult for me, sometimes when I speak at a school, or at church, or sharing at meetings or whatever, you know the world is so small. I sometimes am afraid of who will know that I am an addict because that happened at the job were I am now. The one girl's fiancé and I were in rehab together. So she found out and in the end the manager found out. They were all great with it, but what if I am working at a law firm someday, how's the situation going to be?... Sometimes I'm scared that when I really start working, like at my career, what am I going to do then? What am I going to write on my CV and what, just little things like that. How much of my personal life must I get involved if I'm working somewhere or whatever? I'm doing casual work at the moment, and they've really all been great with it, and I don't know how that's going to be in future.' (Participant 10)

Treatment intervention was also reported to have been positive in terms of helping participants to achieve a clearer perspective of their heroin problem, and the negative effects of it. The **cumulative effect of treatment/intervention**, alluding to multiple interventions, was reported to have facilitated the process of realisation (see 'realisation process' in Theme 4.7.4, p.135), with the period in treatment allowing the user to see what life without the substance misuse problem could be like.

'I underwent a tremendous number of interventions. I think for me, the way that I make sense of it, is that it was a kind of cumulative effect of all the treatment. I was quite... confused. Then I was using, and then I think initially I went to treatment not to get off heroin, but to learn to manage my heroin addiction better... In the end I finally got to a point, about four years before I gave up, before I realised that I would give up everything. Well, I was quite reluctant to do the things that I was being asked to do. Eventually I got to a point were, were I was willing to do what I needed to do and at that point all the interventions that I'd experienced had some meaning.' (Participant 18)

The above extract was quoted by a male participant in his forties, who was a intravenous heroin user of over twelve years, he has remained abstinate from all substances of abuse for eleven years.

4.7.6.2 Positive/ important components of intervention

In order to achieve the positive effects of treatment, certain positive components/needs were reported to be essential for beneficial/successful intervention. One of the components was that of **common experience** in terms of being around other heroin dependants in treatment and the fact that many of the counsellors had some kind of personal experience with dependence. Some of the benefits of this common experience are described in the following examples.

'I would say, I would say that the most important thing actually is if somebody is on drugs, the best person to counsel that person is somebody that was on drugs before, like I told you now-now, people are reading books and they're doing studies, and they're doing research on the internet, but they will never feel how it feels because they weren't there. And it's easy to say, ja (yes), you must do this out of the book and you must do that out of the book, but... no.' (Participant 35)

'You must have a therapist who knows what they're doing. You must have someone who basically understands your problem. It doesn't help me getting a therapist that, for example, has an aptitude for alcoholics, and I'm a heroin junky, that person will not be able to help you because that person will not understand how you feel, you know, you understand what I mean?' (Participant 39)

'Definitely. The rehab that I went to, they have all been through it and are still going through it. A lot of support.' (Participant 11)

'And then I, the people around me were mostly in there 40's and 50's, we were only two guys that were addicted to heroin, and he was nineteen years old, and I was at that time 21. These people were my inspiration, they, I would chat to them the whole day and see that my life wasn't so bugged up. Actually if I hear what's happened in their lives, and then afterwards when I came out I was supposed to go and see the psychologist, but I didn't because I didn't have a need to.' (Participant 15)

'The way I saw others...' (Participant 4)

'In a way, because I think that some people like... you see what they go through. I don't want to land up like that. But anyway, I didn't.' (Participant 3)

'Yes, seeing other friends who weren't doing too well.' (Participant 4)

'In the long run it's up to the person himself. Rehabilitation. As much support as possible I think is the best.' (Participant 5)

'No inpatient... primary, secondary, tertiary care. I can't tell really. I don't know. It's quite a difficult job to get off. I would actually advise someone to go into a treatment centre.' (Participant 9)

'Okay, my process, I was in, it was... it helped me through everything and got me where I am now. I think SANCA they helped a lot because I tried coming clean on my own, but I always went back to the same old routines. But then, I booked in SANCA there. I actually didn't want to go anywhere but I went in the end.' (Participant 15)

'I thought that my mental addiction I thought I could deal with, and then I wanted to leave, because actually I only wanted to detox for a week, that was my entire purpose. Then you and my parents convinced me to stay longer as there were many problems that I had to resolve, that lead me in the first place to abuse, and I know I am not a therapist, but I could feel when I had resolved it. Then I stayed for my full six weeks and I never again tried, the last four weeks I experienced no cravings and up to today I have never craved again.' (Participant 37)

One participant (2.5%) was of the opinion that rehabilitation centres should only be run by rehabilitated drug dependants.

'Ah-ha. Ja (yes), well that's perfect, that's actually a good set-up, that I would say is the best set-up. (Rehabs run by ex-addicts).' (Participant 35)

Another crucial component in early recovery, when the recovering heroin dependant is very vulnerable, was identified by eleven participants (27.5%) as having a **safe or protected environment**.

'They have to... the reason is so that you are taken out of the situation. You understand... there you are not faced with Jannie who stays on the other side that can organise for you. So if you're there the temptation is less and I would even say that your recovery is easier. The circumstances make it easier for you during the period to get out of that - so that you use nothing because you use, you break yourself down and on your own you think I don't need this stuff. While you're there you become positive and you don't need it. You are taken out of the situation so that you can get rid of the drugs so that your brain - so that you can start thinking and functioning correctly.' (Participant 21)

'No, no. I needed to be like in quarantine. Yes.' (Participant 28)

'It was a protected environment. When you're at home you can just go out and get heroin or whatever. You can't go out and buy heroin. Or withdrawing and going crazy, you can't go out and buy stuff.' (Participant 1)

'A protected environment where you know you're safe, where there are no drugs around you and stuff like that. You can't get hold of them no matter what. If you want to, you can't, just for a couple of days so that your body can get its strength back, you realise you don't need it. But they have been by my side all the way, through all my troubles, jail, not jail but court cases, to my rehab, they should have stopped a long time ago to support me, but all the way - by my side.' (Participant 8)

'Being in a protected environment. In a way yes. But also, like I said, by being in a protected environment too when using. I don't, I think you can use it but then always go out and use again. It's not going to stop you from using.' (Participant 11)

'No, it's impossible. The closed unit is the right thing especially for severe addictions such as heroin, because they will do anything to... they will do anything, even deceive their mothers and put them in the boot and drive away with the car and go buy - it's so bad you think you're dying. Yes, definitely. Without it you wouldn't make it.' (Participant 37)

'You get so isolated from the world that you don't know it, so, but like in SHARP you can go out a lot. But even in Houghton (House) that six weeks was long, doing nothing, just sitting in that house, but it was good for me. I'm not complaining.' (Participant 38)

Well I came clean by going to rehab, wanting to do it. Ja (yes), no definitely. Rehab helps because to be on the streets and be exposed to drugs when you are still very vulnerable, it's very difficult. The chances of not using are not that good. (Participant 5)

Some participants also described the need for **specialist therapeutic intervention** such as a halfway house, rather than general help, e.g. medical assistance to detox or psychiatric intervention. In terms of psychiatric hospitalisation, 12.5% ($n = 5$) reported such intervention. While thirty-eight participants (95%) underwent some form of residential intervention. Only three participants (7.5%) had undergone intervention in a half-way house.

'Okay, I'm not sure. I was two weeks, only detox, and I think it did, it served its purpose to me. But I think a month, a minimum or a month would be the best.' (Participant 15)

'And I knew what I needed to do. I still needed help to achieve it. Then I cleaned up in a halfway house and after having had multiple entries, I actually went into a halfway house, and just stayed there and I've been clean ever since then.' (Participant 18)

'In-patient treatment is definitely ja (yes), I think it is, even if it's only for a couple of days. Just to let the person know that in there... a lot of people go to rehab and they think to themselves that they are lonely, that they have nobody to support them, and that they just think about "am I ever going to come clean?", "does somebody worry about me?", things like that. So I think it's a basic guideline. You know what; I went to Magaliesoord through an Article 21 that is mandatory. I had to go otherwise I would have been in court I would think it is basically necessary, but I think it must also be the person himself as well.' (Participant 35)

Treatment intervention structure, which refers to the type/style of treatment intervention that participants considered being beneficial, was also reported to be highly influential to recovery. Eleven participants (27.5%) had undergone **long-term residential programmes**, often spiritually orientated in nature, and were of the opinion that spiritually orientated programme were more beneficial than other types of therapeutic intervention. People who undergo a radical shift in the way they see themselves and the world are often said to have gone through a process of conversion. To varying degrees, many of the participants in this study have gone through processes of spiritual conversion, which helped them to leave behind their deviant lifestyles. Their exposure to and interactions with people in drug treatment and 12-step programmes provided them with a new reference group and perspectives.

'Noupoort laid also a strong foundation as far as spirituality was concerned. There we were read three/four times a week out the Bible. You know, had I not known that, or about Christ as such on that night. I don't know what would have happened. So I would say ja (yes) it did help it a certain extent.' (Participant 32)

'By doing that, you will be able to lead a better life; to live like a Christian and to understand that by taking drugs is a sin, and to use alcohol is a sin. It is all a process of renewing your mind.' (Participant 22)

'You have two kinds of rehabilitation systems: Christian rehabilitation and psychological rehabilitation. I came from the Christian rehabilitation, and my mind-set, in that way it worked for me, that's why I propagate it.' (Participant 2)

'And after that everything is Christian counselling that you get through the whole process and long-term staying clean together with Christian counselling and it is a good combination.' (Participant 13)

'Noupoorts' rehabilitation is based on Christianity - there is only one way that you can come right, and that is with Jesus Christ. That is what you learn there. You feel so guilty when you come out of it and you're sober - for what you did to your family, for what you did to the people around you, for what you did to yourself. There they teach you; look, you can start again from the beginning. He can take away all your sins, you leave it behind and you

can move forward. You have nothing to feel shy about. You do not have to stand back for other people and you can start from new, then you start right.' (Respondent 20)

'And he must... the only guarantee is a real relationship with God, and mercy. And that's why I say it's all... it's a thing that you must do from your side and God does what he must do from his side.' (Participant 21)

'So I can talk about Noupports' programme and so on? Noupports programme is based on a one-step programme - and they, we believe that God is greater than your addiction and that God will be able to help you to get rid of your addiction. We have a programme where people do not physically receive medication to free you from your addiction.' (Participant 22)

'It's Christian based treatment and I think that helped me a lot. To see that the path that I walked was very skew, and that a person cannot carry on like that. To an extent, it also made me more responsible. Actually, those two things together. Yes. The reason why Noupports' programme also helped was because it's a self-help programme. You must get to a point where you realise what you did, and the thing is that you can overcome your addiction and it depends on yourself.' (Participant 22)

A number of participants were of the opinion that long-term residential intervention was necessary in order to provide **sufficient time to facilitate change** in thought processes and behaviour patterns.

'Long-term definitely, definitely. For me I found that from even using for such a short period of time heroin, using heroin I, I wasn't feeling. I became dead of feelings. It takes time for you to regain those feelings, the thought process and the patterns. It takes awhile to regain all of that. I would say a minimum period in a rehabilitation centre I think of six weeks. Definitely being in a protected environment.' (Participant 11)

'How should you treat it differently? Time period - definitely. Long-term, not short term. When I worked a bit in the office, they said that the foremost reason why they decided on a 32 week programme - 8 months, was due to the background of American statistics that said that that takes approximately 32 weeks for heroin... not out of your system, but to get out of your thinking ... to create a new thinking pattern, and it's not necessarily so with other drugs. That's why I have accordingly such an opinion with regards to this - you must have a longer time period to treat heroin addiction and I would say also for coke. I don't know necessarily of the other stuff, but in my case coke and heroin went hand in hand, that's why I probably see it this way. Time period definitely... and shit, you must have it hard to realise the reality of your situation. Okay, it's probably my experience, although other people in there had been in jail and that were prostitutes - and that was not enough for them to realise reality. It is a difficult question Monika. I don't know. But time period definitely made a big difference.' (Participant 20)

'Only long-term treatment in which you can change your thought and behaviour patterns.' (Participant 21)

'Round about, it depends... if you really want to, a long-term programme is the best because you need to sort out lots of things. All people have problems, you have to sort it out because if you are only there for six weeks or two weeks, you don't forget the things - how 'lekker' (nice) it is, you need to get away for a long period of time, and after that you can see how you don't need it. So you need a long-term programme... well I think.' (Participant 8)

'I don't know how these four-week, five-week treatments can really help. It's a good starting point.' (Participant 10)

'Long-term, long-term being clean. I don't think it is anything else. Long-term as in not just through rehabilitation through a year or two, more five years. I think if you are five years clean, five years of being clean, then only I think that you are relatively safe. Until then, I don't think that anyone is safe. So, one must never be too lax, and you must always avoid it.' (Participant 13)

'I always go from the viewpoint, speaking to them and saying to them, a minimum of a year because if you go beyond that, a year is already too much for them, but, the way things are going, a year ain't enough. A year and a half, maybe eighteen months, maybe two years minimum, especially for heroin and crack.' (Participant 2)

'When I stayed in Noupport my last year, for a very long time, the programme was eight months, and then when I was six months there, I committed myself to doing a year, and then, as a year approached, things just worked out and I was teaching at the school so they asked me to stay on. So I was there in total a year and a half.' (Participant 10)

'For heroin - long, and for crack. It's a long time. Just to, I don't know what... just so you can get to that stage where you can give back to the community. When you speak to others, you hear what you are saying and the more you repeat yourself, the more you practice and you hear it and you repeat it and you see it happen in other people's lives. Such things don't happen in six weeks - it happens over a long period of time. The people that have stayed with you for a long time see the change.' (Participant 23)

'I would say... like we spoke about, 28 days was a bit short. Even now, I mean even now, I'm past the 28-day mark, and I'm still... I know where I am, and I must still not... just not a hundred percent to go, to do whatever I need to do. But I also think that too long a period is also wrong. Like the seventeen months I spent in Noupport, that was, it became too long. I started regressing after three months. I got to a certain stage where I was strong enough to come home, then after that, then it was like being forced to stay. I sort of like regressed to a point where I shouldn't have. In that sense it does, because then you just want to get back here, and you just want to

come back and start over, and you don't really care. You're in that mode and you don't care. So you just start and you don't really get... you become really complacent there. You don't really worry too much about where you go, what you do.' (Participant 32)

The following quotes display the opinion held by various participants that intervention should be more intense and/or of a longer duration for heroin as compared to other substances of abuse.

'The attention span on heroin addicts must be far more intense, because heroin addicts experience coming off heroin the morning more intensely than any other.' (Participant 30)

'Yes. From my point of view, yes. Being on another drug and being on heroin is two different things. Heroin doesn't produce a high really - heroin just gives you a sense of inner self fulfilment that... you can describe it as a high but you're not high like other drugs - falling around, everything's spinning. It just calms you down way past. It could work in a group of other addicts, but then, you know, taking a whole group and lets say there are two heroin addicts in a group of six - the other guys on dagga and stuff like that, the attention span should, must, be more on the heroin guys 'cause heroin guys suffer, you suffer your arse off.' (Participant 30)

'No, it's not the same. I think other stuff it's not so heavy. Heroin is, it's bad. So, the more help you can get, the better.' (Participant 16)

'I think heroin guys are harder. I think they should go for a little longer. Heroin is physically addictive and emotionally and mentally addictive. It's also a very hard drug to come off of. A guy maybe uses at parties 'E', they might struggle to get off it, but they don't have to go through as much as a heroin addict.' (Participant 26)

Participants also stated that they were scared of coming out of a treatment centre, furthermore, some participants, particularly those that had undergone long-term residential treatment intervention, stated **that re-integrating into society was very difficult** for them.

'Ja (yes), and then a week later they put me in a rehab. They put me on medication and stuff for that week, so long the doctor prescribed stuff for me and then I went to rehab, to Castle Carey, and I stayed there for seven weeks. I stayed a week longer because I felt I needed it. I was very scared to come out. Ja (yes), I think it really helped me.' (Participant 17)

'I think it was a bit too long, 'cause when I came out, I was so, I remember when I just came out of Noupport I didn't even want to go into the garden I was too scared, because everything was regulated like what magazine I could read, and what radio station and what programme on TV I could watch and all that. And it was hard for me. I think the period was too long. It's so hard to re-integrate into society. But I think maybe a year programme or so is a good starting point.' (Participant 10)

'I think treatments in rehab now for heroin, the time is right. No, not longer. You can keep a guy for a year in Noupport, and I've seen it, and they come out and they relapse and they go on. It's all, actually, what it's all about is you taking him out of his environment, where he's actually introduced his friends and everything. You take him out there and you put a druggie in a perfect place, where nothing can reach him. So nothing from the outside can reach him, and he can't reach the outside - and then his time is finished. You take him out of the perfect environment, and you put him back where he came from. Where the problem actually started... You must get your foundation right. If that's not in place, the patient comes out of rehab, comes back home, and he's back in the hell-hole and it all starts from the beginning, but actually at a faster pace, and it gets worse and worse and worse. You can take him out there; give him his vacation in rehab, because honestly, for me, rehab was a hell of a vacation. 'Cause you reach you inner-side again, and you get pink again, and everything and you can think straight, and then, just a while, actually I was scared... To go out. At first, yes. The mind is powerful because I'm clean for this long - what will one hit do? But after a while, you start realising, hey, the longer I'm clean, the easier it starts to get. Sometimes, your realise, hell, I forgot about it actually for quite a while, but I'm thinking about it now, and then you realise, jees - I'm thinking about heroin. When last did I think about it? 'Cause the other things in life come, like work and relationships and new problems and stuff like that, which normal people have, and then it takes your mind and attention away from it.' (Participant 25)

'They don't always have all the knowledge; they come back and its lion world. They are thrown to the wolves, and there is no one to protect them. One wrong decision and you fall, and then what from then on?' (Participant 21)

One participant (2.5%) did not find it difficult to reintegrate after long-term intervention, and was of the opinion that people make it difficult of themselves.

'Now, not at all, not at all. The first while after Noupport, back in the environment was, the first months or two was difficult. But, just stick to it and made it. Look, you can make it difficult for yourself if your mind is not right. You go back to where you were before, the same situation. Maybe friends who are on the same stuff. For me, it wasn't so difficult, only the thoughts after the first while after you come back. All the thoughts that go through your mind. But after two, three months, then it is over. You must just keep your head clean... you mustn't turn back. It's not easy, many people fall once they come out of rehabilitation, after being clean a long time. But it's because they do not follow the right steps. They look for trouble. But now after three years, I don't ever think about it. It is not my way of life. My way of life has completely changed, so...' (Participant 13)

One participant (2.5%), having been through countless intervention programmes, was of the opinion that intervention should be about **long-term care**, and not necessarily long-term residential treatment. This factor seemed to be a predominate theme in most interviews, and tied up strongly to the concept of ongoing support and resources.

'Well you know, it depends on what we mean when we say long-term residential treatment. I think yea, long-term care. Long-term, people need a lot of support. It's not something that goes away after six weeks. It's not something that they are going to learn to manage in on their own after six weeks. I mean, they need long-term support, they need long-term resources. Whether they need treatment in-patient - don't think so. You know there other more cost-effective ways of offering that to people.' (Participant 18)

The issue of duration of residential intervention some participants felt was strongly linked to the length and chronicity of the heroin dependence.

'Yes, the thing is, I also saw with programmes - the longer the stronger - and I believe that, because for many people, okay, you go to a programme, you do a six-week programme and the whole thing is... say you drugged for four years, it's then four years of thinking pattern and the way that needs to be changed and a person can't just change it in four or six weeks, it's impossible.' (Participant 22)

'I'd say three months at least. Six weeks can help. Also like you said, depends on how long you were using and how... how strong you were, how strong your will is. And when you come off heroin, and you're in that first stage, you have no hope, heroin controls you.' (Participant 30)

'Definitely, especially for heroin and cocaine. I think you need at least a year clean time behind you in a secure environment before you can come back to normal society. Two years is even better, depending on how long you were addicted for. One year at least in a secure environment.' (Participant 6)

'I would say about six weeks maybe. It depends on the person, but mainly between six weeks and two months. I think some people need that. Like heavy heroin "junkies" that have been using for years and years. I believe that if all else fails then, then that has to work. I don't agree with the long-term treatment in our country.' (Participant 17)

Numerous participants cited **short-term to medium-term residential intervention** as sufficient. Of the sampled population, thirty-three (82.5%) of the participants had undergone short-term residential treatment.

'I felt ready after four weeks. I don't know.' (Participant 36)

'I think it's a perfect time period. The manner in which you do it, by letting a person out for two hours, and then two day - to test oneself outside. The big thing is your parents stress those 24 hours because you go do the things that you normally did. You test yourself amongst friends those 24 hours. The evening you might go party - it's the final test that you can give yourself. No... shorter... if it was shorter you would not have enough time to work through all the psychological stuff; there wouldn't have been time for it. Heroin addicts don't trust people easily, they don't trust people at all, and I think four weeks is enough to gain trust in the therapists. If it was shorter it wouldn't work. It depends from person to person. For some people it will be necessary to stay longer because they may have more problems.' (Participant 37)

'Yes it would help. I think more than six weeks. 'Cause at the end of six weeks I felt all right, but something inside just told me that I'm not right, so, I'd say eight to ten weeks, that will help, ja (yes).' (Participant 16)

'Even if it was only for three weeks, it would have been fine. I just wanted it out of my system... so I stopped withdrawing. Giving them more time to think. Not really, a bit more time.' (Participant 4)

'For me personally, ja (yes). I know that some people might stay longer or shorter. I don't know. But for me personally I felt it was sufficient.' (Participant 7)

A few participants were of the opinion that it was not the duration of treatment per se that determines outcome, but rather individual choice alongside professional input.

'Look, it differs from person to person. Some people, I saw, stay clean after six weeks, and never use again, others go for two years to a place and they still relapse. I think it depends on how badly you want to stay clean.' (Participant 26)

'I think the people you go to, the professional people, after they evaluate you and everything, they should decide. Ja (yes). I don't know. I don't know.' (Participant 28)

Of the participants interviewed, fifteen (37.5%) had undergone some form of **out-patient intervention** during the course of their recovery. Many participants were of the opinion that non-residential intervention was too risky.

'Some people don't like that. I'm not a person that one could say to "you must get to a place during which you may not go anywhere".' (Participant 34)

Eight participants (20%) were of the opinion that out-patient intervention was not intense enough, and not being in a protected environment that provides 24-hour care during early recovery was not conducive to long-term abstinence.

'The out-patients go back home, right? No. My cousin was an out-patient at a certain doctor who I really don't like, in Centurion, he's a pompous ass. Yes, everybody who went to that doctor, just went back home and used again. So, that's my cousin, and three male friends and two female friends. So, ja (yes), I don't think out-patient stuff works. For some people it does, for some it doesn't, but I know it wouldn't have worked for me... I would have just gone home and used.' (Participant 28)

'An outpatient? For heroin? I don't think so because I think their chances of recovery are not that good. I believe heroin addiction needs intense treatment. Intense, everyday treatment to get over it because it's, because of the specific drug it is.' (Participant 17)

'No, not as an out-patient, not for heroin. No! Shit. That would have never worked for me. I would have just come and gone home and got all fucked up again. No that would have not worked for me at all.' (Participant 29)

'The thing about out-patient is he comes and he gets medication and he goes home again, so, what is the point of that? Maybe he goes home and he can use again, and when he feels bad again he just goes for a drip or NAD, whatever the situation may be. No, I don't think out-patient is very successful. You need to treat a person for a long time, eight months, five months or six months'. (Participant 35)

'No. Temptation, temptation outside, you can get in the car and go.' (Participant 36)

'Yea, definitely. No, no. I've seen a lot of people do it on out-patient. I don't know, they just go back to using. I think I needed that in-patient to keep me away from it.' (Participant 38)

'You can, but I don't think you will make it. In-patient I think is the best; it's when you get 24-hour attention. There is always someone looking after you, you're in a secure environment. While as an out-patient you're free to go and do what you like, understand? Take Castle Carey, I think six weeks is not really enough for a heroin junky. I think it needs to be a little longer. Say about ten weeks. To sort out your head. I would say approximately eight to ten weeks. I think that for me is the right time.' (Participant 39)

One participant (2.5%) spoke of heroin addicts and dependants who manage to **quit without any form of rehabilitation**. Within the scope of this study, two participants had managed to quit heroin without any form of intervention, however, both substituted heavily with alcohol.

'You get people who stop heroin not even going to a rehab. Heroin just takes so much longer to... I don't really think heroin ever really gets out of your system... that urge. I've been clean for over a year and two months and I still struggle. The feeling you get once you inject... you get this weird taste in your mouth, like this weird powdery feeling... that's what I got. Sometimes even in the middle of the night I wake up with that feeling, with that taste in my mouth.' (Participant 30)

Only one participant (2.5%) was of the opinion that the **mode of intervention** and the **success thereof** lied solely in the hands of the individual and the **choices** and decisions made in terms of abstinence.

'Could it work on an out-patient basis? I would say it would be up to the patient himself. If he's made that absolute choice that he's gonna stop. If he hasn't made that absolute choice, he's definitely going to use again.' (Participant 32)

'If you, no, if you really recovered it won't be difficult. I think that some people go for a year to rehab because they are told to go for a year and they are doing their time. I went, I was told I was going for a year and I did that, and I made it my home, and I did more time out of my own. See, once you start making those decisions, and not having those decisions, and not having other people making the right decisions for you, then you start getting better.' (Participant 2)

Participants stressed the need for life-style change and the fact that it is a **life-long commitment to recovery**; this highlights the concept of life-long treatment/intervention as opposed to the concept of long-term treatment intervention.

'The thing is, the word "long duration treatment", it's actually a "life-time duration treatment." I mean, I'm not in rehab now and I'm still doing all these things that I have to do daily and weekly to stay clean. So I suppose it's actually a "life-time treatment".' (Participant 10)

Several participants also referred to the need for both an individualistic and realistic style of treatment intervention, which should be instantly/easily accessible when required. Finally, another component that was considered crucial for successful treatment was **personal factors**, such as effort, hard work, discipline and commitment. This is a fundamental component since without this treatment cannot be effective regardless of its merits.

'Get that discipline back... hard work, and shake those lazy bones and learn to work again. Because what do we do? We grow... our parents grew up on farms and they didn't have it easy. We were speaking about it last night. Our parents started off this meagre salary, their first glasses they got from the roadhouse were they drank milkshakes and they got the glasses in the house. I already have my own house and everything, and I've only started out. We grew up in a house where we had everything. Everything was easy. The worst that we had to do maybe was to mow the lawn and do school. We never went to work and we were lazy. But it's natural, you know your parents want to give you a better life than they had, and that's why you work, to give a better life to the people that follow. But if there is no discipline and no hard work, you have children who don't know what to do with themselves, and they start doing the wrong things. Now, the only way to break the whole system is to get discipline back, get hard work, and that's only going to happen over a long period of time. It took eighteen years to become the children they are. You are not going to do it in eight months or four weeks.' (Participant 2)

'The reality, discipline and time period.' (Participant 23)

'Long-term Christian rehabilitation with discipline and hard work. That's it in a nutshell.' (Participant 2)

'Because you initially avoid all discipline - it brings you back ... I don't know, reality - you must make your bed every day and must read the Bible, and so you eventually have more interest in what the Bible says, and you listen again in church. Start interacting more with the community in which you live in.' (Participant 23)

Some participants also alluded to the chronicity of heroin use, stating that if a person has been dependant on heroin for over four/five years, coming 'clean' is a much harder process, and creates special needs in terms of intervention. **High level early interventions** are mentioned as an effective means of assisting someone prior to them developing more chronic heroin dependencies.

'Yea, I mean I guess. I mean I think there is a difference in treating long-term heroin addiction. I think, what I think is that if early intervention in heroin addiction, within two/three years are much more likely to succeed. I think after five years of being addicted to heroin for five years, there's a very very low recovery rate. I think that that creates special needs in, on some level. It's not the kind of addiction that peers out. It's kind of... hectic crack cocaine addiction you can't maintain for ten years. Whereas heroin addiction is kind of, it can just go on and on and on and on... and once the habit gets that entrenched, then I think it's very very hard for them to come right on their own. I think, that type of thing, early intervention, early high-level interventions are important. I think that one of the mistakes that I made was the intervention, my early interventions were all low-level interventions, I think that that contributed to the duration of my addiction.' (Participant 18)

'It's not a thing that you do on your own, so... it's a combination. Look, there are practical things involved; you can't only not use heroin or whatever. You function and think in a certain manner, your body and your mind. So, if you used heroin for the past six years every day, I can guarantee you, you will carry on using. It's practical; there isn't another way to do it... The first question that I would ask is probably the same... how long have you been using? How are you using it, and I mean, despite how much the person wants to quit, there are practical things implicated. If a guy has been on heroin for a year or two years or longer of heroin use, then he won't be able to be on his own in Pretoria or Johannesburg or wherever.' (Participant 21)

'But it was a struggle man, you know, five years is a long time. For five years, okay there were a few weeks that I was clean - altogether about three months during those five years, understand. But, it just, it's a struggle. That's how I can explain it to you basically. It's difficult. It takes a man to do it, hear, seriously.' (Participant 39)

Common experience was reported to be beneficial in many ways, for instance, in providing a more **empathetic/understanding environment**, where participants (and counsellors) could positively

relate to each other and draw on their own experiences to provide useful/practical advice and support. Furthermore, many participants described how the common experience of addiction and dependence was beneficial, as they were not able to 'fake' treatment or conceal, for example, if they were lacking motivation for treatment intervention. This common experience was also important in reducing isolation, which was of high significance to (see 'social effects' in Theme 4.7.3.4, p.133).

'To come clean, number one; rehab. My first thing is rehab that actually worked for me. The other rehabs couldn't do it because they didn't give me 24 hours attention, and you, like the sister, for example, every three hours in the evening she will come see if this child is still living, understand? There it is if you sleep, you sleep. If you die in the evening, the people don't worry. Castle Carey also provides a lot of free time to sort out your own head. The free time at times becomes heavy because you don't know what to do with yourself and stuff. But, as you start keeping yourself busy, the people, you start speaking to people about the problems you have.' (Participant 39)

'The thing about Noupoort is that everyone there knows what you are going through. So it's very supportive. When you come back, your parents don't really understand or trust you. But it wasn't an impediment, because after Noupoort you want to prove, you want to show them that you are right. But it takes time.' (Participant 23)

Eight participants (20%) described the benefits of being surrounded by people at different stages of their addiction/dependence, with new/relapsing drug dependence serving as a reminder of the negatives effects of using, and successful recovering dependants (e.g. people in aftercare) instilling **hope** and serving as potential role models or goals to aspire to.

'I think, um... I was in a rehab once, and there was this Irish girl that I had been using with for about two years before, and she was ABSOLUTELY CHAOTIC, and she was doing very, very bad, badly addicted. So was I, but she was and I knew that she was. She wasn't like "play-play", she was kind of, she'd been in my mind "hard core". She was, as she was really, and I related to her. Anyway, I was in this rehab and they came for after-care, and this girl came, and she was eighteen months clean. And she came and shared her story, and I knew her. I knew that she was as bad as I was, and she was eighteen months clean. I think for the first time I saw somebody that had gotten out of it. And then I saw her, she was the first person that I knew was like working the programme that I'd been working at, and was clean and sober and I think that was the beginning for me of like hope. It took me four years from then to clean up, do you know what I mean? But I believed it was possible, hope.' (Participant 18)

'That I might be able to... you know I wasn't committing crime anymore. I wasn't waking up sick anymore. I wasn't kind of in trouble with people anymore. On a daily basis I was holding down a job, things were improving. I was having money in my pocket and not a lot, but you know, something. I could see that things were looking easier. That there was hope, and I think that is one of the key factors in my recovery, and I believe in anyone's recovery is hope and I think that's what I had lost during the years.' (Participant 18)

'The first few months after rehabilitation was hard. But with time it gets easier and it gets simpler. Your start to see other people and what's happening to them and the way things turn out for other people. If you see what happens to other people from your own perspective, you realise what was happening to yourself. You've actually opened your eyes to really look what's happening, it's quite frightening actually.' (Participant 7)

'Yes. And hope. Hope, okay, let's take me for example... when I reached the hectic part of my drugging, was the time when I actually wanted to die, 'cause I thought there's no hope, I can't get out of it. When I started getting hope again, that's when things are sort of... Doing this turning and things are going uphill, sort of - there's hope. I don't know, life is a weird thing, 'cause something hectic will happen, and would have maybe done something wrong, like took something from somebody. Then everybody, it felt like everybody was teaming up against me and they confront me, then I would have thought, "it's the end of my life, and there's no hope" and, and "life is such a hellhole" and that, things like that. But at the end, they actually helped me in, like for instance, I was busted, I never got busted by the family, they knew, but at the end I actually admitted it 'cause they confronted me, and then it's like a hectic thing, and there's no hope, and then everybody it like "no there's hope, you can do it" - and then I start believing it. I think that that's the best I can explain it.' (Participant 25)

'I would actually tell them what happened to me, and I'd tell them everything that happened to me and where I was on my way to. I was almost dead. I will tell them that there is hope for them, because if there's hope for one person, there's hope for a thousand people - always works like that. And rather get one person clean than loosing a thousand people. I will work with them, I will do that yes, because I understand what they're going through, and I know what they're going through. It's not just a physical addiction; it's a mental addiction as well.' (Participant 35)

'I would say he must stop listening to what other people say he must do, because other people don't know how you feel. They can say many things to you, but you must just go and see if you're strong enough and follow your own path. If you can't do it by yourself, if you've seen you can't do it, then you must stop struggling and go get help. There's a lot of help everywhere, everywhere in the country there is help. You adapt. You must just look for help. That's what I did. I went from one place to the next until I eventually got help. You must just not give up hope. That's all that I can say. I don't actually know.' (Participant 26).

'No, I think I had support. I would say yes. It's always nice to know that there's someone close to you, somebody that doesn't give up hope, that's the most important thing I think'. (Participant 35)

'Also, what I can tell a person you know, from person to person, what helped for me may help for you. But if I come across somebody, I'd just give them a detailed description of what can happen if you go back, first of all you feel crap - money wasted first of all, rehabs' not cheap at all. I can... just be strong and you mustn't let... okay of course that's also wishful thinking... at times nothing will bother you but for me I can just, I can just help a person from my experience and what I felt and give them hope and maybe show them a certain rehab who I know can help, 'cause the drug problem... the necessity is to be healed - love as well. Love and a sense of loving somebody, and not all rehabs possess that sense of love. Okay, ToughLove as well, but not always.' (Participant 30)

Being around other recovering heroin dependants also helped some participants to evaluate their own behaviour and thus to facilitate change.

'I don't, I found it very difficult - the first few stages. I was in treatment with other people, but I saw them like cruising through, they were willing to accept it, but I was holding back. So, I don't know. I didn't want to open up. It just took time for me to open up.' (Participant 9)

The following quote illustrates how a lack of hope can lead to further despair and drug use.

*'Yes, for sure. The first time you see it again, of someone next to you who's using it, you're back on it. Many times I said to *****, "I am so hopeless, if I had a car I would drive through and use", many times, especially as a consequence of my mother and father and my sister.'*

Most participants also reported the positive experience of talking about their problems and getting advice in **counselling**. Participants particularly emphasised the need for a non-judgmental attitude from mental health professionals. A minority of participants felt that counselling was of no benefit to them, and that in some cases it could do more harm due to professional ignorance.

'What I think, I think use anything, as long as you can get it right. You see, the same as if you pound him with psychological things - it's not going to work. If you're at that stage were you want to come clean, you don't want to do Rorschach tests and divulge facts about your childhood and stuff, you know, you want to come clean. With heroin I think the main thing is the physical thing first. After that, maybe counselling will obviously be good, but not with force down on a patient who's not really into this. After a month or two, yes. Then the counselling must be smooth. Yea. Because a lot of these psychologists made me feel guilty about it, you know. Which is completely against what they're supposed to do.' (Participant 19)

'Some of my senses came back to me... ah; emotions came back to me, that's why when I was here I had such emotional outbursts... because I couldn't handle what I was feeling. I started, I started feeling again. I started feeling sad again. I was like an ice-cold person. I didn't have any pity or mercy for anyone. So I think therapy like is needed, is needed for anyone to recover.' (Participant 30)

'The counselling part for me doesn't really... counselling can't really make you stop... counselling can just maybe give you like guidelines you know. Once you're on that path you can use the guidelines maybe as, maybe as tips you know for... lets say for instance staying away from old friends, and once you see them it could be like... okay, well I think that's what counselling acts like. Maybe counselling just... a little soul food, you're soul thinks of like a little child, like a child who likes to play anything. So I'd say counselling... it depends on the individual as well.' (Participant 30)

'Who, the psychologist? She helped nothing. Clearly 'cause she never... all that she used to tell me was ah... she just used to tell me a whole lot of stuff that really didn't mean a thing to me.' (Participant 40)

'So then, when I come out of rehab last year, I started going to a psychologist. I went to two different psychologists and it didn't really work out for me. So then last year about August/September I started going to a social worker. I've been going ever since, once a week or once every two weeks now. And it's really helped a lot.' (Participant 10)

'Ja (yes), therapy does. Not really that the therapy helps, but somebody to speak to. Like you were there. You were my therapist, but I didn't see you as my therapist. I can't tell you my fantasies, no, I'm only joking, but you were an easy person to speak to, you were straight forward, and you were there for a reason and you understood the reason, and you were just there to listen. And that was better than what therapy could have been done.' (Participant 29)

'Counselling... I think that's an individual thing. Some counsellors I think will help patients enormously. Others, psychiatrists, can do more harm if they... also once again ignorance, if they don't know what's actually going on.' (Participant 19)

One participant (2.5%) referred to his family has also having to **recover as co-dependents**, as once that had occurred, healthy support and recovery could take place.

'It depends - it's not just a process were you recover; they must also recover from the addiction, because they are sort of co-dependent. The thing is the support and I can't actually say advice, but in my case I can say yes, in a way, it probably did help me. You know the support and the trust again and so on, but also in a way it depends on you.' (Participant 22)

Another participant (2.5%) stated she and her fiancé were both in recovery, and that they only relied on each other for support.

'My fiancé and I supported each. For three months I was alone in the flat, and I don't know why, it was strange, when he was gone, I slept alone in the evenings... I couldn't handle that. I would lie there in front of the TV every evening. I couldn't handle it. I thought for myself; "if I could get heroin I would use it, because I don't like the way things are now." So I think a large part why I stay clean is because we have each other.' (Participant 34)

Participants also verbalised much **support from the medical sector**, such as medical doctors and pharmacists, and the important role such professionals have played in de-stigmatising heroin dependence.

'Most of the pharmacists - there are a lot of pharmacies in the UK - most of the pharmacists are really good, they're really nice people, very understanding, and they don't look down on you. They see it as a medical problem. A medical problem with medical issues, not that you're low life scum - which is good. Don't need to be alienated so much, not like scum. But I found that when I first started it was like that, but now it's not. So it's changed.' (Participant 31)

For many participants, **education regarding various aspects of dependence** was also an important component of positive treatment intervention. For example, participants referred to the importance of learning about the disease model of dependence, or the fact that drug use could have induced their psychotic and paranoid experiences.

'I would say... yes it did, to a certain extent. I mean, there is a large foundation that gets laid. You get to know more, there's more knowledge about drugs, what it does, effects and things like that... they give you a bit of insight into life as such.' (Participant 32)

'I learnt a lot of things about like drug use. The main problems of my life, not really drugs, my family life, my childhood life - sort it out, all of that, just come back. Some of it led to me becoming an addict. So ja (yes), I think it helped a lot.' (Participant 9)

'It gives you more or less an idea as to why you started using it, and why some people are more vulnerable to becoming addicted to it, and why I experimented in the first place. So yes, it did help.' (Participant 34)

'My therapist basically helped me, but, they actually just explained to me why they think the addiction it there, but, they only read the books and find out things like that, but they never went through the experience themselves basically. So psychologists didn't really council me, my therapist just basically explained to me a couple of things, and it's actually just by yourself, it's not by others.' (Participant 35)

A further intervention component that was reported to be influential in producing positive effects was the adoption of a **holistic approach**, whereby the 'whole package' of the person was addressed in treatment, rather than just the substance misuse problem. Participants reported that, in addition to addressing the heroin misuse problem, treatment intervention should address various a range of things including negative behavioural patterns, ways of coping, physical and psychological/emotional problems, practical problems, social and relationship difficulties, and self-awareness.

'We basically prioritised my problems and said these are my eleven problems that I want to resolve, such as my mother and family, the heroin addiction, all the big problems and stuff. And, we basically approached them one at a time, but it wasn't the therapist that solved them for me, the therapist only gave me the ropes and I climbed myself.' (Participant 39)

Of similar importance to many participants was the use of **alternative therapies** in treatment intervention, such as relaxation, or **alternative activities** such as exercise. Participants reported that such therapies/activities were beneficial in numerous ways, such as increasing self-awareness, distracting them from their heroin misuse problem, and providing valued time away from therapy to prevent overload. The following quotes illustrate some of the benefits of alternative therapy.

'Then they must start with a lot of physical activity that helps a lot, physical activity releases the endorphins and in the end it makes you feel better.' (Participant 19)

'No, not at all. I think my will is strong enough, and I've tried to regain things that I'd lost. I got work and the big thing now is that I want to get fit. I was once. I don't want to use anything that can mess up my body.' (Participant 37)

'When they realise they're heading straight for the gutter, maybe shock tactics to show them movies, I don't know if there is a hell of a lot of movies like, what was this one... Requiem for a Dream... incredibly hard hitting movie. And there were a few others over the years.' (Participant 19)

Thirty-one participants (77.5%) viewed **support** as being an integral component for successful treatment intervention, with several participants indicating that practical and informal support from other recovering drug dependants and significant others in particular was beneficial to them.

'Yea, not initially. I mean initially they were very sceptical of me coming out of treatment again and... they were really not that interested. But, when I started to make significant improvement and when they could see the difference, you know, they were 6 000 miles away, but the difference was that I was phoning them and holding a conversation and sounding different, sounding better, and then my mother said come and have a holiday with us and I think for me that was very important. I actually lied to her, that I was cleaned up in June, and I relapsed in September, and I used for a month until the 7th October, and I told her that I'd been clean since June. It was December when she let me come home for a holiday. So I had kind of been clean for that period, and that short relapse. I lied about that, but as far as she was aware of, I was like six months clean and doing very well and um, and yea - she's been there and offered support. I mean, they never offered financial support. They never ever, but they let me stay in their house. They wouldn't give me money, and they wouldn't lend me money, but they would feed me and let me live in their house. Then I got a job and it was fine... I needed an awful lot of support to do that. Fortunately it was available. Support, yea, yea. But it wasn't professional support. For a lot of it, it was informal support from other recovering people.' (Participant 18)

'I'd say my mother, my mother supports me - hard, hundred percent. My bother and my sister and my father, the rest of my family basically, it felt as if they judge me for who and what I am, the junky, the washout. I totally went out and showed them I'm not. I am something completely different. Then everyone's attitude changed toward me. Now I'm a working person, I have good working skills. I'm spontaneous, whereas I was always withdrawn and by myself and lay always fucked on the bench. Whatever, understand? Now... if people will actually come and ask "how's your day been?" Everyone's whole view of me has changed, family-wise. Society-wise, it still feels to me sometimes as if people judge me for who I am and how I look. If I spike my hair and climb on the bus people whisper "check that 'junky'" I hear them saying it. I would say society, yes, I don't think they accepted me, not yet accepted me for who and what I am.' (Participant 39)

'All the way, all the way. Although my own opinion, I think they should have given up a long time ago, a long time ago.' (Participant 8)

'Yea. A lot. They were the ones who helped me recover to the fullest.' (Participant 36)

'It's something that happened, and just getting through it is already an achievement. Especially from my parents, I've received all the support that was necessary. Friends, old friends who were never addicted, and it definitely helps a person. A positive influence in your life of people around you.' (Participant 13)

'I did have a lot of help from my father, who would phone me to see how I'm holding up. But often, as it goes, often they don't realise that you're still hard on the H, because you can function like normally... I think, for addictions, yes, if they have people that support them it would help them a lot.' (Participant 19)

'Support from people that really love you. Lastly, support - that support man. Support is a good thing to me. When you see that people begin value you, then you begin to think differently, yes, same as I said earlier.' (Participant 39)

'Ja (yes), but I mean, my mother used to still think that I am still on heroin. Ah, you know I wanted to stop, but what's really bothering me was the weed. But I mean she is actually supportive towards my rehabilitation and stuff. I think it does you know, 'cause it actually motivates me not to use. Even though I've screwed up a whole lot of times, but then, somebody still believes in me.' (Participant 40)

'It felt supportive, very supportive. No. And the worst people I thought would judge me, support me.' (Participant 36)

*'Yes, my support network, I think, played a big role. If I was at work, then I was at work. If I was at home, my mother knew where I was, even though ***** and I married soon after we left there. I think that because we lived close to them or basically with them, it played a big role.'* (Participant 20)

'Support is very important. I didn't really have support. Support from the church, but I mean, how do you speak to someone from the church that hasn't been through it himself?' (Participant 21)

'Sometimes you have to be cruel to be kind, but sometimes knowing that there is people that really care about you, that you can go to and talk to if you have a problem, and that really helps. I mean you have to be helped. I was here - you helped me. Knowing there is people who really love, and really care about your well being.' (Participant 30)

'My family stands behind me and friends that stand behind me and help. It helps a lot. Yes. So... I also have a girlfriend who helped save my life and who stands behind me a lot. I also have other friends who think I am very bad, I can't come right. So yes, fifty/fifty, one half has hope, the other half not.' (Participant 26)

'Ja (yes) I did. Just the general like support, you know, just to know that they were there, that they were prepared to help me every time. I mean, if they weren't there, I wouldn't be here today, I know that.' (Participant 32)

'They do support me. It does help. Some of my friends who are not using drugs are really there for me, and those that are using drugs are trying to be there, but they are still using it.' (Participant 33)

4.7.6.3 Accessing/commencing intervention

In terms of **accessing/commencing intervention**, it was clear that most participants did not enter treatment (in a committed way) until they reached a **rock bottom-like experience**. Some of the participants described experiencing feeling **nervous, scared or lost before or at the start of treatment intervention**.

'I just read, and then I thought this was the best thing since they invented the guitar... but I found out, shew, a few years down the line, shew... what does it get you to do. All heroin addicts eventually end in the gutter, where you've got no money, no friends... and you just need a fix, and that's a fairly sad place to be. There's nothing poetic or glamorous or romantic about that. When you can realise that, I think that to be your turning point. Because in the beginning you always think it's, it's cool, nobody else knows, they don't know anything. I'm on H, I am master of the universe.' (Participant 19)

'Well firstly, they must really want to quit. Rock bottom - before that, parents can't help them. They must want to themselves and go to a place like Noupoot, and they won't give excuses. So, that's the only answer I can give you, it's long, but it worked for me.' (Participant 23)

'So on the 5th of December my mom and my cousin had to drag me to the car, my cousin had to drive me to Sunnyside, to a dealer, because I was like going crazy and everything and I think that was my rock bottom, because my mom also paid for my drugs.' (Participant 28)

'I think ah - I don't know if I'm going to answer the question... but I think that heroin addicts really need to believe in himself, that he's had enough. He has to really believe inside that he's had enough, not be doing it for the wrong reason. Not be doing it for other people, you've got to do it for yourself. Not do it for you partner, or anyone else because you'll end up relapsing. You've got to hit your own "rock bottom". Everyone has their own "rock bottom", and you've just got to believe that you've got to get sorted out. If you don't, you're not... maybe you'll stay clean for a year, but you'll end up using again.' (Participant 29)

'I think the person must really be at a point were they want to change and want to stop using. I think that's the bottom line. They must get to that point, no matter if they think they've hit rock bottom, and if they think it's horrible to use and they can't do it anymore. They must really get to that point of surrender and giving up and willingness of wanting to change and wanting to stop using forever.' (Participant 10)

Clearly, the existence of such fear reiterates the importance of providing treatment in a **welcoming/supportive environment**, in order to ease the apprehension experienced by participants.

'Calmly. With dignity, they're human.' (Participant 4)

A range of expectations prior to starting treatment was reported by participants (ranging from high to mixed to low), but one common feeling was being **unsure regarding what to expect**. Another less

common but seemingly important expectation was some kind of **false belief in a miracle cure**. Treatment agencies need to be aware of this and be open and realistic with patients regarding the high level of effort required to achieve recovery, and avoid disappointment.

For many participants, there were various **potential barriers to accessing treatment intervention**, the most common of which was a lack of services **or lack of or awareness of existing services**. The following extract provides an example of this lack of awareness.

'Because there wasn't treatment available.' (Participant 27)

Some participants criticised intervention as being monotonous and repetitive, and that **therapeutic skills** (and medical intervention) **lacked** in certain intervention programmes. Clearly, this knowledge is essential in order to engage people in treatment and therefore facilitate behaviour change.

'Yes. I was in Noupooort for a year, and it definitely helped me during the first part with regards to initially getting clean and the withdrawal. It made me positive, especially the first part. The treatment itself was perhaps not always on par, um, that is due to lack of expertise with the people who've been through it. But it had a far more positive influence than a negative influence.' (Participant 21)

'So I left there after about two weeks and a bit and then I went to another rehab, Noupooort Christian Care Centre, where there was no medication and no counselling at all. I was there for 18 months and about the last 6 months they had a social worker there and we would see her once every two weeks and we were in a group of about six or eight. So it really was not beneficial at all.' (Participant 10)

'Then after two weeks I just felt I wanted out, as if I felt I could not learn a lot here. All the other things that I had ever used I stopped myself, it was just the heroin - the withdrawal and the physical addiction was just too severe for me.' (Participant 37)

'I relapsed. I think I was on my own definitely. So we were only allowed to go out in three's. Well, when I was in primary I was only allowed to go out with a counsellor - for the first six months, and after that we were allowed to go out in groups of three, and two people could talk each other into using - while as three, there's less of a chance, one will want to stay clean. So that kept me clean through rehab, so I was like a "dry drunk" when I was in rehab. Yea, very, very, very hard. With my girlfriend, if I told her what I think about a lot of the time, she'd be very, very worried, seriously.' (Participant 31)

Other common barriers were **long waiting lists**, which potentially deterred people from accessing treatment; and personal circumstances/feelings, such as feelings of shame/pride/fear, which hindered them from asking for help/treatment.

4.7.6.4 Pharmacological intervention

The majority of participants had undergone some type of **pharmacological intervention** in an effort to **ease off withdrawal symptoms** and **during their recovery process**. Two participants (5%) underwent a morphine reduction regime in an attempt to ease withdrawal symptoms (one female participant who had 'chased' heroin recalled how a doctor administered morphine intravenously in an attempt to alleviate her withdrawal symptoms). Two participants (5%) underwent no form of medical intervention and withdrew without experiencing 'cold turkey' symptoms, while 40% ($n = 16$) experienced withdrawal symptoms in the midst of 'cold turkey'. Some participants were of the opinion that medication was necessary, but were uncertain as to what medication was ideal. Symptomatic medication was given to 57.5 % ($n = 23$) of the participants at some point in their recovery process, while 35% ($n = 14$) could not recall the medical regimes that they underwent.

'From my point of view, maybe they've discovered some new things that can help addicts you know, which seem to fool the receptors in your brain, they are reading this... your body can seal them off so that your body does not cry out for this thing. Surely medical science will be able to find something eventually.' (Participant 19)

'I think what the medication interventions had done was to keep me alive. I also think that I needed help to detox the last time that I detoxed. Definitely, yea. Subsequent to the withdrawal, I've never had any medical help, counselling interventions. I've never taken any anti-depressants or anti-craving medications or anything like that.' (Participant 18)

'Over the years that I've been using it's changed quite a bit. I've got a lot of friends who are clean who, who used to judge me, who now accept me as I am. Accept me as what I am. Medication has really helped to stabilise life you know. Yea, yea. I think it depends on each individual. I think some individuals need to be abstinate of everything and can cope to be abstinate of doctors' prescriptions or whatever. But I think each person know themselves.' (Participant 31)

'If the withdrawal... I don't know what I would have been like without medication 'cause I was in such pain. I was cramping and not sleeping. I think it is necessary. Ja (yes), but not for after that. No, I think that if you have like bad anxiety or psychotic... I don't know what but I think then you must get something, or very depressed. But I'm not one of these.' (Participant 38)

'Maybe ja (yes). It would make it easier. I'm not sure what though, but maybe ja (yes).' (Participant 17)

'I really believe that, ja (yes), but ja (yes), it's more. It has to be a psychological thing as well; you have to work at it. Medication can help, but it can also be abused.' (Participant 17)

'I would suggest medication. If you're not too badly addicted to heroin, and you're not using it intravenously, then I think one should be able to stop without medication. If you are using it intravenously for longer than, I'd say a week or two, I wouldn't advise someone to quit heroin on their own, cold turkey, because it causes a lot of pain, it's mental and physical pain, and you can become destructive and violent.' (Participant 24)

Twenty-three (57.5%) of the participants had used methadone for detoxification purposes and seven (17.5%) were of the opinion that opioid medications such as **methadone** played a vital role in their recovery. In terms of methadone maintenance programmes, seven participants (17.5%) had undergone methadone maintenance as part of their recovery process. Participants also spoke of the important role that the medical profession has played in de-stigmatising heroin dependence and offering medical assistance and support.

'My use was very, very, very chaotic, and very dangerous, and I think that methadone maintenance kept me alive. I think that detoxing periodically kept me alive. I think being able to detox because without medical intervention I couldn't stop using heroin. I was too sick. I was too frightened of being sick. So I'd go a couple of hours, a few hours of trying - as soon as the withdrawal really started then I'd, then I'd back down. It was very very difficult for me just to stop using heroin, just to go "cold turkey" and I never managed. I think if it weren't, if I hadn't got medical help each time I'd detoxed, I wouldn't be alive today.' (Participant 18)

'The first three days they put you under sedation and that was quite good for me because the first three days are always the worst part of withdrawals. And the medication there, they put me on methadone I think, but, like I didn't feel the methadone. After three days, when I came out of sedation, I wasn't feeling withdrawals or anything. I was a bit depressed, heavy moody and so, but after a while I got the hang of it. Then afterwards... and then I got to the point were I was talking about me, I was heavy depressed and so.' (Participant 15)

'When I came clean, what happened, I did the detox in three weeks, this to me was the wrong side of it, you know, three weeks on methadone, some 50ml down down down to nothing in three weeks. So the minute I walked out of here my nerves were frayed at the edges. I was, I immediately went to the chemist and bought a bottle of codeine. I just couldn't handle this, it's like nerve endings crying out for some, you know, just... and it wasn't a week and I was back on heroin, and even worse than before. So this lasted then for six months... For me at this stage, I think methadone treatment is the most practical way, but you can't just put someone on methadone for three weeks or a month, I would say at least three months, but get them down to a very small dosage... Definitely, you need a doctor definitely, because it is a sickness. A lot of people are not strong physically, they are very frail, so you can't just give them 100ml bottle of methadone, they will drink it all and die. Obviously, as with anything else, you do get wonderful doctors that will care for patients and look after them and you get other persons who don't want anything to do with this because mostly ignorance you know. They don't know about what heroin addiction is. With the Internet, I think it's gonna be much more easy to get information about it... I think the main thing, the first two/three months - that withdrawal is the worst thing in the world. If there is anything new on the market that could help. If they can get something that could help. If they can get something, you know, that can just ease the withdrawal, I think then that a lot of people can be freed of addiction. The main thing is never to get back on, of course.' (Participant 19)

'It does now, yea. Now when I came out, a year after using then I went to see another doctor who was very understanding, and he said he didn't believe in a lot of the 12-step programme, but that I could lead a good quality of life while being on medication, and he told me it didn't matter that I might be on permanent medication for like the next few years, but to him, I'm still clean, because in rehab they told me you're not clean if you're on any medication or anything like that you know and ah, that really helped. He gave me, we tried different medications, and I found that I could stand myself on this medication. Also what's helped is getting away from the scene, a total scenery change, totally getting away from all my old friends, you know, associations, staying

away from it, and not going anywhere near my old places where I was using. What's also helped is totally relocating.' (Participant 31)

'I think medication can help people, you know, but 'cause not all of us have the same will-power. There are some people who can just quit - like smoking, I can't you know. Ja (yes), some people can just quit like that, ja (yes). That's how I did it, 'cause I always used to experiment with things you know, ja (yes), if I didn't really like it, I'd just stop it. But then heroin I stopped after a long while - a year and a half.' (Participant 40)

Five participants (12.5%) had undergone treatment with **buprenorphine**. One participant (2.5%) confessed to the intravenous misuse of buprenorphine. **Naltrexone** at part of a maintenance regime was utilised by two participants (5%).

'It was a very hard process... very mentally, very mentally than physically. I must say physically it was long and hard - it was more mentally. There was medicine, which helped A LOT. I don't think I could have done it without medicine. Subutex, Suboxone on the Internet. I wouldn't have been able to do it without it. First off I used it for the withdrawals, for the cold turkey. Afterwards, they kept me on it, then I realised that if I'm on the Subutex and I use heroin - then it makes me not feel "lekker" (good). It's like a blocker as well. Then I started misusing the Subutex, and then I started thinking... hey, I don't need "H". I can stay on the Subutex, and after that I actually admitted to everybody because I have the "trainspotting" marks on my arms. My medical aid pays it, but only to a certain point, then it's exhausted. Then I must buy it cash. This month and next month, and then by law I can't use it. I don't know if the doctor spoke bull, when I asked him, he explained to me that according to law, it's a chronic medication, and I can only be on it for a certain time period. Only a certain time period, and after that I may not. So, my time's running out... so, I can either now continue with the drugging and throw my life down the drain, or I can actually get my foundation right and actually make something of my life... Then, luckily I had a support group and they helped me to use it right, in the right way. My sister, my, um, fiancé, and my parents, which weren't around me that often, but um, financially they supported me a great deal, that helped, Subutex for seven pills, 8mg, is five hundred bucks or more, six or seven.' (Participant 25)

'Ja (yes), and I didn't use it 'cause it did something to me, it was the thought or the kind of taste, it reminded me ... it's bitter, you know, so... Of heroin. Ja (yes), in a way. I was on it for fourteen days. So for that fourteen days I was withdrawing, but it kept my mind busy, the Subutex, because I thought that I'd abuse it because it tasted like heroin. Yes mind mostly, my mind, yes. I haven't used so far, but I think it would help to use, if I had.' (Participant 16)

Of the sampled population, twenty-seven (67.5%) of the participants had undergone treatment with **clonidine**. **Benzodiazepines** were used by twenty-nine (72.5%) of the participants to ease off withdrawal symptoms and two participants (5%) was treated with a **DPN** infusion. **Sleeping tablets** were prescribed to eight (20%) of the participants. Some participants in alleviating withdrawal symptoms and in helping to cope with cravings viewed clonidine and other tranquillisers and sedatives as beneficial, while others felt that treating heroin withdrawal symptomatically with tranquillisers was not of real benefit.

'Yes, it is. But it's basically to alleviate your pain. Once that pain it alleviated a person already feels better. Then the ideas of jumping over the walls and go buy starts to lessen. As long as you have pain, the muscle pains of heroin is intense, it feels like nails being pushed into your legs. Those cramps, you cannot lie for two seconds in one position - then you must turn. That's why you can't sleep because your body the whole time keeps... your mind, those mind-games that you play with yourself. I think medication is necessary, pain medication, Dixarit. Dixarit helps for that calming... craving effect that it has. Some people say it doesn't work for them, but for me it did, understand? Aterax worked for me - for the anxiety that you get, because the withdrawal... "I need now" you know, that whole effect and, yes, Librium also worked for me, it helped me to chill, but, Aterax at times... because I drank four at a time, made me sometimes feel agro, you know. I just get intensely grumpy, you know, and then I sleep to get rid of the medication, yes, and two basic things that I would recommend is sleeping pills and pain medication.' (Participant 39)

'I got my medication. Medication helped me a lot, you know, sleeping pills especially. Heroin withdrawal is just... I didn't misuse the sleeping pills, I actually used it for what it was meant to be used for, understand?' (Participant 39)

'You can't treat heroin addiction by going... withdrawal, with Valium and all sorts of nonsense.' (Participant 19)

'It's a struggle ja (yes). It really is, because, I mean, if you're feeling down, your natural, your instinct is to you know, to go get drugs, so ja (yes). Talking to people. Trying to do something else like reading or just, you know, switch my mind off.' (Participant 17)

'It's very hard, yes. If someone were to walk into the room now and say "would you like a hit", I wouldn't be able to say no, and I've been off of it for a year. I wouldn't go out and try and buy heroin myself. I would definitely not try and, you know, obtain some or get some from a friend, you know, by getting in my car, or driving to my dealer, to get heroin from them. But if it was offered to me, I wouldn't be able to say no.' (Participant 24)

'Some days yes, other days not. I've found that sitting at home doing nothing is... then I start thinking about it. Or if I see it on TV... then you think about it, but otherwise, if you occupy yourself with other things, then it isn't difficult.' (Participant 34)

'The withdrawals and everything, the cravings still there, but I'm scared of heroin. I don't want to ever... if I ever use that again I think I'll die. I'm quit sure of that. I'm very scared of that, and I think they made me scared, yea.' (Participant 38)

Thirty-seven participants (15%) were treated with **anti-depressant** medication during the process of recovery and also on a long-term basis during their abstinence. No reported cases of medical treatment with anti-psychotic medication was reported within the sampled population.

'The Remeron and the Epilim, I think that I have brain fry or something. I can't be happy without it. I think that my serotonin levels are messed up. Maybe it's temporary, but I think that I am going to use it for the rest of my life. Staying clean, not coming clean.' (Participant 1)

'Medically, I went to Houghton. Then I saw the doctor and she gave me medication, which helped for, with, the cold turkey. Ja (yes), I couldn't, I tried to do it by myself, without any medication, but I don't think I could have survived. I think that medication is quite important. Yes, anti-depressants too. Get some medical advice and medical help, that will help with the cold turkey, and just give up.' (Participant 9)

'The anti-depressant when I was here. It made me calmer. The DPN (diphosphopyridine nucleotide) drip - it did make me sore. I don't know. I don't think so. It's all in the mind.' (Participant 14)

'They put me on medication and all that, and I went through the detox programme. And then from there, on Espiride and Aterax.' (Participant 29)

Other participants were **ambivalent concerning substitute prescribing**, and felt that in some ways substitute prescribing was beneficial for some individuals, but that it was not really a necessity.

'To get off heroin, yes, it helped. The easiest thing is to get off heroin; the easiest thing in the world is to get off heroin. To stay off heroin - no medical intervention that will keep you off. It depends on the addict. If he is a young addict still splashing around or just started, it's good for them to undergo pain, it's part of the learning process. But, if you have a fifty year old heroin addict who's been an addict for fifteen years, and he's coming down hard - you usually have to help him. Well, the only medication that I used was methadone. It helped me and it didn't help me.' (Participant 2)

'It helps if you take it right. If you take it like you're told to take it, then you can get through the day without really going cold turkey. But the thing is, it doesn't take away the cravings. It takes away your pains from the "turkey", but not your craving. So if you're strong enough to withstand your cravings, then it can work for you, but otherwise not. For those who are very desperate and have no other options - try it, it could work. It just depends. For me, it didn't work. But I do know people that it worked for. I have a friend who was addicted to heroin, he quit by himself. He wasn't in a rehab - he bought three bottles of Physeptone that the doctor gave him a prescription for, and he came off.' (Participant 26)

'Ja (yes), in the extent. Like I said, in the beginning, the sedation part that they did to me, that was, I really, that was really something extraordinary, it was really good. I don't know. I'm not using medication, so, it's about your mind power. It's about what you decide. What you want to do in life. What you want to be.' (Participant 15)

Other participants were of the opinion that **medication was only necessary for acute withdrawal**, and was not indicated for a maintenance programme.

'At present I'm not using any medication. I think yes, it is perhaps necessary if a person who is detoxing. I'm not talking about heavy medication. The main thing is that the person must also feel, you understand? You go through it and it is not nice, but if it's not nice you won't be crazy to go through it again. So the worst is what your head goes through while you're going through it, that's the roughest. Never mind your body. The problem is for some people it becomes life threatening if you're going through that. Some people think they're going to die, and if you think you're going to die then you will die. That which you think is also very powerful. So I think medication to a very little degree, depends how it is and only if it's necessary. But not at all... only during withdrawal, not at all afterwards.' (Participant 21)

'Yes, but a week before it I had already stopped, from then on I've stayed clean. I think so for the beginning, yes. Yes, it does though totally take the withdrawal away.' (Participant 34)

4.7.6.5 Difficulties of intervention

Participants also described numerous difficulties of intervention throughout their various experiences. This was demonstrated by the fact that it took some participants a relatively long period of time before they started to feel the benefits of treatment. The clearest difficulty for nearly half of the participants was related to the need to **accept complete abstinence**.

Many participants described experiencing the continued desire to use some sort of substance as a substitute for heroin, predominantly alcohol, while attempting to give up heroin.

'My life remained unmanageable for the next fifteen years. I never managed to sustain relationships. I abused alcohol - nothing changed. All I did was stop heroin. Because I had stopped heroin, and then thought that I was like perfect - because people don't stop heroin, they die. That's it, the needle hype. The urban legend. So I believed there was nothing wrong with me and it helped to cement my denial. Absolutely. In the last three years I have been healthier. Because I was so long off heroin I had a certain amount of celebrity - but people were moving away from me because they couldn't bear the smell of the Old Brown Sherry. You know what I mean.' (Participant 27)

'I think treatment probably is, treatment is difficult because it's different people at different stages. What I'd recommend to them is the same as what I said to you - the only manner to recover is spiritual. Then the practical implications of recovery, such as not using alcohol. People have to grasp it for themselves. And that's what sometimes makes me really negative. If you get guys who used pills for six months and their mother catches them and sends them to rehab. And that guy, he has no intention to stop partying. He actually now has more of a grudge.' (Participant 21)

4.7.6.6 Negative/unsuccessful intervention

Most participants described some kind of general **negative/unsuccessful experience** of intervention at some stage in their dependence, such as **intervention not being intensive or long enough, a lack of alternative activities or education** within intervention, or **not receiving individualistic intervention**.

'Treatment wasn't available. Yea... well yea... when I got down to the bottom, then I was at the top sharing. Used to buy them by the two hundred - all of us. We were extremely rich, you know, it was the rich people's stuff when I was using.' (Participant 27).

'It did help. It gave me a lot of knowledge and I learnt a lot about myself, but I also felt that it wasn't individual enough, it was more as a group thing, which is good, but I also felt that the counsellors treated us too much like a herd of sheep, instead of like individuals, with individual problems, with individual backgrounds, and I wanted individual help - that I, I became unstuck, and why when I came out I felt worse.' (Participant 31)

A **lack of therapeutic skills and specialised knowledge** was also sighted as a void in therapeutic intervention programmes.

'I think at this stage in South Africa, because heroin is a relatively new thing in South African drug market, that the counselling places that are there are not ready, they don't know what heroin is about. In fact, they don't actually have a clue. I am sure the people are trying, you know, but it's quite obvious that there's not much research in this country. I think it's only now, as there are more and more addicts coming out, that I think people are going to start to do research... It's not that I'm criticising the clinics and stuff, but, maybe they've... if they get young people working with addicts like yourself, then it would help tremendously. But they seemed to not understand, that was my impression.' (Participant 19)

Some participants were of the opinion that group therapy was more focussed on alcoholism or dependence in general, and failed to offer specialised intervention for heroin dependence.

'I don't think so, because I saw most of the lectures were for alcoholics, not really having anything to do with drugs. Drugs is a different experience than alcohol. For drug patients.' (Participant 36)

One participant (2.5%) was of the opinion that their ensues an **evasive attitude towards dependence** which in term has negatively affected the availability of interventions.

'I think, I think there is a kind of evasive attitude towards addiction, which is unhelpful in terms of availability of treatment and the availability of help to addicts, but I think on a personal level I never experienced that.' (Participant 18)

Some participants suggested that another difficulty was a result of the **various contradictions they had with treatment intervention services.**

'That's the consequences of your actions and the counselling... you cannot really say that the counselling was anything except from the Bible. I mean, you didn't really get counselling from proper counsellors. It's rehabilitated people that help others. So it's basically other people who've been through it who helped us.' (Participant 20)

Many of the participants felt that using **medication**, specifically an opioid, should be regarded as **substitution**, and thus not safe to use.

'Using medication. The mind-set, when you're using you don't think of the possibilities that the next shot could kill you. From heroin, ja (yes) definitely. I haven't been doing that, to stay clean - in a way also then you would be substituting wouldn't you?' (Participant 5)

'And then medication, I've only gone on anti-depressants two months ago. So medication has not really played such a big role in my recovery. But I know that the methadone also does help a lot for withdrawals, even though I got secondary withdrawals also which is horrible. I don't think that if I was just on methadone... I don't think I would have, I know I wouldn't have stayed clean. I would have relapsed because methadone was just a substitute for heroin, and when the methadone was over I knew that I would have just started using again.' (Participant 10)

'I used no medical aid or stuff like that for withdrawal. I had hectic withdrawal symptoms. Not at all. Not at all, and it's hectic for the first few couple of days, three days, four days at the most, but after that your body gets energy back. You don't need it because heroin, medical aid and pill is only a substitute for heroin. It works out; your body seeks for heroin again and... take your withdrawal like a man, and after that you're fine.' (Participant 8)

'I wouldn't... I would say no. It's not necessary. No, no. The person took their drugs so he must actually go through the drug with his own bodily functions. It helped me like a little bit, but my last time I withdrew; I went sixteen days without medication. I'd say so, yes. I think medication makes it easy for people that used heroin. I don't think it's a short-cut, but I mean, if there's technology available, people can use it, but, I mean then people just go on heroin everytime and they use it at night-time to take the withdrawals away, so what's the point of that? Ja (yes) I do, I think they are.' (Participant 35)

A more specific negative experience of pharmacological intervention reported by participants was related to substitute prescriptions, predominantly methadone, which participants had usually received in earlier stages of their heroin dependence. Some of the participants viewed substitute prescriptions like methadone as negative as they could also use heroin while they were taking it. This was viewed as a 'green light' to continue their use. Several participants also referred to experiencing very bad secondary withdrawal symptoms from methadone. The aspect of **substitute medication prolonging or postponing withdrawal symptoms.**

'Not a good idea. Methadone is a dangerous thing because you begin to withdrawal for it, so it's the same. Like you said earlier, it postpones your withdrawal. Once it's out, your withdrawal hits you four times harder, understand? Methadone no. Subutex is also not a good thing in my opinion, Subutex and Physeptone are not good things, it postpones basically. It's a temporary pain reliever, do you understand? No, I wouldn't recommend it. A person must go through it naturally.' (Participant 39)

'No, not really. I was only on those two little pills that minimised the craving. Yes. But things like methadone and you know that sort of stuff; it just makes the people addicted to the methadone.' (Participant 28)

'It prolongs. Medication only prolongs the process. Yes, and then you have to come off of the medication, and then... I had to use sleeping pills. You just don't, you just can't get that natural sleep - as if when you worked hard the day and you're tired and you sleep well. With heroin you sleep well. It only prolongs the withdrawal process. If people are withdrawing, you can give them a little bit of medication, but that's it.' (Participant 23)

One participant (2.5%) also mentioned not being allowed to take any medication for unrelated drug illnesses while in treatment at fundamentalist centres.

'I struggled a lot, getting secondary withdrawals from the medicine when I got there - no medication. Often even when I was sick, like bronchitis, in Noupoort, no medication, no doctors and anything like that, and it was really hard for me because I felt that it was not a normal approach.' (Participant 10)

Other participants felt that **pharmacological intervention was of no use to them**, or that it was counter-productive within the recovery process.

'Okay, as I said to you before, I don't think that medical intervention really did anything for me.' (Participant 20)

'No medication could help. Medication does not help at all. I tried it a couple of times. It is almost stronger than drugs, the medication that you use, methadone. You just get a prescription from the doctor and you can get it at a pharmacy. It did not work. I went to Noupoort. You do not receive medication there, and you come clean. It takes you about two weeks to detox, to get the stuff out of your system, until the withdrawal stops.' (Participant 13)

'Medical intervention didn't help at all. It was actually 100% discipline what I got. Working hard down in Noupoort, and to believe in yourself, and stay strong, until you at that point that you can believe in yourself enough and that you can do it by yourself. At Noupoort you don't receive any medication or pills. There you must "cold turkey" and then you must start with your life.' (Participant 26)

'I don't think medical assistance helped me because I quit on my own, you know. Ja (yes), so nobody helped me change, because I actually saw what heroin could do to me, ja (yes).' (Participant 40)

The issue of a **lack of medical intervention** at certain treatment centres was also highlighted by a number of participants.

'I didn't go for detox. I would have died because in Family Outreach I felt like dying, they don't believe in any medical treatment.' (Participant 30)

Such **negative experiences** served to **re-emphasise** the importance of some of the **positive components** reported to be essential for successful intervention, such as the **appropriate structure** of intervention.

'I have a lot of stuff that I needed to deal with and I never got a chance to do that while in rehab, because when I had a problem and issues they just tell me to pray about it. No one really helped me there to work the stuff out and I couldn't do it on my own.' (Participant 10)

4.7.7 New labels: References to self in recovery

Recovery is a crucial theme, and has been sub-categorised into various **factors/requirements necessary to achieve current/future recovery**, various **aids to help/facilitate recovery**, and various **changes that occur in recovery**.

TABLE 4.7.7 New labels: References to self in recovery

<p>4.7.7.1 Factors/requirements for recovery</p> <ul style="list-style-type: none"> * Intervention/treatment * Personal requirements * Complete abstinence * Other factors <p>4.7.7.2 Aids to recovery</p> <ul style="list-style-type: none"> * Continued use of aftercare/self-help group/counselling * Safe environment to return to * Narcotic Anonymous * Tough/love * Strategies against continued use * Expectance/coping of cravings

- * One day at a time
- * Motivating factors
- * Holistic approach

4.7.7.3 Changes in recovery

- * Identity restructuring the either excludes or depreciates old values
- * New lifestyle

4.7.7.1 Factors/requirements for recovery

Participants reported that one of the most vital components essential for successful recovery was access to **intervention/treatment** (rather than attempting to recover independently).

The following quote also exemplifies some of the ways in which treatment intervention is seen to aid recovery, for example, in terms of talking about problems in an empathetic environment and reducing isolation by being surrounded by people in similar situations.

'I went to Houghton House and they gave me a lot of medication and stuff, and I was in a lot of pain. I couldn't sleep for weeks I then slept... is that okay? My body was aching and after those two weeks I was okay - the withdrawals were finished, and then I went into the psychological stuff like I wanted and then we did the steps, which was the powerlessness and all that, and the stuff, like all the painful stuff from when I was using heroin and other drugs. I think I got it quite quickly - how to stay clean. I started talking very early because I wanted to get clean, I didn't keep anything from them, I said - blurted out everything that happened in my life.' (Participant 38)

The majority of participants also discussed the importance of various **personal requirements** that were necessary for recovery. These included being focused and committed to putting in effort and hard work; and accepting that their heroin dependence was enduring and that there was no miracle cure. Many participants also described the need to be personally ready to change.

'I think the factor is the age of the patient because if you going to have a child eighteen year old, say he's been using heroin for six months, or using heroin, ecstasy for the last two years. You have to tell him that he's never going to drink again; he's never going to be able to do anything again. How do you tell a eighteen-year-old he's supposed to stop partying? A 27, a 25 or 26 year old, like it was, I can stop doing all those things because I have done it all. That's the problem you've got.' (Participant 6)

'I don't know, just let them try and realise that they are capable of doing it, that they are screwing up their lives.' (Participant 3)

'You want to come clean.' (Respondent 11)

'Made up my mind that I was just finished.' (Participant 14)

'And you have to work, to stay clean you have to work. You can't just say I've done rehab, life's great. You know, my first three months in rehab was a fucking living hell, see all these familiar faces.' (Participant 30)

'I will actually start with becoming clean... it actually starts with yourself, because if you don't have the urge to become clean then you don't have the urge to basically do nothing. Okay, so I wasn't really ready the first couple of times. I just thought I'll do it for my parents, and do it for the people around me but later I learnt that basically sometime sooner or later I must actually start thinking about my life again.' (Participant 35)

'First of all, the first golden rule - do you want to come clean yourself? You have to decide that. You can't go for help if you don't want to. That's the best advice I can give anyone.' (Participant 15)

'You've got to make a decision that you want to do it, then it's fine, but until you come back into society, you must just stick to your decision.' (Participant 20)

'It's a choice that I've made and I can't... it's too easy... I stand with one foot on the one side, and my other foot on the other side. The one path on this side, the other path on that side. The only reason why I am were I am is because of above. I couldn't make any decisions by myself. I did make the decision; it's a choice that I made.' (Participant 21)

'That's just how I am. If I've made a decision in my mind, then I just execute it.' (Participant 21)

'It won't help if people pamper you every day and say "please, you must now stop". People can only help you to a point, and the rest is on your own.' (Participant 22)

'If one really wanted to, one could. But I don't really want to.' (Participant 24)

'To come clean? I say the first thing - you also have to make that choice. You have to be serious about quitting, not just come clean.' (Participant 30)

'They can't see that hell we go through. Each and every day I have to make a choice even after a year and two months, I have to make a choice. Go back to heroin is easy, give a call, and I made that decision to myself. In fact were I was, and were I am now I am happy with the way I am now. Okay, you're not always happy with yourself always - I am fat - stuff like that that typically... but health-wise, and I don't know, personality wise, I am human now. I feel much better than what I felt. I can smell things properly now; I can taste properly now, my senses in my fingers, everything. I don't feel like just a numb piece of meat walking around anymore.' (Participant 30).

'I don't know. Circumstances. Everything around me, you just sit there and do nothing. I just realised that I wanted to do something with my life. If I want to get something, it's going to be up to me. No, that is up to yourself.' (Participant 3)

'In the end, there can be all the counselling and medication and everything, if I don't make that choice that I'm going to stop using, then it doesn't help at all. I seen it with so many people. Everyone helping them, their parents, they've been in eight rehabs and they are being subjected to all strange treatments. I mean a friend of mine who died about a year ago, his parents as a last resort, like go on anaesthetics and they'd give him shocks or something like that, he just didn't want to stop using. He didn't make that choice for himself.' (Participant 10)

Participants stressed the importance of making a **decision to abstain** for themselves and not for other people.

'If you decide yourself, you make the decision yourself, not someone making the decision for you, and then it's forwards and practical. You must make the decision yourself of forwards and practical.' (Participant 21)

'You have to make a decision, no matter what they try to treat you and that... if you don't say "hey" and decide I've got to kick this thing, then you won't kick it because it's a very powerful thing.' (Participant 19)

'If the patient doesn't make his own choices, if the patient doesn't make that 180 degree turn and go the other way, and tell his mates "listen here, cheers, we can't be friends anymore" and start changing the habits, the small things, because it all ends up to the small things - the building blocks.' (Participant 25)

An additional requirement that was deemed necessary to achieve recovery was **complete abstinence** from all substances of abuse rather than controlled use. Although several participants did find this difficult to accept, most of them still recognised the importance of abstinence from all substances of abuse in order to gain successful recovery.

'A way not to kind of, not to have extreme problems that I was experiencing. I didn't really want to stop using heroin. At later stages perhaps I wanted to stop using heroin, but didn't want to stop using other drugs. I wanted to learn to stop using heroin and manage my other drug consumption if you like... Yes. I think it was that I had to maintain abstinence from all other drugs, that was the most fundamental part of getting clean, was not to substitute heroin for methadone, or methadone for coke, or coke for benzo's. Just to swop substances for a while, trying to carry on drinking and it just seemed too difficult to give them all up, or I was unwilling to give them all up. I thought that that would be really bland or bleak - life without.' (Participant 18)

'The thought of not being able to drink anymore bugs me, but ja (yes), I just have to stay clean. I play the movie through you know. I do sometimes think of drugs, quite a lot, but I play the movie through, what happened - and then, I just think of what would happen after, after I used. The problems that would come, depression, and I'm sure that if I do use heroin once - I don't think that I would stop.' (Participant 9)

'Not just for a few weeks and just to detox - so they can start using again without being addicted and also not thinking they can stop using heroin but still drink alcohol or smoke weed now and then, still go clubbing and whatever.' (Participant 10)

Participants also highlighted several **other factors** that they viewed to be important requirements for recovery, the most notable of which was the need to want to change their behaviour for themselves rather than for others. The need for a good support network and the experience of a rock bottom-like experience were also deemed important.

'I would say, your mind must first be right. It doesn't help if your father brings you, or your mother brings you to a rehab if you haven't decided yourself. If they had forced me against my will I would still be using today. It must

come from yourself; other people can do what they like. If you... one of our friends went to rehab, when he came out or rehab, the first thing he did was go buy again and he is now so addicted, he's lying on the street.' (Participant 34)

'I'd say it depends mostly on the person himself. I mean, if you really want to come right, then you can do it. What I just say is that the withdrawal stages are the worst. Once you can get past that, in your mind you want to get clean, then you can't go wrong. Ja (yes). I mean, you need to want to do it for yourself, for no one else.' (Participant 5)

4.7.7.3 Aids to recovery

In terms of aids to recovery, one of the clearest components helping participants achieve current/future recovery was the **continued use of aftercare/self-help group/counselling** post treatment. Thirteen participants (32.5%) were actively involved in some form of after-care/self-help programme.

'After-care helped a lot because I can tell you the stuff.' (Participant 1)

'I've used all the other drugs again once, but I didn't become addicted to them again, except to Cat. I was addicted to Cat for a period of time, but I haven't used it again after I came for after-care, which is now about five months ago. I never used heroin again after coming out of rehab.' (Participant 12)

*'Definitely, because of the people who come out with me, me and **** and ****, we busy with the things. We're keeping involved and it's keeping us clean. The other people, they come, they stay a week with us, and then they disappear - and what disappears with them - their sobriety. So if you don't keep involved, whatever the situation, you're going to loose it.'* (Participant 2)

'But, I think it's important, I've seen with people who stay clean, you know they do the programme and they go to after-care, and then maybe to a halfway house, and then keep on coming to meetings, seeing a psychologist or social worker and all those things.' (Participant 10)

The failure to continue with some sort of long-term care in terms of after-care or follow up is illustrated in the following quote.

'I wouldn't say it makes it difficult. What should be is that you still should follow a programme after you come back. But it's something I never followed. I got advised to not go out, to be home at certain times and they were going to test me every so often, or surprise test, so I mean, just to keep my guard up. But even that sort of, that whole thing just sort of like fell away. I just did what I wanted, when I wanted, how I like and... ja (yes)...' (Participant 32)

The majority of participants described how vital aftercare was for them. They also highlighted the importance of having a **safe environment to return to if required**, which provided them with a strong sense of security.

The role that **Narcotic Anonymous** played within the recovery process proved to be invaluable at some point in the ongoing recovery process to fourteen participants (35%).

'That was kind of, regular, for me, regular twelve-step meetings. I went, in the first few months I went twice a day to Narcotics Anonymous and I'd just go and sit in the coffee shop, wait for the meeting. Go to the meeting, you know, go hang around in the shopping centre and wait for the next meeting. Then go home and go to bed and get up the next morning and do the same thing and that's all I did for the first three months that I was clean - was go to meetings, go to meetings and not use, and take it one day at a time. So you know the role that NA played for me was invaluable. I would never have been able to achieve it without that support. Today I believe that there are other avenues that I could have followed, but that's the one that I did. I think that's the orientation of the treatment that I'd been participating in for the most it was looking at drug addiction as an illness. Looking at Narcotics Anonymous and Alcoholics Anonymous as the vehicles for ongoing recovery. So, yea.' (Participant 18)

'I would say go to NA, definitely, because that has worked for me, and I would say if it's a really big problem I think they must go and get help at a 12-step programme, because that's the only thing that's helped for me. So I believe in the 12-step programme and NA, or AA or CA, all the 12-step programmes. Denmark didn't work for me at all, and I don't know what they were trying to do. I can't even remember trying to do... I can't even remember, but... and I know other treatment.' (Participant 38)

'Using certain guidelines. Doing the NA twelve step programme to guide you in the right direction. Give you more knowledge about what it's been doing to me, and all that which I find has really helped.' (Participant 11)

'Or phone my sponsor from NA.' (Participant 5)

'What was hard for me as well is, I was there for a long time, I mean after eighteen months, coming out there, then I had to do a lot of things that other people in a six week treatment centre get to do already, start doing... In the time I was in Noupoot, and since I've come out one and a half years ago, I've been going to NA meetings and it has really helped me. I find that group therapy and counselling and being around people who are clean and just keep on being reminded or where I come from. Everytime a newcomer comes in there and someone who keeps on relapsing and struggling and that, you know, it can just as well be me.' (Participant 10)

'I think especially following the NA programme I'm doing the steps, it has helped me a lot because I've learnt that I don't just have a drug problem but I've got this character defect. Also like doing my life story and getting all out and getting it behind me you know.' (Participant 10)

'I think it's the support structure you have, you make a lot of friends there 'cause everyone's friendly and everyone gives hugs. You feel like you belong and you can say whatever you want, which you can't say to your friends or family members, you can't say "I'm struggling today, I wanted to use", you can say that to the people in NA, and they will support you because they know what you're going through. I think it's that you feel comfortable. It's the only place you can go were everyone... it's not dangerous for you, but you do feel comfortable around the people, like you belong somewhere. Ja (yes).' (Participant 38)

Two participants (5%) verbalised negativism toward NA; namely being surrounded by other vulnerable people while still vulnerable themselves which could pose as a high risk factor for relapse. Another participant was of the opinion that the NA principle of 'once an addict, always an addict' was too stigmatising and self-limiting.

'Now, I would, the advice is, let's rather not be friends because the two of us won't make us stronger... so rather go your way and help yourself, because I'm helping myself. I am very selfish in this game of recovery, I'm sorry. That's also why I don't want to go to NA.' (Participant 25)

'Judging me? Um, they don't really judge me anymore, they used to, but they don't judge me any longer. Well, specifically to my folks. I mean, people still label you. They still put a certain stigma to you and say that you're an addict and you always will be, 'cause that's a perception that everybody else has that you know. NA says once you're an addict, you're always an addict, and that's something I just don't believe. I can't see myself as an addict if I'm not using it you know. I still smoke cigarettes, but I mean I'm not a heroin addict now that I've quit.' (Participant 32)

Some participants touched on the significant role that **Toughlove** also played in the recovery process, in terms of intervention with significant others that in turn had a positive reciprocal effect in their recovery.

'They joined ToughLove... I think it was one of the main incidents... they offered me help.' (Participant 2)

'Ja (yes), for a long time my mom was (involved in ToughLove).' (Participant 32)

Most participants indicated that another important component in helping their recovery was the learning and use of a range of **strategies to cope with/oppose the numerous reasons/factors for use** (see 'initial heroin use' in Theme 4.7.2.1, p.122 & 'continued/excessive use' in Theme 4.7.2.2, p.124). This referred to a wide range of potential strategies, for example, reducing the high availability of heroin and other substances of abuse by avoiding users; changing social circles from users to non-users to reduce temptation; using distraction to avoid boredom, and using various 'tools'/strategies learned in treatment.

'It helps to be with friends after that, but the right friends. Wrong friends can bring you down so easily.' (Participant 8)

'Interestingly now - in certain circumstances then it is in the back of my mind. But, I beat it by speaking about it to people because I am not shy about it. The more I speak about it to people, it doesn't matter if they are strangers, it has happened so many times, that if I speak about it, strangers say during the course of the conversation "shit I knew someone experiencing that problem", or "how can we help this person?" And that which they learn from you, you have nothing to be shy about... So, in the back of my mind it's for me stupid sometimes if I feel when I'm visiting with my friends who've not been through it, then they think... you know, they do not understand that mind-set and that I'm now out of it. I think they probably sometimes still wonder if there is a possibility that I will fall back into it. But as I say it's my own insecurity, it's not theirs.' (Participant 20)

'I don't know why, but I realised that my friends were not going anywhere. I had a choice to get away from everything... so I went away.' (Participant 7)

'You have to be in a total different environment, get totally different friends, because negative friends lead to negative things.' (Participant 8)

'Not now, it was hard, but I was hard. I was in treatment, and I worked hard, and then we got drugs. So, I didn't use the heroin when I relapsed. I relapsed on coke and Cat and stuff like that. But now it's not hard. I don't see any of the people. I don't go to any other places.' (Participant 38)

'When I made a new group of friends, I found it difficult because they are all normal people. Since I have come out of rehab, I have made really good friends, but I've always felt like I don't really belong and I'm different. But the longer I'm friends with them, the more I realise that I also have an important role to play in their lives and they are very supportive, but, what I find is like when I started a new job and with my boyfriends parents and things like that, it's still difficult for me because I feel they are judgmental.' (Participant 10)

'In the beginning it was difficult especially in a group of people having a conversation. I don't know, I couldn't really talk to many people about my past, except my own friends. It's a life-style change.' (Participant 6)

Many participants also reported the need for **acceptance and expectance of persistent cravings** and problems associated with heroin dependence and the use of **effective strategies to cope** with these. Participants often found it difficult to avoid their old-using circles, and many of them did not have any friends who were not heroin users. All of the participants accepted and acknowledged the importance of breaking out of old circles of friends and routines, basically anything that would be a reminder of their heroin-using days and therefore increase temptation, exposure, availability and desire. This was considered to be a crucial step in moving on, and many of the participants had actively started to do this. This was for most a slow and difficult process, but as participants progressed in their recovery, they had a greater desire to break away from their old lifestyle and became more determined, prepared and happy to do this.

'Ja (yes), there is a major difference. 'Cause heroin addiction is very heavy... craving and withdrawals, some of them they get angry.' (Participant 33)

'Sometimes, especially at night I crave... Music, praying, crying (helps).' (Participant 1)

'It's not easy to stay clean, it's much easier to use. Everything in life, it's much easier for me to drink, it's much easier for me to smoke, um, but not to do those things I feel builds character - its much harder not to do those things.' (Participant 10)

'Not really, I do crave a lot. I start thinking about other things. The flashback comes back or thinking about what happened... I start craving and then I start thinking about other things. That helped me a lot to get to handle it.' (Participant 4)

'For the craving, nothing can really take the craving away. I sometimes think about it, but never to the point were I have to sit down and say, "I wish I can stop craving". I think about it, it is just a passing thought.' (Participant 6)

'How do I cope? Smoke more cigarettes and I don't know, and keep myself busy. Then, then I play excessive amounts of guitar, write an excessive amount of songs, even more that I myself can cope with because it tends to emotionally break my top button... I can't control myself anymore. It gets me fucking nuts. But then it feels like, I can't decide anymore, mixed feelings, hate, I sometimes hate myself due to my own doing that I feel like that.' (Participant 30)

'The thoughts will still come to your mind, and it's what you make of the thought, that you don't play with it. You immediately get it out of your mind. So every time you get the thought, and you block it out and you just put it away then it gets less - so every time you overcome. It's also an important part, your thoughts and if you entertain them. The problem is that when you make a decision it's in your mind... if the thought comes of "cut" and you entertain it, and you even begin to wander about it, then you are in rough waters.' (Participant 21)

'I thought about it a lot, yes that was cravings I know. But never made a mission to go and get it.' (Participant 14)

'Sometimes, yes. Sometimes no. I can have fun and stay sober, that I've seen. But, now and again you get days that you crave. Then I lock myself in my room, which is very difficult for me, but, it's about once in a week that it happens, not often.' (Participant 26)

'Some days yes. There are also a lot of blessings in it. In my case, you crave now and again, especially if you are in a situation and you don't know what how to deal with it. Then you think, "yes, maybe my escape is to

quickly go to my dealer and to say okay and then use", and so on. I saw my ass with drugs - I don't know, some days it is difficult...' (Participant 28)

'The things that can influence you, you must totally avoid. Even though I was older than many of the other people that were there, my parents were still very strict with me the first while when I was back at home. The amount of money I had on me, where I was driving to they had to know. If I was driving say now to town, then they would drive with me, where they new the problem areas were. So they did not leave me there and I think it's necessary, it's really necessary.' (Participant 20)

'What helps me through these times - I've a few things in my life that are kind of like barriers to using. So when I really feel that everything's going really badly, like you said, when reality hits me, and I used to use because I couldn't, I wanted to escape from reality and I felt I wasn't okay and all that stuff. So now I have to deal with all those things without drugs. And it sometimes gets hard for me, like, fear of failure and anything like that sets in... I also have an amazing boyfriend and he also said to me that one of the conditions, our relationship wouldn't work out if I started using again because I only met him after I came clean. So all of these things are like barriers to me using, and I think that really helps me to stay clean.' (Participant 10)

'Not really. We speak about it sometimes, and then we forget completely about it. We sometimes say how it would be nice to smoke a "zol" - and then we laugh about it. Still, at the end of the day we know that it would be stupid. Just to be clean is another kind of high, without having the next day a hangover. If you're with people who drink, it puts you totally off. You see all the disadvantages. I don't know, you probably notice it more because you've been through it yourself.' (Participant 23)

In terms of general coping, several participants advocated the philosophy of **coping one day at a time** rather than projecting too far into the future.

'In the NA programme we learn that "I mustn't use just for today" no matter what, and that really helps me and also thinking of everything that I have to loose, like my clean time, and my relationship with my parents and family and my friends. It also helps me a lot to know that I don't have to do it on my own, and that I've got so much support in my friends, and people in NA, my sponsor, my boyfriend.' (Participant 10)

'But time is a good, 'cause if a patient just, if somebody can just think like this: if I make today right, then my tomorrow's yesterday will be fine, will be alright. And that means, if you can live that for a long time, like just for today. I'm just going to make sure that today is alright, and the next day, today is alright, then you'll start realising... my yesterday is also alright. And then time will go past, and then, it's a funny thing, time is a healer. And people, they forget in time. Not forget forget. But ja (yes), some things they forget.' (Participant 25)

'I don't believe, what some people say, "I've recovered" after staying clean for a certain while or being normal. Like my daily activities are normal now. Like I've got a job and I'm studying and I've got relationships with my friends, and parents, and my boyfriend, and everything is normal and yet it doesn't mean I've recovered just because I'm reintegrated into society. I still have a problem and I think it's important of always being aware of it and still making a daily choice of not to use... I think that's the most important thing that I do, is making a daily choice. Also praying to God to help me.' (Participant 10)

'Ja (yes), it's very hard, but just to take it one day at a time. I try not to remember the good times. I try and remember the bad times, which in the end is much more that the good times. Well, if I am craving too much or something, I'd go speak to my mother or phone my sponsor from NA, or just try get my mind off it as quick as possible. Try get my mind busy on something different.' (Participant 5)

Another component reported to have helped or was expected to help by many of the participants to maintain their behaviour change and recovery was termed **motivating factors**. Most participants discussed the power of support from others to motivate them in recovery. Some also found that being able to change for others, or prove themselves to others, such as close family i.e. children/parents was important. Other motivators included fear of death from resuming their use, and the potential guilt/shame associated with a relapse.

'If he's in a clinic like this or treatment. I don't know. Difficult! Just motivate him. Just keep him positive. Just motivate him and tell him he can come clean, it will, things will change. Just try and motivate a person enough so that he will make his own change.' (Participant 7)

A final aid that was crucial to recovery for many participants was the adoption of a **holistic approach** to recovery. Participants emphasised the need to change 'everything', including problematic behaviours, lifestyle, social circles etc., rather than simply the heroin misuse problem. The quote below provides a clear example emphasising the need for this holistic approach.

'What's important is also a holistic approach of medication and counselling and treatment and after-care and all those things. It's not just, I don't think there's just one thing that works. Different things work for different people.' (Participant 10)

The importance of a holistic approach was also illustrated in numerous interviews where the adoption of just one strategy for behaviour change (as opposed to a range of strategies) resulted in a relapse. In view of the powerful nature of heroin dependence, participants emphasised that a whole range of factors need to be addressed and a wide range of strategies need to be drawn upon or used, in order to achieve recovery.

'But still, I can't just stay clean on my own, there is a lot of things that I have to do to stay clean: go to meetings, have a sponsor, do step work, see my social worker, and I stay away from places that are dangerous like bars and clubs and friends and people from the past. Even, I must even watch, I've realised, like the movies I watch and the music I listen to, 'cause it doesn't have a huge effect on me, but it has an underlying effect on me and even being around people who drink. Often I think I can handle it, but after a long period of time, a few months of doing that, it does affect me in a way. So many little things, like the other day I realised I can't use homeopathic medicine because my mother wanted to take me to a homeopath because I have been having skin problems, and can't use mouthwash and all these stupid little things no-one tells me. I figure it out on my own, and see what works and what doesn't work for me. So it's a long process and it does get a lot better with time. I've also realised what worked for me in my 1st year of staying clean is not going to work for me in my 5th year of staying clean. It's an ongoing process of change and seeing what works for me now and what's going to work for me in a year's time. I suppose it's all different all the time.' (Participant 10)

4.7.7.3 Changes in recovery

Finally, it is clear that many of the participants experienced or were experiencing numerous **changes in their recovery**. In the same way that using seemed to produce changes in the user as a person (see changes in person in Theme 4.7.1, p.121), the process of recovery seemed to restore or reverse these changes, altering the person, their lifestyle, **identity restructuring** and perspective etc.

'I changed my mind-set, my whole life-style, everything basically. I had long hair, I cut it. I changed my whole attitude, my entire vocabulary, my manner of being, everything. And it took me a while, but change... such a change is hard, understand? It's difficult to make such a change. All the friends I had, I've written them all off. I just think it's better. It's such people, for example that I come to friends who look how I used to look. I took out all my piercings except for my eye-ring - that's one thing for sentimental reasons. I changed my whole look further, understand? You arrive at people and they look the same, you get that feeling of... it's nice to sit and visit with them, that whole... I don't know how to explain it to you... that's how it was for me. So now I visit with an entirely new group of people, it's new things, it's not just always "hey, let's go score heroin", "let's go steal", "what we're going to do, who we're going to rob?", you know. Yes, I've changed my entire life-style. Except for the fact that I would have liked to move out of Pretoria, for example. Because Pretoria and Johannesburg are the two greatest killers when it comes to heroin, I mean, see how the children are falling now. I hear everyday of people falling on heroin. It's sad, because heroin kills, understand? It's just so... and yes, that's all I can say basically.' (Participant 39)

'It's been a whole different life. And I don't know it, I'm still exploring.' (Participant 38)

'Yes, it is. Hard times hey? I just look back and I just look at myself and what I did, what I was and just think to myself I'm not going back there again ever.' (Participant 15)

Participants also referred to the actual rebuilding of a **new kind of person or lifestyle**, whilst others (presumably at earlier stages in recovery) expressed the desire to rebuild their lifestyle. Participants also verbalised that recovery is a life-long process. This rebuilding generally involved a happier life without heroin and other substances, and with a study/work placement, a new home, and/or with new/improved relationships with others.

'This is the other thing; it's not a quick solution, after that it's a long-life thing. I think recovery takes at least two/three years to get really over it. Then after that, okay, you must just keep on that because I'm sure that if I had to use again, I'd probably fall back into that trap, so that's why I'll never use again. To me now it's the personification of evil. That's what it does to me now; I don't want to be near it.' (Participant 19)

'They must also realise that it is a life-long process and that they're not allowed to use any mind or mood altering drugs and that no treatment centre or no methadone programme or doctor or psychologist is going to fix things...

I think the following suggestions; staying around people with more clean time than me, having friends that are not addicts, and I think it's important, my boyfriend is also not an addict and he doesn't drink. I mean he chooses, because I don't drink, not to drink and that's important. And even little things as I said, the movies, music and places where I go to. Support from family, friends and I think that's very important. I also think digging deep and realising why did I use, what's the deeper reason, getting to know the deeper reason. Realising I'm not okay and maybe I must go to four meetings this week. Realising the signs. I don't think relapsing is just... one day a guy told me that suddenly his car just drove to Hillbrow. It's not like that. It's a gradual process. I mean the other night I was in a meeting and this woman shared and she was seven years clean and she relapsed and that, she also told us how it was a long progression. She started hanging out with newcomers in the room, she stopped going to meetings, she didn't have a sponsor. This gradual progression, and then suddenly she was using again. Having all these barriers to using, and like if I'm not feeling okay, for a little while I say, for the next week or so I'm not going to go anywhere alone, just for in case. I'm not going to go even walk around in a shopping centre, 'cause that's a safe thing for me to do. When I'm feeling like that, like that not to test myself and see how brave I can be, but rather admitting I'm vulnerable and being in some protected environment makes a lot of sense.' (Participant 10).

'Ja (yes) definitely. Your mind-set has to change. Basically your whole life-style has to change. In my mind-set, I mean look, realising that with heroin you ain't going nowhere in life. You have to, once you're off it, then maybe you can start going somewhere in life.' (Participant 5)
'My friends know that if they're going to a club or whatever, they don't even invite me because they know that I will say no and that I don't go to that.' (Participant 10)

'Yes, the last time. I think my will to go back to my old life again, to start working again, to be successful again, because all that was taken away basically. Just to get somewhere again in life, but I've had hard times yes, I did.' (Participant 35)

'No. No, the first few months was, but it just becomes less and less. When I was using and everything, I used because I ran away from my problems, I couldn't face my problems and everything. Now when I get a problem, were my first thought used to be run away or use, my first thought isn't even, you know, "oh, I wish I could have one more hit". I don't even think about drugs anymore. To be honest, I can't even remember what it's like it to take any drugs. So, it's really easy for me, it's just not a normal thing for me anymore.' (Participant 28)

'For me it was a whole life-style change, because the life-style I led, led me to drugs and alcohol and all that. First you have to get a lot of clean time behind you and you have to change your whole life-style. The way you do things. The way you think about things. The people you hang around with. The places you hang around with.' (Participant 6)

4.8 SUMMARY

In summation, before making the decision to quit using heroin and seek a new direction in life, the participants generally developed a negative, dismal view of themselves as human beings. For the most part, they became tired of their lifestyles. Due to the stigma of heroin use, many hid their habits from their families and loved ones. Some became chronically incarcerated, chronically unemployable or extremely sick. In short, the general course of their lives took a downward spiral over time. As the conditions of their lives changed, so did the way they saw themselves. This, in turn, has a great influence on their eventual decision to make a conscious effort to change.

'That's how I think about it. But I still thank God every day for helping me to stay clean. In my mind, you know, man is very fallible. But now, it's been wonderful... once you start seeing the world again, the changing of the seasons. And you do exercise. Exercise is very important... It's actually a much better life than sneaking off into the dark...' (Participant 19)

CHAPTER 5

DISCUSSION AND CONCLUSION

5.1 INTRODUCTION

The objective of this study was to conduct detailed qualitative/quantitative research into the processes of heroin addiction, dependence and specifically recovery, from the point of view of recovering heroin dependants in various stages of recovery. An account of the interview data has been presented in terms of statistical analyses and content analysis, which revealed seven major themes. Within the themes, numerous important concepts and sub-themes have been highlighted. Although the themes are presented separately, there is clearly an interrelationship between them, and certain aspects within particular themes relate heavily to those contained in other themes.

Despite the differences in emphasis, this study resembles that of McIntosh and McKeganey (2002), in the sense that it does not focus solely on the process of recovery, but also analyses the various processes involved in heroin addiction and dependence, the aim being to provide a complete picture of the processes involved. There is no doubt from this and other studies (e.g. Terry, 1999; Biernacki, 1986; Maddox & Desmond, 1980; Waldorf, 1983; Winick, 1962) that the issues involved in heroin dependence and recovery are extremely complex, and as a result it is argued that the best approach in attempting to understand them is to consider carefully all of the different factors involved in both heroin dependence and recovery. For example, it is of little use to examine whether behaviour change will be successful, if one has no understanding of the factors that promoted continued heroin use in an individual's life.

5.2 DISCUSSION OF BIOGRAPHIC, DEMOGRAPHIC, PARENT AND HEROIN DEPENDENCE PROFILE FINDINGS

5.2.1 Biographic and demographic findings

The statistical analyses of the biographic and sociodemographic profile categories of the recovering heroin dependants life-worlds revealed a strong resemblance to that of the findings reflected in the Gauteng SACENDU statistics for the first half of 2003, specifically in terms of age, gender, marital status and ethnicity.

The older participants were, the longer they had reportedly remained abstinate from heroin ($\chi^2 = 16.841$; $p = 0.001$; $df = 3$). This finding is significant in that it supports the maturing-out hypothesis of Winick (1962). No significant differences could be identified between the age categories regarding length of heroin dependence, length and frequency of psychosocial interventions, or frequency of ways in which heroin dependence was overcome. Ethnicity, highest level of education, employment status, marital status, biological parents' marital status or whether biological parents were deceased or not did not relate to any of the identified behavioral indices. No significant differences could be identified between these categories with regard to length of heroin dependence, length and frequency of psychosocial interventions or frequency of ways in which heroin dependence was overcome and length of recovery.

The participants of this study were generally better educated and less unemployed than that of the sample reflected in the Gauteng SACENDU statistics for the first half of 2003. Participants with a schooling of 12 or more years had abstained from heroin use significantly longer than those with a

schooling ranging between 7-11 years (Mann-Whitney $U = 120.00$; $\rho = 0.055$; $Z = 1.916$; $\alpha < 0.05$). Krivanek (1988) affirmed that higher level of education and employed recovering heroin dependents display a better prognosis. Years taken to complete schooling made no difference to length of heroin dependence, length and frequency of psychosocial interventions or frequency or ways in which heroin dependence was overcome.

Gender did not discriminate between any of the measures except that men in this sample had quit heroin more times on their own than woman (Mann-Whitney $U = 80.00$; $\rho = 0.019$; $Z = -2.342$; $\alpha < 0.05$). This tendency could not be found in any other study findings. No significant differences could be identified between the gender categories regarding length of heroin dependence, length and frequency of psychosocial interventions or ways in which heroin dependence was overcome and length of recovery. In terms of ethnicity representation, in both this study and that of the SACENDU statistics for the first half of 2003; both samples reflected a high percentage of white participants. The reason for this result may be that heroin use and dependence only started to appear within the black African, Asian and coloured population groups toward the commencement of this study.

Most participants lived in urban areas. Place of residence (urban/ rural) did not relate to any of the identified behavioral indices. No significant differences could be identified between the urban and rural category regarding length of heroin dependence, length and frequency of psychosocial interventions, frequency of ways in which heroin dependence was overcome or length of recovery.

5.2.2 Parent profile findings

No detailed parent profile data of recovering heroin dependants could be found in the literature, this aspect of the study makes it unique in that it explores a highly under-researched domain.

5.2.2.1 Biological father profile findings

In terms of biological fathers, the majority of participants stated that their biological fathers were still alive and provided financial consistency and stability during the course of their life-worlds. Minimal signs of severe verbal or physical abuse were apparent and only one case of sexual abuse incurred on a participant by their biological father was reported. The lack of abusive relationships between the participants and biological fathers may be regarded as a stability factor within the majority of the participants' life-worlds.

Approximately half of the participants evaluated that their biological fathers were either alcoholics or divulged in problem drinking. This finding is reflected in DSM-IV-TR (*American Psychiatric Association, 2000*) literature which states that family members of individuals with heroin dependence are more likely to have substance related disorders. Illicit drug use or dependence failed to feature prominently within the biological father profile and few participants' biological fathers had clashing with the law.

In terms of strictness in raising participants, biological fathers tended to range from lenient to moderately strict during the course of the participants' life-worlds. Quality-time spent between participants and their biological fathers seemed to lack, and few participants evaluated that their biological fathers' had been a good parent, although the majority of participants were of the opinion that their biological fathers had always loved them during the course of their life-worlds.

5.2.2.2 Biological mother findings

The majority of participants reported that their biological mothers were currently alive. Approximately half of biological mothers had been employed full-time and contributed toward the family upkeep during the course of the participants' life-worlds.

Loud or abusive arguments with biological mothers failed to feature prominently within the participants' life-worlds. A minority of participants reported some physical abuse to varying degrees, with one participant reporting severe physical abuse from their biological mother on a consistent basis during the course of the participant's life-world. No cases of biological mothers' sexually abusing participants were reported, this aspect might be regarded as a stability factor within the participants' life-worlds.

The minority of participants reported cases of full-blown alcoholic, licit and illicit drug dependant biological mothers. The lack of substance related disorders among participants' biological mothers may be regarded as a stability factor within the participants' life-worlds. Most participants stated that their biological mothers had never had any form of conflict with the law.

Most participants reported that their biological mothers had been lenient in terms of raising them. Less than half of the participants evaluated complete stability in terms of quality time that their biological mother had spent with them. Approximately half of the participants were of the opinion that their biological mothers had been a very good parent. The majority of participants felt that their biological mothers completely loved them; this may be an indication of affection warmth within the family environment and may present as a stability factor within participants' life-worlds.

5.2.2.3 Stepfather profile findings

The majority of participants evaluated that their stepfathers had worked consistently and throughout the course of their life-worlds, however, fewer stepfathers as compared to biological fathers had contributed to the participants' families' upkeep on a consistent basis.

Minimal severe loud or verbally abusive arguments were reported between participants and their stepfathers. However, half of the participants reported varying degrees of verbal abuse/loud arguments during the course of their life-worlds between them and their stepfathers. No participants stated that their stepfathers had hit them hard/had been physically or sexually abusive during the course of their life-worlds, this may be regarded as a stability factor on this profile.

A minority of participants evaluated that their stepfathers had been full-blown alcoholics during the course of their life-worlds; however, half of the participants reported that their stepfathers had abused alcohol to varying degrees. Minimum abuse of illicit substances came to the fore. Most of the participants' stepfathers had had some conflict with the law.

Most stepfathers were reported to be lenient in terms of raising participants. The majority of participants were of the opinion that their stepfathers had not spent enough quality time with them. Only one participant was of the opinion that their stepfather had been a good parent, however, half of the participants evaluated that their stepfathers had really loved them during the course of their life-worlds.

5.2.2.4 Stepmother profile findings

More than half of the participants stated that their stepmothers were employed and contributed financially toward the family upkeep on a consistent basis during the course of their life-worlds.

Loud or abusive arguments with stepmothers featured more prominently compared to that of the biological mother profile. No participants reported severe chronic physical abuse from their stepmothers; however, a significant proportion of participants reported some level of physical abuse to varying degrees incurred by their stepmothers during the course of their life-worlds. No cases of sexual abuse were reported; this aspect may be regarded as a stability factor within the participants' life-worlds.

No cases of full-blown alcoholic stepmothers were either reported, however, some participants reported that of their stepmothers abused alcohol to varying degrees during the course of their life-worlds. The majority of participants reported that their stepmothers had never abused any form of illicit substance. None of the participants' stepmothers had ever had any form of conflict with the law or had been incarcerated.

Most participants evaluated that the quality time stepmothers had spent with them had been a low priority. More than half of the participants were of the opinion that their stepmothers had been reasonably strict in raising them. The majority of participants were of the opinion that their stepmothers had been a good parent to varying degrees during the course of raising them. Less than half of the participants felt that their stepmothers really loved them.

5.2.3 Heroin dependence history profile findings

The duration of heroin abuse varied from less than a year to twelve years of heroin dependence. The mean average of duration of heroin abuse is 2.64 years with a standard deviation of 2.568. The majority of participants abused heroin on a daily basis at the peak of their dependence. The predominant primary mode heroin of ingestion was reported to be intravenous injection, followed by smoking, and lastly snorting. The duration of remaining abstinate from heroin ranged from less than a year (nine of the forty participants) to twenty-seven years. The mean length of abstinence from heroin is 2.88 years.

5.3 RESEARCH FINDINGS

5.3.1 Ways in: The formation and development of heroin dependence

The first major theme that emerged was the nature of heroin addiction/dependence and its development. Although this was one of the shortest themes it was clearly of high importance as in order to begin to understand heroin dependence recovery, one needs an understanding of heroin addiction and dependence, and from exactly what the heroin dependent is recovering. It was clear from the analysis that participants heroin dependence was very powerful in nature and was often viewed as being out of their control, as it trapped or 'took hold' of them. Heroin dependence was regarded as harder to recover from than most other substances of abuse, although some participants attributed this perception to media and stereotypes. This powerful nature seemed to lead to a preoccupation with heroin, as the problem progressively took over their lives and participants also seemed to lack any sense of choice over their heroin dependence. It is likely that as the heroin misuse problem developed, increasing tolerance and physical dependence played a major part in influencing this preoccupation. McIntosh and McKeganey (2002) also found that once heroin addicts became dependent, their lives

became dominated by the need to feed their habit, and the necessity to obtain money became the overriding preoccupation in their lives. For the participants in their sample, living with heroin dependence meant living a life of deceit and manipulation, in which they would do anything to get heroin, including turning to illegitimate means, such as crime and prostitution in order to support their heroin habit. Similarly, in this study it was clear that many participants lacked a sense of responsibility whilst in active heroin dependence, highlighted by numerous reports of irresponsible/negative behaviour including criminal activity such as stealing and the manipulation of others. As in McIntosh and McKeganey's (2002) study, such behaviours were generally conducted in an attempt to fund their habit. Participants in this study, who at the time of the interview had never had any form of legal intervention, were more likely to have quit heroin 'some other way' (such as self-administered detoxifications, pharmacological intervention and substitute maintenance programmes) than those who had undergone some form of legal intervention (Mann-Whitney $U = 66.00$; $\rho = 0.45$; $Z = 1.96$; $\alpha < 0.05$). Current legal status of the participants did not relate to length of heroin dependence, length and frequency of psychosocial interventions or length of recovery.

In terms of how the heroin addiction developed, it was clear that whilst the early stages were characterised by a gradual progression towards excessive use, the later stages of heroin addiction (when participants were generally dependent or at the peak of their habit), involved much more rapid developments. These changes involved a rapid escalation in use, accompanied by a rapid deterioration of the participant, predominantly in terms of the negative effects of their use getting further out of control. Such rapid changes exemplify the powerful nature of heroin dependence, which increasingly took control of most participants' life-worlds. The period between lapse and relapse was also described in similar terms, involving equally rapid changes (the issue of relapse is discussed in more detail later in the discussion).

It was clear from the study that heroin dependence led to a significant changing of the participants as a 'person', in many ways including their life, lifestyle, identity and perspective. This was exemplified by participants who noted numerous differences in themselves when they were in active heroin dependence and when they were in recovery. This finding mirrors McIntosh and McKeganey's (2002) and Terry's (1999) ideas on identity. In this study, the majority of participants referred to their identity in terms of the negative impact that their lives as heroin dependants had on their sense of self, which was generally reported in the form of a deep unhappiness at the person they had become. Sometimes the dependants' sense of revulsion at what they had become was associated with a belief that they had become a 'different' person during their heroin dependence.

5.3.2 Reasons/factors for heroin use

5.3.2.1 Initial heroin use

The second major theme to emerge from this study was the various factors/reasons for heroin use. Participants referred to a wide range of factors, which acted in combination rather in isolation and seemed to contribute to different stages of their participants' use, including their early use, continued/excessive use, and their use following a lapse/relapse. One of the most common factors influencing initial use was experimentation, which predominantly involved teenage experimentation with peers or with a range of different substances. This finding supports the typical findings within the literature of experimentation with softer drugs in early teens, followed by a progression to more powerful drugs such as heroin and regular heroin use in later teens/early twenties (McIntosh & McKeganey,

2002). It also coincides with the existence of phases of experimentation in Waldorf's (1983) model, and the experimental phase in Frykholm's (1985) model. However, with a significant proportion of participants it became evident that there is a recent trend in South Africa toward direct experimentation with heroin. Within McIntosh and McKeganey's (2002) research, compliance appeared to be of a voluntary rather than imposed nature, and likewise this study indicated that initial use was generally a matter of choice rather than the result of force or pressure. These findings are also consistent with a number of other researchers, who recently challenged the assumption that one of the main influences on initial drug use is peer pressure (e.g. Pearson, 1987, Krivanek 1988).

According to McIntosh and McKeganey (2002), another main reasons for participants initial drug use was curiosity; the root of the curiosity being the fact that drug taking was clearly enjoyable for those who took drugs. Similarly, in this study, enjoyment was also highlighted as a major reason influencing both initial and continued/excessive use of heroin. Some participants also highlighted the search for a 'high' as a significant reason for their initial and continued use, which is again reinforced by McIntosh and McKeganey (2002), who found that participants' escalating use was often driven by a continuing desire to experiment and find new 'highs'. High availability of heroin was influential in all stages of participants' use in the study. High availability referred to a variety of situations, such as being in close contact with using persons and being offered and exposed to heroin by them, having lots of money and therefore increasing the potential availability of heroin, or mixing within the heroin sub-culture. This is partially supported by McIntosh and McKeganey (2002), who found that progression to regular use was heavily influenced by the individuals' relationships with their significant others or peer group, since these relationships provided the opportunity and encouragement to use more regularly. The participants in this study who had lived without family and/or friends over the last year subsequent to them being interviewed, as opposed to those who lived with significant others, tended to have been dependent on heroin for longer (Mann-Whitney $U = 38.5$; $p = 0.041$; $Z = 2.048$; $\alpha < 0.05$) and to recover from heroin dependence in ways (such as self administered detoxifications, pharmacological intervention and substitute maintenance programmes) other than 'cold turkey', in a treatment programme or when incarcerated (Mann-Whitney $U = 47.5$; $p = 0.018$; $Z = 2.360$; $\alpha < 0.05$).

This study also highlighted how all of the stages of heroin use were influenced by the occurrence of negative feelings. Using was often reasoned to be participants' way of coping with or suppressing or escaping from such feelings. The analysis revealed a range of negative feelings, including stress, loneliness, depression, boredom, and insecurity, several of which are also highlighted to be important factors in McIntosh and McKeganey's (2002) research (in relation to becoming a regular user only). In particular, within McIntosh and McKeganey's (2002) study, regular drug use was employed to help overcome feelings of personal inadequacy, particularly as an antidote to shyness or lack of confidence. Similarly, in this study one of the clearest examples relating to negative feelings was using heroin as a way of coping with insecurity and building confidence in order to mix better socially. Krivanek (1988) also found that boredom, resulting from unemployment or poor recreational facilities served to heighten the appeal of regular drug use by helping to fill a void in participants' lives. This idea is supported by this study, where a lack of employment led to a preoccupation with using and therefore led to more excessive heroin use. Another reason for more excessive heroin use was in order to escape from the heroin misuse problem itself, and/or the various negative consequences of it, such as a lack of employment. This clearly demonstrates the existence of a 'viscous cycle' of use from which it is difficult to escape. For example, it seemed that participants used more heroin because of increasing

dependence, as a result of this excessive use they lost their job, and subsequently used even more due to a preoccupation with using, because of a lack of activity/employment.

5.3.2.2 Continued/excessive use

This study also highlighted that another significant reason for heroin use (at all stages) was as a result of various life problems, such as bereavement, relationship problems, or work stress. As in the case of negative feelings, using was seen as a way of coping or as a means of suppressing/escaping from these life problems. McIntosh and McKeganey (2002) found that only a small minority started to take heroin as a way of coping with problematic aspects of their lives. They did however find that once participants had encountered the pleasurable and 'therapeutic' effects of their use, it often became an important reason for more regular use. It is possible that these differences may have been influenced by the given sample (discussed later). It also emerged from this study that various background factors, such as parent profiles and childhood problems might have been influential in participants' initial use, although these were considered to be more like potential contributors rather than actual causes/reasons for use. As in McIntosh and McKeganey's (2002) study, one of the clearest factors influencing participants' continued/excessive use was physical dependence and increasing tolerance levels, whereby increasing amounts of heroin had to be taken in order to achieve the desired effect, or in many cases just to function normally and avoid withdrawal. The fear of withdrawal, shared heroin use disorders and the inability to conceptualise a way out of their heroin dependence use were cited as barriers in recovery. Continued heroin use was reported to occur as a result of these various barriers to behaviour change, although these are considered in more detail later in the discussion.

5.3.2.3 Lapse/relapse

This study revealed specific reasons/factors influencing the use of heroin that occurred following a lapse or relapse. Substance dependence is commonly assumed to be a chronic relapsing disorder (Gossop, 2002), and recovery commonly only occurs following a number of unsuccessful attempts. The problem of relapse was strongly emphasised by Marlatt and Gordon (1985), and has subsequently been reinforced by dozens of papers including this study.

One of the major reasons for lapsing was due to a failure to cope adequately with the heroin dependence and the associated cravings. Participants' who had previously received substitute prescriptions, such as methadone and buprenorphine, emphasised that problems arose due to the lack of adequate supporting therapy and the common occurrence of substitute prescriptions being withdrawn too quickly. As a result participants often felt unable to cope as they were withdrawn and returned to their original heroin use. Such a common experience has powerful implications for substitute prescribing practices. Does medicine have a role in heroin dependence recovery? Based on the outcome of this study, it would certainly seem so, and it would continue to do so even if the disease model of substance dependence was completely overturned. A comprehensive response to heroin dependence should include the medical profession because the phenomenon often involves some degree of physical dependence, and heroin dependants as a group are at high risk for various kinds of physical damage.

Other clear factors that participants attributed to causing the lapse/relapse were complacency, whereby participants falsely believed that a small amount of heroin use would not result in a full-blown relapse, and resuming use because they quickly forgot about the associated negative effects. Other (less common) factors influencing relapse included a lack of effort/commitment to behaviour change, the

justification of use as a reward for being clean, and self-destruction, whereby some participants felt that they did not deserve the success that came with being clean. These relapse findings seem to reinforce the importance of lapse prevention models such as that proposed by Marlatt and Gordon (1985), which advocate the use of a range of strategies to avoid relapse. In particular, lapse management strategies seem to be of considerable importance in preventing the lapse from developing into a full-blown relapse, and in combating the abstinence violation effect. Further examples of relapse prevention strategies/approaches are alluded to later in the discussion.

5.3.3 Going deeper: The negative effects of heroin use

The third key theme to emerge from the data was the negative effects of heroin use, which referred a wide range of unpleasant consequences, experienced by the participants. The wide range of negative consequences, related to physical and psychological health, social and practical effects, and the impact on relationships. Many of these consequences were serious; sometimes persisting for a long time after heroin use had stopped.

5.3.3.1 Physical effects

The occurrence of general deterioration in physical health, and various use related illnesses/problems is supported by both Prins (1995) and McIntosh and McKeganey (2002), although Prins (1995) suggests that a bad health situation is not always necessarily the result of heroin use, since all people, including heroin dependants, experience certain health problems. Nevertheless, McIntosh and McKeganey (2002) note that a deteriorating health is a major occupational hazard of heroin use, with common physical problems for injecting users including serious vein damage and the risk of contracting HIV/AIDS or hepatitis B, C & G. It seems probable that many of the associated health problems are likely to have been influenced or at least exacerbated by participants not looking after themselves properly and included such things as the use of unsterile equipment, not exercising or eating properly. It came to light in this study that participants, who had shared needles in the past or known others who had shared needles, were naïve with regard to needle sterilisation procedures. The pros and cons of needle exchange programmes were deliberated on by the participants who had been intravenous heroin dependants. The need for further debate concerning this issue, both in South Africa and world-wide ensues.

5.3.3.2 Emotional/psychological effects

A deterioration of emotional and psychological health was also clear in the interviews, with a reported increase in various negative emotions, such as feeling numb, depressed, or experiencing a breakdown, and a variety of psychological problems, such as depression, anxiety/panic attacks, paranoia, psychosis and eating disorders, supporting DSM-IV-TR (*American Psychiatric Association*, 2000) and Leshner (1999) literature concerning a high co-morbidity prevalence rate in heroin dependence. As was the case in McIntosh and McKeganey's (2002) study, whether participants lived or died became a matter of complete indifference, with some becoming consciously suicidal in a similar way to those in Prins' (1995) and Terrys' (1999) research.

5.3.3.3 Relationship effects

Another clear consequence was in terms of the effect of using heroin on relationships, which resulted in various negative effects such as increased arguments, a bad family atmosphere, or the break-up of many relationships. A further negative consequence was the social effects, which was most notable in terms of the isolation, stigmatisation and loneliness experienced by heroin dependants. This isolation is likely to have been influenced by the fact that many were much less socially active when using heroin (often due to a conscious avoidance of non-users) and the resultant change in social circles. The extreme isolation and stigmatisation experienced by participants is obviously something that needs addressing, and as this study shows, engaging in treatment intervention can act as one means of rebuilding (non-using) social networks.

5.3.3.4 Social effects

Participants reported that meeting ex-dependants reduced isolation by combating their common belief that they were the only one in their situation. Also, the use of groups such as NA and after-care provided good sources of contact for people, although some participants did not have access to such sources, or did not wish to access them. In such cases it appeared that alternative means of reducing isolation were required. Finally, it emerged from the analysis that participants' heroin use resulted in various practical implications, with most of the sample being unable to work during heavy heroin dependence. This further exacerbated their isolation, due to a lack of contact with family/friends/friends/work colleagues.

5.3.3.5 Practical effects

The importance of meaningful employment for sustained recovery was discussed by Krivanek (1988), who suggested that it can provide a particularly useful substitution for the rewards previously found only in using heroin and other substances of abuse. Apart from employment problems, a neglect of other practicalities, such as paying bills and keeping appointments also emerged as a problematic consequence of use, which seemed to relate to a lack of responsibility reported by many participants. As mentioned previously, this involved various irresponsible/negative behaviours, such as being unreliable, untrustworthy, deceitful, and engaging in criminal activity, most of which were conducted as a means of supporting their heroin habit.

5.3.4 Ways out: Realisation process

The fourth significant theme to be highlighted in the study relates to the process of realisation of the heroin misuse problem. It was clear that many of the participants were unaware of their heroin misuse problem in the earlier stages of their addiction. Not only were they unaware of their escalating heroin use and developing dependence, but many were also unaware of the increasing negative effects of their heroin use, and that these negative effects were a consequence of their using. The fact that many participants were unaware of the problem was often reported to be due to a denial of the problem or more simply to a lack of awareness, education or understanding of themselves and their heroin dependence. One black African participant had no idea as to what heroin was or its addictive potential. The same participant also consumed large amounts of alcohol in an attempt to minimise heroin withdrawal symptoms. Young black African males are turning to heroin at an alarming rate. In a sense heroin is replacing the traditional 'manhood' rituals and initiation rites of the traditional black African culture. Traditional African initiation schools, for example, may also be unfamiliar with the heroin dependence phenomenon, and the specialised care that such dependencies necessitate. This clearly

highlights the need for increased education and treatment intervention regarding heroin dependence, especially within communities and amongst youth in disadvantaged areas. This lack of awareness is also highlighted by McIntosh and McKeganey (2002) and Burroughs (1977), who found that progression to regular use tended to involve an unconscious 'drift' rather than a deliberate decision. Although family and friends only occasionally informed the heroin dependants that they thought they had a problem in McIntosh and McKeganey's (2002) study, it seemed that in this study family and friends were generally aware of the problem although many participants tried to hide their dependence problem away from their significant others.

For many of the participants, realisation of the problem seemed to occur as a process later on in the heroin dependence, and it tended to be associated with a series of realisations, relating to both the heroin misuse problem and the negative effects of heroin use.

Participants also described realisations relating to the need to change their behaviour and to get help/treatment in order to change such behaviour. It should be noted that for some participants initial realisation/awareness of the problem did not automatically result in a full recognition/acceptance of the problem, as for several participants it was often very difficult to accept the problem themselves and to admit it to others. Due to these difficulties, it sometimes took considerable time for this acceptance to occur and so it was generally a gradual process involving a series of realisations. However, for a minority of participants, the process involved a sudden realisation, often triggered by 'rock bottom' experiences, highlighting marked individual differences between people in terms of how they experience and recognise their dependence. The presence of individual differences is reinforced by McIntosh and McKeganey (2002), who found that recognition by individuals, could take anything from a few weeks to several months, depending on the chronicity of use and the substance dependants' ability to support their habit.

The experience of withdrawal was an important factor in helping participants to realise their developing heroin dependence. This is reinforced by McIntosh and McKeganey (2002) and Burroughs (1977) who point out that recognition usually came with the experience of withdrawal symptoms and the realisation that they needed heroin to function normally. This often came when they were deprived of heroin for some reasons, such as a lack of money or availability. Similarly a factor that prevented realisation of the problem was the fact that some participants had a continuous supply or used heroin continuously for a period of time, which masked withdrawal symptoms.

The analysis also revealed that the increasing negative effect of heroin use, particularly on children, was also influential in determining participants' realisation that their heroin misuse needed changing. This supports McIntosh and McKeganey's (2002) findings that substance dependants' feelings about the possible impact of their drug-use on their children were so powerful that this was often sufficient enough to make them reassess their drug use. Within this study other less common contributors included the transition to heavier heroin use/increased tolerance, and a realisation following a clean period. It was often a combination of such factors rather than one specific factor/event that influenced the realisation of the problem.

It was also clear from the study that despite realising the problem earlier many participants described having a clearer awareness of the heroin misuse problem and its negative effects, at later stages of their heroin dependence. Generally this seemed to be influenced by the passage of time, with some

participants supporting the 'maturing out' hypothesis, which allowed them to achieve a clearer perspective of the problem and the associated events, as well as the experience of treatment intervention, which was significant in facilitating a clearer outlook. This highlights the importance of treatment intervention. The analysis also revealed that many of the participants' heroin misuse continued for some time after their initial realisation. This is likely to have been influenced by a variety of factors, including the various reasons influencing continued use and the barriers to behaviour change, a number of factors seemed to be particularly influential, including feeling helpless/unsure of how to go about stopping their use, experiencing a lack/very little negative effects at the time therefore not fully questioning the problem, and a lack of support/intervention which was needed in order to change behaviour.

5.3.5 Taking action: Behaviour modification

5.3.5.1 Types of behaviour change

The fifth theme evident from the results relates to behaviour change, and was broad in the sense that it referred to a wide variety of actions taken by participants to attempt to control or stop their heroin misuse. As mentioned previously, virtually all participants reported numerous/successive unsuccessful attempts to change their behaviour, illustrating the high degree of difficulty involved in this. McIntosh and McKeganey (2002) believe that these failed attempts are not simply a waste of time and they play a highly significant role in the recovery process, as a period free from heroin and other drug use can often clarify and highlight the extent to which the heroin dependants' identities have been damaged by heroin. Furthermore during abstinence, the heroin dependent can acquire a first-hand experience of the alternative life to which he/she might aspire.

This analysis revealed that attempts to change could be divided into non-serious/temporary and serious types of behaviour change. Non-serious/temporary attempts referred to a less committed attempt to change behaviour. For example, several participants described temporary changes in their early use while having a family, or in order to support their denial, while some participants described how substitute prescriptions were used as a security/safety net to allow continued use, or how earlier treatment intervention experiences were treated as a respite from use rather than a serious attempt to change behaviour. Another example of non-serious behaviour change was forced change rather than a positive decision to change by, for example, being forced not to use due to a lack of money or contact with a dealer, or coercion into treatment.

5.3.5.2 Decisional balances

These types of non-serious/temporary change tended to occur earlier in an individual's heroin addiction, unlike more serious behaviour change, which tended to occur later in their heroin dependence. These latter changes referred to a commitment to behaviour change following a 'rock bottom'- like experience. In these cases, participants described themselves as being in a 'bad state' and feeling highly depressed, 'half dead' and despondent with their situation and feeling it was absolutely necessary to change. It was clear that serious behaviour change, in terms of making a serious attempt at accessing and 'working' treatment intervention, was usually done when participants described themselves as being at or near rock bottom. Although many people believed that the experience of a rock bottom-type experience was a necessary condition for successful recovery, this view has been challenged by research such as that of Biernacki (1986) and more recently McIntosh and McKeganey (2002), who have identified two principal routes out of drug use. One route is the rock bottom type route whilst the other is exit via

rational decisions. The main difference between which was having to stop in the former and wanting to stop in the latter. Although this study seemed to emphasise the occurrence of both the rock bottom-type experience and rational decision of experiences. Moreover, in spite of the occurrence of rock bottom - type of experiences, there did seem to be evidence of more rational decisions, in the sense that participants seemed to experience various decisional balances regarding behaviour change at different times in their heroin using life-worlds. This involved experiencing various balances/choices that had to be weighed up, for instance in terms of the benefits of staying clean versus the benefits of continued use, or the continued enjoyment of use versus the feeling that use was wrong/dangerous. It seemed that as the heroin dependence progressed the decisional balances generally seemed to shift from favouring continued use, in the early stages, to favouring change rather than continued use, in the later stages. In terms of when the balance favoured continued use rather than change, factors such as continued enjoyment and physical dependence, tended to outweigh any negative effects of use, feelings of wanting to change, or any other factors, which may serve to motivate them to change their behaviour.

5.3.5.3 Influencing factors

For many participants the balance seemed to tip in favour of behaviour change rather than continued use when the negatives of use began to outweigh the positives and reasons/factors for continued use. This finding resembles the first stage of de-addiction in Waldorf's (1963) model, where dependants are 'going through changes' and the negative effects of drug use begin to be felt. The dependent then makes forced or voluntary attempts to stop, which usually end in relapse. More specifically some participants in this study reinforced the influence of a rock bottom-type experienced and described wanting to stop using as a result of being completely fed up with the negative effects of their heroin use or of being too ill not to go to treatment. In this phase, examples of various decisional balances included choosing the dignity of being clean rather than heroin, choosing to have a job rather than heroin, choosing a life rather than a life dictated by heroin, or quite simply choosing life rather than the heroin and potential death. It should be noted that in many cases it took some time for this shift in opinions to translate into actual behaviour change, and it is likely that this is because some of the decisions were not as straightforward as implied, considering the vast range of reasons/factors participants described for wanting/needing to continue using. Clearly there is a conflict between the reasons/factors influencing wanting to change behaviour and the reasons/factors influencing continued/excessive use or lapse/relapse. This view is reinforced by numerous other researchers, such as Prins (1994), Biernacki (1986) and McIntosh and McKeganey (2002), who found that deciding to give up drugs was surrounded by a great deal of ambivalence, with a conflict between a desire to change and a reluctance to give up the drug. Indeed, it is argued that ambivalence is endemic to the lives of heroin dependants and dependants in general, and is present for a large part of their heroin-using career. This view is also reinforced by the stage theorist Frykholm (1985), who argues that the first phase of de-addiction involves a period of ambivalence, where the negative effects of drug use are increasingly felt, which although results in a gradual desire to stop using drugs, is generally offset by a continuation of pleasurable effects of drugs and a physical dependence to drugs. The presence of such ambivalence clearly implies that there is a potential role for therapies such as Motivational Interviewing (Miller, 1983; Miller & Rollnick, 1991), which explores ambivalence, and aim to facilitate compliance and readiness for behaviour change.

Another major factor that seemed to be influential in tipping the balance in favour of behaviour change was the changing effect of the heroin. These usually progressed from being positive to becoming

increasingly negative. As well as cognitive and perceptual shifts, McIntosh and McKeganey (2002) found that important changes in the pharmacological effects of drugs play a major part in the dependants' decision to stop using. It is suggested that the realisation that the drug is no longer a positive part of a dependants' life represents an important turning point; a view that is backed up by numerous researchers (Frykholm, 1985; Prins, 1994). Despite the disagreement amongst stage theorists regarding the precise number of phases/stages involved in addiction, dependence and recovery, the presence of a specific 'turning point' is common to many models (Prins, 1994; Simpson *et al.*, 1986; Shaffer & Jones, 1989). The fact that there seems to be a specific point where the decision to give up heroin is taken and/or consolidated also seems to be evident in this study, although this generally involved a gradual process rather than a specific event.

Another clear factor influencing behaviour change for some participants was the importance of significant others, such as family/children in motivating them to achieve recovery. For example, some participants reported wanting to achieve normality for the sake of their children, or deciding to change their behaviour due to the fear of losing contact with their children. The influence of significant others in the decision to stop using is reinforced in a number of studies (Waldorf, 1983; Frykholm, 1985; Smart, 1994). Since many interviewees felt incredibly guilty about the ways in which their heroin use had affected the lives of their children, children could act as a powerful catalyst for attempting to give up heroin/enter treatment.

Within this study, another major reason for behaviour change was in order to provide relief from the increasing negative effects of heroin use, for example, on health or relationships. Many participants expressed that the need for behaviour change was influenced by a desire for some kind of normality that was free from such negative effects. Again this finding is reinforced in other studies which show that an influential factor in the decision to stop using is deteriorating health or the fear of health problems (Waldorf, 1983; Valliant, 1983; Simpson *et al.*, 1986), as well as the occurrence of more general negative events such as a period in prison or the overdose or death of drug-using friends/associates (Shaffer, 1992; Edwards *et al.*, 1992; Terry, 1999).

The increase in such negative effects seems to be related to the notion of 'burn out', which appears to be one of the most frequent explanations for recovery given by participants in many studies. It seems that sustaining a habit can become an exceptionally difficult and demanding task associated with many problems. This has been demonstrated in studies such as that of Frykholm (1985), where substance dependants' main reason for stopping was that they were 'tired of the life' or words to that effect. McIntosh and McKeganey (2002) point out the similarity of the 'burn out' explanation and Winick's (1962) 'maturing out' hypothesis, since both are products of changes, which could be said to occur naturally with the passage of time. However, there is not widespread agreement regarding this. For example, Vaillant (1996) does not believe there is a specific age where substance dependants recover, arguing that the notion of 'burnout' in middle life is a misinterpretation of the relatively smooth attrition among drug-dependent individuals. Instead, Vaillant (1996) believes that recovery seems to depend on the severity of dependence and on the individual encountering the right kind of natural healing experience. This is not an area that can be debated within the current research, as a sample size of forty cannot be deemed statistically significant, however, indications of the 'maturing out' hypothesis was supported within the scope of this study revealing that the older participants were, the longer they had reportedly remained abstinate from heroin ($\chi^2 = 16.841$; $p = 0.001$; $df = 3$).

McIntosh and McKeganey (2002) found that a similar range of reasons/factors to those highlighted above were influential in behaviour change. However, similarly to Biernacki and Waldorf (Biernacki, 1986; Waldorf, 1983; Waldorf & Biernacki, 1981), McIntosh and McKeganey (2002) and Terry (1999) strongly believe that the factor that distinguishes apparently successful attempts from earlier attempts is related to the addicts' sense of identity, rather than any of these factors. More specifically, they argue that substance dependants are stimulated by a desire to restore what Goffman (1963) described as a 'spoiled identity', as they realise that they exhibit characteristics that are unacceptable to themselves and significant others. Although McIntosh and McKeganey (2002) and Terry (1999) did not claim that a desire to restore identity was sufficient for recovery on its own, they do describe it as a cognitive shift that comes close to being a necessary condition for such change to occur.

McIntosh and McKeganey (2002) suggest that the reason/factors are seldom sufficient in themselves to promote permanent exit from drug misuse, arguing instead that their potential effect is mediated by the meaning which individuals ascribe to them and the implications these interpretations have on their sense of self. The issue of identity was raised in this study as being an influential factor in recovery. A further powerful factor relating to behaviour change seemed to be the existence of various decisional balances, which were strongly emphasised by many participants.

5.3.5.4 Spirituality

Spirituality played a decisive role and was regarded as a crucial factor within the realisation and recovery process for many participants. Some participants referred to undergoing 'spiritual conversions'. Higher levels of religious faith and spirituality have been associated with a more optimistic life orientation, greater perceived social support, higher resilience to stress and lower levels of anxiety. Rabbi Twerski, professor in psychiatry, believes that the source of substance dependence is a spiritual deficiency, and that spirituality should be regarded as a cornerstone in recovery (Arnold *et al*, 2002).

5.3.5.5 Barriers to change

This study's analysis revealed certain barriers, which prevented behaviour change (and therefore acted as reasons/factors for continued use), such as a lack of awareness/denial of the problem, a lack of treatment intervention services or long waiting lists, fear of experiencing withdrawal symptoms, or a feeling of being unable to see a way out of the heroin misuse problem. Obviously such factors need to be addressed if heroin dependants are to be encouraged to engage in behaviour change sooner. In particular, the feeling of being unable to see a way out of the heroin dependence problem meant that even though participants may have recognised that they had a problem and accepted the need to change their behaviour, they may have seen no way of stopping. The need to believe that change is feasible is highlighted as an important factor in producing successful behaviour change by McIntosh and McKeganey (2002), who argue that it was not enough for substance dependants to desire a new identity and life, but they also needed to believe that this was feasible. Without this, any inclination to alter behaviour would simply disappear. Since dependants must believe that they have the power to change their behaviour, the enhancement of self-efficacy seems to be of considerable importance, and as mentioned previously the role of skilled therapists can be particularly important in this respect (Edwards, 2000). The importance of taking positive actions to promote behaviour change is supported by Prins (1995), who argues that although the decision to change/stop using may be a decisive moment/turning point, very often it is not enough on its own, and therefore the decision needs to be backed up by steps to implement it.

5.3.6 Perceived effects of intervention

The sixth major theme that emerged from the analysis related to intervention. This was clearly very important in the sense that all participants, except for two, considered it to be a vital factor in achieving recovery. In this study, all but two participants had accessed treatment at some stage and felt unable to achieve recovery independently. Many were unable to detox independently due to physical dependence or were simply unable to cope with behaviour change without external help/support. This finding supports Frykholm's (1985) treatment phase, in which it is proposed that the dependent perceives a need for external control and support, and so seeks help.

5.3.6.1 Positive effects of intervention

Within this study intervention was clearly central to recovery and in many ways the themes of intervention and recovery are interchangeable/commonly linked together. However, rather than forming a concept within the theme of recovery, intervention formed a theme of its own, since it was deemed so important and clearly encompassed many factors. The reported relief that starting their intervention illustrated the importance of intervention for these participants. The renewed sense of hope spoken about by participants referred to a sense of successful determination in meeting goals in the past, present, and future. According to Strümpfer (2002) hope refers to a sense of being able to generate successful plans to meet goals or the perceived ability to generate routes to get somewhere. Secondly, a sense of hope was influenced by the perceived availability of successful pathways related to goals.

Various intervention experiences were reported to produce a range of positive effects in terms of heroin and other substance use, physical health, confidence levels, isolation and coping method, as well as an altering of the person in terms of their life, lifestyle, perspective, identity, and facilitating a clearer realisation/awareness of the heroin misuse problem. These findings relating to the positive effects of treatment intervention are reinforced by other research (Edwards, 2000). According to Edwards *et al.* (1997), although intervention is one of a number of interactive influences that can play a part in recovery and within the natural healing process (Valliant, 1996), it can be particularly useful, for example, in terms of nudging a person towards a more constructive way of thinking (as demonstrated in the current study), enhancing self-efficacy, or helping with the choice of an appropriate goal. Although 'maturing out' has traditionally been applied solely to the process by which some dependants give up drugs 'naturally' (Winick, 1962; Biernacki, 1986; Prins, 1994). McIntosh and McKeganey (2002) believe that this is too narrow a view of the processes involved. They argue that it is possible for the 'maturing process' to apply as much to those who overcome their dependence with the assistance of treatment, since it is the decision to stop that is important, and whether this occurs with or without treatment is of secondary importance (McIntosh & McKeganey, 2002).

5.3.6.2 Positive/ important components of intervention

According to Edwards' (2000), research demonstrates that a range of competently applied treatment interventions with different theoretical underpinnings are likely to give roughly the same kinds of success rates. This obviously makes it somewhat difficult to establish which aspects of treatment intervention are particularly effective. However, it is possible that this study may shed some light on this issue, as it emerged that the positive effects of treatment intervention seemed to occur as a result of various positive components/needs, which were reported to be essential for beneficial/successful treatment intervention. One of the clearest components was that of common experience, both in terms of being around other substance dependants in treatment and the fact that many of the counsellors having had

some kind of personal experience with substance dependence. Common experience was reported to be beneficial in providing a more empathetic/understanding environment, where participants (and counsellors) could positively relate to each other and provide more useful/practical advice as they could all draw from their own experiences. Common experiences was also important since participants were not able to 'fake' treatment or conceal what was going on, as well as serving to reduce isolation. This is clearly of significance considering the fact that isolation/loneliness was commonly experienced by participants.

Furthermore, many participants described the benefits of being surrounded by people at different stages of dependence, with heroin dependants serving as a reminder of the negatives effects of using, and successful recovering heroin dependants (e.g. people in aftercare) providing hope and serving as potential role models or goals to aspire to. The various benefits of common experience are supported by McIntosh and McKeganey (2002), who found that talking to other recovering substance dependants had three main advantages. Firstly, recovering substance dependants understood first hand what the individuals were going through, and were able to relate and emphasise better; secondly, they had credibility, since they had been there themselves and were knowledgeable; and thirdly, successful recovering substance dependants gave inspiration to those not so far along to sustain the hope that they could succeed.

Education also emerged as a crucial component of treatment intervention, both in terms of the various aspects of heroin and substance dependence, and regarding the availability of treatment services. Some participants felt that earlier education may have been beneficial in engaging them or others earlier in their heroin dependence.

Participants also described how treatment intervention provided them with the benefits of talking about problems and getting feedback/advice in both counselling and group therapy. Often this setting seemed to enhance confidence and self-esteem, as well as reduce isolation (e.g. through bonding with peers). McIntosh and McKeganey's (2002) research supports the positives of therapy, in particular counselling. In the present study views regarding counselling were generally positive, with participants once again highlighting the value of being able to talk to others about the stresses involved in trying to recover from drug dependence. The need to address co-dependence issues was also highlighted by the participants.

A further treatment intervention component that was reported to be influential in producing positive effects was the adoption of a holistic approach, whereby the 'whole package' of the person was addressed in treatment intervention, and not simply the heroin dependence problem. The range of targets included behaviours, coping methods, physical and psychological/emotional problems, practical problems, social and relationship difficulties and self-awareness. Similarly, within the recovery theme, a crucial aid to recovery seemed to be the adoption of a holistic approach, whereby all problematic aspects of the participants' lives needed addressing, such as problematic behaviours, lifestyle, circles etc., rather than just the heroin misuse problem.

The use of alternative therapies in treatment intervention, such as relaxation and exercise was also supported. Participants reported that such therapies/activities were beneficial in numerous ways such as increasing self-awareness, distracting the participant from their heroin misuse problem, and providing valued time away from therapy to prevent overload. The use of alternative activities is reinforced in Marlatt and Gordon's (1985) relapse prevention model, where one strategy employed to try and prevent

relapse involves encouraging clients to pursue non-drinking (although it could be equally applied to heroin dependence) recreational activities previously enjoyed before their substance misuse problem. In addition, it is suggested that cognitive-behavioural skills training approaches, such as relaxation (as mentioned above) can help recovering heroin dependants achieve a greater lifestyle balance. Furthermore, helping the recovering heroin dependant to increase positive activities, such as exercise can also improve mood, health and coping, as well as increase self-efficacy, through acquiring new skills from new activities (Larmier, Palmer & Marlatt, 1999).

An additional component that was considered integral to successful treatment intervention was good support networks. Practical support in particular was beneficial to some participants, which is perhaps unsurprising considering the amount of practical consequences that occurred for participants as a result of their heroin misuse problem. The particular structure of treatment intervention was also crucial to some participants, in the sense that it provided an abstinence-based, structured/intensive residential programme (as opposed to out-patient intervention), sometimes over a relatively long period of time. High level early treatment intervention and long-term care was highlighted as an important strategy in combating chronic heroin dependence. It is however, likely participants contact and relative success with such services had influenced that their views regarding what constituted beneficial treatment interventions. Nevertheless, it was clear that for this sample at least, this type of treatment intervention was considered to be what they needed for recovery.

Some participants described the need for specialist treatment rather than general help, e.g. medical assistance to detox, with several participants referring to the need for both an individualistic, non-judgemental and realistic style of treatment intervention, which should be instantly/easily accessible when required. Participants also highlighted the need in early recovery for safe and protected environments, away from temptations.

The final component that was considered necessary for successful treatment intervention was personal factors, such as effort, hard work, discipline and commitment. This seems to be a fundamental component since without the effort and commitment of the individual; treatment cannot be effective no matter how good it may be.

5.3.6.3 Accessing/commencing intervention

Another crucial component of treatment intervention that emerged was having a welcoming, friendly and safe environment. This idea is supported by McBride (2002) who stresses the importance of making services approachable, not only geographically, but also socially and personally. McBride argued that the ambience of an agency/setting could have a marked impact on the treatment experience. Considering that one of the difficulties of treatment intervention was that participants often felt nervous, scared, lost and unsure of what to expect at the start of treatment, the presence of a welcoming/supportive environment is especially important in helping to ease some of the apprehension experienced.

In relation to commencing treatment, participants reported a range of expectations (from high to mixed to low), although one common feeling experienced by most was a feeling of being unsure regarding what to expect. Another less common but seemingly important expectation was some kind of false belief in a 'miracle cure'. This appears to be something that treatment agencies need to consider with new patients/clients so they can be realistic with them regarding the high level of effort required to achieve

recovery, and therefore avoid disappointment. This is reinforced by Marlatt and Gordon (1985), who believe counteracting misconceptions to be an important part of relapse prevention.

5.3.6.4 Pharmacological intervention

The need for some kind of therapy alongside substitute prescriptions was also reported to be very important for many participants in this study, illustrated by reports of relapse being a result of receiving a 'script' but not having any counselling. Participants found it unsurprising that such an approach may result in relapse, since by giving a substitute prescription often only the physical dependence is addressed, and there is an obvious failure to address other potential problems which may be contributing to the substance misuse. Furthermore, it is difficult to see how recovery may be maintained if there is a failure to teach/provide any advice regarding how to deal with the heroin dependence in the long term, and manage potential cravings.

5.3.6.5 Difficulties of intervention

This analysis revealed a number of potential barriers to accessing treatment intervention, the most common of which being a lack of services, lack of affordable services, long waiting lists and lack of awareness of existing services.

The data also revealed numerous difficulties that participants' experienced through their experiences in treatment. The clearest difficulty was in the need to accept complete abstinence from all substances of abuse. Many participants described experiencing continued desire to use some sort of substance, most commonly alcohol and cannabis, while attempting to give up heroin. Generally however, participants did concede that the acceptance of complete abstinence was an important requirement for recovery. Another difficulty experienced in treatment intervention was related to various contradictions and evasive attitude toward treating heroin dependencies. A number of participants, for example, experienced contradictory feelings with agencies regarding how detoxification should be managed; many were also exposed to fundamentalist and sometimes harsh treatment intervention procedures.

5.3.6.6 Negative/unsuccessful intervention

Most participants described some kind of negative/unsuccessful experience of treatment intervention at some stage in their heroin dependence, including treatment intervention not being intensive/long enough, lack of adequate skills in terms of specialised knowledge of professionals working within the substance dependence field, and a lack of alternative activities or education within treatment services. Clearly such negative experiences served to re-emphasise some of the positive components reported to be essential for successful treatment, for example in terms of the structure of treatment intervention.

Due to a large void in the literature, another important area of research that this study addressed was the recovering heroin addicts' own views of pharmacological intervention. A specific negative experience of pharmacologic intervention was related to substitute prescriptions, and in particular methadone, which participants had usually received in earlier stages of their heroin dependence. Some of the participants viewed substitute prescriptions such as methadone as negative and of no benefit in recovery, with some participants experiencing extreme withdrawal from methadone. Intravenous buprenorphine misuse was also reported. Similarly negative views of methadone were expressed by some of the interviewees in McIntosh and McKeganey's (2002) study, although a significant proportion saw methadone as a wonder drug that had saved them from the depths of their heroin dependence.

Although a controversial issue, research evidence does indicate that methadone and buprenorphine can make a positive contribution in reducing risk behaviour and assisting recovery (Pearson, 1987).

Nevertheless, McIntosh and McKeganey (2002) suggest that our understanding of the role of the various pharmacological interventions for heroin dependence is relatively undeveloped, and therefore there is a need for further research, for example, examining the long-term impact of methadone and buprenorphine on the length of a heroin-using career.

5.3.7 New labels: References to self in recovery

The final theme to emerge from the analysis of the data was recovery. This was obviously one of the most crucial themes. Due to the nature of the sample (most of the participants has undergone residential intervention), treatment intervention was one of the most prominent requirements of recovery (as discussed above). However, a number of other important factors also emerged as important, including various personal requirements, such as being focused and committed to putting in effort and hard work, being personally ready to change, and accepting that heroin dependence was enduring and that there was no miracle cure. The need for such personal requirements is reinforced by Edwards (2000), who suggests in particular, that dependants need to be motivated (and specific intervention like Motivational Interviewing are useful here), as well as ready to change, a view strongly influenced by Prochaska, DiClemente and Norcross' model (1992).

5.3.7.1 Factors/requirements for recovery

Another factor, which emerged as an important requirement for recovery, was the need to accept complete abstinence of all psychoactive substances. This idea supports Edwards *et al.* (1997), who argued that recovery from severe dependence almost inevitably involves acceptance of an abstinence goal.

The analysis also revealed various other factors required in achieving recovery including the need to have hit rock bottom (which has been discussed previously), and the need for a good support network. Edwards (2000) reinforces this, stressing the importance of establishing a personal micro-environment that supports abstinence. For many individuals, groups like NA and after-care support groups can provide such an environment.

This analysis also indicated the need for heroin dependants to change their behaviour for themselves rather than others. McIntosh and McKeganey (2002) also found that substantial numbers of subjects expressed that drug use could only be stopped successfully if it was done 'for yourself'. According to McIntosh and McKeganey (2002), 'doing it for yourself' represents a clear reference to identity, as many participants felt that success would be unlikely if they sought to stop for the sake of others: success would only come if you did it for yourself, i.e. for the sake of your own identity. McIntosh and McKeganey (2002) note that one of the problems with stopping for reasons other than the self, is that the drug is frequently considered more powerful than a range of very good reasons for stopping, and so the only realistic prospect of overcoming this power comes when the drug-using identity is being rejected.

This study revealed that a range of other factors also seemed to be influential in motivating participants in their recovery, including the fear of death from resuming their heroin use, the potential guilt/shame associated with a relapse, as well as the support of significant others, and the positive effects of their

change on others (e.g. family, children). As mentioned previously, the importance of significant others in behaviour change, is reinforced by numerous other researchers.

5.3.7.2 Aids for recovery

The interviews also revealed various aids, which had helped or were helping participants to achieve or sustain their abstinence/recovery from heroin dependence. One of the factors considered to be of most value was the continued use of post-treatment aftercare/counselling, and the importance/security of having a safe environment to return to if required. Similarly, McIntosh and McKeganey (2002) found that their interviewees valued the ability to drop into a facility or contact someone without prior arrangement, since challenges to their recovery could occur at any time. Another highly important component assisting recovery was the learning and use of a range of strategies to combat/oppose the numerous factors/reasons for heroin use. These strategies were either learned through treatment or over time by experience, and included strategies such as reducing high availability of heroin and other drugs/alcohol by avoiding users; changing social circles from users to non-users to reduce temptation; using distraction to avoid boredom which may trigger use.

The need to use such strategies is reinforced by Edwards (2000), who suggests that successful recovery involves avoiding relapse, and this can be done through learning various psychological skills, e.g. through Cognitive Behavioural Therapy. Similarly, in relapse prevention models such as that of Marlatt and Gordon's (1985), one of the goals is to teach recovering substance dependants to anticipate the possibility of relapse and to recognise and cope with high-risk situations. Once high-risk situations have been identified, various strategies can be used to lessen the risks, such as learning more effective coping strategies, or if this is not possible, taking evasive action, such as leaving the situation when cues/triggers for use are identified (Larmier *et al.*, 1999).

This study identified that a particularly important strategy was the acceptance and expectancy of cravings and other problems associated with heroin dependence. This preparation helped participants to avoid panicking when they experienced them, and they could arm themselves with effective ways to cope with them. An important aspect of Marlatt and Gordon's (1985) relapse prevention model, is to teach clients to anticipate and accept cravings as a 'normal' conditioned response to an external stimulus, rather than seeing the urge as an indication of his/her desire to use. The model describes the use of various urge-management techniques, which can be adopted to deal with such cravings.

5.3.7.3 Changes in recovery

Finally, this study found that many participants experienced or were experiencing numerous changes in their recovery. In the same way that using seemed to produce changes in the user as a person, the process of recovery seemed to begin to restore these changes, altering the person, in terms of their lifestyle, identity and perspective. Many participants referred to the actual rebuilding of a new kind of person in terms of identity restructuring that either excluded or depreciated old values, whilst others (presumably at earlier stages in recovery) expressed the desire to rebuild their lifestyle (Terry, 1999). These desires or actual changes generally involved a happier life without heroin and other substances of abuse, and with a study/work place, a new house, and/or new/improving relationships with others. Again, this finding seems to resemble the work of McIntosh and McKeganey (2002), and their spoiled identity theory. However, they do point out that this restoration cannot be achieved by the simple act of the individual declaring that they have stopped using heroin and other drugs, since it has to be built and

constantly reinforced against a variety of often powerful opposing forces. Furthermore, the importance of variations between individuals in their specific requirements for intervention must always be taken into consideration.

Researchers have reported that an equal, or greater, proportion of heroin misusers overcome heroin dependence without formal treatment intervention, as those who do recover following treatment intervention (Waldorf, 1983; Biernacki, 1979). However, the importance of treatment intervention has been emphasised in studies such as that of McIntosh and McKeganey (2002), and it has been suggested that treatment intervention may have the ability to catalyse and support natural processes of recovery (Edwards, 2000). Prochaska and DiClemente's (1992) model of change, which posits that an individual has to be ready to overcome their dependence, otherwise no interventions will affect their behaviour, support this. Furthermore, researchers have long neglected the user's perspective and experiences in assessing drug effects and drug use. In recent years, there has been a slight movement towards considering the user's views of the available treatments for opioid addiction, with attention being placed on the views and experiences of methadone and methadone programmes. Recent work, such as that of McIntosh and McKeganey (2002), has been leading the field in qualitative research into the user views of available substitute prescribing drugs and services.

Similarly, in relation to alcohol misuse, Edwards *et al.* (1997) suggest that although specific factors may influence or precipitate change, abstinence is usually best conceived as something built and secured over time, rather than achieved on a particular day. Recovery is most likely to be held onto in the longer term when the abstinate state is felt to be rewarding, with prime rewards being those that can come from a loving relationship, the discovery of a capacity for altruism, meaningful employment, hobbies, or further education and so on.

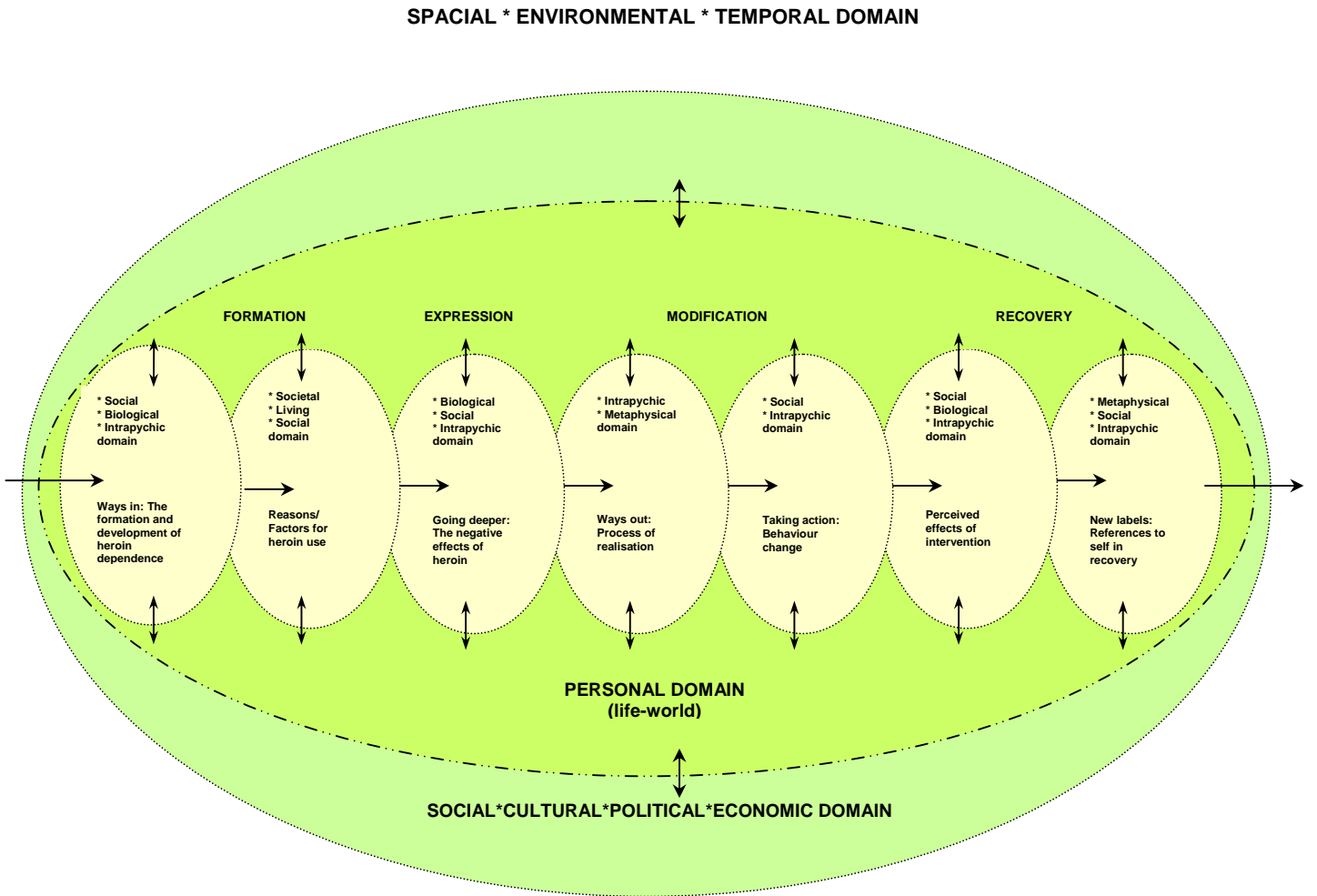
5.4 FRAMEWORK FOR THE DEVELOPMENT OF A HEROIN DEPENDENCE RECOVERY CONTEXTUAL MODEL

Based on the data analyses and the classification categories that emerged, a broad framework for the development of a model for heroin dependence recovery will be briefly outlined. This framework (see Figure 5.1, p. 196) is lacking in clarity and detail but may hopefully stimulate the development of more refined contextual domains identified in processes involved in heroin dependence recovery.

A fundamental problem identified in the development of a holistic conceptualisation of heroin dependence recovery lies within its simultaneously integrative but differential nature. In an attempt to develop a contextualised perspective of the recursive dynamics of this process, a number of interdependent domains have been identified. These include a personal domain or 'life-world', a social; cultural; political and economic domain, and the special, environmental and temporal contexts within which heroin dependants' function (van Staden, 1983).

Within the personal domain (life-worlds), the process of subjective experience in terms of the 'ways' into the formation and development of heroin dependence occurs can be described as a state of arousal within the individual that is initiated by a situational awareness of heroin (perception/appreciation/curiosity), interpreted and appraised against existing motivational intentions and then adopted. The process of interpretation requires that perceived information be filtered through a combination of personality traits and cognitive styles. While the subjective experience regarding the reasons and factors for heroin use largely occurs on a conscious level, it encompasses a range of

Figure 5.1 Framework for a holistic model of heroin dependence recovery



experiential indices that can be differentiated into at least social, biological, intrapsychic (affective and cognitive), living, behavioural and metaphysical dimensions (Jordaan & Jordaan, 1988). However, further clarity and detail on the dynamics involved, the interdependent nature of this process and its contextualisation within broader or more extended domains of heroin dependence recovery has yet to be explored.

Furthermore, the roles of both internal and external mediating factors need to be discerned regarding the formation and development of heroin dependence, the reasons and factors for heroin use and the expression of negative effects of heroin use. The relevance of intervening variables or processes may be more usefully represented as transactional functions amongst individual, social, political and situational characteristics, rather than being interpreted in terms of isolated causal processes. From the participants life-worlds emerge interpretations, expectation and cognitive restructuring which shape and influence individual processes of realisation, behaviour modification and heroin dependence recovery. The social, biological, intrapsychic, living, behavioural and metaphysical dimensions also gives rise to organisational structure which in turn impacts on any one individual recovering heroin dependants implicit/explicit development and expression of motivational intentions and identity restructuring (Jordaan & Jordaan, 1988; Grundlingh & van Staden, 1998/99).

Placing the recovering heroin dependent and collective domains within a framework of space and time provides a perspective of heroin abstinence as a contextual process, which also contains spatial, environmental and temporal domains. Its impression of the individual recovery heroin dependants' life-world can be interpreted as a developmental force in which issues such as age, past experience and encountering settings with different characteristics may help to shape the specific nature of the individual recovering heroin dependent (van Staden, 1983).

The above brief contextualisation of heroin dependence recovery emphasises the integration of personal, social, cultural, political, economic and environmental domains over time as a basic directive for research endeavours, adopting a multi-dimensional interpretation of this field.

5.5 STRENGTHS, CONSTRAINTS, LIMITATIONS AND RECOMMENDATIONS

The specific aim of this study was to conduct detailed qualitative research on the nature of the process of heroin addiction, dependence and specifically recovery, and the potential role of intervention within this. The research was exploratory in nature, and it was anticipated that by obtaining detailed reports from recovering heroin dependants, important issues would emerge that would help to provide a clearer insight into individuals' experiences of heroin dependence and recovery. Although some heroin dependants appear to recover without any recourse to treatment intervention, it is clear that many heroin dependants engage in lengthy and extensive contact with treatment agencies, and since treatment intervention is likely to be of considerable importance, at least to a proportion of heroin dependants, it is important that its potential role within the process of recovery be examined. This sort of mixed design approach needs to be adopted in individual studies with participants from a wide range of treatment services and interventions, and further analyses then undertaken across the various studies (treatment services/interventions). This allows for the enhancement and understanding of specific forms of treatment intervention, as well as about heroin dependence intervention and recovery per se. Without doubt, more effort should be made to conduct research, which focuses on directly eliciting the views of those who have experienced heroin dependence. Needless to say, further research with participants

who have recovered from heroin dependence without recourse to treatment intervention also needs to be undertaken. The recruitment of more female and ethnically representative samples and research undertaken with recovering heroin dependants who have had a long (more than five year) history of heroin dependence is an imperative.

With this particular population, problems of reliability and validity may be considerable. Clinical literature suggests that heroin dependants tend to mislead, especially those undergoing treatment intervention (Stimson, 1973). This is most likely due to situational influences; for example, heroin dependants are to a greater or lesser extent involved in illegal or quasi-legal activities and may be motivated to conceal this. None of the participants were undergoing formal treatment intervention at the time of being interviewed; it is thus anticipated that it is unlikely that participants would have had legitimate reasons for misleading the researcher. In addition to situational factors that influence the participants report, there could occur, what can be phrased as seeing past interventions through 'opiate tinted spectacles' (Stimson, 1973). This implies a general tendency to look back at the past and to interpret and attribute usually in a way that explains why an individual is the way he/she is at that present moment. Recall and perception of family, treatment interventions and so on, and the way the past is interpreted depend on individual personality. Recall of the past, subsequent interventions and perceptions of interventions could thus be influenced by popular conceptions of how dependence is explained and overcome. As the participants in the study were all recovering heroin dependants, the referral to past events was common place, which had influenced the development of their heroin dependence and their path to various interventions/treatments and recovery. Obviously such retrospective data has potential difficulties associated with it, such as the problem of recall and the possibility that events and circumstances might be reinterpreted or presented in ways that suit the individuals' current perspective/perception of self. Although it is obviously important to bear in mind any potential biases, as McIntosh and McKeganey (2002) similarly pointed out in their study, the alternative of following a cohort of recovering heroin dependants was not viable due to the length of time it would taken, the associated expense, and difficulties of following up on participants.

Triangulation is generally considered to be one of the best ways to enhance validity and reliability in qualitative research. Transcripts and analysed texts were also sent back to the participants for their comment on accuracy and possible enrichment. Peer review also aided the validity and reliability in that the researcher supervisor and co-supervisor, together with the participants, could debate the various issues in the research project and come to a consensus regarding these issues. To facilitate triangulation, interviews with heroin dependence experts can also be contrasted/ compared with that of the recovering heroin dependent in extended studies (Babbie & Mouton, 2001).

The study relied on self-report in terms remaining abstinate from active heroin use, deception on the participants' side could have occurred. However, many of the participants were acquainted with the researcher, so the researcher was able to verify in most cases, by means of urine testing and speaking to participants significant others and other recovering drug dependants who socialise in the same or related drug life-worlds, that the participants were in fact abstinate from heroin.

As misuse of heroin alone has been associated with a 14-fold increase in risk of suicide, its assessment and management by all professional staff with whom heroin dependants have contact with, must be regarded as central to general mental health care (Appleby, 2000; Neale, 2000). The assessment of each heroin dependants needs, strengths and lifestyles is necessary in order to individualise

intervention. However, the cost involved in conducting interventions and the lack of general training on the part of programme personnel makes assessment and intervention redundant (Gossop, 2003; Krivanek, 1988).

The greatest challenge in developing intervention treatment models within the South African context has been the training and accreditation of professional and lay staff that work in centres. Today the centres are co-operating in the long and complex process of setting up an accreditation board in South Africa to service this need (Hamlyn, 2000). Generally speaking, there also needs to be a lot more debate concerning harm reduction policies, world-wide and as well as in South Africa. There is also the question of ideological bias; with some treatment intervention centres believing that their programmes are the only solution for all the heroin dependants and that all other programmes are inadequate (Krivanek, 1988; Louw, 2004). However, probably the single most compelling reason for redundancy of adequate interventions in South Africa is the lack of affordable treatment centres to which heroin dependants may actually be directed. It is socially unfair, and unjust, that people with the means to book into a clinic can do so, whereas poorer heroin dependants and other addicts do not have that choice. Though there is a trend to open up state subsidised beds, however, this ought to be, but depends upon political policy.

The modern day heroin users are much more likely to come from intact families, with whom they have retained close links, even if these links have become strained. Indeed, this signifies one of the most significant differences between the new heroin users and the former generation, when heroin use was associated more with the bohemian and counter-culture. However, the dynamics of parental interaction with the heroin dependant has also been shown to have long lasting effects on the heroin dependants' emotional maturity and growth throughout the recovery period. Therapists involved in treatment and aftercare programmes that address family of origin issues, should be aware of this (Sandoz, 1991).

Although not specifically addressed by this study, future studies and intervention initiatives should also consider this aspect of incarcerated heroin dependants undergoing prison service, as prison sentences appear to be an ideal time to focus on rehabilitating heroin and drug dependants, as, in many cases, the individual has no option but to refrain from using illicit substances during their sentence. Potentially heroin drug using individuals in prison could be targeted for high level rehabilitation programmes so that on their release they are prepared with the lifestyle changes and coping mechanism that are vital in overcoming heroin dependence. By placing heroin dependent prisoners on appropriate pharmacotherapy, the chances of them using illicit substances whilst in prison are also extremely reduced, thus focus could be placed on rehabilitation.

The results of this study cannot be generalised to all recovering heroin dependants for a number of reasons. Firstly, the research contained a small sample of forty participants. Secondly, participants in the community were recruited as apposed to those undergoing clinical intervention. However, as noted by Vaillant (1996), the study of community rather than clinical samples avoids bias in that clinical samples used in many studies that are likely to be biased as they are more likely to include heroin dependants co-morbid for other disorders and they are more likely to over-sample the chronically relapsing heroin dependants. There is no doubt that this study has provided a valuable insight into this research area, as recovering heroin dependants from the community were recruited that were not affiliated to any specific treatment facility or specialised intervention. Furthermore, this study has also taken into account of the views of the actual individuals in heroin dependence recovery. A number of

interesting themes, processes and interactions have emerged, which suggests great value in continuing or extending this study further.

This study has provided important information - from recovering heroin dependants themselves - on processes in intervention, which are important for long-term abstinence and recovery from heroin dependence. This sort of research is extremely rare, which is really quite surprising given the amount of money that is poured into drug and alcohol treatment intervention in this country and further afield. If treatment delivery is to be improved and thereby a reduction in the problems that heroin dependence can cause to individuals, their families and friends, and communities a need to carry out research similar to this on a much larger scale is an imperative. This qualitative/ quantitative approach must be adopted in studies with participants from a wide range of treatment services and interventions. This should facilitate the understanding of specific forms of treatment service/intervention and the facilitation of planning and delivery of future services, treatment and recovery per se.

REFERENCES

- Adam & Eve. (2002, August). SABC Carte Blanche broadcast. Retrieved 22 January 2006 from <http://www.cartablanca.co.za>
- Alavi, N., Naicker, S., & Cassim Peer, F. (2003). *The need for a needle exchange programme for drug addicts in Centurion*. Unpublished honours dissertation, Medical University of South Africa & Technikon Pretoria: Pretoria.
- Aloni, L., & Balconi, M. (2002). Adult attachment interview, thematic analysis, and communicative styles in families with substance abuse disorders. *Psychological reports, 90*, 279-299.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders - text revision*. 4th ed. Washington, DC: American Psychiatric Association.
- Appleby, L. (2000). Drug misuse and suicide: a tale of two services. *Addiction, 95*(2), 175-177.
- Arnold, R.M., Avants, S.K., Margolin, A. & Marcotte, S.J. (2002), Patient attitudes concerning the inclusion of spirituality into addiction treatment. *Journal of Substance Abuse Treatment, 23*(4), 319-326.
- Aron, A. & Aron, E.A. (2004). *Statistics for psychology*. New Jersey: Prentice Hall.
- Babbie, E. & Mouton, J. (2001). *The practice of social research*. Oxford: University Press.
- Barlow, D.H. & Durand, V.M. (1995). *Abnormal psychology: an integrated approach*. Pacific Grove: Brooks/Cole.
- Bateson, G. (1972). *Steps to ecology of mind: collected essays in anthropology, psychiatry, evolution and epistemology*. Northvale: Jason Aronson Inc.
- Battaglia, G., Gesi, M., Lenzi, P., Busceti, C.L., Soldani, P., Orzi, F., Rampello, L., Nicoletti, F., Ruggieri, S. & Fornai, F. (2002). Morphological and biochemical evidence that apomorphine rescues striatal dopamine terminal and prevents methamphetamine toxicity. *Academic Science, 965*, 254-266.
- Baynham, S. (1998). The Nigerian Nexus. In The South African Institute of International Affairs. *The illegal drug trade in Southern Africa: international dimensions to a local crisis*. Johannesburg: Jan Smuts House.
- Bearn, J., Gossop, M., & Strang, J. (1996). Randomised double-blind comparison of lofexidine and methadone in the in-patient treatment of opiate withdrawal. *Drug and Alcohol Dependence, 43*, 87-91.
- Biernacki, P. (1986). *Pathways from heroin addiction: recovery without treatment*. Philadelphia: Temple University Press.
- Boone, R. (2001). Update from UNODCCP. In Plüddemann, A., Hon, S., Parry, C., Bhana, A., Matthysen, S., Potgieter, H., Cerff, P., & Gerber, W. *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 9)* (pp. 3-7). Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.
- Booth, M. (1996). *Opium: a history*. Retrieved 18 January 2006 from <http://opioids.com/timeline/index.html>
- Breakwell, G.M., Hammond, S., & Fife-Shaw, C. (1995). *Research methods in psychology*. London: SAGE.
- Brienza, R.S., Stein, M.D., Chen, M-H., Gogineni, A., Sobota, M., Maksad, J., Hu, P. & Clarke, J. (2000). Depression among needle exchange program and methadone maintenance clients. *Journal of Substance Abuse Treatment 18*, 331-337.
- Brits, E. (2001). 'Tussen Colesburg en Middelburg lê die hel'. *Beeld*, 18 May, p.4.
- Brownell, K., Marlatt, G., Lichtenstein, E. & Wilson, G. (1986). Understanding and preventing relapse. *American Psychologist, 41*, 765-82.

Brown, A.S. & Flemming, P.M. (1998). A naturalistic study of home detoxification from opiates using lofexidine. *Journal of Psychopharmacology*, 12, 93-96.

Burroughs, W.S. (1977). *Junky*. London: Penguin Books.

Burroughs, W.S. *Testimony concerning a sickness*. Retrieved 13 July 2004 from <http://www.artdamage.com/wsb/testimony.html>

Carnwath, T., & Hardman, J. (1998). Randomised double-blind comparison of lofexidine and clonidine in the out-patient treatment of opiate withdrawal. *Drug and Alcohol Dependence*, 50, 251-254.

Chemical forums. Retrieved on 21 January 2006 from <http://www.chemicalforums.com/index.php?page=molecules>

Clinton decries 'heroin chic' look. (1997). Retrieved 18 January 2006 from <http://opioids/heroin/heroinchic.html>

Coetzee, G. (2006, May). Heroin use shoots up. *Record*, p.3.

Coomber, R. (ed.). (1994). *Drugs and Drug Use in Society: A Critical Reader*. Greenwich University Press.

Darke, S. & Ross, J. (2000). Fatal heroin overdoses resulting from non-injecting routes of administration, NSW, Australia, 1992-1996. *Addiction*, 95(4), 569-573.

Darke, S. & Ross, J. (2000). The use of antidepressants among injecting drugs users in Sydney, Australia. *Addiction*, 95(3), 407-417.

Darke, J., Sims, J., McDonald, S., & Wickes, W. (2000). Cognitive impairment among methadone maintenance patients. *Addiction*, 95(5), 687-695.

Dawtry, F. (1968). *Social problems of drug abuse*. London: Butterworths.

De Beer, P. (2004). Problems encountered with heroin addicts. In Plüddemann, A., Hon, S., Bhana, A., Harker, N., Potgieter, H., Gerber, W., & Parry, C. (2004). *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 15)* (pp. 76-78). Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.

De Klerk, N. (2001). Veghonde begroet jou. *Beeld*, 18 May, p. 4.

De Klerk, N. & Versluis, J.M. (2001). Strafkamp 'ergste in SA'. *Beeld*, 18 May, p. 1.

De Quincey, T. (1966). *Confessions of an English opium-eater and other writings*. New York: The New American Library.

Densen-Gerber, J.M. (1973). *We mainline dreams: the Odyssey House story*. Maryland: Penguin.

Department of Health, The Scottish Office Department of Health, Welsh Office Department of Health and Social Services, Northern Ireland. (1999). *Drug misuse and dependence-guidelines on clinical management*. Norwich: The Stationary Office Limited.

Detzer, E. (1988). *Poppies: odyssey of an opium eater*. San Francisco: Mercury House, Incorporated.

Dixon, R. (2003, October). Opium production spreading in Afghanistan. *Los Angeles Times*, 5 October. Retrieved 21 January 2006 from <http://opioids.com/red.html>

Donaldson, E. (2001, October). Deliver us from evil. *Style*, pp. 30-34.

Donoghoe, M., Dorn, N., James, C., Jones, S., Ribbens, J., & South, N. (1997). How families and communities respond to heroin. In Dorn, N. & South, N. (eds.). *A land fit for heroin? Drug policies, prevention and practice* (pp. 62-94). Houndsmill: Macmillan Educational Ltd.

Dorn, N. & South, N. (1997). Reconciling policy and practice. In Dorn, N. & South, N. (eds.), *A land fit for heroin? Drug policies, prevention and practice* (pp. 62-94). Houndsmill: Macmillan Educational Ltd.

Dugmore, H. (1999, September). Heroin honeymoon, *Elle*, 4(6), pp. 64-67.

Dugmore, H. (2005, September). Cracking the addiction code. *The Sunday Independent*, p. 13.

Edwards, G. (2000). *Alcohol: The Ambiguous Molecule*. London: Penguin Books Ltd.

Edwards, G., Brown, D., Duckitt, A., Oppenheimer, E., Sheehan, M. & Taylor, C. (1987). Outcome of alcoholism: the structure of patient attributions as to what causes change. *British Journal of Addiction*, 82, 533-45.

Edwards, G., Marshall, E. & Cook, C. (1997). *The treatment of drinking problems: a guide for the helping professions*. Cambridge: Cambridge University Press.

Edwards, G., Oppenheimer, E. & Taylor, C. (1992). Hearing the noise in the system: exploration of textual analysis as a method for studying change in drinking behaviour. *British Journal of Addiction*, 87, 73-81.

Elgie, D. (1998). *The phenomenology of the decision to try heroin for the first time*. Unpublished doctoral thesis, California School of Professional Psychology: Fresno.

Els, L. & Jonker, K. (2000). *Satanism in South Africa*. Pretoria: Amabhuku Publications.

End addiction: Fight harmful laws and attitudes: mainstream and alternative treatments. Retrieved 20 October 2005 from <http://www.firehorse.com.au/addict/treatments.html>

Finnegan, F., (1995). The cognitive structure underlying heroin injecting behaviour. *Journal of Drug Education*, 25(3), 281-287.

Friday, P. J. (1992). *The lived experience of returning to heroin use after a period of abstinence: an empirical phenomenological study*. Unpublished doctoral thesis, Duquesne University: Duquesne.

Friedman, H. (2002, March). A relook at rehab. *Cosmopolitan*, 19(1), 86-88.

Friedman, H. & Oelofse, L. (2001, May 17). Boy dies at rehab centre. *Pretoria News*, p. 1.

Friedman, M. (1992). *Buried alive: the biography of Janis Joplin*. New York: Harmony Books.

Fisher, G., Johnson, R.E., Eder, H., Jagsch, R., Peternell, A., Weninger, M., Langer, M. & Aschauer, H. N. (2000). Treatment of opioid-dependent pregnant women with buprenorphine. *Addiction*, 95(2), 239-244.

Frykholm, B. (1985). The drug career. *Journal of Drug Issues*, 15, 333-46.

Gillman, M.A., & Lichtigfeld, F.J. (2004, June). *Psychotropic analgesic nitrous oxide (PAN): Out-patient treatment of substance abuse withdrawal states*. Paper presented at the Treatment Works Conference: Addictive Disorders and their Treatment Methodologies: Pretoria.

Gleeson, A. (1991). Family therapy and substance abuse. *Australian and New Zealand Journal of Family Therapy*, 12(2), 91-98.

Glossary of terms. (2005). Retrieved on 2 November 2006 from <http://www.advancedpaintreatment.com>

Goffman, E. (1963). *Stigma: notes on the management of a spoiled identity*. Englewood Cliffs, NJ: Prentice Hall.

Gonzalez, J.P. & Brogden, R.N. (1988). Naltrexone: a review of its pharmacodynamic and pharmacokinetic properties and therapeutic efficacy in the management of opioid dependence. *Drugs*, 7, 325-346.

Gossop, M. (2002). Relapse prevention. In Petersen. & McBride, A. (eds.). *Working with substance misusers: a working guide*.

- Gossop, M. (2003). *Drug addiction and its treatment*. Oxford: Oxford University Press.
- Gould, L.C., Walker, A.L., Crane, L.E. & Lidz, C.W. (1974). *Connections: notes from the heroin world*. New Haven: Yale University Press.
- Gruber, K., Chutuape, M. A., & Stitzer, M.L. (2000). Re-enforcement based intensive outpatient treatment for inner city opiate abusers: a short-term evaluation. *Drug and Alcohol Dependence*, 57, 211-223.
- Grundlingh, A. & van Staden, F. (1998/99). Motivation and swimming. *South African Journal for Research in Sport, Physical Education and Recreation*. 21(1), 31-46.
- Hamlyn, A. (2004, June). *The Minnesota Model*. Paper presented at the Treatment Works Conference: Addictive Disorders and their Treatment Methodologies, Pretoria.
- Heroin Times*. Retrieved 21 January 2006 from <http://heriontimes.com>
- Hertzman, M. (2000). Divalproex sodium to treat concomitant substance abuse and mood disorders. *Journal of Substance Abuse Treatment*, 18, 371-372.
- Hopkins, A. & Clark, D. *Using heroin, trying to stop, and accessing treatment*. Retrieved 2 November 2005 from <http://www.substancemisuse.net/pdf/nene1.pdf>
- Hosken, G. (2005, March). Drug pushers target pupils. *Pretoria News*, p. 3.
- Hunt, L.G. & Chambers, C.D. (1976). *The heroin epidemics: a study of heroin use in the United States, 1965-1975*. New York: Spectrum Publications.
- Huysamen, G.K. (1990). *Introductory statistics and research design for the behavioural sciences (vol. I)*. Cape Town: H&R Academica.
- Huysamen, G.K. (1989). *Introductory statistics and research design: for the behavioural sciences (vol. II)*. Cape Town: H&R Academica.
- Illinois Economic and Fiscal Commission. (1975). *Drug abuse programs: an evaluation*. Springfield: Illus.
- James, A (ed.). (1998, March 31). PAN treatment safest, most effective. *Pretoria News*, p. 14.
- James, A (ed.). (1998, March 31). Denial of addiction the stumbling block - Zuma. *Pretoria News*, p. 12.
- James, L. & Clark, P. *Methadone versus subutex: recovering heroin users, views on substitute prescribing*. Retrieved 28 May 2006 from <http://www.substancemisuse.net>
- Jordaan, W.J. & Jordaan, J. (1988). *People in context* (3rd ed.). Johannesburg: Heinemann Higher & Further Education (Pty) Ltd.
- Kaplan. J. (1983). *The hardest drug: heroin and public policy*. Chicago: The University of Chicago Press.
- Kellogg, S. (1993). Identity and recovery. *Psychotherapy* 30(2), 235-245.
- Kenny, M. (1999). *Death by heroin recovery by hope*. Dublin: New Island Books.
- Kohn, M. (1987). *Narcomania on heroin*. London: Faber & Faber limited.
- Krivanek, J. (1988). *Heroin: myths and reality*. Sydney: Allen & Unwin.
- Kruger, G. (1996, January). Dwelms: SA is besig on die stryd te veloor. *Beeld*, pp. 8-9.
- Kwiatkowski, C.F., Booth, R.E., & Lloyd, L.V. (2000). The effects of offering free treatment to street-recruited opioid injectors. *Addiction*, 95(5), 697-704.

- Langendam, M.W., van Brussel, G.H.A., Coutinho, R.A. & van Ameijden, E.J.C. (2000). Methadone maintenance and cessation of injecting drug use: results from the Amsterdam cohort study. *Addiction*, 95(40), 591-600.
- Larmier, M., Palmer, R. & Marlatt, A. (1999). Relapse prevention: an overview of Marlatt's cognitive-behavioural model. *Alcohol Research and Health*, 23(2), 151-159.
- Leggett, T. (2000). *The drug markets of Johannesburg*. Unpublished manuscript.
- Leggett, T. (2001). *Rainbow vice: the drugs and sex industries in the new South Africa*. Claremont: David Philip.
- Leggett, T. (2002). A den of iniquity? Inside Hillbrow's residential hotels. *SA Crime Quarterly*, 2. Retrieved 12 October 2005 from <http://www.iss.co.za/pubs/CrimeQ/No.2/Contents.html>
- Leshner, A.I. (1999). Drug abuse and mental disorders: comorbidity is reality. *NIDA Notes*, 14(4), 3-4.
- Lotringer, S. (2001). *Burroughs live: the collected interviews of William S. Burroughs: 1960-1997*. Los Angeles: Semiotext (e).
- Louw, D.A.P. (1992). *Abnormale gedrag*. Halfweghuis: Southern Boekuitgewers.
- Louw, S. (2004). *Opvoedkundige-sielkundige kriteria vir die evaluering van rehabilitasieprogramme vir dwelmafhanglike adolessente in Suid-Afrika (Educational-psychological criteria for the evaluation of rehabilitation programmes for adolescent drug addicts in South Africa)*. Unpublished doctoral thesis, Rand Afrikaans University: Johannesburg.
- Maddox, F.J., & Desmond, D.P. (1980). New light on the maturing out hypothesis in opioid dependence. *United Nations Office on Drugs and Crime*, 15-25.
- Marlatt, A. & Gordon, J. (1985). *Relapse Prevention*. New York: Guilford.
- McBride, A. (2002). *Client assessment*. In Petersen & McBride, A. (eds.). *Working with Substance Misusers: A Working Guide*.
- McIntosh, J. & McKeganey, N. (2002). *Beating the Dragon: The recovery from dependent drug use*. Prentice Hall.
- Miller, M.S. (1999). *The shamanic drum journey with chemically addicted men: an exploratory phenomenological study of an adjunctive intervention*. Unpublished doctoral thesis, Institute of Integral Studies: California.
- Miller, W. (1983). Motivational Interviewing with problem drinkers. *Behavioural Psychotherapy*, 11, 147-72.
- Miller, W. (1993). Behavioural treatments for drug problems: where do we go from here. In *Behavioural Treatments for Drug Abuse and Dependence*. NIDA Research Monograph, 137, 303-21. Rockville, MD: National Institute of Drug Abuse.
- Miller, W. & Rollnick, S. (1991). *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. New York: Guilford.
- Minnesota AIDS Project. (March, 1995). *Mainline stories: Tyrone and Billy Shoot Safe*. Minnesota: Minnesota AIDS Project.
- Moore, K. (2004). McLean pain doctor sent to prison. *The Connection Newspaper*, 21 December. Retrieved 21 January 2006 from <http://opioids.com/red.html>
- Narcotics Anonymous World Service. (2003). *Narcotics Anonymous*. Chatsworth: Narcotics Anonymous World Services, Inc.
- National Drug Master Plan: Republic of South Africa 1999 - 2004*. Pretoria: Drug Advisory Board.

National Institute on Drug Abuse. (2000, September). *Research Report Series Heroin Abuse and Addiction*. U.S. Department of Health and Human Sciences: National Institute of Health.

Neale, J. (2000). Suicidal intent in non-fatal drug overdose. *Addiction*, 95(1), 85-93.

Nestler, E.J., & Malenka, R.C. (2004). The addicted brain. *Popular Mechanics*, 2(11), 30-39.

Opioid images. Retrieved 18 January 2006 from <http://opioids.com/images/index.html>

Oliver, C. (2004). Iran opium addicts find supplies despite earthquake. *Reuters*, 3 January. Retrieved 21 January 2006 from <http://opioids.com/red.html>

Oliveira, M.T., Rego, C.C., Morgadinho, M.T., Macedo, T.R. & Oliveria, C.R. (2002). Toxic effects of opioid and stimulant drugs on undifferentiated PC12 cells. *Academic Science*, 965, 487-496.

Oxford Advanced Learner's Dictionary 6th ed. (2000). Oxford: Oxford University Press.

OxyCotin: oxycodone hydrochloride c-11. (2005). Retrieved 21 January 2005 from <http://opioids/oxycodone/prescribe/html>

Parker, H.J., Bakx, K., & Newcombe, R. 1988. *Living with heroin: the impact of a drugs 'epidemic' on an English Community*. Buckinghamshire: Open University Press.

Parry, C., & Louw, A. (2001). 3-Metro Arrestee Study - Phase 3. In Plüddemann, A., Hon, S., Parry, C., Bhana, A., Matthysen, S., Potgieter, H., Cerff, P., & Gerber, W. *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 9)* (pp13-14). Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.

Pearson, G. (1987). *The new heroin users*. Oxford: Basil Blackwell Ltd.

Pearson, G. (1997). Social deprivation, unemployment and patterns of heroin use. In Dorn, N. & South, N. (eds.), *A land fit for heroin? Drug policies, prevention and practice* (pp. 62-94). Houndsmill: Macmillan Educational Ltd.

Petrakis, I.L., Carroll, K.M., Nich, C., Gordon, L.T., McCance-Katz, E.F., Frankforter, T., & Rounsaville, J. (2000). Disulfiram treatment for cocaine dependence in methadone-maintained opioid addicts. *Addiction*, 95(2), 219-228.

Petry, N.M. (2000). Effects of increasing income on polydrug use: a comparison of heroin, cocaine and alcohol abuse. *Addiction*, 95(5), 705-717.

Plant, S. (1999). *Writing of drugs*. London: Faber & Faber.

Plüddemann, A. (2004). The nature and extent of heroin use in Cape Town. In Plüddemann, A., Hon, S., Bhana, A., Harker, N., Potgieter, H., Gerber, W., & Parry, C. *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 15)* (pp. 22-23). Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.

Plüddemann, A., Hon, S., Parry, C., Bhana, A., Matthysen, S., Potgieter, H., Cerff, P., & Gerber, W. (2001). *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 9)*. Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.

Plüddemann, A., Hon, S., Parry, C., Bhana, A., Matthysen, S., Potgieter, H., Cerff, P., & Gerber, W. (2002). *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 11)*. Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.

Plüddemann, A., Hon, S., Bhana, A., Harker, N., Potgieter, H., Gerber, W., & Parry, C. (2003). *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 15)*. Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.

- Plüddemann, A., Hon, S., Bhana, A., Harker, N., Potgieter, H., Gerber, W., & Parry, C. (2004). *South African Community Epidemiology on Drug Use (SACENDU): monitoring alcohol and drug abuse trends (phase 16)*. Tygerberg: Medical Research Council: Alcohol & Drug Abuse Research Group.
- Plüddemann, A., Parry, C., Bhana, A., Harker, N., Potgieter, H. & Gerber, W. (2004). *SACENDU research brief: 7(1)*. Tygerberg: Medical Research Council.
- Plüddemann, A., Parry, C. & Flisher, A. J. (2004). *The nature and extent of heroin use in Cape Town. Part 1: a pilot study*. Alcohol & Drug Research Group: Medical Research Council & Department of Psychiatry and Mental Health and Adolescent Health Research Institute: University of Cape Town.
- Practitioner*, (2001). Heroin use in South Africa. Fact Sheet 2, 2(1), pp. 38-41. Central Drug Authority & National Institute on Drug Abuse; Research Report Series Heroin Abuse and Addiction. (2000, September). U.S. Department of Health and Human Sciences.
- Prins, E. (1995). *Maturing out: an empirical study of personal histories and processes in hard-drug addiction*. Van Gorcum.
- Prochaska, J., DiClemente, C. & Norcross, J. (1992). In search of how people change; applications to addictive behaviours. *American Psychologist*, 47(9), 1102-14.
- Ravesafe: Kat essential information*. Retrieved 19 March 2006 from <http://www.ravesafe.org>
- Rawson, R.A., Hasson, A. L., Huber, A.M., McCann, M.J. & Ling, W. (1998). A 3-year progress report on the implementation of LAAM in the United States. *Addiction*, 93, 533-540.
- Reber, A.S. (1985). *The penguin dictionary of psychology*. London: Penguin books.
- Restorative Justice Centre: an introduction*. (2005).
- Risser, D., Uhl, A., Stichenwirth, M., Höningschnabl, S., Hirz, W., Schneider, B., Stellwag-Carion, C., Klupp, N., Vycudilik, W & Bauer, G. (2000). Quality of heroin and heroin-related deaths from 1987 to 1995 in Vienna, Austria. *Addiction*, 95(3), 375-382.
- Robertson, R. (1987). *Heroin, AIDS and society*. London: Hodder & Stoughton.
- Rocha-Silva, L. (1998). *The nature and extent of drug use and the prevalence of related problems in South Africa: a national surveillance*. Pretoria: HSRC.
- Rocha-Silva, L., de Miranda, S., & Erasmus, R. (1996). *Alcohol, tobacco and other drug use among black youth*. Pretoria: HSRC Publishers.
- Robins, L. (1993). Vietnam veterans' rapid recovery from heroin addiction: a fluke or normal expectations? *Addiction*, 88, 1041-54.
- Rothman, R.B., Gorelick, D.A., Heishman, S.J., Eichmiller, P.R., Hill, B. H., Norbeck, J. & Liberto, J.G. (2000). An open-label study of a functional opioid K antagonist in the treatment of opioid dependence. *Journal of Substance Abuse Treatment*, 18, 277-281.
- Rudgley, R. (1998). *The encyclopaedia of psychoactive substances*. New York: St Martin's Press.
- Sadock, B.J. & Sadock, V.P. (2003). *Synopsis of psychiatry: behavioural sciences/clinical psychiatry*. Philadelphia: Lippincollf Williams & Wilkens.
- Sakol, M.S., Stark, C., & Sykes, R. (1989). Buprenorphine and temazepam abuse by drug takers in Glasgow - an increase. *British Journal of Addiction*, 84, 439-441.
- Salter, G., Davies, S. & Clark, D. (2006). *Recovery from addiction and the role of treatment processes*. Retrieved 16 November 2006 from <http://www.substancemisuse.net>
- SANCA: Ahanang Correctional Services project*. (2004, May). Johannesburg: SANCA National Directorate.

Sandoz, C.J. (1991). Locus of control, emotional maturity and family dynamics as components of recovery in recovering alcoholics. *Alcoholism Treatment Quarterly*, 8(4), 17-31.

Sayre, L., Cornille, T.A., Rohrer, G & Hicks, M.W. (1992). Family outreach residential addiction treatment: changes in addicts' beliefs about social support. *Alcoholism Treatment Quarterly*, 9(1), 51-66.

Schauffer, A. (1998, January). Toughlove. *Your Family*, p. 6-8.

Scher, M. (2000, August). Heroin hell. *Fairlady*, 735, pp. 30-32.

Schottenfeld, S.S., Pantalon, M.V., Chawarski, M.C., & Pakes, J. (2000). Community reinforcement approach for combined opioid and cocaine dependence: patterns of engagement in alternate activities. *Journal of Substance Abuse Treatment*, 18, 255-261.

Shaffer, H. (1992). The psychology of stage change: the transition from addiction to recovery. In Lowinson, J., Ruiz, P., Millman, R., & Langrod, J. (eds.) *Substance Abuse: A Comprehensive textbook*. Williams & Wilkins.

Shaffer, H. & Jones, S. (1989). *Quitting Cocaine: The Struggle Against Impulse*. Lexington: Massachusetts.

Sheridan, M.J. (1994). A proposed intergenerational model of substance abuse, family functioning, and abuse/neglect. *Child Abuse & Neglect*, 19(5), 519-530.

Simpson, D., Joe, G., Lehman, W. & Sells, S. (1986). Addiction careers: etiology, treatment and 12 year follow up outcomes. *The Journal of Drug Issues*, 16(1), 107-21.

Singer, K. (1975). *The prognosis of narcotic addiction*. London: Butterworths.

Smart, R. (1994). Dependence and correlates of change: a review of the literature. In Edwards, G., Lader, M. (eds.). *Addiction: Processes of Change*. Oxford: Oxford University Press.

Smetherham, J. (2001, January). Claws of the white dragon. *The Big Issue*, pp 1-2.

Smetherham, J. (2002, 18 June). How heroin is taking hold in city. *Cape Times*, pp1.5.

Smillie, S. (2000). Heroin wave swamps SA youth. *Star*. 18 March, pp.1-2.

Smith, D.E. & Grey, G.R. (1972). *'It's so good. Don't even try it once'*. *Heroin in perspective*. New Jersey: Prentice-Hall.

Stall, R. & Biernacki, P. (1986). Spontaneous remission from the problematic use of substances: an induction model derived from a comparative analysis of the alcohol, opiate, tobacco, and food/obesity literatures. *International Journal of Addictions*, 21, 1-23.

Stimmel, B. (1975). *Heroin dependency*. Stratton Intercontinental Medical Book Corporation: New York.

Stimson, G.V. (1973). *Heroin and behaviour*. Shannon: Irish University Press.

Stimson, G.V. & Oppenheimer, E. (1982). *Heroin addiction: treatment and control in Britain*. London: Tavistock Publications.

Strümpfer, D.J.W. (2002). *Psychofortology: review of a new paradigm marching on*. Working paper under revision: Department of Psychology, University of Pretoria & Rand Afrikaans University.

Substance Misuse Lectures. Retrieved 14 June 2005 from <http://www.substancemisuse.net/problem.users/puaboutdrugs/aboutdrug.htm>

Subutex: Buprenorphine, GP Product Brochure. (2002). Woodmead: Schering-Plough (Pty) Ltd.

Swain, R.C., Oetting, E.R., Thurman, P.J., Beauvais, F. & Edwards, R.W. (1993). American Indian adolescent drug use and socialization characteristics. *Journal of Cross-Cultural Psychology*, 24(1), 53-70.

Szasz, T. (1990). Prologue. In Wistosky, S. *Beyond the war on drugs: overcoming a failed public policy*. New York: Prometheus Books.

Terry, C. M. (1999). *Transcending prisonization and addiction: a study of identity transformation*. Unpublished doctoral thesis, University of California: Irvine.
TCU Methadone Outpatient Forms: Intake. Retrieved 14 August 2000 from <http://www.drugtext.org/library/bookmenu.htm>

The free dictionary. Retrieved 10 June 2006 from <http://encyclopedia.thefreedictionary.com/atropine>

The Professional Board of Psychology, Health Professions Council of South Africa, Ethical Code of Professional Conduct. (2002, April). Pretoria: Health Professions Council of South Africa.

The specialized vocabulary of the heroin subculture. Retrieved 29 October 2005 from <http://heroinhelper.com>

United Nations Office on Drugs and Crime. (2002). *South Africa: country profile on drugs and crime*. Pretoria: United Nations Office on Drugs and Crime.

United Nations Office on Drugs and Crime. (2004). *World Drug Report 2004*. Vienna: United Nations Office on Drugs and Crime.

Urban Dictionary. Retrieved 19 March 2006 from urbandictionary.com/define.php?term=methamphetamine

Vaillant, G. (1983). *The Natural History of Alcoholism*. Cambridge, MA: Harvard University Press.

Vaillant, G. (1996). Addictions over the life course: therapeutic implications. In Edwards, G. & Dare, C. (eds.) *Psychotherapy, psychological treatments and the addictions*. Cambridge: Cambridge University Press.

Van Eeden, E. (2001). *Drugs: facts, arguments and practical advice*. Doctors for life.

Van Staden, F. (1983). From crowding to density: conceptual developments, methods and research. *South African Journal of Psychology*, 13(4), 128-133.

Viega, J. (2005). Heroin addiction gene identified and blocked. *New Scientist*, 31 May. Retrieved 21 January 2006 from <http://opioids.com/red.html>

Waldorf, D. (1970). Life without heroin: some social adjustments during long-term periods of voluntary abstinence. *Social Problems*, 18(2), 229-243.

Waldorf, D. (1983). Natural recovery from opiate addiction: some social-psychological processes of untreated recovery. *Journal of Drug Issues*, 13(2), 237-280.

Waldorf, D. & Biernacki, P. (1981). The natural recovery from heroin addiction: a review of the incidence literature. *Journal of Drug Issues*, 11(1), 61-76.

Webster Dictionary. Retrieved 19 March 2006 from <http://www.websterdictionary.org/definition/Agent/00Orange>

Welsh, I. (1993). *Trainspotting*. London: Martin Secker & Warburg Ltd.

Wilde, O. (1891). The picture of Dorian Grey. In *Collected works of Oscar Wilde*. (1997). Hertfordshire: Wordsworth Editions Limited.

What Definition. Retrieved 19 March 2006 from <http://what-definition.com/xanax>

Whitaker, R. (2001). Taliban prepare to unleash their deadliest weapon. *The Independent*, 2 October. Retrieved 21 January 2006 from <http://opioids.com/red.html>

White, T. (1999). Heroin use as a passive behaviour. *Transactional Analysis Journal*, 29(4), 273-277.

Wikipedia: The Free Encyclopaedia. Retrieved 13 February 2006 from <http://en.wikipedia.org/wiki>

Winick, C. (1962). Maturing out of narcotics addiction. *UN Bulletin on Narcotics*, 14, 1-7.

Wistosky, S. (1990). *Beyond the war on drugs: overcoming a failed public policy*. New York: Prometheus Books.

Words Universe. Retrieved 19 March 2006 from <http://www.words.universe.com/definition/belladonna>

Zandor, D. & Sunjic, S. (2000). Deaths in methadone maintenance treatment in New South Wales, Australia 1990-1995, *Addiction*, 95(1), 77-84.

Zechmeister, E.B. & Shaughnessy, J.J. (1995). *Research methods in psychology*. New York: McGraw-Hill.

Zickler, P. (1999). High-dose methadone improves treatment outcomes. *National Institute on Drug Abuse: Articles that address research on heroin*, 14(5), 11-12.

	<p>Needle sharing. Inadequate methods of needle sterilisation. Needle exchange programmes. Risk of contracting HIV/AIDS, hepatitis and other blood borne diseases. Overdose/death. Death due to violence. Personal consequences/self-care.</p> <p>Negative feelings/emotions. Numbness. Suicidal/didn't care if dead. General emotional effects. Psychological consequences. Co-morbid psychological disorders. Operant conditioning.</p> <p>General effects. Loose relationship/contact.</p> <p>Isolation. Negativity from society. Stigmatisation. Less socially active. Changing social circles.</p> <p>Employment/jobs. Neglect of practicalities. Lack of responsibility. Practical consequences.</p>	<p>Emotional/psychological</p> <p>Relationships</p> <p>Social</p> <p>Practical</p>
<p>Ways out: Process of realisation</p>	<p>Unaware of problem. Factors influencing realisation. Series of realisations. Difficulty in accepting heroin use problem and admitting it to others. Sudden realisation of problem. Factors influencing acceptance of heroin misuse problem. Clearer awareness. Maturing out phenomenon. Continued use despite awareness.</p>	
<p>Taking action: Behaviour change</p>	<p>Serious. Non-serious/temporary.</p> <p>Realisation of problem. Belief in oneself. Importance of family/children. Negative effects of heroin use. Access treatment as cannot change independently. Unable to detox independently. Process of behaviour modification.</p>	<p>Types</p> <p>Influencing factors</p>

	<p>Practical and geographic constraints.</p> <p>Heroin dependence influence on a spiritual level. Spirituality in broad sense. Spirituality as crucial factor in recovery. Spiritual conversions.</p> <p>Continued use rather than change. Tired, sick and almost dead. Change rather than continued use.</p> <p>Barriers to change.</p>	<p>Spirituality</p> <p>Decisional balances</p> <p>Barriers</p>
<p>Perceived effects of intervention</p>	<p>Various improvements. Improved coping mechanisms and self efficacy. Altering person/perspective/life. Special needs in terms of intervention. High level early interventions. Cumulative effect of intervention.</p> <p>Common experience. Safe/protected environment. Specialised intervention/treatment structure. Long term residential intervention. Sufficient time to facilitate change. Difficulty in reintegration. Long-term care. Medium/short term residential intervention. Chronicity of heroin dependence linked to duration of intervention. Outpatient intervention. Heroin abstinence without formal intervention. Intervention success determined by individual choice. Life-long commitment to recovery. Personal factors. High level early interventions preventing chronic heroin dependence. Empathetic/ understanding environment. Hope. Counseling. Co-dependent recovery. Medical sector facilitating de-stigmatisation. Support. Education regarding heroin dependence. Holistic approach. Alternative therapies/activities.</p> <p>Accessed at rock bottom. Feeling nervous/scared at start. Uncertainty of expectations. False belief in a miracle cure. Barriers to accessing treatment.</p>	<p>Positive effects</p> <p>Positive/important components</p> <p>Accessing/commencing treatment intervention</p>

	<p>Medication for withdrawal during recovery process. Methadone. Buprenorphine. Clonidine. Tranquillisers/sedatives. Anti-depressant medication. Ambivalence toward substitute prescribing. Medication only for acute withdrawal.</p> <p>Acceptance of complete abstinence. Substitution.</p> <p>Negative /unsuccessful experiences. Contradictions within treatment services. Intervention not intense or long enough. Lack of alternative activities or education. Inadequate therapeutic skills. Lack of individualistic intervention. Evasive attitude toward addiction/dependence. Contradictions within treatment services. Substitute medication prolongs or postpones withdrawal symptoms. View of medication as substitution. Pharmacological intervention of no use. Lack of medical intervention. Negative experiences re-emphasise the importance of appropriate structure of intervention.</p>	<p>Medical intervention</p> <p>Difficulties of treatment</p> <p>Negative/unsuccessful treatment intervention</p>
<p>New labels: References to self in recovery</p>	<p>Intervention/treatment. Personal requirements. Complete abstinence. Other factors.</p> <p>Continued use of aftercare/self-help group/counselling. Safe environment to return to. Narcotic Anonymous. Tough/love. Strategies against continued use. Expectance/coping of cravings. One day at a time. Motivating factors. Holistic approach.</p> <p>Identity restructuring the either excludes or depreciates old values. New lifestyle.</p>	<p>Factors/requirements for heroin dependence recovery</p> <p>Aids to recovery</p> <p>Changes in recovery</p>

APPENDIX B

DEFEATING THE DRAGON: HEROIN DEPENDENCE RECOVERY

INFORMED CONSENT FORM

You are invited to participate in this research study, in fulfilment of an MA (SS) (Psychology) degree in the Department of Psychology, University of South Africa, which explores your views regarding heroin dependence recovery. Your perception as to the extent that psychosocial and/or medical/pharmacological intervention was able to assist you within the recovery process is also to be explored.

The study comprises two parts, namely:

- * a sociodemographic background questionnaire;
- * a tape-recorded interview.

All information you contribute will be held in strict confidence within the limits of the law (see attached Confidentiality Statement). The results will be kept in a locked cabinet for three years upon completion of the study to which only the researcher has access. After three years all data will be destroyed. All data will be identified by numbers only. All identifying information will be deleted when direct quotes are used in the dissertation. No identifying information will be included in the dissertation itself. Your request to omit from the dissertation particular details that you specify to the researcher will be honoured.

You have the right to:

1. be treated with dignity and respect;
2. be given a clear description of the purpose of the study and what is expected of you as a participant;
3. be told of any benefits or risks to you that can be expected from participating in the study;
4. know the research psychologist's training and experience;
5. ask any questions you may have about the study;
6. decide to participate or not without any pressure from the researcher;
7. have your privacy protected within the limits of the law;
8. refuse to answer any research questions, refuse to participate in any part of the study, or withdraw from the study at any time without any negative effects to you;
9. be given a description of the overall results of the study upon request;
10. discuss any concerns or file a complaint about the study with the study's supervisor, Professor FJ van Staden, Ethics Committee of the Department of Psychology, PO box 392 UNISA, 0003.

Please note the following:

1. participation in the study is voluntary;
2. you have the right to refuse to answer particular question(s) or to discontinue participation at any time;
3. there is no form of direct benefit;
4. you will receive a copy of this consent form;
5. risks in participating in this study include the following:
 - * you may be exploring personal psychological areas that you may have never explored before;
 - * there may be questions which you find distressful or difficult to answer;
6. the completion of the questionnaire and interview should not exceed two hours;
7. you will receive, on request, a copy of the summary of the study's results.

The researcher, Monika dos Santos, will be available before, during or after the interviewing process to talk to you about your concerns, and to facilitate referrals to supervisors, consultants, or therapists if such a need should arise.

CONFIDENTIALITY STATEMENT

Your privacy with respect to information you disclose during participation in this study will be protected within the limits of the law. However, there are circumstances where a psychologist is required by law to reveal information, usually for the protection of a patient, research participant, or others. A report to the police department or the appropriate protective agency is required in the following cases:

1. if in the judgement of the psychologist, a patient or research participant becomes dangerous to himself/herself or others (or their property), and revealing the information is necessary to prevent danger;
2. if there is suspected child abuse, in other words, if the child is under 18 and has been a victim of crime or neglect;
3. if there is suspected elder abuse, in other words, if a male or female aged 60 or older has been a victim of crime or neglect.

If a report is required, the psychologist will discuss its contents and possible consequences with the patient or research participant.

I, _____, consent to participate in the above-mentioned study. I have received a copy of this consent form and the Confidentiality Statement, and I understand that my confidentiality will be protected within the limits of the law.

Research participant

Date

Witness

Date

Witness

Date

If the respondent is under the age of 18:

I, _____, parent/legal guardian/authorised representative of the above-mentioned participant, give consent that he/she may participate in the study. I have received a copy of this consent form and the Confidentiality Statement, and I understand that his/her confidentiality will be protected within the limits of the law.

Parent\ legal guardian\ authorised representative

Date

Witness

Date

Witness

Date

APPENDIX C

QUESTIONNAIRE FOR RESEARCH STUDY: 'DEFEATING THE DRAGON: HEROIN
DEPENDENCE RECOVERY'

ADMINISTERED AND COMPLETED BY RESEARCHER

RECOVERING HEROIN DEPENDANT**A. SOCIODEMOGRAPHIC INFORMATION**

1. AGE: _____

2. GENDER: *Female/Male*

3. RACE/ETHNICITY:

- | | |
|-----------------|--------------------|
| 1. <i>Black</i> | 4. <i>Coloured</i> |
| 2. <i>White</i> | 5. <i>Indian</i> |
| 3. <i>Asian</i> | |

4. AREA OF PERMANENT RESIDENCE: _____

5. WHERE HAVE YOU BEEN LIVING OR STAYING MOST OF THE TIME IN THE LAST YEAR?

- | | |
|---|---|
| 1. <i>With family or other relatives</i> | 5. <i>Hospital, rehabilitation facility, nursing home</i> |
| 2. <i>With group of friend(s) or non-family members (non-institutional)</i> | 6. <i>Jail, prison, or other correctional facility</i> |
| 3. <i>Alone in own dwelling</i> | 7. <i>Other (specify):</i> |
| 4. <i>Homeless</i> | |

6. CURRENT LEGAL STATUS:

- | | |
|---|-------------------------------|
| 1. <i>On probation only</i> | 5. <i>Outstanding warrant</i> |
| 2. <i>On parole only</i> | 6. <i>Case pending</i> |
| 3. <i>On probation and parole</i> | 7. <i>Other (specify):</i> |
| 4. <i>Awaiting charge, trial, or sentence</i> | 8. <i>Not applicable</i> |

7. CURRENT LEVEL OF EDUCATION

- | | |
|----------------------|--------------------------------|
| 1. <i>Illiterate</i> | 9. <i>Grade 8</i> |
| 2. <i>Grade 1</i> | 10. <i>Grade 9</i> |
| 3. <i>Grade 2</i> | 11. <i>Grade 10</i> |
| 4. <i>Grade 3</i> | 12. <i>Grade 11</i> |
| 5. <i>Grade 4</i> | 13. <i>Grade 12</i> |
| 6. <i>Grade 5</i> | 14. <i>Tertiary (specify):</i> |
| 7. <i>Grade 6</i> | 15. <i>Other (specify):</i> |
| 8. <i>Grade 7</i> | |

How many years of schooling have you completed? _____

8. EMPLOYMENT STATUS:

- | | |
|--|-------------------------|
| 1. <i>Unemployed</i> | 3. <i>Part-time job</i> |
| 2. <i>Occasional or irregular work</i> | 4. <i>Full-time job</i> |
| 5. <i>Scholar/Student</i> | |

9. IF UNEMPLOYED, STATE REASON:

1. *Did not try to find work*
2. *Tried but couldn't find work*

3. *Unable to work due to alcohol and drug problems*
4. *Unable to work due to other health problems*
5. *Needed at home*
6. *Other (specify):* _____

10. FAMILY BACKGROUND

- a. Are your natural parents currently alive?

MOTHER: No Yes Unknown
 FATHER: No Yes Unknown

- b. Were they ever divorced or separated from each other: No/Yes

- c. What were your mother and father like while you were growing up?

Using answers from this table, how often would you say your mother/father:

ASK 'MOTHER', THEN 'FATHER'	MOTHER (NATURAL/STEP)					FATHER (NATURAL/STEP)				
	NEVER.....	ALWAYS	NEVER.....	ALWAYS
1. was employed?	1	2	3	4	5	1	2	3	4	5
2. supported your family with money?	1	2	3	4	5	1	2	3	4	5
3. spent enough time with you?	1	2	3	4	5	1	2	3	4	5
4. yelled at you or had loud arguments with you?	1	2	3	4	5	1	2	3	4	5
5. hit you very hard?	1	2	3	4	5	1	2	3	4	5
6. made you engage in sexual acts against your will?	1	2	3	4	5	1	2	3	4	5
7. got drunk?	1	2	3	4	5	1	2	3	4	5
8. used other psychoactive drugs?	1	2	3	4	5	1	2	3	4	5
9. did things against the law?	1	2	3	4	5	1	2	3	4	5
10. spent time in jail or prison?	1	2	3	4	5	1	2	3	4	5
11. was a good parent?	1	2	3	4	5	1	2	3	4	5
12. was very strict?	1	2	3	4	5	1	2	3	4	5
13. really loved you?	1	2	3	4	5	1	2	3	4	5

- d. Were the parents you described your:

1. *Natural mother* 2. *Stepmother* 3. *Other*
 1. *Natural father* 2. *Stepfather* 3. *Other*

11. CURRENT LEGAL MARITAL STATUS:

1. *Never married*
2. *Legally married*
3. *Living as married*
(including common law marriage)
4. *Separated*
5. *Divorced*
6. *Widowed*

Please elaborate on your marital status history: _____

12. TYPE OF PSYCHOSOCIAL INTERVENTION UNDERTAKEN:

Please tick as many as required:

- | | |
|---|--|
| 1. None | 5. Halfway House
(specify):
approximate date/s: |
| 2. In-patient, short term
(less than two months)
(specify):
approximate date/s: | 6. Narcotics Anonymous
approximate date/s: |
| 3. In-patient, long term
(longer than two months)
(specify):
approximate date/s: | 7. Other self-help groups/after-care
(specify):
approximate date/s: |
| 4. Out-patient
(specify):
approximate dates: | 8. Correctional Services intervention
(specify):
approximate date/s: |

Please specify, in chronological order, the facilities where you have undergone psychosocial interventions:

13. TYPE OF MEDICAL INTERVENTION UNDERTAKEN:

Please tick as many as required:

- | | |
|--|--|
| 1. None
(‘cold turkey’ - no withdrawal symptoms)
approximate date/s: | 6. Buprenorphine
approximate date/s: |
| 2. None
(‘cold turkey’ - withdrawal symptoms)
approximate date/s: | 7. Sedatives
approximate date/s: |
| 3. Methadone for detoxification
approximate date/s: | 8. Benzodiazepines/ Tranquillisers:
approximate date/s: |
| 4. Methadone maintenance
approximate date/s: | 9. DPN infusion
approximate date/s: |
| 5. Naltrexone
approximate date/s: | 10. Anti-depressants
approximate dates/s: |
| | 11. Other
(specify): |

Please specify, in chronological order, the types of medical interventions you have undergone:

14. SUBSTANCE ABUSE HISTORY:

a. How long have you been using heroin? _____

b. When you were abusing heroin, what were your modes of ingestion?

- | | |
|--------------------------------|---------------------|
| 1. Smoked (‘chasing’) | 4. Snorted |
| 2. Intravenous (IV, ‘spiking’) | 5. Swallowed |
| 3. Intramuscular (IM) | 6. Other (specify): |

c. What was your primary method of ingestion? _____

- d. How often were you abusing heroin?
1. *daily (approximately how many times?):*
 2. *weekly (approximately how many times?):*
 3. *monthly (approximately how many times?):*
- e. How many times have you quit heroin
1. *on your own 'cold turkey'?*
 2. *in a treatment programme?*
 3. *in jail/prison?*
 4. *some other way? (specify):*
- f. Have you ever quit heroin for a year or longer? No/Yes
Approximate date/s and length of 'clean' period/s: _____
- g. Have you abused any other psychoactive substances during your one year and longer periods of remaining 'clean' from heroin? No/Yes
- If YES, please tick all the substances abused:*
1. *Alcohol*
 2. *Inhalants (glue, Benzene, lighter gas etc.)*
 3. *Cannabis/Hashish*
 4. *Mandrax/ Cannabis combination (white-pipe)*
 5. *Hallucinogens (LSD/psychedelics/mushrooms/Peyote/PCP)*
 6. *Crack Cocaine*
 7. *Cocaine (by itself)*
 8. *Methadone*
 9. *Other Opiates (Opium, Codeine, Morphine, Demerol/Darvon)*
 10. *Methamphetamine (Speed, Ice, Ecstasy)*
 11. *Other Amphetamines (uppers/diet pills)*
 12. *Methcathinone (Cat/Khat)*
 13. *Librium/Xanax/Valium/Minor Tranquillisers*
 14. *Barbiturates*
 15. *Other Sedatives/Hypnotics*
 16. *Other (specify):* _____
- h. Were you undergoing any type of psychosocial intervention during these one year and longer periods of remaining 'clean' from heroin'? No/Yes
- If YES, please specify approximate date/s, length and type of intervention:*
- _____
- _____
- _____
- i. Were you using any type of prescribed medication during these one year and longer periods of remaining 'clean' from heroin'? No/Yes
- If YES, please specify prescribed medication, date and length of usage:*
- _____
- _____
- _____
- j. Have you ever quit heroin for less than one year? No/Yes
- Approximate date/s and length of 'clean' periods:* _____

k. Have you abused any other psychoactive substances during these periods of remaining 'clean' from heroin for less than one year? No/Yes

If YES, please tick all the substances abused:

- 1. Alcohol
- 2. Inhalants (glue, Benzene, lighter gas, etc.)
- 3. Cannabis/Hashish
- 4. Mandrax/ Cannabis combination (white-pipe)
- 5. Hallucinogens (LSD/psychedelics/mushrooms/Peyote/PCP)
- 6. Crack Cocaine
- 7. Cocaine
- 8. Methadone
- 9. Other Opiates (Opium, Codeine, Morphine, Demerol/Darvon)
- 10. Methamphetamine (Speed, Ice, Ecstasy)
- 11. Other Amphetamines (uppers/diet pills)
- 12. Methcathinone (Cat/Khat)
- 13. Librium/Xanax/Valium/Minor Tranquillisers
- 14. Barbiturates
- 15. Other Sedatives/Hypnotics
- 16. Other (specify): _____

l. Were you undergoing any type of psychosocial intervention during these periods of remaining 'clean' from heroin for less than one year? No/Yes

If YES, please specify approximate date/s, length and type of intervention:

m. Were you using any type of prescribed medication during these periods of remaining 'clean' from heroin for less than one year? No/Yes

If YES, please specify prescribed medication, date and length of usage:

n. How long have you been clean from heroin? _____

B. INTERVIEW QUESTION

Describe to the fullest your process in coming 'clean' from heroin, and to the extent that counselling and/or medical intervention was able to assist you.

APPENDIX D

PARTICIPANT 1 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Okay, the Castle Carey part was... I could withdrawal from the stuff and throughout there, it was a protected environment and after-care helped a lot because I can tell you all the stuff. The Remeron and the Epilim, I think that I have brain fry or something.
- Interviewer:* Why do you say that?
- Participant:* Because I can't be happy without it. I think that my serotonin levels are messed up.
- Interviewer:* Do you think that it is temporary?
- Participant:* Maybe it's temporary, but I think that I am going to use it for the rest of my life.
- Interviewer:* So you feel that those things helped you in coming clean?
- Participant:* Staying clean, not coming clean.
- Interviewer:* Okay, but what actual... okay, so that was the treatment, you feel that the treatment helped you. But was there any sort of mind-shift that you needed to make? Or what actually got you to change your mind of not wanting.
- Participant:* One night I was in Castle Carey, I got this spiritual awakening and I became a Christian. I pray, I pray all the time, when I get on my scooter and when I drive and stuff... just pray to help me and protect me.
- Interviewer:* And how do you feel others see you, the way that people treated you, did it help you come clean?
- Participant:* No, not really. The people in Castle Carey did, and my family helped a bit.
- Interviewer:* But not outside in the normal world?
- Participant:* No.
- Interviewer:* Do you feel that the treatment was long enough?
- Participant:* Yes, I think that it was long enough.
- Interviewer:* What do you think could help someone with a heroin problem?
- Participant:* Overdosing, get a big fright, or getting caught by the police.
- Okay, the Castle Carey part... I could withdrawal from the stuff.
It was a protected environment.
After-care helped a lot because I can tell you the stuff.
The Remeron and the Epilim, I think that I have brain fry or something.
- I can't be happy without it.
I think that my serotonin levels are messed up.
- Maybe it's temporary, but I think that I am going to use it for the rest of my life.
- Staying clean, not coming clean.
- One night I was in Castle Carey, I got this spiritual awakening and I became a Christian. I pray, I pray all the time, when I get on my scooter, when I drive... just pray to help me and protect me.
- No, not really.
The people in Castle Carey did, and my family helped a bit.
- No.
- Yes, I think that it was long enough.
- Overdosing.
Get a big fright.
Or getting caught by the police.

- Interviewer:* Do you think there is a difference between treating that, compared to other addictions?
- Participant:* Yes, I think the withdrawal symptoms and all that is worse than ecstasy and dagga (*cannabis*).
Yes, I think the withdrawal symptoms and all that is worse than ecstasy and dagga.
- Interviewer:* You mentioned earlier that being in a protected environment helped you. Why do you say that?
- Participant:* Because you can't go out and buy heroin. Or withdrawing and going crazy, you can't go out and buy stuff. When you're at home you can just go out and get heroin or whatever.
You can't go out and buy heroin. Or withdrawing and going crazy, you can't go out and buy stuff. When you're at home you can just go out and get heroin or whatever.
- Interviewer:* Okay, now that you're back out in the 'normal' world, you've been clean now for quite a length of time, is it hard to stay clean for you?
- Participant:* Sometimes, especially at night I crave.
Sometimes, especially at night I crave.
- Interviewer:* What gets you through that?
- Participant:* Music, praying, crying.
Music, praying, crying.
- Interviewer:* Thanks, I think that covers it.

PARTICIPANT 2 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* The whole story from the start?
- Interviewer:* How do you feel your recovery started?
- Participant:* I think that my parents... they realised what was going on. They joined Tough love and they hooked up here and they helped with... I think it was one of the main incidents... um, with what to do and whatever, they offered me help. In the end I got to a point where I had to steal and I was caught and I was looking at jail. So I didn't have any choice because, I always told my father 'what about my job? I can't lose my job', and this and that, 'I'll do it on my own.' So the stealing... gotten to the point where I just have to give in.
- Interviewer:* Okay, but you mentioned now-now 'Toughlove', so in a sense if nobody had intervened, even your family, you might not have accepted it?
- Participant:* Yes, I believe that no addict wants to quit. You'll want to use forever. If it didn't give you financial problems, or physical problems, it forces you to stop in the end. Otherwise, you will just keep on using. But the money runs out, you deteriorate and you get to a point that you have to stop. I came to Castle Carey for a seven-day detox and then I was off to Noupoot for a month of... what I can only describe as hell... and ended up, my father told me that I was going for a year. But he only paid for eight months, I think, or four months, and then he paid for another four months, and he said I could come home. I said 'no, I'm staying.' So I stayed in the end for one and a half years at Noupoot, and that's it.
- Interviewer:* So do you feel the duration had a role to play in your recovery? In other words, that you were long enough away from the substance? Did that help you in the recovery process?
- Participant:* Yes, I feel that that is key no. 1, the time period. Um, I always go from the viewpoint, speaking to them (*people dependent or significant others of a drug dependent*) and saying to them, a minimum of a year because if you go beyond that, a year is already too much for them, but, the way things are going, a year ain't enough. A year and a half, maybe eighteen months, maybe two years minimum, especially for heroin and crack. Um, that's number one.
- I think that my parents... they realised what was going on.
They joined Toughlove... I think it was one of the main incidents... they offered me help.
In the end I got to a point where I had to steal and I was caught and I was looking at jail.
So I didn't have any choice...
I was told by my father 'what about my job? I can't lose my job'... I'll do it on my own.
So the stealing... gotten to the point where I just have to give in.
- Yes, I believe that no addict wants to quit.
You'll want to use forever.
If it didn't give you financial problems.
Or physical problems.
It forces you to stop in the end.
Otherwise, you will just keep on using. But the money runs out.
You deteriorate and you get to a point that you have to stop.
I came to Castle Carey for a seven-day detox.
Then I was off to Noupoot for a month of... what I can only describe as hell... and ended up, my father told me that I was going for a year. But he only paid for eight months, I think, or four months, and then he paid for another four months, and he said I could come home.
I said 'no, I'm staying.'
So I stayed in the end for one and a half years at Noupoot, and that's it.
- Yes, I feel that that is key no. 1, the time period.
I always go from the viewpoint, speaking to them and saying to them, a minimum of a year because if you go beyond that, a year is already too much for them, but, the way things are going, a year ain't enough.
A year and a half, maybe eighteen months, maybe two years minimum, especially for heroin and crack. That's number one.

Number two, get that discipline back. Number three, hard work, and shake those lazy bones and learn to work again. Because what do we do? We grow... our parents grew up on farms and they didn't have it easy. We were speaking about it last night. Um, our parents started out with a meagre salary, their first glasses they got from the roadhouse were they drank milkshakes and they got the glasses in the house. We just, I already have my own house and everything, and I've only started out. We grew up in a house were we had everything. Everything was easy. The worst that we had to do maybe was to mow the lawn and do school. We never went to work and we were lazy.

Interviewer: So you think that materialism has contributed to the drug problem?

Participant: But it's natural, you know your parents want to give you a better life than they had, and that's why you work, to give a better life to the people that follow. But if there is no discipline and no hard work, you have children who don't know what to do with themselves, and they start doing the wrong things. Now, the only way to break that whole system is to get discipline back, get hard work, and that's only going to happen over a long period of time. It took eighteen years to become the children they are. You are not going to do it in eight months or four weeks.

Interviewer: So it's a long-term process? Okay, but what kind of mind-shift do you feel that you had to make for yourself in order for you to come clean or stay clean.

Participant: I think, um, for me it's going to... you have two kinds of rehabilitation systems; Christian rehabilitation and psychological rehabilitation. I came from the Christian rehabilitation, and my mind-set, in that way it worked for me, that's why I propagate it.

Interviewer: Okay, so you feel that spirituality was important?

Participant: Ja (yes), definitely. I read about that rehab somewhere in the mountains where the Buddhist monks get these people and there is a lot of places like that, and whether it is Hinduism, or whatever the situation, everybody that gets into some religion, um, it's like that, and whether it is Hinduism, or whatever the situation, everybody that gets into some religion, um, it's like they get addicted to it, because there is a definite power in each one of those religions. Um, and in the end you have to replace what you've had with something else, because if you leave that void, it's going to fail and that's what happens with the

Number two, get that discipline back. Number three, hard work, and shake those lazy bones and learn to work again. Because what do we do? We grow... our parents grew up on farms and they didn't have it easy. We were speaking about it last night. Our parents started off this meagre salary, their first glasses they got from the roadhouse were they drank milkshakes and they got the glasses in the house.

I already have my own house and everything, and I've only started out. We grew up in a house were we had everything. Everything was easy. The worst that we had to do maybe was to mow the lawn and do school. We never went to work and we were lazy.

But it's natural, you know your parents want to give you a better life than they had, and that's why you work, to give a better life to the people that follow.

But if there is no discipline and no hard work, you have children who don't know what to do with themselves, and they start doing the wrong things. Now, the only way to break the whole system is to get discipline back, get hard work, and that's only going to happen over a long period of time.

It took eighteen years to become the children they are. You are not going to do it in eight months or four weeks.

You have two kinds of rehabilitation systems; Christian rehabilitation and psychological rehabilitation.

I came from the Christian rehabilitation, and my mind-set, in that way it worked for me, that's why I propagate it.

Ja, definitely.

I read about that rehab somewhere in the mountains where the Buddhist monks get these people and there is a lot of places like that, and whether it is Hinduism, or whatever the situation, everybody that gets into some religion, it's like they get addicted to it. There is a definite power in each of those religions.

In the end you have to replace what you've had with something else.

If you leave that void, it's going to fail and that's what happens with the guys. They have that void, and they go back to heroin and keep on relapsing.

They don't have something else to fall back

guys. They have that void, and they just go back to the heroin and keep on relapsing. They don't have something else to fall back on.

on.

Interviewer: If someone is in, for lack of a better term, let me phrase it a 'protected environment' for a period of time, in other words, they don't have exposure to the drug, is it hard to come out back into the 'normal' world? Is it hard to integrate again in 'normal' society as such?

Participant: If you, no, if you have really recovered it won't be difficult. I think that some people go for a year to rehab because they are told to go for a year and they are doing their time. I went, I was told I was going for a year and I did that, and I made it my home, and I did more time out of my own. See, and once you start making those decisions, and not having other people making the right decisions for you, then you start getting better. The thing is, if you've made the decision out of your own to another year, the chances that you are going to go back on your decision again and start using after that, is very much smaller than when you were forced. So, it comes from yourself in the end. And I always tell parents; you keep him in rehab until he starts making the right decisions. After a year, if he doesn't decide to stay for half a year, you make the decision for him and when it comes to that end and he is still not making the decisions for himself - you make the decisions for them, until he learns to make the right decisions himself. And then when he comes out, he is going to make the right decisions.

If you, no, if you really recovered it won't be difficult.

I think that some people go for a year to rehab because they are told to go for a year and they are doing their time.

I went, I was told I was going for a year and I did that, and I made it my home, and I did more time out of my own. See, once you start making those decisions, and not having other people making the right decisions for you, then you start getting better.

The thing is, if you've made the decision out of your own to another year, the chances that you are going to go back on your decision again and start using after that, is very much smaller than when you were forced. So, it comes from yourself in the end.

I always tell parents; you keep him in rehab until he starts making the right decisions. After a year, if he doesn't decide to stay for half a year, you make the decision for him and when it comes to that end and he is still not making the decisions for himself - you make the decisions for them, until he learns to make the right decisions himself. And then when he comes out, he is going to make the right decisions.

Interviewer: Okay, in terms of medical intervention, you have been through a number of medical interventions for your dependence; did any of them help you?

Participant: Um, to get off heroin, yes, it helped. The easiest thing is to get off heroin; the easiest thing in the world is to get off heroin. To stay off heroin - no medical intervention that will keep you off.

To get off heroin, yes, it helped.

The easiest thing is to get off heroin; the easiest thing in the world is to get off heroin.

To stay off heroin - no medical intervention that will keep you off.

Interviewer: So it helped for the withdrawal symptoms?

Participant: Yes.

Yes.

Interviewer: But not to keep clean?

Participant: No.

No.

Interviewer: Do you feel that it is necessary to have medical intervention while the person is withdrawing?

Participant: It depends on the addict. If he is a young addict still splashing around or just started, it's good for them to undergo pain, it's part of the learning process. But, if you have a fifty year old heroin addict who's been an addict for fifteen years, and he's coming down, he's coming down hard - and you usually have to help him.

Interviewer: *Any specific medications that helped you or didn't help you?*

Participant: Well, the only medication that I used was methadone. It helped me and it didn't help me.

Interviewer: *Okay, the way that people saw you when you were recovering, did that assist you or not?*

Participant: Did that assist me?

Interviewer: *Did they assist you?*

Participant: Assist me? No, I don't understand the question.

Interviewer: *Okay, people out there in the 'normal' world, in society, do you feel that they treated you or perceived you in a way that was conducive towards recovery? In other words, did you feel that people were basically non-judgmental towards you, or reached out to you, or was there more of a stigma attached?*

Participant: I don't think it's really applicable because I was out of society for a year and a half. That's when the change takes place. They didn't really have an influence, but on the other side, everybody, family, friends, everybody was rooting for me.

Interviewer: *So you feel that you had support?*

Participant: Yes.

Interviewer: *What do you feel is the best way to treat someone with a heroin problem?*

Participant: Long-term Christian rehabilitation with discipline and hard work. That's it in a nutshell.

Interviewer: *Okay, and do you feel that the treatment of heroin addiction is different to that of other psychoactive substances?*

Participant: No.

Interviewer: *So you see it as similar in treatment manner, except maybe for the duration of treatment? Or is that not a factor?*

Participant: I think the factor is the age of the patient because if you going to have a child eighteen years old, say he's been using

It depends on the addict. If he is a young addict still splashing around or just started, it's good for them to undergo pain, it's part of the learning process. But, if you have a fifty year old heroin addict who's been an addict for fifteen years, and he's coming down hard - you usually have to help him.

Well, the only medication that I used was methadone. It helped me and it didn't help me.

I don't think it's really applicable because I was out of society for a year and a half. That's when the change takes place. They didn't really have an influence, but on the other side, everybody, family, friends, everybody was rooting for me.

Yes.

Long-term Christian rehabilitation with discipline and hard work. That's it in a nutshell.

No.

I think the factor is the age of the patient because if you going to have a child eighteen year old, say he's been using heroin for six

heroin for six months, or using ecstasy for the last two years. The thing is, you have to tell him that he's never going to drink again; he's never going to be able to do anything again. How do you tell a eighteen-year-old he's supposed to stop partying? A 27, a 25 or 26 year old, like I was, I can stop doing all those things because I have done it all. That's the problem you've got. I don't know...

Interviewer: Do you feel that helping other people contributes to your personal recovery?

*Participant: Definitely, because, uh, you know, because of the people who came out with me, me and ***** and ***** , we busy with the things. We keeping involved and it's keeping us clean. The other people, they come, they stay a week with us, and then they disappear - and what disappears with them - their sobriety. So if you don't keep involved, whatever the situation, you're going to loose it.*

Interviewer: Okay that's great, thanks a lot.

months, or using heroin ecstasy for the last two years. You have to tell him that he's never going to drink again; he's never going to be able to do anything again. How do you tell a eighteen-year-old he's supposed to stop partying?

A 27, a 25 or 26 year old, like it was, I can stop doing all those things because I have done it all.

That's the problem you've got.

Definitely, because of the people who come out with me, me and ***** and ***** , we busy with the things.

We're keeping involved and it's keeping us clean.

The other people, they come, they stay a week with us, and then they disappear - and what disappears with them - their sobriety.

So if you don't keep involved, whatever the situation, you're going to loose it.

PARTICIPANT 3 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin, and to the extent that counselling and/or medical intervention was able to assist you.
- Participant: Okay, like the other day... addicts that... I can't really remember much, but you know... it's throwing up, (*inaudible*). The first few months were quite bad. I went to a psychologist and stuff.
- Interviewer:* Do you feel that that was able to assist you?
- Participant: The psychologist?
- Interviewer:* Yes.
- Participant: Not really, no.
- Interviewer:* Okay, and the actually being in rehab? Do you think that it contributed to you coming clean, or also not?
- Participant: In a way, because I think that some people like, um, you see what they go through. I don't want to land up like that. But anyway, I didn't. But then, actually, my parents realised that it was (*a problem - inaudible*). I think that is what helped me. They advised me.
- Interviewer:* Okay, do you feel that it was some sort of mind-set change? What got you to actually make that paradigm shift?
- Participant: I don't know. Circumstances. Everything around me. I think just looking at everyone around me; you just sit there and do nothing. I just realised that I want to do something with my life. If I want to get something, it's going to be up to me, and um...
- Interviewer:* The medical intervention, did you feel that it helped you in coming clean or staying clean, or not really?
- Participant: It can contribute towards coming clean. Obviously it did help me to cope with everything.
- Interviewer:* But not necessarily to stay clean?
- Participant: No, that is up to yourself.
- Interviewer:* Okay. The perception of other people, say your family, society in general, do you feel it (the perceptions) was conducive towards recovery or not? In other words, do you feel that people supported you out there? Did that help you? Or do you feel that it held you back, for example, that they were judgmental?
- I can't really remember much. The first few months were quite bad. I went to a psychologist.
- The psychologist?
- Not really, no.
- In a way, because I think that some people like... you see what they go through. I don't want to land up like that. But anyway, I didn't. But then... my parents realised. I think that is what helped me. They advised me.
- I don't know. Circumstances. Everything around me; you just sit there and do nothing. I just realised that I wanted to do something with my life. If I want to get something, it's going to be up to me.
- It can contribute towards coming clean. Obviously it did help me to cope with everything.
- No, that is up to yourself.
- No, that is up to yourself.

- Participant: They were judgmental. I used to get along with everyone... everyone just turned. In front of you they obviously, everyone is, you know, 'you need help', and... my parents were, I don't know. Friends were always my life, but then afterwards were like gone. My parents were still there. So that also helped me a bit. People were judgmental. Obviously by doing that, they do get you down and you just want someone to comfort you.
- Participant: They were judgmental. I used to get along with everyone... everyone just turned. In front of you everyone is 'you need help', my parents were, I don't know. Friends were always my life, but then afterwards were like gone. My parents were still there. So that also helped me a bit. People were judgmental. By doing that, they do get you down and you just want someone to comfort you.
- Interviewer: *What in your opinion could help someone with a heroin problem? How would you go about helping someone with a heroin problem?*
- Participant: I really don't know. Obviously you've got to get people to understand that they are addicts and they must get some sort of help. I don't know, just let them try and realise that they are capable of doing it, and that they are screwing up their lives. But I find that I can't just help people, they always come up to me - and if they don't want to be helped, then they keep on falling back, keep on falling back. Obviously you can relapse, but if you don't want to be helped it doesn't work.
- Participant: I really don't know. You've got to get people to understand that they are addicts and they must get some sort of help. I don't know, just let them try and realise that they are capable of doing it, that they are screwing up their lives. I find that I can't just help people, they always come up to me - and if they don't want to be helped, then they keep on falling back, keep on falling back. Obviously you can relapse, but if you don't want to be helped it doesn't work.
- Interviewer: *Do you feel that by trying to help people, that it helps you as well?*
- Participant: Yes, it definitely helps.
- Participant: Yes, it definitely helps.
- Interviewer: *Thank you.*

PARTICIPANT 4 TRANSCRIPTION

Interviewer: The question that I want to pose to you is: describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: I'm uncertain... I'm uncertain.

Interviewer: In other words, how do you feel that your recovery started? How did you come clean?

Participant: Rehab. My own will. Rehab.
My own will.

Interviewer: Your own will, was that the main...

Participant: I needed to come clean. I needed to come clean.

Interviewer: But what got you to the point where you felt that you needed to change or wanted to change?

Participant: Getting arrested, and seeing how I actually looked. Getting arrested.
Seeing how I actually looked.

Interviewer: So did that scare you?

Participant: Yes, and seeing other friends who weren't doing too well. Yes, seeing other friends who weren't doing too well.

Interviewer: Alright. Do you feel that your treatment was long enough?

Participant: Yes. Yes.

Interviewer: You don't feel that you needed longer treatment then?

Participant: Even if it was only for three weeks, it would have been fine. Even if it was only for three weeks, it would have been fine.

Interviewer: Three weeks would have been fine for you?

Participant: I just wanted to get it out of my system... so I stopped withdrawing. I just wanted it out of my system... so I stopped withdrawing.

Interviewer: So you feel that it was a mind-set thing that changed? What in your mind-set had to change, because you used for quite a long time?

Participant: All that which I was going through. The way I saw others... and... All which I was going through.
The way I saw others...

Interviewer: So you feel that you got to a point that you were desperate to change?

Participant: Yes. Yes.

Interviewer: The way other people saw you, um, society, do you feel that that helped you in your recovery, or do you feel that people were judgmental. Did it help you or not?

Participant:	Yes, it helped.	Yes, it helped.
<i>Interviewer:</i>	<i>So you feel that people supported you and that they don't judge you now?</i>	
Participant:	Ja (yes), none of them actually judged me... people I know.	Ja, none of them actually judged me... people I know.
<i>Interviewer:</i>	<i>What do you think would help someone with a heroin problem to come clean? How should one treat them in your opinion?</i>	
Participant:	Calmly. With dignity, they're human.	Calmly. With dignity, they're human.
<i>Interviewer:</i>	<i>And what type of treatment do they need to get? With your life experience with other people who've used, what do you think would help them to come off?</i>	
Participant:	Rehab... the way they work with them.	Rehab... the way they work with them.
<i>Interviewer:</i>	<i>Okay... medically speaking, do you think that they need medication at all? Do you feel that medication is necessary?</i>	
Participant:	Yes.	Yes.
<i>Interviewer:</i>	<i>Do you feel that the medication you received for your withdrawal symptoms...</i>	
Participant:	Yes.	Yes.
<i>Interviewer:</i>	<i>So it was sufficient, you didn't need stronger stuff or less stronger...</i>	
Participant:	No actually, in the beginning - stronger stuff.	No actually, in the beginning - stronger stuff.
<i>Interviewer:</i>	<i>Alright.</i>	
Participant:	After awhile it gets... your body gets used to it.	After awhile it gets... your body gets used to it.
<i>Interviewer:</i>	<i>Do you feel that treating heroin is different to other drugs? Would you go about treating, say now someone with an alcohol problem, in the same manner?</i>	
Participant:	No, it's different.	No, it's different.
<i>Interviewer:</i>	<i>Could you elaborate on that?</i>	
Participant:	Heroin is more... you don't want to do much...	Heroin is more... you don't want to do much.
<i>Interviewer:</i>	<i>Okay, so how would you go about treating it differently then.</i> <i>(long pause)</i>	
Participant:	Giving them more time to think.	Giving them more time to think.

Interviewer: That period could be long then. Although you managed to quit in quite a short period. Maybe that's an exception, um, but if you look at the majority of cases, you know a lot of people who are still using, do you think that they could... I think you were in treatment for six weeks hey? Do you think that would be sufficient for the others too?

Participant: Not really, a bit more time. Not really, a bit more time.

Interviewer: So what was your secret?

Participant: No, I wanted to come clean. I knew it was bad... and then... *(long pause)*. No, I wanted to come clean. I knew it was bad...

Interviewer: So you had made a decision?

Participant: I wanted to go there, and eat healthily and get the right medication. I wanted to go there, eat healthily and get the right medication.

Interviewer: Okay. Do you struggle to stay clean now?

Participant: Not really, but I do crave a lot. Not really, I do crave a lot.

Interviewer: How do you deal with that?

Participant: I start thinking about other things. The flashback comes back or thinking about what happened... I start craving, ja (yes), and then I start thinking about other things. That helped me a lot to get to handle it. I start thinking about other things. The flashback comes back or thinking about what happened... I start craving and then I start thinking about other things. That helped me a lot to get to handle it.

Interviewer: Thanks a lot.

PARTICIPANT 5 TRANSCRIPTION

- Interviewer:* The question that I want to pose to you is; describe to the fullest your process in coming clean from heroin, and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Say that again please.
- Interviewer:* Describe to the fullest your process in coming clean from heroin, and to the extent that counselling and/or medical intervention was able to assist you. In other words, how did you come clean?
- Participant:* Um, well I came clean by going to rehab, and wanting to do it and, I mean, just taking all the support that I could get. And using the medication... so that, also coming off it.
- Interviewer:* Okay, so you've mentioned a couple of things that helped you to come clean. So you felt that rehab did help you?
- Participant:* Ja (yes), no definitely.
- Interviewer:* Could you elaborate on that a bit?
- Participant:* I... look rehab helps because I mean, to be on the streets and be exposed to drugs when you are still very vulnerable, it's very difficult. The chances of not using are not that good.
- Interviewer:* So you actually saying that you have to be in some sort of protected environment?
- Participant:* Ja (yes).
- Interviewer:* In other words, away from the drug?
- Participant:* Ja (yes), for that very first, for that very vulnerable stage.
- Interviewer:* Okay. Do you feel that it was some sort of mind-set that had to change?
- Participant:* Um, ja (yes) definitely. Your mind-set has to change, your, basically your whole life-style has to change.
- Interviewer:* What within your mind-set changed to help you come clean?
- Participant:* Um, in my mind-set, I mean look, realising that, you know, with heroin you ain't going nowhere in life. I mean, you have to, once you're off it, then maybe you can start going somewhere in life. I mean, the mind-set, I mean before, I mean, when you're using you don't think of the possibilities that the next shot could kill you, and what what. But I mean once you're in there, and you start learning all this then you also realise, you know, once you're clean your mind can focus much more on the bigger parts of the story, and
- Well I came clean by going to rehab, wanting to do it, Just taking all the support that I could get. Using medication.
- Ja, no definitely.
- Rehab helps because to be on the streets and be exposed to drugs when you are still very vulnerable, it's very difficult. The chances of not using are not that good.
- Ja.
- Ja, for that very first, for that very vulnerable stage.
- Ja definitely. Your mind-set has to change. Basically your whole life-style has to change.
- In my mind-set, I mean look, realising that with heroin you ain't going nowhere in life. You have to, once you're off it, then maybe you can start going somewhere in life. The mind-set, when you're using you don't think of the possibilities that the next shot could kill you. But I mean, once you're in there, you start learning all this then you realise once you're clean your mind can focus much more on the bigger parts of the story, and you have to, once you're off it, then maybe you can

you have to, once you're off it, then maybe you can start going somewhere in life. I mean, not just the, not just the getting high, and just getting through the day.

start going somewhere in life. I mean, not just the, not just the getting high, and just getting through the day.

Interviewer: *Do you feel that your treatment was long enough? You've been in various rehabs, how long do you feel someone should be in treatment for something like heroin?*

Participant: I'd say it depends mostly on the person himself. I mean, if you really want to come right, then you can do it. What I just say is the withdrawal stages are the worst. Once you get past that, in your mind you want to get clean, then you can't go wrong.

I'd say it depends mostly on the person himself.

I mean, if you really want to come right, then you can do it.

What I just say is that the withdrawal stages are the worst. Once you can get past that, in your mind you want to get clean, then you can't go wrong.

Interviewer: *So do you feel then that medication is necessary to come clean?*

Participant: Um, from heroin, ja (yes), definitely.

From heroin, ja definitely.

Interviewer: *Okay, and to stay clean? Does it help?*

Participant: Um well, I haven't been doing that, but I mean, to stay clean - in a way also then you would be substituting wouldn't you?

I haven't been doing that, to stay clean - in a way also then you would be substituting wouldn't you?

Interviewer: *Okay, so you feel that it had to be a 'mind-set thing' more?*

Participant: Ja (yes). I mean, you need to want to do it for yourself, for no one else.

Ja. I mean, you need to want to do it for yourself, for no one else.

Interviewer: *Alright. Do you feel that the way people treated you outside in society, did it help you within the recovery process? Or was it a stumbling block? In other words, do you feel that people supported you or were they judgmental towards you?*

Participant: Um, depends who - you find the judgmental people and the supportive people.

Depends who - you find the judgmental people and the supportive people.

Interviewer: *Okay, and the people closest to you?*

Participant: Ja (yes), they have always been very supportive.

Ja, they have always been very supportive.

Interviewer: *How would you go about treating someone with a heroin problem, like similar to the problem you've had? What do you think would help them in the long run?*

Participant: Um, well in the long run it's up to the person himself. Rehabilitation and as much support as possible I think is the best.

In the long run it's up to the person himself.

Rehabilitation.

As much support as possible I think is the best.

Interviewer: *Is it hard to stay clean?*

- Participant: Ja (yes), it's very hard, but just to take it one day at a time. I try not to remember the good times. I try and remember the bad times, which in the end is much more than the good times.
- Participant: Ja, it's very hard, but just to take it one day at a time.
I try not to remember the good times. I try and remember the bad times, which in the end is much more than the good times.
- Interviewer: How do you get through the hard times now?*
- Participant: How do I get through them?
- Interviewer: The hard times?*
- Participant: Um, well if I am craving too much or something, you know, I'd go speak to my mother or phone my sponsor from NA, or just try and get my mind off it as quick as possible. Try get my mind busy on something different.
- Participant: Well, if I am craving too much or something, I'd go speak to my mother or phone my sponsor from NA, or just try get my mind off it as quick as possible. Try get my mind busy on something different.
- Interviewer: Thank you very much. I think that covers everything.*

PARTICIPANT 6 TRANSCRIPTION

Interviewer: The question I want to pose to you is: describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: I only had medical intervention right in the beginning... methadone, to come off the worst, worst withdrawal. I only had medical intervention right in the beginning... methadone, to come off the worst, worst withdrawal.

Interviewer: So, do you feel that it helped you in any way?

Participant: Definitely. Definitely.

Interviewer: For withdrawal?

Participant: Only for withdrawal. Only for withdrawal.

Interviewer: But not to stay clean?

Participant: For the craving, nothing, nothing can really take the craving away. For the craving, nothing can really take the craving away.

Interviewer: And in terms of other interventions? What exactly got you to come clean?

Participant: Well, Noupoot is a Christian programme, and I came to repentance and through the Bible and Christian principles. Noupoot is a Christian programme, I came to repentance through the Bible and Christian principles.

Interviewer: So you feel that spirituality played a very important role.

Participant: A major role. A major role.

Interviewer: Was that the most important role for you?

Participant: Yes. Yes.

Interviewer: Okay, do you feel that people outside, in other words, your family and maybe society in general, do you feel that how they treated you and their perceptions - was it conducive towards your recovery?

Participant: Conducive?

Interviewer: Do you feel that people were judgmental towards you or were they overall supportive?

Participant: My family was very supportive. Old friends from school and that - they were very judgmental and prejudiced. But obviously all the people at Noupoot was very supportive. My direct family was very supportive and all my friends. My family was very supportive. Old friends from school were very judgmental and prejudiced. All the people at Noupoot was very supportive. My direct family was very supportive and all my friends.

Interviewer: When you left the therapeutic community did you find it difficult to reintegrate into normal society, for lack of a better term, coming back into mainstream life?

- Participant: In the beginning it was difficult especially in a group of people having a conversation. I don't know I couldn't really; I couldn't really talk to many people about my past, except my own friends. But when I joined the church and the cell group... there wasn't really much to talk about and that was a bit difficult.
- Participant: In the beginning it was difficult especially in a group of people having a conversation. I don't know, I couldn't really talk to many people about my past, except my own friends. When I joined the church and the cell group... there wasn't really much to talk about and that was a bit difficult.
- Interviewer: *How would you go about... or let me rather first ask you, do you feel it is different treating a heroin addiction, or is it the same as other addictions? Would you go about treatment in a similar way?*
- Participant: I think that heroin together with cocaine and alcohol are probably the most severe addictions. Dagga (*cannabis*) and all that is not as severe as heroin and cocaine.
- Participant: I think that heroin together with cocaine and alcohol are probably the most severe addictions. Dagga and all that is not as severe as heroin and cocaine.
- Interviewer: *How would you go about treating someone with a heroin addiction? What advice would you give them?*
- Participant: Um, for me it was a whole life-style change, because the life-style I led, led me to drugs and alcohol and all that. First you have to get a lot of clean time behind you and you have to change your whole life-style. The way you do things, the way you think about things, the people you hang around with, the places you hang around with.
- Participant: For me it was a whole life-style change, because the life-style I led, led me to drugs and alcohol and all that. First you have to get a lot of clean time behind you and you have to change your whole life-style. The way you do things. The way you think about things. The people you hang around with. The places you hang around with.
- Interviewer: *Okay. So it's a mind-set change?*
- Participant: It's a life-style change.
- Participant: It's a life-style change.
- Interviewer: *Okay. Do you feel that the duration of treatment plays a role?*
- Participant: Definitely, especially for heroin and cocaine. I think you need at least a year clean time behind you in a secure environment before you can come back to normal society. Two years is even better, depending on how long you were addicted for. But one year at least in a secure environment.
- Participant: Definitely, especially for heroin and cocaine. I think you need at least a year clean time behind you in a secure environment before you can come back to normal society. Two years is even better, depending on how long you were addicted for. One year at least in a secure environment.
- Interviewer: *Okay, now that you've been clean for three years, that's a long stretch of time, is it hard for you to stay clean?*
- Participant: No, no.
- Participant: No, no.
- Interviewer: *Not in any way?*
- Participant: No.
- Participant: No.
- Interviewer: *You don't even crave at this point, nothing?*
- Participant: I sometimes think about it, but never to the point where I have to sit down and say 'I wish I can stop craving'. I think about it, it is just a passing thought.
- Participant: I sometimes think about it, but never to the point where I have to sit down and say 'I wish I can stop craving'. I think about it, it is just a passing thought.
- Interviewer: *Thank you very much, that covers it.*

PARTICIPANT 7 TRANSCRIPTION

- Interviewer:* The question I would like to pose to you is: describe to the fullest your process in coming clean from heroin and to the extent counselling and/or medical intervention was able to assist you.
- Participant:* Well, can I say about Castle Carey?
- Interviewer:* Yes.
- Participant:* I arrived at Castle Carey. I was like clean for a month, and my intervention was trying to (*inaudible*) balance. When I came here I came for counselling and I explained my situation. They tried to get me to realise what my situation was. But at that time I don't think I was quite open enough to counsellors to listen to them to what they really say. But I learnt pretty much and I got my head sort of together from all my friends and other (*inaudible*) stuff and I went home and I had a fall-back. I don't know. I just got partying with my old friends again. I don't know why, but I realised that my friends were not going anywhere, and I had a choice to get away from everything... so I went away.
- Interviewer:* So do you feel that the treatment helped you to some extent?
- Participant:* Ja (yes), it opened my eyes a bit, it made me look a bit further than just to a front wall.
- Interviewer:* Alright. Do you feel that the treatment period was long enough for you?
- Participant:* For me personally, ja (yes). I know that some people might stay longer or shorter. I don't know. But for me personally I felt it was sufficient.
- Interviewer:* Okay, did you use any specific medication for withdrawal symptoms that you can recall?
- Participant:* Not really. I remember I used a bit of medication, but I can't remember the stuffs name.
- Interviewer:* Did it help you or not?
- Participant:* It calmed my nerves, it just calmed me down and stuff.
- Interviewer:* How would you go about treating someone with a heroin problem? What would be your advice to them?
- I arrived at Castle Carey. I was clean for a month. When I came I came for counselling and I explained my situation. They tried to get me to realise what my situation was. At that time I don't think I was quite open enough to counsellors to listen to them to what they really say. I learnt pretty much and I got my head sort of together from all my friends and other stuff and I went home and I had a fall-back. I don't know. I just got partying with my old friends again. I don't know why, but I realised that my friends were not going anywhere. I had a choice to get away from everything... so I went away.
- Ja, it opened my eyes a bit, it made me look a bit further than just to a front wall.
- For me personally, ja. I know that some people might stay longer or shorter. I don't know. But for me personally I felt it was sufficient.
- Not really. I remember I used a bit of medication, but I can't remember the stuffs name.
- It calmed my nerves, it just calmed me down.

- Participant: Well, if he's in a clinic like this or like treatment... I don't know (*laughs*). Difficult! Just motivate him. Just keep him positive. Just motivate him and tell him he can come clean, it will, things will change. Just try and motivate a person enough so that he will make his own change. I don't know...
- Participant: If he's in a clinic like this or treatment. I don't know. Difficult! Just motivate him. Just keep him positive. Just motivate him and tell him he can come clean, it will, things will change. Just try and motivate a person enough so that he will make his own change. I don't know.
- Interviewer: *Do you feel that the people in your life were supportive in your recovery? Or were they judgmental? So in other word, also society's views, was it helpful in your recovery or did it hold you back?*
- Participant: From my parents I felt a bit of resentment. I don't know. I felt like they were getting back at me the whole time. Maybe it was because I was very young, so it felt like they were trying to block me the whole time with everything. With other people, I don't know, I felt like they wanted to help me and I don't know... my parents I felt were different. I was angry with them. I was letting them down, so maybe they resented me. I felt like resentment from them, but it changed with time. Time heals all wounds.
- Participant: From my parents I felt a bit of resentment. I don't know. I felt like they were getting back at me the whole time. Maybe it was because I was very young, so it felt like they were trying to block me the whole time with everything. With other people, I felt like they wanted to help me... My parents I felt were different. I was angry with them. I was letting them down, so maybe they resented me. I felt like resentment from them, but it changed with time. Time heals all wounds.
- Interviewer: *Okay, what mind-set change had to happen for you in order for you to stay clean?*
- Participant: My whole perception about life. My whole perception.
- Participant: My whole perception about life.
- Interviewer: *In what way did that change? Can you elaborate on that?*
- Participant: Um, I don't know. Before when I was on drugs I didn't feel motivated about life so, like, were I was going, what am I going to do oneday? I had like dreams that I wanted to do, but I didn't really make commitments to do it. I didn't really know what to do to do it. So then, when I cleared my mind, I knew sort-of were I was going and I was starting to find 'rigting' (*direction*). So...
- Participant: I don't know. Before when I was on drugs I didn't feel motivated about life so, like were I was going, what am I going to do oneday? I had dreams that I wanted to do, but I didn't really make commitments to do it. I didn't really know what to do to do it. So then, when I cleared my mind, I know sort-of were I was going and I was starting to find 'rigting'.
- Interviewer: *So that gave you hope?*
- Participant: Yes, sort of, yes. When I was in Castle Carey we had a dominee (*minister*) that came to speak to us, that had counselling with us. He not really preached, but he told us stories out of the Bible and then we had our own... what do you call it, not court case...
- Participant: Yes, sort of, yes. When I was in Castle Carey we had a dominee hat came to speak to us, that had counselling with us. He not really preached, but he told us stories out of the Bible.
- Interviewer: *Was it a discussion?*
- Participant: Ja (*yes*) discussion, and everyone had their own perspective... we all sorted it out and spoke about it.
- Participant: Ja discussion, and everyone had their own perspective... we all sorted it out and spoke about it.
- Interviewer: *So spirituality played a role in changing your mind-set?*
- Participant: Very much so.
- Participant: Very much so.

Interviewer: *Is it hard for you to stay clean?*

Participant: Um, the first, the first few months after rehabilitation was hard. But with time it gets easier and it gets simpler. You start to see other people and what's happening to them and the way things turn out for other people. I think that's the biggest influence. If you see what happens to other people from your own perspective, you realise what was happening to yourself. You've actually opened your eyes to really look what's happening, it's quite frightening actually.

The first few months after rehabilitation was hard.

But with time it gets easier and it gets simpler. You start to see other people and what's happening to them and the way things turn out for other people.

If you see what happens to other people from your own perspective, you realise what was happening to yourself.

You've actually opened your eyes to really look what's happening, it's quite frightening actually.

Interviewer: *Thank you for everything.*

PARTICIPANT 8 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* I was in Noupport, I went to Noupport alright. I was desperate. Um, I didn't use no medical aid or stuff like that for withdrawal symptoms. I had hectic withdrawal symptoms. They taught me from the Bible; I relied on God's strength to pull through the withdrawal and stuff like that. Medication for me is a substitute for drugs, for heroin, and you can survive without medication and rely on Gods strength.
- Interviewer:* Okay, so you don't feel that medication is necessary for recovery.
- Participant:* Not at all.
- Interviewer:* And the withdrawal symptoms?
- Participant:* Not at all, and it's hectic for the first few couple of days, three days, four days at the most, but after that your body gets energy back and stuff like that. You don't need it because heroin, medical aid and pills is only a substitute for the heroin. It works out, your body seeks for heroin again and... take your withdrawal like a man, and after that you're fine.
- Interviewer:* Okay, but you do feel that people need treatment? In other words, they need to be away from the drug for long enough in order to...
- Participant:* Ja (yes), and it has to be a decision from your own self. If you just get a place were you cannot just get the stuff, then your body automatically tells you that it doesn't need it. After a few couple of days, then your body is fine.
- Interviewer:* So you need to be in a protected environment?
- Participant:* A protected environment where you know you're safe, where there are no drugs around you and stuff like that. And you can't get hold of them no matter what. If you want to, you can't, just for a couple of days so that your body can get its strength back, you realise you don't need it.
- Interviewer:* How long do you think someone needs to be in treatment for, or in a protected environment?
- I was in Noupport. I went to Noupport alright. I was desperate.
I used no medical aid or stuff like that for withdrawal. I had hectic withdrawal symptoms.
They taught me from the Bible, I relied on God's strength to pull through the withdrawal. Medication for me is a substitute for drugs, for heroin.
You can survive without medication and rely on Gods strength.
- Not at all.
- Not at all, and it's hectic for the first few couple of days, three days, four days at the most, but after that your body gets energy back.
You don't need it because heroin, medical aid and pill is only a substitute for heroin.
It works out, your body seeks for heroin again and... take your withdrawal like a man, and after that you're fine.
- Ja, and it has to be a decision from your own self.
If you can just get a place were you cannot just get the stuff, then your body automatically tells you that is doesn't need it.
After a few couple of days, then your body it fine.
- A protected environment where you know you're safe, where there are no drugs around you and stuff like that.
You can't get hold of them no matter what.
If you want to, you can't, just for a couple of days so that your body can get its strength back, you realise you don't need it.

- Participant: Round about, it depends... but if you really want to, a long-term programme is the best because you need to sort out lots of things. All people have problems, you have to sort it out because if you are only there for six weeks or two weeks or stuff like that, you don't forget the things - how 'lekker' (*nice*) it is, you need to get away for a long period of time, and after that you can see how you don't need it and stuff like that. So you need a long-term programme... well I think.
- Participant: Round about, it depends... if you really want to, a long-term programme is the best because you need to sort out lots of things. All people have problems, you have to sort it out because if you are only there for six weeks or two weeks, you don't forget the things - how 'lekker' it is, you need to get away for a long period of time, and after that you can see how you don't need it. So you need a long-term programme... well I think.
- Interviewer: *Alright. Do you think there is a difference between treating heroin addiction compared to other addictions such as dagga (cannabis) or alcohol?*
- Participant: Heavy. Because heroin is something your body gets used to so quickly and without it your body is weak. Compared to dagga (*cannabis*), dagga you just get 'rustig' (*relaxed*) if you smoke dagga. Compared to heroin - your body needs it to function, so if you use dagga (*cannabis*) or buttons (*mandrax/methaqualone*) or stuff like that - it's not that addictive. You get addicted to it, but it's not that addictive that you need it every day. So heroin, you need it every day to survive or your body can't even walk.
- Participant: Heavy. Because heroin is something your body gets used to so quickly and without it your body is weak. Compared to dagga, dagga you just get 'rustig' if you smoke dagga. Compared to heroin - your body needs it to function, so if you use dagga or buttons - it's not that addictive. You can get addicted to it, but it's not that addictive that you need it every day. So heroin, you need it every day to survive or your body can't even walk.
- Interviewer: *What advice would you give to someone with a heroin problem in terms of helping them?*
- Participant: My advice to people would be just to realise you can't live with a thing that substitutes life, so you can't fulfil your life with a drug, you have to enjoy life as it is. You can rely on God's strength to give you strength to go through the tribulations in your life and just, if look down, don't look down and stuff like that, don't fall back to drugs to replace that void in your life. Just look forward, take each day as it is, never look back, and remember how life was before you used drugs and rely on God to prepare your day for you. That's the main thing.
- Participant: My advice to people would be just to realise you can't live with a thing that substitutes life, so you can't fulfil your life with a drug, you have to enjoy life as it is. You can rely on God's strength to give you strength to go through the tribulations in your life and just, if you look down, don't look down, don't fall back to drugs to replace that void in your life. Just look forward, take each day as it is, never look back, and remember how life was before you used drugs. Rely on God to prepare your day for you. That's the main thing.
- Interviewer: *Do you find it hard to stay clean?*
- Participant: Sometimes, depends on the environment you're in. If you're in an environment with lots of friends and all of them in a partying mood and stuff like that... you find yourself - you want to be with them, be in the group - that's where peer pressure comes in. You just have to sometimes; you have to make decisions, to turn your back. Sometimes it's not 'lekker' (*nice*) to do that, but on your own, if you think about it, you realise it's the right thing to do. After awhile you get into the mood of saying 'no'. It helps to be with friends' after that, but the right friends. Wrong friends can bring you down so easily. You have to be in a total different
- Participant: Sometimes, depends on the environment you're in. If you're in an environment with lots of friends and all of them in a partying mood... you find yourself - you want to be with them, be in the group - that's where peer pressure comes in. You have to sometimes; you have to make decisions, to turn your back. Sometimes it's not 'lekker'; to do that, but on your own, if you think about it, you realise it's the right thing to do. After awhile you get into the mood of saying 'no'. It helps to be with friends after that, but the right friends. Wrong friends can bring you down so easily.

environment, get totally different friends, because negative friends lead to negative things.

Interviewer: Do you feel that the people close to you supported you, or do you feel they've been judgmental?

Participant: All the way, all the way. Although my own opinion, I think they should have given up a long time ago, a long time ago. But they have been by my side all the way, through all my troubles, jail, not jail but court cases, to my rehab, and, um, they should have stopped a long time ago to support me, but all the way - by my side.

Interviewer: Thank you so much for all your input and I wish you the best for your future.

You have to be in a total different environment, get totally different friends, because negative friends lead to negative things.

All the way, all the way.
Although my own opinion, I think they should have given up a long time ago, a long time ago.
But they have been by my side all the way, through all my troubles, jail, not jail but court cases, to my rehab, they should have stopped a long time ago to support me, but all the way - by my side.

PARTICIPANT 9 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Okay, um, well I tried to get off heroin by myself, but I couldn't. Um, I can describe it as... feeling lost, like trying to get off it, you don't know what to do, you know, and I mean, just going through the 'cold turkeys' and the cold sweats, um, I just couldn't stand that. Medically, I went to Houghton (*House*), and then I saw the doctor and she gave me medication, which helped for, with, the 'cold turkey'.
- Interviewer:* So you feel that medication was necessary for the 'cold turkey'?
- Participant:* Ja (yes), I couldn't, I tried to do it by myself, without any medication, but I don't think I could have survived. I think that medication is quite important.
- Interviewer:* Do you feel that medication is necessary to stay clean?
- Participant:* Yes, anti-depressants too.
- Interviewer:* Okay, so it helped you. Okay, what, do you feel that treatment was helpful to you?
- Participant:* I learnt a lot of things about like drug use and all that. The main problems of my life, not really drugs, my family life, my childhood life - sort it out, all of that, just come back. Some of it led to me becoming an addict. So ja (yes), I think it did help a lot.
- Interviewer:* Was there some sort of mind-set change that you feel had to happen?
- Participant:* Ja (yes), I think, it's like coming to admit that you have a drug problem. I think that is were my mind-set changed. Once I accepted that I had a problem, a drug problem, then that's when I opened up to recovery.
- Interviewer:* Is it hard for you to stay clean at this point in time?
- Participant:* Yes it is, it is. Um, I mean, with life pressure, peer pressure, I'd say that's also like getting me down. I do kind of manage to get out of it. The thought of not being able to drink anymore bugs me, but ja (yes), I just have to stay clean.
- Interviewer:* If you are craving, what helps you get through that?
- Participant:* Just like, I play the movie through you know. I do sometimes think of drugs, quite a lot and, but I just play the movie through, what happened - and then, I just
- Well I tried to get off heroin by myself, but I couldn't.
I can describe it as... feeling lost, like trying to get off it, you don't know what to do.
Just going through the 'cold turkeys' and the cold sweats, I just couldn't stand that.
Medically, I went to Houghton.
Then I saw the doctor and she gave me medication, which helped for, with, the 'cold turkey'.
- Ja, I couldn't, I tried to do it by myself, without any medication, but I don't think I could have survived.
I think that medication is quite important.
- Yes, anti-depressants too.
- I learnt a lot of things about like drug use.
The main problems of my life, not really drugs, my family life, my childhood life - sort it out, all of that, just come back. Some of it led to me becoming an addict.
So ja, I think it helped a lot.
- Ja, I think, it's like coming to admit that you have a drug problem.
I think that is were my mind-set changed.
Once I accepted that I had a problem, a drug problem, then that's when I opened up to recovery.
- With life pressure, I'd say that's also like getting me down. I do kind of manage to get out of it.
The thought of not being able to drink anymore bugs me, but ja, I just have to stay clean.
- I play the movie through you know.
I do sometimes think of drugs, quite a lot, but I play the movie through, what happened - and then, I just think of what would happen

- think of what would happen after, after I used, you know. The problems that would come, depression, and I'm sure that if I do use heroin once - I don't think that I would stop.
- after, after I used. The problems that would come, depression, and I'm sure that if I do use heroin once - I don't think that I would stop.
- Interviewer: Do you think that the duration of treatment plays a role in recovery? In other words, how long do you think someone should be in treatment for?*
- Participant: I'd say, for a year actually for treatment. I've got friends who are in treatment at the moment.
- I'd say, for a year actually for treatment. I've got friends who are in treatment at the moment.
- Interviewer: Are you referring to out-patient treatment?*
- Participant: No inpatient... primary, secondary, tertiary care.
- No inpatient... primary, secondary, tertiary care. *Are you referring to outpatient?*
- Interviewer: Okay, so you feel that a year is a good gage?*
- Participant: Ja (yes).
- Ja.
- Interviewer: How would you go about treating someone with a heroin problem? Or what advice would you give to someone?*
- Participant: Um, I can't really tell hey. I don't know. It's quite a difficult job to get off. So I would actually advise someone to go into a treatment centre. Get some medical advice and medical help, that will help with the 'cold turkey', and just give it up.
- I can't tell really. I don't know. It's quite a difficult job to get off. I would actually advise someone to go into a treatment centre. Get some medical advice and medical help, that will help with the 'cold turkey', and just give up.
- Interviewer: Do you feel that the way people treated you, um, the people close to you, and also maybe people in general, do you feel that is was conducive to your recovery? Or do you feel that it held you back, in other words, that people were judgmental?*
- Participant: Ja (yes) it did hold me back you know. I just thought that like why would, I mean, if someone treated me bad, then I just thought that I was worthless, and all that, so I would just carry on using. So that kind of like held me back from recovery.
- Ja it did hold me back you know. I just thought that like why would, I mean, if someone treated me bad, then I just thought that it was worthless, and all that, so I would just carry on using.
- Interviewer: Okay, and the people closest to you, were they supportive or not?*
- Participant: I wouldn't say that before I came into recovery, but now they are more supportive of me. But before that, I mean, I fight a lot with my mother, it just made me to go back and just want to use more.
- I wouldn't say that before I came into recovery, but now they are more supportive of me. But before that, I mean, I fight a lot with my mother. It just made me go back and just want to use more.
- Interviewer: Do you think that there is a difference between treating someone with a heroin problem as opposed to someone with another addiction, like alcohol or dagga (cannabis)?*

- Participant: Ja (yes), I think that depression, the depression that I get from heroin was like intense. So, I think that it would be different to treat someone with a heroin problem. Um, I don't, I found it very difficult - the first few stages. I was in treatment with other people, but I saw them like cruising through, they were willing to accept it, but I was like holding back. So, I don't know, I didn't want to open up. It just took time for me to open up.
- Participant: Ja, I think that depression, the depression that I get from heroin was intense. So, I think that it would be different to treat someone with a heroin problem. I don't, I found it very difficult - the first few stages. I was in treatment with other people, but I saw them like cruising through, they were willing to accept it, but I was holding back. So, I don't know. I didn't want to open up. It just took time for me to open up.
- Interviewer: *Thank you very much. I think you're an inspiration to the others and it's good to see you doing well. Good luck for the future.*
- Respondent: Thank you.

PARTICIPANT 10 TRANSCRIPTION

Interviewer: The question that I'd like to pose to you is: describe to the fullest your process in coming clean from heroin and to the extent counselling and/or medical intervention was able to assist you.

Participant: Um, the last time I came clean, um, I also started using methadone prescribed by a GP and then I went into a rehab, Staanvas, where they also gave me methadone and sleeping tablets and vitamins and all kinds of things like that and also counselling, um, group therapy and psychologists and that. But, um, at that stage I didn't really co-operate and I don't think I was really open to change and co-operating and that. Um, so that was not really successful. So I left there after about two weeks and a bit and then I went to another rehab, Noupoot Christian Care Centre, where there was no medication and no counselling at all. I was there for 18 months and about the last 6 months they had a social worker there and we would see her once every two weeks and we were in a group of about six or eight. So it was really not beneficial at all. I struggled a lot, I mean, getting secondary withdrawals from the medication, when I got there - no medication. Often even when I was sick, like bronchitis and that, in Noupoot, no medication, no doctors and anything like that, and it was really hard for me because I felt that it was not a normal approach. What was hard for me as well is, I was there for a long time, I mean, after eighteen months, coming out there, then I had to do a lot of things that other people in a six week treatment centre get to do already, start doing and um,... In the time I was in Noupoot, and since I've come out one and a half years ago, I've been going to NA (*Narcotics Anonymous*) meetings and it has really helped me a lot. I find that group therapy and counselling and that, and being around other people who are clean and just keep on being reminded of where I come from. Everytime a newcomer comes in there and someone who keeps on relapsing and struggling and that, you know, it can just as well be me. So then, when I come out of rehab last year, I started going to a psychologist and it didn't really work out for me. So then last year about August/September I started going to a social worker. I've been going ever since, once a week or once every two weeks now. And it's really helped me a lot. I have a lot of stuff that I needed to deal with and I never got a chance to do that while I was in rehab, because when I had a problem and issues and stuff, they just tell me to pray about it. No one really helped me there to work the stuff out and

The last time I also started using methadone prescribed by a GP.

Then I went into a rehab, Staanvas, where they also gave me methadone and sleeping tablets and vitamins and all kinds of things like that.

Also counselling, group therapy and psychologists and that.

But at that stage I didn't really co-operate and I don't think I was really open to change and co-operating. So that was not really successful.

So I left there after about two weeks and a bit and then I went to another rehab, Noupoot Christian Care Centre, where there was no medication and no counselling at all.

I was there for 18 months and about the last 6 months they had a social worker there and we would see her once every two weeks and we were in a group of about six or eight.

So it really was not beneficial at all.

I struggled a lot, getting secondary withdrawals from the medicine when I got there - no medication.

Often even when I was sick, like bronchitis, in Noupoot, no medication, no doctors and anything like that, and it was really hard for me because I felt that it was not a normal approach.

What was hard for me as well is, I was there for a long time, I mean after eighteen months, coming out there, then I had to do a lot of things that other people in a six week treatment centre get to do already, start doing...

In the time I was in Noupoot, and since I've come out one and a half years ago, I've been going to NA meetings and it has really helped me.

I find that group therapy and counselling and being around people who are clean and just keep on being reminded of where I come from.

Everytime a newcomer comes in there and someone who keeps on relapsing and struggling and that, you know, it can just as well be me.

So then, when I come out of rehab last year, I started going to a psychologist. I went to two different psychologists and it didn't really work out for me.

So then last year about August/September I started going to a social worker. I've been going ever since, once a week or once every two weeks now. And it's really helped a lot.

I have a lot of stuff that I needed to deal with and I never got a chance to do that while in rehab, because when I had a problem and issues they just tell me to pray about it.

I couldn't do it on my own. And then medication, I've only gone on anti-depressants two months ago. So medication has not really played such a big role in my recovery, but I know that the methadone also does help a lot for withdrawals, even though I got secondary withdrawals also which was horrible. I don't think that if I was just on methadone... I don't think I would have, I know I wouldn't have stayed clean. I would have relapsed because methadone was just a substitute for heroin, and when the methadone was over I knew that I would have just started using again.

Interviewer: *Is it hard for you to stay clean?*

Participant: Um, sometimes it is. It's not an easy thing...

Interviewer: *What gets you through the difficult times or the cravings?*

Participant: I've got... no. I think especially following the NA programme I'm doing the steps, it has helped me a lot because I've learnt that I don't just have a drug problem but I've got this character defect. And also like doing my life story and getting all out and getting it behind me you know. There were reasons; there were things in my life that were already there long before I used drugs. I think it was almost like inevitable that I would use, like my low self-esteem, and my depression and feeling I don't belong and feeling I'm not good enough, being so perfectionistic and judgmental and critical and always setting myself up to be a victim and my inner anger and all that stuff. What helps me through these times - I've a few things in my life that are kind of like barriers to using. So when I really feel that everything's going really badly, like you said, when reality hits me, and I used to use because I couldn't, I wanted to escape from reality and I felt I wasn't okay and all that stuff. So now I have to deal with all those things without drugs. And it sometimes gets hard for me, like, fear of failure and anything like that sets in. So, sometimes I really feel like relapsing, at that time I often feel like I don't care in myself, because I am still struggling with my self-confidence. In the NA programme we learn that 'I mustn't use just for today' no matter what, and that really helps me and also thinking of everything that I have to loose, like my clean time, and my relationship with my parents and family and my friends. I also have an amazing boyfriend and he also said to me that one of the conditions, our relationship wouldn't work out if I started using again because I only met him after I came clean. So all of these things are like barriers to me using, and I think that really helps me to stay clean. And then also then, my relationship with God and I

No one really helped me there to work the stuff out and I couldn't do it on my own.

And then medication, I've only gone on anti-depressants two months ago.

So medication has not really played such a big role in my recovery.

But I know that the methadone also does help a lot for withdrawals, even though I got secondary withdrawals also which is horrible.

I don't think that if I was just on methadone... I don't think I would have, I know I wouldn't have stayed clean. I would have relapsed because methadone was just a substitute for heroin, and when the methadone was over I knew that I would have just started using again.

Sometimes it is. It's not an easy thing.

I think especially following the NA programme I'm doing the steps, it has helped me a lot because I've learnt that I don't just have a drug problem but I've got this character defect.

Also like doing my life story and getting all out and getting it behind me you know. There were reasons; there were things in my life that were already there long before I used drugs.

I think it was almost like inevitable that I would use, like my low self-esteem, and my depression and feeling I don't belong and feeling I'm not good enough, being so perfectionistic and judgmental and critical and always setting myself up to be a victim and my inner anger and all that stuff.

What helps me through these times - I've a few things in my life that are kind of like barriers to using.

So when I really feel that everything's going really badly, like you said, when reality hits me, and I used to use because I couldn't, I wanted to escape from reality and I felt I wasn't okay and all that stuff. So now I have to deal with all those things without drugs. And it sometimes gets hard for me, like, fear of failure and anything like that sets in.

So, sometimes I really feel like relapsing, at that time I often feel like I don't care in myself, because I am still struggling with my self-confidence.

In the NA programme we learn that 'I mustn't use just for today' no matter what, and that really helps me and also thinking of everything that I have to loose, like my clean time, and my relationship with my parents and family and my friends.

I also have an amazing boyfriend and he also said to me that one of the conditions, our relationship wouldn't work out if I started using again because I only met him after I came clean.

So all of these things are like barriers to me using, and I think that really helps me to

pray, and when I feel like I want to use then I just think... I just take it for like an hour or half an hour at a time, and then think, okay just until 12 o'clock, and then until 3 o'clock and that, it really helps me get through the day. But these days, as the longer I stay clean, the less they become. It's not easy to stay clean, it's much easier to use. Everything in life, it's much easier for me to drink, it's much easier for me to smoke, um, but not to do those things I feel builds character - it's much harder not to do those things. Um, it's not often that I pity myself, but sometimes I feel unhappy with the choices I've made and guilty and ashamed. And to know that I am an addict for the rest of my life and I have this disease of addiction and I'm responsible for my recovery, and I can do something about it and I'm not helpless, and that really helps me. But still, I can't just stay clean on my own, there is a lot of things that I have to do to stay clean: go to meetings, have a sponsor, do step work, see my social worker, and I stay away from places that are dangerous like bars and clubs and friends and people from the past. Even, I must even watch, I've realised, like the movies I watch and the music I listen to, 'cause it doesn't have a huge effect on me, but it has an underlying effect on me and even being around people who drink. Often I think that I can handle it, but after a long period of time, a few months of doing that, it does affect me in a way. So many little things. Like the other day I realised I can't use homeopathic medicine because my mother wanted to take me to a homeopath because I have been having skin problems, and I can't use mouthwash and all these stupid little things no-one tells me. I figure it out on my own, and see what works and what doesn't work for me. So it's a long process and it does get a lot better with time. But I've also realised what worked for me in my 1st year of staying clean is not going to work for me in my 5th year of staying clean. It's an ongoing process of change and seeing what works for me now and what's going to work for me in a year's time. I suppose it's all different all the time. I don't believe, what some people say, 'I've recovered' after staying clean for a certain while or being normal. Like my daily activities are normal now. Like I've got a job and I'm studying and I've got relationships with my friends, and parents, and my boyfriend, and everything is normal and yet it doesn't mean I've recovered just because I'm reintegrated into society. I still have a problem and I think it's important of always being aware of it and still making a daily choice of not to use. In the end, there can be all the counselling and medication and everything, if I don't make that choice that I'm going to stop using,

stay clean.

Then also then, my relationship with God and I pray, and when I feel like I want to use then I just think...

I just take it for like an hour or half an hour at a time, and then think, okay just until 12 o'clock, and then until 3 o'clock and that, it really helps me get through the day. But these days, as the longer I stay clean, the less they become.

It's not easy to stay clean, it's much easier to use. Everything in life, it's much easier for me to drink, it's much easier for me to smoke, um, but not to do those things I feel builds character - it's much harder not to do those things.

It's not often that I pity myself, but sometimes I feel unhappy with the choices I've made and guilty and ashamed.

And to know that I am an addict for the rest of my life and I have this disease of addiction and I'm responsible for my recovery, and I can do something about it and I'm not helpless, and that really helps me.

But still, I can't just stay clean on my own, there is a lot of things that I have to do to stay clean: go to meetings, have a sponsor, do step work, see my social worker, and I stay away from places that are dangerous like bars and clubs and friends and people from the past. Even, I must even watch, I've realised, like the movies I watch and the music I listen to, 'cause it doesn't have a huge effect on me, but it has an underlying effect on me and even being around people who drink. Often I think I can handle it, but after a long period of time, a few months of doing that, it does affect me in a way. So many little things, like the other day I realised I can't use homeopathic medicine because my mother wanted to take me to a homeopath because I have been having skin problems, and can't use mouthwash and all these stupid little things no-one tells me.

I figure it out on my own, and see what works and what doesn't work for me. So it's a long process and it does get a lot better with time.

I've also realised what worked for me in my 1st year of staying clean is not going to work for me in my 5th year of staying clean. It's an ongoing process of change and seeing what works for me now and what's going to work for me in a year's time. I suppose it's all different all the time.

I don't believe, what some people say, 'I've recovered' after staying clean for a certain while or being normal.

Like my daily activities are normal now. Like I've got a job and I'm studying and I've got relationships with my friends, and parents, and my boyfriend, and everything is normal and yet it doesn't mean I've recovered just because I'm reintegrated into society. I still have a problem and I think it's important of always being aware of it and still making a daily choice of not to use.

In the end, there can be all the counselling

then it doesn't help at all. I seen it with so many people. Everyone helping them, their parents, they've been in eight rehabs and they are being subjected to all strange treatments. I mean a friend of mine who died about a year ago, his parents as a last resort, like go on anaesthetics and they'd give him shocks or something like that, he just didn't want to stop using. He didn't make that choice for himself. I think that's the most important thing that I do, is making a daily choice and also praying to for God to help me. Um, it also helps me a lot to know that I don't have to do it on my own, and that I've got so much support in my friends, my family, and people in NA, my sponsor, my boyfriend.

Interviewer: *So you felt that the support was always there and that people weren't judgmental?*

Participant: I struggle with that a bit. My family has been good with support and that. When I made a new group of friends, I found it difficult because they are all normal people. Since I have come out of rehab, I have made really good friends, but I've always felt like I don't really belong and I'm different. But the longer I'm friends with them, the more I realise that I also have an important role to play in their lives and they are very supportive, but, what I find is like when I started a new job and with my boyfriends' parents and things like that, it's still difficult for me because I feel they are judgmental. It's hard for me, because, especially the idea of society of the drug addict it like a horrible thing. You know, I feel like that no matter how long I stay clean, it's always going to be with me kind of. I am still an alcoholic. It doesn't go away. And I mean, sometimes I go to parties, and the people don't understand why I don't drink and I say to them; 'I choose not do drink'. I've gotten to a point in my life were I feel that I don't need to explain myself all the time and say 'I can't drink because of this and this and this...' and sometimes people aren't supportive and think I'm strange and it's not easy. Um, my friends know that if they're going to a club or whatever, they don't even invite me because they know that I will say no and that I don't go to that. Sometimes I'm scared that when I really start working, like at my career, what am I going to do then? What am I going to write on my CV and what, just little things like that. How much of my personal life must I get involved if I'm working somewhere or whatever? I'm doing casual work at the moment, and they've really all been great with it, and I don't know how that's going to be in future. And, it's sometimes difficult for me, sometimes when I speak at a school, or

and medication and everything, if I don't make that choice that I'm going to stop using, then it doesn't help at all. I seen it with so many people. Everyone helping them, their parents, they've been in eight rehabs and they are being subjected to all strange treatments.

I mean a friend of mine who died about a year ago, his parents as a last resort, like go on anaesthetics and they'd give him shocks or something like that, he just didn't want to stop using. He didn't make that choice for himself.

I think that's the most important thing that I do, is making a daily choice.

Also praying to God to help me.

It also helps me a lot to know that I don't have to do it on my own, and that I've got so much support in my friends, and people in NA, my sponsor, my boyfriend.

I struggle with that a bit. My family has been good with support and that.

When I made a new group of friends, I found it difficult because they are all normal people. Since I have come out of rehab, I have made really good friends, but I've always felt like I don't really belong and I'm different.

But the longer I'm friends with them, the more I realise that I also have an important role to play in their lives and they are very supportive, but, what I find is like when I started a new job and with my boyfriends' parents and things like that, it's still difficult for me because I feel they are judgmental.

It's hard for me, because, especially the idea of society of the drug addict it like a horrible thing.

You know, I feel like that no matter how long I stay clean, it's always going to be with me kind of. I am still an alcoholic. It doesn't go away. And I mean, sometimes I go to parties, and the people don't understand why I don't drink and I say to them; 'I choose not do drink'.

I've gotten to a point in my life were I feel that I don't need to explain myself all the time and say 'I can't drink because of this and this and this...' and sometimes people aren't supportive and think I'm strange and it's not easy.

My friends know that if they're going to a club or whatever, they don't even invite me because they know that I will say no and that I don't go to that.

Sometimes I'm scared that when I really start working, like at my career, what am I going to do then? What am I going to write on my CV and what, just little things like that. How much of my personal life must I get involved if I'm working somewhere or whatever? I'm doing casual work at the moment, and they've really all been great with it, and I don't know how that's going to be in future.

sharing at meetings or whatever, you know the world is so small. I sometimes am afraid of who will know that I am an addict because that happened at the job were I am now. The one girl's fiancé and I were in rehab together. So she found out and in the end the manager found out. They were all great with it, but what if I am working at a law firm someday, how's the situation going to be? Sometimes I am judgmental on myself feeling like I don't fit in and I don't belong and there is something wrong with that to be? and me. But, with time that is also getting less and less. So, I wouldn't be the person today if it wasn't for the road I walked, and it's the way I am living my life.

Interviewer: Do you feel that the duration of treatment plays a role in recovery?

Participant: Yes I do. I don't know how these four-week, five-week treatments can really help. It's a good starting point. But, I think it's important, I've seen with people who stay clean, you know they do the programme and they go to after-care, and then maybe to a halfway house, and then keep on coming to meetings, seeing a psychologist or social worker and all those things. When I stayed in Noupoot my last year, for a very long time, the programme was eight months, and then when I was six months there, I committed myself to doing a year, and then, as a year approached, things just worked out and I was teaching at the school so they asked me to stay on. So I was there in total a year and a half. I think it was a bit too long, 'cause when I came out, I was so, I remember when I just came out of Noupoot I didn't even want to go into the garden I was too scared, because everything was regulated like what magazine I could read, and what radio station and what programme on TV I could watch and all that. And it was hard for me. I think the period was too long. It's so hard to re-integrate into society. But I think maybe a year programme or so is a good starting point. The thing is, the word 'long duration treatment', it's actually a 'life-time duration treatment.' I mean, I'm not in rehab now and I'm still doing all these things that I have to do daily and weekly to stay clean. So I suppose it's actually a 'life-time treatment'.

Interviewer: Do you think that there is a difference between treating a heroin addiction compared to other addictions?

It's sometimes difficult for me, sometimes when I speak at a school, or at church, or sharing at meetings or whatever, you know the world is so small. I sometimes am afraid of who will know that I am an addict because that happened at the job were I am now. The one girl's fiancé and I were in rehab together. So she found out and in the end the manager found out. They were all great with it, but what if I am working at a law firm someday, how's the situation going to be?

Sometimes I am judgmental on myself feeling like I don't fit in and I don't belong and there is something wrong with that and me.

But, with time that is also getting less and less.

So, I wouldn't be the person today if it wasn't for the road I walked, and it's the way I am living my life.

Yes I do.

I don't know how these four-week, five-week treatments can really help. It's a good starting point.

But, I think it's important, I've seen with people who stay clean, you know they do the programme and they go to after-care, and then maybe to a halfway house, and then keep on coming to meetings, seeing a psychologist or social worker and all those things.

When I stayed in Noupoot my last year, for a very long time, the programme was eight months, and then when I was six months there, I committed myself to doing a year, and then, as a year approached, things just worked out and I was teaching at the school so they asked me to stay on. So I was there in total a year and a half.

I think it was a bit too long, 'cause when I came out, I was so, I remember when I just came out of Noupoot I didn't even want to go into the garden I was too scared, because everything was regulated like what magazine I could read, and what radio station and what programme on TV I could watch and all that. And it was hard for me. I think the period was too long. It's so hard to re-integrate into society. But I think maybe a year programme or so is a good starting point.

The thing is, the word 'long duration treatment', it's actually a 'life-time duration treatment.'

I mean, I'm not in rehab now and I'm still doing all these things that I have to do daily and weekly to stay clean.

So I suppose it's actually a 'life-time treatment'.

- Participant: I do think so. I've found like a certain type of person uses heroin. Like I want to numb the pain of living. You can't cope with life. Other people, like, I've been to Cocaine Anonymous meetings and people who just smoke and the crack addicts and cocaine addicts are much different. Um, and I know that's why they have separate meetings for it. And people who just smoke weed (*cannabis*) are different. Are much different.
- Participant: I do think so. I've found like a certain type of person uses heroin. Like I want to numb the pain of living. You can't cope with life. Other people, like, I've been to Cocaine Anonymous meetings and the crack addicts and cocaine addicts are much different. Um, and I know that's why they have separate meetings for it. And people who just smoke weed are different. Are much different.
- Interviewer: *In what way?*
- Participant: Um, they just looking for some spiritual type of escape, and being creative and being on a different wavelength and that. I've really seen that with people who just addicted to weed (*cannabis*). Using heroin is like the forbidden territory almost. I remember when I started using it, and I know a lot of other people also like that, I think it's okay to smoke weed (*cannabis*) and it's okay to use ecstasy and acid and coke and all these things, but I used to say to myself; 'I am never going to use heroin, because it's, even in the circle of using drugs it's like, a dangerous thing to do because heroin addicts die and that's it. And heroin addicts get AIDS, and heroin addicts throw their lives away and become prostitutes and live with the Nigerians. Um, there's such, even between junkies, there's like this stigma attached to heroin addicts. And I got to a point in my life were I just didn't care about living, and I had no self-respect left and dignity and... using heroin was like an inevitable option almost. And I know that the first time I used it was like the drug I've been looking for all along, the high, but also... being completely comfortably numb, feeling nothing and that's the one thing I miss of using heroin. I like being numb. I like not having to feel my emotions, reality and stress, and anxiety and all these things that I am always prone to. So, I think there is a big difference. Lots of people I know use heroin once and hate it, and lots of people love it. I mean, using heroin for the first time is not actually a lovely experience. The first few times you're nauseous or throw up and itching. But why did I carry on using you know? Lots of people are put off by that, but why did I, it's like starting to smoke. In the beginning it's not nice, you're coughing and whatever. But why did I keep on smoking until it almost got better, until it was nice to smoke. Until it was nice to use heroin, even though that nice period lasts for a very short time and the horrible period lasts for a long, long time. Why could I never stop using? And also being physically addicted to it, having to use all the time. Ja (yes), I think there's a big difference. Almost now when I meet an addict, you can like almost know the difference, who's a heroin addict and
- Participant: They just looking for some spiritual type of escape, and being creative and being on a different wavelength and that. I've really seen that with people who just addicted to weed. Using heroin is like the forbidden territory almost. I remember when I started using it, and I know a lot of other people also like that, I think it's okay to smoke weed and it's okay to use ecstasy and acid and coke and all these things, but I used to say to myself; 'I am never going to use heroin, because it's, even in the circle of using drugs it's like, a dangerous thing to do because heroin addicts die and that's it. And heroin addicts get AIDS, and heroin addicts throw their lives away and become prostitutes and live with the Nigerians. Even between junkies, there's like this stigma attached to heroin addicts. I got to a point in my life were I just didn't care about living, and I had no self-respect left and dignity and... using heroin was like an inevitable option almost. And I know that the first time I used it was like the drug I've been looking for all along, the high, but also... being completely comfortably numb, feeling nothing and that's the one thing I miss of using heroin. I like being numb. I like not having to feel my emotions, reality and stress, and anxiety and all these things that I am always prone to. So, I think there is a big difference. Lots of people I know use heroin once and hate it, and lots of people love it. Using heroin for the first time is not actually a lovely experience. The first few times you're nauseous or throw up and itching. But why did I carry on using you know? Lots of people are put off by that, but why did I, it's like starting to smoke. In the beginning it's not nice, you're coughing and whatever. But why did I keep on smoking until it almost got better, until it was nice to smoke. Until it was nice to use heroin, even though that nice period lasts for a very short time and the horrible period lasts for a long, long time. Why could I never stop using? Also being physically addicted to it, having to use all the time. Ja, I think there's a big difference. Almost now when I meet an addict, you can like almost know the difference, who's a heroin addict and who's not.

who's not.

Interviewer: What advice would you give to someone with a heroin problem, or how would you go about treating them?

Participant: I think the person must really be at a point where they want to change and want to stop using. I think that's the bottom line. They must get to that point, no matter if they think they've hit rock bottom, and if they think it's horrible to use and they can't do it anymore. They must really get to that point of surrender and giving up and willingness of wanting to change and wanting to stop using forever, not just for a few weeks and just to detox - so they can start using again without being addicted and um, also not thinking they can stop using heroin but still drink alcohol or smoke weed now and then, still go clubbing and whatever. Um, they must also realise that it is a life-long process and that they're not allowed to use any mind or mood altering drugs and that no treatment centre or no methadone programme or doctor or psychologist is going to fix things. And, um, what's important is also a holistic approach of medication and counselling and treatment and after-care and all those things. It's not just; I don't think there's just one thing that works. Different things work for different people. Some people just go to church and they're fine and go for deliverance and suddenly they have no cravings. I've met these people, but I don't know... um, I know what worked for me and what works for me I've seen work for a lot of other people. And I think the following suggestions; staying around people with more clean time than me, having friends that are not addicts, and I think it's important, my boyfriend is also not an addict and he doesn't drink. I mean he chooses, because I don't drink, not to drink and that's important. And even little things as I said, the movies, music and places where I go to. Um, support from family, friends and I think that's very important and I also think digging deep and realising why did I use, what's the deeper reason, getting to know the deeper reason. Realising I'm not okay and maybe I must go to four meetings this week. Realising the signs. I don't think relapsing is just... one day a guy told me that suddenly his car just drove to Hillbrow. It's not like that. It's a gradual process. I mean the other night I was in a meeting and this woman shared and she was seven years clean and she relapsed and that, she also told us how it was a long progression. She started hanging out with newcomers in the room, she stopped going to meetings, she didn't have a sponsor. This gradual progression, and then suddenly she was using again. Um, having all these barriers to using, and like if I'm not feeling

I think the person must really be at a point where they want to change and want to stop using. I think that's the bottom line. They must get to that point, no matter if they think they've hit rock bottom, and if they think it's horrible to use and they can't do it anymore. They must really get to that point of surrender and giving up and willingness of wanting to change and wanting to stop using forever, not just for a few weeks and just to detox - so they can start using again without being addicted and also not thinking they can stop using heroin but still drink alcohol or smoke weed now and then, still go clubbing and whatever.

They must also realise that it is a life-long process and that they're not allowed to use any mind or mood altering drugs and that no treatment centre or no methadone programme or doctor or psychologist is going to fix things.

What's important is also a holistic approach of medication and counselling and treatment and after-care and all those things. It's not just; I don't think there's just one thing that works.

Different things work for different people. Some people just go to church and they're fine and go for deliverance and suddenly they have no cravings. I've met these people, but I don't know... um, I know what worked for me and what works for me I've seen work for a lot of other people.

I think the following suggestions; staying around people with more clean time than me, having friends that are not addicts, and I think it's important, my boyfriend is also not an addict and he doesn't drink. I mean he chooses, because I don't drink, not to drink and that's important. And even little things as I said, the movies, music and places where I go to.

Support from family, friends and I think that's very important.

I also think digging deep and realising why did I use, what's the deeper reason, getting to know the deeper reason.

Realising I'm not okay and maybe I must go to four meetings this week. Realising the signs.

I don't think relapsing is just... one day a guy told me that suddenly his car just drove to Hillbrow. It's not like that. It's a gradual process. I mean the other night I was in a meeting and this woman shared and she was seven years clean and she relapsed and that, she also told us how it was a long progression. She started hanging out with newcomers in the room, she stopped going to meetings, she didn't have a sponsor.

okay, for a little while I say, for the next week or so I'm not going to go anywhere alone, just for in case. I'm not going to go even walk around in a shopping centre, 'cause that's a safe thing for me to do. When I'm feeling like that, like that not to test myself and see how brave I can be, but rather admitting I'm vulnerable and being in some protected environment makes a lot of sense.

Interviewer: *You've given me such valuable information. Thank you so much. All the best for the future. You've got a lot to offer other people too, good luck.*

Participant: Thank you so much!

This gradual progression, and then suddenly she was using again.

Having all these barriers to using, and like if I'm not feeling okay, for a little while I say, for the next week or so I'm not going to go anywhere alone, just for in case. I'm not going to go even walk around in a shopping centre, 'cause that's a safe thing for me to do. When I'm feeling like that, like that not to test myself and see how brave I can be, but rather admitting I'm vulnerable and being in some protected environment makes a lot of sense.

PARTICIPANT 11 TRANSCRIPTION

Interviewer: The question I'd like to ask you is: describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: You want to come clean. Scared of dying. You want to come clean. Scared of dying.

Interviewer: Do you feel that your treatment helped you in coming clean?

Participant: Definitely. Definitely.

Interviewer: In what way? Can you elaborate on that?

Participant: Being in a protected environment, um, using certain guidelines, doing the NA (*Narcotics Anonymous*) twelve step programme to guide you in the right direction. Give you more knowledge about what's it's been doing to me, and all that which I find has really helped. Being in a protected environment. Using certain guidelines. Doing the NA twelve step programme to guide you in the right direction. Give you more knowledge about what it's been doing to me, and all that which I find has really helped.

Interviewer: Any medical intervention? Do you feel that that assisted in your recovery or not?

Participant: Taking physeptone and all that, ja (yes) definitely. Taking physeptone and all that, ja definitely.

Interviewer: Did it help you?

Participant: Yes, it helped for seven days. Yes, it helped for seven days.

Interviewer: In what way?

Participant: Just to ease that need of wanting to just use all the time, your know. Um, going through your withdrawals, it makes it so much easier. I felt. Just to ease that need of wanting to just use all the time. Going through the withdrawals, it makes it so much easier. I felt.

Interviewer: Did it help you stay off?

Participant: Um, in a way yes. By also, like I said, by being in a protected environment too when using. I don't feel, I think you can use it but then always go out and use again. It's not going to stop you from using. In a way yes. But also, like I said, by being in a protected environment too when using. I don't, I think you can use it but then always go out and use again. It's not going to stop you from using.

Interviewer: You mean the medication?

Participant: Ja (yes), the medication. But I find by also being in a protected environment and also being so far away from anywhere. It's not really easy for me to just jump the wall and use. Ja, the medication. But I find by also being in a protected environment and also being so far away from, from anywhere. It's not really easy for me to just jump the wall and use.

Interviewer: Okay, if you had not been in a protected environment and you were using the medication, would you have been able to abstain from drugs?

Participant: Not at all. Not at all.

Interviewer: So you feel the combination of a protected environment plus the medication helps you?

Participant: It's very necessary. It's very necessary.

Interviewer: Okay. Do you feel there's is a difference between treating heroin addiction and other forms of addiction?

Participant: Is it necessary?

Interviewer: Is there a difference?

Participant: Ja (yes) there is a big difference because of that physical need and that physical want. Um, it's very different to pills for example, ecstasy, it's not like you have to have your daily fix of it, with heroin you do otherwise you become sick. It's a big thing. Ja there is a big difference because of that physical need and that physical want. It's very different to pills for example, ecstasy, it's not like you have to have your daily fix of it, with heroin you do otherwise you become sick. It's a big thing.

Interviewer: Do you feel that the duration of treatment plays a role in recovery?

Participant: Long-term definitely, definitely. For me I found that from even using for such a short period of time heroin, using heroin I, I wasn't feeling. I became dead of feelings and all that. It takes time for you to regain those feelings, the thought process and the patterns. It takes awhile to regain all of that. Long-term definitely, definitely. For me I found that from even using for such a short period of time heroin, using heroin I, I wasn't feeling. I became dead of feelings. It takes time for you to regain those feelings, the thought process and the patterns. It takes awhile to regain all of that.

Interviewer: What advice would you give to someone with such a drug problem like heroin?

Participant: I would say a minimum period in a rehabilitation centre I think of six weeks. Definitely being in a protected environment, um, and I think you are going to have to make the decision to want to come clean; you've got to want it. I would say a minimum period in a rehabilitation centre I think of six weeks. Definitely being in a protected environment. I think you are going to have to make the decision of want to come clean; you've got to want it.

Interviewer: Okay, do you feel that you've had support from the people around you, your significant others? Or do you feel that people were judgmental or society judgmental, and how has that affected you in your recovery?

Participant: Um, for me now that I am out of rehab, I still tell people or if they ask me where have I been, I tell them that I have been in a rehab because of a crack and heroin addiction so that I could protect myself in a way that, you know. If the time comes were they want to go out and do the social thing, they'll know exactly were I come from now, just to be protected. I don't mind telling people. They may be judgmental of me but I don't have a problem with it. For me now that I am out of rehab, I still tell people or if they ask me where have I been, I tell them that I have been in a rehab because of a crack and heroin addiction so that I could protect myself. If the time comes were they want to go out and do the social thing, they'll know exactly were I come from now, just to be protected. I don't mind telling people. They may be judgmental of me but I don't have a problem with it.

Interviewer: Do you feel that you have had support, has that played an important part in your recovery?

- Participant: Yes, definitely. Family have been very supportive, especially the rehab that I went to, they have all been through it and are still going through it. A lot of support.
- Interviewer: *Is it hard for you to stay clean?*
- Participant: Um, 50/50 I'd say. I know that it is very easy for me to jump back into that whole behaviour and using again. But um, I also know were I've been. Luckily with the rehab were I have gone to the tools that they provide you with I now put in practice to prevent myself from going off the track, or going back to bad behaviour or doing certain things that I know will put me back on the wrong path. Time takes time, time takes time.
- Interviewer: *Thank you so much.*
- Participant: Yes, definitely.
Family have been very supportive.
The rehab that I went to, they have all been through it and are still going through it.
A lot of support.
- Participant: 50/50 I'd say.
I know that it is very easy for me to jump back in to the whole behaviour and using again. I also know were I've been.
Luckily with the rehab were I have gone to the tools that they provide you with I now put in practice to prevent myself from going off the track, or going back to bad behaviour or doing certain things that I know will put me back on the wrong path.
Time takes time, time takes time.

PARTICIPANT 12 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: Well, treatment didn't really help me... I wasn't really ready and I was rebelling. The medication that I took for the first couple of days really helped.

Interviewer: You took methadone?

Participant: Yes.

Interviewer: In what way did it help you? Can you elaborate on that?

Participant: It helped get my head straight and for withdrawal. Later I was more open towards treatment.

Interviewer: Do you feel that your family was supportive within your recovery process?

Participant: My father. To a lesser extent the rest of my family.

Interviewer: The way in which society viewed you, their perceptions of you as a recovering addict, was it conducive towards your recovery or not.

Participant: Society has there own perceptions, but I don't give a fuck what they think and whether they want to accept me or not. My friends were supportive.

Interviewer: Is it hard for you to stay clean?

Participant: Only from heroin, as it controlled my mind, at a stage it meant everything to me.

Interviewer: So you don't struggle to stay clean from the other drugs?

Participant: I've used all the other drugs again once, but I didn't become addicted to them again, except to Cat (*methcathinone*). I was addicted to Cat (*methcathinone*) for a period of time, but I haven't used it again after I came for after-care, which is now about five months ago. I never used heroin again after coming out of rehab.

Interviewer: What advice would you give to someone with a heroin problem?

Participant: I really don't know... nothing.

Interviewer: So do you feel then that they should be left alone?

Participant: No, I think being in a safe environment is best where they can be left to figure things out for themselves.

Interviewer: Thank you for your participation.

Well, treatment didn't really help me... I wasn't really ready and I was rebelling. The medication that I took for the first couple of days really helped.

Yes.

It helped get my head straight and for withdrawal. Later I was more open towards treatment.

My father.
To a lesser extent the rest of my family.

Society has there own perceptions, but I don't give a fuck what they think and whether they want to accept me or not. My friends were supportive.

Only from heroin, as it controlled my mind, at a stage it meant everything to me.

I've used all the other drugs again once, but I didn't become addicted to them again, except to Cat. I was addicted to Cat for a period of time, but I haven't used it again after I came for after-care, which is now about five months ago. I never used heroin again after coming out of rehab.

I really don't know...
Nothing.

No.
I think being in a safe environment is best where they can be left to figure things out for themselves.

PARTICIPANT 13 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Read again...
- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* How did I come clean?
- Interviewer:* Yes, how did you come clean?
- Participant:* No medication could help. Medication does not help at all. I tried it a couple of times. It is almost stronger than drugs, the medication that you use.
- Interviewer:* What medication are you referring to?
- Participant:* Methadone. You just get a prescription from the doctor and you can get it at a pharmacy. It did not work. I went to Noupoort. You do not receive medication there, and you come clean. It takes you about two weeks to detox, to get the stuff out of your system, until the withdrawal stops. And after that everything is Christian counselling that you get through the whole process and long-term staying clean together with Christian counselling and it is a good combination.
- Interviewer:* So the spiritual aspect was an important part of the recovery?
- Participant:* Yes, definitely. You see the other side of life that you know but never experience. So I think the big thing for me was long-term and spiritual orientation and being able to see the better side of life.
- Interviewer:* Okay. Is it hard to stay clean?
- Participant:* It is very, very hard. It's a 24 hour a day addiction that you have. An hour passes and you must use otherwise your muscles are sore and it feels as though you literally want to die from the pain of withdrawal. And it's a matter of an hour, two hours then you can start...
- Interviewer:* But is it hard now for you to stay clean?
- Participant:* Now, not at all, not at all. The first while after Noupoort, back in the environment was, the first months or two was difficult. But, just stick to it and made it.
- Interviewer:* Was it difficult to stay clean, or to re-integrate into society? Or a combination of the two?
- No medication could help. Medication does not help at all. I tried it a couple of times. It is almost stronger than drugs, the medication that you use.
- Methadone. You just get a prescription from the doctor and you can get it at a pharmacy. It did not work. I went to Noupoort. You do not receive medication there, and you come clean. It takes you about two weeks to detox, to get the stuff out of your system, until the withdrawal stops. And after that everything is Christian counselling that you get through the whole process and long-term staying clean together with Christian counselling and it is a good combination.
- Yes, definitely. You see the other side of life that you know but never experience. So I think the big thing for me was long-term and spiritual orientation and being able to see the better side of life.
- It is very, very hard. It's a 24 hour a day addiction that you have. An hour passes and you must use otherwise your muscles are sore and it feels as though you literally want to die from the pain of withdrawal. And it's a matter of an hour, two hours then you can start...
- Now, not at all, not at all. The first while after Noupoort, back in the environment was, the first months or two was difficult. But, just stick to it and made it.

- Participant: Look, you can make it difficult for yourself if your mind is not right. You go back to where you were before, the same situation. Maybe friends who are on the same stuff. For me, it wasn't so difficult, only the thoughts after the first while after you come back. All the thoughts that go through your mind. But after two, three months, then it is over. You must just keep your head clean... you mustn't turn back. It's not easy, many people fall once they come out of rehabilitation, after being clean a long time. But it's because they do not follow the right steps. They look for trouble. But now after three years, I don't ever think about it. It is not my way of life. My way of life has completely changed, so...
- Participant: Look, you can make it difficult for yourself if your mind is not right. You go back to where you were before, the same situation. Maybe friends who are on the same stuff. For me, it wasn't so difficult, only the thoughts after the first while after you come back. All the thoughts that go through your mind. But after two, three months, then it is over. You must just keep your head clean... you mustn't turn back. It's not easy, many people fall once they come out of rehabilitation, after being clean a long time. But it's because they do not follow the right steps. They look for trouble. But now after three years, I don't ever think about it. It is not my way of life. My way of life has completely changed, so...
- Interviewer: So it's also a life-style change? Do you think there is a difference between heroin addiction and other forms of addiction, with regards to treatment?*
- Participant: With regards to treatment?
- Interviewer: Yes.*
- Participant: I tend to think so. I think heroin is the worst addiction that you get. Apart from cigarettes that 80% of the world uses, but that is physically bad for your body. Heroin is top of the rank.
- Participant: I tend to think so. I think heroin is the worst addiction that you get. Apart from cigarettes that 80% of the world uses, but that is physically bad for your body. Heroin is top of the rank.
- Interviewer: So how should one treat it differently?*
- Participant: Long-term, long-term being clean. I don't think it is anything else. Long-term as in not just through rehabilitation through a year or two, more (*like*) five years. I think if you are five years clean, five years of being clean, then only I think that you are relatively safe. Until then, I don't think that anyone is safe. So, one must never be too lax, and you must always avoid it.
- Participant: Long-term, long-term being clean. I don't think it is anything else. Long-term as in not just through rehabilitation through a year or two, more (*like*) five years. I think if you are five years clean, five years of being clean, then only I think that you are relatively safe. Until then, I don't think that anyone is safe. So, one must never be too lax, and you must always avoid it.
- Interviewer: Do you feel that you have had people around you that have supported you? Has it been an important aspect?*
- Participant: Yes, it is a very important aspect.
- Participant: Yes, it is a very important aspect.
- Interviewer: Okay, and society...how do you feel society perceives you? Has it helped you in the long-run, or not really?*
- Participant: Yes, definitely.
- Participant: Yes, definitely.
- Interviewer: So you don't feel that people have judged you?*
- Participant: Not at all. It's something that happened, and just getting through it is already an achievement. Especially from my parents, I've received all the support that was necessary. Friends, old friends who were never addicted, and it definitely helps a person. A positive influence in your life of people around you.
- Participant: Not at all. It's something that happened, and just getting through it is already an achievement. Especially from my parents, I've received all the support that was necessary. Friends, old friends who were never addicted, and it definitely helps a person.

Interviewer: Okay, thank you very much.

Participant: Pleasure.

A positive influence in your life of people around you.

PARTICIPANT 14 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: What do I say?

Interviewer: How did you come and stay clean?

Participant: Hell... I just came clean and when I craved... it was just not for me... Hell... I just came clean and when I craved... it was just not for me.

Interviewer: Okay, so was it a sort-of a mind-set change, or just a decision?

Participant: Both.

Interviewer: Okay, can you tell me a bit more?

Participant: Um, no I don't know. Just stopped. Made up my mind that I was just finished. No I don't know. Just stopped. Made up my mind that I was just finished.

Interviewer: Okay, did medication help you?

Participant: The anti-depressant when I was here (rehab). It made the DPN (diphosphopyridine nucleotide) drip and me calmer, - it did make me sore. The anti-depressant when I was here. It made me calmer. The DPN drip - it did make me sore.

Interviewer: Do you feel that it helped you with your withdrawal or to come clean or to stay clean?

Participant: I don't know, I don't think so. It's all in the mind. I don't know. I don't think so. It's all in the mind.

Interviewer: Is it hard for you to stay clean?

Participant: No. No.

Interviewer: You do not struggle with cravings?

Participant: No. No.

Interviewer: Not in the beginning?

Participant: I thought about it a lot, yes that was cravings I know. But never made a mission to go and get it. I thought about it a lot, yes that was cravings I know. But never made a mission to go and get it.

Interviewer: Okay. Do you feel that you got support from the people around you, did that help?

Participant: Yes, it did. Yes, it did.

Interviewer: Okay. In terms of society in general, do you feel that people were judgmental towards you? Or do you feel that they generally supported you?

Participant: Some people don't trust me, some people love me a lot and trust me and let me visit with their children and it's not a problem. Other people keep me away, it doesn't bother me. Some people don't trust me. Some people love me a lot and trust me and let me visit with their children and it's not a problem. Other people keep me away, it doesn't bother me.

Interviewer: It doesn't bother you?

Participant: It's their problem, not? It's their problem, not?

Interviewer: Yes. Do you think there is a difference in treating heroin addiction in comparison to other drugs?

Participant: I think heroin is just a little harder than others. I think heroin is just a little harder than others.

Interviewer: Okay, say now someone who is hooked on it came to you...

Participant: Heroin or what? Heroin or what?

Interviewer: Yes. What advice would you give to the person?

Participant: Come to Castle Carey. Come to Castle Carey.

Interviewer: So you feel that treatment plays a role, it is a good thing then?

Participant: Yes.
You cannot just say to him go sit in your room and lock yourself away, then you will die of heroin. You will not survive. Yes.
You cannot just say to him go sit in your room and lock yourself away, then you will die of heroin. You will not survive.

Interviewer: Okay. Thank you for everything, you are a miracle.

PARTICIPANT 15 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and /or medical intervention was able to assist you.

Participant: Okay, my process, I was in, it was... it helped me through everything and got me where I am now. I think SANCA they helped a lot because I tried coming clean on my own, but I always went back to the same old routines. But then, I booked in SANCA there. I actually didn't want to go anywhere but I went in the end. And the first three days they put you under sedation and that was quite good for me because the first three days are always the worst part of withdrawals. And the medication there, they put me on methadone I think, but, like I didn't feel the methadone. After three days, when I came out of sedation, I wasn't feeling withdrawals or anything. I was a bit depressed, heavy moody and so, but after a while I got the hang of it. And then afterwards... (phone call interrupts interview) and then I got to the point where I was talking about me, I was heavy depressed and so. And then I, the people around me were mostly in there 40's and 50's, we were only two guys that were addicted to heroin, and he was nineteen years old, and I was at that time 21. These people were my inspiration, they, I would chat to them the whole day and see that my life wasn't so bugged up. Actually if I hear what's happened in their lives, and then afterwards when I came out I was supposed to go and see the psychologist, but I didn't because I didn't have a need to. And then I went to my sister. There I got a contract to work, and I think that was a motivation for me, every day I just worked harder and harder. In the end it payed off.

Interviewer: So you feel that being in treatment did help you then in the process to come clean?

Participant: Ja (yes), I couldn't have done it without it. I am sure of that.

Interviewer: Okay. And the medication, do you think that it helped you?

Participant: Ja (yes), in the extent. Like I said, in the beginning, the sedation part that they did to me, that was, I really, that was really something extraordinary, it was really good.

Interviewer: And to stay clean? Do you think medication helps?

Okay, my process, I was in, it was... it helped me through everything and got me where I am now. I think SANCA they helped a lot because I tried coming clean on my own, but I always went back to the same old routines.

But then, I booked in SANCA there. I actually didn't want to go anywhere but I went in the end.

The first three days they put you under sedation and that was quite good for me because the first three days are always the worst part of withdrawals.

And the medication there, they put me on methadone I think, but, like I didn't feel the methadone.

After three days, when I came out of sedation, I wasn't feeling withdrawals or anything. I was a bit depressed, heavy moody and so, but after a while I got the hang of it.

Then afterwards... and then I got to the point where I was talking about me, I was heavy depressed and so.

And then I, the people around me were mostly in there 40's and 50's, we were only two guys that were addicted to heroin, and he was nineteen years old, and I was at that time 21. These people were my inspiration, they, I would chat to them the whole day and see that my life wasn't so bugged up. Actually if I hear what's happened in their lives, and then afterwards when I came out I was supposed to go and see the psychologist, but I didn't because I didn't have a need to.

And then I went to my sister. There I got a contract to work, and I think that was a motivation for me, every day I just worked harder and harder. In the end it payed off.

Ja, I couldn't have done it without it. I am sure of that.

Ja, in the extent. Like I said, in the beginning, the sedation part that they did to me, that was, I really, that was really something extraordinary, it was really good.

- Participant: I don't know. I'm not using medication, so, but I think you can do it on your own; it's about your mind power. It's about what you decide. What you want to do in life. What you want to be.
- I don't know. I'm not using medication, so, it's about your mind power. It's about what you decide. What you want to do in life. What you want to be.
- Interviewer: Is it hard to stay clean?*
- Participant: Yes, it is.
- Yes, it is.
- Interviewer: What gets you through the hard times?*
- Participant: Hard times hey? I just look back and I just look at myself and what I did, what I was and just think to myself I'm not going back there again ever.
- Hard times hey? I just look back and I just look at myself and what I did, what I was and just think to myself I'm not going back there again ever.
- Interviewer: Do you think there is a difference in treating heroin addiction compared to other addictions?*
- Participant: I'm not sure. I don't know how to answer this question 'cause it has come up before. And I've asked a person, and he, the psychologist, actually she said to me you can't actually compare 'cause it's a, sometimes it gets psychologically involved... involves a person psychologically, so you can't actually compare. But if you can talk about physical, I'd say heroin is the hardest part to get off, but I can't compare other drugs and other people.
- I'm not sure.
I don't know how to answer this question 'cause it has come up before.
I've asked a person, and he, the psychologist, actually she said to me you can't actually compare 'cause it's a, sometimes it gets psychologically involved... involves a person psychologically, so you can't actually compare.
But if you can talk about physical, I'd say heroin is the hardest part to get off, but I can't compare other drugs and other people.
- Interviewer: Okay.*
- Participant: Addiction is addiction.
- Addiction is addiction.
- Interviewer: Well, do you think the duration of treatment plays a role? How long do you think that someone should be in treatment for?*
- Participant: Okay, I'm not sure. I was two weeks, only detox, and I think it did, it served its purpose to me. But I think a month; a minimum or a month would be the best.
- Okay, I'm not sure. I was two weeks, only detox, and I think it did, it served its purpose to me.
But I think a month; a minimum or a month would be the best.
- Interviewer: Do you feel that your family, or the people around you were supportive in your recovery, did that help you at all?*
- Participant: Some people were supportive, some people afterwards when I came back from my sister, I went to everyone and I apologised to them 'cause it was part of the programme. But I did it because I wanted to do it, not because of the programme. Some people rejected me, some people accepted the apologies and we made up, now we are best friends again and what what what. Some people just... they don't understand.
- Some people were supportive, some people afterwards when I came back from my sister, I went to everyone and I apologised to them 'cause it was part of the programme. But I did it because I wanted to do it, not because of the programme.
Some people rejected me, some people accepted the apologies and we made up, now we are best friends again and what what what.
Some people just... they don't understand.
- Interviewer: So you feel that society is judgmental towards heroin addicts.*

Participant: Ja (yes), but you can't change them. Ja (yes), in a way, in a way not hey.

Interviewer: What advice would you give to someone with a heroin problem?

Participant: First of all, the first golden rule - do you want to come clean yourself? You have to decide that. You can't go for help if you don't want to. That's the best advice I can give anyone.

Interviewer: Thank you so much.

Participant: Pleasure

Ja, but you can't change them.
Ja, in a way.
In a way not, hey.

First of all, the first golden rule - do you want to come clean yourself? You have to decide that.
You can't go for help if you don't want to.
That's the best advice I can give anyone.

PARTICIPANT 16 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you. So what got you to come clean?

Participant: Um, firstly myself, the help of Castle Carey. I did work; it did work, 'cause I didn't think that I was going to come clean. And so for the medicine, um...

Interviewer: The Subutex (Buprenorphine)?

Participant: Ja (yes), and I didn't use it 'cause it did something to me, it was the thought or the kind of taste, it reminded me... it's bitter, you know, so...

Interviewer: What did it remind you of?

Participant: Of heroin. Ja (yes), in a way, (*inaudible*). And I was on it for fourteen days. So for that fourteen days I was withdrawing, but it kept my mind busy, the Subutex, because I thought that I'd abuse it because it tasted like heroin. So, um...

Interviewer: Do you feel that the Subutex helped you?

Participant: Yes.

Interviewer: To come clean?

Participant: Yes

Interviewer: Or just to help you with mind, or both?

Participant: Mind mostly.

Interviewer: Okay.

Participant: My mind, yes.

Interviewer: Do you feel that you need medication to stay clean?

Participant: I haven't used so far, but I think it would help to use, if I had.

Interviewer: Okay. Is it hard for you to stay clean?

Participant: Not with the right people. But with the wrong people, yes. But not that I'm saying my old friends, it's people at my work. You know, it's like they, they look at me otherwise. They think ja (yes), they are judging me and stuff, so...

Interviewer: So you feel that the people out there haven't always been supportive, and that has held you back in your recovery?

Participant: My mother was there.

Interviewer: She was supportive.

Participant: Mmmm.

Firstly myself, the help of Castle Carey. I did work; it did work, 'cause I didn't think that I was going to come clean. And so for the medicine, um...

Ja, and I didn't use it 'cause it did something to me, it was the thought or the kind of taste, it reminded me... it's bitter, you know, so...

Of heroin. Ja, in a way. I was on it for fourteen days. So for that fourteen days I was withdrawing, but it kept my mind busy, the Subutex, because I thought that I'd abuse it because it tasted like heroin.

Yes.

Yes

Mind mostly.

My mind, yes.

I haven't used so far, but I think it would help to use, if I had.

Not with the right people. But with the wrong people, yes. But not that I'm saying my old friends, it's people at my work. You know, they look at me otherwise. They think ja, they are judging me.

My mother was there.

Mmmm.

Interviewer: Okay. Do you think that there is a difference between treating heroin compared to other addictions?

Participant: No, it's not the same. No, it's not the same.

Interviewer: Okay, in what way do you think that it is different?

Participant: Um, I think other stuff it's not so heavy. Heroin is, it's bad. So, the more help you can get, the better. I think other stuff it's not so heavy. Heroin is, it's bad.
So, the more help you can get, the better.

Interviewer: Okay, what would you do to help someone with a heroin problem?

Participant: I would tell them, just get your mind set. Just get your mindset and what you want to be in life. I would tell them, just get your mind set.
Just get your mindset and what you want to be in life.

Interviewer: Do you feel that the duration of treatment would play a role in someone's' recovery and prognosis?

Participant: Yes it would help. Yes it would help.

Interviewer: How long do you feel treatment should be?

Participant: I think more than six weeks. 'Cause at the end of six weeks I felt all right, but something inside just told me that I'm not right, so, I'd say eight to ten weeks, that will help, ja (yes). I think more than six weeks.
'Cause at the end of six weeks I felt all right, but something inside just told me that I'm not right, so, I'd say eight to ten weeks, that will help, ja.

Interviewer: Thank you, good luck.

Participant: Pleasure.

PARTICIPANT 17 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* The process? The process?
- Interviewer:* Yes.
- Participant:* Um, including the police and everything? Including the police and everything?
- Interviewer:* Yes.
- Participant:* Okay, I was using heroin and then one day I went to go buy heroin and then the police busted me and I was taken to my parents' house, my dad's house and he was... um, the police talked to him about it and stuff and that was the first time he found out that I was using. Ja (yes), and then a week later they put me in a rehab, um, they put me on medication and stuff for that week, so long the doctor prescribed stuff for me and then I went to rehab, to Castle Carey, and I stayed there for seven weeks. I stayed a week longer because I felt I needed it. I was very scared to come out, and ja (yes), I think it really helped me. I was using heroin and then one day I went to go buy heroin and then the police busted me and I was taken to my parents' house, my dad's house. The police talked to him about it and stuff and that was the first time he found out that I was using.
Ja, and then a week later they put me in a rehab.
They put me on medication and stuff for that week, so long the doctor prescribed stuff for me and then I went to rehab, to Castle Carey, and I stayed there for seven weeks. I stayed a week longer because I felt I needed it.
I was very scared to come out.
Ja, I think it really helped me.
- Interviewer:* Do you think that getting caught by the police was part of your recovery?
- Participant:* Yes, because that was like a sign to me you know. That was like, you know, the whole thing, you know, I was locked up and everything in the holding cell. So I mean that experience proved to me that I had another chance because I didn't, I got off of it you know without anything, without a criminal record or anything. Yes, because that was like a sign to me you know. That was like, you know, the whole thing, you know, I was locked up and everything in the holding cell.
So I mean that experience proved to me that I had another chance because I didn't, I got off of it you know without anything, without a criminal record
- Interviewer:* Do you feel that medication helped you to come clean?
- Participant:* I really believe that, ja (yes), but ja (yes), it's more - it has to be a psychological thing as well; you have to work at it. But medication can help, but it can also be abused. I really believe that, ja, but ja, it's more.
It has to be a psychological thing as well; you have to work at it.
Medication can help, but it can also be abused.
- Interviewer:* Do you feel that medication would help, would it be easier if you had medication to stay clean now?
- Participant:* Um, maybe ja (yes). It would make it easier. I'm not sure what though, but maybe ja (yes). Maybe ja.
It would make it easier.
I'm not sure what though, but maybe ja.
- Interviewer:* Is it hard for you to stay clean?
- Participant:* It's a struggle ja (yes). It really is, because, I mean, if you're feeling down, your natural, your instinct is to you know, to go get drugs, so ja (yes). It's a struggle ja. It really is, because, I mean, if you're feeling down, your natural, your instinct is to you know, to go get drugs, so ja.

Interviewer: What gets you through the hard times?

Participant: Um, talking to people, um, trying to do something else like reading or just, you know, switch my mind off.

Interviewer: Do you feel you've had support, um, from the people close to you, in your recovery? Or do you feel that people have been judgmental. Has it held you back?

Participant: A bit of both, but um, generally the people were very supportive, my family and everything, um, but it also, I've seen it, really um, people judge you as well. Some people in my family, but it's generally supportive.

Interviewer: And how about the rest of society?

Participant: Um...

Interviewer: Do you feel that people are generally speaking supportive?

Participant: There is a stigma, there is a stigma that I perceive, but I mean, parts of society. A lot of people, like when I go talk about it, um, in front of people, they're very supportive. So it's a bit of both.

Interviewer: Okay. Do you think that there is a difference between treating heroin addiction compared to other addictions?

Participant: Definitely, ja (yes).

Interviewer: Could you elaborate on that?

Participant: Um, heroin is, because heroin is so physically addictive and the withdraws are psychological but mainly physical as well and the withdraws are very intense, um, I would say it would make it a lot more difficult to deal with.

Interviewer: How long do you think that someone should be in in-patient treatment for heroin?

Participant: I would say, um, about six weeks maybe. It depends on the person, but mainly between six weeks and two months.

Interviewer: And what about long-term treatment? Do you have any opinion on that? People in rehab for a year plus?

Participant: Um, I think some people need that. Like heavy heroin 'junkies' that have been using for years and years. I believe that if all else fails then, then that has to work. I don't agree with the long-term treatment in our country.

Interviewer: Why not?

Talking to people.
Trying to do something else like reading or just, you know, switch my mind off.

A bit of both.
Generally the people were very supportive, my family and everything.
But it also, I've seen it, really, people judge you as well.
Some people in my family, but it's generally supportive.

There is a stigma, there is a stigma that I perceive, but I mean, parts of society.
A lot of people, like when I go talk about it, in front of people, they're very supportive.
So it's a bit of both.

Definitely, ja

Heroin is, because heroin is so physically addictive and the withdraws are psychological but mainly physical as well and the withdraws are very intense.
I would say it would make it a lot more difficult to deal with.

I would say about six weeks maybe. It depends on the person, but mainly between six weeks and two months.

I think some people need that.
Like heavy heroin 'junkies' that have been using for years and years.
I believe that if all else fails then, then that has to work.
I don't agree with the long-term treatment in our country.

- Participant: Because, the only place that I know of is Noupoot and um, I don't agree with the management and everything.
- Participant: Because, the only place that I know of is Noupoot.
I don't agree with the management and everything.
- Interviewer: What advice would you give to someone with a heroin problem? What would you say to them in order to get them on a path that could help them?*
- Participant: You can't really say something to somebody; you can only relate your personal experience. Um, and... because they know its killing them and they know how bad it is. They have to, some things you have to live through to um, understand it, you know. So, if it's somebody. Most heroin addicts are depressed I believe, so if its somebody I'll just tell them you know, get clean because it's worthless, you're screwing up your life. What else, you know? I can tell my own story and... ja (yes).
- Participant: You can't really say something to somebody; you can only relate your personal experience. Because they know its killing them and they know how bad it is. They have to, some things you have to live through to um, understand it, you know. So, if it's somebody. Most heroin addicts are depressed I believe, so if its somebody I'll just tell them you know, get clean because it's worthless, you're screwing up your life. What else, you know?
I can tell my own story and... ja.
- Interviewer: Do you then think that somebody could then be an outpatient?*
- Participant: An outpatient?
- Participant: An outpatient?
- Interviewer: Yes.*
- Participant: For heroin?
- Participant: For heroin?
- Interviewer: Yes.*
- Participant: I don't think so because I think their chances of recovery are not that good.
- Participant: I don't think so because I think their chances of recovery are not that good.
- Interviewer: Could you elaborate on that?*
- Participant: Because um, I believe heroin addiction needs intense treatment. Intense, everyday treatment to get over it because it's, because of the specific drug it is.
- Participant: I believe heroin addiction needs intense treatment. Intense, everyday treatment to get over it because it's, because of the specific drug it is.
- Interviewer: Okay. Thank you so much.*
- Participant: Okay thanks.

PARTICIPANT 18 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: I underwent a tremendous number of interventions, um, and I think for me, the way that I make sense of it, is that it was a kind of cumulative effect of all the treatment, you know... I was quite... confused, you know what I mean, and then I was using, and then I think initially I went to treatment not to get off heroin, but to learn to manage my heroin addiction better. A way not to kind of, not to have extreme problems that I was experiencing. I didn't really want to stop using heroin. At later stages perhaps I wanted to stop using heroin, but didn't want to stop using other drugs, do you know what I mean? I wanted to learn to stop using heroin and manage my other drug consumption if you like. In the end I finally got to a point, about four years before I gave up, before I realised that I would give up everything. Um, well, I was quite reluctant to do the things that I was being asked to do. Eventually I got to a point where, where I was willing to do what I needed to do um, and at that point all the interventions that I'd experienced had some meaning, do you know what I mean? And I knew what I needed to do. I still needed help to achieve it. And then I cleaned up in a halfway house and after having had multiple entries, I actually went into a halfway house, and just stayed there and I've been clean ever since then, so...

Interviewer: You said that you knew what you needed to do?

Participant: Yes.

Interviewer: Could you elaborate on that?

Participant: Yea, I mean I think it was that I had to maintain abstinence from all other drugs, that was the most fundamental part of getting clean, was not to substitute heroin for methadone, or methadone for coke (cocaine), or coke for benzo's (benzodiazepines), or... you know what I mean? Just to swop substances for a while, trying to, you know, carry on drinking and it just seemed too difficult to give them all up, or I was unwilling to give them all up. I thought that that would be really bland or bleak - life without, you know what I mean? I had a 'poncho' for drugs you know - from an early age, I always wanted to use drugs. I had always enjoyed using drugs, it was really difficult to get my head around the idea that I had to stop using all together, and

I underwent a tremendous number of interventions.

I think for me, the way that I make sense of it, is that it was a kind of cumulative effect of all the treatment.

I was quite... confused.

Then I was using, and then I think initially I went to treatment not to get off heroin, but to learn to manage my heroin addiction better.

A way not to kind of, not to have extreme problems that I was experiencing.

I didn't really want to stop using heroin. At later stages perhaps I wanted to stop using heroin, but didn't want to stop using other drugs. I wanted to learn to stop using heroin and manage my other drug consumption if you like.

In the end I finally got to a point, about four years before I gave up, before I realised that I would give up everything.

Well, I was quite reluctant to do the things that I was being asked to do. Eventually I got to a point where, where I was willing to do what I needed to do and at that point all the interventions that I'd experienced had some meaning.

And I knew what I needed to do.

I still needed help to achieve it.

Then I cleaned up in a halfway house and after having had multiple entries, I actually went into a halfway house, and just stayed there and I've been clean ever since then.

Yes.

I think it was that I had to maintain abstinence from all other drugs, that was the most fundamental part of getting clean, was not to substitute heroin for methadone, or methadone for coke, or coke for benzo's. Just to swop substances for a while, trying to carry on drinking and it just seemed too difficult to give them all up, or I was unwilling to give them all up. I thought that that would be really bland or bleak - life without.

I had a 'poncho' for drugs you know - from an early age, I always wanted to use drugs. I had always enjoyed using drugs.

It was really difficult to get my head around the idea that I had to stop using all together, and eventually I kind of knew, and when I knew that that was what I needed to do, I knew exactly what help I needed in order to achieve that.

eventually I kind of knew, and when I knew that that was what I needed to do, I knew exactly what help I needed in order to achieve that. Um, and that was kind of, regular, for me, regular twelve-step meetings. I went, in the first few months I went twice a day to Narcotics Anonymous and I'd just go and sit in the coffee shop, wait for the meeting. Go to the meeting, you know, go hang around in the shopping centre and wait for the next meeting. And then go home and go to bed and get up the next morning and do the same thing and that's all I did for the first three months that I was clean - was go to meetings, go to meetings and not use, and take it one day at a time. So you know the role that NA played for me was invaluable. I would never have been able to achieve it without that support. Um, today I believe that there are other avenues that I could have followed, but that's the one that I did, and I think that's the orientation of the treatment that I'd been participating in for the most it was looking at drug addiction as an illness and looking at Narcotics Anonymous and Alcoholics Anonymous as the vehicles for ongoing recovery. So, yea.

Interviewer: *And in terms of the medical intervention, do you feel that it helped you in your recovery?*

Participant: I think what the medication interventions had done was to keep me alive. I mean I think, you know, umm, my use was very, very, very chaotic, do you know what I mean? And very dangerous, and I think that methadone maintenance kept me alive. I think that detoxing periodically kept me alive. I think being able to detox because without medical intervention I couldn't stop using heroin. I was too sick. I was too frightened of being sick. So I'd go a couple of hours, a few hours of trying - as soon as the withdrawal really started then I'd, then I'd back down. It was very very difficult for me just to stop using heroin, just to go 'cold turkey' and I never managed and I think if it weren't, if I hadn't got medical help each time I'd detoxed, I wouldn't be alive today. I also think that I needed help to detox the last time that I detoxed; do you know what I mean?

Interviewer: *So you feel that it helped then for the withdrawal?*

Participant: Definitely, yea.

Interviewer: *And subsequent to the withdrawal?*

That was kind of, regular, for me, regular twelve-step meetings. I went, in the first few months I went twice a day to Narcotics Anonymous and I'd just go and sit in the coffee shop, wait for the meeting. Go to the meeting, you know, go hang around in the shopping centre and wait for the next meeting.

Then go home and go to bed and get up the next morning and do the same thing and that's all I did for the first three months that I was clean - was go to meetings, go to meetings and not use, and take it one day at a time.

So you know the role that NA played for me was invaluable. I would never have been able to achieve it without that support.

Today I believe that there are other avenues that I could have followed, but that's the one that I did.

I think that's the orientation of the treatment that I'd been participating in for the most it was looking at drug addiction as an illness.

Looking at Narcotics Anonymous and Alcoholics Anonymous as the vehicles for ongoing recovery.

So, yea.

I think what the medication interventions had done was to keep me alive.

My use was very, very, very chaotic, and very dangerous, and I think that methadone maintenance kept me alive.

I think that detoxing periodically kept me alive. I think being able to detox because without medical intervention

I couldn't stop using heroin. I was too sick.

I was too frightened of being sick. So I'd go a couple of hours, a few hours of trying - as soon as the withdrawal really started then I'd, then I'd back down.

It was very very difficult for me just to stop using heroin, just to go 'cold turkey' and I never managed.

I think if it weren't, if I hadn't got medical help each time I'd detoxed, I wouldn't be alive today. I also think that I needed help to detox the last time that I detoxed.

Definitely, yea.

- Participant: Subsequent to the withdrawal, I've never had any medical help, counselling interventions. I've never taken any anti-depressants or anti-craving medications or anything like that.
- Participant: Subsequent to the withdrawal, I've never had any medical help, counselling interventions. I've never taken any anti-depressants or anti-craving medications or anything like that.
- Interviewer: *Okay. Is it hard to stay clean for you?*
- Participant: It's very, very hard to stay clean (*laughs*). Initially, I mean. I think for the first nine months that I was clean it was the first thing I thought every morning as I woke up - was about heroin, and it was a daily decision, do you know what I mean? Then I managed not to use. It's not enough to just wake up in the morning and saying 'I'm not going to use', you are presented with situations during the day where you have to continue making decisions and I think a lot of that was habit, but a lot of it was kind of was, was biochemical. I was just so used to being 'stoned' that everything reminded me of heroin. Everything reminded me of using. Everyday situations, my natural response to everything was to get 'stoned', and I think that was really hard, part of that psychologically, part of that as I say I think is really physical, do you know what I mean? Um, and I needed an awful lot of support to do that. Fortunately it was available, um...
- Participant: It's very, very hard to stay clean. Initially, I mean. I think for the first nine months that I was clean it was the first thing I thought every morning as I woke up - was about heroin, and it was a daily decision. Then I managed not to use. It's not enough to just wake up in the morning and saying 'I'm not going to use', you are presented with situations during the day where you have to continue making decisions and I think a lot of that was habit, but a lot of it was kind of was, was biochemical. I was just so used to being 'stoned' that everything reminded me of heroin. Everything reminded me of using. Everyday situations, my natural response to everything was to get 'stoned', and I think that was really hard, part of that psychologically, part of that as I say I think is really physical. I needed an awful lot of support to do that. Fortunately it was available.
- Interviewer: *Is that what got you through the hard times then?*
- Participant: Support, yea, yea. But it wasn't professional support. For a lot of it, it was informal support from other recovering people, um... I remember waking up nine months or ten months after the last time I used and drug, and like getting to that 12 o'clock in the day, and like fuck, I haven't used heroin once today - profound, do you know what I mean - like 12 o'clock, and then eight, four hours I hadn't thought about heroin at all, and it just slowly got better from there but I think the first year was really, really difficult. I think one of the things about, because I, there were really seriously, serious improvements in my life within that year. I think that helped me to see that what I was doing in my work, do you know what I mean? And that I might be able to... you know I wasn't committing crime anymore. I wasn't waking up sick anymore. I wasn't kind of in trouble with people anymore (*laughs*). On a daily basis I was holding down a job, things were improving. I was having money in my pocket and not a lot, but you know, something. And I could see that things were looking easier. And that there was hope, and I think that is one of the key factors in my recovery, and I believe in anyone's recovery is hope and I think that's what I had lost - do you know what
- Participant: Support, yea, yea
But it wasn't professional support.
For a lot of it, it was informal support from other recovering people.
I remember waking up nine months or ten months after the last time I used and drug, and like getting to that 12 o'clock in the day, and like fuck, I haven't used heroin once today - profound, do you know what I mean - like 12 o'clock, and then eight, four hours I hadn't thought about heroin at all, and it just slowly got better from there but I think the first year was really, really difficult.
I think one of the things about, because I, there were really seriously, serious improvements in my life within that year.
I think that helped me to see that what I was doing in my work.
That I might be able to... you know I wasn't committing crime anymore.
I wasn't waking up sick anymore. I wasn't kind of in trouble with people anymore. On a daily basis I was holding down a job, things were improving. I was having money in my pocket and not a lot, but you know, something.
I could see that things were looking easier.
That there was hope, and I think that is one of the key factors in my recovery, and I believe in anyone's recovery is hope and I think that's what I had lost during the years.

I mean - during the years.

Interviewer: *But what gave you hope?*

Participant: I think, um... I was in a rehab once, and there was this Irish girl that I had been using with for about two years before, and she was ABSOLUTELY CHAOTIC, um, and she was doing very, very bad, badly addicted. So was I, but she was and I knew that she was. She wasn't like 'play-play', she was kind of, she'd been in my mind 'hard core', do you know what I mean? She was, as she was really, and I related to her. Anyway, I was in this rehab and they came for after-care, and this girl came, and she was eighteen months clean. And she came and shared her story, and I knew her, you know what I mean. And I knew that she was as bad as I was, and she was eighteen months clean. And I think for the first time I saw somebody that had gotten out of it, do you know what I mean? Because in using circles there is kind of, there's a message 'no-one gets out of this alive'; do you know what I mean? And, that's what I believed. I'm not talking about, I mean this is really going back to my sick thinking, but I thought like, there's people who are kind of, people who are not serious about their addictions, they have been using a couple of years. They kind of part-time addicts, do you know what I mean? And there's a bunch of people, quite a considerable bunch of people who've been shooting heroin for more than five years or more than ten years and they're like committed to it. And none of those people get well ever, you know what I mean, that's what I thought. Like us, we never get better. Do you know what I mean? And so, that was the attitude that permeated the circles that I was... yea people would go to rehab, come back and they'd use again. And everybody seemed to, and obviously well if I didn't see them, if I never saw them again it didn't mean they were using, in fact if I ever saw them again it was because they would be using. So it kind of reinforced itself. But it was certainly the inclination I was in, that I won't get better, it's a life sentence. And then I saw her, she was the first person that I knew was like working the programme that I'd been working at, and was clean and sober and I think that was the beginning for me of like hope. It took me four years from then to clean up, do you know what I mean? But I believed it was possible, hope.

Interviewer: *Do you feel that you had support from you family, um, in your recovery? Was that helpful?*

I think, um... I was in a rehab once, and there was this Irish girl that I had been using with for about two years before, and she was ABSOLUTELY CHAOTIC, and she was doing very, very bad, badly addicted. So was I, but she was and I knew that she was. She wasn't like 'play-play', she was kind of, she'd been in my mind 'hard core'. She was, as she was really, and I related to her.

Anyway, I was in this rehab and they came for after-care, and this girl came, and she was eighteen months clean. And she came and shared her story, and I knew her.

I knew that she was as bad as I was, and she was eighteen months clean. I think for the first time I saw somebody that had gotten out of it, Because in using circles there is kind of, there's a message 'no-one gets out of this alive', and that's what I believed.

I'm not talking about, I mean this is really going back to my sick thinking, but I thought like, there's people who are kind of, people who are not serious about their addictions, they have been using a couple of years. They kind of part-time addicts, do you know what I mean?

There's a bunch of people, quite a considerable bunch of people who've been shooting heroin for more than five years or more than ten years and they're like committed to it.

None of those people get well ever, that's what I thought. Like us, we never get better. Do you know what I mean?

So, that was the attitude that permeated the circles that I was... yea people would go to rehab, come back and they'd use again. Everybody seemed to.

Obviously well if I didn't see them, if I never saw them again it didn't mean they were using, in fact if I ever saw them again it was because they would be using. So it kind of reinforced itself.

But it was certainly the inclination I was in, that I won't get better, it's a life sentence.

And then I saw her, she was the first person that I knew was like working the programme that I'd been working at, and was clean and sober and I think that was the beginning for me of like hope.

It took me four years from then to clean up, do you know what I mean?

But I believed it was possible, hope.

- Participant: Yea, not initially. I mean initially they were very sceptical of me coming out of treatment again and... they were really not that interested. But, when I started to make significant improvement and when they could see the difference, you know, they were 6 000 miles away, but the difference was that I was phoning them and holding a conversation and sounding different, sounding better, and um, and then my mother said come and have a holiday with us and I think for me that was very important. I actually lied to her (*laughs*), that I was cleaned up in June, and I relapsed in September, and I used for a month until the 7th October, and I told her that I'd been clean since June. It was December when she let me come home for a holiday. So I had kind of been clean for that period, and that short relapse. I lied about that, but as far as she was aware of, I was like six months clean and doing very well and um, and yea - she's been there and offered support. I mean, they never offered financial support. They never ever, but they let me stay in their house. They wouldn't give me money, and they wouldn't lend me money, but they would feed me and let me live in their house, and then I got a job and I was fine.
- Participant: Yea, not initially. I mean initially they were very sceptical of me coming out of treatment again and... they were really not that interested. But, when I started to make significant improvement and when they could see the difference, you know, they were 6 000 miles away, but the difference was that I was phoning them and holding a conversation and sounding different, sounding better, and then my mother said come and have a holiday with us and I think for me that was very important. I actually lied to her, that I was cleaned up in June, and I relapsed in September, and I used for a month until the 7th October, and I told her that I'd been clean since June. It was December when she let me come home for a holiday. So I had kind of been clean for that period, and that short relapse. I lied about that, but as far as she was aware of, I was like six months clean and doing very well and um, and yea - she's been there and offered support. I mean, they never offered financial support. They never ever, but they let me stay in their house. They wouldn't give me money, and they wouldn't lend me money, but they would feed me and let me live in their house. Then I got a job and it was fine.
- Interviewer: *Societies perception... um, do you feel that people were judgmental towards you. Are there stereotypes? Did that make recovery harder?*
- Participant: No, I don't think it did. I don't think societies perceptions had anything really to do with whether I cleaned up or not. I think my perception had much to do with it. And to a really larger extent the only people, the only people that I tell ever, that I tell about my addiction are people that I think will be supportive of it. I've been patronised a few times, but I've never had a negative response, do you know what I mean? Patronising is not a negative response. Like people, like a bit... patronising, but friendly and supportive - but in quite a patronising way. Mostly though, I've only ever had um, yea, active support. People think it's good, and 'well done', do you know what I mean? I think, um, I think there is a kind of evasive attitude towards addiction, which is unhelpful in terms of availability of treatment and the availability of help to addicts, but I think on a personal level I never experienced that, you know what I mean?
- Participant: No, I don't think it did. I don't think societies perceptions had anything really to do with whether I cleaned up or not. I think my perception had much to do with it. To a really larger extent the only people, the only people that I tell ever, that I tell about my addiction are people that I think will be supportive of it. I've been patronised a few times, but I've never had a negative response, do you know what I mean? Patronising is not a negative response. Like people, like a bit... patronising, but friendly and supportive - but in quite a patronising way. Mostly though, I've only ever had yea, active support. People think it's good, and 'well done', do you know what I mean? I think, I think there is a kind of evasive attitude towards addiction, which is unhelpful in terms of availability of treatment and the availability of help to addicts, but I think on a personal level I never experienced that.
- Interviewer: *And the criminal aspect, do you think that that... that it is illegal, makes addicts' criminals...*

- Participant: Um, yea. I think if it were... if using drugs were legal I don't think it would make addicts not criminals. I mean, I think the process of addiction make people criminal or make people indulge in criminal behaviour in order to maintain an addiction...
- Participant: I think if it were... if using drugs were legal I don't think it would make addicts not criminals. I think the process of addiction make people criminal or make people indulge in criminal behaviour in order to maintain an addiction.
- Interviewer: *Money wise?*
- Participant: Money wise, but also in other ways you know, alcohol people, most alcoholics break the law, they drink and drive, they, you know, and that's illegal. Do you know what I mean? I think that, that um, a lot of alcohol impairs judgement. I mean if you are wasted all day (*laughs*), every day you're not going to make good decisions about what to do next. Do you know what I mean? And I think add to that desperation and a lack of unmanageability and people are going to indulge in criminal behaviour. I don't think that making drugs illegal will reduce criminal behaviour in people with addiction problems.
- Participant: Money wise, but also in other ways you know, alcohol people, most alcoholics break the law, they drink and drive, they, you know, and that's illegal. I think that a lot of alcohol impairs judgement. I mean if you are wasted all day, every day you're not going to make good decisions about what to do next. I think add to that desperation and a lack of unmanageability and people are going to indulge in criminal behaviour. I don't think that making drugs illegal will reduce criminal behaviour in people with addiction problems.
- Interviewer: *Do you feel that there is a difference between treating heroin addiction compared to other addictions?*
- Participant: Yea, I mean I guess. I mean I think there is a difference in treating long-term heroin addiction. I think, what I think is that early intervention in heroin addiction, within two/three years are much more likely to succeed. I think after five years of being addicted to heroin for five years, there's a very very low um, recovery rate. And I think that that creates special needs in, on some level. Do you know what I mean? It's not the kind of addiction that peers out. It's kind of... hectic crack cocaine addiction you can't maintain for ten years, you know what I mean? People um either really hit bottom quickly or mess up quickly or they get clean, do you know what I mean? Whereas heroin addiction is kind of, it can just go on and on and on and on... and once the habit gets that entrenched, then I think it's very very hard for them to come right on their own. I think, that type of thing, early intervention, early high-level interventions are important. I mean, I think that one of the mistakes that I made was the intervention, my early interventions were all low-level interventions, I think that that contributed to the duration of my addiction.
- Participant: Yea, I mean I guess. I mean I think there is a difference in treating long-term heroin addiction. I think, what I think is that early intervention in heroin addiction, within two/three years are much more likely to succeed. I think after five years of being addicted to heroin for five years, there's a very very low recovery rate. I think that that creates special needs in, on some level. It's not the kind of addiction that peers out. It's kind of... hectic crack cocaine addiction you can't maintain for ten years. Whereas heroin addiction is kind of, it can just go on and on and on and on... and once the habit gets that entrenched, then I think it's very very hard for them to come right on their own. I think, that type of thing, early intervention, early high-level interventions are important. I think that one of the mistakes that I made was the intervention, my early interventions were all low-level interventions, I think that that contributed to the duration of my addiction.
- Interviewer: *For someone with a long-term heroin problem, do you think then long-term treatment is the best opinion?*
- Participant: Well you know, it depends on what we mean when we say long-term residential treatment. But I think yea, long-term care; do you know what I mean? Long-
- Participant: Well you know, it depends on what we mean when we say long-term residential treatment. I think yea, long-term care. Long-term, people need a lot of support.

term, people need a lot of support. It's not something that goes away after six weeks. It's not something that they are going to learn to manage in on their own after six weeks. I mean, they need long-term support, they need long-term resources. Whether they need treatment in-patient - don't think so. You know there other more cost-effective ways of offering that to people, um...

(phone rings - interview terminated)

It's not something that goes away after six weeks. It's not something that they are going to learn to manage in on their own after six weeks.

I mean, they need long-term support, they need long-term resources.

Whether they need treatment in-patient - don't think so.

You know there other more cost-effective ways of offering that to people.

PARTICIPANT 19 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: I think at this stage in South Africa, because heroin is a relatively new thing in South African drug market, that the counselling places that are there are not ready, they don't know what heroin is about. In fact, they don't actually have a clue. You can't treat heroin addiction by going... withdrawal, with valium and all sorts of nonsense. But, I am sure the people are trying, you know, but it's quite obvious that there's not much research in this country. I think it's only now, as there are more and more addicts coming out, that I think people are going to start to do research. Counselling... I think that's an individual thing. Some counsellors I think will help patients enormously. And others, psychiatrists, can do more harm if they... also once again ignorance, if they don't know what's actually going on. You can't, you know I think addiction is a physical addiction, much more than it's a psychological thing. You can become a heroin addict by accident, you know, after a few times that you've used it, that for me is the worst thing, that physical dependence. Because that's what it is. They always seem to go straight for the psychological things, you know... fill in this questionnaire, unhappy childhood whatever, I think that's a load of rubbish. A lot of people become a heroin addict wilfully. Well not wilfully, but they start using heroin. I did, I tried it and then liked it, for the first few months you know, until the lions' nest starts. It's not that I'm criticising the clinics and stuff, but, maybe they've... if they get young people working with addicts like yourself, then it would help tremendously. But they seemed to not understand, that was my impression. When I came clean, what happened, I did the detox in three weeks, this to me was the wrong side of it, you know, three weeks on methadone, some 50ml down down down to nothing in three weeks. So the minute I walked out of here (*Castle Carey*) my nerves were frayed at the edges. I was, I immediately went to the chemist and bought a bottle of codeine. I just couldn't handle this, it's like nerve endings crying out for some, you know, just... and it wasn't a week and I was back on heroin, and even worse than before. So this lasted then for six months. When I finally decided what had happened, my wife kicked me out of the house, you know. Can't go on like this because I mean it does destroy everything around you. You spend all your money on it. I was fortunate in that I was always earning enough to support the habit and to provide for the family.

I think at this stage in South Africa, because heroin is a relatively new thing in South African drug market, that the counselling places that are there are not ready, they don't know what heroin is about. In fact, they don't actually have a clue.

You can't treat heroin addiction by going... withdrawal, with valium and all sorts of nonsense.

I am sure the people are trying, you know, but it's quite obvious that there's not much research in this country. I think it's only now, as there are more and more addicts coming out, that I think people are going to start to do research.

Counselling... I think that's an individual thing. Some counsellors I think will help patients enormously.

Others, psychiatrists, can do more harm if they... also once again ignorance, if they don't know what's actually going on.

You can't, you know I think addiction is a physical addiction, much more than it's a psychological thing.

You can become a heroin addict by accident, you know, after a few times that you've used it, that for me is the worst thing, that physical dependence. Because that's what it is.

They always seem to go straight for the psychological things, you know... fill in this questionnaire, unhappy childhood whatever, I think that's a load of rubbish.

A lot of people become a heroin addict wilfully. Well not wilfully, but they start using heroin.

I did, I tried it and then liked it, for the first few months you know, until the lions' nest starts.

It's not that I'm criticising the clinics and stuff, but, maybe they've... if they get young people working with addicts like yourself, then it would help tremendously. But they seemed to not understand, that was my impression.

When I came clean, what happened, I did the detox in three weeks, this to me was the wrong side of it, you know, three weeks on methadone, some 50ml down down down to nothing in three weeks.

So the minute I walked out of here my nerves were frayed at the edges. I was, I immediately went to the chemist and bought a bottle of codeine. I just couldn't handle this, it's like nerve endings crying out for some, you know, just... and it wasn't a week and I was back on heroin, and even worse than before.

So this lasted then for six months.

When I finally decided what had happened, my wife kicked me out of the house, you know. Can't go on like this because I mean it does destroy everything around you.

You spend all your money on it. I was fortunate in that I was always earning enough to support the habit and to provide for the family.

But your whole family goes to bits because you're not even interested in them. You know, heroin becomes your God, your one and only thing. Then when I realised how bad I was, in the gutter you know what mean, that's were you've got to make that decision so you've got to kick, beat this thing. And I think once you get that link, that when you think of heroin you think of bad things then you are really on the road to recovery. But up until that time, I always just think of heroin as mmm, my best friend, you see. You have to make a decision, no matter what they try to treat you and that... if you don't say 'hey' and decide I've got to kick this thing, then you won't kick it because it's a very powerful thing. Um, even it's milder forms, any opiate is a, is a physically addictive thing, you know. So if it's opium or morphine or heroin, you know, it's the same thing, it's the same evil basically. The history of opiate addiction goes back centuries, you know. There was a time when it seemed to ease off, because the thing with the needles, you know, but then it became very fashionable again when they started smoking it and 'chasing the dragon'. But what I think, I don't know, from my point of view, maybe they've discovered some new things that can help addicts you know, which seem to fool the receptors in your brain, you see, they are reading this... your body can seal them off so that your body does not cry out for this thing. And surely medical science will be able to find something eventually. For me at this stage, I think methadone treatment is the most practical way, but you can't just put someone on methadone for three weeks or a month, I would say at least three months, but get them down to a very small dosage. And then they must start with a lot of physical activity, that helps a lot, physical activity releases the endorphins and in the end it makes you feel better. But if you can get the patient to understand there are only two ways. With heroin you will die eventually, there is no other way out. They've got to get this thing that's it's the devil, or it's bad you know. Connect it with evil, or bad things, then it will be easier for them to beat it. Until they've reached that point, it's always going to be their best friend.

Interviewer: *So you feel that the medical interventions were important?*

Participant: Definitely, you need a doctor definitely, because it is a sickness. And a lot of people are not strong physically, they are very frail, so uh, you can't just give them 100ml bottle of methadone, they will drink it all and die. But obviously, as with anything else, you do get wonderful doctors that will care for patients and look after them and you get other persons who don't want anything to do with this

But your whole family goes to bits because you're not even interested in them.

You know, heroin becomes your God, your one and only thing.

Then when I realised how bad I was, in the gutter, that's were you've got to make that decision so you've got to kick, beat this thing.

I think once you get that link, that when you think of heroin you think of bad things then you are really on the road to recovery. But up until that time, I always just think of heroin as my best friend.

You have to make a decision, no matter what they try to treat you and that... if you don't say 'hey' and decide I've got to kick this thing, then you won't kick it because it's a very powerful thing.

Even it's milder forms, any opiate is a, is a physically addictive thing, you know. So if it's opium or morphine or heroin, you know, it's the same thing, it's the same evil basically.

The history of opiate addiction goes back centuries. There was a time when it seemed to ease off, because the thing with the needles, but then it became very fashionable again when they started smoking it and 'chasing the dragon'.

From my point of view, maybe they've discovered some new things that can help addicts you know, which seem to fool the receptors in your brain, they are reading this... your body can seal them off so that your body does not cry out for this thing. Surely medical science will be able to find something eventually.

For me at this stage, I think methadone treatment is the most practical way, but you can't just put someone on methadone for three weeks or a month, I would say at least three months, but get them down to a very small dosage.

Then they must start with a lot of physical activity that helps a lot, physical activity releases the endorphins and in the end it makes you feel better.

If you can get the patient to understand there are only two ways. With heroin you will die eventually, there is no other way out. They've got to get this thing that's it's the devil, or it's bad you know. Connect it with evil, or bad things, then it will be easier for them to beat it. Until they've reached that point, it's always going to be their best friend.

Definitely, you need a doctor definitely, because it is a sickness.

A lot of people are not strong physically, they are very frail, so you can't just give them 100ml bottle of methadone, they will drink it all and die.

Obviously, as with anything else, you do get wonderful doctors that will care for patients and look after them and you get other persons who don't want anything to do with

because mostly ignorance you know. They don't know about what heroin addiction is. With the Internet, I think it's gonna be much more easy to get information about it.

Interviewer: Is it hard for you to stay clean?

Participant: Not any more. No, not at all... I mean, it's amazing, it's a... when I think of heroin, I just think of how stupid I was, you know. I wasted a lot of time and money on this stupid white powder. Life is much better without it. I don't know how I got into it, it's the whole thing with the rock 'n roll thing, you meet people with drugs and stuff so, so that's how I got into drugs. I just read, and then I thought this was the best thing, you know, since they invented the guitar... but I found out, shew, a few years down the line, shew... what does it get you to do. I don't, all heroin addicts eventually end in the gutter, where you've got no money, no friends... and you just need a fix, and that's a fairly sad place to be. There's nothing poetic or glamorous or romantic about that. When you can realise that, I think that to be your turning point. Because in the beginning you always think it's, it's cool, nobody else knows, they don't know anything. I'm on H; I am master of the universe. When they realise they're heading straight for the gutter, maybe shock tactics to show them movies, I don't know if there is a hell of a lot of movies like, what was this one... *Requiem for a Dream*... incredibly hard hitting movie. And there were a few others over the years. When you see what happens... it's a very dangerous game, heroin addiction, you can die easily. I must have OD'd, I don't know, many times. I was just lucky.

Interviewer: Do you feel you had support from people? Did that help you in the recovery process?

Participant: Well, my wife always helped me, until she was really desperate and said 'get out', which I can't blame her for. That actually, that turned me around, because I was going to loose my family. The rest of my family doesn't want to know me because... you know what happens. You're very antisocial, you just want to be by yourself, in a dark place. So that for me was also the help to realise I'm going to loose, you know, people close to me because of this, this white powder. I did have a lot of help from my father, who would phone me to see how I'm holding up. But often, as it goes, often they don't realise that you're still hard on the H, because you can function like normally. Certain things that don't function like your sexuality, just goes zero, you know, no interest in that. But that's things that other people wouldn't actually know,

this because mostly ignorance you know. They don't know about what heroin addiction is.

With the Internet, I think it's gonna be much more easy to get information about it.

Not any more. No, not at all... it's amazing, when I think of heroin, I just think of how stupid I was.

I wasted a lot of time and money on this stupid white powder. Life is much better without it.

I don't know how I got into it, it's the whole thing with the rock 'n roll thing, you meet people with drugs and stuff so, so that's how I got into drugs.

I just read, and then I thought this was the best thing since they invented the guitar... but I found out, shew, a few years down the line, shew... what does it get you to do.

All heroin addicts eventually end in the gutter, where you've got no money, no friends... and you just need a fix, and that's a fairly sad place to be. There's nothing poetic or glamorous or romantic about that.

When you can realise that, I think that to be your turning point.

Because in the beginning you always think it's, it's cool, nobody else knows, they don't know anything. I'm on H; I am master of the universe.

When they realise they're heading straight for the gutter, maybe shock tactics to show them movies, I don't know if there is a hell of a lot of movies like, what was this one... *Requiem for a Dream*... incredibly hard hitting movie. And there were a few others over the years.

When you see what happens... it's a very dangerous game, heroin addiction, you can die easily. I must have OD'd, I don't know, many times. I was just lucky.

Well, my wife always helped me, until she was really desperate and said 'get out', which I can't blame her for.

That actually, that turned me around, because I was going to loose my family.

The rest of my family doesn't want to know me because... you know what happens. You're very antisocial, you just want to be by yourself, in a dark place. So that for me was also the help to realise I'm going to loose, you know, people close to me because of this, this white powder.

I did have a lot of help from my father, who would phone me to see how I'm holding up.

But often, as it goes, often they don't realise that you're still hard on the H, because you can function like normally.

Certain things that don't function like your sexuality, just goes zero, you know, no interest in that. But that's things that other people wouldn't actually know, for the

(inaudible) for the nodding off all the time, falling asleep in the middle of the day. I know, I think, for addictions, yes, if they have people that support them it would help them a lot. I think the main thing, the first two/three months - that withdrawal is the worst thing in the world. If there is anything new on the market that could help. If they can get something that could help. If they can get something, you know, that can just ease the withdrawal, I think then that a lot of people can be freed of addiction. The main thing is never to get back on, of course.

Interviewer: Societies perceptions, do you feel that there are stereotypes? Have you prejudice? Does that make it harder?

Participant: Society, you see, especially here, quite a large... because I don't know how many, what percentage of young people are using heroin in this country, but it's probably not that high...

Interviewer: It's actually the second most abused illicit substance in Gauteng.

Participant: At the moment?

Interviewer: Yes.

Participant: I saw this coming, years ago. Because this thing is easily available on every street corner in Pretoria, almost you know. Only in the old days we had to go to Johannesburg, to Hillbrow. Now then, a year, even a year or two later, we've found a dealer here in town. And people don't, once again, people don't understand. Poor parents, they go to work and come home. They don't realise their kid's an addict now, until it becomes bad. And then they think, oh well, this is just something... they send him to rehab, and then you'll be fine after three weeks. It's not that, it's a long-term thing. This is the other thing; it's not a quick solution, after that it's a long-life thing. I think recovery takes at least two/three years to get really over it. And then after that, okay, you must just keep on that because I'm sure that if I had to use again, I'd probably fall back into that trap, so that's why I'll never use again. To me now it's the personification of evil. That's what it does to me now; I don't want to be near it.

Interviewer: Is there a spiritual aspect in your recovery?

Participant: Definitely. When man is frail or threatened or close to death, then he finds God very quickly - to suit him you see. But I must admit that I'm not really this religious kind of guy. I have always believed in God, but not the way that

nodding off all the time, falling asleep in the middle of the day.

I know, I think, for addictions, yes, if they have people that support them it would help them a lot.

I think the main thing, the first two/three months - that withdrawal is the worst thing in the world. If there is anything new on the market that could help.

If they can get something that could help. If they can get something, you know, that can just ease the withdrawal, I think then that a lot of people can be freed of addiction.

The main thing is never to get back on, of course.

Participant: Society, you see, especially here, quite a large... because I don't know how many, what percentage of young people are using heroin in this country, but it's probably not that high...

Participant: I saw this coming, years ago. Because this thing is easily available on every street corner in Pretoria, almost you know.

Only in the old days we had to go to Johannesburg, to Hillbrow.

Now then, a year, even a year or two later, we've found a dealer here in town.

People don't, once again, people don't understand.

Poor parents, they go to work and come home. They don't realise their kid's an addict now, until it becomes bad.

Then they think, oh well, this is just something... they send him to rehab, and then you'll be fine after three weeks.

It's not that, it's a long-term thing.

This is the other thing; it's not a quick solution, after that it's a long-life thing.

I think recovery takes at least two/three years to get really over it.

Then after that, okay, you must just keep on that because I'm sure that if I had to use again, I'd probably fall back into that trap, so that's why I'll never use again.

To me now it's the personification of evil. That's what it does to me now; I don't want to be near it.

Participant: Definitely.

When man is frail or threatened or close to death, then he finds God very quickly - to suit him you see.

But I must admit that I'm not really this religious kind of guy. I have always believed

structured religion portrays it. But I did pray very heavily and I did read the Bible, to look for guidelines, and I'm sure that helped me, because imagining doesn't matter - as long as it helps. If you're a Buddhist, or Islam, I don't know if Muslims ever get involved with stuff like this. Very interesting. They actually use it as a weapon against the infidels, you know. I think for this question you want to know - I think spirituality can be a very powerful force to a pure addict as well. And if it works, then it's wonderful. If he becomes a re-born Christian it doesn't matter, then, I mean, if it helps him to recover then it's wonderful. If they become Buddhists, even better, I think Buddhists have a much better way of dealing with stuff like this as well, the Zen way, you know. But, what I think, I think use anything, as long as you can get it right. But pounding with religion is not going to work. You see, the same as if you pound him with psychological things - it's not going to work. If you're at that stage were you want to come clean, you don't want to do Rorschach tests and divulge facts about your childhood and stuff, you know, you want to come clean. With heroin I think the main thing is the physical thing first. After that, maybe counselling will obviously be good, but not with force down on a patient who's not really into this. After a month or two, yes. Then the counselling must be smooth and...

(long pause)

Interviewer: More natural?

Participant: Ja (yes). Because a lot of these psychologists made me feel guilty about it, you know. Which is completely against what they're supposed to do.

Interviewer: It's patronising?

Participant: Ja (yes). That's how I think about it. But I still thank God every day for helping me to stay clean. In my mind, you know, man is very fallible. But now, it's been wonderful... once you start seeing the world again, the changing of the seasons and you do exercise. Exercise is very important... and it's actually a much better life than sneaking off into the dark...

Interviewer: Thank you so much. I wish you well.

in God, but not the way that structured religion portrays it. But I did pray very heavily and I did read the Bible, to look for guidelines, and I'm sure that helped me, because imagining doesn't matter - as long as it helps. If you're a Buddhist, or Islam, I don't know if Muslims ever get involved with stuff like this. Very interesting. They actually use it as a weapon against the infidels, you know.

I think for this question you want to know - I think spirituality can be a very powerful force to a pure addict as well. And if it works, then it's wonderful.

If he becomes a re-born Christian it doesn't matter, then, I mean, if it helps him to recover then it's wonderful. If they become Buddhists, even better, I think the Buddhists have a much better way of dealing with stuff like this as well, the Zen way.

What I think, I think use anything, as long as you can get it right.

What I think, I think use anything, as long as you can get it right.

You see, the same as if you pound him with psychological things - it's not going to work.

If you're at that stage were you want to come clean, you don't want to do Rorschach tests and divulge facts about your childhood and stuff, you know, you want to come clean.

With heroin I think the main thing is the physical thing first.

After that, maybe counselling will obviously be good, but not with force down on a patient who's not really into this. After a month or two, yes. Then the counselling must be smooth.

Yea. Because a lot of these psychologists made me feel guilty about it, you know. Which is completely against what they're supposed to do.

Ja. That's how I think about it. But I still thank God every day for helping me to stay clean.

In my mind, you know, man is very fallible.

But now, it's been wonderful... once you start seeing the world again, the changing of the seasons.

And you do exercise. Exercise is very important.

It's actually a much better life than sneaking off into the dark.

PARTICIPANT 20 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: Okay, as I said to you before, I don't think that medical intervention really did anything for me. But Noupports rehabilitation is based on Christianity - there is only one way that you can come right, and that is with Jesus Christ. That is what you learn there. Um, you feel so guilty when you come out of it and you're sober - for what you did to your family, for what you did to the people around you, for what you did to yourself. And there they teach you; look, you can start again from the beginning. He can take away all your sins, you leave it behind and you can move forward. You have nothing to feel shy about. You do not have to stand back for other people and you can start from new, then you start right. And that's the consequences of your actions and the counselling... you cannot really say that the counselling was anything except from the Bible. I mean, you didn't really get counselling from proper counsellors. Um, it's rehabilitated people that help others. So it's basically other people who've been through it who helped us.

Interviewer: Is it difficult for you to stay clean?

Participant: No, there is a period of time that you must overcome, when you are back at home and you've actually succeeded, then, let me just put it this way, it begins with your rehabilitation. You've got to make a decision that you want to do it, then it's fine, but until you come back into society, you must just stick to your decision. And the things that can influence for you, you must totally avoid. Even though I was older than many of the other people that were there, my parents were still very strict with me the first while when I was back at home. The amount of money I had on me, where I was driving to they had to know. If I was driving say now to town, then they would drive with me, where they new the problem areas were. So they did not leave me there and I think it's necessary, it's really necessary.

Interviewer: So you feel that you got support?

Participant: Yes, my support network, I think, played a big role. If I was at work, then I was at work. If I was at home, my mother knew where I was, even though ***** and I married soon after we left there. I think that because we lived close to them or basically with them, it played a big role.

Okay, as I said to you before, I don't think that medical intervention really did anything for me.

Noupports rehabilitation is based on Christianity - there is only one way that you can come right, and that is with Jesus Christ. That is what you learn there.

You feel so guilty when you come out of it and you're sober - for what you did to your family, for what you did to the people around you, for what you did to yourself. There they teach you; look, you can start again from the beginning.

He can take away all your sins, you leave it behind and you can move forward. You have nothing to feel shy about. You do not have to stand back for other people and you can start from new, then you start right.

That's the consequences of your actions and the counselling... you cannot really say that the counselling was anything except from the Bible. I mean, you didn't really get counselling from proper counsellors.

It's rehabilitated people that help others. So it's basically other people who've been through it who helped us.

No, there is a period of time that you must overcome, when you are back at home and you've actually succeeded.

Let me just put it this way; it begins with your rehabilitation.

You've got to make a decision that you want to do it, then it's fine, but until you come back into society, you must just stick to your decision.

The things that can influence for you, you must totally avoid.

Even though I was older than many of the other people that were there, my parents were still very strict with me the first while when I was back at home.

The amount of money I had on me, where I was driving to they had to know. If I was driving say now to town, then they would drive with me, where they new the problem areas were. So they did not leave me there and I think it's necessary, it's really necessary.

Yes, my support network, I think, played a big role.

If I was at work, then I was at work.

If I was at home, my mother knew where I was, even though ***** and I married soon after we left there. I think that because we lived close to them or basically with them, it played a big role.

And the fact that we have a child - then you no longer go out. You don't go party anymore, you don't go looking for those things anymore... I think with us it was a bit of a different situation, you have a child to keep clean for, and how do you explain that to her? It is still something we will have to resolve when she's older. I still don't know how (*laughs*). Yes, support systems, I would say is a key factor.

Interviewer: Do you feel that people out there judged you? Did it make it difficult for you at the end of the day?

Participant: Interestingly now - in certain circumstances then it is in the back of my mind. But, I beat it by speaking about it to people because I am not shy about it. The more I speak about it to people, it doesn't matter if they are strangers, it has happened so many times, that if I speak about it, strangers say during the 'course of the conversation 'shit I knew someone experiencing that problem', or 'how can we help this person'? And that which they learn from you, you have nothing to be shy about. It chooses any person. It's not that you're bad or good, or poor or rich, that doesn't matter. So, in the back of my mind it's for me stupid sometimes if I feel when I'm visiting with my friends who've not been through it, then they think... you know, they do not understand that mind-set and that I'm now out of it. I think they probably sometimes still wonder if there is a possibility that I will fall back into it. But as I say it's my own insecurity, it's not theirs.

Interviewer: Do you feel there is a difference in treating heroin addiction compared to other addictions?

Participant: Definitely. Because heroin makes you physically addicted. Okay, my addiction in my eyes is a choice, in short, it's your choice to start - no-one makes that decision for you. Um, but because you use heroin and you then stop one day - your body gets sore and it feels like you're going to die. Then you know you have to get it (*heroin*). So that's why I think it's initially a choice with heroin. And the other thing, with heroin, it's not a 'high', it's a neutral - you feel just fine. Where as coke and crack, which was also a huge problem for me, that is actually why I used heroin. That 'high' was actually more what I was looking for. But then I used heroin to come down - to just feel 'normal', not 'normal', but to feel stable. So, because it is physically addictive, I think, I think it is just completely different. I've seen too many people that was with us in rehab, that were on other drugs and those that were on heroin, there is definitely a difference.

And the fact that we have a child - then you no longer go out. You don't go party anymore, you don't go looking for those things anymore... I think with us it was a bit of a different situation, you have a child to keep clean for, and how do you explain that to her? It is still something we will have to resolve when she's older. I still don't know how. Yes, support systems, I would say is a key factor.

Interestingly now - in certain circumstances then it is in the back of my mind. But, I beat it by speaking about it to people because I am not shy about it. The more I speak about it to people, it doesn't matter if they are strangers, it has happened so many times, that if I speak about it, strangers say during the 'course of the conversation 'shit I knew someone experiencing that problem', or 'how can we help this person'? And that which they learn from you, you have nothing to be shy about. It chooses any person. It's not that you're bad or good, or poor or rich, that doesn't matter. So, in the back of my mind it's for me stupid sometimes if I feel when I'm visiting with my friends who've not been through it, then they think... you know, they do not understand that mind-set and that I'm now out of it. I think they probably sometimes still wonder if there is a possibility that I will fall back into it. But as I say it's my own insecurity, it's not theirs.

Definitely. Because heroin makes you physically addicted. Okay, my addiction in my eyes is a choice, in short, it's your choice to start - no-one makes that decision for you. But because you use heroin and you then stop one day - your body gets sore and it feels like you're going to die. Then you know you have to get it. So that's why I think it's initially a choice with heroin. With heroin, it's not a 'high', it's a neutral - you feel just fine. Where as coke and crack, which was also a huge problem for me, that is actually why I used heroin. That 'high' was actually more what I was looking for. But then I used heroin to come down - to just feel 'normal', not 'normal', but to feel stable. So, because it is physically addictive, I think, I think it is just completely different. I've seen too many people that was with us in rehab, that were on other drugs and those that were on heroin, there is definitely a difference.

And especially... I can't tell you, when I was in the girls' house, bulimia and anorexia is a huge problem in girls' mind with heroin. Because they want to be heroin thin. You know, say about 50% of the girls that were with me in the house had an eating disorder and all of them who had an eating disorder, say about 90%, relapsed in order to be thin. That's what's scary (*laughs*). Then it says to me that it forms more part of a psychological problem, because I don't have a concept of an eating disorder, but that which I saw there showed to a large extent that the two can go hand in hand.

Interviewer: *I think what you say is very true; you are the first person who's mentioned it.*

Participant: And you know, the girl that I shared a room with, she would... over there (*Noupoort*) if they catch you you're in trouble. She would binge 3 o'clock in the morning. She would set her alarm to eat, and binge 5 o'clock in the morning. She would set her alarm to vomit, and throw it outside in a packet. So, so bad is it. There (*Noupoort*) I experienced it for the first time and I could not believe it. And yes, that's why I think it's more psychological, I don't know. I don't know exactly how to describe it to you. But if you are there amongst the people, then you know there's a difference between a heroin 'junky' and another 'junky.'

Interviewer: *Okay.*

Participant: And even between coke and party drugs. Um, party drugs you find more amongst young people. You're cool and you're happening and cocaine - older or business people, anyone. And heroin I think is someone who has gradually done everything. I don't think you get someone who's just a heroin junky, eventually, in the long run, only heroin. But they've first been through the spectrum to get to heroin. Although when we used... it was so... but I don't know if today the kids at school get just heroin. Then they're not going to bother with the rest. I don't know how it is so, but in our time it was so.

Interviewer: *But how do you think heroin addicts must undergo treatment differently?*

Participant: How should you treat it differently?

Interviewer: *Do you feel that time period or duration of treatment plays a role?*

I can't tell you, when I was in the girls' house, bulimia and anorexia is a huge problem in girls' mind with heroin. Because they want to be heroin thin. You know, say about 50% of the girls that were with me in the house had an eating disorder and all of them who had an eating disorder, say about 90%, relapsed in order to be thin. That's what's scary. Then it says to me that it forms more part of a psychological problem, because I don't have a concept of an eating disorder, but that which I saw there showed to a large extent that the two can go hand in hand.

The girl that I shared a room with, she would... over there if they catch you you're in trouble. She would binge 3 o'clock in the morning. She would set her alarm to eat, and binge 5 o'clock in the morning. She would set her alarm to vomit, and throw it outside in a packet. So, so bad is it. There I experienced it for the first time and I could not believe it. Yes, that's why I think it's more psychological, I don't know. I don't know exactly how to describe it to you. But if you are there amongst the people, then you know there's a difference between a heroin 'junky' and another 'junky.'

Even between coke and party drugs. Party drugs you find more amongst young people. You're cool and you're happening and cocaine - older or business people, anyone. Heroin I think is someone who has gradually done everything. I don't think you get someone who's just a heroin junky, eventually, in the long run, only heroin. But they've first been through the spectrum to get to heroin. Although when we used... it was so... but I don't know if today the kids at school get just heroin. Then they're not going to bother with the rest. I don't know how it is so, but in our time it was so.

How should you treat it differently?

- Participant: Time period - definitely. Long-term, not short term. When I worked a bit in the office (*in rehab*), they said that the foremost reason why they decided on a 32 week programme - 8 months, was due to the background of American statistics that said that that takes approximately 32 weeks for heroin... not out of your system, but to get out of your thinking ... to create a new thinking pattern, and it's not necessarily so with other drugs. That's why I have accordingly such an opinion with regards to this - you must have a longer time period to treat heroin addiction and I would say also for coke. I don't know necessarily of the other stuff, but in my case coke and heroin went hand in hand, that's why I probably see it this way. Time period definitely... and shit, you must have it hard to realise the reality of your situation. Okay, it's probably my experience, although other people in there had been in jail and that were prostitutes - and that was not enough for them to realise reality. It is a difficult question Monika. I don't know. But time period definitely made a big difference.
- Interviewer: *If someone comes your path that has a heroin problem, what advice do you give them?*
- Participant: Go to Noupport (*laughs*). I always say, because a lot of parents come see me, either one of three paths, and that's precisely what the doctor said to me that time... you die because you OD, you die because... all the paths end up there. You get caught for possession. Or stealing, or whatever, to get it in your hands. You end up in jail, and from there on it can't go well with you - it's just downward. Otherwise you share needles with people who have AIDS and you die. So there isn't another path except for... and that's the seriousness of it. Since ***** and I have been out, now three years, sixteen people who were with us have died, and I always say that - it's not a joke. And all of them, or many of them that we know, they did not think it was so serious. Sixteen is not a little, and that's the few that we know. Sixteen in three years out of the 160 of the people that were there. Okay, you do not know of everyone, but we were close to some of the people and some of our friends, here in Pretoria North, two specifically are dead. If people come speak to me, I give them the harsh reality. I know a person mustn't say fuck it up now - the only reason why I say it is out of experience. I don't know where ***** and I could have ended up, do you understand?
- Interviewer: *I think you're part of a miracle.*
- Participant: Time period - definitely. Long-term, not short term. When I worked a bit in the office, they said that the foremost reason why they decided on a 32 week programme - 8 months, was due to the background of American statistics that said that that takes approximately 32 weeks for heroin... not out of your system, but to get out of your thinking... to create a new thinking pattern, and it's not necessarily so with other drugs. That's why I have accordingly such an opinion with regards to this - you must have a longer time period to treat heroin addiction and I would say also for coke. I don't know necessarily of the other stuff, but in my case coke and heroin went hand in hand, that's why I probably see it this way. Time period definitely... and shit, you must have it hard to realise the reality of your situation. Okay, it's probably my experience, although other people in there had been in jail and that were prostitutes - and that was not enough for them to realise reality. It is a difficult question Monika. I don't know. But time period definitely made a big difference.
- Participant: Go to Noupport. I always say, because a lot of parents come see me, either one of three paths, and that's precisely what the doctor said to me that time... you die because you OD, you die because... all the paths end up there. You get caught for possession. Or stealing, or whatever, to get it in your hands. You end up in jail and from there on it can't go well with you - it's just downward. Otherwise you share needles with people who have AIDS and you die. So there isn't another path except for... and that's the seriousness of it. Since ***** and I have been out, now three years, sixteen people who were with us have died, and I always say that - it's not a joke. All of them, or many of them that we know, they did not think it was so serious. Sixteen is not a little, and that's the few that we know. Sixteen in three years out of the 160 of the people that were there. Okay, you do not know of everyone, but we were close to some of the people and some of our friends, here in Pretoria North, two specifically are dead. If people come speak to me, I give them the harsh reality. I know a person mustn't say fuck it up now - the only reason why I say it is out of experience. I don't know where ***** and I could have ended up, do you understand?

Participant: Yes definitely, nothing out of my own accord.

Yes definitely, nothing out of my own accord.

Interviewer: Thank you for your participation

Participant: Is that all? I can speak for hours about it!

PARTICIPANT 21 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Um, I didn't get counselling or medical treatment. When I came out I didn't do the basic things correctly. I used alcohol; as a result I relapsed on ecstasy, one time with coke and a few times with crack - every time I used alcohol. It's been a process over the last three years until now, for me to use nothing. The period of the relapses were short, were periods of... my first was for a month, two weeks, two weeks, two weeks. December - then the college confronted me, then again I was right. Then I used three times on my second and once the end of last year. Every time I used alcohol - that's where I ended up. I never used heroin again and it was during this year that I made the final decision - no alcohol. It's a choice that I've made and I can't... it's too easy... I stand with one foot on the one side, and my other foot on the other side. The one path on this side, the other path on that side. The only reason why I am where I am is because of above. I couldn't make any decisions by myself. I did make the decision; it's a choice that I made. But everything is from above. And it's the only chance you have to recover. That is my opinion as I've seen it. God has really blessed me. In March/April I met a girl that God blessed me with, and I believe it's all blessings for the decision that I've made. Amazing girl. I can't believe that He loves me so much that He gave such a girl to me. But the process you mustn't fear. It's human to fall, and love, if you fall you're not going to hell and it's all over and whatever the case. People can fall, and God forgives you and it's a process and you carry on. To grasp this type of thing it's... it's the truth. And the only thing, and it's my opinion - I feel very strongly about it... and I'm certain once you've completed your research you will see that these are the things that mostly come out. It's just hope, it's only God.
- Interviewer:* So you feel that spirituality was the primary aspect in your recovery?
- Participant:* Yes, it was faith in something that you cannot see. In something that is not possible.
- Interviewer:* You were in a treatment centre or rehab for a year; do you feel that that helped you in the recovery process?
- Participant:* Yes. I was in Noupoot for a year, and it definitely helped me during the first part with regards to initially getting clean and the withdrawal. It made me positive, especially the first part. The treatment
- I didn't get counselling or medical treatment. When I came out I didn't do the basic things correctly. I used alcohol; as a result I relapsed on ecstasy, one time with coke and a few times with crack - every time I used alcohol. It's been a process over the last three years until now, for me to use nothing. The period of the relapses were short, were periods of... my first was for a month, two weeks, two weeks, two weeks. December - then the college confronted me, then again I was right. Then I used three times on my second and once the end of last year. Every time I used alcohol - that's where I ended up. I never used heroin again and it was during this year that I made the final decision - no alcohol. It's a choice that I've made and I can't... it's too easy... I stand with one foot on the one side, and my other foot on the other side. The one path on this side, the other path on that side. The only reason why I am where I am is because of above. I couldn't make any decisions by myself. I did make the decision; it's a choice that I made. But everything is from above. It's the only chance you have to recover. That is my opinion as I've seen it. God has really blessed me. In March/April I met a girl that God blessed me with, and I believe it's all blessings for the decision that I've made. Amazing girl. I can't believe that He loves me so much that He gave such a girl to me. But the process you mustn't fear. It's human to fall, and love, if you fall you're not going to hell and it's all over and whatever the case. People can fall, and God forgives you and it's a process and you carry on. To grasp this type of thing it's... it's the truth. The only thing, and it's my opinion - I feel very strongly about it... and I'm certain once you've completed your research you will see that these are the things that mostly come out. It's just hope, it's only God.
- Yes, it was faith in something that you cannot see. In something that is not possible.
- Yes. I was in Noupoot for a year, and it definitely helped me during the first part with regards to initially getting clean and the withdrawal. It made me positive, especially

itself was perhaps not always on par, um, that is due to lack of expertise with the people who've been through it. But it had a far more positive influence than a negative influence. If my mother never sent me there for treatment, were would have I gone? And a three-month programme or a six-month programme - it doesn't work for heroin.

Interviewer: *But why do you feel you have to be away from the house?*

Participant: They have to... the reason is so that you are taken out of the situation. You understand... there you are not faced with Jannie who stays on the other side that can organise for you. So if you're there the temptation is less and I would even say that your recovery is easier. The circumstances make it easier for you during the period to get out of that - so that you use nothing because you use, you break yourself down and on your own you think I don't need this stuff. While you're there you become positive and you don't need it. You are taken out of the situation so that you can get rid of the drugs so that your brain - so that you can start thinking and functioning correctly. The whole thing is a habit pattern. You fall and you use and use and use. They say it takes 42 days to change a habit - for those neuron bonds to regenerate or whatever the case may be.

Interviewer: *Does medication play a role? What's your opinion?*

Participant: At present I'm not using any medication. And my biggest thing... I view it almost the same as alcohol. I don't want to... because it is chemicals at the end of the day! You understand...

Interviewer: *And for withdrawal?*

Participant: I think yes, it is perhaps necessary for a person who is detoxing. I'm not talking about heavy medication. The main thing is that the person must also feel, you understand? You go through it and it is not nice, but if it's not nice you won't be crazy to go through it again. So the worst is what your head goes through while you're going through it, that's the roughest. Never mind your body. The problem is for some people it becomes life threatening if you're going through that. Some people think they're going to die, and if you think you're going to die then you will die. That which you think is also very powerful. So I think medication to a very little degree, depends how it is and only if it's necessary. But not at all... only during withdrawal, not at all afterwards.

Interviewer: *Is it hard for you to stay clean?*

the first part.

The treatment itself was perhaps not always on par, um, that is due to lack of expertise with the people who've been through it.

But it had a far more positive influence than a negative influence.

If my mother never sent me there for treatment, were would have I gone? And a three-month programme or a six-month programme - it doesn't work for heroin.

They have to... the reason is so that you are taken out of the situation. You understand... there you are not faced with Jannie who stays on the other side that can organise for you. So if you're there the temptation is less and I would even say that your recovery is easier. The circumstances make it easier for you during the period to get out of that - so that you use nothing because you use, you break yourself down and on your own you think I don't need this stuff. While you're there you become positive and you don't need it. You are taken out of the situation so that you can get rid of the drugs so that your brain - so that you can start thinking and functioning correctly.

The whole thing is a habit pattern.

You fall and you use and use and use.

They say it takes 42 days to change a habit - for those neuron bonds to regenerate or whatever the case is.

At present I'm not using any medication. My biggest thing... I view it almost the same as alcohol. I don't want to... because it is chemicals at the end of the day! You understand.

I think yes, it is perhaps necessary for a person who is detoxing. I'm not talking about heavy medication.

The main thing is that the person must also feel, you understand?

You go through it and it is not nice, but if it's not nice you won't be crazy to go through it again.

So the worst is what your head goes through while you're going through it, that's the roughest. Never mind your body.

The problem is for some people it becomes life threatening if you're going through that.

Some people think they're going to die, and if you think you're going to die then you will die. That which you think is also very powerful.

So I think medication to a very little degree depends how it is and only if it's necessary.

But not at all... only during withdrawal, not at all afterwards.

- Participant: No. I must say, the first while it was difficult. The biggest thing is the fear. The fear of falling or if it doesn't work, or what then? That's the biggest thing. Then the devil rides you. He rides you because he says to you, um, 'you aren't going to make it', or 'there isn't a way of getting out'. The recovery rate is what, one or two percent for heroin?
- Interviewer: *It depends to an extent on how long you've used it for.*
- Participant: Oh is that so. Um, so what was the question?
- Interviewer: *Is it hard for you to stay clean?*
- Participant: No, since I've made a decision not to use it, more once again, it's only mercy from above. I'm still... and it's again with the uppers... but it's as with any, let us say you struggled with girls or whatever the case is. You will still get the thoughts. The thoughts will still come to your mind, and it's what you make of the thought, that you don't play with it. You immediately get it out of your mind. So every time you get the thought, and you block it out and you just put it away then it gets less - so every time you overcome. It's also an important part, your thoughts and if you entertain them. The problem is that when you make a decision it's in your mind... if the thought comes of 'cut' and you entertain it, and you even begin to wander about it, then you are in rough waters. That's just how I am. If I've made a decision in my mind, then I just execute it.
- Interviewer: *If someone came to you with a heroin problem what advice would you give them?*
- Participant: The first question that I would ask is probably the same... how long have you been using? How are you using it, and I mean, despite how much the person wants to quit, there are practical things implicated. If a guy has been on heroin for a year or two years or longer of heroin use, then he won't be able to be on his own in Pretoria or Johannesburg or wherever. Only long-term treatment in which you can change your thought and behaviour patterns. And he must... the only guarantee is a real relationship with God, and mercy. And that's why I say it's all... it's a thing that you must do from your side and God does what he must do from his side. It's not a thing that you do on your own, so... it's a combination. Look, there are practical things involved; you can't only not use heroin or whatever. You function and think in a certain manner, your body and your mind. So, if you used heroin for the past six years every day, I can guarantee you, you will carry on using. You understand?
- No.
I must say, the first while it was difficult. The biggest thing is the fear. The fear of falling or if it doesn't work, or what then? That's the biggest thing.
Then the devil rides you. He rides you because he says to you, um, 'you aren't going to make it', or 'there isn't a way of getting out'. The recovery rate is what, one or two percent for heroin?
- No, since I've made a decision not to use it, more once again, it's only mercy from above. I'm still... and it's again with the uppers... but it's as with any, let us say you struggled with girls or whatever the case is. You will still get the thoughts. The thoughts will still come to your mind, and it's what you make of the thought, that you don't play with it. You immediately get it out of your mind. So every time you get the thought, and you block it out and you just put it away then it gets less - so every time you overcome. It's also an important part, your thoughts and if you entertain them. The problem is that when you make a decision it's in your mind... if the thought comes of 'cut' and you entertain it, and you even begin to wander about it, then you are in rough waters. That's just how I am.
If I've made a decision in my mind, then I just execute it.
- The first question that I would ask is probably the same... how long have you been using? How are you using it, and I mean, despite how much the person wants to quit, there are practical things implicated.
If a guy has been on heroin for a year or two years or longer of heroin use, then he won't be able to be on his own in Pretoria or Johannesburg or wherever.
Only long-term treatment in which you can change your thought and behaviour patterns.
And he must... the only guarantee is a real relationship with God, and mercy. And that's why I say it's all... it's a thing that you must do from your side and God does what he must do from his side.
It's not a thing that you do on your own, so... it's a combination.
Look, there are practical things involved; you can't only not use heroin or whatever. You function and think in a certain manner, your body and your mind.
So, if you used heroin for the past six years every day, I can guarantee you, you will carry on using.

It's practical; there isn't another way to do it.

It's practical; there isn't another way to do it.

Interviewer: Peoples' perceptions in society, do you feel people supported you, or did it count against you?

Participant: Yes... it's a combination of both. Some people look down on you firstly and they feel sorry for you. They think you, there's something wrong with you or you're weaker than they are, while at the end of the day you only have issues in one area, and they have issues in another area. So, if it's drugs or pornography or medication or alcoholism... and I would say... even now if you asked me to take someone in who is addicted to heroin, I would probably do it, but I would probably watch him carefully for two years! And a person goes through that, and in the long run they don't trust you, even if your intentions are right. Support is very important. I didn't really have support. Support from the church, but I mean, how do you speak to someone from the church that hasn't been through it himself? I'd say that's the biggest void that we now have, a lack of discipleship. Discipleship work from that which you've been through. You can help others through it so that they in turn can help others. It's a discipleship network that's not applied. They get treatment and come clean, and everything is positive. They don't always have all the knowledge; they come back and it's lion world. They are thrown to the wolves, and there is no one to protect them. And one wrong decision and you fall, and then what from then on?

Yes... it's a combination of both. Some people look down on you firstly and they feel sorry for you. They think you, there's something wrong with you or you're weaker than they are, while at the end of the day you only have issues in one area, and they have issues in another area. So, if it's drugs or pornography or medication or alcoholism... and I would say... even now if you asked me to take someone in who is addicted to heroin, I would probably do it, but I would probably watch him carefully for two years! A person goes through that, and in the long run they don't trust you, even if your intentions are right. Support is very important. I didn't really have support. Support from the church, but I mean, how do you speak to someone from the church that hasn't been through it himself? I'd say that's the biggest void that we now have, a lack of discipleship. Discipleship work from that which you've been through. You can help others through it so that they in turn can help others. It's a discipleship network that's not applied. They get treatment and come clean, and everything is positive. They don't always have all the knowledge; they come back and it's lion world. They are thrown to the wolves, and there is no one to protect them. One wrong decision and you fall, and then what from then on?

Interviewer: Do you think there is a difference in treating someone with a heroin problem compared to other drugs?

Participant: The advantage, you're probably going to think it's crazy, the advantage that a heroin addict has is that you realise how addicted you were to a drug. While acid (LSD) and coke (cocaine) and those type of drugs, you don't click it always. So you realise what drugs do to you, how it damages and that type of thing. Um, I think treatment probably is, treatment is difficult because it's different people at different stages. What I'd recommend to them is the same as what I said to you - the only manner to recover is spiritual and then the practical implications of recovery, such as not using alcohol. People have to grasp it for themselves. And that's what sometimes makes me really negative. If you get guys who used pills for six months and their mother catches them and sends them to rehab. And that guy, he has no intention to stop partying. He actually now has more of a grudge. If you decide yourself, you make the decision yourself, not someone making the decision for you,

The advantage, you're probably going to think it's crazy, the advantage that a heroin addict has is that you realise how addicted you were to a drug. While acid and coke and those type of drugs, you don't click it always. So you realise what drugs do to you, how it damages and that type of thing. I think treatment probably is, treatment is difficult because it's different people at different stages. What I'd recommend to them is the same as what I said to you - the only manner to recover is spiritual. Then the practical implications of recovery, such as not using alcohol. People have to grasp it for themselves. And that's what sometimes makes me really negative. If you get guys who used pills for six months and their mother catches them and sends them to rehab. And that guy, he has no intention to stop partying. He actually now has more of a grudge. If you decide yourself, you make the decision

um, and then it's forwards and practical.
You must make the decision yourself of
forwards and practical.

yourself, not someone making the decision for
you, and then it's forwards and practical. You
must make the decision yourself of forwards
and practical.

Interviewer: *Thank you very much and good luck.*

Participant: Thanks.

PARTICIPANT 22 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean for heroin, and to what extent counselling and/or medical intervention was able to assist you.

Participant: So I can talk about Noupports programme and so on?

Interviewer: Yes.

Participant: Okay, Noupports programme is based on a one-step programme - and they, we believe that God is greater than your addiction and that God will be able to help you to get rid of your addiction, and we have a programme where people do not physically receive medication to free you for your addiction. The whole thing is that if you take medication you're replacing one thing with another thing, and the thing is also, for me that really helped because previously I tried to come off drugs I always replaced one thing with another thing. In that way it is easier to relapse because you never have a clear mind, you always want to replace the one thing with something else, and the reason why Noupports programme also helped was because it's a self-help programme. You must get to a point where you realise what you did, and the thing is that you can overcome your addiction and it depends on yourself. It won't help if people pamper you every day and say 'please, you must now stop'. People can only help you to a point, and the rest is on your own. Um, Noupports programme also helps you in that rather to replace your addiction with another addiction form such as with another medication and so on, it helps you to get another addiction... to take God into your life, to take that as a replacement, and in my case it really helped. There was a stage, all addicts feel so, you feel empty - you have to fill that gap with something and why can't you give it a go to, you know, fill it with Christianity? And also by doing that, you will be able to lead a better life; to live like a Christian and to understand that by taking drugs is a sin, and to use alcohol is a sin. It is all a process of renewing your mind.

Interviewer: So you feel that spirituality played the most prominent role in your recovery?

Participant: I must say, it helped me a great deal.

Interviewer: Do you feel that the period of time in an in-patient facility played a role in recovery?

Participant: Yes - the thing is, I also saw with programmes - the longer the stronger - and I believe that, because for many people, okay, you go to a programme, you do a six-week programme and the whole

So I can talk about Noupports programme and so on?

Noupports programme is based on a one-step programme - and they, we believe that God is greater than your addiction and that God will be able to help you to get rid of your addiction.

We have a programme where people do not physically receive medication to free you for your addiction.

The whole thing is that if you take medication you're replacing one thing with another thing, and the thing is also, for me that really helped because previously I tried to come off drugs I always replaced one thing with another thing. In that way it is easier to relapse because you never have a clear mind, you always want to replace the one thing with something else.

The reason why Noupports programme also helped was because it's a self-help programme. You must get to a point where you realise what you did, and the thing is that you can overcome your addiction and it depends on yourself.

It won't help if people pamper you every day and say 'please, you must now stop'. People can only help you to a point, and the rest is on your own.

Noupports programme also helps you in that rather to replace your addiction with another addiction form such as with another medication and so on, it helps you to get another addiction... to take God into your life, to take that as a replacement, and in my case it really helped. There was a stage, all addicts feel so, you feel empty - you have to fill that gap with something and why can't you give it a go to, you know, fill it with Christianity?

By doing that, you will be able to lead a better life; to live like a Christian and to understand that by taking drugs is a sin, and to use alcohol is a sin.

It is all a process of renewing your mind.

I must say, it helped me a great deal.

Yes - the thing is, I also saw with programmes - the longer the stronger - and I believe that, because for many people, okay, you go to a programme, you do a six-week programme and the whole thing is... say you drugged for four years, it's then four years of thinking

thing is... say you drugged for four years, it's then four years of thinking pattern and the way that needs to be changed and a person can't just change it in four or six weeks, it's impossible.

pattern and the way that needs to be changed and a person can't just change it in four or six weeks, it's impossible.

Interviewer: Do you feel that societies perceptions as well as your significant others, such as your family, assisted you in the recovery process, or did it impede you?

Participant: It depends - it's not just a process were you recover; they must also recover from the addiction, because they are sort of co-dependent. The thing is the support and I can't actually say advice, but in my case I can say yes, in a way, it probably did help me. You know the support and the trust again and so on, but also in a way it depends on you. You can't every time... you can't put your trust in other people and so on. The people around you will always, you know, disappoint you - it doesn't help placing your trust in other people, or in my case, it is so - that's what I've learnt. Sometimes person's expectations are too great and um, it doesn't happen that way, it is also a dangerous place to be in if you begin to place your trust in your family because usually disappointment is a reality.

It depends - it's not just a process were you recover; they must also recover from the addiction, because they are sort of co-dependent. The thing is the support and I can't actually say advice, but in my case I can say yes, in a way, it probably did help me. You know the support and the trust again and so on, but also in a way it depends on you. You can't every time... you can't put your trust in other people and so on. The people around you will always, you know, disappoint you - it doesn't help placing your trust in other people, or in my case, it is so - that's what I've learnt. Sometimes person's expectations are too great and um, it doesn't happen that way, it is also a dangerous place to be in if you begin to place your trust in your family because usually disappointment is a reality.

Interviewer: But do you feel that people out there judge you or is their attitude mostly supportive?

Participant: Um, in a way people are supportive, but as I said, it doesn't help you going to look for people the whole time for reassurance. That's my opinion.

In a way people are supportive, but as I said, it doesn't help you going to look for people the whole time for reassurance. That's my opinion.

Interviewer: Do you feel there is a difference between treating someone who was hooked on heroin, compared to other drugs?

Participant: Um, I don't know. It depends from person to person. It depends totally, I mean, many people take heroin to sort of... other drugs is an escape route from reality. I believe so. I don't believe... all addicts have the same motive, and that's it. That's what I believe. But also people need to be treated individually - we are not all the same, but we have the same motive.

I don't know. It depends from person to person. It depends totally, I mean, many people take heroin to sort of... other drugs is an escape route from reality. I believe so. I don't believe... all addicts have the same motive, and that's it. That's what I believe. But also people need to be treated individually - we are not all the same, but we have the same motive.

Interviewer: Is it hard for you to stay clean?

Participant: Some days yes. But, the thing is, there are also a lot of blessings in it. In my case, you crave now and again, especially if you are in a situation and you don't know what how to deal with it. Then you think 'yes, maybe my escape is to quickly go to my dealer and to say okay and then use', and so on. But the thing is, I saw my ass with drugs - I don't know, some days it is difficult...

Some days yes. There are also a lot of blessings in it. In my case, you crave now and again, especially if you are in a situation and you don't know what how to deal with it. Then you think 'yes, maybe my escape is to quickly go to my dealer and to say okay and then use', and so on. I saw my ass with drugs - I don't know, some days it is difficult.

Interviewer: How do you get through the difficult times?

Participant:

Okay, the thing that I learnt in Noupport is you must place all your trust in God, and he will help you it doesn't matter what. It says in Hebrews 'he will never leave you nor forsake you', and it's also not his plan for people on earth to suffer. There is also a scripture in the Bible that says In Jeremiah 29:11, 'God knows the plans I have for you, it's only plans to prosper you and he will also give you a future and a hope, and when you call upon Him and approach Him, He will listen'. And God will really, if you have enough faith, you can overcome anything. It is just so, and I believe in that, and there is also a scripture that says 'rather give it to God', for me it's so much easier, because I can give all my things to God. It is only through Him that I am clean today, through no one else.

The thing that I learnt in Noupport is you must place all your trust in God, and he will help you it doesn't matter what.

And God will really, if you have enough faith, you can overcome anything. It is just so, and I believe in that.

For me it's so much easier, because I can give all my things to God. It is only through Him that I am clean today, through no one else.

Interviewer:

Thank you so much for your input. I wish all the best for your future.

PARTICIPANT 23 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent counselling and/or medical intervention was able to assist you.
- Participant:* The reality, discipline and time period. The reality, discipline and time period.
- Interviewer:* You mentioned discipline, how do you feel that contributed toward recovery?
- Participant:* Because you initially avoid all discipline - it brings you back... I don't know, reality - you must make your bed every day, and must read the Bible, and so you eventually have more interest in what the Bible says, and you listen again in church and start interacting more with the community in which you live in. You stay in a clean home, and you keep your room clean and you understand why it must be so. Because you initially avoid all discipline - it brings you back... I don't know, reality - you must make your bed every day And must read the Bible, and so you eventually have more interest in what the Bible says, and you listen again in church. Start interacting more with the community in which you live in. You stay in a clean home, and you keep your room clean and you understand why it must be so.
- Interviewer:* You feel that the duration of treatment plays an important role in the recovery process? How long do you think the duration should be?
- Participant:* For heroin - long, and for crack. It's a long time. Just to, I don't know what... just so you can get to that stage were you can give back to the community. For heroin - long, and for crack. It's a long time. Just to, I don't know what... just so you can get to that stage were you can give back to the community.
- Interviewer:* You feel that by helping other people contributes? That is an important factor?
- Participant:* When you speak to others, you hear what you are saying and I mean, the more you repeat yourself, the more you practice and you hear it and you repeat it and you see it happen in other peoples lives. And such things don't happen in six weeks - it happens over a long period of time. The people that have stayed with you for a long time see the change. When you speak to others, you hear what you are saying and the more you repeat yourself, the more you practice and you hear it and you repeat it and you see it happen in other peoples lives. Such things don't happen in six weeks - it happens over a long period of time. The people that have stayed with you for a long time see the change.
- Interviewer:* You mentioned the spiritual aspect. Did that help in a paradigm shift?
- Participant:* It helped me now. Now that I am out of Noupoot, that I am out of that place, I have something to fall back on I believe that if you... Christianity - if you have that discipline of the Bible, the rules of life - if you keep to that, then you will prosper and you have something to fall back on. It helped me now. Now that I am out of Noupoot, that I am out of that place, I have something to fall back on I believe that if you... Christianity - if you have that discipline of the Bible, the rules of life - if you keep to that, then you will prosper and you have something to fall back on.
- Interviewer:* Do you feel that there is a difference in treating heroin addiction compared to that of other substances?
- Participant:* Yes. Heroin you withdraw more and also I think psychologically one gets addicted to it. You like that high. Heroin people take heroin because you want to be relaxed, and then you get addicted. Yes. Heroin you withdraw more and also I think psychologically one gets addicted to it. You like that high. Heroin people take heroin because you want to be relaxed, and then you get addicted.

- Interviewer:* You spoke of a physical addiction. Do you feel that medication helps?
- Participant: It prolongs. Medication only prolongs the process. It prolongs. Medication only prolongs the process.
- Interviewer:* The withdrawal process?
- Participant: Yes, and then you have to come off of the medication, and then... I had to use sleeping pills. You just don't, you just can't get that natural sleep - as if when you worked hard the day and you're tired and you sleep well (*inaudible*). With heroin you sleep well! It (*medication*) only prolongs the withdrawal process. If people are withdrawing, you can give them a little bit of medication, but that's it. Yes, and then you have to come off of the medication, and then... I had to use sleeping pills. You just don't, you just can't get that natural sleep - as if when you worked hard the day and you're tired and you sleep well. With heroin you sleep well. It only prolongs the withdrawal process. If people are withdrawing, you can give them a little bit of medication, but that's it.
- Interviewer:* Do you feel that societies perceptions toward someone with a heroin addiction, and also your significant others such as your family, was it positive? Did it help in the recovery process? Or do you feel that it impeded you? Do you feel that people were judgmental?
- Participant: The thing about Noupooort is that everyone there knows what you are going through. So it's very supportive. When you come back, your parents don't really understand or trust you. But it wasn't an impediment, because after Noupooort you want to prove, you want to show then that you are right. But it takes time. The thing about Noupooort is that everyone there knows what you are going through. So it's very supportive. When you come back, your parents don't really understand or trust you. But it wasn't an impediment, because after Noupooort you want to prove, you want to show then that you are right. But it takes time.
- Interviewer:* You don't feel that people are judgmental towards you?
- Participant: No. No.
- Interviewer:* Is it hard for you to stay clean?
- Participant: Not really. We speak about it sometimes, and then we forget completely about it (*inaudible*). We sometimes say how it would be nice to smoke a 'zol' (*cannabis*) - and then we laugh about it. Still, at the end of the day we know that it would be stupid. Just to be clean is another kind of high, without having the next day a hangover. And if you're with people who drink, it puts you totally off. You see all the disadvantages. I don't know, you probably notice it more because you've been through it yourself. Not really. We speak about it sometimes, and then we forget completely about it. We sometimes say how it would be nice to smoke a 'zol' - and then we laugh about it. Still, at the end of the day we know that it would be stupid. Just to be clean is another kind of high, without having the next day a hangover. If you're with people who drink, it puts you totally off. You see all the disadvantages. I don't know, you probably notice it more because you've been through it yourself.
- Interviewer:* If someone came to you and said they had a heroin problem, what could help them to come clean and to stay clean?
- Participant: Well firstly, they must really want to quit. Rock bottom - before that, parents can't help them. They must want to themselves and go to a place like Noupooort, and they won't give excuses. So, that's the only answer I can give you, it's long, but it worked for me. Well firstly, they must really want to quit. Rock bottom - before that, parents can't help them. They must want to themselves and go to a place like Noupooort, and they won't give excuses. So, that's the only answer I can give you, it's long, but it worked for me.
- Interviewer:* Thank you very much and good luck.

PARTICIPANT 24 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Um well, as I said, I went 'cold turkey', so there was no medical assistance, there was no psychological assistance. My parents didn't even know that I stopped using heroin. So they weren't aware of the fact that I had, or that I was withdrawing. I basically stayed in my room all day, you know, or stayed in the garden all day, and steered clear from their attention, because I didn't want them to know that I was using heroin, even though they did know that I was. But... they had found syringes and they had found, you know, foil and all that. So they were aware that I was taking. They did try and stop me from further abusing it, but you know, the only reason I stopped is because you can't afford it anymore and it wasn't available.
- Interviewer:* Okay, so for you the two primary reasons, what helped you to quit, was the lack of availability...
- Participant:* The lack of availability and the lack of finance.
- Interviewer:* So was there any sort of paradigm shift you felt you had to make in your mind to stay clean, or not really?
- Participant:* No, not really.
- Interviewer:* Do you think there is a difference between treating heroin addiction as compared to other substances?
- Participant:* Yea. Absolutely, absolutely.
- Interviewer:* Could you elaborate on that?
- Participant:* Um, well, heroin - the withdrawals physically are quite strenuous on your body and you find it goes into... how can I say? One cannot perform or function as a normal human being. You get muscular pains, you get headaches and migraines, you know. Whereas alcohol you might just feel that you do need a beer, and your body might say 'listen, have a "dop" (drink)'. You might feel queasy. And I think with ecstasy as well, I think ecstasy is more of a mental addiction than a physical addiction. But, once one uses heroin intravenously, and you are addicted to it, to go clean is extremely, extremely difficult. And one experiences um, a hell of a lot of physical pain and suffering to try and come clean, which lasts between three and five days, before one starts being able to function as a normal... or even stand up to go to the bathroom.
- I went 'cold turkey', so there was no medical assistance, there was no psychological assistance. My parents didn't even know that I stopped using heroin. So they weren't aware of the fact that I had, or that I was withdrawing. Basically stayed in my room all day or stayed in the garden all day, and steered clear from their attention, because I didn't want them to know that I was using heroin, even though they did know that I was. They had found syringes and they had found, you know, foil and all that. So they were aware that I was taking. They did try and stop me from further abusing it. The only reason I stopped is because you can't afford it anymore and it wasn't available.
- The lack of availability and the lack of finance.
- No, not really.
- Yea. Absolutely, absolutely.
- Heroin - the withdrawals physically are quite strenuous on your body and you find it goes into... one cannot perform or function as a normal human being. You get muscular pains, you get headaches and migraines. Whereas alcohol you might just feel that you do need a beer, and your body might say 'listen, have a "dop" '. You might feel queasy. I think with ecstasy as well, I think ecstasy is more of a mental addiction than a physical addiction. But, once one used heroin intravenously and you are addicted to it, to go clean is extremely, extremely difficult. One experiences a hell of a lot of physical pain and suffering to try and come clean, which lasts between three and five days, before one starts being able to function as a normal... or even stand up to go to the bathroom.

- Interviewer:* Do you think then that all heroin addicts could go 'cold turkey'?
- Participant:* No not all. No not all.
- Interviewer:* Should one take medication?
- Participant:* I would suggest medication. Um, if it's possible, if you can, if you're not too badly addicted to heroin, and you're not using it intravenously, then I think one should be able to stop without medication. But if you are using it intravenously for longer than, I'd say, a week or two, I wouldn't advise someone to quit heroin on their own, 'cold turkey' because it causes a lot of pain, it's mental and physical pain, and you can become destructive and violent, so... I would suggest medication. If you're not too badly addicted to heroin, and you're not using it intravenously, then I think one should be able to stop without medication. If you are using it intravenously for longer than, I'd say, a week or two, I wouldn't advise someone to quit heroin on their own, 'cold turkey' because it causes a lot of pain, it's mental and physical pain, and you can become destructive and violent.
- Interviewer:* Did you?
- Participant:* Yea, you take your moms' car and you ride it into the wall. Or you throw your appliances out the window or you become agitated, scream and shout at family and friends. Um, you become a completely different person. You're not yourself. You would never in your normal mind, no matter how intoxicated you were with alcohol, you would not perform such, or do any such harmful things to somebody else, even a close friend, who you'd verbally abuse because of the fact that you are withdrawing, and not to do with anything else. You take your moms' car and you ride it into the wall. Or you throw your appliances out the window or you become agitated, scream and shout at family and friends. You become a completely different person. You're not yourself. You would never in your normal mind, no matter how intoxicated you were with alcohol, you would not perform such, or do any such harmful things to somebody else, even a close friend, who you'd verbally abuse because of the fact that you are withdrawing, and not to do with anything else.
- Interviewer:* Is it hard for you to stay clean?
- Participant:* It's very hard, yes. If someone were to walk into the room now and say 'would you like a hit', I wouldn't be able to say no, and I've been off of it for a year. I wouldn't go out and try and buy heroin myself. I would definitely not try and, you know, obtain some or get some from a friend, you know, by getting in my car, or driving to my dealer or phoning a dealer, to get heroin from them. But if it was offered to me, I wouldn't be able to say no. It's very hard, yes. If someone were to walk into the room now and say 'would you like a hit', I wouldn't be able to say no, and I've been off of it for a year. I wouldn't go out and try and buy heroin myself. I would definitely not try and, you know, obtain some or get some from a friend, you know, by getting in my car, or driving to my dealer, to get heroin from them. But if it was offered to me, I wouldn't be able to say no.
- Interviewer:* That's quit interesting, because it seems like if you really wanted to, you could get it. You have the money.
- Participant:* If one really wanted to, one could. But I don't really want to. If one really wanted to, one could. But I don't really want to.
- Interviewer:* But what got you to that point were you decided that you don't really want to anymore?
- Participant:* Well, your... your physical, your body starts taking a lot of strain. You become very pale, you can't urinate properly, you loose a hell of a lot of weight. A friend of mine, same height as me, almost two metres tall, weighed 53kg when he went to rehab the first time. You get dark rings under your eyes, you become, you look as if

under your eyes, you become, you look as if you're an Aids victim. You look as if you got some type of terminal disease. You feel like that too. That stops me mainly.

you're an Aids victim. You look as if you got some type of terminal disease. You feel like that too. That stops me mainly.

Interviewer: If someone came to you and said they had a heroin problem, what advice would you give them?

Participant: Well, book yourself into a decent rehab, if you're using it intravenously and if you're using it longer than a month. Otherwise, go home, tell your parents about it, discuss it with them. See if they can assist you, maybe send you on a holiday somewhere or go with them away somewhere, where you're not in touch with your crowd of friends that you would be taking heroin with, or not living close to a dealer or never even close to a telephone, because you're most likely to pick up the phone and get hold of the dealer and make a plan to get hold of heroin. But, with regard to someone else who has obviously been using for longer than a month, I'd say, go to rehab because it's the only way you're going to stop.

Well, book yourself into a decent rehab, if you're using it intravenously and if you're using it longer than a month. Otherwise, go home, tell your parents about it, discuss it with them. See if they can assist you, maybe send you on a holiday somewhere or go with them away somewhere, where you're not in touch with your crowd of friends that you would be taking heroin with, or not living close to a dealer or never even close to a telephone, because you're most likely to pick up the phone and get hold of the dealer and make a plan to get hold of heroin. But, with regard to someone else who has obviously been using for longer than a month, I'd say, go to rehab because it's the only way you're going to stop.

Interviewer: Although you managed to stop without...

Participant: Yes, but I stay 400 km away from a dealer, so that stopped me from using (*laughs*), but I didn't have money to get in the car and drive all the way to Jo'burg to pick it up, so...

Yes, but I stay 400 km away from a dealer, so that stopped me from using, but I didn't have money to get in the car and drive all the way to Jo'burg to pick it up.

Interviewer: Okay. Were you sharing needles ever?

Participant: Never.

Never.

Interviewer: Okay. So you were careful. Were you worried about contracting HIV?

Participant: Extremely worried about it. We always made sure that we used our own syringes. Before we even left Tzaneen to ride to Jo'burg to pick up our heroin, we always stopped at the chemist to buy. Each person would buy their own syringe, or, you know, at a stage we had a big packet and every time we'd use, we'd just help ourselves, and maybe use your own syringe more than once, boil it in water if you didn't have another syringe. Boil it in water and then use it again on your own, but we'd never share, we never shared. We were very, very holy about not sharing, because of HIV, and there's quite a few others...?

Extremely worried about it. We always made sure that we used our own syringes. Before we even left Tzaneen to ride to Jo'burg to pick up our heroin, we always stopped at the chemist to buy. Each person would buy their own syringe, at a stage we had a big packet and every time we'd use, we'd just help ourselves, and maybe use your own syringe more than once, boil it in water if you didn't have another syringe. Boil it in water and then use it again on your own, but we'd never share, we never shared. We were very, very holy about not sharing, because of HIV, and there's quite a few others.

Interviewer: Yea. Hepatitis?

Participant: Hepatitis, yea.

Hepatitis, yea.

Interviewer: Do you think though that other intravenous users are as careful? Do you have any idea?

- Participant: Not really. I've actually seen people share needles. They would use a needle, and then rinse the needle in normal tap water, and then give it to another person, they would also use it. It all depends from person to person I'd say. But the majority of the people who do use intravenously, I would presume or I would assume, I actually think that they do not share their needles with other people, unless they're in dire straits and they really need a hit, and there is only one needle - they most likely share it, um, after thoroughly disinfecting it, boiling it in water etc. But, I'd say the majority of users are very careful with regard to their own clean use.
- Participant: Not really. I've actually seen people share needles. They would use a needle, and then rinse the needle in normal tap water, and then give it to another person, they would also use it. It all depends from person to person I'd say. The majority of the people who do use intravenously, I would presume or I would assume, I actually think that they do not share their needles with other people, unless they're in dire straits and they really need a hit, and there is only one needle - they most likely share it, um, after thoroughly disinfecting it, boiling it in water. I'd say the majority of users are very careful with regard to their own clean use.
- Interviewer: *Do you feel that society perceptions and your family's perceptions and support were conducive toward recovery? Or do you feel that people have been judgmental?*
- Participant: Well, you don't really share your addiction or you don't tell many people about you addiction, because you don't want people to know you are using heroin, or any other drug for that matter. Um, but with regard to family and friends, they... I personally feel your friends don't really give a damn. They might but, you know, they suggest to you, you know; 'you look like shit - stop taking heroin'. But if you're a heroin addict you don't really care what you look like. Family... I think one has to have a very close bond within a family, a strong family, a strong relationship within your family, for one to start taking advice from them. Because once you're addicted to heroin and you use it intravenously, you become detached with normal reality, day-to-day life. Things that you would perceive as normal, other people would perceive as completely crazy, do you know what I mean? People still ask me today, 'aren't you scared of a needle?', or 'didn't it hurt?' And it doesn't, because you block yourself off from that physical pain, and even mental pain from you family and friends, who might verbally abuse you because you don't listen to anyone else. They can't talk to you nicely and say 'listen, stop using heroin', because you won't listen to them. Which eventually lands up in arguments and fights and, um, physically abusing each other, to an extent that you, you know, you both just detach yourself from each other. So, it's quite sad, but you know...
- Participant: Well, you don't really share your addiction or you don't tell many people about you addiction, because you don't want people to know you are using heroin, or any other drug for that matter. With regard to family and friends, I personally feel your friends don't really give a damn. They might, they suggest to you; 'you look like shit - stop taking heroin'. But if you're a heroin addict you don't really care what you look like. Family... I think one has to have a very close bond within a family, a strong family, a strong relationship within your family, for one to start taking advice from them. Once you're addicted to heroin and you use it intravenously, you become detached with normal reality, day-to-day life. Things that you would perceive as normal, other people would perceive as completely crazy. People still ask me today, 'aren't you scared of a needle?', or 'didn't it hurt?' And it doesn't, because you block yourself off from that physical pain, and even mental pain from you family and friends, who might verbally abuse you because you don't listen to anyone else. They can't talk to you nicely and say 'listen, stop using heroin', because you won't listen to them. Which eventually lands up in arguments and fights and physically abusing each other, to an extent that you, you know, you both just detach yourself from each other. So, it's quite sad.
- Interviewer: *Do you feel though that your family has supported you?*
- Participant: They have supported me tremendously, they have supported me. With regard to heroin, I didn't receive much support from them because I kept it a secret as much as possible. But with regard to drinking and stuff, they have supported me tremendously. Without them, and my
- Participant: They have supported me tremendously, they have supported me. With regard to heroin, I didn't receive much support from them because I kept it a secret as much as possible. With regard to drinking and stuff, they have supported me tremendously. Without them,

aunt, I would most likely not be here.

and my aunt, I would most likely not be here.

Interviewer: *Thank you so much*

Participant: You're welcome.

PARTICIPANT 25 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin, and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Basically, okay. I don't understand the question... but, um, it was a very hard process... very mentally, very mentally than physically. I must say physically it was long and hard - it was more mentally. And, um, there was medicine, which helped A LOT. I don't think I could have done it without medicine.
- Interviewer:* Can you specify the medication?
- Participant:* Subutex, Suboxone (*Buprenorphine*) on the Internet. I wouldn't have been able to do it without it.
- Interviewer:* Did you use it for withdrawal as well?
- Participant:* First off I used it for the withdrawals, for the 'cold turkey'. Afterwards, they kept me on it, then I realised that if I'm on the Subutex and I use heroin - then it makes me not feel 'lekker' (*well*). It's like a blocker as well. So, um, and then I started misusing the Subutex, and then I started thinking... hey, I don't need 'H'. I can stay on the Subutex, and after that I actually admitted to everybody because I have the 'trainspotting' marks on my arms, and um, ja (*yes*) and then, luckily I had a support group and they helped me to use it right, in the right way.
- Interviewer:* And who was the support group?
- Participant:* My sister, my, um, fiancé, and um, my parents, which weren't around me that often, but um, financially they supported me a great deal, that helped. And, um, 'cause you know, Subutex for seven pills, 8mg, is five hundred bucks or more, six or seven.
- Interviewer:* Does your medical aid cover it?
- Participant:* My medical aid pays it, but only to a certain point, then it's exhausted. Then I must buy it cash.
- Interviewer:* Do you think that you will need Subutex for a long period still?
- Participant:* I see it as... this month and next month, and then by law I can't use it 'cause it's a... I don't know if the doctor spoke bull, when I asked him, he explained to me that according to law, it's a chronic medication, and I can only be on it for a certain time period. Only a certain time period, and after that I may not. So, my time's running out... so, I can either now continue with the drugging and throw my life down the drain, or I can actually get my foundation
- It was a very hard process... very mentally, very mentally than physically. I must say physically it was long and hard - it was more mentally. There was medicine, which helped A LOT. I don't think I could have done it without medicine.
- Subutex, Suboxone on the Internet. I wouldn't have been able to do it without it.
- First off I used it for the withdrawals, for the 'cold turkey'. Afterwards, they kept me on it, then I realised that if I'm on the Subutex and I use heroin - then it makes me not feel 'lekker'. It's like a blocker as well. Then I started misusing the Subutex, and then I started thinking... hey, I don't need 'H'. I can stay on the Subutex, and after that I actually admitted to everybody because I have the 'trainspotting' marks on my arms. Then, luckily I had a support group and they helped me to use it right, in the right way.
- My sister, my, um, fiancé, and my parents, which weren't around me that often, but um, financially they supported me a great deal, that helped Subutex for seven pills, 8mg, is five hundred bucks or more, six or seven.
- My medical aid pays it, but only to a certain point, then it's exhausted. Then I must buy it cash.
- This month and next month, and then by law I can't use it. I don't know if the doctor spoke bull, when I asked him, he explained to me that according to law, it's a chronic medication, and I can only be on it for a certain time period. Only a certain time period, and after that I may not. So, my time's running out... so, I can either now continue with the drugging and throw my life down the drain, or I can actually get my foundation right and actually make something of my life.

right and actually make something of my life.

Interviewer: Okay. So you feel that medical intervention did help you, and is still busy helping you. What about therapeutic intervention, has it helped or not?

Participant: For each person it is different. I'm certain that if I got the right person that could work with me - then it could have worked. But, I am not very easy to work with, I think. I either 'click' with someone and I'm open, or start playing mind games with the therapist. And 99% of the time I played games with them. And actually I fooled myself. I wasted my parents' money. Pretty much, I was so 'moerse' (very) clever, so 'slim vang sy baas' (clever catches it's boss).

Interviewer: If someone comes your way that also has a heroin problem, that advice would you give to them?

Participant: Now, I would, the advice is, let's rather not be friends because the two of us won't make us stronger... so rather go your way and help yourself, because I'm helping myself. I am very selfish in this game of recovery, I'm sorry. That's also why I don't want to go to NA.

Interviewer: Do you think there is a difference in treating heroin addiction compared to other drugs?

Participant: Hectic. Hectically.

Interviewer: Could you elaborate on that?

Participant: It's like day and night. Like you can't treat every person the same, so you can't treat every drug the same. If you on, let's say cocaine, basically you end up... maybe steal and scheme and do stuff to get that drug. But, more likely, it's the upper class people that use coke, but not necessarily. Um, the upper class people also use heroin. I know lots of computer guys who earn a lot of money, that use heroin. Um, I just think that as the drugs differ-treatment is different. Because, um, the effect of the heroin, the, actually, the negative effect that heroin gives you, like the withdrawals, um, you see, if you go down on crack, you're confused in your head. Coke and all the rest is more mentally. Heroin is physically, you know you can die of withdrawals, physically withdrawals of heroin.

Interviewer: So do you feel that treatment should focus on medical aspects more?

Participant: No, 'cause like I said earlier, it's actually all in the head, all in your mind. My problem wasn't actually drugs actually, my problem was the needle.

For each person it is different. I'm certain that if I got the right person that could work with me - then it could have worked. But, I am not very easy to work with, I think. I either 'click' with someone and I'm open, or start playing mind games with the therapist. And 99% of the time I played games with them. And actually I fooled myself. I wasted my parents' money. Pretty much, I was so 'moerse' clever, so 'slim vang sy baas'.

Now, I would, the advice is, let's rather not be friends because the two of us won't make us stronger... so rather go your way and help yourself, because I'm helping myself. I am very selfish in this game of recovery, I'm sorry. That's also why I don't want to go to NA.

Hectic. Hectically.

It's like day and night.

Like you can't treat every person the same, so you can't treat every drug the same. If you on, let's say cocaine, basically you end up... maybe steal and scheme and do stuff to get that drug. But, more likely, it's the upper class people that use coke, but not necessarily. The upper class people also use heroin. I know lots of computer guys who earn a lot of money, that use heroin.

I just think that as the drugs differ- treatment is different. Because the effect of the heroin, the, actually the negative effect that heroin gives you, like the withdrawals.

If you go down on crack, you're confused in your head. Coke and all the rest is more mentally.

Heroin is physically, you know you can die of withdrawals, physically withdrawals of heroin.

No, 'cause like I said earlier, it's actually all in the head, all in your mind.

My problem wasn't actually drugs actually, my problem was the needle

- Interviewer:* What do you mean by that?
- Participant:* Just the routine of spoon, something in the spoon, cook up, slurp, tie up, hit. The routine, that's actually how I discovered to mainline Subutex, 'cause Subutex wasn't the first thing, other than heroin, that I mainlined. I experimented with anything 'cause it's fun to mainline. You get an all different effect. And thank God I didn't reach to Wellconol. Because, I promise you, I would have mainlined it as well. And then it would have been tickets.
- Participant:* Just the routine of spoon, something in the spoon, cook up, slurp, tie up, hit. The routine, that's actually how I discovered to mainline Subutex, 'cause Subutex wasn't the first thing, other than heroin, that I mainlined. I experimented with anything 'cause it's fun to mainline. You get an all different effect. Thank God I didn't reach to Wellconol. Because, I promise you, I would have mainlined it as well.
- Interviewer:* So what must treatment focus on? Do you think that treatment must be longer for heroin? I'm not necessarily talking about in-patient treatment; I'm just talking about intervention.
- Participant:* I think treatments in rehab now for heroin is, um, the time is right.
- Participant:* I think treatments in rehab now for heroin, the time is right.
- Interviewer:* So you don't think it needs to be long-term?
- Participant:* No, not longer. You can keep a guy for a year in Noupoort, and I've seen it, and they come out and they relapse and they go on. It's all; actually, what it's all about is you taking him out of his environment, where he's actually introduced his friends and everything. You take him out there and you put a druggy in a perfect place, where nothing can reach him. So nothing from the outside can reach him, and he can't reach the outside - and then his time is finished. You take him out of the perfect environment, and you put him back where he came from. Where the problem actually started. And if the patient doesn't make his own choices, if the patient doesn't make that 180 degree turn and go the other way, and tell his mates 'listen here, cheers, we can't be friends anymore', and um, and start changing the habits, the small things, because it all ends up to the small things - like I said - the building blocks. You must get your foundation right. Um, if that's not in place, the patient comes out of rehab, comes back home, and he's back in the hell-hole and it all starts from the beginning, but actually at a faster pace, and it gets worse and worse and worse. And you can take him out there; give him his vacation in rehab, because honestly, for me, rehab was a hell of a vacation. 'Cause you reach you inner-side again, and you get pink again, and everything and you can think straight, and then, just a while, actually I was scared...
- Participant:* No, not longer. You can keep a guy for a year in Noupoort, and I've seen it, and they come out and they relapse and they go on. It's all; actually, what it's all about is you taking him out of his environment, where he's actually introduced his friends and everything. You take him out there and you put a druggy in a perfect place, where nothing can reach him. So nothing from the outside can reach him, and he can't reach the outside - and then his time is finished. You take him out of the perfect environment, and you put him back where he came from. Where the problem actually started. If the patient doesn't make his own choices, if the patient doesn't make that 180 degree turn and go the other way, and tell his mates 'listen here, cheers, we can't be friends anymore' and start changing the habits, the small things, because it all ends up to the small things - the building blocks. You must get your foundation right. If that's not in place, the patient comes out of rehab, comes back home, and he's back in the hell-hole and it all starts from the beginning, but actually at a faster pace, and it gets worse and worse and worse. You can take him out there; give him his vacation in rehab, because honestly, for me, rehab was a hell of a vacation. 'Cause you reach you inner-side again, and you get pink again, and everything and you can think straight, and then, just a while, actually I was scared...
- Participant:* (long pause)
- Interviewer:* To go out?
- Participant:* To go out.
- Participant:* To go out.

Interviewer: *The way people see you, society, and your family and significant others, do you feel that they are supportive in your recovery? Or do you feel that people are judgmental towards you?*

Participant: I feel people are judgmental. But I also feel people support me. I don't blame them, because I think they're scared. They scared that, they're scared... they're scared. Because the thing about a heroin addict is, he's not just ruining his own life; he's ruining everybody around him that has contact with him. He's destroying their lives as well, because he takes from them, he's ruining them, he's wheeling and dealing and, not necessarily with drugs, but he'll sell and he'll take, you know, and um, but time is a good, 'cause if a patient just, if somebody can just think like this: if I make today right, then my tomorrow's yesterday will be fine, will be alright. And that means, if you can live that for a long time, like just for today. I'm just going to make sure that today is alright, and the next day, today is alright, then you'll start realising... my yesterday is also alright. And then time will go past, and then, it's a funny thing, time is a healer. And people, they forget in time. Not forget forget. But ja (yes), some things they forget, so busy they also know...

Interviewer: *They can put it in perspective?*

Participant: Yes. And hope.

Interviewer: *Hope? What do you mean by hope?*

Participant: Hope, okay, let's take me for example... when I reached the hectic part of my drugging, was the time when I actually wanted to die, 'cause I thought there's no hope, I can't get out of it. And, when I started getting hope again, that's when things are sort of... doing this turning and things are going uphill, sort of - there's hope (laughs).

Interviewer: *What gave you hope?*

Participant: I don't know, um, life is a weird thing, 'cause something hectic will happen, and would have maybe done something wrong, like took something from somebody. And then everybody, it felt like everybody was teaming up against me and they confront me, and um, then I would have thought: 'it's the end of my life, and there's no hope' and, and 'life is such a hellhole' and that, things like that. But at the end, they actually helped me in, like for instance, I was busted, I never got busted by the family, but um, they knew, but at the end I actually admitted it 'cause they confronted me, and then it's like a hectic thing, and there's no hope, and then everybody it like 'no there's hope, you can do it' - and then I start believing it.

I feel people are judgmental.

But I also feel people support me. I don't blame them, because I think they're scared. They scared that, they're scared... they're scared. Because the thing about a heroin addict is, he's not just ruining his own life; he's ruining everybody around him that has contact with him. He's destroying their lives as well, because he takes from them, he's ruining them, he's wheeling and dealing and, not necessarily with drugs, but he'll sell and he'll take.

But time is a good, 'cause if a patient just, if somebody can just think like this: if I make today right, then my tomorrow's yesterday will be fine, will be alright. And that means, if you can live that for a long time, like just for today. I'm just going to make sure that today is alright, and the next day, today is alright, then you'll start realising... my yesterday is also alright. And then time will go past, and then, it's a funny thing, time is a healer. And people, they forget in time. Not forget forget. But ja, some things they forget.

Yes. And hope

Hope, okay, let's take me for example... when I reached the hectic part of my drugging, was the time when I actually wanted to die, 'cause I thought there's no hope, I can't get out of it. When I started getting hope again, that's when things are sort of... Doing this turning and things are going uphill, sort of - there's hope.

I don't know, life is a weird thing, 'cause something hectic will happen, and would have maybe done something wrong, like took something from somebody.

Then everybody, it felt like everybody was teaming up against me and they confront me, then I would have thought: 'it's the end of my life, and there's no hope' and, and 'life is such a hellhole' and that, things like that.

But at the end, they actually helped me in, like for instance, I was busted, I never got busted by the family, they knew, but at the end I actually admitted it 'cause they confronted me, and then it's like a hectic thing, and there's no hope, and then everybody it like 'no there's hope, you can do it' - and then I start believing it. I think that that's the best I can explain it.

- I think that that's the best I can explain it.
- Interviewer:* Yes. *But even the fact that your family confronted you was in a sense an intervention, because if they hadn't confronted you...*
- Participant:* But they knew, and they actually talk about it everyday, like warned me and preached and stuff like that.
- Interviewer:* *So you think that helped you in the long run?*
- Participant:* Ja (yes), it actually did, 'cause you go to your room and you actually think about it. And, to be quite honest, you're not actually proud of who you are. You, you're scheming, you're stealing, you're doing everything wrong in the book. You're loosing all you friends, your dear friends, and you're breaking relationships. You're not proud of who you are. And then, all this advice is coming to your side, and um, you actually go and you think about it. And you actually start knowing what's right and wrong, but, you're trapped in this hellhole and you can't get out. Afterwards, you know exactly what you're doing, you know it's wrong, and then on your mission to Sunnyside, you actually start hating yourself and want to die, and it's just a bad thing.
- Interviewer:* *Is it hard for you to stay clean?*
- Participant:* At first, yes. The mind is powerful because I'm clean for this long - what will one hit do? But after a while, you start realising, hey, the longer I'm clean, the easier it starts to get. Sometimes, you realise, hell, I forgot about it actually for quite a while, but I'm thinking about it now, and then you realise, jees - I'm thinking about heroin. When last did I think about it? 'Cause the other things in life come, like work and relationships and new problems and stuff like that, which normal people have, and then it takes your mind and attention away from it.
- Interviewer:* *When you were still using drugs intravenously, did you share needles?*
- Participant:* You end up like... two friends in a car and the needles' actually got mixed up, and they're so certain, this is mine and this is mine, this is mine - and I can be certain by certain marks that this is mine, but of course it's touched the other guys' needles. I don't know how or who had it... but I took it anyway. I had withdrawals, 'cold turkey', so I learnt - you can get your fix, my fix will be better because I waited longer, and they were so (inaudible) - yes, you're actually right.
- Interviewer:* *So you were never scared of AIDS?*
- But they knew, and they actually talk about it everyday, like warned me and preached and stuff like that.
- Ja, it actually did, 'cause you go to your room and you actually think about it. To be quite honest, you're not actually proud of who you are. You, you're scheming, you're stealing, you're doing everything wrong in the book. You're loosing all you friends, your dear friends, and you're breaking relationships. You're not proud of who you are. Then, all this advice is coming to your side, you actually go and you think about it. You actually start knowing what's right and wrong, but, you're trapped in this hellhole and you can't get out. Afterwards, you know exactly what you're doing, you know it's wrong, and then on your mission to Sunnyside, you actually start hating yourself and want to die, and it's just a bad thing.
- At first, yes.
The mind is powerful because I'm clean for this long - what will one hit do? But after a while, you start realising, hey, the longer I'm clean, the easier it starts to get. Sometimes, you realise, hell, I forgot about it actually for quite a while, but I'm thinking about it now, and then you realise, jees - I'm thinking about heroin. When last did I think about it? 'Cause the other things in life come, like work and relationships and new problems and stuff like that, which normal people have, and then it takes your mind and attention away from it.
- You end up like... two friends in a car and the needles' actually got mixed up, and they're so certain, this is mine and this is mine, this is mine - and I can be certain by certain marks that this is mine, but of course it's touched the other guys' needles. I don't know how or who had it... but I took it anyway. I had withdrawals, 'cold turkey', so I learnt - you can get your fix, my fix will be better because I waited longer.

Participant: No one, never ever.

No one, never ever.

Interviewer: Did your friends share needles?

Participant: Yes, but only with certain people. But the thing is, how I thought is... Koosie only shares with Jannie needles, but Jannie shares only with Sunny and Koosie needles. And you know it's like a sick thing that will end up. Not even AIDS, any disease, like yellow fever, or anything, anything. That's also like, my friends would say; 'you can share with me I don't have AIDS you know.' I usually told them; 'no listen here, I'm not scared of AIDS, I'm scared of a cold', or something like that, that's a small disease, a germ. They actually fell for it.

Yes, but only with certain people. But the thing is, how I thought is... Koosie only shares with Jannie needles, but Jannie shares only with Sunny and Koosie needles. You know it's like a sick thing that will end up. Not even AIDS, any disease, like yellow fever, or anything, anything. That's also like, my friends would say; 'you can share with me I don't have AIDS you know'. I usually told them; 'no listen here, I'm not scared of AIDS, I'm scared of a cold', or something like that, that's a small disease, a germ. They actually fell for it.

Interviewer: Thank you so much and all the best.

Participant: Pleasure and thank you.

PARTICIPANT 26 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Medical intervention didn't help at all. It was actually 100% discipline what I got. Working hard down in Noupoot, and to believe in yourself, and stay strong, until you at that point that you can believe in yourself enough and that you can do it by yourself. At Noupoot you don't receive any medication or pills. There you must 'cold turkey' and then you must start with your life.
- Interviewer:* How long do you think must someone be in treatment for?
- Participant:* Look, it differs from person to person. Some people, I saw, stay clean after six weeks, and never use again, others go for two years to a place and they still relapse. I think it depends on how badly you want to stay clean.
- Interviewer:* Okay. Do you think there is a difference between treating someone with on heroin compared to other drugs? Or do you think it's the same?
- Participant:* I think heroin guys are harder. I think they should go for a little longer. Heroin is physically addictive and emotionally and mentally addictive. And it's also a very hard drug to come off of. A guy maybe uses at parties 'E' (ecstasy), they might struggle to get off it, but they don't have to go through as much as a heroin addict. Heroin addicts have actually sold their soul.
- Interviewer:* What do you mean?
- Participant:* They're emotionless. They only live for heroin. They worry about nothing or anybody. They don't care about themselves. All they're looking for is their drugs, and that's it. They don't care who they hurt and how much they're hurting themselves. They're only looking for their drugs - that's why I say - they are the dead walking. They don't have a soul.
- Interviewer:* What do you think happened then to change your thought patterns? Did discipline help, or was it something else?
- Participant:* Um, it's Christian based treatment and I think that helped me a lot. To see that the path that I walked was very skew, and that a person cannot carry on like that. To an extent, it also made me more responsible. Actually, those two things together.
- Medical intervention didn't help at all. It was actually 100% discipline what I got. Working hard down in Noupoot, and to believe in yourself, and stay strong, until you at that point that you can believe in yourself enough and that you can do it by yourself. At Noupoot you don't receive any medication or pills. There you must 'cold turkey' and then you must start with your life.
- Look, it differs from person to person. Some people, I saw, stay clean after six weeks, and never use again, others go for two years to a place and they still relapse. I think it depends on how badly you want to stay clean.
- I think heroin guys are harder. I think they should go for a little longer. Heroin is physically addictive and emotionally and mentally addictive. It's also a very hard drug to come off of. A guy maybe uses at parties 'E', they might struggle to get off it, but they don't have to go through as much as a heroin addict. Heroin addicts have actually sold their soul.
- They're emotionless. They only live for heroin. They worry about nothing or anybody. They don't care about themselves. All they're looking for is their drugs, and that's it. They don't care who they hurt and how much they're hurting themselves. They're only looking for their drugs - that's why I say - they are the dead walking. They don't have a soul.
- It's Christian based treatment and I think that helped me a lot. To see that the path that I walked was very skew, and that a person cannot carry on like that. To an extent, it also made me more responsible. Actually, those two things together.

Interviewer: So the spiritual aspect was important to you?

Participant: Yes. Yes.

Interviewer: Yes. There was a stage when you were on Physeptone, hey? Do you feel that it helped, or not? How do you view it?

Participant: It helps if you take it right. If you take it like you're told to take it, then you can get through the day without really going 'cold turkey'. But the thing is, it doesn't take away the cravings. It takes away your pains from the 'turkey', but not your craving. So if you're strong enough to withstand your cravings, then it can work for you, but otherwise not. It helps if you take it right. If you take it like you're told to take it, then you can get through the day without really going 'cold turkey'. But the thing is, it doesn't take away the cravings. It takes away your pains from the 'turkey', but not your craving. So if you're strong enough to withstand your cravings, then it can work for you, but otherwise not.

Interviewer: Would you recommend it?

Participant: For those who are very desperate and have no other options - try it, it could work. For those who are very desperate and have no other options - try it, it could work.

Interviewer: So it depends?

Participant: It just depends. For me, it didn't work. But I do know people that it worked for. I have a friend who was addicted to heroin, he quit by himself. He wasn't in a rehab - he bought three bottles of Physeptone that the doctor gave him a prescription for, and he came off. It just depends. For me, it didn't work. But I do know people that it worked for. I have a friend who was addicted to heroin, he quit by himself. He wasn't in a rehab - he bought three bottles of Physeptone that the doctor gave him a prescription for, and he came off.

Interviewer: Is it hard for you to stay clean?

Participant: Um, sometimes, yes. Sometimes no. I can have fun and stay sober, that I've seen. But, now and again you get days that you crave. And then I lock myself in my room, which is very difficult for me, but, it's about once in a week that it happens, not often. But my family stands behind me and friends that stand behind me and help. Sometimes, yes. Sometimes no. I can have fun and stay sober, that I've seen. But, now and again you get days that you crave. Then I lock myself in my room, which is very difficult for me, but, it's about once in a week that it happens, not often. My family stands behind me and friends that stand behind me and help.

Interviewer: Okay, so you feel you have support. Does the support help?

Participant: It helps a lot. It helps a lot.

Interviewer: Other people's perceptions, such as society and perhaps your family, do you feel it's positive, that they support you? Or do you feel that people are judgmental?

Participant: My family supports me. But my broader family, my aunts and uncles, they say nothing. They see no hope in me, which is difficult for me. I can no longer go to family gatherings. If I go to them, everyone is scared of me. They don't know if I'm going to steal things or do something wrong there. It's bad for me that my own family wants nothing to do with me, except for my father, mother, brother and sister - that's all. My family supports me. But my broader family, my aunts and uncles, they say nothing. They see no hope in me, which is difficult for me. I can no longer go to family gatherings. If I go to them, everyone is scared of me. They don't know if I'm going to steal things or do something wrong there. It's bad for me that my own family wants nothing to do with me, except for my father, mother, brother and sister - that's all.

Interviewer: Do you feel then that the others have actually impeded you?

Participant: Yes. So... I also have a girlfriend who helped save my life and who stands behind me a lot. I also have other friends who think I am very bad, I can't come right. So yes, fifty/fifty, one half has hope, the other half not.

Interviewer: When you were still on heroin, were you ever worried about AIDS?

Participant: No.

Interviewer: Did you share needles?

Participant: Yes.

Interviewer: You did...

Participant: I wasn't bothered. As long as I got heroin I was happy. Often I was close and then the needle would get stuck, jis, and then I'd need, and I see a guy in a parking lot, and he would give me. I just didn't care.

Interviewer: Did the other guys also share?

Participant: Yes. Three, four guys in a room, all three/four would share one needle. When I think about it now, I get frightened - I can't believe I did it. It's really bad.

Interviewer: If someone came your path who has a heroin problem - what do you think would help them?

Participant: I would say he must stop listening to what other people say he must do, because other people don't know how you feel. They can say many things to you, but you must just go and see if you're strong enough and follow your own path. If you can't do it by yourself, if you've seen you can't do it, then you must stop struggling and go get help. There's a lot of help everywhere, everywhere in the country there is help. You adapt. You must just look for help. That's what I did. I went from one place to the next until I eventually got help, you must just not give up hope. That's all that I can say. I don't actually know.

Interviewer: Thank you so much. It's good to see you this way.

Yes. So... I also have a girlfriend who helped save my life and who stands behind me a lot. I also have other friends who think I am very bad, I can't come right. So yes, fifty/fifty, one half has hope, the other half not.

No.

Yes.

I wasn't bothered. As long as I got heroin I was happy. Often I was close and then the needle would get stuck, jis, and then I'd need, and I see a guy in a parking lot, and he would give me. I just didn't care.

Yes. Three, four guys in a room, all three/four would share one needle. When I think about it now, I get frightened - I can't believe I did it. It's really bad.

I would say he must stop listening to what other people say he must do, because other people don't know how you feel. They can say many things to you, but you must just go and see if you're strong enough and follow your own path. If you can't do it by yourself, if you've seen you can't do it, then you must stop struggling and go get help. There's a lot of help everywhere, everywhere in the country there is help. You adapt. You must just look for help. That's what I did. I went from one place to the next until I eventually got help. You must just not give up hope. That's all that I can say. I don't actually know.

PARTICIPANT 27 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: There was no medical intervention on any level. My process was - I did a geographical. I made a decision that I wouldn't go on and I couldn't die. I just overdosed again, and that brought me round, and I - in the end that I could see of getting clean was to remove myself to another country - so I did a geographical to a place where I knew I couldn't get the stuff. To a very remote island, and I went 'turkey', so I was very, I was quite ill. In retrospect, it was like having a bad flu, because I became dependent again on morphine in 1999.

Interviewer: How long did the morphine dependence last for?

Participant: Um, I don't know - because it was medically administered after an accident.

Interviewer: I see, okay. Do you think that medication could have helped you in retrospect?

Participant: It could have made it... it could have made it more comfortable, as long as it was monitored. Had I been given medication to do it on my own - I would have, um, abused it. I wouldn't have been able to not use heroin.

Interviewer: Okay, and in terms of treatment; do you think that could have helped you?

Participant: It would have definitely helped.

Interviewer: Why didn't you ever go for treatment?

Participant: Because there wasn't treatment available.

Interviewer: Okay. Do you think there is a difference in treating heroin addiction compared to other forms of addiction?

Participant: No. I do think that heroin addicts tend to be angrier than most people, because it's such a big downer.

Interviewer: So do you feel that the anger is caused by physiological effects or other...

Participant: I think you've got it. I think it's both nature, I think it's probably nature and nurture. But to take such a major downer - heroin addicts are generally angry with parents, with life, they're angry people - and it's passive anger, but it comes out in like rage. Um, and for sure, I think that the pharmacotherapy for heroin addiction needs different treatment. But I don't believe that that... heroin addicts always

There was no medical intervention on any level.
My process was - I did a geographical. I made a decision that I wouldn't go on and I couldn't die. I just overdosed again, and that brought me round, and I - in the end that I could see of getting clean was to remove myself to another country - so I did a geographical to a place where I knew I couldn't get the stuff. To a very remote island, and I went 'turkey', so I was very, I was quite ill. In retrospect, it was like having a bad flu, because I became dependent again on morphine in 1999.

I don't know - because it was medically administered after an accident.

It could have made it... it could have made it more comfortable, as long as it was monitored.
Had I been given medication to do it on my own - I would have abused it. I wouldn't have been able to not use heroin.

It would have definitely helped.

Because there wasn't treatment available.

No.
I do think that heroin addicts tend to be angrier than most people, because it's such a big downer.

I think you've got it.
I think it's both nature, I think it's probably nature and nurture.
But to take such a major downer - heroin addicts are generally angry with parents, with life, they're angry people - and it's passive anger, but it comes out in like rage.
For sure, I think that the pharmacotherapy for heroin addiction needs different treatment.
I don't believe that that... heroin addicts

think they're different, or special, that they're the worst addicts - the best addicts, the worst addicts. I think that's got a lot to do with media.

Interviewer: *And societies perceptions?*

Participant: Yip.

Interviewer: *Do you feel that societies perceptions infl...*

Participant: Big time.

Interviewer: *... the recovery?*

Participant: Big time.

Interviewer: *In what way? Could you elaborate on that?*

Participant: Because society thinks that heroin addicts are hopeless, everybody that uses heroin dies, and it's just not true. Studies show that, and I know people who used for twenty years and not died. You don't die.

Interviewer: *In terms... do you think heroin is different in terms of that? I'm actually asking you that because there is a phenomenon, I'm not sure if you're familiar with it, called the 'maturing out' process.*

Participant: Yea, absolutely.

Interviewer: *You're familiar with it?*

Participant: Yea.

Interviewer: *Which is quite unique, unique to heroin - and is not known in alcohol really.*

Participant: No.

Interviewer: *Okay.*

Participant: Because that's I think again, because of the social - heroin is a very antisocial drug. You spend a lot of time on your own and in toilets.

Interviewer: *You're one of the few people I've come across since I started this that's aware of the 'maturing out' phenomenon.*

Participant: A lot of people I used with 'matured out'. I'm not saying that they didn't cross-addict to alcohol.

Interviewer: *Alright. I think in the period when you were actively addicted to heroin, there wasn't and AIDS epidemic...*

Participant: Treatment wasn't available.

always think they're different, or special, that they're the worst addicts - the best addicts, the worst addicts.
I think that's got a lot to do with media.

Yip.

Big time.

Big time.

Big time.

Because society thinks that heroin addicts are hopeless, everybody that uses heroin dies, and it's just not true. Studies show that, and I know people who used for twenty years and not died. You don't die.

Yea, absolutely.

Yea.

No.

Because that's I think again, because of the social - heroin is a very antisocial drug. You spend a lot of time on your own and in toilets.

A lot of people I used with 'matured out'. I'm not saying that they didn't cross-addict to alcohol.

Treatment wasn't available.

- Interviewer:* Treatment wasn't available, and there wasn't an AIDS epidemic at that stage, but was needle sharing common practice?
- Participant:* Yea... well yea... when I got down to the bottom, then I was at the top sharing. Used to buy them by the two hundred - all of us. We were extremely rich, you know, it was the rich people's stuff when I was using.
- Interviewer:* You managed to do it on your own?
- Participant:* I didn't. What I did was leave heroin, nothing else. Nothing changed. My life remained unmanageable for the next fifteen years. I never managed to sustain relationships. I abused alcohol - nothing changed. All I did was stop heroin. And, because I had stopped heroin, and then thought that I was like perfect - because people don't stop heroin, they die. That's it, the needle hype. The urban legend. So I believed there was nothing wrong with me and it helped to cement my denial.
- Interviewer:* So it's a process, even after one is clean?
- Participant:* Absolutely. And having said that, my recovery (*inaudible*), in the last three years I have been healthier. Because I was so long off heroin I had a certain amount of celebrity - but people were moving away from me because they couldn't bear the smell of the Old Brown Sherry. You know what I mean.
- Yea... well yea... when I got down to the bottom, then I was at the top sharing. Used to buy them by the two hundred - all of us. We were extremely rich, you know, it was the rich people's stuff when I was using.
- I didn't.
What I did was leave heroin, nothing else. Nothing changed.
My life remained unmanageable for the next fifteen years.
I never managed to sustain relationships.
I abused alcohol - nothing changed.
All I did was stop heroin.
Because I had stopped heroin, and then thought that I was like perfect - because people don't stop heroin, they die.
That's it, the needle hype. The urban legend.
So I believed there was nothing wrong with me and it helped to cement my denial.
- Absolutely. In the last three years I have been healthier. Because I was so long off heroin I had a certain amount of celebrity - but people were moving away from me because they couldn't bear the smell of the Old Brown Sherry. You know what I mean.

PARTICIPANT 28 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: Okay, I um, a friend came over and he OD in my house. Nobody was there except me and my cousin and, um, luckily we got to call the emergency, the ambulance, and they got there just in time, but they had to work on him in our house, and um, it gave me such a fright that I flushed down my, um, I think it was 200 grams worth of heroin, down the toilet. And then, I did like sort of quit, I went 'cold turkey' for four days, and I started seeing ***** (psychologist), but I could only go and see him on the Thursday 7th. So on the 5th of December my mom and my cousin had to drag me to the car, my cousin had to drive me to Sunnyside, to a dealer, because I was like going crazy and everything and I think that was my rock bottom, because my mom also paid for my drugs. And um, I went to see ***** (psychologist) and he suggested that I, um, you know, go for an interview at Castle Carey, because my mom wanted to put me in Noupoot though. So that was the Thursday evening, and then the Friday afternoon at one I had an interview with ***** (psychologist) and ***** and ***** (social workers), and I just remember crying a lot because I knew that I had a problem but I didn't know how to stop it. I couldn't stop it, I just couldn't do it by myself. And that was still when Castle Carey only took in like dagga (cannabis) and like a little bit of mandrax (methaqualone) that was like before the whole heroin birth. And so you took like a chance on me, and I was booked in that afternoon. So I last used on the evening of the 7th of December 2000, and um, I was in Castle Carey for eight weeks and I still saw ***** (psychologist) and um I remember in when my six weeks came up, and ***** (psychologist) said I can't go out and that in a couple of hours I will be at the nearest crack dealer, and I was so angry, I was shouting and throwing plastic chairs around me and I seriously threw a temper tantrum. I went out for a weekend leave and everything and I'm so glad I came back because in my seventh week I had this huge crack craving, um, like, it that okay?

Interviewer: Yes, yes. So you feel than that the intervention was necessary? Do you feel that you could have done it on an out-patient basis?

Participant: No, no. I needed to be like in quarantine. Yes.

A friend came over and he OD in my house. Nobody was there except me and my cousin and luckily we got to call the emergency, the ambulance, and they got there just in time, but they had to work on him in our house. It gave me such a fright that I flushed down my, I think it was 200 grams worth of heroin, down the toilet.

I did like sort of quit, I went 'cold turkey' for four days.

I started seeing ***** but I could only go and see him on the Thursday 7th.

So on the 5th of December my mom and my cousin had to drag me to the car, my cousin had to drive me to Sunnyside, to a dealer, because I was like going crazy and everything and I think that was my rock bottom, because my mom also paid for my drugs.

I went to see ***** and he suggested that I, um, you know, go for an interview at Castle Carey, because my mom wanted to put me in Noupoot though. So that was the Thursday evening, and then the Friday afternoon at one I had an interview with ***** and ***** and ***** and I just remember crying a lot because I knew that I had a problem but I didn't know how to stop it.

I couldn't stop it, I just couldn't do it by myself. That was still when ***** only took in like dagga and like a little bit of Mandrax that was like before the whole heroin birth. So you took like a chance on me, and I was booked in that afternoon. So I last used on the evening of the 7th of December 2000.

I was in Castle Carey for eight weeks and I still saw ***** and I remember in when my six weeks came up, and ***** said I can't go out and that in a couple of hours I will be at the nearest crack dealer, and I was so angry, I was shouting and throwing plastic chairs around me and I seriously threw a temper tantrum.

I went out for a weekend leave and everything and I'm so glad I came back because in my seventh week I had this huge crack craving.

No, no.
I needed to be like in quarantine. Yes.

- Interviewer:* *In other words do you feel that you needed to be protected? Or do you feel you could have done it in some other way? What would you recommend for someone with a heroin addiction? How would you go about treating them?*
- Participant: The out-patients go back home, right? The out-patients go back home, right?
- Interviewer:* *That's correct.*
- Participant: No. My cousin was an out-patient at a certain doctor who I really don't like, in Centurion, he's a pompous ass. And yes, everybody who went to that doctor, um, just went back home and used again. So, that's my cousin, and three male friends and two female friends. So, ja (yes), I don't think out-patient stuff works. Um, for some people it does, for some it doesn't, but I know it wouldn't have worked for me... I would have just gone home and used. No. My cousin was an out-patient at a certain doctor who I really don't like, in Centurion, he's a pompous ass. Yes, everybody who went to that doctor, just went back home and used again. So, that's my cousin, and three male friends and two female friends. So, ja, I don't think out-patient stuff works. For some people it does, for some it doesn't, but I know it wouldn't have worked for me... I would have just gone home and used.
- Interviewer:* *Do you have any thoughts on the duration of treatment?*
- Participant: Um, I think um, the people you go to, the professional people, after they evaluate you and everything, they should decide. I think the people you go to, the professional people, after they evaluate you and everything, they should decide.
- Interviewer:* *Okay, so you don't think it's a fixed thing for everyone, it would depend?*
- Participant: Ja. Ja.
- Interviewer:* *Okay. A lot of people feel the long term thing... a year, two years; do you think that's necessary?*
- Participant: I don't know. I don't know hey. I don't know. I don't know.
- Interviewer:* *Okay. A lot of people recommend medical intervention, I don't know if you have experience with that. Any thoughts? Do you think that medication is necessary for treatment, or not?*
- Participant: No, not really. I was only on those two little pills that minimised the craving. No, not really. I was only on those two little pills that minimised the craving.
- Interviewer:* *The Dixarit (Clonidine)?*
- Participant: Yes. But things like methadone and you know that sort of stuff; it just makes the people addicted to the methadone. Yes. But things like methadone and you know that sort of stuff; it just makes the people addicted to the methadone.
- Interviewer:* *Okay, so you're not in favour of methadone treatment, and long-term methadone maintenance?*
- Participant: No, no I'm not. No, no I'm not.

Interviewer: Okay. Societies perceptions, um, and also your family's, when you left treatment and you were in recovery, do you feel that people outside were judgmental toward you? Or were they supportive, and if so, did that help you in the recovery process?

Participant: Um, some were supportive and yes it helped me a lot, but some weren't. Um, the people were supportive with, you know, open-minded. Then there were like these crude people who just think, 'oh, she's a druggy, now we have to lock up all our valuables and everything'. But mostly I received support, so, and it helped me a lot.

Some were supportive and yes it helped me a lot, but some weren't.

The people were supportive with, you know, open-minded. Then there were like these crude people who just think, 'oh, she's a druggy, now we have to lock up all our valuables and everything'.

But mostly I received support, so, and it helped me a lot.

Interviewer: Is it hard for you to stay clean?

Participant: No. No, the first few months was, but it just becomes less and less. Um, when I was using and everything, I used because I ran away from my problems, I couldn't face my problems and everything. Now when I get a problem, were my first thought used to be run away or use, my first thought isn't even, you know, 'oh, I wish I could have one more hit'. I don't even think about drugs anymore. To be honest, I can't even remember what it's like it to take any drugs. So, it's really easy for me, it's like, um, it's just not a normal thing for me anymore.

No. No, the first few months was, but it just becomes less and less. When I was using and everything, I used because I ran away from my problems, I couldn't face my problems and everything.

Now when I get a problem, were my first thought used to be run away or use, my first thought isn't even, you know, 'oh, I wish I could have one more hit'. I don't even think about drugs anymore. To be honest, I can't even remember what it's like it to take any drugs.

So, it's really easy for me, it's just not a normal thing for me anymore.

Interviewer: Well that's great to hear that.

Participant: Ja (yes).

Interviewer: Thank you. I wish you the best.

PARTICIPANT 29 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Ah, I went to you guys, and gone... they put me on medication and all that, and I went through the detox programme. And then from there, on Espiride and Aterax, and then after you guys I went to ***** (psychiatrist).
- Interviewer:* So do you feel that it was necessary to be on medication, or not?
- Participant:* Yheee, well you guys should know that after I nearly cleaned out the whole unit. I needed to calm down.
- Interviewer:* Okay, so you think for that temporary period it was useful?
- Participant:* Ja (yes).
- Interviewer:* Okay.
- Participant:* Especially to calm me down and stuff like that.
- Interviewer:* Okay, and in terms of therapy, do you think that therapy helped at all.
- Participant:* Ja (yes), therapy does. Not really that the therapy helps, but somebody to speak to... ja (yes). Like you were there.
- Interviewer:* Okay. Um...
- Participant:* You were my therapist, but I didn't see you as my therapist.
- Interviewer:* Mmmm, what do you mean by that? Could you elaborate?
- Participant:* Ah, I can't tell you my fantasies (laughs), no, I'm only joking, but ah, you were an easy person to speak to, you were straight forward, and you were there for a reason and you understood the reason, and you were just there to listen. And that was better than what therapy could have been done.
- Interviewer:* Okay. Do you have any thoughts on duration of treatment? Do you think in-patient treatment is necessary? Or do you think you could have done it on an out-patient basis?
- Participant:* Ah no, in-patient.
- Interviewer:* Why do you feel in-patient?
- Participant:* In-patient is necessary, I mean, because if you're an out-patient the dangers of the temptations are so much more than what... you've got a little bit of enclosure
- I went to you guys.
They put me on medication and all that, and I went through the detox programme. And then from there, on Espiride and Aterax.
Then after you guys I went to *****.
- Well you guys should know that after I nearly cleaned out the whole unit.
I needed to calm down.
- Ja.
- Especially to calm me down and stuff like that.
- Ja, therapy does.
Not really that the therapy helps, but somebody to speak to. Like you were there.
- You were my therapist, but I didn't see you as my therapist.
- I can't tell you my fantasies, no, I'm only joking, but you were an easy person to speak to, you were straight forward, and you were there for a reason and you understood the reason, and you were just there to listen. And that was better than what therapy could have been done.
- No, in-patient.
- In-patient is necessary, I mean, because if you're an out-patient the dangers of the temptations are so much more than what... you've got a little bit of enclosure on the in-

on the in-patient. And I think if you can just get to the feel of it on the inside, you're a lot... you just come out a lot stronger than what you ever get outside. Do you understand what I'm saying?

Interviewer: *Mm yes, do you think that six weeks is long enough?*

Participant: I wasn't there six weeks. I was there I think seven or eight.

Interviewer: *Yes. So you don't think a year is necessary, or two years?*

Participant: Ah well that's stretching it a bit, places like Noupoot... it's stretching it a little bit... a hell of a lot actually. Because the period you spend in rehab... you owe it to yourself to come right. You know it's either make or brake. If you brake then you know... the steps should be taken. But if it doesn't brake you know it was successful.

Interviewer: *Is it hard for you to stay clean?*

Participant: Ah ja (yes), every day.

Interviewer: *Every day still?*

Participant: Ja (yes).

Interviewer: *How do you get through it?*

Participant: My fiancé, and... I don't know. Just the will to stay clean.

Interviewer: *Okay. Do you feel that people outside in society, and your family and significant others, do you feel that they have judged you? Or do you feel that they have been supportive, and has that helped you in the recovery process, or has it held you back?*

Participant: Well they haven't been supportive, (inaudible) everybody.

Interviewer: *So has that made it harder?*

Participant: Well, it wasn't really their decision to do anything... to take anything, it was mine. So I think it's all got me... mentally wise, it was my decision to take. I don't think they had... they pushed but there wasn't (inaudible).

Interviewer: *Your fiancé?*

Participant: Very.

Interviewer: *Supportive?*

Participant: Ja (yes).

Interviewer: *Okay.*

Participant: Understanding and supportive.

patient. I think if you can just get to the feel of it on the inside, you're a lot... you just come out a lot stronger than what you ever get outside. Do you understand what I'm saying?

I wasn't there six weeks. I was there I think seven or eight.

That's stretching it a bit, places like Noupoot... it's stretching it a little bit... a hell of a lot actually. Because the period you spend in rehab... you owe it to yourself to come right. You know it's either make or brake. If you brake then you know... the steps should be taken. But if it doesn't brake you know it was successful.

Ja, every day.

Ja.

My fiancé and... I don't know. Just the will to stay clean.

Well they haven't been supportive, everybody.

Well, it wasn't really their decision to do anything... to take anything, it was mine. So I think it's all got me... mentally wise, it was my decision to take. I don't think they had, they pushed.

Very.

Ja.

Understanding and supportive.

Interviewer: Okay. When you were using intravenously, were you sharing needles with other people?

Participant: Ah ah, no. I would always buy needles. No. I would always buy needles.

Interviewer: So you knew the dangers involved in sharing?

Participant: No I never. We were in groups and stuff but never... I used my own needles; I made a point of it. No I never. We were in groups and stuff but never... I used my own needles; I made a point of it.

Interviewer: Why did you make a point of it?

Participant: Ah, it's like using a condom, (*laughs*), I don't know... it's just something; you don't use somebody else's needles. It's like using a condom. It's just something; you don't use somebody else's needles.

Interviewer: Okay, did the other guys share needles?

Participant: Yea, they shared needles. Yea, they shared needles

Interviewer: Did they sterilise the needles first or not?

Participant: No, it was the same needles over and over and over. I used to steal my needles, new needles... I never had a problem with that. No, it was the same needles over and over and over. I used to steal my needles, new needles... I never had a problem with that.

Interviewer: If someone came to you with a heroin problem, what is the best way to help someone who is addicted to heroin?

Participant: Go to Castle Carey. Send them to a place that knows what to do and that knows how to handle it. Don't send them to a place like Noupoot, I don't know, I just got something against Noupoot. You just need a little bit of support and lets say guidance. He needs to know it can happen and how it can happen to himself (*recovery*), because in the state that he is in he doesn't know it. Go to Castle Carey. Send them to a place that knows what to do and that knows how to handle it. Don't send them to a place like Noupoot, I don't know, I just got something against Noupoot. You just need a little bit of support and lets say guidance. He needs to know it can happen and how it can happen to himself, because in the state that he is in he doesn't know it.

Interviewer: Thank you so much.

PARTICIPANT 30 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical was able to assist you.
- Participant:* Um, counselling and medical intervention, you know, it helped up to a certain extent, when you're just lying in a park - not really... for me counselling and medical... okay the medical aspect ja (yes) helped when I was withdrawing... all those pills and stuff. I got really helped, but the counselling part for me doesn't really... counselling can't really make you stop... counselling can just maybe give you like guidelines you know. Once you're on that path you can use the guidelines maybe as, maybe as tips you know for... let's say for instance staying away from old friends, and once you see them it could be like... okay, well I think that's what counselling acts like. Maybe counselling just... a little soul food, your soul thinks of like a little child (*inaudible*)... you know, like a child who likes to play anything. So I'd say counselling... it depends on the individual as well.
- Interviewer:* I think what I mean by... sorry, not actually necessarily counselling, but any sort of therapeutic intervention. So in other words, do you think that in-patient treatment was necessary for you? Or do you think you could have maybe done it on an outpatient basis?
- Participant:* No, not as an out-patient, not for heroin. Um, you mean like just coming in?
- Interviewer:* Yes, and going back home everyday.
- Participant:* No! Shit. That would have never worked for me. I would have just come and gone home and got all fucked up again. No that would have not worked for me at all.
- Interviewer:* So do you think in-patient treatment is necessary?
- Participant:* Yes, definitely.
- Interviewer:* Why? Could you elaborate?
- Participant:* Okay. Like I said, you're in a confined space, not locked in, but it keeps you, it keeps you away from drugs... it will give your body a chance to heal, because for me the greatest thing was my senses coming back... well, though only some of my senses. Some of my senses came back to me... ah, emotions came back to me, that's why when I was here I had such emotional outbursts... because I couldn't handle what I was feeling. I started, I started feeling again. I started feeling sad again. I was like an ice-cold person. I didn't have any pity or mercy for anyone. So I think therapy like is needed, is needed for anyone to recover.
- Counselling and medical intervention it helped up to a certain extent, when you're just lying in a park - not really... for me counselling and medical... okay the medical aspect ja helped when I was withdrawing... all those pills and stuff. I got really helped. The counselling part for me doesn't really... counselling can't really make you stop... counselling can just maybe give you like guidelines you know. Once you're on that path you can use the guidelines maybe as, maybe as tips you know for... let's say for instance staying away from old friends, and once you see them it could be like... okay, well I think that's what counselling acts like. Maybe counselling just... a little soul food, your soul thinks of like a little child, like a child who likes to play anything. So I'd say counselling... it depends on the individual as well.
- No, not as an out-patient, not for heroin.
- No! Shit. That would have never worked for me. I would have just come and gone home and got all fucked up again. No that would have not worked for me at all.
- Yes, definitely.
- You're in a confined space, not locked in, but it keeps you away from drugs... it will give your body a chance to heal, because for me the greatest thing was my senses coming back... well, though only some of my senses. Some of my senses came back to me... ah, emotions came back to me, that's why when I was here I had such emotional outbursts... because I couldn't handle what I was feeling. I started, I started feeling again. I started feeling sad again. I was like an ice-cold person. I didn't have any pity or mercy for anyone. So I think therapy like is needed, is needed for anyone to recover.

mercy for anyone. So I think therapy like is needed, is needed for anyone to recover.

Interviewer: *If someone came your path who had a heroin problem, what do you think would help them to come...?*

Participant: To come clean?

To come clean?

Interviewer: *To stay clean, not only to come clean.*

Participant: I say the first thing - you also have to make that choice. You have to be serious about quitting, not just come clean. Also, what I can tell a person you know, from person to person, what helped for me may help for you. But if I come across somebody, I'd just give them a detailed description of what can happen if you go back, you know, first of all you feel crap - money wasted first of all, rehabs not cheap at all. I can... just be strong and you mustn't let... okay of course that's also wishful thinking... at times nothing will bother you but for me I can just, I can just help a person from my experience and what I felt and give them hope (*inaudible*), and maybe show them a certain rehab who I know can help, you know, 'cause the drug problem... the necessity is to be healed - love as well. Love and a sense of loving somebody, and not all rehabs possess that sense of love. Okay, Tough/love as well, but not always...

I say the first thing - you also have to make that choice.
You have to be serious about quitting, not just come clean.
Also, what I can tell a person you know, from person to person, what helped for me may help for you. But if I come across somebody, I'd just give them a detailed description of what can happen if you go back, first of all you feel crap - money wasted first of all, rehabs not cheap at all. I can... just be strong and you mustn't let... okay of course that's also wishful thinking... at times nothing will bother you but for me I can just, I can just help a person from my experience and what I felt and give them hope and maybe show them a certain rehab who I know can help, 'cause the drug problem... the necessity is to be healed - love as well. Love and a sense of loving somebody, and not all rehabs possess that sense of love.
Okay, Tough/love as well, but not always.

Interviewer: *Not always tough?*

Participant: Sometimes, sometimes you have to be cruel to be kind, but sometimes knowing that there is people that really care about you, that you can go to and talk to if you have a problem, and that really helps. I mean you have to be helped. I was here - you helped me. Knowing there is people who really love, and really care about your well being, and you know that's, that's what (*inaudible*).

Sometimes you have to be cruel to be kind, but sometimes knowing that there is people that really care about you, that you can go to and talk to if you have a problem, and that really helps. I mean you have to be helped. I was here - you helped me. Knowing there is people who really love, and really care about your well being.

Interviewer: *Do you have any thoughts on the time period? How long do you think is necessary for someone with a heroin addiction specifically?*

Participant: I'd say three months at least. Six weeks can help. Also like you said, depends on how long you were using and how... how strong you were, how strong your will is. And when you come off heroin, and you're in that first stage, you have no hope, heroin controls you. Heroin is your God - it tells you what to do.

I'd say three months at least.
Six weeks can help. Also like you said, depends on how long you were using and how... how strong you were, how strong your will is. And when you come off heroin, and you're in that first stage, you have no hope, heroin controls you. Heroin is your God - it tells you what to do.

Interviewer: *While you're still vulnerable? Was there some sort of mind-shift that you made?*

Participant: Describe?

Interviewer: What actually changed within your mind to make you decide to quit?

Participant: I was so... oneday I was all spiked up and I was drunk with it as well. I got home very late one night and I came to my room and as I walked into my room there's a mirror, and I caught a glimpse of myself in the mirror and when I looked at my blood eyes I was so shocked. You know, well I can't really explain what I see... what I saw and how I felt. I saw the inner demon, the hate, all the bad things on the outside, and I got a fright of myself you know. This is how people see me know, they don't see ****, they see this thing, because you become heroin. Basically you... okay, ja (yes) okay figuratively speaking, but once you're... heroin is like different bits and pieces of a demon or something bad that your building a demon or something bad, and it takes over your body and you do things that you never thought you would ever do, say things you don't mean.

Oneyday I was all spiked up and I was drunk with it as well. I got home very late one night and I came to my room and as I walked into my room there's a mirror, and I caught a glimpse of myself in the mirror and when I looked at my blood eyes I was so shocked. You know, well I can't really explain what I see... what I saw and how I felt. I saw the inner demon, the hate, all the bad things on the outside, and I got a fright of myself you know. This is how people see me know, they don't see ****, they see this thing, because you become heroin. Basically you... okay, ja okay figuratively speaking, but once you're... heroin is like different bits and pieces of a demon or something bad that your building a demon or something bad, and it takes over your body and you do things that you never thought you would ever do, say things you don't mean and you're in that first stage, you have no hope, heroin controls you. Heroin is your God - it tells you what to do.

Interviewer: Do you also see it in a spiritual manner?

Participant: Yes. On a spiritual level - yes definitely. 'Cause it's like taking heroin is THE DRUG - you know there is nothing that can compare to the heroin anywhere... you know not even a beautiful woman. If you had to put heroin or a model... the perfect woman... you will take heroin, because nothing can give you what heroin can give you - or nothing - that's what I thought at that time. On a spiritual level yea - it's more the thinking, you feel on top of the world, you feel like a God. You feel so much more powerful. So much more confident. So it definitely affects you in a spiritual way as well, definitely.

Yes. On a spiritual level - yes definitely. 'Cause it's like taking heroin is THE DRUG - you know there is nothing that can compare to the heroin anywhere... you know not even a beautiful woman. If you had to put heroin or a model... the perfect woman... you will take heroin, because nothing can give you what heroin can give you - or nothing - that's what I thought at that time. On a spiritual level yea - it's more the thinking, you feel on top of the world, you feel like a God. You feel so much more powerful. So much more confident. So it definitely affects you in a spiritual way as well, definitely.

Interviewer: Do you think there is a difference between treating heroin addiction compared to other forms of chemical addictions or other drug addictions?

Participant: Yes. From my point of view, yes. Because of... being on another drug and being on heroin is two different things. Heroin doesn't produce a high really - heroin just gives you a sense of inner self fulfilment that... you can describe it as a high but you're not high like other drugs - falling around, everything's spinning. It just calms you down way past. It could work in a group of other addicts, but then, you know, taking a whole group and lets say there are two heroin addicts in a group of six - the other guys on dagga (cannabis) and stuff like that... um, the attention span should, must, be more on the heroin guys 'cause heroin guys suffer, you suffer your arse off.

Yes. From my point of view, yes. Being on another drug and being on heroin is two different things. Heroin doesn't produce a high really - heroin just gives you a sense of inner self fulfilment that... you can describe it as a high but you're not high like other drugs - falling around, everything's spinning. It just calms you down way past. It could work in a group of other addicts, but then, you know, taking a whole group and lets say there are two heroin addicts in a group of six - the other guys on dagga and stuff like that, the attention span should, must, be more on the heroin guys 'cause heroin guys suffer, you suffer your arse off.

- Interviewer:* So you think that coupled with the length of treatment as well?
- Participant:* A bit longer.
- Interviewer:* Longer for heroin?
- Participant:* If it works. You get people who stop heroin not even going to a rehab. Heroin just takes so much longer to... I don't really think heroin ever really gets out of your system... that urge. I've been clean for over a year and two months and I still struggle. The feeling you get once you inject... you get this weird taste in your mouth, like this weird powdery feeling... that's what I got. Sometimes even in the middle of the night I wake up with that feeling, with that taste in my mouth. It's like when you want cigarettes, especially after you've eaten, you need that cigarette. That's how I feel. And I started substituting heroin with coffee and cornflakes. Because black coffee and cornflakes you put the cornflakes on your tongue, you swallow coffee and it gives the same...
- Interviewer:* Sensation?
- Participant:* Ja (yes), almost the same taste you get so that's why I'm actually getting addicted to coffee, ten twelve cups a day, and I can feel that. But ja (yes), the attention span on heroin addicts must be far more intense, because heroin addicts experience coming off heroin the morning more intensely than any other. I didn't go for detox. I would have died because in Family Outreach I felt like dying, they don't believe in any medical treatment.
- Interviewer:* So you feel medication is necessary?
- Participant:* In the beginning stages - yes. Because you've got cramps. When I was on heroin before I came here (*rehab*). My mom didn't know what to do, and you know you can't sleep you're screaming, you're going... my mom had to lock me in my room. I went crazy - banging the doors, scratching the door, I had cramps. Feels like your body wants to burst from the inside. You can't like die you know. Yes, so... I was permanently biting my face; my eyes looked like they were popping out. You're so vulnerable... you just go crazy, become like a wild animal.
- Interviewer:* Do you think medication is necessary for long term?
- Respondent:* Not long-term.
- Interviewer:* Okay.
- Respondent:* Just that beginning. Often what happens with relapsing - that's the guy on medication, you know especially for heroin.
- If it works. You get people who stop heroin not even going to a rehab. Heroin just takes so much longer to... I don't really think heroin ever really gets out of your system... that urge. I've been clean for over a year and two months and I still struggle. The feeling you get once you inject... you get this weird taste in your mouth, like this weird powdery feeling... that's what I got. Sometimes even in the middle of the night I wake up with that feeling, with that taste in my mouth. It's like when you want cigarettes, especially after you've eaten, you need that cigarette. That's how I feel. And I started substituting heroin with coffee and cornflakes. Because black coffee and cornflakes you put the cornflakes on your tongue, you swallow coffee and it gives the same...
- Ja, almost the same taste you get so that's why I'm actually getting addicted to coffee, ten twelve cups a day, and I can feel that. But ja, the attention span on heroin addicts must be far more intense, because heroin addicts experience coming off heroin the morning more intensely than any other. I didn't go for detox. I would have died because in Family Outreach I felt like dying, they don't believe in any medical treatment.
- In the beginning stages - yes. Because you've got cramps. When I was on heroin before I came here. My mom didn't know what to do, and you know you can't sleep you're screaming, you're going... my mom had to lock me in my room. I went crazy - banging the doors, scratching the door, I had cramps. Feels like your body wants to burst from the inside. You can't like die you know. Yes, so... I was permanently biting my face; my eyes looked like they were popping out. You're so vulnerable... you just go crazy, become like a wild animal.
- Not long-term.
- Just that beginning. Often what happens with relapsing - that's the guy on medication, you know especially for heroin.

- Interviewer:* Okay. Um, were you sharing needles when you were using heroin?
- Respondent:* I was... once or twice, actually when I had no choice, but you just go to the hospital; 'can I have the needles please?' No problem. I'm not racist, but usually the black people don't think like that... you know, they just give.
- Interviewer:* Give needles?
- Respondent:* Give needles. Okay, I can only get needles, but I'd use the same needle over and over.
- Interviewer:* On yourself?
- Respondent:* Yes.
- Interviewer:* Um, other guys, that you know, were they sharing needles at all?
- Respondent:* Yes, yes. I only shared with a few guys once or twice like I said. I shared (*inaudible*), when heroin is calling, it's calling.
- Interviewer:* So you did actually share, did you sterilise? Did you sterilise your needles first?
- Respondent:* Um, all that we did was just burn the needles with a lighter - and then you sterilise it. But um... I don't have AIDS (*inaudible*). When I was at Family Outreach that was my biggest worry, but I had an AIDS test when I was at Family Outreach, to my relief it came out negative. In that aspect, like I said, when heroin is calling, it's calling - like I shared that needle, and actually I was going downhill - down a cliff.
- Interviewer:* Okay. Societies perceptions, and your families and significant others, do you feel it's been supportive, or do you feel that people have judged you? Has that made recovery harder?
- Respondent:* Let's say, I've had mixed feelings from society, you don't mind me swearing? I don't give a fuck about society, because society neglected me. They all turned their backs on me and walked away. Some of society treated me like glass. I can't speak to people without them 'oh, aren't you *****, the one on drugs? You're the ***** that was in rehab.' You know, or like when I speak to a girl, and when I hear someone warning 'he was on drugs, he was on heroin, stay away for him'. You know that really affects me as I have no confidence, just going up to somebody... look, everybody knows I was on drugs. But the world's perception of drugs is totally fucked because they can't see the life of a recovering person through their eyes.
- I was... once or twice, actually when I had no choice, but you just go to the hospital; 'can I have the needles please?' No problem. I'm not racist, but usually the black people don't think like that... you know, they just give.
- Give needles. Okay, I can only get needles, but I'd use the same needle over and over.
- Yes.
- Yes, yes. I only shared with a few guys once or twice like I said. I shared, when heroin is calling, it's calling.
- All that we did was just burn the needles with a lighter - and then you sterilise it. I don't have AIDS. When I was at Family Outreach that was my biggest worry, but I had an AIDS test when I was at Family Outreach, to my relief it came out negative. In that aspect, like I said, when heroin is calling, it's calling - like I shared that needle, and actually I was going downhill - down a cliff.
- Let's say, I've had mixed feelings from society, you don't mind me swearing? I don't give a fuck about society, because society neglected me. They all turned their backs on me and walked away. Some of society treated me like glass. I can't speak to people without them 'oh, aren't you *****, the one on drugs? You're the ***** that was in rehab.' You know, or like when I speak to a girl, and when I hear someone warning 'he was on drugs, he was on heroin, stay away for him'. You know that really affects me as I have no confidence, just going up to somebody... look, everybody knows I was on drugs. But the world's perception of drugs is totally fucked because they can't see the life of a recovering person through their eyes.

Interviewer: So that makes it harder?

Respondent: They can't see that hell we go through. Each and every day I have to make a choice even after a year and two months, I have to make a choice. Go back to heroin is easy, give a call, and I made that decision to myself. In fact where I was, and were I am now I am happy with the way I am now. Okay, you're not always happy with yourself always - I am fat - stuff like that that typically... but health-wise, and I don't know, personality wise, I am human now. I feel much better than what I felt. I can smell things properly now, I can taste properly now, my senses in my fingers, everything. I don't feel like just a numb piece of meat walking around anymore so...

They can't see that hell we go through. Each and every day I have to make a choice even after a year and two months, I have to make a choice. Go back to heroin is easy, give a call, and I made that decision to myself. In fact where I was, and were I am now I am happy with the way I am now. Okay, you're not always happy with yourself always - I am fat - stuff like that that typically... but health-wise, and I don't know, personality wise, I am human now. I feel much better than what I felt. I can smell things properly now, I can taste properly now, my senses in my fingers, everything. I don't feel like just a numb piece of meat walking around anymore.

Interviewer: Is it hard for you to stay clean?

Respondent: Yes.

Yes.

Interviewer: What gets you through the hard times? How do you cope?

Respondent: How do I cope? Smoke more cigarettes (*laughs*) and I don't know, and keep myself busy. Then, then I play excessive amounts of guitar, write an excessive amount of songs, even more that I myself can cope with because it tends to emotionally break my top button... I can't control myself anymore. It gets me fucking nuts. But then it feels like (*inaudible*), I can't decide anymore, mixed feelings, hate, I sometimes hate myself due to my own doing that I feel like that. But sometimes I am also glad that I maybe went through this, made me feel like a strange person. Feel like I can, feel like I can cope and handle more than your average normal person will be able to handle. Not... you get strong people I feel, I feel my perception to handle certain situations will be more... will be more careful than the average guy, girl, granddad. Definitely heroin is not an option, it's an ongoing battle, but the enemy is falling one by one. Slowly but surely I am battling through the enemy line (*inaudible*). I'm not on the defend now, I'm on the attack. And you have to work, to stay clean you have to work. You can't just say I've done rehab, life's great. You know, my first three months in rehab was a fucking living hell, see all these familiar faces (*inaudible*). I thought I was happy while I was on drugs, but my subtle instinct, it's not actually you... it's believing in something that doesn't exist. Also my problem now with staying clean is um, I can't be in a group with a lot of people, let's say thirty people, or twenty people, I get... I feel like I'm going crazy. I don't know why, not that I'm claustrophobic, or... it's just with a lot of people... you see, I don't know like, you know, I say personally every kind of drug,

How do I cope?
Smoke more cigarettes and I don't know, and keep myself busy. Then, then I play excessive amounts of guitar, write an excessive amount of songs, even more that I myself can cope with because it tends to emotionally break my top button... I can't control myself anymore. It gets me fucking nuts. But then it feels like, I can't decide anymore, mixed feelings, hate, I sometimes hate myself due to my own doing that I feel like that.
But sometimes I am also glad that I maybe went through this, made me feel like a strange person. Feel like I can, feel like I can cope and handle more than your average normal person will be able to handle. Not... you get strong people I feel, I feel my perception to handle certain situations will be more... will be more careful than the average guy, girl, granddad. Definitely heroin is not an option, it's an ongoing battle, but the enemy is falling one by one. Slowly but surely I am battling through the enemy line. I'm not on the defend now, I'm on the attack.
And you have to work, to stay clean you have to work. You can't just say I've done rehab, life's great. You know, my first three months in rehab was a fucking living hell, see all these familiar faces.
I thought I was happy while I was on drugs, but my subtle instinct, it's not actually you... it's believing in something that doesn't exist. Also my problem now with staying clean is I can't be in a group with a lot of people, let's say thirty people, or twenty people, I get... I feel like I'm going crazy. I don't know why, not that I'm claustrophobic, or... it's just with a lot of people... you see, I don't know like, you know, I say personally every kind of drug, the... from the Higher Power out there, he gives it and um, or he will.

the... from the Higher Power out there, he gives it and um, or he will. For me, all my senses are coming back, my hearing like... hearing what people say becomes, it becomes much stronger, it's not like... sometimes hearing all those people speak I can't really take it. I hear so much things being said, it's not a bad thing (*inaudible*) seeing what's going on these days and what's been done to me, I'd rather lock myself away from life, then I'd be fine. Just give me a computer, guitar and cigarettes - it can last. That's how I feel. You might think I'm crazy.

For me, all my senses are coming back, my hearing like... hearing what people say becomes, it becomes much stronger, it's not like... sometimes hearing all those people speak I can't really take it. I hear so much things being said, it's not a bad thing seeing what's going on these days and what's been done to me, I'd rather lock myself away from life, then I'd be fine. Just give me a computer, guitar and cigarettes - it can last. That's how I feel. You might think I'm crazy.

Interviewer: Thank you so much for your input, all the best.

PARTICIPANT 31 TRANSCRIPTION

Interviewer: Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: Um, it's a long story really, but I'll try and cut it down. Um, I went to see a doctor who my mother, my mother who was searching one day and pulled her hand out with a needle stuck through it - and had to have a HIV test and everything, and my Dad made me go see a doctor, who set me up the counsellor. Um, but I was doing it for the wrong reason. I was doing it because of my parents and not because of myself. I didn't really, you know, I had no intention of getting myself clean, I was just doing it for them. Um, I got taken out of society... about six months later I cut myself. I cut my arms... I harmed myself... I got put on an 'at risk' list, so I had to then go see a counsellor every week, and then ah, my life deteriorated. Four or five years later ah, I got to a low point where I had to go seek help otherwise I would have been dead. I would have died within months. I had friends around me who died regularly, um, or go to jail. Um, I went into rehab - four different rehabs, twelve months - um, then I was totally clean off methadone and heroin and all medications, but when I came out I felt at the time worse than when I went in. I was totally bedridden, and I felt like I couldn't stand up. I felt worse when I came out, and I started using again because I felt worse.

Interviewer: Do you feel that the counselling or the therapeutic or in-patient treatment, was it necessary? Did it actually help you or not?

Participant: It did help. It gave me a lot of knowledge and I learnt a lot about myself, but I also felt that it wasn't individual enough, it was more as a group thing, which is good, but ah, I also felt that the counsellors treated us too much like a herd of sheep, instead of like individuals, with individual problems, with individual backgrounds, and ah, I wanted individual help - that I, I became unstuck, and why when I came out I felt worse. I felt like naked as I was walking down the street... naked 'cause I was so used to from when I was young having one thing or another as a barrier, drugs is a barrier to keep me away from reality. And then after my rehab I was totally clean, but I was a 'dry drunk', do you know what I mean? And then I started using again but ah... I was more mixed up in my head that ever because I had been to rehab, and if that couldn't keep me clean, then what's going to help?

It's a long story really, but I'll try and cut it down. I went to see a doctor who my mother, my mother who was searching one day and pulled her hand out with a needle stuck through it - and had to have a HIV test and everything, and my Dad made me go see a doctor, who set me up the counsellor. But I was doing it for the wrong reason. I was doing it because of my parents and not because of myself. I didn't really, you know, I had no intention of getting myself clean, I was just doing it for them.

I got taken out of society... about six months later I cut myself. I cut my arms... I harmed myself... I got put on an 'at risk' list, so I had to then go see a counsellor every week, and then ah, my life deteriorated.

Four or five years later ah, I got to a low point where I had to go seek help otherwise I would have been dead. I would have died within months. I had friends around me who died regularly or go to jail.

I went into rehab - four different rehabs, twelve months - then I was totally clean off methadone and heroin and all medications, but when I came out I felt at the time worse than when I went in. I was totally bedridden, and I felt like I couldn't stand up.

I felt worse when I came out, and I started using again because I felt worse.

It did help.

It gave me a lot of knowledge and I learnt a lot about myself, but I also felt that it wasn't individual enough, it was more as a group thing, which is good, but I also felt that the counsellors treated us too much like a herd of sheep, instead of like individuals, with individual problems, with individual backgrounds, and I wanted individual help - that I, I became unstuck, and why when I came out I felt worse.

I felt like naked as I was walking down the street... naked 'cause I was so used to from when I was young having one thing or another as a barrier, drugs is a barrier to keep me away from reality.

Then after my rehab I was totally clean, but I was a 'dry drunk', do you know what I mean? Then I started using again. I was more mixed up in my head that ever because I had been to rehab, and if that couldn't keep me clean, then what's going to help?

Interviewer: Did medication help?

Participant: It does now, yea. Now when I came out, a year after using then I went to see another doctor who was very understanding, and he said he didn't believe in a lot of the 12-step programme, um, but that I could lead a good quality of life while being on medication, and he told me it didn't matter that I might be on permanent medication for like the next few years, but to him, I'm still clean, because in rehab they told me you're not clean if you're on any medication or anything like that you know and ah, that really helped. He gave me um, we tried different medications, and I found that I could stand myself on this medication. But also, um, what's helped is getting away from the scene, a total scenery change, totally getting away from all my old friends, you know, associations, staying away from it, and not going anywhere near my old places where I was using. What's also helped is totally relocating.

It does now, yea. Now when I came out, a year after using then I went to see another doctor who was very understanding, and he said he didn't believe in a lot of the 12-step programme, but that I could lead a good quality of life while being on medication, and he told me it didn't matter that I might be on permanent medication for like the next few years, but to him, I'm still clean, because in rehab they told me you're not clean if you're on any medication or anything like that you know and ah, that really helped. He gave me, we tried different medications, and I found that I could stand myself on this medication. Also what's helped is getting away from the scene, a total scenery change, totally getting away from all my old friends, you know, associations, staying away from it, and not going anywhere near my old places where I was using. What's also helped is totally relocating.

Interviewer: Do you mean by relocating coming to South Africa? Or do you mean going to England, or both?

Participant: Both. What kept me clean in rehab was (*inaudible*) I relapsed. I think I was on my own definitely. So we were only allowed to go out in three's. Well, when I was in primary I was only allowed to go out with a counsellor - for the first six months, and after that we were allowed to go out in groups of three, and ah, two people could talk each other into using - while as three, there's less of a chance, one will want to stay clean. So that kept me clean through rehab, so I was like a 'dry drunk' when I was in rehab.

I relapsed. I think I was on my own definitely. So we were only allowed to go out in three's. Well, when I was in primary I was only allowed to go out with a counsellor - for the first six months, and after that we were allowed to go out in groups of three, and two people could talk each other into using - while as three, there's less of a chance, one will want to stay clean. So that kept me clean through rehab, so I was like a 'dry drunk' when I was in rehab.

Interviewer: Is it hard for you to stay clean?

Participant: Yea, very, very, very hard. With my girlfriend, if I told her what I think about a lot of the time, she'd be very, very worried, seriously.

Yea, very, very, very hard. With my girlfriend, if I told her what I think about a lot of the time, she'd be very, very worried, seriously.

Interviewer: What gets you through the hard times?

Participant: Um, thinking of consequences, ah - for me, being in South Africa - ignorance, 'cause I don't know where to go in South Africa and in the city I don't know where to go to score, and I try to make sure that I don't, that's why I don't go to NA (*Narcotics Anonymous*), because I don't want to meet someone who might point me to the wrong direction. So I... do you know what I mean? Do you understand? So I try to keep myself ignorant while I'm here, and that's why I've never used while I've been in South Africa.

Thinking of consequences. For me, being in South Africa - ignorance, 'cause I don't know where to go in South Africa and in the city I don't know where to go to score, and I try to make sure that I don't. That's why I don't go to NA, because I don't want to meet someone who might point me to the wrong direction. So I try to keep myself ignorant while I'm here, and that's why I've never used while I've been in South Africa.

- Interviewer:* Societies perceptions, your families and significant others, do you feel that they've been supportive in recovery? Or have they judged you, has that made it harder?
- Participant:* Um... start with my family. My sisters were very supportive. I didn't really involve my mum in my recovery, and my dad just looks at me as a, you know, 'junkie', a waste of space. But over the years of me being clean, they tried hard to slowly come to understand a bit more. People look down on me you know, and I've lost jobs, because someone said to someone, said to someone 'he's a junkie', or whatever, 'he's not clean', um, and I've been looked at as scum, I've had that a lot. But since I've been in South Africa no-one knows you know, it's only my girlfriend and her immediate family that know.
- Interviewer:* And how's their perception or attitude?
- Participant:* Um, her brothers', her older brother I'm not sure. They say to me that they're supportive, but I don't know really what they think. Her mum and dad's very supportive, they're like Christians, Afrikaans Christians, and I think that even though they don't like black people (*laughs*)... which I find really strange (*laughs*), they can tolerate me in there house!
- Interviewer:* Because you can tolerate them?
- Participant:* Yea (*laughs*). I find it difficult you know, it's very difficult... hard for me to understand how they can be like that if they're Christian, as Christians they go to church every Sunday.
- Interviewer:* When you were using heroin, were you sharing needles?
- Participant:* With friends yea. Um, the only reason that I've been in that situation was where I've been going through serious withdrawal and there's just one needle in the house and it's been like... well I worry about the consequences. I didn't always think about the consequences you know.
- Interviewer:* Do you think that needle exchange programme are necessary?
- Participant:* Definitely, you need them. They are very good yea. You go to a pharmacist, hand in your old ones and pick up new ones - clean ones, and I reckon it stops the spread of Hepatitis C and....
- Interviewer:* HIV?
- Participant:* HIV, yea. Definitely.
- Start with my family. My sisters were very supportive. I didn't really involve my mum in my recovery, and my dad just looks at me as a, you know, 'junkie', a waste of space. But over the years of me being clean, they tried hard to slowly come to understand a bit more. People look down on me you know, and I've lost jobs, because someone said to someone, said to someone 'he's a junkie', or whatever, 'he's not clean', and I've been looked at as scum, I've had that a lot. But since I've been in South Africa no-one knows you know, it's only my girlfriend and her immediate family that know.
- Her brothers', her older brother I'm not sure. They say to me that they're supportive, but I don't know really what they think. Her mum and dad's very supportive, they're like Christians, Afrikaans Christians, and I think that even though they don't like black people... which I find really strange, they can tolerate me in there house!
- I find it difficult you know, it's very difficult... hard for me to understand how they can be like that if they're Christian, as Christians they go to church every Sunday.
- With friends yea. The only reason that I've been in that situation was where I've been going through serious withdrawal and there's just one needle in the house and it's been like... well I worry about the consequences. I didn't always think about the consequences you know.
- Definitely, you need them. They are very good yea. You go to a pharmacist, hand in your old ones and pick up new ones - clean ones, and I reckon it stops the spread of Hepatitis C and...
- HIV, yea. Definitely.

- Interviewer:* So you don't think it encourages heroin use?
- Participant:* No, not at all. I think that people who are going to use their needle and they're heroin addicts, aren't going to go... if they're handing out free needles, they're not going to go and use heroin you know. People don't know about it until they're in that situation, then they find out you can get clean needles. Nobody who's using - it's definitely not where they start. I think it's a very good thing that they do needle exchange. The needle exchange in the UK, you get um, little pads... antiseptic pads to clean your wound...
- Interviewer:* A bleach kit?
- Participant:* Yea, you get everything you need. You get a 'sharps bin' to put your needles in so as not to leave needles around. And most of the pharmacists - there are a lot of pharmacies in the UK - most of the pharmacists are really good, they're really nice people, very understanding, and they don't look down on you. And they see it as a medical problem. A medical problem with medical issues, not that you're low life scum - which is good. Don't need to be alienated so much, not like scum. But I found that when I first started it was like that, but now it's not. So it's changed.
- Interviewer:* So society...
- Participant:* Over the years that I've been using it's changed quite a bit. And I've got a lot of friends who are clean who, who used to judge me, who now accept me as I am. Accept me as what I am. Medication has really helped to stabilise life you know.
- Interviewer:* Some people do view it as substitution, you know about that?
- Participant:* Yea, yea.
- Interviewer:* Do you feel that the goal should eventually be abstinence, or do you feel not necessarily?
- Participant:* Um, I think it depends on each individual. I think some individuals need to be abstinate of everything and can cope to be abstinate of doctors' prescriptions or whatever. But I think each person know themselves.
- Interviewer:* Do you think that there is a difference between treating someone with a heroin addiction compared to someone with another form of chemical addiction?
- No, not at all.
I think that people who are going to use their needle and they're heroin addicts, aren't going to go... if they're handing out free needles, they're not going to go and use heroin you know. People don't know about it until they're in that situation, then they find out you can get clean needles. Nobody who's using - it's definitely not where they start. I think it's a very good thing that they do needle exchange. The needle exchange in the UK, you get um, little pads... antiseptic pads to clean your wound...
- Yea, you get everything you need. You get a 'sharps bin' to put your needles in so as not to leave needles around. Most of the pharmacists - there are a lot of pharmacies in the UK - most of the pharmacists are really good, they're really nice people, very understanding, and they don't look down on you. They see it as a medical problem. A medical problem with medical issues, not that you're low life scum - which is good. Don't need to be alienated so much, not like scum. But I found that when I first started it was like that, but now it's not. So it's changed.
- Over the years that I've been using it's changed quite a bit. I've got a lot of friends who are clean who, who used to judge me, who now accept me as I am. Accept me as what I am. Medication has really helped to stabilise life you know.
- Yea, yea.
- I think it depends on each individual. I think some individuals need to be abstinate of everything and can cope to be abstinate of doctors' prescriptions or whatever. But I think each person know themselves.

- Participant: No, at all. There is no difference at all. The alcoholic, the heroin addict, there is no difference. It's all the same really. Whether the individual needs some form of chemical to get by in the day - whether it's heroin or whatever, you know, um, my mum is on prescription stuff from the doctor, from the pharmacists, and she understands there is not much difference between me having to prescribe myself heroin to get through the day, and the doctor prescribing her anti-depressants and so forth to help her get through the day. There's not much difference. You know, someone was prescribing her - I was prescribing myself basically at the end of the day... to get through the day.
- Participant: No, at all. There is no difference at all. The alcoholic, the heroin addict, there is no difference. It's all the same really. Whether the individual needs some form of chemical to get by in the day - whether it's heroin or whatever. My mum is on prescription stuff from the doctor, from the pharmacists, and she understands there is not much difference between me having to prescribe myself heroin to get through the day, and the doctor prescribing her anti-depressants and so forth to help her get through the day. There's not much difference. You know, someone was prescribing her - I was prescribing myself basically at the end of the day... to get through the day.
- Interviewer: *Do you feel there is any specific intervention that is useful for heroin addiction?*
- Participant: Um, I think ah - I don't know if I'm going to answer the question... but I think that heroin addicts really need to believe in himself, that he's had enough. He has to really believe inside that he's had enough, not be doing it for the wrong reason. Not be doing it for other people, you've got to do it for yourself. Not do it for you partner, or anyone else because you'll end up relapsing. You've got to hit your own 'rock bottom'. Everyone has there own 'rock bottom', and you've just got to believe that you've got to get sorted out. If you don't, you're not... maybe you'll stay clean for a year, but you'll end up using again.
- Participant: I think ah - I don't know if I'm going to answer the question... but I think that heroin addicts really need to believe in himself, that he's had enough. He has to really believe inside that he's had enough, not be doing it for the wrong reason. Not be doing it for other people, you've got to do it for yourself. Not do it for you partner, or anyone else because you'll end up relapsing. You've got to hit your own 'rock bottom'. Everyone has there own 'rock bottom', and you've just got to believe that you've got to get sorted out. If you don't, you're not... maybe you'll stay clean for a year, but you'll end up using again.
- Interviewer: *What made you get to that point? What paradigm shift, or what changed for you to not want to use anymore?*
- Participant: Um, well for me it was like a slow gradual slide down and um, I got to a point were I would just spend hours in the bathroom trying to get one hit. Um, I would be standing with a needle in my neck, I would just be covered in blood with holes, and this went on for a few years and ah I was abusing friends, family, um through my addiction... aunts, uncles who wouldn't speak to me in the street. Friends, friends who ah... police knocking at my door, police knocked at my door saying 'can we interview you 'cause we need to know you're whereabouts 'cause so and so was found dead in a crackhouse', or whatever, ' and we need to know if you used with him when he died'. Over the last few years it was really like that. Most of my friends are in jail or died. And my sister threatened me. A few friends, who are clean, close friends and my mother, over a couple of years I saw what I was doing to them - and ah, I saw what I was doing to myself. This was the thing; I never really look what I was doing to myself,
- Participant: Well for me it was like a slow gradual slide down and I got to a point were I would just spend hours in the bathroom trying to get one hit. I would be standing with a needle in my neck, I would just be covered in blood with holes, and this went on for a few years and I was abusing friends, family through my addiction... aunts, uncles who wouldn't speak to me in the street. Friends, friends who... police knocking at my door, police knocked at my door saying 'can we interview you 'cause we need to know you're whereabouts 'cause so and so was found dead in a crackhouse', or whatever, and we need to know if you used with him when he died'. Over the last few years it was really like that. Most of my friends are in jail or died. And my sister threatened me. A few friends, who are clean, close friends and my mother, over a couple of years I saw what I was doing to them. I saw what I was doing to myself. This was the thing, I never really look what I was doing to myself, and it was going to be just a matter of time before I'd probably over-dosed myself or something stupid because my mind was so messed up. I'd probably have ended up

I was doing to myself, and it was going to be just a matter of time before I'd probably over-dosed myself or something stupid because my mind was so messed up. I'd probably have ended up killing myself physically and then over a few months or so I thought about it quite a lot. I didn't want that. I really needed to get help, so I did.

killing myself physically and then over a few months or so I thought about it quite a lot. I didn't want that. I really needed to get help, so I did.

Interviewer: *Thank you so much and I wish you the best.*

Participant: Is that it? Thank you very much.

PARTICIPANT 32 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Must I speak about the last six weeks that I came clean now?
- Interviewer:* The whole period. Your long period and this period now.
- Participant:* Well, like I said, it's been like a four year process, at the moment, um, for years I didn't really do too much, you know, it was in and out programmes, followed rules, except for Magaliesoord which I left, all the other ones I completed - never ran away. But then I came out and I stayed clean for a certain period after that, then I was back to the heroin. It was like a planned thing - then I knew I was going to use. When I came out of SANCA I knew I was going to use again, same as Magaliesoord, same as the first time when I came out of Noupoot... also I knew I was going to use again. Um, then the last time I came out of Noupoot I was really determined to stay clean, and then okay, a few incidents had happened, but, but I wasn't really equipped to really deal with it at that stage, and then, um, I started using again. Now the last time it really became bad because I was back on the streets, and um, I didn't really have cash or a place to stay or anything. I was literally on the streets. It was like before when I had money and I could stay somewhere, or get around, and um, the last time I was going to use, I don't know what it was... it definitely wasn't heroin. Um, everything was lame. I couldn't walk. I couldn't do anything, and um, for the first time. And I can honestly say this, something that I'm not really ashamed to say about it that I cried out to God. That was my saving grace. I managed to get to a telephone, and I phoned my parents, and um, my dad said to me 'okay, just hang on', he'll be there now, I was in Sunnyside. After an hour, he wasn't there yet, so I phoned him again, said to him 'are you going to come and pick me up or not?' I said I wasn't really feeling very well. I didn't want to tell him what happened. He knew I had used, but I didn't want to tell him about how I was feeling... with like what I had injected myself, 'cause I didn't know myself. My dad said to me, no, he's not going to come pick me up, I must get myself to Mike if I really want to get back here. So, to get to Mike is 41km from Sunnyside to his place. The only option that I had was to walk there, and I couldn't really walk, and, like I said, I cried to God and I walked all the way there, I walked the whole night, managed
- Must I speak about the last six weeks that I came clean now?
- It's been like a four year process, for years I didn't really do too much, it was in and out programmes, followed rules, except for Magaliesoord which I left, all the other ones I completed - never ran away. But then I came out and I stayed clean for a certain period after that, then I was back to the heroin. It was like a planned thing - then I knew I was going to use. When I came out of SANCA I knew I was going to use again, same as Magaliesoord, same as the first time when I came out of Noupoot... also I knew I was going to use again. Then the last time I came out of Noupoot I was really determined to stay clean. A few incidents had happened but I wasn't really equipped to really deal with it at that stage, and then I started using again. Now the last time it really became bad because I was back on the streets and I didn't really have cash or a place to stay or anything. I was literally on the streets. It was like before when I had money and I could stay somewhere, or get around and the last time I was going to use, I don't know what it was... it definitely wasn't heroin. Everything was lame. I couldn't walk. I couldn't do anything and for the first time. And I can honestly say this, something that I'm not really ashamed to say about it that I cried out to God. That was my saving grace. I managed to get to a telephone, and I phoned my parents and my dad said to me 'okay, just hang on', he'll be there now, I was in Sunnyside. After an hour, he wasn't there yet, so I phoned him again, said to him 'are you going to come and pick me up or not?' I said I wasn't really feeling very well. I didn't want to tell him what happened. He knew I had used, but I didn't want to tell him about how I was feeling... with like what I had injected myself, 'cause I didn't know myself. My dad said to me, no, he's not going to come pick me up, I must get myself to Mike if I really want to get back here. So, to get to Mike is 41km from Sunnyside to his place. The only option that I had was to walk there, and I couldn't really walk, and, like I said, I cried to God and I walked all the way there, I walked the whole night, managed to get there. When I got there he offered me a cup of coffee. It was probably the best cup of coffee I've ever had, and then, since that day I've

to get there. When I got there he offered me a cup of coffee. It was probably the best cup of coffee I've ever had, and then, since that day I've been clean up until now, and my only saving grace was, was God, Christ, that's all.

been clean up until now, and my only saving grace was, was God, Christ, that's all.

Interviewer: You said earlier that initially you hadn't made the absolute choice to quit. So there was ambivalence?

Participant: Yea.

Interviewer: And then later you decided you wanted to, was spirituality the factor that changed your paradigm? Was that the main factor or were there other factors?

Participant: Um, there was another factor, I mean, I met a girl last year, and um, the last time I saw her she... when I looked into her face, the tears. I mean, I've seen it in my parent's face before, but it didn't really bug me, and um, she basically told me to just choose joy and just to choose, you know, like a better life. I mean, she was in Noupoot for a year as well, and um, after that night, that's when I made up my mind, I said, 'to here and no more, and no more'. I didn't want anything more to do with it at all. And that was just a choice that I made. Basically it came down to a choice, either I was going to use, or I wasn't going to use anymore, and that was it.

There was another factor, I mean, I met a girl last year and the last time I saw her she... when I looked into her face, the tears. I mean, I've seen it in my parent's face before, but it didn't really bug me and she basically told me to just choose joy and just to choose, you know, like a better life. I mean, she was in Noupoot for a year as well and after that night, that's when I made up my mind, I said, 'to here and no more, and no more'. I didn't want anything more to do with it at all. And that was just a choice that I made. Basically it came down to a choice, either I was going to use, or I wasn't going to use anymore, and that was it.

Interviewer: Do you feel that treatment helped you?

Participant: Um, I would say... yes it did, to a certain extent. I mean, there is a large foundation that gets laid. You get to know more, there's more knowledge about drugs, what it does, effects and things like that... they give you a bit of insight into life as such, and Noupoot laid also a strong foundation as far as spirituality was concerned. There we were read three/four times a week out the Bible. You know, had I not known that, or about Christ as such on that night. I don't know what would have happened. Um, so I would say ja (yes) it did help it a certain extent.

I would say... yes it did, to a certain extent. I mean, there is a large foundation that gets laid. You get to know more, there's more knowledge about drugs, what it does, effects and things like that... they give you a bit of insight into life as such, and Noupoot laid also a strong foundation as far as spirituality was concerned. There we were read three/four times a week out the Bible. You know, had I not known that, or about Christ as such on that night. I don't know what would have happened. So I would say ja it did help it a certain extent.

Interviewer: Do you think that one could consider out-patient? Is in-patient necessary? Could it work? Whatever that means, on an out-patient basis?

Participant: Could it work on an out-patient basis?

Could it work on an out-patient basis?

Interviewer: Yes.

Participant: I would say it would be up to the patient himself. If he's made that absolute choice that he's gonna stop. If he hasn't made that absolute choice, he's definitely going to use again.

I would say it would be up to the patient himself. If he's made that absolute choice that he's gonna stop. If he hasn't made that absolute choice, he's definitely going to use again.

- Interviewer:* So you don't necessarily feel that it's about treatment period? Do you think that plays a role in recovery?
- Participant:* Um, I would say... like we spoke about, 28 days was a bit short. Even now, I mean even now, I'm past the 28-day mark, and I'm still... I know where I am, and I must still not... just not a hundred percent to go, to do whatever I need to do. But I also think that too long a period is also wrong. Like the seventeen months I spent in Noupoot, that was, it became too long.
- Interviewer:* Why do you say that?
- Participant:* I started regressing after three months. I got to a certain stage were I was strong enough to come home, then after that, then it was like being forced to stay. I sort of like regressed to a point were I shouldn't have.
- Interviewer:* Did it make reintegration difficult or not?
- Participant:* In that sense it does, because then you just want to get back here, and you just want to come back and start over, and you don't really care. You're in that mode and you don't care. So you just start and you don't really get... you become really complacent there. You don't really worry too much about where you go, what you do.
- Interviewer:* And then when you're back in... for lack of a better term, 'normal' society, it's not a protected environment, does that make that difficult? To suddenly be confronted again?
- Participant:* I wouldn't say it makes it difficult. Um, what should be is that you still should follow a programme after you come back. You should still have several (*inaudible*), but it's something I never followed. I got advised to not go out, you know, to be home at certain times, to, you know, and they were going to test me every so often, or surprise test, so I mean, just to keep my guard up. But even that sort of, that whole thing just sort of like fell away. I just did what I wanted, when I wanted, how I like and... ja (yes).
- Interviewer:* Do you think there is a difference between treating heroin addiction compared to other forms of drug or chemical addiction?
- Participant:* I don't really think so. I don't think there's really much of a difference between any addiction, whether it's alcoholism or heroin. I don't think there's much of a difference. It's still the same. The perception... you're still like, how can I say? The addiction itself is... how can I say? The actual problem itself is not using the heroin, or using alcohol, there's
- I would say... like we spoke about, 28 days was a bit short. Even now, I mean even now, I'm past the 28-day mark, and I'm still... I know where I am, and I must still not... just not a hundred percent to go, to do whatever I need to do. But I also think that too long a period is also wrong. Like the seventeen months I spent in Noupoot, that was, it became too long.
- I started regressing after three months. I got to a certain stage were I was strong enough to come home, then after that, then it was like being forced to stay. I sort of like regressed to a point were I shouldn't have.
- In that sense it does, because then you just want to get back here, and you just want to come back and start over, and you don't really care. You're in that mode and you don't care. So you just start and you don't really get... you become really complacent there. You don't really worry too much about where you go, what you do.
- I wouldn't say it makes it difficult. What should be is that you still should follow a programme after you come back. But it's something I never followed. I got advised to not go out, to be home at certain times and they were going to test me every so often, or surprise test, so I mean, just to keep my guard up. But even that sort of, that whole thing just sort of like fell away. I just did what I wanted, when I wanted, how I like and... ja.
- I don't really think so. I don't think there's really much of a difference between any addiction, whether it's alcoholism or heroin. I don't think there's much of a difference. It's still the same. The perception... you're still like, how can I say? The addiction itself is... how can I say? The actual problem itself is not using the heroin, or using alcohol, there's

using the heroin, or using alcohol, there's other issues that are involved. Um, so I basically see them all as the same, whether it's ecstasy, or LSD, or heroin, or coke (*cocaine*). Whether it's physiologically addictive or how can you say? Psychologically addictive or whatever, it's all the same thing really.

other issues that are involved. So I basically see them all as the same, whether it's ecstasy, or LSD, or heroin, or coke. Whether it's physiologically addictive or how can you say? Psychologically addictive or whatever, it's all the same thing really.

Interviewer: Do you feel that you've had a support system in terms of your family? Has that helped your in your recovery process?

Participant: Ja (yes) I did. Um, just the general like support, you know, just to know that they were there, that they were prepared to help me every time. Um, I mean, if they weren't there, I wouldn't be here today, I know that.

Ja I did. Just the general like support, you know, just to know that they were there, that they were prepared to help me every time. I mean, if they weren't there, I wouldn't be here today, I know that.

Interviewer: So that was a crucial factor?

Participant: That was a crucial factor. Whether it's family of just anybody else whose prepared to stand in and actually just give you the support that you need, you know, but the real support, not the little nursing you on, you know, 'don't worry about it, it's okay, I'll get hold of you sometime'. That's the thing, you know what I mean. People, I've seen it in Noupoot plenty, the people get like, they say it's a hard place, but that's because they've always been nursed, and always been spoon fed everything their entire life, you know, want to be treated like a five-star hotel, you know. They're not prepared to make their beds. It's a whole life-style you've got to change. You've got to completely change you're life-style. It's not just to just stop using, or 'clean time' - because that's what NA teaches you. How many days you been clean, how many weeks you've been clean, it's not about that. It's an entire lifestyle change that's what it is.

That was a crucial factor. Whether it's family of just anybody else whose prepared to stand in and actually just give you the support that you need, but the real support, not the little nursing you on, you know, 'don't worry about it, it's okay, I'll get hold of you sometime'. That's the thing, you know what I mean. People, I've seen it in Noupoot plenty, the people get like, they say it's a hard place, but that's because they've always been nursed, and always been spoon fed everything their entire life, want to be treated like a five-star hotel. They're not prepared to make their beds. It's a whole life-style you've got to change. You've got to completely change you're life-style. It's not just to just stop using, or 'clean time' - because that's what NA teaches you. How many days you been clean, how many weeks you've been clean, it's not about that. It's an entire lifestyle change that's what it is.

Interviewer: So a life-style change would mean how you view life and how you go about doing things?

Participant: Ja (yes) everything, it involves everything.

Ja everything, it involves everything.

Interviewer: Is it hard for you to stay clean?

Participant: Not at the moment, no. At the moment it's not hard for me to stay clean at all because I've actually made that final choice. You know, I don't want anything to do with it. Um, no drug at all, um, what's hard for me at the moment is being confined to like this little yard, that's what makes it hard, and not being able to speak to some of the people that I want to speak to.

Not at the moment, no. At the moment it's not hard for me to stay clean at all because I've actually made that final choice. You know, I don't want anything to do with it. No drug at all, what's hard for me at the moment is being confined to like this little yard, that's what makes it hard, and not being able to speak to some of the people that I want to speak to.

Interviewer: Where your parent involved with 'Tough Love' at all?

- Participant: Ja (yes), of a long time my mom was, ja (yes).
Ja, of a long time my mom was, ja.
- Interviewer: *Do you feel that societies perceptions and that, and your family; do you feel that it's conducive toward recovery? Or do you feel that people judge you? Does that make recovery harder?*
- Participant: Judging me? Um, they don't really judge me anymore, they used to, but they don't judge me any longer.
Judging me? Um, they don't really judge me anymore, they used to, but they don't judge me any longer.
- Interviewer: *Are you referring to your family or in general?*
- Participant: Well, specifically to my folks. I mean, people still label you. They still put a certain stigma to you and say that you're an addict and you always will be, 'cause that's a perception that everybody else has that you know. NA says once you're an addict, you're always an addict, and that's something I just don't believe. I can't see myself as an addict if I'm not using it you know. I still smoke (laughs) cigarettes, but I mean I'm not a heroin addict now that I've quit.
Well, specifically to my folks. I mean, people still label you. They still put a certain stigma to you and say that you're an addict and you always will be, 'cause that's a perception that everybody else has that you know. NA says once you're an addict, you're always an addict, and that's something I just don't believe. I can't see myself as an addict if I'm not using it you know. I still smoke cigarettes, but I mean I'm not a heroin addict now that I've quit.
- Interviewer: *When you were using intravenously, where you sharing needles?*
- Participant: Um, I shared three times the entire time I was using it.
I shared three times the entire time I was using it.
- Interviewer: *Okay. And other guys around you? Where they sharing?*
- Participant: Um, well, I was pretty careful with that sort of issue. I knew the people that I was sharing with, we were always together. I knew their lifestyle. Although it wasn't a very smart choice to make, you don't always know everything about them, but it was... then it was like I was desperate - the only thing to do at that stage, and that's why I did it. Other than that, no, I wouldn't share.
Well, I was pretty careful with that sort of issue. I knew the people that I was sharing with, we were always together. I knew their lifestyle. Although it wasn't a very smart choice to make, you don't always know everything about them, but it was... then it was like I was desperate - the only thing to do at that stage, and that's why I did it. Other than that, no, I wouldn't share.
- Interviewer: *Any thought on what you think is the best way to treat an addiction to heroin similar to yours? How would one go about coming clean? Or what advice would you give?*
- Participant: The only advice that I would give to people is to, is just to give God a chance. 'Cause that's... many people don't believe in God you know, in what He can do, but, just let other people... just give it a chance, you know what I mean? If it's not real, nothing will happen, but if it is real, then it will change your life. At least be prepared to just give it a chance. Okay, that's the only thing I really think can save you and actually set you free from it completely.
The only advice that I would give to people is to, is just to give God a chance. 'Cause that's... many people don't believe in God you know, in what He can do, but, just let other people... just give it a chance, you know what I mean? If it's not real, nothing will happen, but if it is real, then it will change your life. At least be prepared to just give it a chance. Okay, that's the only thing I really think can save you and actually set you free from it completely.
- Interviewer: *Thanks so much, all the best.*

PARTICIPANT 33 TRANSCRIPTION

Interviewer: Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: Believing in myself, and co-operating with you guys, and trying to be (*inaudible*).

Interviewer: Do you think people need treatment or not?

Participant: Ja (yes) they do, because they can't stay sober by themselves.

Interviewer: Okay. So do you think they have to be in a special place away from the drug? Or do you think they can do it on what we call an out-patient basis? They come here (rehabilitation centre) and then go home... they come here and then go home.

Participant: No, I don't think so, they must be inside.

Interviewer: Okay, why do you think they must be inside?

Participant: When they go home they will use drugs. The drug will take over their mind, they will go buy a bag and use it.

Interviewer: How long do you think treatment should be for?

Participant: Ah, maybe eight weeks.

Interviewer: Eight weeks? That's a bit longer than the time you stayed.

Participant: Ja (yes).

Interviewer: Okay, is it hard for you to stay clean?

Participant: Ja (yes) the first time it was, but when I started believing in myself and saying to myself that I can make it, it wasn't that much hard.

Interviewer: What changed in your mind, do you think, that made you decide that you didn't want to use?

Participant: The problems that I had with drugs and everything.

Interviewer: What kind of problems

Participant: (*inaudible*)... not coming home, rejecting people, not believing in myself, not being the child that my mother wanted.

Interviewer: Do you feel that your family supports you? Or do you feel they make it hard for you? Are they still angry with you, do they judge you? Or do you feel they support you?

Participant: They do support me.

Believing in myself, and co-operating with you guys.

Ja they do, because they can't stay sober by themselves.

No, I don't think so, they must be inside.

When they go home they will use drugs. The drug will take over their mind, they will go buy a bag and use it.

Ah, maybe eight weeks.

Ja.

Ja the first time it was, but when I started believing in myself and saying to myself that I can make it, it wasn't that much hard.

The problems that I had with drugs and everything.

Not coming home, rejecting people, not believing in myself, not being the child that my mother wanted.

They do support me.

Interviewer: Does that help?

Participant: It does help. It does help.

Interviewer: Okay, and other people, your friends, society...

Participant: Some of my friends who are not using drugs are really there for me, and those that are using drugs are trying to be there, but they are still using it. Some of my friends who are not using drugs are really there for me, and those that are using drugs are trying to be there, but they are still using it.

Interviewer: So they're still struggling?

Participant: Ja (yes). Ja.

Interviewer: What do you think would help someone with a heroin problem?

Participant: Just believe in yourself and that you can do it, and stop using drugs. That's all. Just believe in yourself and that you can do it, and stop using drugs. That's all.

Interviewer: Do you think there is a difference between treating heroin addiction compared to other drug problems like dagga (cannabis) or a mandrax problem? Is there a difference or not really?

Participant: Ja (yes), there is a major difference. Ja, there is a major difference.

Interviewer: What do you mean by that?

Participant: Cause heroin addiction is very heavy... craving and withdrawals, some of them they get angry (*inaudible*). Cause heroin addiction is very heavy... craving and withdrawals, some of them they get angry.

Interviewer: Thank you very much.

PARTICIPANT 34 TRANSCRIPTION

<i>Interviewer:</i>	<i>Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.</i>	
Participant:	What do you mean? Everything in detail?	What do you mean? Everything in detail?
<i>Interviewer:</i>	<i>Yes, how did you get to this point of being clean for a long period of time? How did you get it right?</i>	
Participant:	I got the medication. I think I used it for a week.	I got the medication. I think I used it for a week.
<i>Interviewer:</i>	<i>Withdrawal medication?</i>	
Participant:	Yes, but a week before it I had already stopped, from then on I've stayed clean.	Yes, but a week before it I had already stopped, from then on I've stayed clean.
<i>Interviewer:</i>	<i>Do you feel that medication is necessary or not?</i>	
Participant:	I think so for the beginning, yes.	I think so for the beginning, yes.
<i>Interviewer:</i>	<i>Only for withdrawal?</i>	
Participant:	Yes, it does though totally take the withdrawal away.	Yes, it does though totally take the withdrawal away.
<i>Interviewer:</i>	<i>And after that?</i>	
Participant:	No.	No.
<i>Interviewer:</i>	<i>Okay, did counselling help you or not? How do you see it?</i>	
Participant:	Yes.	Yes.
<i>Interviewer:</i>	<i>Could you elaborate?</i>	
Participant:	It gives you more or less an idea as to why you started using it, and why some people are more vulnerable to becoming addicted to it, and why I experimented in the first place. So yes, it did help.	It gives you more or less an idea as to why you started using it, and why some people are more vulnerable to becoming addicted to it, and why I experimented in the first place. So yes, it did help.
<i>Interviewer:</i>	<i>What in your mind had to change to not want to do it, to decide that you no longer wanted to do it?</i>	
Participant:	I actually got engaged. I always fought against it, and then I decided that I wanted to stop because there are other things to live for. Eventually you start getting withdrawal symptoms, then your head tells you; 'your mind is right, it is now over', you accept it. The withdrawal is bad.	I actually got engaged. I always fought against it, and then I decided that I wanted to stop because there are other things to live for. Eventually you start getting withdrawal symptoms, then your head tells you; 'your mind is right, it is now over', you accept it. The withdrawal is bad.
<i>Interviewer:</i>	<i>Is it hard for you to stay clean?</i>	
Participant:	Some days yes, other days not. Um, I've found that sitting at home doing nothing is... then I start thinking about it. Or if I see it on TV... then you think about it, but otherwise, if you occupy yourself with other things, then it isn't difficult.	Some days yes, other days not. I've found that sitting at home doing nothing is... then I start thinking about it. Or if I see it on TV... then you think about it, but otherwise, if you occupy yourself with other things, then it isn't difficult.

Interviewer: So it helps you through the difficult times, keeping yourself busy?

Participant: Yes. Yes.

Interviewer: Okay. Do you feel that your family and society, do you feel their perceptions are positive and that it supports you in the recovery process, or do you feel that people judge you and that it makes it harder?

Participant: I want to say it's as if there's a board around your neck that you wear for the rest of your life. It never goes away. They are always scared and they don't trust you because you did it. I want to say it's as if there's a board around your neck that you wear for the rest of your life. It never goes away. They are always scared and they don't trust you because you did it.

Interviewer: So that makes it harder?

Participant: Yes, and they keep throwing it back in your face. I regret telling the people that I told. I should have just kept quiet. Yes, and they keep throwing it back in your face. I regret telling the people that I told. I should have just kept quiet.

Interviewer: Are you referring to people outside of your family, or are you speaking of others?

Participant: Yes, family. People outside of your family, they... how can I say... they are not... they know about it, but they don't judge you the whole time. It's not them that hang a board around your neck. Yes, family. People outside of your family, they... how can I say... they are not... they know about it, but they don't judge you the whole time. It's not them that hang a board around your neck.

Interviewer: So you feel it's more your family?

Participant: Yes, it's more immediate family. Yes, it's more immediate family.

Interviewer: So you don't really have... or do you feel that you received support within the recovery process? Did you have a support system?

Participant: My fiancé and I supported each other. My fiancé and I supported each other.

Interviewer: There's no-one else?

Participant: ***** (clinical psychologist) too. ***** too.

Interviewer: This is maybe a difficult question to answer; you say that you and your fiancé supported each other; he also has a history of heroin addiction, was he motivated from the beginning to quit, or not?

Participant: Well, when I decided that's it and no further, he decided... we basically decided together. But for both of us the withdrawal was too bad, that's why we tried many times to quit, but, the withdrawal was too bad, and, and then you drive and go buy again. Well, when I decided that's it and no further, he decided... we basically decided together. But for both of us the withdrawal was too bad, that's why we tried many times to quit, but, the withdrawal was too bad, and, and then you drive and go buy again.

- Interviewer:* And he hasn't relapsed? Say now, I mention it because it's happened in other relationships were both use, if he relapses, will it be difficult for you to keep clean?
- Participant:* If he relapses he's out the door, out of my life. If he relapses he's out the door, out of my life.
- Interviewer:* Okay, so you've set that ultimatum?
- Participant:* Yes, if he takes again, or if he associates with anything, except for his friends, or if he uses not heroin, but something else... that's why we don't go visit there, and they must come visit us, so... Yes, if he takes again, or if he associates with anything, except for his friends, or if he uses not heroin, but something else... that's why we don't go visit there, and they must come visit us.
- Interviewer:* So it's also a lifestyle change?
- Participant:* Yes, for sure. The first time you see it again, of someone next to you who's using it, you're back on it. Many times I said to *****, 'I am so hopeless, if I had a car I would drive through and use', many times, especially as a consequence of my mother and father and my sister. Yes, for sure. The first time you see it again, of someone next to you who's using it, you're back on it. Many times I said to *****, 'I am so hopeless, if I had a car I would drive through and use', many times, especially as a consequence of my mother and father and my sister.
- Interviewer:* What about them? The frustration you experience, or something else? Or the fact that they judge you?
- Participant:* They don't really understand me, and funny enough, I said to *****, (psychologist); 'don't let people bluff you, ***** (sister) makes as if she cares a lot, and she sends me flowers, (inaudible), I know why she did it, so... want the whole family to think that she helped me, but she didn't really help... it is due to her that I quit', and everyone has this attitude that I must be thankful for her, which is not true. She, in the first place, I went home to her and said I was addicted to the stuff. It wasn't necessary for her to do anything. I could have called myself and sought help, and for easily the first month she was there, and then she was gone. So how did she actually help me? She helped me through my withdrawal symptoms, and then she was gone. It depends on me as to whether I was going to stay clean. It was not at all easy, not at all. It was hell... now, it's now. They don't really understand me, and funny enough, I said to *****, 'don't let people bluff you, ***** makes as if she cares a lot, and she sends me flowers, I know why she did it, so... want the whole family to think that she helped me, but she didn't really help... it is due to her that I quit', and everyone has this attitude that I must be thankful for her, which is not true. She, in the first place, I went home to her and said I was addicted to the stuff. It wasn't necessary for her to do anything. I could have called myself and sought help, and for easily the first month she was there, and then she was gone. So how did she actually help me? She helped me through my withdrawal symptoms, and then she was gone. It depends on me as to whether I was going to stay clean. It was not at all easy, not at all. It was hell... now, it's now.
- Interviewer:* So they think they're helping but they actually making it worse?
- Participant:* Yes. That's why ***** (psychologist) said to me he wishes that I could get away from them. I must stop working for my father. That's why I am very excited about moving to Centurion, and I'm so looking forward to not working with my father, because they will no longer know anything about me. Yes. That's why ***** said to me he wishes that I could get away from them. I must stop working for my father. That's why I am very excited about moving to Centurion, and I'm so looking forward to not working with my father, because they will no longer know anything about me.

Interviewer: Do they know you're moving?

Participant: Yes, they know.

Interviewer: Okay. Do they support the move?

Participant: I can't say that they completely support it. They feel I should stay, another thing it that my daughter stays with them. It has been said to me that she may not visit me where I'm going to live in Centurion. If I want to see her, I have to go back there, so it's a manoeuvre to keep me there, so that they can still watch me. ***** said to me my mother and father uses me like a puppet, as they pull the strings. I sat and thought about things that have happened, and it is so true, really.

Interviewer: Do you think there is a difference in treating someone with a heroin problem compared to other substances?

Participant: Yes.

Interviewer: Why do you think so?

Participant: The drugs are not the same.

Interviewer: What makes heroin different then?

Participant: The physical addiction, your body is addicted. That's what makes it so bad. I used other drugs before I got addicted to heroin. I smoked rocks; I was not addicted to it. I used Cat (*methcathinone*), it wasn't nice, so I used it once and if someone offered it to me again I said no. I used coke (*cocaine*), if people approach me now I'll still say 'no thank you', but give me heroin; I will not be able to say no.

Interviewer: In your opinion...

Participant: Or you'll be better for a certain period of time, and then if they offer it you'll say 'no', and they'll walk away. But if he asks you and...

Interviewer: What do you think is the best way to help someone with a heroin problem?

Participant: I would say, your mind must first be right. It doesn't help if your father brings you, or your mother brings you to a rehab if you haven't decided yourself. If they had forced me against my will I would still be using today. It must come from yourself; other people can do what they like. If you... one of our friends went to rehab, when he came out or rehab, the first thing he did was go buy again and he is now so addicted, he's lying on the street.

Interviewer: So it's not necessarily in-patient treatment that's better, it's about other

Yes, they know.

I can't say that they completely support it. They feel I should stay, another thing it that my daughter stays with them. It has been said to me that she may not visit me where I'm going to live in Centurion. If I want to see her, I have to go back there, so it's a manoeuvre to keep me there, so that they can still watch me. ***** said to me my mother and father uses me like a puppet, as they pull the strings. I sat and thought about things that have happened, and it is so true, really.

Yes.

The drugs are not the same.

The physical addiction, your body is addicted. That's what makes it so bad. I used other drugs before I got addicted to heroin. I smoked rocks; I was not addicted to it. I used Cat, it wasn't nice, so I used it once and if someone offered it to me again I said no. I used coke, if people approach me now I'll still say 'no thank you', but give me heroin; I will not be able to say no.

Or you'll be better for a certain period of time, and then if they offer it you'll say 'no', and they'll walk away. But if he asks you and...

I would say, your mind must first be right. It doesn't help if your father brings you, or your mother brings you to a rehab if you haven't decided yourself. If they had forced me against my will I would still be using today. It must come from yourself; other people can do what they like. If you... one of our friends went to rehab, when he came out or rehab, the first thing he did was go buy again and he is now so addicted, he's lying on the street.

aspects? Or would it have been easier for you if you had gone for in-patient treatment?

Participant: Some people don't like that.

Some people don't like that.

Interviewer: Okay.

Participant: I'm not a person that one could say to 'you must get to a place during which you may not go anywhere'.

I'm not a person that one could say to 'you must get to a place during which you may not go anywhere'.

Interviewer: *Do you have any thoughts on time-period for treatment?*

Participant: I saw ***** (psychologist) from August.

I saw ***** from August.

Interviewer: *Seven months on out-patient?*

Participant: Six months. For three months I was alone in the flat, and I don't know why, it was strange, when he was gone, I slept alone in the evenings... I couldn't handle that. I would lie there in front of the TV every evening. I couldn't handle it. I thought for myself; 'if I could get heroin I would use it, because I don't like the way things are now'. So I think a large part why I stay clean is because we have each other.

Six months. For three months I was alone in the flat, and I don't know why, it was strange, when he was gone, I slept alone in the evenings... I couldn't handle that. I would lie there in front of the TV every evening. I couldn't handle it. I thought for myself; 'if I could get heroin I would use it, because I don't like the way things are now'. So I think a large part why I stay clean is because we have each other.

Interviewer: *Thank you very much.*

PARTICIPANT 35 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Um, I will actually start with um becoming clean... it actually starts with yourself, because if you don't have the urge to become clean then you don't have the urge to basically do nothing. Okay, so I wasn't really ready the first couple of times. I just thought I'll do it for my parents, and do it for the people around me, but, um, later I learnt that basically sometime sooner or later I must actually start thinking about my life again. And, my therapist basically helped me, but, they actually just explained to me why they think the addiction is there, but, they only read the books and find out things like that, but they never went through the experience themselves basically. So, um, psychologists didn't really council me, my therapist just basically explained to me a couple of things, and it's actually just by yourself, it's not by others.
- Interviewer:* Do you feel that in-patient treatment is necessary or not?
- Participant:* Um, I would think it is basically necessary, but I think it must also be the person himself as well. But in-patient treatment is definitely ja (yes), I think it is, even if it's only for a couple of days.
- Interviewer:* Okay, so why for a couple of days?
- Participant:* Just to let the person know that in there... a lot of people go to rehab and they think to themselves that they are lonely, that they have nobody to support them, and that they just think about 'am I ever going to come clean?', 'does somebody worry about me?', things like that. So I think it's a basic guideline.
- Interviewer:* You referred to that the person must want to; they must get to that point. What in your mind-set changed to get you to that point? Can you identify anything?
- Participant:* You know what; I went to Magaliesoord through an Article 21 that is mandatory. I had to go otherwise I would have been in court again and got sentenced. So I thought to myself it is actually time because now it's me and the law, and if I'm going to be against the law for the rest of my life I'm not going to get anywhere, so I might as well take the programme and see if it works this time and really be dedicated to do my side as well.
- Interviewer:* Okay, medication-wise, do you think it's necessary that one looks at medication or not? How do you view medication in the
- I will actually start with becoming clean... it actually starts with yourself, because if you don't have the urge to become clean then you don't have the urge to basically do nothing. Okay, so I wasn't really ready the first couple of times. I just thought I'll do it for my parents, and do it for the people around me but later I learnt that basically sometime sooner or later I must actually start thinking about my life again. My therapist basically helped me, but, they actually just explained to me why they think the addiction is there, but, they only read the books and find out things like that, but they never went through the experience themselves basically. So psychologists didn't really council me, my therapist just basically explained to me a couple of things, and it's actually just by yourself, it's not by others.
- I would think it is basically necessary, but I think it must also be the person himself as well. But in-patient treatment is definitely ja, I think it is, even if it's only for a couple of days.
- Just to let the person know that in there... a lot of people go to rehab and they think to themselves that they are lonely, that they have nobody to support them, and that they just think about 'am I ever going to come clean?', 'does somebody worry about me?', things like that. So I think it's a basic guideline.
- You know what; I went to Magaliesoord through an Article 21 that is mandatory. I had to go otherwise I would have been in court again and got sentenced. So I thought to myself it is actually time because now it's me and the law, and if I'm going to be against the law for the rest of my life I'm not going to get anywhere, so I might as well take the programme and see if it works this time and really be dedicated to do my side as well.

treatment process?

- Participant: I wouldn't... I would say no. It's not necessary. I wouldn't... I would say no. It's not necessary.
- Interviewer: Not for withdrawal? Also not?*
- Participant: No, no. The person took their drugs so he must actually go through the drug with his own bodily functions. No, no. The person took their drugs so he must actually go through the drug with his own bodily functions.
- Interviewer: Okay, so the medication you used didn't actually help you in your recovery process?*
- Participant: It helped me like a little bit, but my last time I withdrew; I went sixteen days without medication. It helped me like a little bit, but my last time I withdrew; I went sixteen days without medication.
- Interviewer: Okay, the medication played a minor role?*
- Participant: I'd say so, yes. I think medication makes it easy for people that used heroin. I'd say so, yes. I think medication makes it easy for people that used heroin.
- Interviewer: Do you think it is a short-cut?*
- Participant: I don't think it's a short-cut, but I mean, if there's technology available, people can use it, but, I mean then people just go on heroin everytime and they use it at night-time to take the withdrawals away, so what's the point of that? I don't think it's a short-cut, but I mean, if there's technology available, people can use it, but, I mean then people just go on heroin everytime and they use it at night-time to take the withdrawals away, so what's the point of that?
- Interviewer: Do you feel that they're not really staying clean in the process?*
- Participant: Ja (yes) I do, I think they are. Ja I do, I think they are.
- Interviewer: Do you feel that you had support in your recovery from your significant others? Or do you feel that they judged you? Did that hold you back?*
- Participant: No, I think I had support. No, I think I had support.
- Interviewer: Do you think that that was an important factor in your recovery or not?*
- Participant: I would say yes. It's always nice to know that there's someone close to you, somebody that doesn't give up hope, that's the most important thing I think. I would say yes. It's always nice to know that there's someone close to you, somebody that doesn't give up hope, that's the most important thing I think.
- Interviewer: Did you have hope in your recovery?*
- Participant: Yes, the last time. Yes, the last time.
- Interviewer: The last time. What gave you hope?*
- Participant: I think my will to go back to my old life again, to start working again, to be successful again, because all that was taken away basically. Just to get somewhere again in life, but I've had hard times yes, I did. I think my will to go back to my old life again, to start working again, to be successful again, because all that was taken away basically. Just to get somewhere again in life, but I've had hard times yes, I did.

- Interviewer:* Societies perceptions, do you feel that people out there are supportive as well, or do you feel there's stigmas in general?
- Participant: I think they're two-faced people, the society people, because they see a drug addict as a person who has a habit, they get confused between those two. It's not a bad person who uses drugs, it's a bad habit.
- Interviewer:* You said you used intravenously a couple of times, on and off, did you ever share needles?
- Participant: No.
- Interviewer:* And those around you? Do you know if they shared needles?
- Participant: No, I never say anyone sharing needles.
- Interviewer:* Any thoughts on the length of treatment if somebody does go for in-patient treatment?
- Participant: I would say, I would say that the most important thing actually is if somebody is on drugs, the best person to counsel that person is somebody that was on drugs before, like I told you now-now, people are reading books and they're doing studies, and they're doing research on the internet, but they will never feel how it feels because they weren't there. And it's easy to say, ja (yes), you must do this out of the book and you must do that out of the book, but...
- Interviewer:* So you don't necessarily feel that long-term is necessary?
- Participant: No.
- Interviewer:* There are rehabs in South Africa that are run by ex-addicts and they're long-term.
- Participant: Ah-ha. Ja (yes), well that's perfect, that's actually a good set-up, that I would say is the best set-up.
- Interviewer:* You're a supporter of that?
- Participant: Ja (yes).
- Interviewer:* Okay. If someone came along your way who had a heroin problem, what would you recommend for them? How would you advise them?
- Participant: I would actually tell them what happened to me, and um, I'd tell them everything that happened to me and where I was on my way to. I was almost dead, and I will tell them that there is hope for them, because if there's hope for one person, there's hope for a thousand people -
- I think they're two-faced people, the society people, because they see a drug addict as a person who has a habit, they get confused between those two. It's not a bad person who uses drugs, it's a bad habit.
- No.
- No, I never say anyone sharing needles.
- I would say, I would say that the most important thing actually is if somebody is on drugs, the best person to counsel that person is somebody that was on drugs before, like I told you now-now, people are reading books and they're doing studies, and they're doing research on the internet, but they will never feel how it feels because they weren't there. And it's easy to say, ja, you must do this out of the book and you must do that out of the book.
- No.
- Ah-ha. Ja, well that's perfect, that's actually a good set-up, that I would say is the best set-up.
- Ja.
- I would actually tell them what happened to me, and I'd tell them everything that happened to me and where I was on my way to. I was almost dead. I will tell them that there is hope for them, because if there's hope for one person, there's hope for a thousand people - always

always works like that. And rather get one person clean than loosing a thousand people. I will work with them, I will do that yes, because I understand what they're going through, and I know what they're going through. It's not just a physical addiction; it's a mental addiction as well.

works like that. And rather get one person clean than loosing a thousand people. I will work with them, I will do that yes, because I understand what they're going through, and I know what they're going through. It's not just a physical addiction; it's a mental addiction as well.

Interviewer: Out-patient treatment, any thoughts on it?

Participant: Um, the thing about out-patient is he comes and he gets medication and he goes home again, so, what is the point of that? Maybe he goes home and he can use again, and when he feels bad again he just goes for a drip or NAD, whatever the situation may be.

The thing about out-patient is he comes and he gets medication and he goes home again, so, what is the point of that? Maybe he goes home and he can use again, and when he feels bad again he just goes for a drip or NAD, whatever the situation may be.

Interviewer: So you don't really think that it can work?

Participant: No, I don't think out-patient is very successful. You need to treat a person for a long time, eight months, five months or six months.

No, I don't think out-patient is very successful. You need to treat a person for a long time, eight months, five months or six months.

Interviewer: Do you think there's a difference between treating heroin addiction compared to other forms of chemical addiction?

Participant: Yip, absolutely, yes.

Yip, absolutely, yes.

Interviewer: Could you elaborate?

Participant: I think heroin is basically, um, one of the worst chemical addictions one can get, that and basically Wellconol as well... I did that as well. You can't compare alcohol with heroin, or dagga (*cannabis*) with heroin.

I think heroin is basically one of the worst chemical addictions one can get, that and basically Wellconol as well... I did that as well. You can't compare alcohol with heroin, or dagga with heroin.

Interviewer: Thank you so much.

PARTICIPANT 36 TRANSCRIPTION

Interviewer: Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: Come again.

Interviewer: Describe to the fullest...

Participant: My recovery?

Interviewer: Correct, how did you recover?

Participant: When I told my parents. I told them Monday morning... when I told my parents. When I told my parents. I told them Monday morning... when I told my parents.

Interviewer: Told your parents what?

Participant: That I need help. That I need help.

Interviewer: Okay.

Participant: That I come here (rehab). That I come here.

Interviewer: Okay, so by telling them, were they supportive in the process?

Participant: Yea. Yea.

Interviewer: Do you feel that your family has helped you?

Participant: A lot. They were the ones who helped me recover to the fullest. A lot. They were the ones who helped me recover to the fullest.

Interviewer: Okay. Do you feel that in-patient treatment is necessary or not? Could you have maybe done it on an out-patient basis?

Participant: No. No.

Interviewer: Why do you feel that way?

Participant: Temptation, temptation outside, you can get in the car and go. Temptation, temptation outside, you can get in the car and go.

Interviewer: Okay. So do you feel that a protected environment was necessary for a certain period of time?

Participant: Ja (yes). Ja.

Interviewer: How long do you think the time should be?

Participant: I felt ready after four weeks. I felt ready after four weeks.

Interviewer: Okay. So you think a minimum of a four-week period?

Participant: I don't know (inaudible). I don't know.

Interviewer: Okay, do you think the therapeutic input that you received, has that been beneficial or not in your recovery?

Participant: I don't think so, because I saw most of the lectures were for alcoholics, not really having anything to do with drugs. Drugs is a different experience than alcohol.

Interviewer: *Okay, so you think in treatment the focus should be on drugs?*

Participant: For drug patients.

Interviewer: *Okay. In terms of medication, do you think medication is necessary for someone who has a heroin problem?*

Participant: I think for the first few days.

Interviewer: *For withdrawal?*

Participant: Just for withdrawal, ja (yes).

Interviewer: *Do you think that somebody could do it without medication.*

Participant: They can try, it's gonna be hard.

Interviewer: *What within your mind-set made you change for not wanting to use anymore? What changed for you?*

Participant: That I didn't want anymore.

Interviewer: *But what made you get to that choice?*

Participant: It was when I saw it became a big problem... couldn't get rid of it. Couldn't, had to use it as part of my day.

Interviewer: *Do you mean physically?*

Participant: Physically.

Interviewer: *Okay. So it was mainly the physical aspect that made you change your mind?*

Participant: And image.

Interviewer: *What do you mean by image?*

Participant: You don't want to be associated with someone using heroin, and I've got a baby daughter, so...

Interviewer: *How did your daughter play a role?*

Participant: To recovery... she was a motivation.

Interviewer: *Okay.*

Participant: A big motivation.

Interviewer: *What advice would you give to someone with a heroin problem?*

Participant: Get help as soon as possible.

Interviewer: *What do you mean by help?*

Participant: Get treatment.

I don't think so, because I saw most of the lectures were for alcoholics, not really having anything to do with drugs. Drugs is a different experience than alcohol.

For drug patients.

I think for the first few days.

Just for withdrawal, ja

They can try, it's gonna be hard.

That I didn't want anymore.

It was when I saw it became a big problem... couldn't get rid of it. Couldn't, had to use it as part of my day.

Physically.

And image.

You don't want to be associated with someone using heroin, and I've got a baby daughter, so...

To recovery... she was a motivation.

A big motivation.

Get help as soon as possible.

Get treatment

Interviewer: What kind of treatment?

Participant: In-patient treatment. In-patient treatment.

Interviewer: Okay.

Participant: Get isolated. Get isolated.

Interviewer: Isolated. Okay. You mean away from the drug?

Participant: Away from the drug. Away from the drug.

Interviewer: To give yourself enough time?

Participant: Ja (yes)... Ja.

Interviewer: Okay. Do you think there is a difference between heroin addiction compared to other forms of drug addiction, or not really?

Participant: Not sure (*inaudible*), because the first time is actually... Not sure, because the first time is actually...

Interviewer: Okay, if you had to compare heroin to other drugs, do you think there is a difference or not?

Participant: Heroin, heroin's the worst one. Heroin, heroin's the worst one.

Interviewer: In what way?

Participant: Um, ecstasy is not a problem, you can't get addicted to ecstasy for, in the same way that you can get to heroin. Ah, coke (*cocaine*) maybe. Ecstasy is not a problem, you can't get addicted to ecstasy for, in the same way that you can get to heroin. Ah, coke maybe.

Interviewer: Coke (*cocaine*) maybe?

Participant: Maybe. Maybe.

Interviewer: Okay.

Participant: I like coke (*cocaine*), but it was too expensive. I like coke, but it was too expensive.

Interviewer: Okay, if you look at society perceptions, do you feel that it's generally supportive? Um, people out there and your family, or do you feel that people are judgmental? Does that make recovery harder?

Participant: It felt supportive, very supportive. It felt supportive, very supportive.

Interviewer: You never felt that they've been judgmental?

Participant: No. No.

Interviewer: Okay.

Participant: And the worst people I thought would judge me support me. And the worst people I thought would judge me support me.

Interviewer: Thank you so much for your input and I wish you well.

PARTICIPANT 37 TRANSCRIPTION

Interviewer: Describe to the fullest your process incoming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: It's big words. Um, my place...

Interviewer: How did you get to this point?

Participant: I realised that my life had totally deteriorated and my body too, and I went to speak to my mother. I told her what I was doing and what I was using, 'I want to stop, I cannot carry on like this'. And from Thursday on they... I told them, they kept my car keys in the safe so that I could not drive to the city. Then, I was clean, I didn't use anything from that Thursday until the Sunday one o'clock, and for those four days I hardly slept. I experienced badly withdrawal throughout. That Sunday afternoon I thought that after three days it would be better, compared to the previous time, and it did not get at all better, it only got worse, then I decided that I could not do it on my own - because I started thinking that it would be easier to die. Then it was Sunday at one o'clock, I phoned one of my friends who I knew for quite a long time. I called him and he came to fetch me with his motorbike. I thought I would never do that, because one of my friends died on a motorbike. I said I would never climb on one, but that it was so bad that I climbed on one and went to town and got the stuff (*heroin*). When I came back it was probably two hours later, I had smoked two bags, and my mother saw. I had told her that Thursday that it makes your eyes small, and I had told her of all the effects, and I told her that I had used again and she then realised that they could not help me at home and they began looking for help and they called and that Monday at approximately twelve they called around and decided that you (*Castle Carey*) were the best one, and when I heard that Thursday was my assessment and admission. My withdrawal began again, and I decided that as I was coming here, I would use for the last time. I scratched my car mirror, without using keys I started the car and drove to town and I smoked again, and it was for the last time. I came here and my first three days my withdrawal wasn't bad, and I was surprised. I think the reason was, the doctor also said so, I had already withdrawn, that little bit I used couldn't start everything from the beginning. And then after two weeks I just felt I wanted out, as if I felt I could not learn a lot here (*rehab*). All the other things that I had ever used I stopped myself, it was just the heroin - the withdrawal and the physical addiction

I realised that my life had totally deteriorated and my body too, and I went to speak to my mother. I told her what I was doing and what I was using, 'I want to stop, I cannot carry on like this'. And from Thursday on they... I told them, they kept my car keys in the safe so that I could not drive to the city. Then, I was clean, I didn't use anything from that Thursday until the Sunday one o'clock, and for those four days I hardly slept. I experienced badly withdrawal throughout. That Sunday afternoon I thought that after three days it would be better, compared to the previous time, and it did not get at all better, it only got worse.

I decided that I could not do it on my own - because I started thinking that it would be easier to die.

Then it was Sunday at one o'clock, I phoned one of my friends who I knew for quite a long time. I called him and he came to fetch me with his motorbike. I thought I would never do that, because one of my friends died on a motorbike.

I thought I would never do that, because one of my friends died on a motorbike. I said I would never climb on one, but that it was so bad that I climbed on one and went to town and got the stuff. When I came back it was probably two hours later, I had smoked two bags, and my mother saw. I had told her that Thursday that it makes your eyes small, and I had told her of all the effects, and I told her that I had used again and she then realised that they could not help me at home and they began looking for help and they called and that Monday at approximately twelve they called around and decided that you were the best one, and when I heard that Thursday was my assessment and admission. My withdrawal began again, and I decided that as I was coming here, I would use for the last time. I scratched my car mirror, without using keys I started the car and drove to town and I smoked again, and it was for the last time. I came here and my first three days my withdrawal wasn't bad, and I was surprised. I think the reason was, the doctor also said so, I had already withdrawn, that little bit I used couldn't start everything from the beginning. Then after two weeks I just felt I wanted out, as if I felt I could not learn a lot here. All the other things that I had ever used I stopped myself, it was just the heroin - the withdrawal and the physical addiction was just too severe for me. I thought that my mental addiction I thought I could deal with, and then I wanted to leave, because actually I only wanted to detox for a week, that was my entire purpose.

was just too severe for me. And I thought that my mental addiction I thought I could deal with, and then I wanted to leave, because actually I only wanted to detox for a week, that was my entire purpose. But then you and my parents convinced me to stay longer as there were many problems that I had to resolve, that lead me in the first place to abuse, and I know I am not a therapist, but I could feel when I had resolved it. Then I stayed for my full six weeks and I never again tried, the last four weeks I experienced no cravings and up to today I have never craved again.

Then you and my parents convinced me to stay longer as there were many problems that I had to resolve, that lead me in the first place to abuse, and I know I am not a therapist, but I could feel when I had resolved it. Then I stayed for my full six weeks and I never again tried, the last four weeks I experienced no cravings and up to today I have never craved again.

Interviewer: Do you feel that in-patient treatment is necessary? Could you have done it on an out-patient basis?

Participant: No, it's impossible. The closed unit is the right thing especially for severe addictions such as heroin, because they will do anything to... they will do anything, even deceive their mothers and put them in the boot and drive away with the car and go buy - it's so bad you think you're dying.

No, it's impossible. The closed unit is the right thing especially for severe addictions such as heroin, because they will do anything to... they will do anything, even deceive their mothers and put them in the boot and drive away with the car and go buy - it's so bad you think you're dying.

Interviewer: So you feel that one needs to get away from your environment to a protected place?

Participant: Yes, definitely. Without it you wouldn't make it.

Yes, definitely. Without it you wouldn't make it.

Interviewer: You stated earlier that you could quit the other drugs by yourself but not heroin. Do you think that there is a difference between heroin and other drugs?

Participant: Yes, definitely. Heroin makes every cell, everything in your body, every muscle, it makes everything addicted. Um, the moment you quit, then it feels as if your muscles get life and you get cramps and yes, mentally, that addiction is also severe because it keeps you in a constant depression basically. It's not a high, it's a downer, and the moment you start coming clean, and you stop smoking, you start craving severely. Yes, there's definitely a difference.

Yes, definitely. Heroin makes every cell, everything in your body, every muscle, it makes everything addicted. The moment you quit, then it feels as if your muscles get life and you get cramps and yes, mentally, that addiction is also severe because it keeps you in a constant depression basically. It's not a high, it's a downer, and the moment you start coming clean, and you stop smoking, you start craving severely. Yes, there's definitely a difference.

Interviewer: You were here (rehab) for six weeks. Do you think six weeks is sufficient? Any thoughts on treatment time period?

Participant: I think it's a perfect time period.

I think it's a perfect time period.

Interviewer: Okay.

Participant: And the manner in which you do it, by letting a person out for two hours, and then two days - to test oneself outside. The big thing is your parents stress those 24 hours because you go do the things that you normally did. You test yourself amongst friends those 24 hours. The

The manner in which you do it, by letting a person out for two hours, and then two days - to test oneself outside. The big thing is your parents stress those 24 hours because you go do the things that you normally did. You test yourself amongst friends those 24 hours. The evening you might go party - it's the final

evening you might go party - it's the final test that you can give yourself. No... shorter... if it was shorter you would not have enough time to work through all the psychological stuff; there wouldn't have been time for it. Heroin addicts don't trust people easily, they don't trust people at all, and I think four weeks is enough to gain trust in the therapists. If it was shorter it wouldn't work. It depends from person to person. For some people it will be necessary to stay longer because they may have more problems.

test that you can give yourself. No... shorter... if it was shorter you would not have enough time to work through all the psychological stuff; there wouldn't have been time for it. Heroin addicts don't trust people easily, they don't trust people at all, and I think four weeks is enough to gain trust in the therapists. If it was shorter it wouldn't work. It depends from person to person. For some people it will be necessary to stay longer because they may have more problems.

Interviewer: Is it hard for you to stay clean?

Participant: No, not at all. I think my will is strong enough, and I've tried to regain things that I'd lost. I got work and the big thing now is that I want to get fit. I was once. I don't want to use anything that can mess up my body.

No, not at all. I think my will is strong enough, and I've tried to regain things that I'd lost. I got work and the big thing now is that I want to get fit. I was once. I don't want to use anything that can mess up my body.

Interviewer: People outside, such as your family and society - do you feel that they support you, or do you feel that they judge you, does it make recovery harder?

Participant: No, they support me 100%, especially my parents and friends. And the people I smoked with, before I came, before I stopped, they don't break me down, in fact they look up to me, they have a lot of respect for me.

No, they support me 100%, especially my parents and friends. The people I smoked with, before I came, before I stopped, they don't break me down, in fact they look up to me, they have a lot of respect for me.

Interviewer: If someone came your way who has a heroin problem, what advice would you give them?

Participant: I wouldn't say to them they must now stop because I know it's not possible to stop. I would rather then refer them to rehab if they really want to stop. But if they don't want to stop, there is nothing you can do, you can't help them.

I wouldn't say to them they must now stop because I know it's not possible to stop. I would rather then refer them to rehab if they really want to stop. But if they don't want to stop, there is nothing you can do, you can't help them.

Interviewer: What changed in your mind to not want to use? What got you to make that paradigm shift?

Participant: I think the big thing was I realised that my family and my parents, and the people that I had hurt long ago, what they meant to me. It's not nice being alone. The last four/five months I was alone. It was me, there were those who smoked with me, but they were strangers, you wouldn't tell them anything. And I think that's the thing, I'm scared of being alone again. I know that if I smoke again I'm going to loose my parents, I'm going to loose the few friends I've made now, and yes, that's the big thing.

I think the big thing was I realised that my family and my parents, and the people that I had hurt long ago, what they meant to me. It's not nice being alone. The last four/five months I was alone. It was me, there were those who smoked with me, but they were strangers, you wouldn't tell them anything. I think that's the thing, I'm scared of being alone again. I know that if I smoke again I'm going to loose my parents, I'm going to loose the few friends I've made now, and yes, that's the big thing.

Interviewer: Thank you for everything

PARTICIPANT 38 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming clean for heroin, and to what extent counselling and/or medical intervention was able to assist you.
- Participant:* Um, okay, I went to Houghton House um, and they gave me a lot of medication and stuff, and I was in a lot of pain. I couldn't sleep, um, for weeks I then slept... is that okay? My body was aching, um, and after those two weeks I was okay - the withdrawals were finished, and um, then I went into the psychological stuff like I wanted and then we did the steps, which was the powerlessness and all that, and the stuff, like all the painful stuff from when I was using heroin and other drugs. I think I got it quite quickly - how to stay clean. I started talking very early because I wanted to get clean, um, I didn't keep anything from them, I said - blurted out everything that happened in my life, um, the withdrawals and everything, the cravings still there, but I'm scared of heroin. I don't want to ever... if I ever use that again I think I'll die. I'm quit sure of that. I'm very scared of that, and um, I think they made me scared (*laughs*), yea.
- Interviewer:* Do you feel that in-patient treatment is necessary?
- Participant:* Yea, definitely.
- Interviewer:* Do you think you could have done it on an out-patient basis?
- Participant:* No, no. I've seen a lot of people do it on out-patient. I don't know, they just go back to using. I think I needed that in-patient to keep me away from it.
- Interviewer:* To stay away from it, do you mean in a sort of protected area in order to stabilise?
- Participant:* I didn't go because I wanted to. I didn't use because I wanted to. I just used like I needed to, my body needed it and I needed it in order to do anything. So I didn't want to use heroin at all basically.
- Interviewer:* What got you to make that sort of mind-set change of not wanting to use anymore?
- Participant:* Um, it was all the... don't know what it was, but it - they started, I think they sort of tell you all the stuff when you're still a little bit psychotic and it just stayed in my brain. So, it's like, I'm gonna die and all that... the stuff that happened. I was prostituting myself to get heroin, and I don't want to go back there, and I was stealing, and I just... got raped once on heroin, and, just don't want to go back to that life. I lived on the street for a few weeks. I lived in a crack house for four weeks. I lived in a crack house for four weeks, ja... just
- I went to Houghton House and they gave me a lot of medication and stuff, and I was in a lot of pain. I couldn't sleep for weeks I then slept... is that okay? My body was aching and after those two weeks I was okay - the withdrawals were finished, and then I went into the psychological stuff like I wanted and then we did the steps, which was the powerlessness and all that, and the stuff, like all the painful stuff from when I was using heroin and other drugs. I think I got it quite quickly - how to stay clean. I started talking very early because I wanted to get clean, I didn't keep anything from them, I said - blurted out everything that happened in my life. The withdrawals and everything, the cravings still there, but I'm scared of heroin. I don't want to ever... if I ever use that again I think I'll die. I'm quit sure of that. I'm very scared of that, and I think they made me scared, yea.
- Yea, definitely.
- No, no. I've seen a lot of people do it on out-patient. I don't know, they just go back to using. I think I needed that in-patient to keep me away from it.
- I didn't go because I wanted to. I didn't use because I wanted to. I just used like I needed to, my body needed it and I needed it in order to do anything. So I didn't want to use heroin at all basically.
- It was all the... don't know what it was, but it - they started, I think they sort of tell you all the stuff when you're still a little bit psychotic and it just stayed in my brain. So, it's like, I'm gonna die and all that... the stuff that happened. I was prostituting myself to get heroin, and I don't want to go back there, and I was stealing, and I just... got raped once on heroin, and, just don't want to go back to that life. I lived on the street for a few weeks. I lived in a crack house for four weeks, ja... just

weeks, ja (yes)... just never want to go back there. Um, I think that all that stuff builds up powerlessness, and that happened and stuff. I think that's when everything started to click. I really saw what I did and happened to me, and that... ja (yes), anyway, ja (yes), heroin is just bad for... I didn't work with heroin, it's not like... we say we still love our drug, but we can't use it, but I don't like heroin, not at all.

never want to go back there.

I think that all that stuff builds up powerlessness, and that happened and stuff. I think that's when everything started to click.

I really saw what I did and happened to me and that... ja, anyway, ja.

Heroin is just bad for... I didn't work with heroin, it's not like... we say we still love our drug, but we can't use it, but I don't like heroin, not at all.

Interviewer: Do you think there's a difference between treating heroin addiction and other substances?

Participant: Um, I think there is a difference, but I think it all comes down onto the same thing. I think that heroin just grips you different, it brings you down. It makes you physically... you need it just everyday. Because I smoked crack as well, and I didn't need that every day, but that took all my money away. But heroin was just every day, and it was non-stop, that's all I was thinking about.

I think there is a difference, but I think it all comes down onto the same thing. I think that heroin just grips you different, it brings you down. It makes you physically... you need it just everyday. Because I smoked crack as well, and I didn't need that every day, but that took all my money away. But heroin was just every day, and it was non-stop, that's all I was thinking about.

Interviewer: Is it hard for you to stay clean?

Participant: Not now, it was hard, but I was hard. I was in treatment, and I worked hard, and then we got drugs. So, I didn't use the heroin when I relapsed. I relapsed on coke (cocaine) and Cat (methcathinone) and stuff like that. But now it's not hard. I don't see any of the people. I don't go to any other places.

Not now, it was hard, but I was hard. I was in treatment, and I worked hard, and then we got drugs.

So, I didn't use the heroin when I relapsed. I relapsed on coke and Cat and stuff like that. But now it's not hard.

I don't see any of the people. I don't go to any other places.

Interviewer: So it's been a change in your life-style?

Participant: It's been a whole different life. And I don't know it. I'm still exploring.

It's been a whole different life. And I don't know it, I'm still exploring.

Interviewer: People out there - your family and societies perceptions, have they been supportive or judgmental?

Participant: Um, I think they're very judgmental. I don't think they know what's going on, what's really happening and the whole drug addiction world, because, it's not like I want to hurt anyone, it just happened while I'm doing it, it's so selfish. Um, and I don't think they know what happens in your head. I don't even know what happens in my head. But my family is supportive now, but when they didn't know what was going on, they didn't know what to do. I don't think society will ever really fully understand.

I think they're very judgmental. I don't think they know what's going on, what's really happening and the whole drug addiction world, because, it's not like I want to hurt anyone, it just happened while I'm doing it, it's so selfish. I don't think they know what happens in your head. I don't even know what happens in my head.

But my family is supportive now, but when they didn't know what was going on, they didn't know what to do. I don't think society will ever really fully understand.

Interviewer: There's a lot of stereotypes?

Participant: Ja (yes).

Ja.

Interviewer: How long do you think someone should be in treatment for?

- Participant: Um, I think I was in treatment for too long, it was two and a half months, but I think that last month was a bit, like I just did everything over and over and over. I had nothing more to talk about. The only work I did was on relationships with people. But I think that last month was a bit too long, but it was good for me. So, um, ja (yes), I don't like this whole Serenity eight months stay. I think that's too long for someone. I think you must start to *live*.
- Participant: I think I was in treatment for too long, it was two and a half months, but I think that last month was a bit, like I just did everything over and over and over. I had nothing more to talk about. The only work I did was on relationships with people. But I think that last month was a bit too long, but it was good for me. So ja, I don't like this whole Serenity eight months stay. I think that's too long for someone. I think you must start to *live*.
- Interviewer: *Do you think that if it's too long it 's hard to re-integrate?*
- Participant: Ja (yes) definitely. You get so isolated from the world that you don't know it, so, but like in SHARP you can go out a lot. But even in Houghton (*House*) that six weeks was long, doing nothing, just sitting in that house (*laughs*), but it was good for me. I'm not complaining.
- Participant: Ja definitely. You get so isolated from the world that you don't know it, so, but like in SHARP you can go out a lot. But even in Houghton that six weeks was long, doing nothing, just sitting in that house, but it was good for me. I'm not complaining.
- Interviewer: *What do you think is the best way to treat someone, to help someone with a heroin problem?*
- Participant: Um, like appearance?
- Participant: Like appearance?
- Interviewer: *How would you go about helping? What advice would you give them?*
- Participant: Um, I would say go to NA (*Narcotics Anonymous*), definitely, because that has worked for me, um, and I would say if it's a really big problem I think they must go and get help at a 12-step programme, because that's the only thing that's helped for me. So I believe in the 12-step programme and NA, or AA (*Alcoholics Anonymous*) or CA. (*Cocaine Anonymous*), all the 12-step programmes. Denmar didn't work for me at all, and I don't know what they were trying to do. I can't even remember trying to do... I can't even remember, but... and I don't know other treatment.
- Participant: I would say go to NA, definitely, because that has worked for me, and I would say if it's a really big problem I think they must go and get help at a 12-step programme, because that's the only thing that's helped for me. So I believe in the 12-step programme and NA, or AA or CA, all the 12-step programmes. Denmar didn't work for me at all, and I don't know what they were trying to do. I can't even remember trying to do... I can't even remember, but... and I know other treatment.
- Interviewer: *What about NA do you think helps in recovery?*
- Participant: I think it's the support structure you have, um, you make a lot of friends there 'cause everyone's friendly and everyone gives hugs. You feel like you belong and you can say whatever you want, which you can't say to your friends or family members, you can't say 'I'm struggling today, I wanted to use', you can say that to the people in NA, and they will support you because they know what you're going through. I think it's that you feel comfortable. It's the only place you can go were everyone... it's not dangerous for you, but you do feel comfortable around the people, like you belong somewhere. Ja (yes).
- Participant: I think it's the support structure you have, you make a lot of friends there 'cause everyone's friendly and everyone gives hugs. You feel like you belong and you can say whatever you want, which you can't say to your friends or family members, you can't say 'I'm struggling today, I wanted to use', you can say that to the people in NA, and they will support you because they know what you're going through. I think it's that you feel comfortable. It's the only place you can go were everyone... it's not dangerous for you, but you do feel comfortable around the people, like you belong somewhere. Ja.

Interviewer: Do you think medication's necessary?

Participant: Um, if the withdrawal... I don't know what I would have been like without medication 'cause I was in such pain. I was cramping and not sleeping. I think it is necessary.

If the withdrawal... I don't know what I would have been like without medication 'cause I was in such pain. I was cramping and not sleeping. I think it is necessary.

Interviewer: For the withdrawals?

Participant: Ja (yes), but not for after that.

Ja, but not for after that.

Interviewer: Not after that?

Participant: No, I think that if you have like bad anxiety or psychotic... I don't know what but I think then you must get something, or very depressed. But I'm not one of these, so...

No, I think that if you have like bad anxiety or psychotic... I don't know what but I think then you must get something, or very depressed. But I'm not one of these.

Interviewer: Thank you so much.

PARTICIPANT 39 TRANSCRIPTION

Interviewer: Describe to the fullest your process in coming clean from heroin and to the extent that counselling and/or medical intervention was able to assist you.

Participant: You mean like Castle Carey?

You mean like Castle Carey?

Interviewer: How did you come and stay clean?

Participant: Um, I went to Castle Carey, rehab because I decided myself that I can't carry on the way it was. I was on heroin for five years. Its five years of my life that I lost, understand? I did work during that time but I lost my work due to heroin. I lost my flat that I had, my girlfriend, everything... my car, everything that I possessed. I sold everything, cellphones. I basically just decided that fear of heroin, it can't carry on, because heroin was always to me 'the fear' - you never knew where it is, it always comes and it teases you and follows you, you understand? And I went to Castle Carey, and the withdrawal symptoms that I experienced there was heavy. It was my severest withdrawal ever. I think it was because I knew it would be my last time. Um, muscle pain, stomach pain; um later it felt like DT's (*dementia tremens*) - those DT hallucinations that you get. The pain got so bad that it felt like I was in a dream world, understand? Just to try and stop the pain, understand? Because the pain was intense for me, it was as if my body was saying to me 'kry vir jou' (spite yourself), understand? Um, I got my medication. Medication helped me a lot, you know, sleeping pills especially. Heroin withdrawal is just... I didn't misuse the sleeping pills, I actually used it for what it was meant to be used for, understand? Um, the counselling that I received I would say of all the rehabs that I've been to, it was the best counselling that I've ever received, understand. We basically prioritised my problems and said these are my eleven problems that I want to resolve, understand, such as my mother and family, the heroin addiction, um, all the big problems and stuff. And, we basically approached them one at a time, but it wasn't the therapist that solved them for me, the therapist only gave me the ropes and I climbed myself, understand? But it was a struggle man, you know, five years is a long time. For five years, okay there were a few weeks that I was clean - altogether about three months during those five years, understand. But, it just, it's a struggle. That's how I can explain it to you basically. It's difficult. It takes a man to do it, hear (*laughs*), seriously.

I went to Castle Carey, rehab because I decided myself that I can't carry on the way it was. I was on heroin for five years. Its five years of my life that I lost, understand?

I did work during that time but I lost my work due to heroin. I lost my flat that I had, my girlfriend, everything... my car, everything that I possessed. I sold everything, cellphones.

I basically just decided that fear of heroin, it can't carry on, because heroin was always to me 'the fear' - you never knew where it is, it always comes and it teases you and follows you, you understand?

I went to Castle Carey, and the withdrawal symptoms that I experienced there was heavy. It was my severest withdrawal ever. I think it was because I knew it would be my last time. Um, muscle pain, stomach pain; um later it felt like DT's - those DT hallucinations that you get. The pain got so bad that it felt like I was in a dream world, understand? Just to try and stop the pain, understand? Because the pain was intense for me, it was as if my body was saying to me 'kry vir jou', understand?

I got my medication. Medication helped me a lot, you know, sleeping pills especially. Heroin withdrawal is just... I didn't misuse the sleeping pills, I actually used it for what it was meant to be used for, understand?

The counselling that I received I would say of all the rehabs that I've been to, it was the best counselling that I've ever received. We basically prioritised my problems and said these are my eleven problems that I want to resolve, such as my mother and family, the heroin addiction, all the big problems and stuff. And, we basically approached them one at a time, but it wasn't the therapist that solved them for me, the therapist only gave me the ropes and I climbed myself.

But it was a struggle man, you know, five years is a long time. For five years, okay there were a few weeks that I was clean - altogether about three months during those five years, understand. But, it just, it's a struggle. That's how I can explain it to you basically. It's difficult. It takes a man to do it, hear, seriously.

Interviewer: Do you feel that in-patient treatment is necessary? Could you have done it on an out-patient basis?

- Participant: You can, but I don't think you will make it. In-patient I think is the best; it's when you get 24 hour attention. There is always someone looking after you, um, you're in a secure environment. While as an out-patient you're free to go and do what you like, understand? Take Castle Carey, I think six weeks is not really enough for a heroin junky. I think it needs to be a little longer.
- Participant: You can, but I don't think you will make it. In-patient I think is the best; it's when you get 24 hour attention. There is always someone looking after you, you're in a secure environment. While as an out-patient you're free to go and do what you like, understand? Take Castle Carey, I think six weeks is not really enough for a heroin junky. I think it needs to be a little longer.
- Interviewer: *How long do you think?*
- Participant: Um, say about ten weeks. To sort out your head. I would say approximately eight to ten weeks. I think that for me is the right time so...
- Participant: Say about ten weeks. To sort out your head. I would say approximately eight to ten weeks. I think that for me is the right time
- Interviewer: *You spoke of medication, um, do you feel then it's necessary for withdrawal?*
- Participant: Yes, it is. But it's basically to alleviate your pain. Once that pain is alleviated a person already feels better, understand? Then the ideas of jumping over the walls and go buy starts to lessen. As long as you have pain, the muscle pains of heroin is intense, it feels like nails being pushed into your legs. Those cramps, you cannot lie for two seconds in one position - then you must turn. That's why you can't sleep because your body the whole time keeps... your mind, those mind-games that you play with yourself. I think medication is necessary, pain medication, Dixarit (*Clonidine*). Dixarit helps for that calming... craving effect that it has. Some people say it doesn't work for them, but for me it did, understand? Aterax worked for me - for the anxiety that you get, because the withdrawal... 'I need now' you know, that whole effect and, yes, Librium also worked for me, it helped me to chill, but, Aterax at times... because I drank four at a time, made me sometimes feel agro, you know. I just get intensely grumpy, you know, and then I sleep to get rid of the medication, yes, and two basic things that I would recommend is sleeping pills and pain medication.
- Participant: Yes, it is. But it's basically to alleviate your pain. Once that pain is alleviated a person already feels better. Then the ideas of jumping over the walls and go buy starts to lessen. As long as you have pain, the muscle pains of heroin is intense, it feels like nails being pushed into your legs. Those cramps, you cannot lie for two seconds in one position - then you must turn. That's why you can't sleep because your body the whole time keeps... your mind, those mind-games that you play with yourself. I think medication is necessary, pain medication, Dixarit. Dixarit helps for that calming... craving effect that it has. Some people say it doesn't work for them, but for me it did, understand? Aterax worked for me - for the anxiety that you get, because the withdrawal... 'I need now' you know, that whole effect and, yes, Librium also worked for me, it helped me to chill, but, Aterax at times... because I drank four at a time, made me sometimes feel agro, you know. I just get intensely grumpy, you know, and then I sleep to get rid of the medication, yes, and two basic things that I would recommend is sleeping pills and pain medication.
- Interviewer: *Just for the short-term?*
- Participant: Yes, ten days.
- Participant: Yes, ten days.
- Interviewer: *How do you feel about maintenance programmes such as methadone maintenance?*
- Participant: Not a good idea. Methadone is a dangerous thing because you begin to withdrawal for it, so it's the same. Like you said earlier, it postpones your withdrawal. Once it's out, your withdrawal hits you four times harder, understand? Methadone no. Subutex (*Buprenorphine*) is also not a good thing in my opinion, subutex and physeptone are not good things, it postpones
- Participant: Not a good idea. Methadone is a dangerous thing because you begin to withdrawal for it, so it's the same. Like you said earlier, it postpones your withdrawal. Once it's out, your withdrawal hits you four times harder, understand? Methadone no. Subutex is also not a good thing in my opinion, subutex and physeptone are not good things, it postpones basically. It's a temporary pain reliever, do you understand? No, I wouldn't recommend

- basically. It's a temporary pain reliever, do you understand? No, I wouldn't recommend it. A person must go through it naturally.
- it. A person must go through it naturally.
- Interviewer:* 'Cold turkey'?
- Participant: Yes Yes
- Interviewer:* *Is it hard for you to stay clean?*
- Participant: Now at the moment, no. But my previous four years were, yes, because I was so deep in the drug culture, understand? Dealing, and it was difficult... friends. Now at the moment, no. But my previous four years were, yes, because I was so deep in the drug culture, understand? Dealing, and it was difficult... friends.
- Interviewer:* *Do you feel then that you changed your mind-set when you hit 'rock-bottom'?*
- Participant: Yes, it did. I changed my mind-set, my whole life-style, everything basically. I had long hair, I cut it. I changed my whole attitude, my entire vocabulary, my manner of being, everything. And it took me a while, but change... such a change is hard, understand? It's difficult to make such a change. All the friends I had, I've written them all off. I just think it's better. It's such people, for example that I come to friends who look how I used to look. I took out all my piercings except for my eye-ring - I changed my whole look further, understand? You arrive at people and they look the same, you get that feeling of... it's nice to sit and visit with them, that whole... I don't know how to explain it to you... that's how it was for me. So now I visit with an entirely new group of people, it's new things, it's not just always 'hey, let's go score heroin', 'let's go steal', 'what we're going to do, who we're going to rob?', you know. Yes, I've changed my entire life-style, understand? Except for the fact that I would have liked to move out of Pretoria, for example, understand? Because Pretoria and Johannesburg are the two greatest killers when it comes to heroin, I mean, see how the children are falling now. I hear everyday of people falling on heroin, understand? And it's sad, because heroin kills, understand? It's just so... and yes, that's all I can say basically. Yes, it did. I changed my mind-set, my whole life-style, everything basically. I had long hair, I cut it. I changed my whole attitude, my entire vocabulary, my manner of being, everything. And it took me a while, but change... such a change is hard, understand? It's difficult to make such a change. All the friends I had, I've written them all off. I just think it's better. It's such people, for example that I come to friends who look how I used to look. I took out all my piercings except for my eye-ring - that's one thing for sentimental reasons. I changed my whole look further, understand? You arrive at people and they look the same, you get that feeling of... it's nice to sit and visit with them, that whole... I don't know how to explain it to you... that's how it was for me. So now I visit with an entirely new group of people, it's new things, it's not just always 'hey, let's go score heroin', 'let's go steal', 'what we're going to do, who we're going to rob?', you know. Yes, I've changed my entire life-style. Except for the fact that I would have liked to move out of Pretoria, for example. Because Pretoria and Johannesburg are the two greatest killers when it comes to heroin, I mean, see how the children are falling now. I hear everyday of people falling on heroin. It's sad, because heroin kills, understand? It's just so... and yes, that's all I can say basically.
- Interviewer:* *People out there, like your parents and society, do you feel that they judge you or support you?*
- Participant: I'd say my mother, my mother supports me - hard, hundred percent. Um, my bother and my sister and my father, the rest of my family basically, it felt as if they judge me for who and what I am, the junky, the washout. I totally went out and showed them I'm not. I am something completely different. Then everyone's attitude changed toward me. Now I'm a working person, I have good working skills. I'm spontaneous, whereas I was I'd say my mother, my mother supports me - hard, hundred percent. My bother and my sister and my father, the rest of my family basically, it felt as if they judge me for who and what I am, the junky, the washout. I totally went out and showed them I'm not. I am something completely different. Then everyone's attitude changed toward me. Now I'm a working person, I have good working skills.

always withdrawn and by myself and lay always fucked on the bench. Whatever, understand? Now... if people will actually come and ask 'how's your day been?' Everyone's whole view of me has changed, family-wise. Society-wise, um, it still feels to me sometimes as if people judge me for who I am and how I look, understand? If I spike my hair and climb on the bus people whisper 'check that junky', I hear them saying it. Understand, I would say society, yes, I don't think they accepted me, understand, not yet accepted me for who and what I am.

Interviewer: Do you feel then that your family's support contributed toward your recovery?

Participant: Yes, especially the support from my mother. The nights I make her cry due to heroin. It's not nice to see that. The other days that I made her laugh due to my cleanness - it's another feeling, it's great, understand? They don't need to lock their things away, it can now lie around and everything. It's something else, that I can actually now feel love that comes from my parents, especially my father and I. The past few years walked a very hard path, him and I. We always physically took each other on. I attacked him with knives, and he, I can't say he tempted me to do it, he said to me; "if you want to hit me, come, let us do it and get it over with, and then I will show you that you're a junky, you can't hit." But it's totally different now. It's great. I have a nice relationship with my mother and everyone. It's friendly. I can't remember how long ago that we fought, you understand? I can't remember, it's nice.

Interviewer: Did you share needles?

Participant: Yes.

Interviewer: Okay...

Participant: A lot of times.

Interviewer: And the people around you?

Participant: Yes.

Interviewer: Did they share?

Participant: Yes. I haven't yet picked up AIDS, so I was lucky. I only shared needles with people I knew, like my girlfriends, for example, my sister and my sister's boyfriend that she had. Only with people that I knew, understand? But I do go regularly, every six months, for HIV tests because I'm scared of that disease, understand? I've used dirty needles; needles that I dug out of rubbish bins and that's for me... you're looking for it now.

I'm spontaneous, whereas I was always withdrawn and by myself and lay always fucked on the bench. Whatever, understand? Now... if people will actually come and ask 'how's your day been?' Everyone's whole view of me has changed, family-wise.

Society-wise, it still feels to me sometimes as if people judge me for who I am and how I look. If I spike my hair and climb on the bus people whisper 'check that junky', I hear them saying it.

I would say society, yes, I don't think they accepted me, not yet accepted me for who and what I am.

Yes, especially the support from my mother. The nights I make her cry due to heroin. It's not nice to see that. The other days that I made her laugh due to my cleanness - it's another feeling, it's great. They don't need to lock their things away, it can now lie around and everything. It's something else, that I can actually now feel love that comes from my parents, especially my father and I. The past few years walked a very hard path, him and I. We always physically took each other on. I attacked him with knives, and he, I can't say he tempted me to do it, he said to me; "if you want to hit me, come, let us do it and get it over with, and then I will show you that you're a junky, you can't hit." But it's totally different now. It's great. I have a nice relationship with my mother and everyone. It's friendly. I can't remember how long ago that we fought. I can't remember, it's nice.

Yes.

A lot of times.

Yes.

Yes. I haven't yet picked up AIDS, so I was lucky. I only shared needles with people I knew, like my girlfriends, for example, my sister and my sister's boyfriend that she had. Only with people that I knew. But I do go regularly, every six months, for HIV tests because I'm scared of that disease. I've used dirty needles; needles that I dug out of rubbish bins and that's for me... you're looking for it now. When I came home my needles were gone, my mom threw them

When I came home my needles were gone, my mom threw them away in the dustbin - it's a backyard rubbish bin. I climbed halfway into that rubbish bin to get that needle, I didn't even clean it. When I started with heroin five years ago, I always bought a pack of ten, and then after I used a clean needle I would throw it away. If I maybe used it a second time, I would first dip it in boiling water, understand?

away in the dustbin - it's a backyard rubbish bin. I climbed halfway into that rubbish bin to get that needle, I didn't even clean it. When I started with heroin five years ago, I always bought a pack of ten, and then after I used a clean needle I would throw it away. If I maybe used it a second time, I would first dip it in boiling water.

Interviewer: That doesn't disinfect it...

Participant: Yes. That's what I believed, understand? Later it became... you buy one needle, four people would use it. Afterwards it would become so blunt and everything. When you force it into your skin, your skin becomes taught, it's sore understand? It becomes physically painful and then you begin to miss inject because you can't find a vein, and the thing is so blunt that it presses on your vein. Yes, we shared needles, like mad hey, so... not with so many people. I shared with eight different people during my entire heroin career - girlfriends that I had.

Yes. That's what I believed, understand? Later it became... you buy one needle, four people would use it. Afterwards it would become so blunt and everything. When you force it into your skin, your skin becomes taught, it's sore. It becomes physically painful and then you begin to miss inject because you can't find a vein, and the thing is so blunt that it presses on your vein. Yes, we shared needles, like mad hey, so... not with so many people. I shared with eight different people during my entire heroin career - girlfriends that I had.

Interviewer: How do you feel about needle exchange programmes?

Participant: Like in Amsterdam - if you use needles you can give your old needles and get new ones?

Like in Amsterdam - if you use needles you can give your old needles and get new ones?

Interviewer: Do you think it can help or not? Does it make everything worse?

Participant: I think it will keep heroin people on heroin, understand? Places overseas where it is already for people on heroin, yes, it's a good thing.

I think it will keep heroin people on heroin. Places overseas where it is already for people on heroin, yes, it's a good thing.

Interviewer: Because you avoid HIV?

Participant: Yes, because you avoid HIV in the first place. Not really actually, two people can still share that needle, understand? But needle exchange is a good thing because you can always get clean needles, and I think it's for free, understand? So it's a good thing in a way, but it's also a bad thing when it comes to the aspect of heroin 'junkies', understand?

Yes, because you avoid HIV in the first place. Not really actually, two people can still share that needle, understand? But needle exchange is a good thing because you can always get clean needles, and I think it's for free. So it's a good thing in a way, but it's also a bad thing when it comes to the aspect of heroin 'junkies', understand?

Interviewer: What do you mean by that? Can you elaborate?

Participant: Um, let me try and explain it to you. In a good way it's... okay, if you don't have money for needles, then I can go and give in my old needles, understand? In a bad way, you will always continue using heroin; the problem will always be there.

Let me try and explain it to you. In a good way it's... okay, if you don't have money for needles, then I can go and give in my old needles, understand? In a bad way, you will always continue using heroin; the problem will always be there.

Interviewer: And if there's both? In other words, needle exchange and help?

Participant: I don't think you will then make it. I don't think you will then make it.

Interviewer: Is it then two conflicting messages?

Participant: Basically, yes. It won't work. It's two negatives together. Basically, yes. It won't work. It's two negatives together.

Interviewer: What do you think is the best path to follow for someone who wants to overcome a heroin problem like the one that you had? If someone came your way, what would you advise them?

Participant: To come clean, number one; rehab, and get his Christianity right, because I believe that without God you won't make it. I became a Christian in Castle Carey. I was involved with Satanism. It's scary you understand? And everyone's always said to me that without Christianity you won't get it right. So that's my number two point. Ah, number three, support from people that really love you, you know. Four, you must have a therapist who knows what they're doing. You must have someone who basically understands your problem. It doesn't help me getting a therapist that, for example, has an aptitude for alcoholics, and I'm a heroin junky, that person will not be able to help you because that person will not understand how you feel, you know, you understand what I mean? Lastly, support - that support man. Support is a good thing to me. When you see that people begin value you, then you begin to think differently, yes, same as I said earlier. My first thing is rehab, that actually worked for me. The other rehabs couldn't do it because they didn't give me 24 hours attention, and you, like the sister, for example, every three hours in the evening she will come see if this child is still living, understand? There it is if you sleep, you sleep. If you die in the evening, the people don't worry, you understand? It's you know, Castle Carey also provides a lot of free time, understand, to sort out your own head. The free time at times becomes heavy because you don't know what to do with yourself and stuff. But, as you start keeping yourself busy, the people, you start speaking to people about the problems you have, understand? Because I believe each druggies drug problem came about due to something that happened in his life. Understand, whether it was peer pressure or sexual abuse as a child, whatever, I believe every druggy had a problem and that's why he shifted to drugs, you understand, there must have been something, something big that triggered the child to decide let me move onto drugs, let me experiment with it, understand? Um, I believe you must face your problem. So

To come clean, number one; rehab. Get his Christianity right, because I believe that without God you won't make it. I became a Christian in Castle Carey. I was involved with Satanism. It's scary you understand? Everyone's always said to me that without Christianity you won't get it right. So that's my number two point. Number three, support from people that really love you. Four, you must have a therapist who knows what they're doing. You must have someone who basically understands your problem. It doesn't help me getting a therapist that, for example, has an aptitude for alcoholics, and I'm a heroin junky, that person will not be able to help you because that person will not understand how you feel, you know, you understand what I mean? Lastly, support - that support man. Support is a good thing to me. When you see that people begin value you, then you begin to think differently, yes, same as I said earlier. My first thing is rehab, that actually worked for me. The other rehabs couldn't do it because they didn't give me 24 hours attention, and you, like the sister, for example, every three hours in the evening she will come see if this child is still living, understand? There it is if you sleep, you sleep. If you die in the evening, the people don't worry. Castle Carey also provides a lot of free time to sort out your own head. The free time at times becomes heavy because you don't know what to do with yourself and stuff. But, as you start keeping yourself busy, the people, you start speaking to people about the problems you have. I believe each druggies drug problem came about due to something that happened in his life. Understand, whether it was peer pressure or sexual abuse as a child, whatever, I believe every druggy had a problem and that's why he shifted to drugs, there must have been something, something big that triggered the child to decide let me move onto drugs, let me experiment with it, understand? I believe you must face your problem. So long as you run away, and the problem runs behind you, you know what I'm speaking about, the problem becomes bigger, so you won't be able to just leave it and think that you can mainline it away. You must face

long as you run away, and the problem runs behind you, you know what I'm speaking about, the problem becomes bigger, so you won't be able to just leave it and think that you can mainline it away. You must face it, you must just stop and actually face your problems, because what heroin does it's a short-term pain reliever in terms of your bodily pain and your emotional pain, understand? I have all these problems... where am I going to get money? Once you've mainlined, it's just whoa... it felt to me everytime that I mainlined I felt like a God, understand, anything could come my way, understand? I don't really thing so, it's just an illusion that's given to you. Yes.

Interviewer: Thank you so much and I wish you all the best.

it, you must just stop and actually face your problems, because what heroin does it's a short-term pain reliever in terms of your bodily pain and your emotional pain, understand? I have all these problems... where am I going to get money? Once you've mainlined, it's just whoa... it felt to me everytime that I mainlined I felt like a God, understand, anything could come my way. I don't really thing so, it's just an illusion that's given to you. Yes.

PARTICIPANT 40 TRANSCRIPTION

- Interviewer:* Describe to the fullest your process in coming 'clean' from heroin and to the extent that counselling and/or medical intervention was able to assist you.
- Participant:* Ah, I don't think medical assistance helped me because I quit on my own, you know. Ja (yes), so nobody helped me change, because I actually saw what heroin could do to me, ja (yes), 'cause I saw from my friends, some of them, like my other friend got killed - 'cause we used to do a lot of things together check, but then I quit, I just quit. After my friends' death I just quit straight.
- Interviewer:* So seeing someone die made you think differently about taking heroin?
- Participant:* Yes, we were close; we were really very close friends. You know, when you see your friend dying... because he died next to me, we were like brothers together, and like, he just died there - he was shot in the head.
- Interviewer:* So it wasn't because of heroin that he died?
- Participant:* Not really, we were actually making money for drugs, check.
- Interviewer:* Were you selling drugs?
- Participant:* Mmm, we had stolen something, then like, apparently... when they came they started shooting and they shot the guy and I guess I was lucky.
- Interviewer:* Do you think medication is necessary even though you didn't take, do you think it would have been easier for you if you did take? Or do you think it's better to just stop using?
- Participant:* I think medication can help people, you know, but um, 'cause not all of us have the same will-power. There are some people who can just quit - like smoking, I can't you know. Ja (yes), some people can just quit like that, ja (yes). That's how I did it, 'cause I always used to experiment with things you know, ja (yes), if I didn't really like it, I'd just stop it. But then heroin I stopped after a long while - a year and a half.
- Interviewer:* You were seeing a psychologist at the time, you weren't in a rehabilitation centre, do you feel that helped you or not?
- Participant:* Who, the psychologist?
- Interviewer:* Yes.
- Participant:* She helped nothing. Clearly 'cause she never... all that she used to tell me was
- I don't think medical assistance helped me because I quit on my own, you know. Ja, so nobody helped me change, because I actually saw what heroin could do to me, ja, 'Cause I saw from my friends, some of them, like my other friend got killed - 'cause we used to do a lot of things together check, but then I quit, I just quit. After my friends' death I just quit straight.
- Yes, we were close; we were really very close friends. You know, when you see your friend dying... because he died next to me, we were like brothers together, and like, he just died there - he was shot in the head.
- Not really, we were actually making money for drugs.
- We had stolen something, then like, apparently... when they came they started shooting and they shot the guy and I guess I was lucky.
- I think medication can help people, you know, but 'cause not all of us have the same will-power. There are some people who can just quit - like smoking, I can't you know. Ja, some people can just quit like that, ja. That's how I did it, 'cause I always used to experiment with things you know, ja, if I didn't really like it, I'd just stop it. But then heroin I stopped after a long while - a year and a half.
- Who, the psychologist?
- She helped nothing. Clearly 'cause she never... all that she used

- ah... she just used to tell me a whole lot of stuff that really didn't mean a thing to me.
- to tell me was ah... she just used to tell me a whole lot of stuff that really didn't mean a thing to me.
- Interviewer:* Okay. Do you think in-patient treatment is necessary? Do you think that could have helped it? Would it have been easier for you if you had been in a rehabilitation centre?
- I think so.
- I think so.
- Interviewer:* Okay. Society, people out there and your family - do you think that they judge you, or are they supportive? If so, does that make recovery easier/
- Participant: Ja (yes), but I mean, my mother used to still think that I am still on heroin, check. Ah, you know I wanted to stop, but what's really bothering me was the weed (*cannabis*). But I mean she is actually supportive towards my rehabilitation and stuff.
- Ja, but I mean, my mother used to still think that I am still on heroin. Ah, you know I wanted to stop, but what's really bothering me was the weed. But I mean she is actually supportive towards my rehabilitation and stuff.
- Interviewer:* Does that help you or not?
- Participant: I think it does you know, 'cause it actually motivates me not to use. Even though I've screwed up a whole lot of times, but then, somebody still believes in me.
- I think it does you know, 'cause it actually motivates me not to use. Even though I've screwed up a whole lot of times, but then, somebody still believes in me.
- Interviewer:* Do you think there is a difference between treating heroin addiction compared to other drugs like dagga (*cannabis*), is it different?
- Participant: Ja (yes), I think it's a whole lot different 'cause like with dagga (*cannabis*) you don't get, you don't get like those stomach cramps, I mean. I used to, I used to like, um, my stomach would get knots, that's how bad, immediately when you let go then like bad gasses, like you feel you're really dying, ja (yes). Do, I mean like, even in a rehab if a person had to get that, I think it would really hurt.
- Ja, I think it's a whole lot different 'cause like with dagga you don't get, you don't get like those stomach cramps, I mean. I used to, I used to like, um, my stomach would get knots, that's how bad, immediately when you let go then like bad gasses, like you feel you're really dying, ja. Do, I mean like, even in a rehab if a person had to get that, I think it would really hurt.
- Interviewer:* Okay. Do you think one would have to look at more intense treatment or something like that?
- Participant: Ja (yes).
- Ja.
- Interviewer:* Okay. What advice would you give to someone who had a heroin problem or that's addicted to heroin, what do you think would help for them? Any advice you'd give them?
- Participant: I mean I got off because of the alcohol that I was using by then, because whenever I used to get those cramps I used to drink alcohol, so then, I wouldn't wish other people to use that - but then it helped me out at the end. On the long run I came out the winner, check.
- I mean I got off because of the alcohol that I was using by then, because whenever I used to get those cramps I used to drink alcohol, so then, I wouldn't wish other people to use that - but then it helped me out at the end. On the long-run I came out the winner.

- Interviewer:* Do you think there are other ways of coming clean? What do you think could be a safer way? Or do you think there is a safer way of coming clean of heroin?
- Participant:* I don't know. I don't know.
- Interviewer:* Was that the only option you had at the time?
- Participant:* Ja (yes), 'cause I didn't have like a facility like a rehab. I didn't even know of this place. Maybe if I had I would have asked my parents to bring me here. Ja, 'cause I didn't have like a facility like a rehab. I didn't even know of this place. Maybe if I had I would have asked my parents to bring me here.
- Interviewer:* Okay. Is there anything else that happened, you mentioned your friend that died, but was there any other factor that made you change your mind-set that made you decide 'I don't want to use heroin'?
- Participant:* Ja (yes), I mean I actually wanted to stop, check, 'cause like I... it's just that the heroin stuff wore me out. I could feel that I was getting a high, but then I wasn't being myself anymore, check. I was starting to be someone else, and I never used to have time for my girlfriend. I really missed my old life, check. That's why. Ja, I mean I actually wanted to stop, 'cause like I... it's just that the heroin stuff wore me out. I could feel that I was getting a high, but then I wasn't being myself anymore. I was starting to be someone else, and I never used to have time for my girlfriend. I really missed my old life. That's why.
- Interviewer:* You said you'd become someone else, in what way did you change?
- Participant:* I'd become like a Barbarian, 'cause like heroin... when I used to smoke heroin I... my face became gaunt and down. I was always sleeping you know. When my girlfriend used to come over I'd always be scared of her you know, because she always used to tell me that my heroin will kill me, check. I was like scared of her, and how can I be scared of somebody who loves me? If there are people who love me, they don't trust me anymore, you know, because of the heroin, so then, I had to stop you know. I had to draw a line there because I would have lost my entire life. I'd become like a Barbarian, 'cause like heroin... when I used to smoke heroin I... my face became gaunt and down. I was always sleeping you know. When my girlfriend used to come over I'd always be scared of her you know, because she always used to tell me that my heroin will kill me. I was like scared of her, and how can I be scared of somebody who loves me? If there are people who love me, they don't trust me anymore, you know, because of the heroin, so then, I had to stop you know. I had to draw a line there because I would have lost my entire life.
- Interviewer:* Thank you so much for everything, all the best.

Figure 1.1

Adam and Eve

Carte Blanche

18 August 2002

Producer: Nicola de Chaud

Presenter: Ruda Landman

Researcher: Ashleigh Hamilton



Christo Harrison: "The girl indicated and asked me for a lift. I checked them both out, they looked like decent children and I said, 'Yes why not?'"

On a Tuesday night in July last year, Christo Harrison played the Good Samaritan and picked up two young hitchhikers in Pretoria West. Little did he know who he was inviting into his car.

Christo: "I turned right into Louise Street, and felt something in my side. I looked down and saw it was a gun. I asked him what he thought he was doing."

The two would-be hijackers wrote detailed diaries recounting events of that time.

Boy (diary extract): "We tried to get a car but it didn't work. The guy with the car called the police."

Girl (diary extract): "And the police caught us. I was scared. I thought it was the end of my life."

Christo: "The expression on his face - I could see he was nervous and scared."

Ruda: "What was your impression of them?"

Christo: "Decent children, I didn't think they were capable of doing something like this."

What Christo did not know at the time was that these two were capable of far, far worse.

In fact, the story started five days earlier in a block of flats where the two youngsters - she was 15 at the time, he was 17 - ended an afternoon of sex and drugs with a bloody, gruesome murder.

Girl (diary extract): "Around 10 o'clock Saturday morning, 7th of July, my boyfriend and I went to Sunnyside to buy heroin."

Boy (diary extract): "We used it around 4 o'clock in the afternoon."

Girl (diary extract): "At 7:20 the woman came home from work. We fought."

Boy (diary extract): "She told me that she and the auntie fought and she was very upset."

Girl (diary extract): "Me and my boyfriend cleaned the flat that day and made food because I didn't feel like arguing with the woman again."

Boy (diary extract): "The auntie said I could stay over and we all watched TV. After a while the auntie fell asleep. That's when we decided to kill her."

Girl (diary extract): "We counted 1,2,3 and he started stabbing her again and again. I just sat on the couch and watched. Then

I stood up, went to the kitchen, got a knife for myself, came back and started to stab her."

Boy (diary extract): "My knife broke and I fetched another one."

Girl (diary extract): "When we finished stabbing her we threw a duvet over her, sat on our couch and smoked a cigarette."

Captain Bernice Cronje, a detective with Pretoria murder and robbery, was the first person on the scene.

Captain Bernice Cronje: "The whole flat was full of blood. They stabbed her 37 times in the back and the chest. The whole house was in a mess, because the people who did it stayed there for three days. We couldn't believe that people could kill someone and then carry on living in the flat. It was clear from the evidence that they had stayed there."

Dr Irma Labuscagne, a criminal psychologist, was intimately involved with the case.

Dr Irma Labuscagne: "It's like a television story how two children could come together, having such similar backgrounds and similar problems. Nobody would ever have thought this could have happened - you know, there must have been a trigger here or there - yes. But the process, the growing up, that's where it all started."

Irma believes that things went completely haywire for the two as they grew into adolescence. They were both latchkey kids who found solace among peers with destructive habits.

Irma: "They had lost the plot. It is an awful, downward spiral of sex, of drugs, of alcohol. I have truly never seen it as bad as with these two youngsters."

Girl (diary extract): "I started long ago with different kinds of drugs, like heroin, cocaine, rocks, dagga, acid, LSD, ecstasy. My boyfriend didn't know when we started going out."

Boy (diary extract): I asked her out on the 9th of February 2001. I was on serious drugs at that time, she didn't know but found out later. She was also on drugs. We loved each other very much. Later I saw how her family treated her like dirt and I didn't like it at all."

Girl (diary extract): "At that time the woman humiliated me in front of my friends and hers. She hit me in front of them and then laughed at me when I cried."

A distant relative says the girl lived under a constant threat of abandonment. She says the murdered woman had previously given up two other children in her care.

Relative: "It was said in so many words, 'You're not wanted - if you don't do this, if you don't do that, I'm going to give you away'."

The boy, too, lived an insecure life of constant change.

Boy (diary extract): "I was kicked out of boarding school because I was always stoned or drunk."

Irma: "The boy was expelled something like nine times - the first time in Grade 2."

Boy (diary extract): "Because my life meant nothing to me and I upset everyone, I kept thinking that no one loved me."

The one constant in the girl's life was her father. He died when she was 12 years old.

Relative: "When he died - she was absolutely mad about him, crazy about him - then she thought, 'Now there's nothing left'."

The boy and girl found an anchor in one another. They dubbed themselves "Adam and Eve". Diaries and love letters paint a picture of obsessive infatuation between them. Her journal is filled with lovesick writings typical of the first flush of teenage passion.

Irma: "It is so sad that they ever met up with each other because that became such a tragedy. But on the other hand, it was all each one of the two had. You know, they truly, truly

believed this was their salvation, one in the other."

Girl (diary extract): "It's so special, the shooting star, the feeling in my heart, meditating, everything. That same day we decided 'Adam and Eve Garden' were our names to be. I couldn't believe I finally found a guy who is the same as me, shares the same dreams, wishes, confusions, scares."

Irma: "When first you see her, she does look like a cherub - but once you work closely with her there is a hardness that upsets one."

Irma says the girl toyed with the idea of murder long before it happened. She says they tried out sizes of knives a month before they did it. On that day it took no more than a tiny push to send them over the edge.

Irma: "It was as simple as the caregiver fell asleep on the couch, they had this anger in them, they had this idea in their heads, she falls asleep, they decide to have sex in the kitchen. At the moment they were without clothes, she woke up and said, 'Bring me some tea'. And that's when they decided, 'This is it, she's in our way, she won't let us do as we please and now we're going to do it'."

The frenzied violence of the two shocked officials on the case, but more scandalous were letters left at the scene, detailing the gory aftermath of the crime.

Girl (diary extract): "Right now we are waiting for my uncle to arrive here at the flat, where the woman's body is lying. We just moved her so that nobody can see her when they look through the window."

Boy (diary extract): "The uncle was here. The dumb f**k didn't suspect anything. We ate some jelly I made last night after supper, then we made love because I was horny and had nothing else to do."

Girl (diary extract): "This adrenalin rush is not so good for my heart. I know my baby is also scared - he just sits there full of stress and mixed emotions."

For three days they stayed cooped up with the bloody body, eating and having sex, until the botched hijack led to their arrest.

Captain Guy Wheeler was the investigating officer.

Ruda: 'What was the most difficult aspect of this case?'

Captain Guy Wheeler: 'For me it was the naiveté, the fact that they didn't understand the consequences of their actions.'

Captain Bernice Cronje: "During questioning they said they were willing to get it off their chests. They both said the truth would set them free."

The young couple co-operated fully with police -10 months later the case came to court in Pretoria and they pleaded guilty to all charges.

Captain Bernice Cronje: "They are ultimately still just children. The day of the judgement, when I asked how they were doing, they said 'Auntie please hold thumbs for us'."

Irma: "They were two frightened children - that's what they were - but kept up a very brave front."

The first time the girl showed any emotion was when the judge read extracts from her diary as part of the verdict. On hearing the sentence - 20 years' imprisonment, no parole before 15 years are up - she broke down completely.

Relative: "You know what, 15 years is a long, long time."

Girl (diary extract): "I'm feeling better, and I look forward to the future when I get out of jail. In jail I will study so that I can make something of my life when I get out. And so that no one can look at me and say I am nothing."

The girl's actions have left her with no one in the world but her distant relative as support.

Relative: "She's highly gifted - she can be anything that she wants in life, and there was nobody to guide her."

Irma: "I have never felt so sad about two, in fact, beautiful children who could have had it all and the extreme tragedy of you seeing, as an adult, no hope for the future. That, to me, is so tragic."

Source: <http://www.cartelblanche.co.za>



Beata Beatrix
Dante Gabriel Rossetti
1864-1870
Tate Gallery, London

Rossetti painted this intensely spiritual picture as a memorial to his wife, who died of a Laudanum overdose in 1862. In it he expresses his love for Lizzie, whose death had left him grief-stricken. The bird is a messenger of death, carrying a poppy - a flower that induces sleep.



Figure 2.16 Thai white heroin
Source: <http://opioids.com/images/index.html>



Figure 2.17 China white heroin
Source: <http://opioids.com/images/index.html>



Figure 2.18 Black tar heroin
Source: <http://opioids.com/images/index.html>



Figure 2.19 Brown sugar heroin
Source: <http://opioids.com/images/index.html>



Figure 2.20 Opium smoker
Source: <http://opioids.com/images/index.html>



Figure 2.21 Intravenous heroin use
Source: <http://opioids.com/images/index.html>



Figure 2.22 Chasing the dragon
Source: <http://opioids.com/images/index.html>



Figure 2.23 Heroin 'works'
Source: <http://opioids.com/images/index.html>