FACTORS CONTRIBUTING TO RELAPSE OF SUBSTANCE ABUSERS POST REHABILITATION AT THE SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE, POLOKWANE, LIMPOPO, SOUTH AFRICA

by

MITJIE DAVID MOGOALE

MINI-DISSERTATION

Submitted in fulfilment of the requirements for the degree of

MASTER OF PUBLIC HEALTH

in the

FACULTY OF HEALTH SCIENCES

(School of Health Care Sciences)

at the

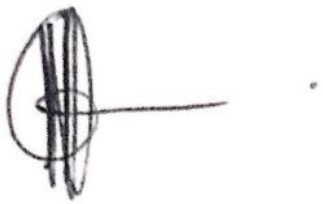
UNIVERSITY OF LIMPOPO

SUPERVISOR: Mr. MP KEKANA

2021

DECLARATION

"I declare that the mini-dissertation hereby submitted to the University of Limpopo, for the degree of Master of Public health, **"Factors Contributing To Relapse Of Substance Abusers Post Rehabilitation At The South African National Council On Alcoholism And Drug Dependence, Polokwane, Limpopo, South Africa"** has not previously been submitted by me for a degree at this university or any other university; that it is my work in design and in execution, and that all the material contained herein has been duly acknowledged".



Mogoale MD ***08 September 2021***

Signature, Name and Initials: Date:

DEDICATION

It is with genuine gratitude and warm regard that this work is completely dedicated to my respectful parents (Mr Mogoale Philemon and Mrs Mogoale Victoria); and my caring siblings / family (Mogoale Clive; Kgasago Ivy; my brother-in-law Mr Kgasago Hudson; Mogoale Juliet; Mogoale Paula; Tumelo Kgasago (nephew); Kabelo Kgasago (nephew); and my late younger brother Oscar Mogoale, may his Soul Rest In Peace) whose support continued to give me the strength I needed in difficult moments; and my supervisor (Mr MP Kekana) under whose constant guidance I have completed this dissertation and has also enlightened me with academic knowledge.

This work is also dedicated to my closest and respected individuals in my life; (Mr Shiburi MG, Mr Phihlela LE, Ms Makgahlela D, Ms Mahopo M, Khwinana KG, Ms Makwela M, Mr Mabusa T, and Mr Thosago NA), for being one of the best support system during the hardships incurred; providing all the necessary encouragement and motivation when needed.

I admire, value and appreciate you all; thank you.

ACKNOWLEDGEMENTS

I would like to express my deepest appreciation, and extend my deepest gratitude to the following:

- My supervisor, Mr MP Kekana, for his unlimited assistance and efforts; academic guidance; continued encouragement; and patience during the period of my study.
- South African National Council On Alcoholism And Drug Dependence (SANCA), Polokwane, Limpopo for granting me the opportunity and permission to conduct the study.
- All the respondents that took part in the study.
- Again, the University of Limpopo for giving me the best of opportunities to embark on this academic experience, and to further my academic studies.

ABSTRACT

PURPOSE OR OBJECTIVE: The purpose of this study was to investigate factors that contribute to the relapse of substance abusers post rehabilitation at South African National Council On Alcoholism And Drug Dependence (SANCA) Polokwane.

METHOD: A quantitative research method or approach, and a descriptive research design were employed respectively to conduct the study. Data was collected using group-administered questionnaires / surveys amongst substance abusers who relapsed post rehabilitation at the SANCA, and a total number of sixty-one (61) respondents at the centre responded to the questionnaires.

FINDINGS: Findings revealed that personal factors that predisposed the relapse of substance abusers post rehabilitation include lack of coping mechanism; less committed and motivated towards staying clean or sober; having a craving for drugs; challenged with too many triggers; lack of believe in themselves; thinking they could deal with their emotions by using drugs; thinking they could be able to control my use; community members still look down on them for using drugs; peer pressure from peer group; easily influenced by others; significant relationship in their lives ending; social group still abusing drugs; finding it difficult to avoid social gathering; lack of financial support; feeling lonely and being bored.

Findings also indicated that substance abuser receive sufficient support from their family. On the contrary, however, findings further show that respondents have indicated that they receive poor from their friends, community members, peers and the rehabilitation centre attended.

CONCLUSION: The study successfully identified, and discussed diverse causes or factors that contribute or influence relapse amongst substance abusers post rehabilitation at SANCA, as listed above. Furthermore, also assessing the availability of social support systems post rehabilitation.

Key Words: Factors, Contributing, Substance Abusers, Relapse Post Rehabilitation, and Social Support

i. DEFINITION OF CONCEPTS

a. Relapse

In this study, relapse refers to the return of drug use, after detoxification and in-patient treatment for at least six to twelve weeks; together with the marked return of behaviours associated with drug use. Upon discharge, substance abusers are once again surrounded by temptations with no support from their peers, and the struggle to stay clean and away from their addicted behaviours becomes real, and consequently resulting to return of drug use (Binswanger, Nowels, Corsi, Glanz, Booth & Steiner, 2012).

b. Substance Abusers

In this study, substance abusers are referred to as individuals that use harmful or hazardous psychoactive substances, including alcohol and illicit drugs that can lead to a dependence syndrome comprising of a strong desire to take the drug, difficulties in controlling its use, and persisting in its use despite harmful consequences. Individuals involved in this cluster of behavior are referred to as “substance abusers” (National Institute on Drug Abuse, 2014).

c. Rehabilitation

This study defines rehabilitation as the action of restoring someone to health or normal life through training and therapy after imprisonment, addiction, or illness. It is designed to assist recovery through a step-by-step process after a life changing event. It is a process of helping individuals achieve the highest level of function, independence, and possible quality of life (Oxford English Dictionary, 2011).

ii. ABBREVIATIONS

a. **CBT:** Cognitive Behavioural Therapy
b. **DSD:** Department of Social Development (Republic of South Africa)
c. **NADA:** National Anti-Drug Agency (Malaysia)
d. **NIDA:** National Institute on Drug Abuse
e. **SACENDU:** South African Community Epidemiology Network on Drug Use
f. **SANCA:** South African National Council on Alcoholism and Drug Dependence
g. **SPSS:** Statistical Package for Social Science
h. **TREC:** Turfloop Research Ethics Committee
i. **WHO:** World Health Organization

TABLE OF CONTENTS

CHAPTER 2

LITERATURE REVIEW

CHAPTER 3

RESEARCH METHODOLOGY

CHAPTER 4

PRESENTATION AND INTERPRETATION OF RESULTS

CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

FIGURES AND TABLES

CHAPTER 1

OVERVIEW OF THE RESEARCH STUDY

1.1. INTRODUCTION AND BACKGROUND

The harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs can lead to a dependence syndrome comprising of a strong desire to take the drug, difficulties in controlling its use, and persisting in its use despite harmful consequences. Individuals involved in this cluster of behaviour are referred to as “substance abusers” (National Institute on Drug Abuse, 2014). Once a substance abuser has been identified and there is willingness from the client, patient or individual, they can either voluntarily go to a treatment centre or rehabilitation centre for rehabilitation, or can be referred by a social worker, a psychologist or by a court order to the centre.

According to Binswanger, Nowels, Corsi, Glanz, Booth and Steiner (2012), the addiction rehabilitation process involves four key steps which are intake, detox, rehabilitation, and ongoing recovery. Relapse refers to the return of drug use, after detoxification and in-patient treatment for at least six to twelve weeks; together with the marked return of behaviours associated with drug use. Upon discharge, substance abusers are once again surrounded by temptations with no support from their peers, and the struggle to stay clean and away from their addicted behaviours becomes real, and consequently resulting to return of drug use.

Relapse to substance misuse is a worldwide problem that is conceptualized as an essential part of the recovery process (Appiah, Danquah, Nyarko, Ofori-Atta & Aziato, 2016; Reagon, 2016) .Hammerbacher and Lyvers (2009) state that drug abuse is an ongoing problem in Australia, despite advances in treatment, client compliance is generally poor, with relapse to problematic drug/alcohol use a common occurrence. Reasons cited by addicts for their relapses are diverse, and include depression, anxiety, positive mood, social pressure, adverse life events, work stress, and marital conflict.

According to Chie, Tam, Bonn, Dang, and Khairuddin (2016), family and peer influence are frequently emphasized in Western research on contributing factors to

substance addiction and relapse. Parental substance abuse, chaotic and unfavourable family settings, and the strength of the relational family system or relationship have all been recognized as major predictors of substance addiction. On the other hand, positive relationships and family communication regarding drug addiction have been demonstrated to be crucial protective factors.

In Malaysia, surveys of stimulant users have frequently identified peer encouragement as the primary motivator for initiating or relapsing drug use. Peers affect others' behaviour through frequent association and reinforcement, especially during the vital teenage years. Often individuals use substances due to social pressure to belong and be accepted by their peer group and to conform to group identities such hip hop, and reggae; often associated with the use of marijuana and other substances. However, such effects can be controlled by individual factors such as assertiveness, where assertiveness and substance use results often suggest that preferred stimulants and delayed patients tended to be less assertive, less socially assertive and more socially anxious than non-users. Thus, it is of the notion that people with more assertive personalities are probably better able to withstand peer pressure than others (Chie et al., 2016).

Positive/negative emotional reinforcements, sense of loss, interpersonal conflicts, peer influence, familial, religion-cultural, and treatment-related concerns all conspire to initiate and prolong the relapse cycle in Ghana, according to the research. The findings add to our understanding of Ghana's relapse problem (Appiah et al., 2016)**.** Considering South African statistics, in 2013, 22% of admissions into treatment centers were re-admissions (SACENDU, 2014). SACENDU (2021) indicated that 15% of the admissions into treatment centres in the Gauteng Province, 24% in the Northern Region (Mpumalanga and Limpopo) and 18% in Kwa Zulu-Natal are not first-time admissions. The problem of relapse is undoubtedly one of the most important challenges facing the field of addictions. A reflection is made that young African adults' communities (environments) are not conducive to recovery in South Africa, the Guateng Province. This together with intrapersonal differences make maintaining abstinence difficult for the young African adults (Swanepoel, GeyerII, & Crafford, 2015).

In line with literature and what the researcher has identified as a raising issue, it has become apparent that substance abusers are being re-admitted on a frequent basis at the South African National Council on Alcoholism and Drug Dependence (SANCA) (Polokwane) and the need for research amongst this target group was thus confirmed.

1.2. RESEARCH PROBLEM / PROBLEM STATEMENT

Having had an opportunity to work at Voortrekker District Hospital, dealing with substance abuse, the researcher identified that there was a definite relapse rate amongst individuals who previously had undergone treatment for substance abuse. After making referrals to SANCA in Polokwane and other Rehabilitation Centres, it became evident that majority of the patients relapsed from substance abuse rehabilitation post their treatment program in rehabilitation. After their release by their respective rehabilitation centre, patients would remain sober of addiction for a couple of months but would later return to their addictive ways of abusing substances after a particular period.

This matter has made it clear, in the researcher's opinion, that there was a gap or void that needed to be investigated regarding this matter, which made it clear that treatment and preventative measures were not effectively being exercised and were consequently putting the patients' health at risk. Moreover, what was not yet known was what causes the relapse of substance abusers following the treatment for substance abuse, and if there was an availability of effective after-treatment support by family members, colleagues, community members, friends, and other peers. With that said, this motivated the researcher to show interest in understanding, investigating and probing the reasons or factors that contributed to such behaviour, and again trying to find out counteractive measures that might be critical in alleviating the relapse of substance abusers post rehabilitation because research with regard to the causes of relapse in the South African context seemed to be lacking.

1.3. PURPOSE OF THE STUDY

The significance of the study was to provide findings regarding the factors that contributed to the relapse of substance abusers post rehabilitation at SANCA Polokwane. This study is educative in nature and provides insight and empowerment not only to the researcher and other researchers, but to also the centre (SANCA Polokwane), the participants of the study, and to anyone who shows interest to the

topic. Apart from that, this study also aims to provide recommendations on how to counteract or alleviate relapse of substance abusers post rehabilitation, point out burning aspects of the factors identified, and use the recommendations to assist the centre, individuals who are victims of this issue, other researchers, and anyone who shows interest to effectively try and alleviate the issue.

1.3.1 Aim of the Study

- The aim of this study was to investigate factors that contribute to the relapse of substance abusers post rehabilitation at SANCA Polokwane.

1.3.2 Objectives of the Study

Objectives of the study were:

- To identify personal factors that influence the relapse of substance abusers post rehabilitation at SANCA Polokwane.
- To determine the availability of social support systems within the community after rehabilitation.

1.4. RESEARCH QUESTION

What are the factors that contribute to the relapse of substance abusers post rehabilitation at SANCA Polokwane?

1.5. LITERATURE REVIEW

Literature relevant to the study on factors contributing to relapse of substance abusers post rehabilitation at the SANCA, was reviewed and will be discussed fully in Chapter 2.

1.6. METHODOLOGY

This account of the methodology is only a summary of what is comprehensively discussed in Chapter 3.

1.6.1. Study Site

The study was conducted at the SANCA, Polokwane Organization, Limpopo province.

1.6.2. Research design

A quantitative research method or approach, and a descriptive research design were used respectively to conduct the study.

1.6.3. Population and sampling

The target population of this study are substance abusers who have relapsed post rehabilitation that are consulting with SANCA for assistance with substance misuse rehabilitation or seeking assistance to recover from their addiction. In this regard, a purposive sampling method, complemented by a census sampling method was used to select substance abusers who have relapsed post rehabilitation (the study participants) at the SANCA; thus, this assisted in to obtaining accurate results.

1.6.4. Data collection

Data was collected using group-administered questionnaires / surveys amongst substance abusers who relapsed post rehabilitation at the SANCA.

1.6.5 Data analysis

Data was captured, interpreted and analysed using a Statistical Package for Social Science (SPSS) (version 26) in this study. Frequency tables and graphs were also used for interpretation of data.

1.7. ETHICAL CONSIDERATIONS

Ethical clearance to conduct the study was granted by Turfloop Research and Ethics Committee (TREC) on the 12th of November 2020. Permission to collect data at SANCA was granted by the Director / Manager on the 23rd of November 2020. Consent was also obtained from the participants prior to data collection.

1.8. BIAS

Bias is defined as any tendency which prevents unprejudiced consideration of a question (Delport & Roestenburg, 2011; Pietersen & Maree, 2010). Bias will be effectively discussed in chapter 3.

1.9. CONCLUSION

This chapter introduced the problem statement, the purpose and summarises the methodology of how the study was conducted. Chapter 2 will review the literature relevant to this study.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

This chapter provides a review, and an overview of the objectives of the study and the aspects of the topic that the study intends to consider. As a result, important aspects of the topic and its objectives have been reviewed extensively to help guide the researcher to reach the ultimate aim of the study and gain more insight to the study. The review of personal factors that influence the relapse of substance abusers post rehabilitation, and the availability of social support systems within the community after rehabilitation were scrutinized as they are objectives of the study and assisted in investigating the factors that contribute to the relapse of substance abusers post rehabilitation at SANCA Polokwane as they assisted the researcher in conducting the study, and effectively assisting in interpreting the findings.

It has been noted that many drug addicts relapse to drug use after being discharged from successful treatment and rehabilitation programs. Thus, it is imperative and timely to address and explore the issues that prompt relapsed addiction (Chie et al., 2016). Drug rehabilitation is the process of medical or psychotherapeutic treatment for dependency on psychoactive substances such as alcohol, prescription drugs, and street drugs such as cocaine, crystal meth, heroin, marijuana, 'Flakka', or 'nyaope'. The general intent is to enable the patient / individual / client to confront substance dependence, if present, and cease substance abuse to avoid the psychological, legal, financial, social, and physical consequences that can be caused, especially by extreme abuse (Sinha, 2011).

Drug abuse is not a new concept and there is no doubt that it is a public health problem as it has reached epidemic proportions both nationally and internationally. With the increase in drug abuse, treatment demands are also proven to be increasing. Even more so, the rate of re-admissions into treatment centres following relapse after previous in-patient treatment for drug abuse, is also on the increase (Hendershot, Witkiewitz, George & Marlatt, 2011). Global statistics on rates of relapse after substance abuse treatment are disturbingly high, averaging about 75% within a 3 to 6 month duration after treatment (Appiah, Danquah, Nyarko, Ofori-Atta & Aziato, 2016). It is much more difficult to stay away from drug misuse and drunkenness in society

than it is in an inpatient treatment program. For one thing, there is enough of support in rehab from both fellow addicts and counsellors. Second, patients are shielded from temptations and the risk of relapsing into addiction. When they are released from the rehabilitation programme, they are once again surrounded by temptations and have no support from their friends, making the effort to stay clean and away from their addictive behaviours even more difficult (Gorski, 2000).

Hendershot et al. (2011) state that entering a substance abuse treatment programme and successfully completing it is a huge accomplishment, but it certainly does not mean that your sobriety is guaranteed. Often, when an individual leaves a rehab centre they are reasonably motivated and confident about their future. However, once they return to their normal day-to-day living, they may find that addiction recovery is a bit more challenging than they thought. The truth is, addicts are at risk of relapsing back into substance abuse for weeks, months or even years after their substance abuse treatment. Therefore, some type of aftercare treatment is required, particularly during the first couple of years of recovery (Melemis, 2015).

2.2. FACTORS CONTRIBUTING TO RELAPSE AMONG DRUG ADDICTS

Family issues and peer influence are frequently mentioned in Western literature as contributing factors to substance usage and relapse. Parental substance usage, unstable and unsupportive family situations, and being raised in a single-parent or adopted home have all been recognized as important predictors of substance dependence (NADA, 2013). Similarly, peer influence is frequently cited as the leading cause of substance use initiation or relapse in Malaysian surveys of substance users. Peers affect others' behavior through frequent association and reinforcement, especially throughout the formative years of adolescence (Chie et al., 2016). Similarly, studies of substance rehab patients in Peninsular Malaysia discovered that self-confidence, social support, and family support were important protective factors against relapse (Melemis, 2015; Chie et al., 2016).

Amongst other factors that have been associated with relapsed addiction are peer pressure especially from the old friends who still use drugs. The WHO (2010) found that 50% of old friends influenced former addicts to pick up the drug taking habit after they were discharged from rehabilitation centres. The research also showed that 76% of the old friends assist rehabilitated individuals to get the needed supply of drugs.

These situations further induced the relapsed addiction amongst former addicts who have been getting rehabilitation treatments. However, Yahya and Mahmood (2002) also found that peer support could help former addicts from not getting back to the old habit and further concluded that high emotional and spiritual support will indirectly increase the addicts' self-confidence and decrease the risk towards relapsed addiction. In a statement providing insight on how to alleviate relapse of substance abusers, Gregoire and Snively (2001) reported that addicts who are discharged from rehabilitation centres and living in drug-free social environments could be linked with higher abstinence rates and low in relapse of drug use.

2.1.1. Peer Pressure as a Contributing Factor to Substance Abuse Relapse

According to Chie, Tam, Bonn, Dang and Khairuddin (2016), peer influence from old friends within the neighbourhood and workplace and family conflicts are the main external factors for relapse by substance abusers post rehabilitation. The inability to withstand drug urges after re-entering society is also a personal factor for relapse. This factor is closely associated with old peer influence. In addition, the temptation to use substances arises when individuals attempt to cope with life and societal pressures after leaving the centre. Comparisons of non-user friends, who achieved career success, married and had children, on top of work stress, and personal relationship issues are viewed as driving factors for substance relapse.

Substance relapse is exclusively attributed to two personal factors (lack of willpower and mental health difficulties). Lack of willpower is mistakenly interpreted as a lack of mental strength, leading people to believe they could easily overcome substance abuse. Thus, people who suffer from depression, which can be caused by family fights and shattered family connections, are at risk of relapsing. (Chie et al., 2016).

According to Shafiel, Hoseini, Bibak and Azmal (2014), peer pressure is powerful, and the need to fit in is a biological urge, one that is hard to ignore at every age and stage. When it comes to the use of drugs and alcohol, peer pressure can play a key role, not only in one's attitudes toward use of drugs and alcohol but also in how often they have access to dangerous substances. Also, in the absence of healthier coping mechanisms, being surrounded by people who continually turn to substance abuse as a way of relaxing or managing stress can make it more difficult to identify alternative behavioural responses.

When it is time to undergo treatment, peer groups continue to be a factor. Creating an entirely new support system is often necessary and, though difficult, is critical to long-term success in recovery. This process begins during treatment and should continue as the person transitions into independent, drug-free living (Sapkota, Khadka & Akela, 2017; Shafiel, Hoseini, Bibak & Azmal, 2014).

2.1.2. Environmental Factors as Contributing Factors to Substance Abuse Relapse

Chie et al. (2016) state that there are two environmental factors (easy substance accessibility, and parental rejection) cited as substance relapse factors. It is reported that most substance sources are peers within the neighbourhood and, thus, it is difficult to avoid the temptation to buy and use substances again. Parental rejection is also cited as a harsh reality when individuals are attempting to start new post-treatment, this leads to relapse episodes to cope with sadness and disappointment.

The environment in which someone lives contributes significantly to their perspectives in the world and the choices they make. If, for example, someone is raised with parents who routinely abuse alcohol or have drugs around the house, it is more likely that someone will have a permissive attitude toward drug use in general, both by their friends and for themselves. In the same way, if one lives in a neighbourhood where it is common for people to sit outside and drink heavily, drugs are sold on the street, or schoolmates frequently and openly use drugs and alcohol, then trying and/or using drugs and alcohol regularly may not feel like an issue – it becomes normal and something that is just done without question. Additionally, the details of use are often shaped by environment and peers as well (Sapkota, Khadka & Akela, 2017; Shafiel, Hoseini, Bibak & Azmal, 2014).

Sapkota, Khadka and Akela (2017) state that the substances that are most frequently in use among peers are likely to be the substances that are used and abused by an individual. If, in a certain neighbourhood, a high number of people use crack cocaine, for example, then it is more likely that an individual in this environment will also use this drug at higher rates. When there are certain substances that are more easily accessible than others, such as a high number of liquor stores or bars in a neighbourhood or certain drugs that are popular among different groups, then frequent exposure may decrease any taboo associated with the use of the drug and increase

the likelihood that someone will not only experiment with the substance but also use it frequently.

2.2. THE AVAILABILITY OF SOCIAL SUPPORT SYSTEMS WITHIN THE COMMUNITY AFTER REHABILITATION

According to Kathlene and Wallace (2016), peer support can be defined as the process of giving and receiving nonprofessional, nonclinical assistance from individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, and/or other drug-related problems. Peer and community support can be a very powerful and beneficial force in the recovery process for substance abusers. The benefits may include a sense of belongingness and inclusion, a sense of safety and security, reduced stress, decreased isolation and loneliness, an enhanced sense of meaning and purpose, hope and optimism about the future, and the opportunity to escape the narrow world of one's own concerns.

The process of recovery post rehabilitation is supported through relationships and social networks. This often involves family members who become the champions of their loved one’s recovery. Families of people in recovery may experience adversities that lead to increased family stress, guilt, shame, anger, fear, anxiety, loss, grief, and isolation. The concept of resilience in recovery is also vital for family members who need access to intentional supports that promote their health and well-being. The support of peers and friends is also crucial in engaging and supporting individuals in substance abuse recovery (White, 2009).

According to Sapkota, Khadka and Akela (2017), learning how to connect with others who are actively in recovery, building positive relationships with friends and family that may have fallen to the wayside during active addiction, and creating positive new connections out in the world are essential pieces of long-term recovery. This begins with learning how to get needs met healthfully in treatment, and it continues after returning home in personal therapy sessions, therapy sessions with close family members, and support group meetings. It is also a process of trial and error, and it requires a commitment to check with oneself and trusted others when making choices in relationships and getting close to other people.

2.3. CONCLUSION

This chapter has critically outlined literature relevant to the study, and has distinctively detailed literature related to the factors that contribute to the relapse of substance abusers post rehabilitation, the availability of social support systems within the community after substance rehabilitation, other aspects that relate to the objectives of the study. Chapter 3 presents the methodology that was relevant to this study to conduct the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1. INTRODUCTION

Research methodology considers and explains the logic behind research methods and techniques (Welman, Kruger & Mitchell, 2005). It has a much wider scope than research method such as opinion polls, which in turn, have a much wider scope than research techniques such as attitude scales.

3.2. RESEARCH METHOD

The research approach that was utilized in this study was a quantitative research approach. Quantitative research method or approach is defined as a research approach or method that is used to quantify the problem or data collected by generating numerical data or data that can be transformed into usable statistics. It is used to quantify attitudes, opinions, behaviours, and other defined variables, and generalizing results from a larger sample population. Quantitative research uses measurable data to formulate facts and uncover patterns in research. Quantitative data collection methods are much more structured, and use methods that include various forms of surveys (Pietersen & Maree, 2010; Babbie, 2007; De Vos, Strydom, Fouche & Delport, 2011).

The quantitative approach to the research was the most appropriate method for the implementation of this study because the study intended to determine the factors contributed to the relapse of substance abuser post rehabilitation (De Vos, Strydom, Fouche & Delport, 2011). The implementation of this study falls within this research category. This research was also descriptive in nature as it was be conducted to gain insight into the factors contributing the relapse of substance abusers post rehabilitation which relate to the South African context (De Vos, Strydom, Fouche & Delport, 2011).

3.3. RESEARCH DESIGN

Since the study is quantitative in nature, a descriptive research design was considered the most appropriate research design for this study (Pietersen & Maree, 2010). Descriptive research design presents a picture of the specific details of a situation, social setting or relationship, and focuses on “how” and “why” questions. Descriptive

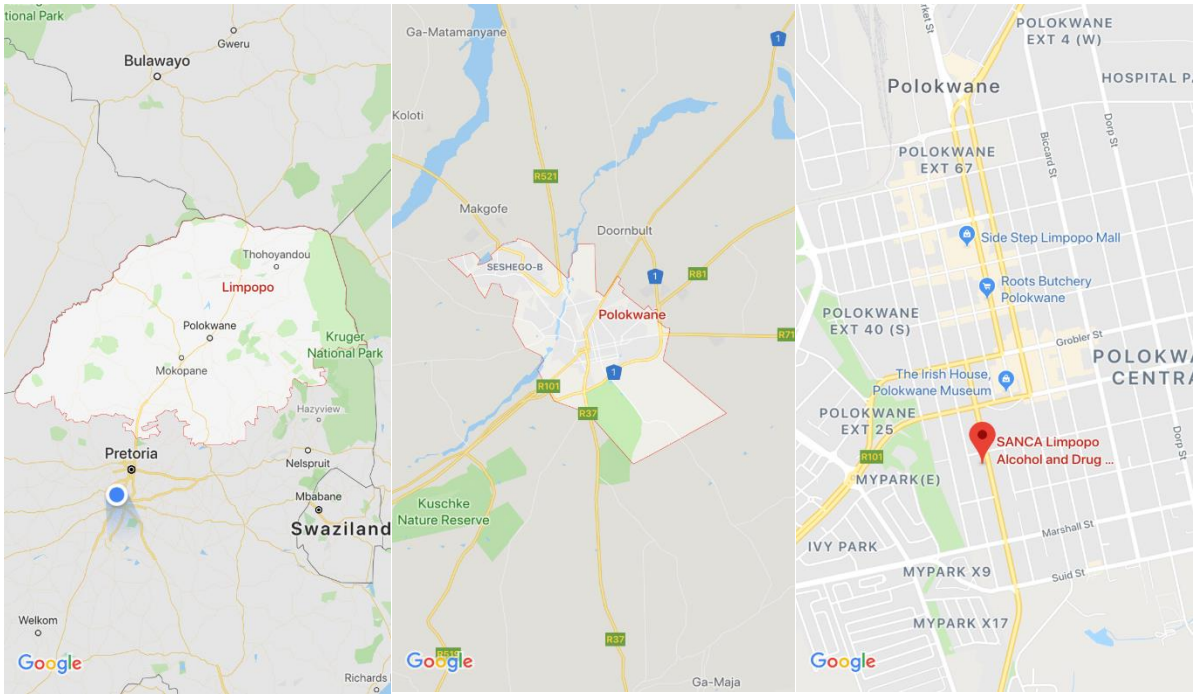
research design is a scientific method which involves observing and describing the behavior of a subject without influencing it in any way. It is a study designed to depict the participants in an accurate way; where no manipulation of variables takes place and it does not include an experimental or control group (De Vos et al., 2011). Descriptive research design is a valid method for researching specific subjects and as a precursor to more quantitative studies (Babbie, 2007). In this study, a survey was undertaken to collect quantitative data from the respondents. This collected data was used to determine the factors contributing to the relapse of substance abusers post rehabilitation (Pietersen & Maree, 2010).

3.4. STUDY SITE

This research study was conducted at the SANCA, Polokwane Organization, Limpopo province.

SANCA (South African National Council on Alcoholism and Drug Dependency) is a non-profit organization and in existence since 1969. The Centre officially opened as a rehabilitation center on 7 March 1984. Though situated in Polokwane, the organization delivers services to the whole Limpopo Province. Services are rendered on an out-patient basis, to substance abusers, their families and the community at large. SANCA Limpopo has positioned itself as a leader and specialist in the field of addiction in the Limpopo province.

3.4.1. Figure 3.1: Study Site



The above figure illustrates a map of the researcher's study site obtained from Google maps (Limpopo, Polokwane). As illustrated, SANCA Polokwane is situated in South Africa, Limpopo Province, within the city of Polokwane.

3.5. STUDY POPULATION AND SAMPLING

3.5.1. Study Population

The population that formed part of the study was from the described centre "SANCA Polokwane" of the research studies where both genders and all racial groups were taken into consideration, and individuals of all ages that are victims of substance abuse and relapse formed part of the study. The centre assists and provides counselling to 65 substance abusers who have relapsed post rehabilitation quarterly. This is the total average population of substance abusers who have relapsed post rehabilitation that the centre provides assistance to. This statistic is based on the institution's 2020 annual statistics.

3.5.2. Sampling Technique

A sample comprises elements or a subset of the population considered for actual inclusion in the study, therefore, a sample can be referred to as a small portion of the total objects, events or persons from which a representative selection is made (De Vos

et al., 2011). The study was conducted by applying the purposive sampling in the selection of respondents.

Purposive sampling was conducted with the specific purpose in mind to target respondents that meet the criteria to participate in the study. This technique is also called judgmental sampling. This type of sample is based entirely on the judgement of the researcher, in that a sample is composed of elements that contain the most characteristics, representative or typical attributes of the population that serve the purpose of the study best (De Vos et al., 2011).

3.5.3. Sampling Size

Larger samples enables researchers to draw more representative and more accurate conclusions, and to make more accurate predictions than in smaller samples, although this is more costly. The researcher was always aware that sample size can impact on the statistical tests by making it either insensitive (at small sample size) or overly sensitive (at very larger sample sizes) (De Vos et al., 2011).

The ever increasing need for a representative statistical sample in empirical research has created the demand for an effective method of determining sample size. Due to the small population size, the researcher employed a census sampling method, where he used the entire population size (N = 61) as the sample size for this study for better, and effective analysis after data has been collected. According to De Vos et al. (2011) a census method is the method of statistical enumeration where all members of the population are studies; it is an attempt to gather information about every individual in a population, and consequently this would deliver the most accurate results.

3.6. INCLUSION AND EXCLUSION CRITERIA

Inclusion criteria are characteristics that the prospective subjects must have if they are to be included in the study, while exclusion criteria are those characteristics that disqualify prospective subjects from inclusion in the study. Inclusion and exclusion criteria may include factors such as age, sex, race, ethnicity, type and stage of disease, the subject's previous treatment history, and the presence or absence (as in the case of the "healthy" or "control" subject) of other medical, psychosocial, or emotional conditions (Patino & Ferreira, 2018).

According to Patino and Ferreira (2018), inclusion and exclusion criteria are meant to ensure patients' safety during the study, provide data (justification) of subject appropriateness for the study, to minimize withdrawal (also costs) and ensure that primary end-points of study are reached.

In this study, respondents from both genders, any racial group, any ethnic group and any age group that have relapsed from substance abuse treatment or recovery treatment formed part of the study. As a results, these participants formed part of the inclusion criteria of the study that took place at SANCA Polokwane.

Individuals who did not consent to be part of the study, provide any relevant consent requirements or those that are absent from the session formed part of the exclusion criteria.

3.7. DATA COLLECTION

As a quantitative data-collection method for the purpose of this study, the researcher used group-administered questionnaire. Group administered questionnaire is a method of data collection where respondents are gathered in a group, questionnaires are handed out to each and the questionnaires are completed within the group situation.

The advantages of implementing a group-administered questionnaire in this study is that many respondents will complete the questionnaire in a short space of time and the researcher was able to immediately assist with aspects of the questionnaire which are unclear to the respondents; again, costs are saved since a whole group of respondents completes the questionnaire at the same time, they are handled simultaneously and consequently also exposed simultaneously to the same stimulus (Pietersen & Maree, 2010; De Vos et al., 2011). One limitation of group-administered questionnaires is that some respondents might experience difficulties in understanding certain questions and instructions, but might be too embarrassed to ask for clarification in the group and thus answer the question haphazardly (Delport & Roestenburg, 2011). The researcher mentioned to the group, prior to the completion of the questionnaire, that they can summon him in private to assist them.

Each respondent in the group completed his or her own questionnaire, without discussion with the other members of the group and in the presence of the researcher,

who availed himself for giving certain instructions and to clarify the uncertainties of the respondents (Delport & Roestenburg, 2011). Babbie (2007) defines a questionnaire as a document containing questions and, or other types of items designed to solicit information appropriate for analysis. A typical questionnaire will probably contain as many statements as questions, especially if the researcher in interested in determining the extent to which respondents hold a particular attitude or perspective. Its objective is to obtain facts and opinions about a phenomenon from people who are informed on the particular issue (De Vos et al., 2011).

The researcher collaborated with SANCA where he requested from the manager and supervisor (second-in-charge) to assist in organizing a group session with substance abusers who have relapsed post rehabilitation. The sample selected was divided into five groups, each with its own session that took place within three day.

The researcher has constructed the questionnaire based on literature that clearly clarified precisely what information is needed to be obtained by such questionnaire. This was determined by doing literature study (De Vos et. al., 2011). The researcher has adopted, and amended the attached questionnaire (Annexure E) from (Swanepoel, GeyerII & Crafford, 2015), and has, through consultation with his supervisor seen it as the best data collection tool for this study. And in order to obtain valid and reliable data, the researcher ensured, before implementing the study that the measurement procedure and the measurement instrument used had acceptable levels of reliability and validity (Delport & Roestenburg, 2011).

3.8. DATA ANALYSIS

In the view of the comprehensive work involved in the classification and analysis of data collected in large investigations, mechanical and electronic facilities are utilized as far as possible. In order to use the computer in the analysis of data, the questionnaire should be compiled in a certain manner, for example it should incorporate item numbers that can be used in a data set. The researcher can also divide the questionnaire into different sections in order to facilitate the eventual processing of data (De Vos et al., 2011).

After the data was collected, coding was done on the questionnaire itself, and captured on a computer as numbers, in a grid format, by making use of a spreadsheet. The data was furthermore processed with the aid of the Department of Statistics of the Health

Science Faculty of the University of Limpopo. The data in this study was analysed by making use of descriptive statistics (De Vos et al., 2011).

A Statistical Package for Social Science (SPSS) (Version 26) software was employed for data capturing, and effective analysis of collected data, not excluding the comparison of data where necessary. Furthermore, data was presented and interpreted using frequency tables and graphs.

3.9. RELIABILITY AND VALIDITY

Validity and reliability are key aspects of all research. Thorough attention to these two aspects can make the difference between good research and poor research and can help to assure that fellow researchers accept findings as credible and trustworthy.

3.9.1. Reliability

Reliability is concerned with the consistency, stability and repeatability of the respondents 'accounts as well as the researchers' ability to collect and record information accurately. It refers to the ability of a research method to yield consistently the same results over repeated testing periods. In other words, it requires that a researcher using the same or comparable methods obtained the same or comparable results every time he uses the methods on the same or comparable research respondents. It further requires that the researcher has to develop consistent responses or habits in using the method and scoring or rating its results and that factors related to subjects and testing procedures have been managed to reduce measurement error (Delport & Roestenburg, 2011; Pietersen & Maree, 2010).

Reliability of the questionnaires means that the researcher will be able to repeat it at different times or administer it to different respondents from the same population or sample (Delport & Roestenburg, 2011). The reliability of the questionnaire was based on the internal consistency of the questionnaire, seeing that a number of items will be formulated to measure a certain construct (Pietersen & Maree, 2010).

3.9.2. Validity

Validity in research is concerned with the accuracy and truthfulness of scientific findings. A valid study should demonstrate what actually exists and a valid instrument or measure should actually measure what it is supposed to measure. In other words,

validity of the questionnaire involves whether it will measure what it claims to measure (Factors contributing to relapse), and if these factors will be measured accurately. There are two types of validity, face validity and content validity. Face validity refers to the extent to which the instrument “looked” valid; and content validity of the questionnaire, refers to the extent to which it covers all the different aspects of the factors contributing to the relapse of substance abusers (Pietersen & Maree, 2010).

Face validity and content validity was established prior data collection, by presenting a provisional version to experts in the field for their comments before finishing the instrument (Delport & Roestenburg, 2011; Pietersen & Maree, 2010). Again, face validity and content validity were established prior data collection, by presenting a provisional version to the supervisor, the Postgraduate and Research Ethics Committee of the Faculty of Health Sciences, for their comments before finalizing the instrument.

3.10. BIAS

Bias is defined as any tendency which prevents unprejudiced consideration of a question. In research, bias occurs when “systematic error is introduced into sampling or testing by selecting or encouraging one outcome or answer over others”. Bias can occur at any phase of research, including study design or data collection, as well as in the process of data analysis and publication (Delport & Roestenburg, 2011; Pietersen & Maree, 2010). The following are the two types of bias that the researcher aimed to avoid during the course of the research project.

3.10.1. Selection Bias

According to Delport and Roestenburg (2011), selection bias may occur during identification of the study population. The ideal study population is clearly defined, accessible, reliable, and at increased risk to develop the outcome of interest. When a study population is identified, selection bias occurs when the criteria used to recruit and enrol patients into separate study cohorts are inherently different. In this instance, the researcher has taken careful consideration into the selection of study respondents that fall within the category of the inclusion criteria of the research study. To avoid this type of bias, respondents or the sample size originated from the same general population size of the study.

3.10.2. Information Bias

An information bias occurs during data collection. The most important type of information bias is the misclassification bias. Correct classification of individuals, and of exposures and participant characteristics, is an essential element of any study. Misclassification occurs when individuals are assigned to a different category than the one they should be in. This can lead to incorrect associations being observed between the assigned categories and the outcomes of interest. Prevention of bias from misclassification includes using the most accurate measurements available and thinking carefully about the categorization of individuals or data points into groups (Delport & Roestenburg, 2011; Pietersen & Maree, 2010).

In a nutshell, the researcher avoided both selection bias and information bias by prioritizing the inclusion criteria, validity and reliability of the research study as one of the guiding principles of the study by paying careful attention to sampling, minimizing non-response, standardization of measurements, training and quality control, and blinding (De Vos et al., 2011).

3.11. ETHICAL CONSIDERATIONS

Research should be based on mutual trust, acceptance, cooperation, promises and well accepted conventions and expectations between all parties involved in a research project (De Vos, Strydom, Fouche, & Delport, 2011). Ethics are seen as a set of moral principles, put forward by an individual or group, which is widely accepted and offers rules and behavioral expectations about most correct conduct towards those involved in the research project (De Vos et al., 2011). This study has received ethical clearance from the University of Limpopo's Faculty of Health Sciences, Research Ethics Committee. In this study, the following ethical issues were applicable:

3.11.1. Avoidance of Harm

The fundamental ethical rule of social research is that it must bring no harm to respondents (Babbie, 2007). Researchers are responsible for causing something to happen in relation to the lives of the research respondents, and they need to consider the potential risks that they may be introducing; and how researchers will take responsibility for addressing these potential risks.

Taking into consideration that the risks may be physical or psychological; the researcher must be responsible for satisfying himself that the level of risk is justified by the importance and relevance of the research study; the risk is unavoidable within the study's objectives; in absolute terms, the level of risk is minimized; respondents are fully aware of the level and nature of the risk before they agree, freely, to take part in the study; precautions are in place to deal adequately with the effect of participation (De Vos et al, 2011).

The risks may be physical, but it is more likely that they will be psychological, and associated with such things as: discussion of sensitive topics; maintenance of confidentiality; stirring painful memories; disclosure of personal information; voicing of unwelcome opinion; and discomfort and uncertainty (De Vos et al, 2011). To avoid harm to respondents and considering that relapse can be a sensitive phenomenon; the researcher provided respondents with thorough information about the study before the study embarks.

3.11.2. Voluntary Participation

The ethical principle followed by researchers is that of voluntary consent, which implies that no individual will be forced to participate in this research. It is important to avoid instances where respondents will feel obliged to participate in the study because they currently receiving treatment for substance abuse relapse, or are victims of relapse (De Vos et al, 2011). The respondents were informed beforehand that they are not obliged to participate just because they are currently receiving treatment for substance abuse relapse, or are victims of relapse.

3.11.3. Informed consent

Respondents have to be made adequately aware of the type of information the researcher wants to obtain from them, why the information is being sought, what purpose it would be put to, how they were expected to participate in the study and how it will directly and indirectly affect them. Informed consent in the form a written agreement, in English, was given to the respondents to sign in order to participate in the study after they were given relevant information regarding the research study as attached, and illustrated in annexure D. Consent was required and acquired from respondents to participate in the study, which in turn helped avoid respondents' right to self-determination being impaired. Again, the researcher strained to insure that the

respondents are competent people and are capable of signing the consent letter (De Vos et al, 2011). Furthermore, the researcher informed the respondents that the data collected from them will be archived for 15 years as in accordance with the University of Limpopo's Policy.

3.11.4. Deception of Respondents

The researcher has avoided the deception of respondents by not misleading the respondents and by not deliberately misinterpreting facts or withholding information from them (De Vos et al, 2011). The purpose of the study was clarified from the inception and there was no hidden agenda. The respondents were not misled by being offered incorrect information to ensure their participation.

3.11.5. Violation of Privacy and Confidentiality

The researcher protected the privacy of respondents by not disclosing the individual's identity after information is gathered. This took two forms, namely, anonymity and confidentiality. The respondents remained nameless, information was kept in confidence and were assured that the information will not be released in a way that does not permit linking specific responses (De Vos et al, 2011). The researcher has handled information obtained from the respondents in a confidential manner and in this way, protect their right to privacy. No identifying documents were used, only a numbering system was implemented.

Violation of privacy, the right to self-determination and confidentiality can be viewed as being synonyms. Participants should be informed of all possible limits to this principle as well as the steps that will be taken to ensure that no breach of this principle will take place (Morris, 2006).

Whoever the respondents or funder may be, it's a good idea for the ethics statement to address the key principles for research ethics. So, the researcher needs to be able to explain how he is ensuring quality and integrity of the research and the research respondents; how he will seek informed consent, how he will respect the confidentiality and anonymity of the research responders; how he will ensure that the participants will participate in the study voluntarily, how the researcher will avoid harm to their participants, moreover, the researcher needs to show that their research is independent and impartial.

The researcher wrote and submitted a research proposal to the Faculty of Health Science, Department of Public Health Senior Degrees Committee at the University of Limpopo for approval, after which, it was presented to the TREC to obtain ethical clearance (Ethical Clearance Certificate obtained on the 21/10/2020 – annexure H). Consequently, permission to conduct the study was given (Permission Letter obtained on the 23/11/2020 - annexure G).

3.12. CONCLUSION

This chapter has discussed and elaborated the methodology of the study, which included; the research method, study design, study site, the study population and sampling, the inclusion and exclusion criteria, data collection, data analysis, reliability and validity, bias and the ethical considerations. The following chapter, Chapter 4, comprises of an analysed detailed discussion relating to the collected data relevant to this study.

CHAPTER 4

PRESENTATION, INTERPRETATION AND DISCUSSION OF RESULTS

4.1. INTRODUCTION

The previous chapter outlined the research methodology used in the study. In this chapter, the results of the study are presented and interpreted from the quantitative data collected through group administered questionnaires. These results are based on the respondents' responses on the factors contributing to the relapse of substance abusers post rehabilitation. Chapter 4 is divided into three subsections namely: (1) demographic characteristics of the patients; (2) personal factors contributing to the relapse of substance abusers post rehabilitation; and (3) the availability of social support system within the community post rehabilitation.

Analysis and interpretation of the quantitative research findings will be outlined in this chapter, and where applicable, literature will be integrated with the findings and interpreted by the researcher. By integrating literature with the findings, it places the researcher's efforts into perspective, situating the topic in a larger knowledge pool (Fouche & Delport, 2011). Mccann, Burnhams, Albertyn and Bhoola (2011) state that research requires engagement with literature at each and every stage of the process.

4.2. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

A total of 61 respondents (n = 61) participated in this study, and the biographic or demographic information of respondents include gender and age. Mccann, Burnhams, Albertyn, and Bhoola (2011) found that social fragmentation, poverty and youthful populations are factors that contribute to South Africa's crime problem in general and to its drug problem in particular.

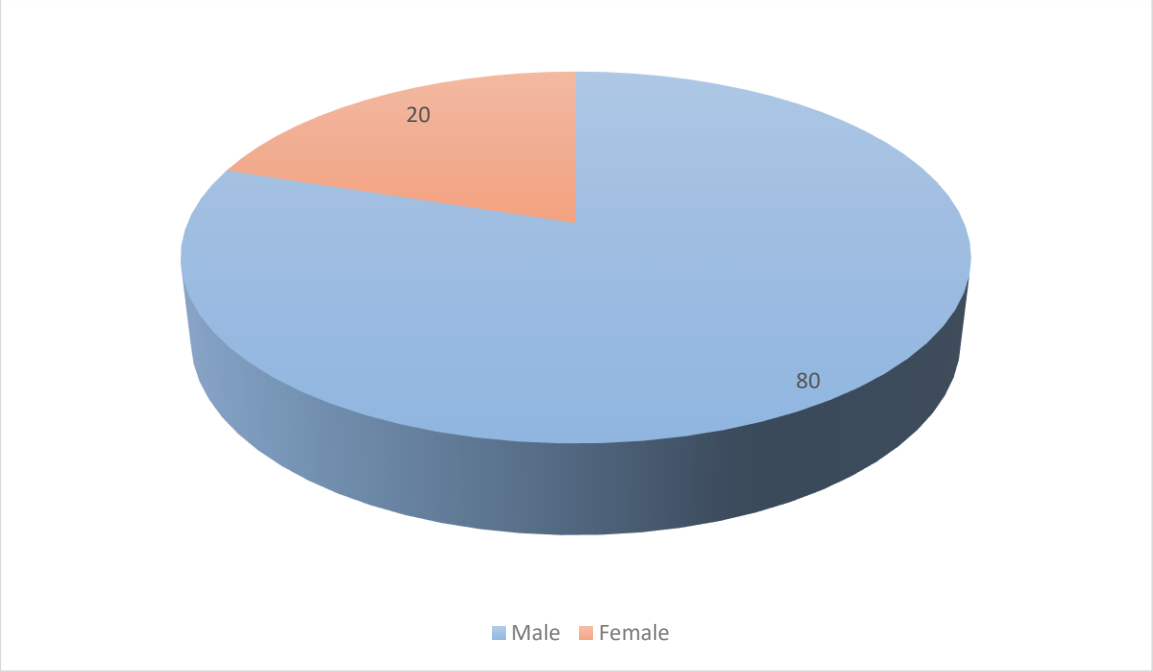


Figure 4.1: Gender Distribution

Figure 4.1 represents the distribution of gender amongst the respondents. Sixty-one (n = 61) respondents participated in the study, of which, figure 4.1 illustrates that 80% of the respondents were males, and 20 % were females. As per SACENDU (2014), in January to June 2013, 87% of admissions to treatment centres in Gauteng were male and only 13% female.

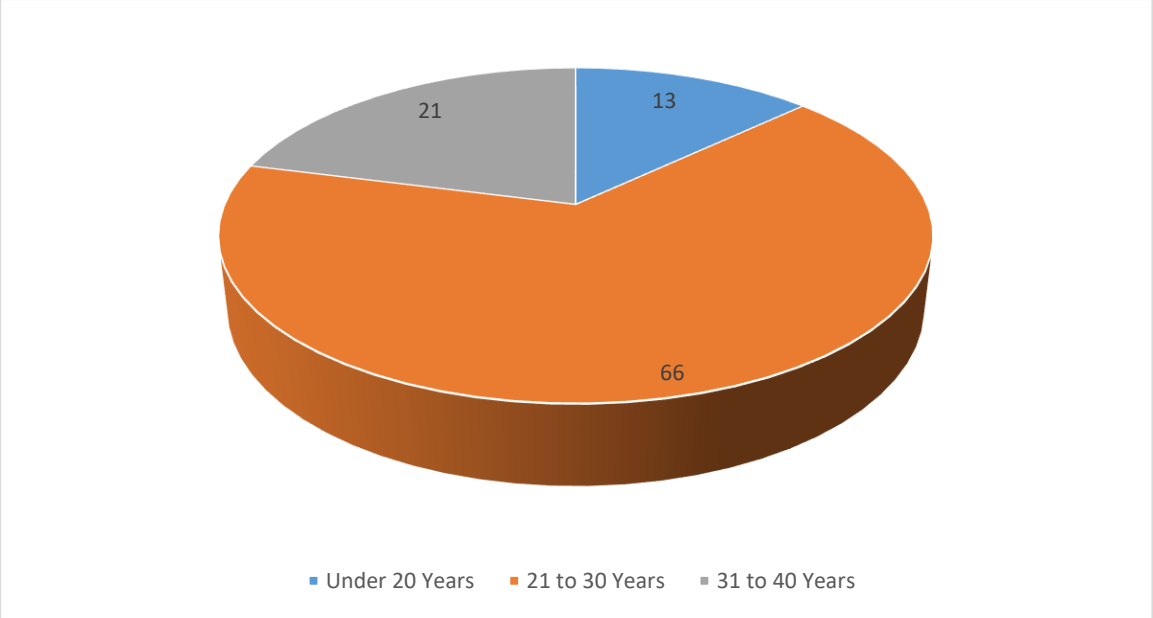


Figure 4.2: Age Distribution

Figure 4.2 illustrates the age distribution of respondents in the study, where the majority of respondents are of the ages 21 to 30 (66%), with respondents aged 31 to 40 accumulating 21% and the least percentage of 13% being that of respondents under the age 20. With that, the mean (average) age of the above data is 26.37 and the standard deviation is 4.6.

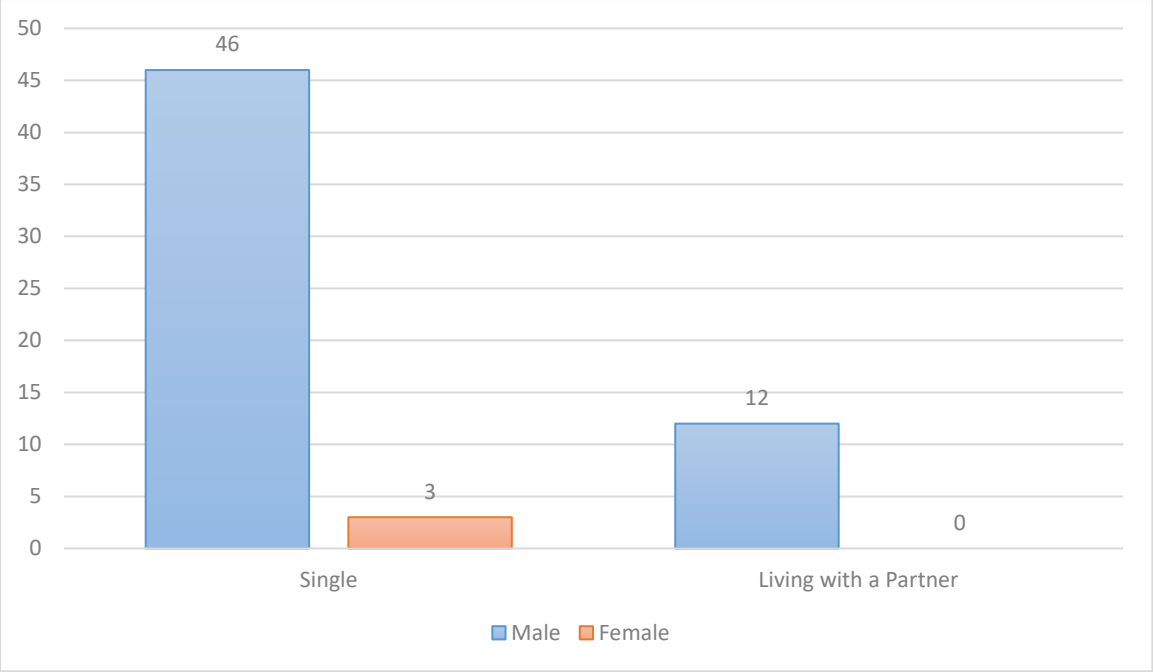


Figure 4.3: Marital Status Distribution

The above figure (figure 4.3) shows a cross illustration of gender and marital status, where of the 61 respondents a total of 95% (n = 58) are single, and only 5% (n = 3) are living with their partners. The figure further illustrates that 75 % (n = 46) of males are single, as compared to 20% (n = 12) of females, and there is only 5% (n = 3) of the males living with their partners.

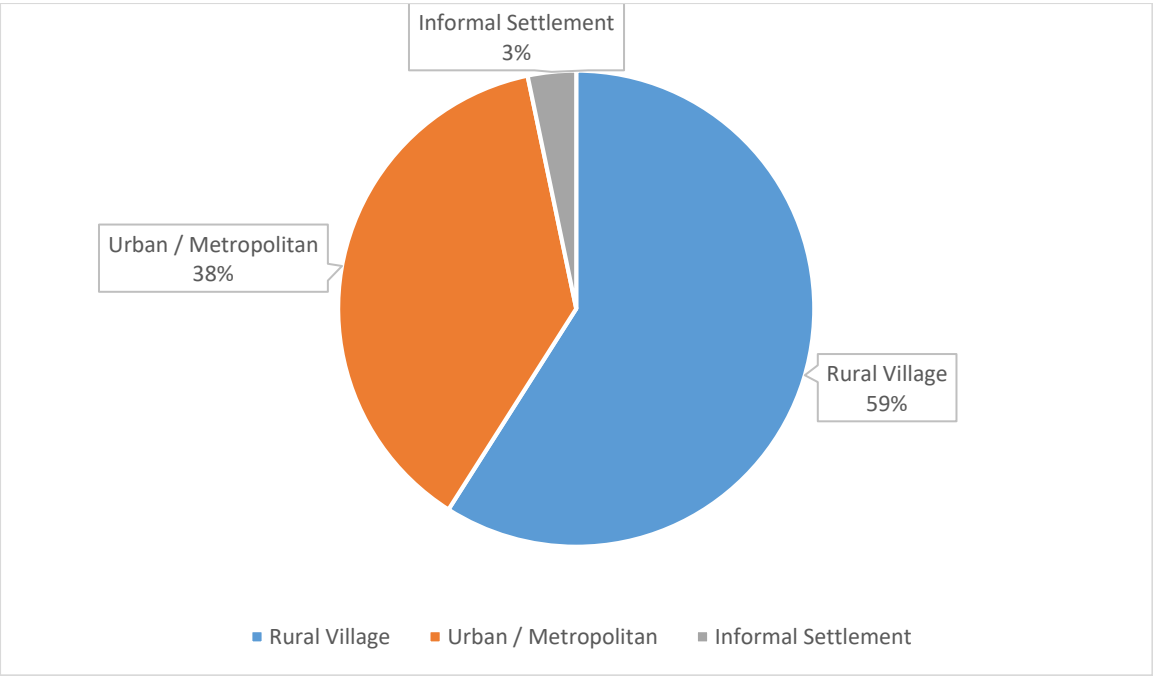


Figure 4.4: Neighbourhood Distribution

Figure 4.4 further shows that majority (59%) of the respondents reside in rural villages, as compared to 38% of those who live in urban or metropolitan areas and the 3% of those who reside in informal settlements.

4.3. PERSONAL FACTORS CONTRIBUTING TO / INFLUENCING THE RELAPSE OF SUBSTANCE ABUSERS POST REHABILITATION

The goal of this research study was to determine the factors contributing to the relapse of substance abusers post rehabilitation. Factors contributing to the relapse of substance abuser will be demonstrated in table format, and interpretation of the findings will be discussed. The researcher has reported on the column percentage for each factor, and each factor will be scrutinized and carefully discussed to their association and satisfaction or dissatisfaction of the research objective and research question. Ghosh (2013) states that in a nation already beleaguered by high rates of unemployment, poverty, HIV infection, violent crime and rape, the poor black underclass of South Africa is dealing with yet another crisis that is ravaging their communities - an epidemic of substance addiction. It should also be kept in mind that of all the respondents that participated in the study (n = 61); 80% of the respondents were males, as compared to 20% of females, with the percentages calculated in accordance to the number of respondents that participated in the study. Lastly,

interpretation to this data is carefully linked to respondents that either agreed in contrast to those who either disagreed to the factors that contributed to their relapse post rehabilitation.

Table 4.1: Personal factors contributing to the relapse of Substance Abusers Post rehabilitation

PERSONAL FACTORS INFLUENCING RELAPSE	AGREE	DISAGREE	MISSING
Lack of effective coping mechanism	39 (63.9%)	19 (31.2%)	3 (4.9%)
I started feeling less committed and motivated towards feeling sober	38 (62.3%)	20 (32.8%)	3 (4.9%)
I had a craving for drugs	37 (60.6)	21 (34.5%)	3 (4.9%)
I was challenged with too many triggers	32 (56%)	27 (44%)	2 (3.3%)
I thought I could deal with my emotions by using drugs	38 (65.3%)	20 (29.8%)	3 (4.9%)
I thought this time I would be able to control my use	41 (67%)	17 (27.9%)	3 (4.9%)
I decided not to attend aftercare support groups after my discharge	47 (77.1%)	11 (18%)	3 (4.9%)
I found it hard to avoid social gatherings (e.g. taverns, clubs, pubs)	45 (73.8%)	13 (21.3%)	3 (4.9%)
Community members still look down on me for using drugs	45 (73.8%)	13 (21.3%)	3 (4.9%)
Peer pressure from my peer group	36 (59%)	22 (36.1%)	3 (4.9%)
Peer pressure from a friend to use again	45 (73.8)	13 (21.3%)	3 (4.9%)
I am easily influenced by others	41 (67.2%)	17 (27.9%)	3 (4.9%)
I lacked support needed after treatment	42 (68.8%)	16 (26.3%)	3 (4.9%)
I felt lonely	41 (67.2%)	17 (27.9%)	3 (4.9%)
I was bored	39 (64%)	19 (31.1%)	3 (4.9%)

Table 4.1 above presents the findings on the personal factors contributing to or influencing the relapse of substance abusers post rehabilitation. Indication is shown where factors with the highest or most percentage by the respondents that indicate

the highest likelihood of factors that could contribute to their relapse. In this regard, the respondents indicated the factors that influence their relapse of substance abuse post rehabilitation, and the factors are:

- Lack of effective coping mechanism: 63.9%
- Less committed and motivated towards staying clean or sober: 62.3%
- I had a craving for drugs: 60.6%
- I was challenged with too many triggers: 56%
- I thought I could deal with my emotions by using drugs: 65.3%
- I though this time I would be able to control my use: 67.3%
- I decided not to attend aftercare support groups after discharge: 77.1%
- I found it difficult to avoid social gathering (e.g. taverns, clubs, pubs): 73.8%
- Community members still look down on me for using drugs: 73.8%
- Peer pressure from peer group: 59%
- Peer pressure from friend to use again: 73.8%
- I am easily influenced by others: 67.2%
- Lack of support needed after treatment: 68.8%
- I felt lonely: 67.2%
- I was bored: 64%

The above data provides findings for percentages of those who agreed to the presented factors that influence their relapse of substance abuse post rehabilitation, with consideration made on aspects that scored from a minimum 50% or more; consequently making those factors the prominent contributing factors to relapse post discharge.

Furthermore, the respondents view these factors as contributory aspects that influence their relapse post rehabilitation. The presented factors sum up to an average of 65.7%, where respondents either agreed to the above factors as contributory aspects that influence their relapse post rehabilitation. These findings support the below literature regarding the factors that contribute to the relapse of substance abuser post rehabilitation (and vice versa).

- *Lack of effective coping mechanism*.

There are many reasons why a person may turn to drugs or alcohol initially, including using mind-altering substances as a coping mechanism for stress, difficult emotions,

physical ailments, and other issues. Drugs and alcohol can provide a temporary respite from reality and everyday life; they can enhance pleasure and decrease inhibitions and anxiety (Melemis, 2015). Coping mechanisms are compulsions, or habits formed over time, that serve to help a person manage with situations or stress levels. A coping mechanism is a method of dealing with unhappiness, stress, or other potential issues. It is whatever a person does to handle negative emotions or problems; and addiction can be an unhealthy coping mechanism (Shevlin, Murphy, Mallett, Stringer & Murphy, 2013).

It was notable to find that 63.9% of the respondents reported that they lacked effective coping mechanisms that lead to relapse. According to the researcher if a person believes in oneself, that person would also feel capable of coping effectively in stressful situations. Torrecillas, Cobo, Delgado and Ucles (2015) further state that the goal of the individual when adopting a coping mechanism is to reduce the present of probable negative symptoms associated with the stress that is being experienced. Mericle (2014) also adds that coping responses are those strategies you utilize to get yourself through high-risk situations without a return to active addiction.

According to Kelly, O'Grady, Schwartz, Peterson, Wilson and Brown (2010) stress has long been known to increase vulnerability to addiction; it is a well-known risk factor in the development of addiction and in addiction relapse vulnerability. The term “stress” refers to processes involving perception, appraisal, and response to harmful, threatening, or challenging events or stimuli. Nikmanesh, Baluchi and Motlagh (2017) define a stressor as an event or status that occurs in one's environment that is likely to pose a threat and when experiencing a stressor, it generally requires a response so that the individual avoids negative stress-reaction symptoms.

As indicated above, most respondents expressed that they lack effective coping mechanisms, which could be in relation to stressful life events; such as interpersonal conflict, loss of relationship, death of a close family member, job loss, lack of financial means, loss of a child, etc. (Nashee, Amjad, Rafique & Naz, 2014).

In relation to stress and abstinent addicts, Harrington Cleveland and Harris (2010) suggest that recovering addicts who avoid coping with stress succumb easily to cravings for addictive substances, making them more likely to relapse during recovery seeing that cravings are a strong predictor of relapse. Harrington Cleveland and Harris

(2010) asserts that the use of drugs is the central coping mechanism for day-to-day life for addicts but it is necessary for individuals to identify specific coping mechanisms for different thoughts, feelings or moods, and situations.

- *Less committed and motivated towards staying clean or sober.*

Motivation is the extent to which an individual desires to refrain from problematic substance use (Mericle, 2014). As maintained by Nashee, Amjad, Rafique and Naz (2014), motivation may relate to the relapse process in two distinct ways, the motivation for positive behaviour change and the motivation to engage in the problematic behaviour. Harrington Cleveland and Harris (2010) found that the individual's motivation to change his or her behaviour or to return to past behaviours have been found to play an important role in successfully coping with drug-use cues. In this study, 59.3% of the respondents reported that they started to lose motivation and felt less committed to staying abstinent.

Substance abusers might lose interest in maintaining a sober lifestyle for various reasons influencing their motivation and commitment to maintaining abstinence. Some of the reasons might include the above-mentioned predisposing factors to relapse - dealing with emotions, loneliness (by using drugs they become part of a peer group which is more beneficial to them than being lonely), stigmatisation by community members (they are perceived as drug abusers even after treatment thus influencing their perception of themselves), stress and lack of effective coping mechanisms. By using drugs substance users cope with day-to-day challenges, being under the influence of drugs makes these challenges seem less threatening, in turn making the drug-abuse lifestyle seem more comfortable; as a result, might also affect motivation and commitment to maintaining abstinence.

- *I had a craving for drugs.*

Cravings are a strong predictor of relapse, and in this study; findings show that 60.6% of the respondents regard having a craving for drugs as influencing or contributing factor to their relapse post rehabilitation (Harrington Cleveland and Harris, 2010).

Melemis (2015); and Alvarez, Fabrero, Tanyag, and Orbon (2017) view a drug craving as a powerful motivational state or intense desire that drives the user to seek the substance. Harrington Cleveland and Harris (2010) state that a craving in itself is a

poor predictor of relapse, it may be triggered by drug-use cues (smells, the sight of the drug, sounds etc.) and trigger moods and memories that predispose the individual to substance use. Melemis, (2015); Alvarez, Fabrero, Tanyag, and Orbon (2017); and Harrington Cleveland and Harris (2010) give evidence that as the person's drive for immediate fulfilment grows, ongoing cravings may erode the person's commitment to abstinence; as a result, 67.3% of substance users in this study reported that they turn to drugs after rehabilitation assuming they'll be able to control their usage. Cravings are thus activated by certain environmental cues, which influence the underlying process of a craving: an individual is confronted with a trigger (high-risk situation), which is followed by thoughts of taking drugs, eventually leading to a want for drug usage. According to the study, responders may be exposed to more drug-use cues, which may lead to increased craving.

- *I was challenged with too many triggers.*

From the findings, there was a considerable high report rate of users being challenged by too many triggers (such as people, places, things, and times) and not being able to cope effectively with triggers, amongst the respondents. Where 56% of the respondents reporting that their reason for relapse is influenced by encountering too many triggers. Alvarez, Fabrero, Tanyag and Orbon (2017) found that environmental cues elevate the risk of a relapse when addicts encounter people, places or paraphernalia associated with earlier drug use. Substance abusers are faced with various environmental cues or triggers following treatment, many of which are unavoidable. During treatment service, users are provided with the necessary information, knowledge and skills to enable them effectively cope with environmental cues (Harrington, Cleveland & Harris, 2010).

Environmental cues, including the availability and access to drugs, are part of the recovering drug abuser's environment after he/she is discharged from a treatment centre. Entailing that the recovering drug abuser should cope with environmental conditions or be affected by the influences thereof (Barone, Roy, & Frederickson, 2011). If the recovering drug abuser cannot cope with environmental cues it might result in relapse. This factor can also be correlated with the predisposing influence of being unable to avoid social gathering as a contributing factor to relapse post rehabilitation as 73.8% indicated that they relapsed because they were unable to avoid social gatherings such as taverns, clubs and pubs.

- *I thought I could deal with my emotions by using drugs.*

According to Alvarez, Fabrero, Tanyag and Orbon (2017), the time an addict spends struggling with their emotions determines whether or not they would relapse.

Table 4.1 demonstrates that 65.3% of respondents indicate that they relapsed after thinking using substances can help alleviate or stop negative emotions experienced. Mericle (2014) also established that the primary problem with addicts is dealing with their emotions. They seem to be sensitive to negative emotions because they experience them as overwhelmingly painful and 'out of control', so much so they are forced to self-medicate with substances (Brooks, Lòpez, Ranucci, Krumlauf & Walle, 2017). Empirical research supports the idea that some of the most frequent high-risk situations for relapse is when negative emotions are experienced (Horvath et al., 2019b; Horvath et al., 2019a). There is a strong association between negative affect and relapse (Melemis, 2015). Shevlin, Murphy, Mallett, Stringer and Murphy, (2013) declare that the most frequent reason for relapse among drug users is a negative state of mood.

Illicit drugs are psychoactive (mood altering) and give pleasure to the consumer (Alvarez et al., 2017). By using these drugs their moods are altered and pleasure is received meaning that these people never really learn how to cope with emotions on their own seeing that they are used to depending on drugs in order to cope better with their emotions. Harrington, Cleveland and Harris (2010) confirm that drug users use drugs to modify and change troublesome emotions and supplant them with at least temporary feelings of pleasure and happiness. This is the way in which negative emotions and feelings were previously dealt with. Centre for Substance Abuse Treatment (2014) found that emotions and feelings need to be recognised and disclosed which allows the person to experience the emotion and in this way troublesome feelings can be dealt with.

- *I decided not to attend aftercare support groups after discharge.*

The decision not to attend aftercare services is a decision often made lightly by service users after treatment. In this study, (n = 47) 77.1% of the respondents see their decision to not attend aftercare as an influencing factor to their relapse post discharge.

Mericle (2014) as quoted by Melemis (2015) states that through a series of seemingly irrelevant decisions the newly recovered individuals will place themselves in a high-risk situation, possibly without being aware of more than the last decision in a chain of choices that ultimately results in a relapse. A central characteristic of mini-decisions is that they do not involve a decision to actively use chemicals, rather, these irrelevant decisions will collectively set the stage for relapse (Torrecillas, Cobo, Delgado & Ucles, 2015). Deciding not to attend aftercare services following treatment can cause a downward spiral for substance users seeing that it might give way to a chain of wrong, not well-thought through decisions. Aftercare is an essential part of the recovery process and will receive attention in the concluding chapters of this research report.

- *Community members still look down on me for using drugs.*

Drug abuse is socially unacceptable and is frowned upon even more by society because of associated behaviours such as crime and gangsterism causing anxiety amongst community members; and finding to this study show that 73.8% of the respondents illustrated that the community that they are living in still look down on them for using drugs, and that even after treatment community members still looked down on them. This feeling of being looked-down upon while trying to change affects confidence in ability to maintain abstinence and can also influence motivation and commitment to maintain abstinence.

Kelly, O'Grady, Schwartz, Peterson, Wilson and Brown (2010) define stigmatisation according to Wisconsin law as "disqualification from social acceptance, derogation, marginalization and ostracism encountered by persons who abuse alcohol or other drugs as the result of societal negative attitudes, feelings, perceptions, representations and acts of discrimination". According to Torrecillas, Cobo, Delgado, and Ucles (2015); Horvath et al. (2019b) and Horvath et al. (2019a), there is little doubt that a person who abuses a substance faces stigma in its various forms, including enacted, perceived, and self-stigma, especially during recovery. Such stigmatization can also entail social discrimination such as difficulty in obtaining employment, reduced access to housing, poor support for treatment, or interpersonal rejection.

- *Peer pressure from peer group (peer group influence)*

Alvarez et al. (2017) present peer pressure as one of the most frequent high risk situations for relapse. In the category of peer group influence the findings on whether

the social group still abuses drugs and/or alcohol, drug abuse is glamorised in the peer group and finding it difficult to avoid social gathering places such as pubs, bars, clubs and taverns are also included as they relate to social groups. In this regard, findings from this study illustrate that 59% and 73.8% of the respondents agree that peer pressure from peer group influence and friends and seen as contributing factors to their relapse in their lives.

In line with peer group influence, Melemis (2015) states that individuals in recovery have substance-using peer groups that either actively discourage sobriety, model continued drug use, or do not possess the skills to help in managing high-risk situations. Depending on the influence from one's peer group, relapse is probable if one is returning to the same drug-abusing peers as before treatment. Deliberate steps need to be taken to detach oneself from a social network that is supportive of drug use and access new social networks that support new behaviour (Mericle, 2014). The researcher perceives this as a major challenge for substance abusers, as they find it more difficult to avoid drug-using peers.

- *Lack of support needed after treatment.*

Lack of support after treatment was also one of the most highly indicated predisposing factors for relapse amongst substance abusers post rehabilitation; where 68.8% of the respondents indicating that they did not have support after rehabilitation. Poor or lack of support can directly or indirectly be a predisposing or an influencing factor to the relapse of substance abusers post rehabilitation.

Respondents indicated that they had relapsed after previous treatment because they did not have sufficient support following treatment. Support does not only imply support from family members and should be regarded as a responsibility of the recovering drug abuser to seek support after treatment. As stated by Van der Westhuizen et al. (2013), aftercare is an essential component of treatment, even though practice indicates a lack of focus on aftercare. Mericle (2014) as cited in Van der Westhuizen et al. (2013) refers to aftercare as continued support and guidance to develop a sober lifestyle and to reintegrate into society to prevent relapses.

- *I felt lonely and bored*

Loneliness and boredom were found to be predisposing factors that influenced relapse amongst the respondents, with both aspects accumulating 67.2% and 64% respectively. Definitions of loneliness include "sadness because one has no friends or company", "solitariness" and "isolation" (Oxford English Dictionary, 2011). Loneliness is defined as being "without friendship or companionship" and the feeling of being "depressed from lack of friendship or companionship", "lacking people", "unfrequented" or "deserted". All of the above definitions imply that a person will have negative emotional consequences (sadness or depressed) when there is a lack of meaningful or close relationships.

Alvarez et al. (2017) found that loneliness was one of the main contributing factors in relapse. Stickley, Koyanagi, Koposov, Schwab-Stone and Ruchkin (2014) state that loneliness can be an extremely painful and distressing phenomenon, with Shevlin, Murphy, Mallett, Stringer and Murphy (2013) agree that loneliness is an emotionally unpleasant state resulting from inadequate or poor quality social relationships. Stickley et al. (2014) state that in order to cope with, or minimise, the painful feelings that can emanate from loneliness people pursue 'alternative gratifications' which might include risky health behaviours. One of these risky health behaviours includes drug abuse. Consequently, loneliness as a contributing factor to relapse leads to boredom, which is another relating factor if not similar aspect in question.

Other findings in this study can also be related to loneliness and boredom seeing that it can contribute to the feeling of loneliness or boredom. Many respondents reported a lack of support and stigmatisation by community members - increasing the feeling of loneliness since both resemble rejection causing people to feel rejected and a lack of belonging. Respondents reported highly on peer pressure being a predisposing factor to relapse, this might be because they seek and eventually find a sense of belonging within their peer groups, compensating for the lack of belonging that they feel in their families and communities.

Considering the eco-systems perspective, it can be considered that the mesa-level (interpersonal) influences micro-level (intrapersonal) functioning, seeing that inadequacies in the mesa-level environment cause instability in the micro-environment. The findings include negative emotional states; loneliness; lack of

effective coping mechanisms; ineffective stress management; lack of assertiveness and easily influenced by others; cravings; losing motivation and feeling less committed to maintain abstinence; and decision- making. It can be concluded that if a recovery drug abuser is experiencing difficulty in adapting to the mesa-environment following treatment which might affect the individual's micro-level functioning and cause to the above-mentioned becoming risk for relapse amongst the substance users. In a nutshell, understanding these categories of relapse can enable both patients and clinicians to realise the role of their social support systems in helping them avoid drug and substance reuse.

4.4. THE AVAILABILITY OF SOCIAL SUPPORT WITHIN THE COMMUNITY POST REHABILITATION

The respondents (n = 61) were requested to indicate their availability of social support within the community post rehabilitation; and findings in this study show family support as an aspect or factor that accumulates majority of the support received by respondents as compared to other aspects that were identified. According to Melemis (2015), substance addiction is a behavioural and psychological disorder that can cause unprecedented social, mental and physiological effects. A patient’s neighbourhood, peers, family members, and spouse, play crucial roles in relapse prevention. The main disadvantage of traditional addiction treatments includes lack of focus on how an individual’s environmental factors may impact on relapse prevention (Mericle, 2014; Nashee, Amjad, Rafique & Naz, 2014). Nikmanesh, Baluchi and Motlagh (2017) further adds that drug addiction is a medical issue, which requires secondary and primary interventions.

Following the treatment for drug abuse and aftercare support services; the Department of Social Development's Substance Abuse Aftercare Programme Manual (2013) indicates that the initial period following substance abuse rehabilitation offers the greatest potential for relapse and aftercare is offered, following in-patient treatment, for continued support as the service user eases back into society.

By exploring the causes of relapse amongst substance abusers, aftercare programmes and support from families, friends, community members, peers, and those that they closely interact with can be formulated to specifically incorporate and

focus on the causes of relapse in an attempt to prevent relapse amongst abusers (Kelly, O'Grady, Schwartz, Peterson, Wilson and Brown, 2010).

Table 4.2: The availability of social support within the community post rehabilitation

AVAILABILITY OF SOCIAL SUPPORT	DISAGREE	AGREE
Family	11 (18%)	50 (82.3%)
Friends	47 (77%)	14 (23%)
Community Members	54 (88.5%)	7 (11.5%)
Peers	59 (96.7%)	2 (3.3%)
School Teachers / Lecturers	58 (95.1%)	3 (4.9%)
Colleagues	56 (91.9%)	5 (8.1%)
Aftercare support groups	57 (93.5%)	4 (6.5%)
Rehabilitation Centre Attended	43 (70.5%)	18 (29.5%)

Social support has been confirmed to be a fundamental aspect of the drug addiction recovery and relapse prevention processes (Horvath, Misra, Epner & Cooper, 2019a). Table 4.2 above illustrates that 82% of the respondents (n = 50) agree to receiving support from their close family members post rehabilitation. It is also shown that family support is the only support that they receive from the community as compared to other aspects of support that they could receive.

Horvath et al. (2019b) suggest that the family has a central role to play in the treatment of any health problem, including substance abuse. In this regard, Horvath, Misra, Epner, and Cooper (2019a) defined social support in addiction treatment as a beneficial and powerful tool. Horvath et al. (2019a) noted that social support created a sense of inclusion, security, belongingness, and safety for patients. In addition to this, a patient’s family can demonstrate support for an addict's path to recovery by offering concrete assistance, such as driving someone to a doctor’s appointment or taking care of their children as they seek professional assistance. Family members can also buy an addicted patient treatment and recovery books or help patients navigate through addiction recovery websites to enable them to understand the stages involved in their care (Center for Substance Abuse Treatment, 2014).

On the contrary, table 4.2 further shows that respondents receive poor support from influential aspects within their communities that could help them cope with substance misuse, and abstaining from the use of substances post rehabilitation as they have disagreed to receive support from friends (77.1%), community members (88.5%), peers (96.7%), school teachers (95.1%), colleagues (91.9%), aftercare support groups (93.5%) and rehabilitation centre attended (70.5%). These findings can also be correlated or linked with finding or responses detailed in paragraph 4.3 (or chapter 4, point number 4.3 of the study), where respondents indicated that they relapsed due to influence from their peers (friends), continued stigmatization from community members, and their inability to attend aftercare services as contributing factors to their relapse. These aspects can also be viewed as supporting attributes to their relapse post rehabilitation.

Brooks, Lòpez, Ranucci, Krumlauf and Walle (2017) state that social support can be a very powerful and beneficial force in the recovery process of substance users. The benefits of social support include a sense of belongingness and inclusion (from community members and friends), a sense of safety and security (from family), reduced stress, decreased isolation and loneliness (from peers and friends), an enhanced sense of meaning and purpose, hope and optimism about the future (personal attribute with continuous encouragement from family and the community at large), the opportunity to escape the narrow world of one's own concerns, and again, social support can counteract shame, isolation and secrecy (Torrecillas, Cobo, Delgado, & Ucles, 2015; Horvath et al. 2019b; Center for Substance Abuse Treatment, 2014).

Kelly et al. (2010) further indicate that social support includes the provision of various forms of help, including providing valuable information, providing necessary or desirable resources, providing concrete assistance, and providing emotional support. Torrecillas et al. (2015) argued that social support refers to a concept in which a drug addict shares his or her problems with close friends and relatives to find amicable solutions. As defined by Nikmanesh et al. (2017), social support is the strangest device to cope with chronic illness and tensions that make it humble and easy to encounter the problems. The previous findings by Kelly et al. (2010) established that effective treatment and rehabilitation rely on the quality of a patient's interpersonal relationships.

Kelly et al. (2010) noted that the degree of neighbourhood deviance might impact a patients' perceptions of the degree of support provided by their immediate family and the community at large. According to Kelly et al. (2010), communities that are characterized by higher rates of deviance; such as drug use and crime often lack the informal social control structures that are essential for maintaining public order. Community members who demonstrate a desire to maintain law and order may fear to interact with criminals and substance abusers. Communities, where crime is rampant, may lack appropriate clinical infrastructures to fight increasing drug use (Nikmanesh et al., 2017; Kelly et al., 2010; Torrecillas et al.; 2015).

Drug abuse is an enduring and chronic lifestyle disorder that presents a challenging healthcare issue. Drug addiction causes psychiatric, mental and physical impacts on communities, families and individuals (Alvarez, Fabrero, Tanyag & Orbon, 2017).

Undoubtedly, some individuals recover from addiction without social support; however, research determined that attendance in a recovery support group is associated with recovery. In fact, social support is so necessary that several approaches to addiction treatment focus on the reorganization of social support. Thus, families, friends, peers, community members, rehabilitation centre attended, aftercare support groups, and colleagues can engage addict patients in enjoyable social activities to enable them to cope with their psychological trauma and feelings of isolation. These findings indicate the need to identify the role of social factors in addiction treatment and relapse prevention, which form the primary goal of this analysis (Alvarez, Fabrero, Tanyag & Orbon, 2017; Van der Westhuizen, Alpaslan and De Jager, 2013; Center for Substance Abuse Treatment, 2014; Melemis, 2015; Horvath et al., 2019a; Horvath et al., 2019b).

With regard to aftercare and the availability of social support post rehabilitation, the Prevention of and Treatment for Substance Abuse Act 70 of 2008 defines aftercare and social support as on-going professional support to a service user after a formal treatment episode has ended to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning. According to NIDA (2012), it is important for individuals, following stays in residential treatment programmes, to remain engaged in outpatient treatment programmes and/or aftercare programmes. These programmes help to reduce the risk of relapse once a patient

leaves the residential setting. However, as described by Van der Westhuizen, Alpaslan and De Jager (2013), aftercare and social support availability appears to be a neglected area in service delivery, contributing to the high relapse potential following treatment.

4.5. CONCLUSION

Chapter 4 presented the findings of the study on the factors contributing to the relapse of substance abusers post rehabilitation at SANCA, Limpopo province. The results focused on the personal factors contributing to the relapse of substance abusers post rehabilitation, and the availability of social support system within the community post rehabilitation. The following chapter will provide a summary of the results, conclusion and recommendations based on empirical findings and limitations of the study.

CHAPTER 5
SUMMARY OF FINDINGS, CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

5.1. INTRODUCTION

In the previous chapter, the researcher provided empirical research findings through a quantitative research method. In this chapter, the researcher will indicate how the objectives were met, and subsequently answer the research question. A discussion on the findings, recommendations and limitations of the study will also be considered.

The objectives of the study were:

- To identify personal factors that influence the relapse of substance abusers post rehabilitation at SANCA Polokwane.
- To determine the availability of social support systems within the community after rehabilitation.

5.2. DEMOGRAPHICS OR BIOGRAPHICAL INFORMATION

5.2.1. Gender

As indicated in the previous chapter, a high percentage of respondents that took part of the study were males (80%) as associated to the 20% of the respondents that took part in the study. SACENDU (2014) data from specialised treatment centres suggest that the use of certain substances is still mainly a male phenomenon, and male patients continue to dominate admissions for treatment. Again, according to McCann, Burnhams, Albertyn and Bhoola (2011); and supported by literature from a study by Swanepoel, GeyerII, and Crafford (2015) several studies have found that males had higher drug prevalence rates than females; this does not necessarily indicate lower levels of usage among women, but it could indicate that women face greater hurdles and barriers to treatment.

5.2.2. Age

Furthermore, the respondents were grouped into three groups; respondents under the age of 20, respondents aged from the ages 21 to 30 and those that are aged 31 and older. From the study, majority of the respondents are within the age category of 21 to 30 years (66 %), followed by those that are aged between 31 years and older (21%)

and the least of the respondents being those that are under the age of 20 (13%). The mean or average age of the respondents was 26.37 and the standard deviation is 4.6.

During young adulthood, people are faced with various developmental tasks including demands, transitions and challenges. Most of these tasks include social role changes, development of adult identity, adolescent initiation (in African cultures), preparation for career, employment (including development towards independence), changes in social group and development of socially acceptable behaviour and establishing positions in society and socio-economic status. Consistent with the developmental stage of young adulthood, Urbanoski, Kelly, Hoeppner, and Slaymaker (2011) state that this stage of development also carries significant risk of harmful use of drugs and for the onset of substance use disorders.

5.2.3. Marital Status

The study categorized the respondents into six groups that could show their marital status (single, married, separated, divorced, widow / widower, and living with a partner). From that, finding have shown that a majority of the respondents (95%) are single, and only 5% (n = 3) are living with their partners.

5.2.4. Neighbourhood

The study has further shown that most (59%) of the respondents reside in rural villages, 38% reside in urban or metropolitan areas, and the least (3%) reside in informal settlements.

5.3. FACTORS THAT INFLUENCE THE RELAPSE OF SUBSTANCE ABUSERS POST REHABILITATION AT SANCA POLOKWANE

Supported by literature, the empirical findings presented in Chapter 4 indicate that this objective was met by presenting the following personal factors that influence or predisposed the relapse of substance abusers post rehabilitation, and they include lack of coping mechanism, less committed and motivated towards staying clean or sober, having a craving for drugs, challenged with too many triggers, lack of believe in themselves, thinking they could deal with their emotions by using drugs, thinking they could be able to control my use, community members still look down on the, for using drugs, peer pressure from peer group, easily influenced by others, significant

relationship in their lives ending, social group still abusing drugs, finding it difficult to avoid social gathering, lack of financial support, feeling lonely and being bored.

5.4. AVAILABILITY OF SOCIAL SUPPORT WITHIN THE COMMUNITY POST REHABILITATION

Interpretation of the availability of support was also indicated in chapter 4. Data collected in the study indicates that substance abuser receive ample support from family. In contrast, finding further shows that respondents have indicated that they receive poor from their friends, community members, peers and the rehabilitation centre attended.

Following the treatment for drug abuse is aftercare support services. The Department of Social Development's Substance Abuse Aftercare Programme Manual (2013) indicates that the initial period following substance abuse rehabilitation offers the greatest potential for relapse and aftercare is offered, following in-patient treatment, for continued support as the service user eases back into society. This Substance Abuse Aftercare Programme Manual stipulates that aftercare programming can vary greatly depending on the needs of the service user. By exploring the causes of relapse amongst substance abusers, aftercare programmes can be formulated to specifically incorporate and focus on the causes of relapse in an attempt to prevent relapse amongst substance abuser.

5.5. KEY FINDINGS

The key findings on the factors influencing relapse of substance abusers post rehabilitation, and the availability of social support systems are listed below:

- Respondents are faced with too many triggers after being released from treatment and interestingly also showing that they also lack coping skills to effectively cope with the triggers they are exposed to after treatment.
- The study shows that respondents are affected by peer group influence, and it is also reflected that they struggle to avoid social gathering places such as taverns, bars and clubs. They are faced with peer pressure to use again and are triggered to use drugs again by glamorising drug abuse in their peer groups. Findings also show that respondents are influenced by the thought that their

social group is still abusing drugs and/or alcohol; and adding to that; and linked to peer group influence, it is also shown that they easily influenced by others.

- Respondents have indicated, and felt that stigmatisation by the community following treatment caused them to relapse. Stigmatisation is degrading and it affects one's motivation and interest in maintaining abstinence. Indication is also shown that respondents were also affected by losing motivation and commitment to maintain abstinence. Abstinence seems to become less attractive when faced with challenges that used to be coped with by using drugs.
- Loneliness amongst respondents was highly indicative as a predisposing relapse. In conjunction with loneliness, the lack of support and stigmatisation by community members following treatment for drug abuse was significant in that they increase the feeling of loneliness. As discussed before, peer pressure was also rated highly, indicating that substance abusers might end up going back to their peer groups to find a sense of belonging which compensates for the lack of belonging they feel in their families and communities.
- When confronted with stress or certain stressors, respondents lack coping abilities. They recollect using drugs as a coping mechanism for personal concerns, which eventually led to cravings. Subsequently, cravings also being a strong predisposing factor to relapse amongst substance abusers.
- In this study, respondents reported that they experienced cravings which caused them to relapse. According to Fisher and Harrison (2012), it is not a craving in itself that predisposes relapse but rather the triggers (drug use cues) that predispose the individual to drug use. It might be that substance abusers are thus faced with more triggering factors that lead to cravings.
- The lack of; or poor commitment and motivation in maintaining abstinence was reported by respondents in this study. Abstinence might become less attractive when substance abusers are faced with challenges that were coped with in the past by using drugs.
- Respondents have reported a very high level of belief that drug use may be managed after treatment. On the contrary, the desire to be able to regulate drug usage inevitably leads to relapse.

- Despite indication that respondents receive ample support from their families, the findings further show that poor support is received from peers, friends, colleagues and the community at large.

5.6. CONCLUSION

The researcher was able to identify the causes or factors that contribute or influence relapse amongst substance abusers post rehabilitation at SANCA. The following conclusions can be made:

- Various factors, such as, peer influence, being faced with too many riggers, lack of commitment or motivation to stay sober, loneliness, usage of substances as a coping mechanism, loneliness and boredom, availability and accessibility of drugs, lack of recreational activities, limited services, and stigmatisation within the communities for substance abusers make adapting to the environments outside a treatment centre difficult.
- The increasing availability and accessibility of drugs within communities; again becoming increasingly common in the society makes it evident that substance abuser are functioning in environments that are not conducive to recovery and rehabilitation.
- Substance abuser lack basic life skills such as coping skills, self-control, self-commitment, determination, and assertiveness; which, if acquired, can help them avoid substance abuse. As a result, there is a lack of ability to manage with emotions, cues, and substance abuse triggers that are encountered.
- Supported by Swanepoel, GeyerII, and Crafford (2015); Boredom is aggravated by a lack of recreational activities and the difficulty in finding work, for example; both of which have an impact on recovery. Substance addicts usually spend more time with their peer groups due to a lack of recreational activities, culminating in drug experimentation or relapse.
- Additionally, lack of community support and stigmatization can lead to a sense of isolation or rather loneliness in this regard; making substance abusers feel less committed and driven to continue their abstinence. Thus, during recovery, commitment and motivation to maintain abstinence seem to decrease. Consequently, loneliness can lead substance abusers to seek solace or support from their drug-abusing peers once more.

- Relapse amongst substance abusers following treatment by rehabilitation centres is caused by cravings and the hope of being able to regulate or control their drug usage after treatment.
- Based on the findings, an assumption can also be made that Skills and knowledge acquired during treatment are not internalized, resulting in the skills not being implemented once the patient is discharged from treatment.
- There is a lack of attendance of aftercare support services amongst substance abusers following treatment. This lack of attendance of aftercare can be associated with a lack of motivation to attend and making the intentional decision not to attend, but also to financial constraints that prohibit them to attend aftercare.

In a nutshell, rehabilitation of people with drug abuse problems must be holistic and address not only the psychological developmental issues of the person but his or her environmental challenges as well (Van Wormer & Davis, 2013), especially seeing that substance abusers experience apparent difficulty in effectively adapting to their environments following in-patient treatment.

5.7. LIMITATION TO THE STUDY

The study was limited by the small sample size, particularly due to the drop or negative influx of clients seeking assistance from the centre. A larger sample will allow for more conclusive findings. Due to covid-19 pandemic, the SANCA facility experienced a drop in clients seen for assistance with rehabilitation, making it difficult for the researcher to work effectively, efficiently and timeously conduct the study. Getting respondents to form part of the study was also a hassle, and some did not adhere to the request to participate in the study, and others showing no interest or whatsoever to participate in the study.

5.8. RECOMMENDATIONS

Based on the above key findings and conclusions, the recommendations from this study will be made. The recommendations are made to improve professional services delivered by treatment centres and aftercare services to substance abusers post rehabilitation, making service delivery more specific, in an attempt to prevent relapse and increasing the availability of social support systems within the communities. In

addition, recommendations are made for future research. The researcher makes the following recommendations:

5.8.1. Recommendations for treatment centres to improve service delivery to substance abusers receiving treatment at SANCA

- In order to provide information on addiction and develop appropriate and effective support for service users, it is beneficial to include substance users' close peers, such as family or community members, in certain group sessions with the recovering drug addict.
- There is a need for preventative programs since peer group influence plays a large role in initial drug experimentation and relapse; and in order to avoid drug experimentation at a young age, prevention programs should be more audio-visual and include dramas and graphical pictures that the audience can relate to.
- Treatment should aim to divide service users according to their specific developmental phase (emerging adulthood, 18 to 24 years; young adulthood, 25 to 38 years; and adulthood, 39 to 60 years) in order to make treatment more specific with regard to challenges faced by different age groups, taking into account the categorization of the age groups in the study.
- Service users should be helped to acquire emotional maturity by allowing them to feel, admit, manage, and take responsibility for their feelings by social workers or other relevant specialists in substance misuse treatment. Life skills should be improved during therapy, with a particular focus on emotions, given that an inability to cope well with emotions has been linked to recurrence or relapse.
- Collaboration of diverse state departments such as the Department of Public Works (e.g. Expanded Public Works Program), the Department of Social Development, the Department Sports, Arts, and Culture, and the Department of Health, they should develop a program where service users can be absorbed into a system that aids in reintegration into society, recreational activities, and employment opportunities. Boredom can be avoided by absorbing oneself in training or labour, as well as participating in activities (such as sports, arts, and culture).

- During intervention, the researcher would recommend that social workers, health care practitioners and other relevant practitioners or professionals to do intervention from the eco-systems perspective and the adaptation model. It will assist the service user by understanding that his/her environment outside of the treatment did not necessarily change but that he/she should have changed and should use the knowledge and skills gained during treatment to prevent relapse. American Psychiatric Association (2013) states that the rehabilitation of people with substance abuse problems must be holistic and address not only the psychological developmental issues of the person but his or her environmental challenges as well. Referral social workers should aim to address challenges in the communities, such as stigmatisation through macro-interventions, and referral to resources with regard to services.

Respondents indicated notable aspects regarding the diverse causes of relapse as presented in the study. Treatment programmes can be more specific for service users to benefit more from treatment by including the research findings in the treatment programmes. The following are some possible measures or standards for substance abusers' treatment programs that could be incorporated into present treatment programs:

- Identifying environmental cues and techniques to deal with them to minimize recurring cravings;
- Appropriate methods for dealing with urges;
- Training in assertiveness and drug-refusal abilities;
- Encouraging and empowering substance users that other than going to pubs, bars, and clubs, there are other methods to socialize.
- Encourage people to think of new ways to avoid loneliness and boredom in order to make better use of their free time.
- Raise community understanding about stigmatization and how to deal with it.
- Information on community-based skill-building programs and support services, as well as emotional awareness initiatives should also be considered in this regard.
- Advise against controlled drug use and focus on measures to manage motivation and commitment to maintain abstinence
- Benefits and importance of attending aftercare services

It does not appear that service users are internalizing the information and skills they are given during therapy, which prevents successful application after release. Because it allows people to practically focus on day-to-day living difficulties, Cognitive Behavioural Therapy (CBT) can be explained and utilized to lead therapy. In accordance with American Psychiatric Association (2013) CBT can assist with the understanding of behaviour as being a result of behavioural conditioning, combined with the thinking processes. Faulty thinking can make unacceptable behaviour more likely to occur. CBT consists of the acquisition and performance of coping skills used to manage high risks for substance abuse situations, and to enhance the service user's confidence in his or her ability to stay abstinent (McCann, Burnhams, Albertyn & Bhoola, 2011).

5.8.2. Recommendations for aftercare (and reintegration) support services

- The researcher recommends that the Department of Social Development, SANCA, other stakeholders, and rehabilitation centres must be more thorough in monitoring aftercare services seeing that this service was indicated as being underutilised. Aftercare services should be trained to social workers and other relevant experts in the field of substance misuse, and a referral framework for service users should be built to ensure that aftercare services are used. Moreover, it is critical that they're well-equipped for the job of providing aftercare services.
- The development of coping skills and basic life skills such as stress management, assertiveness, effective emotion regulation, and problem-solving should all be part of the aftercare program.
- To develop support, the family and community should be requested to participate in aftercare services; and to reduce idle time and boredom, aftercare programs should offer a variety of leisure activities to service users.
- Barriers that contribute to the non-attendance of aftercare should be addressed by SANCA and other service delivery institutions in order to promote attendance amongst service users.

5.8.3. Recommendations for future research

- There is a need for research amongst social workers, healthcare workers and other stakeholders that are involved in substance abuse treatment, with regard

to reluctance in providing aftercare services in the communities. By identifying the factors or barriers that hinder aftercare from happening the way it is proposed, the ignorance, or logistical problems, with regard to aftercare can be addressed.

- The aim of substance abuse treatment is to assist the service user in relapse prevention. The effects of including skills development programmes in substance abuse programmes should be researched to explore whether skills development might improve treatment outcomes.
- There is a need to identify the factors that hinder efficient family support to recovering drug abusers in order for these factors to be addressed and in turn improve family support.
- Further research is also recommended on the factors that contribute or influence the relapse of substance abusers post rehabilitation by health scientists, social scientist and researchers in general.

REFERENCES

Alvarez, S. A., Fabrero, E., Tanyag, N., & Orbon, M. (2017). Determinants of risk of relapse among drug surrenderees. Abstract Proceedings International Scholars Conference, 5(1), 4. doi:10.35974/isc.v5i1.1584

American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (DSM- V). Washington, DC: APA.

Appiah, R., Danquah, S.A., Nyarko, K., Ofori-Atta A.L., & Aziato, L. (2016). *Precipitants of Substance Abuse Relapse in Ghana: A Qualitative Exploration*. Available: https://doi.org/10.1177/0022042616678612

Babbie, E. (2007). *The practice of Social Research*. 11th Edition. Belmount: Thomson Wadsworth.

Barone, S.H., Roy, C.L. & Frederickson, K.C. (2011). Instruments used in Roy Adaptation Model-Based Research: review, critique, and future directions. Nursing Science Quarterly, 21(4):353-362

Binswanger, I. A., Nowels, C., Corsi, K. F., Glanz, J., Long, J., Booth, R. E. & Steiner, J. F. (2012). *Return to drug use and overdose after release from prison: a qualitative study of risk and protective factors.* Addiction Science & Clinical Practice, 7(1), 3. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3414824/

Brooks, A. T., Lòpez, M. M., Ranucci, A., Krumlauf, M., & Wallen, G. R. (2017). A qualitative exploration of social support during treatment for severe alcohol use disorder and recovery. Addictive Behaviors Reports, 6, 76-82.

Center for Substance Abuse Treatment. (2014). Substance abuse treatment and family therapy. In Treatment Improvement Protocol (TIP). Retrieved From https://www.ncbi.nlm.nih.gov/books/NBK64269/

Chie, Q.T, Tam, C.L, Bonn, G., Dang, H.M. and Khairuddin R. (2016). *Substance Abuse, Relapse, and Treatment Program Evaluation in Malaysia: Perspective of Rehab Patients and Staff Using the Mixed Method Approach.* Front Psychology. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4881619/

De Vos, A.S., Strydom, H., Fouche, C.D., & Delport, C.S.L. (2011). *Research at Grassroots: For the Social Sciences and Human Profession.* 4th edition. Pretoria: Van Schaik publisher.

Department of Social Development. (2013). Substance abuse aftercare programme manual. Pretoria: Government Printers.

Delport, C.S.L. & Roestenbur, W.J.H. (2011). Quantitative Data Collection Methods: Questionnaires, Checklists, Structured Observation and Structured Interview Schedules.2nd ed.

Fisher, G.L. & Harrison, T.C. (2012). Substance Abuse: Information for School Counsellors, Social Workers, Therapists and Counsellors. 5th ed. Boston: Pearson Education Inc.

Fouche, C.B. & Delport, C.S.L. (2011). In depth review of literature. In De Vos, A.S. (Ed.), Strydom, H., Fouche, C.B. & Delport, C.S.L. Research at Grass Roots for the social sciences and human seNice professions. 4th ed. Pretoria: Van Schaik Publishers.

Ghosh, P. (2013). Nyaope: Cheap Drug Cocktail Ravaging Black Townships of South Africa. International Business Times, 20 September. Available: www.ibtimes.com/nyaope-cheap-drug-coctail-ravaging-black-townships.com (Accessed on 25/07/2014).

Gorski, T.T. (2000). The CENAPS model of relapse prevention therapy (CMRPT). In National Institute on Drug Abuse. Approaches to Drug Abuse Counselling. Available: http://www.disintossicazionedranet.org/lineeguidaligu_pdf/approa_co.pdf#page=21

Gregoire, T. K., & Snively, C. A. (2001). *The relationship of social support and economic self-sufficiency to substance abuse outcomes in a long term recovery program for women.* Journal of Drug Education, 31(3), 221–237.

Hammerbacher, M. & Lyvers, M. (2009*). Factors associated with relapse among clients in Australian substance disorder treatment facilities*. 387-394.

Harrington Cleveland, H. & Harris, K.S. (2010). The role of coping in moderating within-day associations between negative triggers and substance use cravings: A daily diary investigation. Addictive Behaviors, 35(1): 60.

Hendershot, C.S., Witkiewitz, K., George, W.H. & Marlatt, G.A. (2011). *Relapse prevention for addictive behaviors. Substance Abuse Treatment, Prevention, and Policy.* 6.17.

Horvath, T., Misra, K., Epner, A., & Cooper, G. M. (2019a). Recovery from addiction: Social support. Retrieved from https://www.centersite.net

Horvath et al., (2019b). The social support approach to addictions recovery: Recovery support groups. Retrieved from https://www.gulfbend.org

Kathlene and Wallace (2016). *Benefits of peer support groups in the treatment of addiction.* Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5047716/

Kelly, S. M., O'Grady, K. E., Schwartz, R. P., Peterson, J. A., Wilson, M. E., & Brown, B. S. (2010). The relationship of social support to treatment entry and engagement: The community assessment inventory. Substance Abuse, 31(1), 43–52. doi:10.1080/08897070903442640

Krejcie, R.V., & Morgan, D.W., (1970). *Determining Sample Size for Research Activities. Educational and Psychological Measurement*.

Mccann, M., Burnhams, N.H., Albertyn, C. & Bhoola, U. (2011). Alcohol, drugs and employment. 2nd ed. Claremont: Juta & Co Ltd.

Melemis, S.M. (2015). Relapse Prevention and the Five Rules of Recovery. *The Yale Journal of Biology and Medicine*. 88(3). 325–332.

Mericle, A., (2014). The role of social networks in recovery from alcohol and drug abuse. The American Journal of Drug and Alcohol Abuse, 40(3), 179-180.

Morris, T. (2006). *Social Work Research Methods: Four Alternative Paradigms.* London: SAGE.

NADA – National Anti-Drug Agency (Malaysia). (2013). *Kajang, Selangor: Ministry of Home Affairs, Policy, Planning and Research Department*. Available from: http://www.adk.gov.my/html/laporandadah/2013/Laporan%20Dadah%20Bulan%20Disember%202013.pdf

Nashee, Q., Amjad, N., Rafique, R, & Naz, A. (2014). Perceive social support and relapse proneness in persons with substance use disorders. Journal of Addiction Research and Therapy, 5(3), 111-20

National Institute on Drug Abuse. (2014). Drugs, Brains, and Behavior: The Science of Addiction – Treatment and Recovery. Available: https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery

Nikmanesh, Z., Baluchi, M. H., & Motlagh, A. A. P. (2017). The role of self-efficacy beliefs and social support on the prediction of addiction relapse. International Journal of High-Risk Behaviors and Addiction, 6(1), e21209.

Oxford English Dictionary. (2011). 9th Edition. New York: Oxford University Press.

Patino, C.M. and Ferreira J.C. (2018). Inclusion and exclusion criteria in research studies: definitions and why they matter. J Bras Pneumol. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6044655/

Pietersen, J. & Maree, K. (2010). *Standardisation ofa Questionnaire.* Pretoria: VanSchaik Publishers.

Reagon, T. (2016). *Latest Drug Statistics – South Africa 2016.* Available: https://christiandrugsupport.wordpress.com/2016/04/21/latest-drug-statistics-south-africa-2016/

Sapkota, S., Khadka, A., & Akela, G. (2017). *Contributing factors to relapse of drug addiction among clients attending rehabilitation centres of Dharan, Nepal*. Journal of Chitwan Medical College, 6(3), 20-25. https://doi.org/10.3126/jcmc.v6i3.16695

Shafiel, E., Hoseini, A.F., Bibak, A. & Azmal, M. (2014). *High risk situations predicting relapse in self-referred addicts to Bushehr province substance abuse treatment centers.* International Journal of High Risk Behaviors & Addiction, 3(2).

Shevlin, M., Murphy, S., Mallett, J., Stringer, M. & Murphy, J. (2013). Adolescent loneliness and psychiatric morbidity in Northern Ireland. British Journal of Clinical Psychology, 52:230-234.

Sinha, R. (2011). *New findings on biological factors predicting addiction relapse vulnerability*. Current Psychiatry Reports. 13(5). 398–405.

South African Community Epidemiology Network on Drug Use (SACENDU). (2021). Monitoring alcohol and drug abuse treatment admissions in South Africa: June 2014 - July 2020 (Phase 48). Available: https://www.samrc.ac.za/intramural-research-units/atod-sacendu

South African Community Epidemiology Network on Drug Use (SACENDU). (2014). Monitoring alcohol and drug abuse treatment admissions in South Africa: July 1996 - June 2013 (Phase 34). Available: http://www.sahealthinfo.orq/admodule/sacendu.html. (Accessed 2014/06/06).

South African Community Epidemiology Network on Drug Use (SACENDU). (2008). *Monitoring Alcohol and Drug abuse treatment adminssions in South Africa: January to June 2008 (Phase 24).*

Stickley, A., Koyanagi, A., Koposov, R, Schwab-Stone, M. & Ruchkin, V. (2014). Loneliness and health risk behaviours among Russian and U.S. adolescents: a cross-sectional study. BMC Public Health, 14: 366-387.

Swanepoel, I., GeyerII, S., Crafford, G. (2015). *The causes of relapse amongst young African adults following in-patient treatment for drug abuse in the Gauteng Province*. Available: http://hdl.handle.net/2263/46180

The South African Health News Service (2013). *Government switches strategy on drugs.* Available: health-e.org.za/2013/10/16/government-switches-strategy-drugs/

Torrecillas, F.L., Cobo, M.A.T., Delgado, P., Ucles, I.R. (2015). Predictive Capacity of Self-Efficacy in Drug Dependence and Substance Abuse Treatment. J Psychol Clin Psychiatry 2(3): 00073. Available: 10.15406/jpcpy.2015.02.00073

Urbanoski, K.A., Kelly, J.F., Hoeppner, B.B. & Slaymaker, V. (2011). The role of therapeutic alliance in substance use disorder treatment for young adults. Journal of substance abuse treatment, 42(1):1-8.

Van Westhuizen, M., Alpaslan, A.H. & De Jager, M. (2013). Aftercare to chemically addicted adolescents: An exploration of their needs. Health SA Gesondheid, 18(1):1-11.

Van Wormer, K. & Davis, D.R. (2013). Addiction treatment: A strengths perspective. 3rd ed. Belmont: Brooks/Cole Cengage Learning.

Welman, K.G., Kruger, M., & Mitchell, C. (2005). *Research Methodology*. Cape Town: Oxford University Press.

White, W.L. (2009). *Peer-Based Addiction Recovery Support: History, Theory, Practice, and Scientific Evaluation*. Chicago, IL: Great Lakes Addiction Technology.

World Health Organization (WHO). (2010). *Atlas on substance use (2010): Resources for the prevention and treatment of substance use disorders*. Geneva: World Health Organization

Yahya, D., & Mahmood, N.M. (2002). Penagihan Dadah & Perlakuan Jenayah: The Influence of Psychological Factors and institutions. Psychology Journal Malaysia. July 2002. Bil.16: ISSN 0127-8029.

6. ANNEXURES

ANNEXURE A: PERMISSION TO COLLECT DATA

PERMISSION LETTER REQUESTING TO CONDUCT RESEARCH AT SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (SANCA), POLOKWANE.

Researcher: MOGOALE MITJIE DAVID

Tel. Number: 071 205 1765 / 061 490 9797

E-mail Address: mitjiedavid@gmail.com

Date: ……

For Attention: ……...

RE: Research on the factors contributing to the relapse of substance abusers post rehabilitation at South African National Council on Alcoholism and Drug Dependence (SANCA) Polokwane.

I, Mogoale Mitjie David, am a Social Worker by profession, registered with SACSSP (10-40535) and I'm currently enrolled with the University of Limpopo as a full time student studying Master of Public Health (MPH) (Second year) at the Faculty of Health Sciences, School of Health Care Sciences, Department of Public Health. In fulfilment of the partial requirements for the Master's degree, the researcher has to undertake a research project and have consequently identified a need to investigate the following research topic: Factors contributing to the relapse of substance abusers post rehabilitation at South African National Council on Alcoholism and Drug Dependency (SANCA) Polokwane. The goal or aim of this study is to investigate the factors that contribute to the relapse of substance abusers post rehabilitation at SANCA Polokwane. This research project originated as a result of a gap or void that needs

investigating regarding the relapse of substance abusers post rehabilitation, and the factors that may cause the relapse of substance abusers post rehabilitation.

The information gathered can be used to formulate guidelines for relapse prevention programmes, aftercare programmes and other recommendations which are more applicable within the South African context regarding substance abuse, and relapse post rehabilitation. A copy of the researcher's research proposal will also accompany this letter in order to familiarize you with the proposed research study.

The researcher humbly requests the rehabilitation/treatment centre's permission to conduct research with its clients/patients because they are the best knowledgeable to speak assertively about the topic. With that said, the researcher hereby requests the centre to allow access to its clients/patients, in this study. The decision to participate in this research project is voluntary and clients/patients that qualify to participate in this study based on the criteria will be expected to complete a questionnaire. Individuals that the researcher would like to include as part of this research project should comply with the following inclusion criteria: Respondents from both genders, any racial group, any ethnic group and any age group and that have relapsed from substance abuse treatment or recovery treatment will form part of the study, moreover, Individuals who do not consent to be part of the study, provide any relevant consent requires or those that are absent from the session will form part of the exclusion criteria. There are no risks and benefits involved by participating in this research project (study).

Should the centre agree to participate, the clients/patients would be requested to participate in answering a questionnaire. The questionnaire will be kept confidential. Neither, the client/patient's name, nor the institution's name will appear on the questionnaire, so as to protect identity. The questionnaires will be stored in a safe place and only the researcher will have access to them. The questionnaires will be made available to the researcher's promoter (Supervisor), and statistics with the sole purpose of assessing and guiding the researcher with data capturing and statistical analysis.

The questionnaire will not take more than 30 minutes to complete, and the researcher will be available while the clients/patients answer the questionnaire to assist with any queries. The proposed date for the commencement or undertaking of the questionnaire or data collection will be when the researcher has received ethical

clearance to conduct the research study by the Turfloop Research Ethics Committee (TREC). Once confirmation is received, data will be collected within a time frame of two months. This will be confirmed with the centre well in advance.

If the centre is willing to allow its clients/patients to be involved in this study please sign the form below that acknowledges that you have read the explanatory statement, that you understand the nature of the study being conducted, and that you give permission for the research to be conducted at your rehabilitation/treatment centre.

Based upon all the information provided to you above, the researcher would like to ask for your assistance to introduce me to your clients/patients who comply with the criteria for inclusion stated above in view of participation in this study.

For any questions or concerns about the study, feel free to contact the researcher at the following numbers and email address: 071 205 1764/061 490 9797 or mitjiedavid@gmail.com

Thank you,

Mogoale MD

ANNEXURE B: PERMISSION LETTER TO CONDUCT RESEARCH

STUDY AT SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (SANCA), POLOKWANE

I (Name: ……..) as (Role/Title :……..) of (Rehabilitation Centre Name :……..) having fully been informed as to the nature of the research study, give my permission for the study to be conducted. I reserve the right to withdraw this permission at any time.

STAMP:

Signature: …….

Date: ……..

ANNEXURE C: RESEARCH BUDGET

Detailed Research Budget for 2019/2020: The table below provides some items for the researcher's guidance in preparation for the research budget.

	Unit	Rate	Total	Comments
RESEARCH				
ESTIMATED BUDGET FOR DATA COLLECTION				
Accommodation During Data collection	**0**	**R0.00**	**R0.00**	**The researcher does not need accommodation during data collection.**
Transport (Taxi Fare/Petrol Money)	**1**		**R5000.00**	**Transport fare or petrol money, to and from the research site.**
Stationary, writing pads, pens, printing units for questionnaires.	**1**		**R3000.00**	**Stationary to be used for data collection purposes.**
Research Assistants Remuneration (Data Collection and Transcription)	**0**	**R0.00**	**R0.00**	**The researcher does not intend to use any research assistants for the research Study.**
ADMINISTRATION: (School fees 2019 - 2021 as indicated on the proof of registration)				
Master of Public Health (Post Graduate)	**1**		**R6270.00**	
Administration Fee	**1**		**R1780.00**	
SRC Levy	**1**		**R560.00**	
Total			**R29 150.00**	

ANNEXURE D: CONSENT FORM

CONSENT FORM

PART A:
INFORMED CONSENT

PARTICIPANT/CAREGIVER CONSENT FORM

(For each participant/caregiver, please read and understand the document before signing)

1. RESEARCH TITLE

FACTORS CONTRIBUTING TO THE RELAPSE OF SUBSTANCE ABUSERS POST REHABILITATION AT SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (SANCA), POLOKWANE, LIMPOPO PROVINCE, SOUTH AFRICA

2. INTRODUCTION

This is an invitation to participate in the study as a volunteer. This is to help you decide if you would like to participate and should there be any questions please feel free to ask the researcher.

3. The purpose of the study

The significance of the study is to provide findings regarding the factors that contribute to the relapse of substance abusers post rehabilitation at SANCA Polokwane. Objectives of the study that are available to achieve the aim of the study include identifying personal factors that influence the relapse of substance abusers post rehabilitation at SANCA Polokwane, and determining the availability of social support systems within the community after rehabilitation. This study will be educative in nature, and it will provide insight and empowerment not only to the researcher and other researchers, but to also the centre (SANCA Polokwane), the participants of the study, and to anyone who shows interest to the topic. Apart from that, this study also aims to provide recommendations on how to counteract or alleviate relapse of substance abusers post rehabilitation, point out burning aspects of the factors

identified, and use the recommendations to assist the centre, individuals who are victims of this issue, other researchers, and anyone who shows interest to effectively try and alleviate the issue.

Moreover, the information gathered can be used to formulate guidelines for relapse prevention programmes, aftercare programmes and other recommendations which are more applicable within the South African context regarding substance abuse, and relapse post rehabilitation.

The required sample size for this study is 92. Therefore, the researcher aims to have a total number of 92 respondents participating in the study.

Before the study you will need to complete:

- This consent form and
- Short biographical information request

During the study, you are free to withdraw from the study without giving a reason, and that participation is voluntary.

- The aim of the study is to investigate the factors that contribute to the relapse of substance abusers post rehabilitation at SANCA Polokwane.
- The study will take six months to complete upon approval of the Turfloop Research Committee, and SANCA for the collection of data (Researcher aims to take two months for the collection of data at the institution).

4. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study will commence upon approval from the Turfloop Research Ethics Committee, and the South African National Council on Alcoholism and Drug Dependence (SANCA), Polokwane, Limpopo.

5. RIGHTS OF PARTICIPANTS OF THE STUDY

Participation is voluntary and you have a right to refuse participation in the study. Refusal to participate will not in any way influence any future relationships with the University or the interviewer.

6. ARE THERE ANY RISKS

There are no risks attached.

7. DISCONTINUATION OF PARTICIPANTS IN THE STUDY

No pressure will be exerted on the participant to consent to participate in the study and the participant may withdraw at any stage without penalization.

8. ANY FINANCIAL ARRANGEMENTS

There are no financial resources that participants can benefit from the study, and the researcher is not going to receive any incentives.

9. CONFIDENTIALITY

All information provided to the research team will be treated as confidential.

PART B:

INFORMED CONSENT FORM TO BE SIGNED BY THE PARTICIPANTS/CAREGIVER

I hereby confirm that I have been informed by the investigator, **MOGOALE MITJIE DAVID,** about the nature, conduct, benefits and risks of this study. I have also read the above information regarding this study.

I may withdraw my consent as well as my participation in the study and declare that I had sufficient opportunity to ask questions and therefore declare myself prepared to participate in the study.

Participant/Caregiver Name: _____

Participant/Caregiver' Signature: _____

Date: _____

Investigator's Name: _____

Investigator's Signature: _____

Date: _____

I, **MOGOALE MITJIE DAVID** herewith confirm that the above participant has been informed fully about the nature of the study.

Witness name: _____

Witness signature: _____ **Date** _____

ANNEXURE E: QUESTIONNAIRE (Data Collection Tool)

FACTORS CONTRIBUTING TO THE RELAPSE OF SUBSTANCE ABUSERS POST REHABILITATION.

Dear Respondent,

My name is Mitjie David Mogoale, and I am a post-graduate student in the Department of Public Health, Faculty of Health Science, and the School of Health Care Sciences at the University of Limpopo working under the supervision of Mr M.P. Kekana.

I am currently studying my Master's Degree in Public Health, and I'm attempting to determine the factors contributing to the relapse of substance abusers post rehabilitation at SANCA Polokwane.

You are requested to participate in my research by filling out the following questionnaire. The information gathered will assist in relapse prevention and aftercare services being more specific, and based on your needs.

Thank you for your time and cooperation in filling out the questionnaire. Please be aware that absolutely no attempt will be made to identify you personally or couple your answers to you personally. The information supplied by you will be treated with the utmost confidentiality and will be bulked with the answers supplied by other respondents to enable statistical data processing to be conducted by the Department of Statistics at the University of Limpopo.

Thank you,

Mr Mitjie David Mogoale

The Questionnaire follows on the next page…

QUESTIONNAIRE: FACTORS CONTRIBUTING TO THE RELAPSE OF SUBSTANCE ABUSERS POST REHABILITATION.

Respondent Number: [.....]

Please answer the questions by circling, ticking or marking with an (x) on an appropriate number in a shaded box.

SECTION A: BIOGRAPHICAL INFORMATION

1. What is your **gender**?

Male	1
Female	2

2. What is your **age**?

3. What is your **marital status**?

Single	1
Married	2
Separated	3
Divorced	4
Widow/Widower	5
Co-Habiting (Living with a partner)	6

4. What is your **highest level of education** completed?

Grade 4 to Grade 7	1
Grade 8 to Grade 11	2
Matriculated	3
Tertiary Education (e.g. University, FET, Tech)	4

5. What is your **employment status**? (Please indicate a single answer)

Employed (Incl. Self-Employed)	1
Part-time Employed	2
Unemployed	3
Retrenched	4
Suspended	5
Full-Time Student	6
Part-Time Student	7

Section A continues on the next page...

6. Number of people living in the house?

7. What is the type of **neighbourhood** where you live?

Rural Village	1
Urban/Metropolitan Area	2
Informal Settlement	3

SECTION B: PERCEPTIONS, VIEWS AND EXPERIENCES RELATED TO DRUG ABUSE

Questions in this section ask about your substance abuse history.

8. What is (are) your **drug(s) of choice and frequency** of use?

Drug of Choice	Once Per Day	More than 3x per Day	1 to 3x per week	4 or more x per week
Marijuana ('dagga', 'ganja', 'grass', 'weed')	1	2	3	4
Heroin	1	2	3	4
Heroin and Dagga mix ('Nyaope')	1	2	3	4
Madrax ('White Pipe')	1	2	3	4
Mandrax and dagga mix	1	2	3	4
Cocaine	1	2	3	4
Crack – (Smokable form of cocaine)	1	2	3	4
Other (Please Specify):	1	2	3	4

Section B continues on the next page…

9. At what age did you start **experimenting** with drugs?

Please read the following statements carefully and rank each of them as honestly as possible on the scale provided.

10.. I started experimenting because….	Strongly Disagree	Disagree	Agree	Strongly Agree
My peer group introduced me to drugs	1	2	3	4
A friend introduced me to drugs	1	2	3	4
Of my curiosity	1	2	3	4
I was looking for excitement	1	2	3	4
I heard it will help me cope with my emotions	1	2	3	4
I observed its effects on my friends	1	2	3	4
I observed its effects on my family members	1	2	3	4
Other (Please Specify)	1	2	3	4

11. After initially experimenting with a drug, after what time did your drug abuse become problematic? (Please select a single answer)

First to second week	1
Third week to a month	2
2 – 6 months	3
After 6 – 12 months	4
After 1 year to 2 years	5
After 2 – 3 years	6
After 3 – 4 years	7
After 4 – 5 years	8
After 5 – 6 years	9
After 6 years and more	10

12. Please indicate the possible abuse of substance by your family members	Not Applicable	Alcohol	Illicit Drugs
Mother	1	2	3
Father	1	2	3
Siblings	1	2	3
Aunt or Uncle	1	2	3
Nephew or Niece	1	2	3
Grandparents	1	2	3

Section B continues on the next page…

13. Which of the following does your social group abuse?

Not Applicable	1
Alcohol	2
Illicit Drugs	3

SECTION C: PERCEPTIONS, VIEWS AND EXPERIENCES REGARDING DRUG ABUSE TREATMENT.

Questions in this section ask about rehabilitation.

14. How many previous admissions, to a treatment centre have you had?

15. Where did you receive your first treatment for drug abuse?

(Please select a single answer)

A Private Rehabilitation Centre	
A government treatment centre	
A government hospital	
A private hospital	
A church	
Other (Please Specify)	

16. Who funded your first treatment for drug abuse?

(Please select a single answer)

Medical Aid	1
My Employer	2
My Family	3
Myself	4
Church	5
Government	6
Other (Please Specify)	

Section C continues on the next page…

17. Who referred you to the treatment center for your first treatment for drug abuse?

(Please select a single answer)

Friends	1
Family	2
Court	3
Welfare Organization	4
Employer	5
School	6
Church	7
Other (Please Specify)	

18. Did you complete your previous treatment for drug abuse in full?

Yes	1
No	2

19. If you answered “No” to Question 22, in the space below, please indicate no more than three reasons for not completing your previous drug treatment programme.

(Please do not mention more than three reasons)

SECTION D: PERCEPTION, VIEWS AND EXPERIENCES RELATED TO AVAILABILITY OF SOCIAL SUPPORT POST REHABILITATION

Questions in this section ask about the availability of support post rehabilitation.

20. What was the length of time of your previous drug treatment? (**Weeks**)

21. How did you experience the aftercare service?

(Please indicate only what was applicable to you)

I did not attend any aftercare	1
I had a lack of financial means to be able to attend aftercare	2
I had no transport available to be able to attend aftercare	3
I had a lack of knowledge about aftercare services	4
I was not referred to aftercare	5
There is no aftercare services provided in my area of residence	6
I had no family support to enable me to attend aftercare	7
Lack of motivation to attend aftercare	8

22. Do you get any support, encouragement or motivation after rehabilitation from,	Strongly Disagree	Disagree	Agree	Strongly Agree
Family	1	2	3	4
Friends	1	2	3	4
Community Members	1	2	3	4
Peers	1	2	3	4
School Teacher/Lecturers	1	2	3	4
Colleagues	1	2	3	4
Aftercare support groups	1	2	3	4
Rehabilitation Centre attended	1	2	3	4
Other (Please Specify)	1	2	3	4

SECTION E: PERCEPTION, VIEWS AND EXPERIENCES RELATED TO RELAPSE.

Questions in this section ask about rehabilitation.

Please read the following statements carefully and rank each of them on a scale of "1" to "4", with "1" indicating "strongly Disagree", "2" indicating "Disagree", "3" indicating "Agree", and "4" indicating "Strongly Agree".

23. I **relapsed** because…	Strongly Disagree	Disagree	Agree	Strongly Disagree
I lack effective coping mechanisms	1	2	3	4
I started to feel less committed and motivated towards staying clean/sober	1	2	3	4

I had a craving for alcohol/drugs	1	2	3	4
I was challenged with too many triggers	1	2	3	4
I don't believe in myself	1	2	3	4
I experienced negative emotional states (feelings of depression or anxiety)	1	2	3	4
I experienced euphoric states (feelings of happiness, excited, optimistic)	1	2	3	4
I thought I could deal with my emotions by using drugs	1	2	3	4
There was a change in my employment status (I found a job, lost a job, was promoted, etc.)	1	2	3	4
I thought this time I would be able to control my use	1	2	3	4
I decided not to attend aftercare support groups after my discharge from treatment	1	2	3	4
I experienced physical pain	1	2	3	4
I had financial problems	1	2	3	4
Of overcrowded living conditions	1	2	3	4
I found it difficult to avoid social gathering places (e.g. taverns, pubs, clubs, etc.)	1	2	3	4
Community members still look down on me for using drugs	1	2	3	4
Of peer pressure from my peer group	1	2	3	4
Of peer pressure from a friend to use again	1	2	3	4
I am easily influenced by others	1	2	3	4
I lacked support needed after treatment	1	2	3	4
I thought I could deal better with the conflict when I use drugs	1	2	3	4
I was presented with a new opportunity to experiment with a new drug	1	2	3	4
I find it difficult to find a job	1	2	3	4
There was a change in my marital status (e.g. I got divorced, got married, lost a partner, etc.)	1	2	3	4
A significant relationship in my life ended	1	2	3	4
One or more of my family members abuses drugs or alcohol	1	2	3	4

Section E continues on the next page……

*I **relapsed** because….*	Strongly Disagree	Disagree	Agree	Strongly Agree
My social group still abuse drugs and/or alcohol	1	2	3	4
In my peer group we glamorized or idealised drug abuse	1	2	3	4
I found it difficult to avoid social gatherings	1	2	3	4
I was approached by my dealer after treatment	1	2	3	4
I experienced a stressful life event (e.g. losing a job, being diagnosed with an illness, etc.)	1	2	3	4
I lacked financial support	1	2	3	4
I had money available to me to use according to my will	1	2	3	4
I felt lonely	1	2	3	4
I was bored	1	2	3	4

24. Please indicate in the space below, no more than two causes for your relapse ***(Please do not mention more than two causes)***

25. Do you feel that you will be able to maintain abstinence from drug usage after your current treatment for drug abuse?

Yes	1
No	2
Uncertain	3

26. Please indicate in the space below, no more than two reasons for your answer to Question 26.

THANK YOU… !!!!

ANNEXURE F: TIME FRAME AND TARGET DATES

ACTIVITY	MARCH 2019	APRIL2019	MAY 2019	JUNE 2019	JULY 2019	AUGUST 2019 – AUGUST 2020	SEPTEMBER 2020	OCTOBER 2020	NOVEMBER 2020	DECEMBER 2020
SUBMISSION TO SUPERVISOR										
CLASS PRESENTATION										
DEPARTMENTAL PRESENTATION										
SREC										
FHDC										
TREC										
REQUEST TO COLLECT DATA										
DATA COLLECTION										
DATA ANALYSIS										
FINALIZATION OF CHAPTERS, AND FINAL SUBMISSION TO SUPERVISOR										

NOTE: *The researcher has waited for more than ten months for a response from both the School Committee, and the Faculty Committee (From September 2019 to August 2020)*

ANNEXURE G: PERMISSION TO COLLECT DATA AT SANCA

PERMISSION LETTER TO CONDUCT A RESEARCH

STUDY AT THE SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE (SANCA), POLOKWANE

I (Name: Shimoung Mashala) as (Role/Title : Social work Supervisor) of (Rehabilitation Centre Name : Sanca Limpopo Alcohol and Drug Centre) having fully been informed as to the nature of the research study, give my permission for the study to be conducted. I reserve the right to withdraw this permission at any time.

STAMP:

Name: Shimoung M.M

Signature: .....

Date: 2020-11-23

SANCA LIMPOPO
ALKOHOL EN DWELM SENTRUM
ALCOHOL AND DRUG CENTRE
33 KERK ST. / STR. 33
1147
POLOKWANE 0700
☎ 015 295 3700

ANNEXURE H: ETHICAL CLEARANCE LETTER (TREC)

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3766, Fax: (015) 268 2306, Email:makoetja.ramusi@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: **21 October 2020**

PROJECT NUMBER: **TREC/325/2020: PG**

PROJECT:

Title:	Factors Contributing To Relapse Of Substance Abusers Post Rehabilitation At The South African National Council On Alcoholism And Drug Dependence, Polokwane, Limpopo, South Africa
Researcher:	MD Mogoale
Supervisor:	Mr MP Kekana
Co-Supervisor/s:	N/A
School:	Health Care Sciences
Degree:	Master of Public Health

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE
The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

ANNEXURE I: EDITOR'S LETTER

P.O BOX 663
THOLONGWE
0734
03 April 2021

Dear Sir/Madam

This is to certify that the mini-dissertation entitled "Factors Contributing to Relapse of Substance Abusers Post Rehabilitation at the South African National Council on Alcoholism and Drug Dependence, Polokwane, Limpopo Province, South Africa" by Mogoale Mitjie David (student number 201201467) has been edited and proofread for grammar, spelling, punctuation, overall style and logical flow. The edits were carried out using the "Track changes" feature in MS Word, giving the author final control over whether to accept or reject effected changes prior to submission, provided the changes I recommended are effected to the text, the language is of an acceptable standard.

Please don't hesitate to contact me for any enquiry.

Kind regards

Dr. Hlaviso Motlhaka (BEDSPF-UL, BA Hons-UL, MA-IUP: USA, PhD-WITS, PGDiP-SUN)

Cell number: 079-721-0620/078-196-4459
Email address: hlavisomhlanga@yahoo.com