THE PERCEIVED SUCCESS OF SELECTED THERAPY PROGRAMMES ON MITIGATING THE RELAPSES OF PATIENTS WITH SUBSTANCE USE DISORDERS IN GAUTENG, SOUTH AFRICA

BY

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DATE: 21 DECEMBER 2021

Declaration

I Nyasha Chatikobo, declare that the content of my thesis is my original work, none of it has ever been presented or submitted at any other university anywhere. I declare that I have complied with the University of Fort Hare Plagiarism Policy.

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Abstract

This study aimed at evaluating the perceived success of selected therapy programs in mitigating the relapse of patients with substance use disorders at two selected rehabilitation centres in the Gauteng province of South Africa. The methodology used for this study was a mixed-method approach, although more emphasis was on qualitative methods. The qualitative data was collected from four focus groups, and 6 in-depth interviews from key informants. The quantitative data was collected using questionnaires that were completed by 100 primary carers of discharged patients from the selected drug treatment centres.

The main findings of the study showed that substance use disorder is a complex disease that requires several factors to be considered to avoid any relapses. The study showed that rehabilitation centres are hugely contributing to efforts of solving substance use in Gauteng and South Africa as a whole. These rehabilitation centres offered various treatment programs to individuals who suffer from substance use disorders. The findings also indicated that the selected therapy programmes at the rehabilitation centres met their objectives. However, some of the programmes were successful in mitigating the relapses of patients recovering from addiction to a lesser extent. The study also found out that the number of individuals who relapse is relatively high, however, the study did not dive into the depth of the causing factors. This may be room for future studies.

Findings further indicated that the rehabilitation centres lacked in the application of a holistic approach to addiction treatment, even though there were several treatment programs offered. The issue of exorbitant residential fees in private rehabilitation facilities was also highlighted by the data collected.

The research concluded by suggesting several recommendations such as research to improve policy for substance use with a focus on the human rights approach to the drug problem. Recommendations to the Department of Social Development which is responsible for the rehabilitation centres in South Africa. To ensure that all centres that are registered for offering treatment for substance use disorder be mandated to use a comprehensive multidisciplinary approach, diversifying and individualizing treatments for better outcomes. Lastly, recommendations were suggested to the social work practice, to support rehabilitation facilities by providing continuous specialized training to their social workers. Recommendations to social work training and curriculum to include in-depth substance use disorders during education, training, and field placements, for best practice amongst new social work practitioners placed in rehabilitation centres.

Supervisor's confirmation

I hereby confirm that I have supervised the thesis of the student mentioned below and confirm it has been submitted with my authorization.

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Dedication

Firstly I dedicate this project to my mother, late father and late grandmother, this one is for you ☺.

Secondly, I dedicate this project to Professor John Rautenbach & Dr Nyanhoto, it's been a long journey, your faith brought me this far.

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LIST OF ACRONYMS AND ABBREVIATIONS

Abbreviation Meaning

AA Alcoholics Anonymous

CDA Central Drug Authority

DSD Department of Social Development

HIV/AIDs Human Immunodeficiency Virus Infection/Acquired Immune Deficiency Syndrome

NA Narcotics Anonymous

NASW National Association of Social Workers

NDMP National Drug Master Plan

NDSD National Department of Social Development

NICRO National Institute for Crime Prevention and Reintegration of Offenders (South African)

NIDA National Institute on Drug Abuse (American)

SACENDU South African Community Epidemiology Network on Drug Use

SACSSP South African Council for Social Services Professions

SANCA South African Council on Alcohol and Drug Dependence

SPSS Statistical Package for Social Sciences

UNDCP United Nations International Drug Control Programme

UNDP United Nations Development Programme

UNODC United Nations Office on Drugs and Crime

USA United States of America

WHO World Health Organization

1 CHAPTER 1:
GENERAL OVERVIEW OF THE STUDY

1.1 Introduction

This study sought to evaluate the perceived success of selected therapy programmes on mitigating the relapses of patients with substance use disorders in Gauteng, South Africa. A study in this specific context is of great importance in South Africa as the use of substances and illicit drugs is one of the social vices that have adverse negative effects. Providing detailed research in this area and providing useful recommendations would be valuable to Policy, social work disciple as well as rehabilitation centres.

The issue of drug use has been a global problem for many years and efforts to mitigate it have proved rather futile in most countries. There have been recent clinical definitions of substance use disorders provided by the American Psychiatric Association (DSM-5) (2013) and the World Health Organization's International Classification of disease and related health problems. The DSM updated addictions to be referred to as substance use disorders, which define a cluster of cognitive behavioural and physiological symptoms. Hence, those with addiction problems such as relapses are described as individuals with substance use disorders. Van Zyl, (2013) and Victor, Kappeler, and Potter (2017), identified the following drugs as the most commonly used in South Africa and globally, Cannabis, Benzo diazepam, Methaqualone, Heroin, Whoonga, a-Pyrrolidinopentiophenone (flakka), Cocaine, Crack cocaine, Cocaine, Crystal meth, Mandrax, Cat, Alcohol, Ecstasy, Acid, Whoonga/Nyaope. Individuals who are inactive addiction for various reasons use the just mentioned drugs. Some theories suggest that intrapersonal and interpersonal

factors are the main reasons to use substances. These factors include emotional positions such as feelings of frustration, anger, anxiety, depression and boredom (Salani, Albuja & Zdanowicz 2018). Relationship dynamics such as fights, arguments, peer pressure and conflict associated with any interpersonal relationship like marriage, friendship, family members, or employer-employee relations may also lead to substance abuse (Chetty 2012). In efforts to attain drug-free societies, various interventions such as rehabilitation programmes, the twelve steps programme, and the outpatient programmes have been implemented, but great percentages of those in recovery continue to face the problem of multiple relapses. Kabisa, Biracyaza, Habagusenga, Umubyeyi (2021), concur with this by noting that relapses after successful detoxication and rehabilitation are a public health concern globally.

Substance use has been directly and indirectly linked to the spreading of non-communicable diseases such as HIV/AIDS, cancers, heart diseases and psychological disorders (Prus 2017). It continues to represent a major source of revenue for organized crime networks (UNODC 2017). Given the patterns of relapse and remission, a variety of interpretations of the nature of substance use as a disease condition and its treatment has evolved. Worldwide, it is estimated that yearly, a minimum of 190,000 people die prematurely from drug use, the majority attributable to the use of opioids (UNODC 2017).

Realistically, the phenomenon of substance use has threatened many countries' fulfilment of achieving the Sustainable Millennium Development Goal of seeing people of all ages enjoy a modest state of health and well-being. Substance use relapse continues to pose a global challenge with reports by the World Drug Report (2021) indicating that about 5.6 % (275 million people) of the global population aged

15-64 have used drugs. Also according to this report, the demographic factors project the global number of people using substances to rise by 11% and in Africa alone by 40%. While literature indicates that taking some of the drugs could have some curative and medicinal value, on the other hand, the use of illicit substances presents horrendous negative effects on the users with the potential of causing permanent mental disorders.

This first chapter presents the problem statement, the aim of the study, objectives and research questions and lastly the theoretical frameworks and methodology which was employed.

1.2 Significance of the Study

This study was focused on exploring the perceived success of selected therapy programmes in mitigating the relapse of patients with substance use disorders. The study was therefore crucial and significant to various stakeholders including the government, substance use rehabilitation centres, families, companies and community organisations who all stand to benefit if the problem of relapse is eliminated. As already illustrated earlier in this chapter, the South African government loses up to R20 billion per annum due to costs associated with substance use including subsidising treatment of the addicted, bankrolling prevention and harm reduction strategies as well as damage to property (Van Wyk, 2011). In this regard, ensuring that interventions become more effective in thwarting relapse will go a long way in reducing the recurring costs of caring for and supporting those affected by the drug problem in the country. More so, available literature shows that the bane of substance abuse in South Africa is ruinous to families who have to contend with disruptive violence, damage to property, domestic violence and neglect of children (Mpanza, Govender & Voce 2021; Messineo, Cattaruzza, Prestigiacomo, Giordano

& Marsella, 2017; Kadam, Sinha, Nimkar, Matcheswalla & De Sousa, 2017). If this study successfully establishes ways through which prevention strategies can be fortified, families will be relieved of the horrendous and economically ruinous detriments of substance use and relapse.

Additionally, indications are that professionals who work in substance use rehabilitation facilities are increasingly getting frustrated by the ever-growing number of substance users who are falling victim to the phenomenon of relapse (Makuyana, 2018). This study will therefore go a long way in assisting professionals in drug rehabilitation centres on how they can reconfigure and rejuvenate their programmes towards achieving better outcomes and success. More so, Messineo et. al. (2017) writes that companies continue to lose potential revenue due to high workplace accidents involving inebriated workers. Concurringly, Kadam et. al. (2017) underscore that production environments in the workplace are often threatened by employees who sometimes attempt or use dangerous equipment while they are intoxicated thus endangering their own lives, that of their workmates and damaging the equipment. Given the foregoing, this study was important in that it will help to eliminate the problem of substance use relapse thus aiding the effectiveness of interventions modalities and contributing to thwarting the drug problem and its attendant ills on society.

The study stood to contribute immensely to the discourse of substance use relapse which up-to-date has not received much attention in South Africa (Rudzinski, McDonough, Gartner & Strike, 2017). The study also illuminated individual, organisational and systemic gaps that render relapse prevention strategies and modalities ineffective in the selected rehabilitation facilities, and by extension in South

Africa. More so, the study's significance is derived from its potential to generate credible evidence which can be used to inform new policy and practise directions in current and future National Drug Master Plans.

1.3 Problem Statement

The relapse of patients who have completed therapy programmes have been attributed to possible glitches in the rehabilitation treatment programmes, or mere failure to observe treatment protocols by the patients (Watson, Fayter, Mdege, Stirk, Sowden & Godfrey 2013).

The ongoing battle of fighting substance use seems to be futile with the percentages of substance use relapses increasing daily. This has posed horrendous challenges to individuals and their families, the government, as well as the management of the rehabilitation centres. The phenomenon also defeats South Africa's motto of achieving a drug-free South Africa (Van Zyl 2013). Perhaps a perfidious effect of multiple substance use relapse entails many of the people with substance use disorders attending treatment centres with the hope of coming up with recovery resolutions, but instead, the users get prompted to continue abusing the same substance as before, or even becoming worse persons who use substances s (Sanders 2016). Perhaps the phenomenon raises many questions of whether these clients have fallen victim to poor treatment, the ineffectiveness of the treatment interventions, or the wrong approach towards the treatment generally. These questions are valid because the cardinal role of rehabilitation treatment centres with their programmes is to assist individuals with substance use disorders to recover with success. The relapse of patients who would have received treatment at rehabilitation centres, could either be caused by internal factors or external factors such as

treatment programmes that are not comprehensive or effective, toxic environments, triggers and many other factors. This study seeks to evaluate the environment affecting relapse among those who have undergone treatment modalities in selected rehabilitation centres in Gauteng, to assess the contribution of the treatment programmes.

1.4 Aim and Objectives

This study aimed to evaluate the perceived success of selected therapy programmes on mitigating the relapse of patients with substance use disorders. To achieve this aim, the perceptions of the patients who were admitted several times at the rehabilitation centres were sort, as well as of the caregivers of the patients, the social workers, and the directors of the rehabilitation centres. The research questions mentioned below will be answered by the responses of the aforementioned population categories.

1.5 Specific Objectives

To achieve this aim, the research sort to accomplish the following objectives:

A. To establish the nature of selected therapy programmes and examine the extent to which they are meeting their objectives, as perceived by drug users, key informants from rehabilitation centres and primary caregivers?
B. To determine the extent to which selected therapy programmes assist in the prevention of substance use relapse, as perceived by drug users, key informants from rehabilitation centres and primary caregivers?
C. To formulate recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use relapses.

1.6 Specific Research Questions

Each objective was also being expressed as a specific research question that ultimately informed the data collection and analysis.

A. To what extent are the selected therapy programmes meeting their objectives.
B. To what extent do selected therapy programmes assist in the prevention of substance use relapses?
C. What recommendations or interventions can be suggested towards improving the selected programmes used by rehabilitation centres to treat substance use relapses?

1.7 Theoretical Framework

The Relapse Prevention Model and the Utilization-Focused Evaluation approach formed the theoretical foundations for this study. These will be discussed in chapter three and will be integrated through the thesis.

1.8 Research Methodology

Research methodology is a systematic approach towards purposive investigation, which entails collecting data on relevant variables, analysing and interpreting results and reaching conclusions either in the form of a solution, or a generalization (Dagnino & Cinici 2015).

1.9 Research Approach

The study used mixed methods concurrently, with the qualitative method being predominant and the quantitative approach being less dominant (Dagnino & Cinici 2015). The reason for choosing the qualitative method is to get an in-depth

understanding of the efforts being put by the rehabilitation centres through their programmes. On the other hand, the quantitative approach, through a mini-survey, allowed a quantified perception about substance use relapse.

1.10 Research Design

In sync with its mixed methodology, this study was underlain by both qualitative and quantitative designs. The below table provides details of the research design.

Table 1: Research Design

Research Design	Justifications
Qualitative Design	The qualitative component of the study was conceptualized using an exploratory design to dig deeper into insights into the research. The substance use relapse patients from the two selected rehabilitation facilities, the social workers and directors employed at the selected rehabilitation facilities formed the population study under this design.
Quantitative Design	The quantitative aspect was based on an explanatory design to gain significant insights into the research. The study's population were the caregivers of substance users who were in recovery.
Mixed Method Design	The research used the integration of qualitative and quantitative data in order for high quality outputs which inform the results.

Samples for the study were selected using both probability and non-probability techniques. Samples for the quantitative component of the study were selected using purposive sampling while systematic stratified random sampling was used in selecting primary caregivers for the mini-survey. The study used a unit of analysis consisting of 146 participants. Table 2 below presents the structure and categorical sizes of the unit of analysis in the study.

Table 1: Structure and size of the unit of analysis

Sample Category	Sample Size
Key informant	6
Focus group	40
Mini-Survey	100
Total	146

Data for the study was collected through focus group discussions, key informant interviews, secondary data review and a mini-survey. The collected data was analysed using thematic analysis and statistical analysis. A comprehensive discussion of the research methodology used in this study is provided in chapter four of this thesis which is exclusively dedicated to explaining the methodological processes, procedures and implications.

1.11 Delineation and Scope of the Study

Delineation in research can be construed as a deliberate undertaking by a researcher to set boundaries within which the study and its findings can be understood and applied by readers (Creswell 2014). Conceptually, this study primarily focused on exploring the perceived success of selected therapy programmes on mitigating the relapse of patients with substance use disorders in Gauteng, South Africa. Ideally, the study sought to understand the social constructions including the practical outcomes associated with substance users partaking in the selected relapse prevention therapy programmes. While the study indicates that its focal point is in the Gauteng Province, it serves to highlight that practically, the study focused only on two specific rehabilitation centres, which were chosen to be representative of the entire Province's rehabilitation facilities.

Understandably, relapse prevention in Gauteng, South Africa and the world at large is done through an assortment of programmes; however, this study prioritised the success of therapy programmes provided within the confines of selected residential drug treatment centres. Given this reductionist approach, the findings of the study ought to be understood to not be necessarily reflective of the success of interventions at a national level, but rather that of the selected rehabilitation centres.

1.12 Outline of the study

Chapter 1: Introduction **-**This chapter gave an introduction to the study. Aims, objectives, research questions and the research problem were discussed.

Chapter 2: Literature review - This chapter will provide a review of literature on substance abuse relapses in South Africa and beyond

Chapter 3: Theoretical and legislative framework – The chapter will discuss the Relapse prevention model and the Utilisation Focused Evaluation approach. The legislative framework on substance use and relapses will also be discussed.

Chapter 4: Research Methodology - Methodology, research design, methods of data collection methods, the procedure for data collection, instruments, analysis and ethical considerations.

Chapter 5: Presentation and discussion of findings - Qualitative and qualitative data were presented and discussed.

Chapter 6: Conclusions and Recommendations.

2 CHAPTER TWO : LITERATURE REVIEW

2.1 Introduction

The previous chapter conceptualised the problem of substance use relapse and provided a precise outline of the background issues surrounding substance use relapse. The chapter also outlined the primary aim and specific objectives of the study as well as the research questions in whose context the study was founded, implemented, interpreted and concluded. Snippets of the research methodology and the significance of the study were offered. The current chapter discusses the literature which relates to the specific issues linked to the objectives and research questions of the study as outlined in chapter one. Precisely, the literature review in this chapter presents substance use relapse as a local, national, regional and global problem that requires commitment and apt programming from all relevant stakeholders to thwart its proliferation. Largely, the chapter was framed based on readily available literature from scholarly dissertations, journal articles, books, policy reports and other government documents on and around the subject of substance use treatment and care and more specifically on substance use relapse. It starts by providing an in-depth discussion of the historical terrain associated with the notion of substance use treatment in general and more specifically issues around substance use relapse prevention.

2.2 Historical Evolution of Substance Use Treatment

Generally, substance use treatment and more specifically, relapse prevention and treatment traversed a very long and sometimes irregular journey largely informed by

intuition and social observations. According to White and Kelly (2011), the history of substance use treatment and the cause, substance use relapse prevention is largely mounted on the events and historical developments and recordings in the Western World, particularly in the United States of America and Britain. The next section will first provide that history dating from the 1750s and later discuss the South African context which surfaced after the 1940s.

2.2.1 History of Western countries predominantly the United States of America

According to Harvey, Howanitz, Parrella, White, Davidson, Mohs and Davis (1998), the first organised attempt at providing interventions for those suffering from substance use related problems can be traced back to around 1750 and 1800 when the Alcoholic mutual aid societies were formed in the United States. The ideology in many of these Alcoholic mutual aid societies was largely framed around the need to restore and revitalise the American cultural identity which was fast being eroded by an emerging trend of alcoholism. Along the way, the issue of substance use and its impact were gaining momentum in Western societies as evidenced by the 1774 publication of the very first American essay on alcoholism by Anthony Benezet whose essay was titled: Mighty Destroyer Displayed (White 2000). The article gained significant prominence and induced authorities and the media to seriously look at the subject of alcoholism and substance abuse in America. Between 1784 and 1810, Dr Benjamin Rush became very popular through his ground-breaking research which concluded that substance use is a disease that requires the intervention of clinicians. Dr Benjamin Rush underscored the need for the establishment of "Sober Houses" for the care of confirmed drunkards (Antonio, Diehl, Niel, Pillon, Ratto, Pinheiro & Ushida 2017).

The period from around 1810 up to 1850 saw a regression in the narrative of drug and substance use interpretations and subsequent interventions. This period coincided with Rev. Lyman Beecher's Six Sermons on Intemperance (lack of moderation or restraint) in which he described alcoholism as a sin for which individuals were to be severely punished for their iniquity. According to Antonio et. al. (2017), the regression to the archaic description of substance use as a sin and or moral deficit saw a rise in the inhumane treatment of drug users in asylums and reignited a strong perception that substance use was a shame to the individual, family and society as a whole (White 2000). Substance users were thus locked in filth and dilapidating sanatoriums where many of them died in pitiful conditions.

The early 1860s saw a radical shift in how substance users were perceived and treated in America and Britain. The period saw a shift from the gendered lenses of viewing the substance use problem as being a male problem to the more modern perception that the problem is universal. To this end, the Martha Washington Home in Chicago was established in 1867 to specifically deal with feminine substance users. Around the same period, some prominent facilities including the New York State Inebriate Asylum, Lodging Homes and Home for the Fallen were established (Hall & Appelbaum 2002).

Another significant milestone in the development of substance use treatment was the coinage of the notion of “Alcoholismus chronicus” by Magnus Huss who was a Swedish Physician in 1849 (Sournia 1987). Analysts posit that this is where the notion of addiction in its modern interpretation is hailed. Magnus Huss generally construed addiction as a disease requiring lifelong interventions and recovery. Sournia (1987) notes that developments during the period from the 1850s onwards largely revolved

around lobbying by individuals and voluntary organisations for the state to intervene and provide respite to both those who were infected by addiction and others who were affected by the same. The general overview was that failure to provide state-sponsored substance use interventions was concomitant with the dereliction of governments' social contract with the citizens.

According to Odejide (2006), the period running from 1845 onwards saw a sharp rise in incidents of inebriation of African Americans. This motivated the adoption of Afro-centric models of recovery and exacerbated calls for ending the slave trade (Odejide 2006). In the 1870s the American Association for the Cure of Inebriety published the first journal on inebriety, this making the framing of the addiction and disease model grow. However, the inebriate asylums and homes were closed down during the 1870s because of the negative resentments that had grown towards addiction and drug users (Taylor-Wickenden 2015).

By 1901, the very first privately owned hospital, the Charles B. Towns Hospital for Drug and Alcoholic Addictions was formally launched. The hospital was largely for affluent persons as its fees were steep for ordinary people. According to Rose and Cherpitel (2011), the Charles B. Towns Hospital for Drug and Alcoholic Addictions was generally referred to as the "drying out" hospital in which drug users were medically assisted to detoxify.

2.2.2 Inclusion of South Africa's historical evolution of substance use treatment

The period from 1907 up to 1950 was largely characterised by the development of legislative frameworks for the control and treatment of drug users. Among the

prominent crop of laws and policies developed during the era in United States include the Harrison Narcotics Act of 1914.

Cannabis also known as dagga had gained popularity in South Africa around the 1920s and that lead to the country introducing the first drug legislation concerning cannabis in 1928 (Wright, 1991). During the same period, the Marihuana Tax Act of 1937 in the United States was developed, and a formal narcotics control organ called the Federal Bureau of Narcotics (FBN) was established implying that issues of substance use were extricated from the Federal Justice System.

Furthermore, in 1935, the Alcoholics Anonymous (AA) was established by Dr Bob Wilson and Bill, W. This was to be followed up with the publication of the all-time famous Alcoholics Anonymous book in 1939. Events post the creation of the AA can be directly linked to the modern conceptualisation and development of substance use treatment (Ferraioli 1996). Between 1940 to 1945, there were significant movements associated with recovering drug users who underwent treatment in AA groups were recruited by Remington Arms, DuPont, Kaiser, Shipyards, and North American Aviation to provide expert assistance in the workplace (Trice & Schonbrunn 1981). In 1944, the National Committee for Education on Alcoholism which later changed to (National Council on Alcoholism & Drug Dependence) was established based on five fundamental principles including that:

- Alcoholism is a disease.
- The alcoholic, therefore, is a sick person.
- The alcoholic can be helped.
- The alcoholic is worth helping.
- Alcoholism is our No. 4 public health problem and our public responsibility

Just two years preceding that in 1946, the first AA group was formed in South Africa, this became the conduit for more lobbying for the rights and welfare of substance users. Among the core issues of lobbying has been the need for the government to raise awareness and thus prevent cases of people indulging in substance use; encouraging hospitals to admit alcoholics and drug users for acute detoxification. Establishing local clinics for the diagnosis and treatment of alcoholism and lastly, establishing "rest centres" for the long-term care of alcoholics (Kuerbis, Sacco, Blazer, & Moore 2014).

From the early 1950s up to the 1970s, there was extensive growth in both research and practical steps aimed at finding lasting solutions for the drug and substance use problem in most countries of the globe.

By 1950, Pioneer House, Hazelden, and Willmar State Hospital collaborated in developing the “Minnesota Model” (Galanter 2007). Moreover, efforts were also increasingly becoming visible from physicians who started a movement towards pharmacological interventions. Interventions by physicians led to the development of medicines such as Disulfiram (Antabuse), barbiturates, amphetamines (Benzedrine), and LSD were adopted. Some of these were to be found later to be more problematic than the problems they were designed to cure. In 1956 South Africa’s authorities realised the need for collaboration rather than competition in designing and implementing programmes for curbing alcoholism and substance use problems and established a national body called the South African National Council on Alcoholism and Drug Dependence (SANCA) (Parry 2005). The purpose of SANCA was to partner with the government and the community in developing and implementing strategies towards the prevention and treatment of substance use.

The period from the 1970s largely signified the onset of modern drug and substance use interventions. Key during this period has been issues and debates around the de-criminalisation of drug use, measurement of drug potency, development of national and global drug control systems and conventions, integration of treatment modalities for better efficacy and prevention and management of relapses (Carrier & Klantschnig 2020)

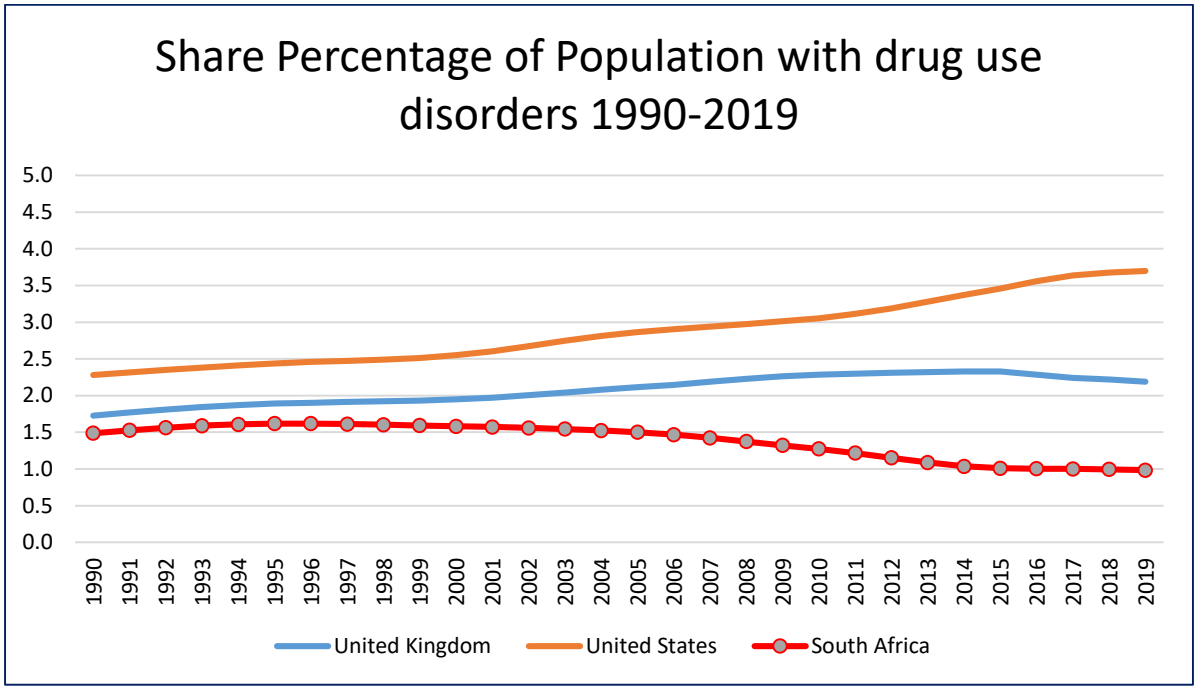
Ever since the 1970s, the problem of drug and substance use has grown to affect virtually all countries and territories of the world with an unprecedented impact. The use of substances gradually increased in South Africa and several national plans or strategies to address different aspects of substance abuse were drafted during the 1980s and early 1990s. However, they did not provide a comprehensive response to the deteriorating drug problem of South Africa and were not properly implemented (Parry 2005). Towards the end of the apartheid era around 1992-1994, there was a drastic increase in the trade, the use and transport of illicit substances. The late former President of South Africa Nelson Mandela in his opening address to the parliament mentioned substance use as a dire social problem that needed to be addressed with a sense of urgency. By this time due to the opening of borders and South Africa all sorts of substances had penetrated most parts of the country, it was very necessary for prevention and treatment efforts by the government. The substances used at that time included alcohol, methaqualone, cannabis, ecstasy, cocaine, amphetamines, LSD and heroin.

This led to the establishment of the Drug Advisory Board in 1995, who later in 1997 at the directive of the Minister of Welfare and Population Development developed a National Drug Master Plan for South Africa in efforts to solve the ‘drug problem’ “in

accordance with international practice" (Parry 2005). The National Drug Master Plan which was introduced stipulated strategies to control the effects and availability through prevention, treatment and rehabilitation. Furthermore, in 2005 the National Department of Education updated its curriculum as a prevention strategy. This had been inspired by the former late president Nelson Mandela who had initiated the Culture of Learning, Teaching and Service (COLTS) Campaign to address the use of substances and crime in schools. To date South Africa has been continuously guided by the National Drug Master Plan which is reviewed every five years. Efforts towards prevention, treatment and rehabilitation are enabled by partnerships of the government (Department of Social development) with organisations like the South African National Council on Alcoholism and Drug Abuse **(SANCA)**, the South African Alliance for the Prevention of Substance Abuse **(SAAPSA)**, other NGOs Carrier, N., & Klantschnig, G. (2020).

The Figures below will show the progress that had been done over the year and perhaps the gaps still there in South Africa's war against substance use and its detriments.

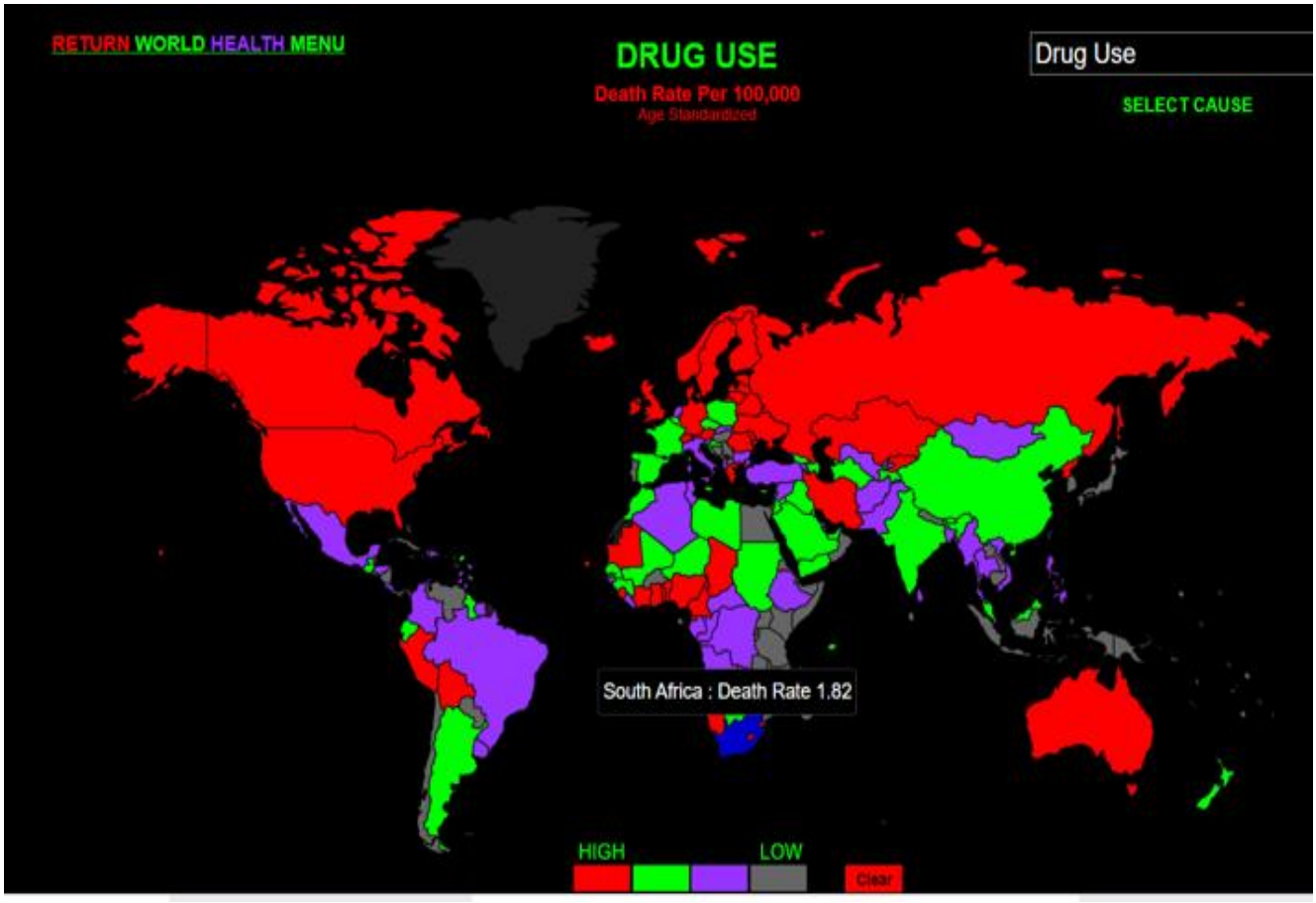
Table 2: Population with Substance Use disorders in South Africa



Source IHME, Global Burden of Disease Collaborative Network (2019)

According to the graph above by the IHME, Global Burden of Disease Collaborative Network (2019) according to the percentages, people with substance use disorders in South Africa has been slowly going down to 0.92% of a 57 000 000 population. The trend line indicates slight improvements which might mean the efforts of prevention, treatment and rehabilitation have been yielding some results.

Figure 1: South Africa's Substance use Death Rate



Source: /www.worldlifeexpectancy.com

According to World Life expectancy researchers who obtain their information from the World Health Organisation reports, there are several deaths associated with substance use. Figure 2 shows that deaths associated with substance use in South Africa are still high, out of the 183 countries in the world South Africa is ranked number 53 with a substance use death rate of 1.82 per 100 000. This rate is close to the high rate, meaning more intervention is needed to reduce more of these deaths.

2.3 Defining Substance Use

Before delving into the discussion of the literature on specific study objectives, it suffices to first present a conceptual discussion aimed at defining the notions of substance use and substance use relapse.

Generally, substance use is construed as a complex disorder that can involve virtually every aspect of an individual's functioning in the family, at the workplace, school, and in the community (Ashenberg Straussner & Senreich 2002). The terms "substance use", "substance abuse" and "drug abuse" are used interchangeably to refer to excessive usage and in some instances consumption of illicit substances. According to the World Health Organisation (WHO) (2007), substance/drug use/abuse is construed to constitute a proclivity of an individual to over-consume intoxicating substances such as psychoactive drugs, prescription medication and alcohol. However, experts argue against the concepts of "substance/drug abuse" on the basis that such concepts are premised on value judgment and inherently constitute some level of stigma towards drug users. The argument is that the term "abuse", is indicative of moral deficit on the part of the individual who consumes substances and thus presents the phenomenon as a choice rather than a mental health problem (White & Kelly 2011). In this study, the concept of "substance use" is used to identify persons who consume substances excessively and for recreational purposes other than for their prescribed purposes.

The most recent Diagnostic and Statistical Manual of Mental Disorders (DSM-5), categorises substance use as a mental health problem. The manual recognises substance use disorders resulting from the use of ten distinct classes of substances including, alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives,

hypnotics/anxiolytics, stimulants and tobacco. Generally, substance use disorder is construed to mean a situation in which an individual's use of alcohol or another substance (drug) leads to health issues or problems at work, school, or home (Bain 2004). Notwithstanding the long-running history of research in substance use prevention, treatment and harm reductions, there is no specific reason known to be causative of the phenomenon. Recent research has however pinpointed among other issues, biological predispositions, peer influence and negative social environments, poverty and disturbed emotional states as some of the rudimentary and contributory factors responsible for initiation and maintenance of substance use behaviours.

Wadhwa (2009) writes that notwithstanding other foundational factors which predispose an individual to drug use, in many instances of substance misuse, the driving factor will be the need for the pleasurable effects of the substance. WHO (2007), mentions that psychoactive substances are referred to as substances that can alter an individual's mood, consciousness, behaviour, and thinking ability. To this end, substance use is concomitant with the need by an individual to alter their states of mind through ingesting, spiking smoking or snorting substances. Alternatively, Ray and Ksir (2002) describe drug use as an act of using substances that are not common within a social group and are disapproved by the majority of its group members. To this end Doweiko (2006) underscore that drug users tend to have a socio-cultural dimension, one can only be considered to be a drug user or more conventionally, drug abuser if he/she uses substances that are legally prohibited by prevailing laws in a country or community or are considered alien to local environments. Viewed from this perspective, a substance user has considered out of character if his/her usage involves unconventional drugs and or if the usage supersedes acceptable levels within a given community/society. A typical example is that in many countries, alcohol

is legally permissible and its usage in such communities is not considered problematic unless it affects the individual's socio-cultural and economic functioning.

To this end, substance use may be conceived as overindulgence of a substance by an individual to the extent where such usage affects the social, economic and cultural functioning of the individual (Elek, Miller-Day & Hecht 2006).

One of the key discourses on substance use and its treatment has been the need to determine the point at which normal drug usage straddles the line of normality to become problematic (Pilarinos, Barker, Nosova, Milloy, Hayashi, Wood & DeBeck 2020). Among the outcomes of this debate has been the view that substance use can best be analysed on a graded continuum of complexity which ranges from substance use, which is usually casual with the individual able to retain and maintain control over their usage, to the second phase of substance abuse and substance dependence (Fairbairn, Briley, Kang, Fraley, Hankin & Ariss 2018). In this continuum, substance use is construed to be morally wrong but the individual remains able to perform all requisite functions. Substance abuse is understood to signify deepening of the usage resulting in problems in personal and interpersonal relationships, the quantity used become worrisome (Fairbairn et. al. 2018; Chatikobo 2016). Lastly, substance dependence signifies the end of the substance use spectrum characterised by high volume usage, the inability to stop or reduce usage despite well-meaning efforts (Pilarinos et. al. 2020).

2.3.1 Criteria of substance use disorders

Substance dependence signifies the end of the substance use spectrum characterised by high volume usage, inability to stop or reduce usage despite well-meaning efforts. Figure 3 below graphically depicts the criteria used in DSM-5 in determining the complexity of substance use disorders updated by (Hartney 2020).

Figure 2: Criteria of substance use disorders

Source: Verywell / Brianna Gilmartin (Hartney 2020).

- More specifically, the American National Survey on Drug Use and Health DSM-5 (Substance Abuse & Mental Health Services Administration 2016) outlines eleven different criteria which can be used in identifying problematic drug use and these include:
- Taking substances in larger amounts or longer than you're meant to
- Wanting to cut down or stop using the substance but not managing to do so
- Spending a lot of time getting, using, or recovering from use of the substance
- Having cravings and urges to use the substance

- Not managing to do what you should do at work, home, or school because of the substance
- Continuing to use even when it is causing problems in relationships
- Giving up important social, occupational, or recreational activities because of substance use
- Using substances over and over again even when it puts you in danger
- Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance
- Needing more of the substance to get the effect you used to get at lesser dosages (tolerance)
- The development of withdrawal symptoms can be relieved by taking more of the substance.

2.3.2 Conceptualising Substance Use Relapse

Generally, the primary goal of substance use rehabilitation is to assist a substance user to abstain from drug usage (Sibhayi 2019). However, in many instances, the process of substance use recovery is not predictable, meaning that it may take one individual a single admission in a rehabilitation facility and they come out fully recovered, while others may take several admissions to eventually emerge victorious over their addictions (Kelly, Fallah-Sohy, Cristello & Bergman 2017). Implicitly, some people fall back into active drug usage after initial treatment thus warranting that they are readmitted and treated all over again (Sibhayi 2019). This process of returning to drug usage after initial treatment constitutes what is generally conceptualised as a relapse. Kelly et. al. (2017) write that along the journey to recovery, substance users

often encounter stressors that make them regress in their recovery process. Huang, Zhang, Dai, Zhang, Yang, Fan and Chen (2018) stress that for many substance users, cravings or flashbacks of the residual joy which can be extracted from using substances do not completely vanish as a result of treatment, rather they become latent and they can be easily revived when one faces a stressful situation for which they cannot handle.

Recent research on substance use relapse has largely concurred that relapse is a common outcome for many substance users who attempt recovery (Lal, Malla, Marandola, Thériault, Tibbo, Manchanda & Banks 2019). Some schools of thought have projected relapse as a normal and expected part of the recovery process for which recovering drug users and their families should anticipate and be capacitated to navigate and mitigate (Notley & Collins 2018). However, there is also another school of thought that projects that relapses are common in substance use recovery. It should not be conceived as an integral part of the recovery process, as doing so constitutes a disempowering and negative outlook (Swanepoel, Geyer & Crafford 2016). Swanepoel et.al (2016), goes on to say the high prevalence of substance use relapses, does not mean sobriety is inevitable. These scholars underscore that substance users ought to be vigilant and know their triggers and corresponding warning signs which often precede a relapse for them to be able to prevent it from happening or to at least reduce its duration and intensity.

Marlatt and Witkiewitz (2005) add that relapse is not an event that suddenly happens, rather, it is a process that unfolds in cumulative stages along which the urge to reuse gains momentum. According to Menon and Kandasamy (2018), in most instances, relapses start as casual contemplations and or flashbacks about the pleasurable

effects of substances or past desirable experiences associated with drug use. These contemplations get emboldened over time and they are converted from being mere thoughts to becoming physical compulsions (Costa, Cabral, Hohl & Fontes 2019). Concurringly Roos, Bowen and Witkiewitz (2017) aver that if remedial actions are not taken during the initial stages of the onset of the relapse process, it might gain momentum and become overpowering. Goode and Maren (2019) write that relapse start as a mere thought which if not disrupted is elevated to fantasizing about the drug. The fantasizing phase can become overpowering to the extent that the individual actively solicits for the drug and eventually reuse (Adinoff, Talmadge, Williams, Schreffler, Jackley & Krebaum 2010).

Marlatt and Witkiewitz (2005) mention that the initial usage is known as a lapse and a drug user has the potential to realise that it's a mistake and immediately seek help to avoid going full-blown into drug usage. These scholars differentiate between a substance use relapse and a lapse by indicating that the former constitutes a situation in which a recovery plan is completely abandoned with the drug user being aware of their intentions in drug usage. On the other hand, a lapse is construed as a single and often unplanned consumption of a substance and is often accompanied by remorse and regret (Maisto, Witkiewitz, Moskal & Wilson 2016). Brownell, Marlatt, Lichtenstein and Wilson (1986) pose that the rehabilitation process must capacitate drug users with skills to differentiate between a lapse and a relapse. Incorrect deduction and conceptualisation of relapse and lapse can result in substance users becoming de-motivated in their recovery after a lapse and giving in to a full-blown relapse (Priddy, Howard, Hanley, Riquino, Friberg-Felsted & Garland 2018).

2.3.3 Cause of Relapse

The initial transgression of problem behaviour after a quit attempt is defined as a **"lapse,"** which could eventually lead to continued transgressions to a level that is similar to before quitting and is defined as a **"relapse".** Another possible outcome of a lapse is that the client may manage to abstain and thus continue to go forward in the path of positive change, **"prolapse".** Many researchers define relapse as a process rather than as a discrete event and thus attempt to characterize the factors contributing to relapse (Menon & Kandasamy 2018).

The conceptualisation of the relapse process needs a prerequisite for identifying high-risk situations that lead to relapse (Melemis 2015). Commonly patients with substance use disorders are likely to relapse if they are presented with high-risk situations that they fail to overcome. These are situations/ environments/ moods/ cognitive patterns which are difficult and increase one's desire to use. High-risk situations need to be identified so a particular effort can be made in preventing the temptation to use the substance.

According to the document review from Rehabilitation centre A, the three P's of recovery refer to the 1st the Places, 2nd People and 3rd Playthings. The first P of the places refers to the environment, which can increase the risk of relapsing if it is infested with toxicity. Environments that resemble places of past drug use have the potential of luring individuals in recovery back to their old habits. Despite the number of times an individual receives treatment, if they are not protective over their environments, it is difficult to overcome high-risk situations. Bain (2004) says that environments have great potential of triggering even at a long period of abstinence,

as environmental stimuli (cues) associated with the drug use itself can produce withdrawal and craving in the absence of the drug (Swanepoel 2014).

The 2nd P refers to People who are toxic and who trigger relapsing. Individuals in recovery ought to keep themselves away from ex-using associates who model continued drug use, discourage sobriety and do not have skills to manage high-risk situations. After treatment, if one returns to the same associates as before it is likely probable to fall back. The pressure to use substances may be a result of overt pressure from friends who use substances or covert pressure within an individual to reignite friendship with toxic old friends (Wadhwa 2009). Even if peers display retrogressive behaviour covert pressure can lead an individual in recovery to follow suit regardless of the negative personal consequences of relapse there might be. Social networks are a huge contributor to either abstinence or relapse, according to Doweiko (2006), individuals with strong support systems and constructive social networks survive during craving times, unlike the direct opposite.

The 3rd P refers to Playthings, and these include all the things that could trigger cravings. Play things vary they could be specific foods, a movie, handling money and or any other patterns such as celebrations. Therefore, every individual in recovery should be aware of the playthings that are a temptation to them and work at avoiding them at all costs.

More to that interpersonal factors can expose an individual to high-risk situations which set off the memories of substance dependence. Peltzer and Ramlagan (2010), notes that unemployment and poverty are associated with active drug use, in general, the percentages of individuals who seek employment in South Africa are high. The employment field becomes barren especially for ex-users coming from treatment,

even in the event of the employment being available, employers become untrusting of the individual's fidelity. This becomes a high-risk situation when the pressure of unemployment burdens an individual in recovery.

Relapses usually occur when negative emotions are experienced, inability to manage these emotions can be risky to individuals in recovery as the most frequently cited reason for relapse was negative mood states such as stress, depression, sadness, boredom, anger, resentment, disappointment and loneliness amongst others. However, some of the mentioned mood states can be difficult to avoid but the individuals in recovery can learn to disclose, experience these emotions and resolve them in constructive ways rather than quick fixes which always leads to relapse.

Mastering the art of coping is vital in recovery, these assist in overcoming high-risk situations. Coping is referred to by Doweiko (2006) as an individual's ability to call on learned coping resources when confronted with drug-use cues. This also helps in overcoming cravings that may be triggered by drug-use cues, especially in cases of ongoing cravings that have the potential of breaking the commitment to abstinence.

More to that relapses are increased by the consideration of the only positive outcome of drug use neglecting the negative long-term consequences associated with it. Motivation plays a vital role in individuals in recovery as it may lead to sobriety or the opposite.

However, it seems some individuals are at a higher risk of relapsing than others due to their genetic propensity (Swendsen & Le Moal 2011). Passive-aggressive and compulsive personalities make it difficult for individuals to adjust to small routine changes thus giving them greater chances of relapsing (Doweiko 2006). Physical dependence is also a risk factor that can facilitate relapses, once the body gets used

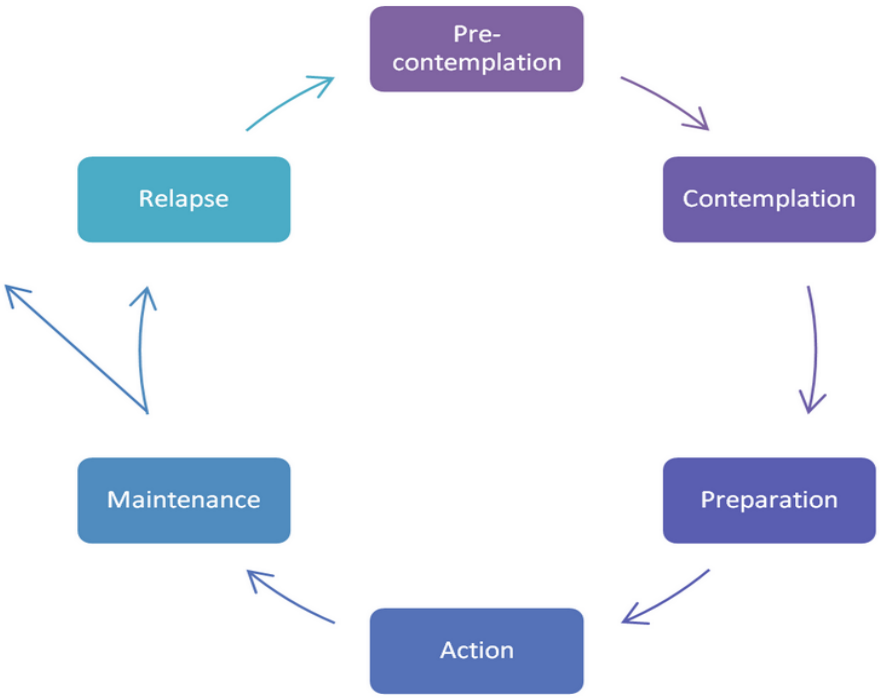
to being intoxicated any attempt to abandon it results in harsh withdrawal symptoms that only the drug can take away. This dependence that the body gets accustomed to is the negative physical and psychological effects that pose a high risk of relapses, especially amongst heroin and nyaope users.

2.3.3.1 Relapse as an outcome of the Change Process: A Change Process Perspective

Towards explaining locating the place of relapse in the grand scheme of the change process, Prochaska and DiClemente (1983) developed a five-stage model. The model underscores that the change process ranges from the stage of pre-contemplation, contemplation, preparation, action, maintenance through to change or relapse (Prochaska & DiClemente 1983).

The figure below graphically presents the schema of the change process.

Figure 3: Relapse Cycle



Source: Prochaska and DiClemente (1983)

2.3.3.2 Pre-Contemplation

As shown in the figure above, the change process including the substance use recovery process starts at the stage of pre-contemplation (Ali, Green, Daughters & Lejuez 2017). According to Livingston (2020) at this stage of the change process, drug users will be strongly opposed or have no intention to remedy their situation in the foreseeable future. Ali et.al. (2017) operationally defined "foreseeable future" as constituting at least six months. Castine, Albein-Urios, Lozano-Rojas, Martinez-Gonzalez, Hohwy and Verdejo-Garcia, (2019) write that during the pre-contemplation phase, the drug user is often unaware of his/her negative behaviour and its impacts on other people. The phase is also punctuated by extensive denial and ignorance of the problem (Ali et. al. 2017).

According to Prochaska and DiClemente (1983), the second stage of the change process is contemplation. Gareikitse and Plattner (2016) mention that in substance abuse interventions, contemplation entails that the individual becomes aware of the problem and they start to consider the benefits of abstinence. However, despite the acknowledgement of the problem, the phase is characterised by high levels of ambivalence and conflicted emotions and perceptions (Ali et.al). Gareikitse and Plattner (2016) write that in many instances people who get admitted into rehabilitation facilities voluntarily do so when they are at this stage. This phase is followed up by the action phase which according to Prochaska and DiClemente (1983) involves the individual becoming ready to experiment with small changes in his/her life. Castine et. al. (2019) mention that during the action phase, the individual demonstrates a willingness for change but remains sceptical of their potential to

succeed in the change process. They start to actively solicit for information to initiate and sustain new changes and develop change/recovery plans (Ali et. al. 2017).

Through mastering small changes and adopting of positive attitude requisite for sustaining change, drug users enter the next stage of the change process which according to Prochaska and DiClemente (1983) is termed the maintenance phase. The maintenance phase entails that the individual becomes more concerned about finding ways of making their newfound change more entrenched and permanent (Glynn & van den Berg 2017). The individual becomes aware of his/her weaknesses and is vigilant to avoid temptations that may cause him/her to regress. Ali et. al. (2017) writes that effective maintenance of behaviour change initiatives may entail the need to develop objective self-appraisal and self-rewarding systems. Unsuccessful change maintenance results in relapse while successful mastery and retention of change outcomes result in long-term recovery (Prochaska & DiClemente 1983). Those who fail to sustain change will fall back into their old habits (Glynn and van den Berg 2017). The stage of relapse is marked by strong feelings of disappointment, frustration and severely undercuts one's belief in their capacity for change (Glynn and van den Berg 2017; Prochaska & DiClemente 1983). After a relapse, an individual falls back into the change cycle all over again (Prochaska & DiClemente 1983).

2.3.4 Nature of substances on which substance users relapse on

According to White and Kelly (2011), there are many drug categories and specific drug types on which substance users relapse and seek interventions. Swanepoel et.al (2016) outline substances that in general, all drug categories including stimulants, depressants and hallucinogens are often associated with the

phenomenon of relapse. Bain (2004) adds that in most instances, relapse is a function of the potency of the drug, with highly potent drugs having a higher likelihood of causing a relapse. Commenting on the same issue, Campos (2009) mentions that there is no universal agreement on the specific drug types which cause the most relapse. According to this scholar, this is because substance use relapse is often concomitant with various factors including biological pre-dispositions, social environment, individual coping mechanisms, the efficacy of treatment programmes, individual support structure and personal belief in the ability to achieve and maintain recovery. To this end, the propensity towards relapse onto any substance varies from individual to individual regardless of the specific drug type they use. The table below graphically presents the various categories of drugs, the specific drugs which fall under each category, the method of consumption of the drug and lastly the general effects of each drug type.

Table 3: Drugs and drug effects

Category	Drug	How the drug is taken	Effects of the Drugs
Stimulants	Cocaine	Snorted	Alters the actions of the brain's Neurotransmitters, mostly dopamine (Sherman 2017)
	Crack Cocaine	Snorted	Same as Cocaine (Sherman 2017)
	Ecstasy	Smoked, injected	Enhanced sense of well-being, increased extroversion, emotional warmth, empathy toward others, enhanced sensory perception, high blood pressure, faintness World Health Organization (2011)
	Nicotine/tobacco	Smoked, chewed, inhaled	lung cancer, emphysema, and bronchial disorders. World Health Organization (2011)
Depressants	Alcohol	Drank	Depression, Liver damage. Cancer, Depression of the Immune system, Reduced sexual

			performance. World Health Organization (2011)
	Heroin	smoked, injected	high degree of dependence, valves, heart lining infection, pneumonia, abscesses, collapsed veins, fatal overdose (Khine & Mokwena, 2016).
	Nyaope	smoked, injected	Same as Heroin (Khine & Mokwena, 2016).
	Benzodiazepines	Drank	Drowsiness, confusion, dizziness, trembling impaired coordination, vision problems, grogginess feelings of depression Carrier and Klantschnig 2012)
Hallucinogens	Cannabis	Smoked	Disorientation, toxic psychosis, fluctuating emotions, fragmentary thoughts, paranoia, panic attacks, hallucinations (Carrier and Klantschnig 2012)
	LSD	Drank as pill, snorted	Serious psychological distress, Mental health problems, Suicidal thoughts, Suicidal plans, Suicide attempts, Depression and Anxiety (Sherman 2017)
	Crystal Meth	Snorted, smoked	Increased chances of developing cancer, Liver failure, Malnutrition Kidney failure, Birth defects Reproductive issues (miscarriages and infertility) Blackened, rotting teeth, Overdose Death (Kapp 2008)
	Flakka	Snorted, smoked	Bizarre behaviour and some effects as of crystal meth (Salani, Albuja & Zdanowicz 2018)

The next section will discuss literature related to the first objective of this research study: to establish the nature of relapse prevention therapeutic programmes used in selected rehabilitation centres in Gauteng Province of South Africa.

2.4 The Nature of Therapy Programmes used in Substance use Relapse Prevention

Evidence abounds showing that treatment of substance use relapse has continued to evolve over the years. Indications are that their evolvement has largely been influenced and tied to several socio-political transformations (Mbulayi & Makuyana 2017; Smart & Pacula 2019) medical discoveries (Worley 2017) and technological advancements (Swanepoel et.al 2016). Indications are that substance users who find themselves confronted with the problem of relapsing into substance use after a supposedly complete treatment regime have often found themselves getting help from programmes such as Short-Term/Inpatient/residential programmes, Long term residential programmes, Outpatient Programmes, Individualized Drug Counselling and Group Counselling (Geyer & Lombard 2014).

2.4.1 Short Term Inpatient/Residential Programmes

According to Stahler, Mennis, and DuCette (2016), short-term residential treatment programmes offer intensive but short-lived interventions which are usually tailored around a modified 12-Steps approach. Bisaga, Mannelli, Sullivan, Vosburg, Compton, Woody and Kosten (2018) note that short-term residential programmes were traditionally designed to specifically cater to persons battling with alcohol use problems. However, its scope has since been extended to cater for other substances (Stahler et. al 2016). According to Makuyana (2018), the length of short-term residential programmes generally ranges between three up to six weeks of intensive interventions. Precisely, McCarty, Braude, Lyman, Dougherty, Daniels, Ghose, and Delphin-Rittmon (2014) write that short-term residential programmes vary widely in terms of duration, recovery philosophy, and degree of structure. Some inpatient

treatment programmes range from 6 to 12 weeks, where patients receive 24-hour supervision with the management of the medical and psychiatric conditions while working on their recovery from addiction (Zhu & Wu 2018). Stahler et. al. (2016) add that most short-term residential programmes combine pharmacological and psychosocial interventions and make referrals for extended outpatient therapy and participation in self-help groups which are mainly known as aftercare support groups. The pharmacological component of short-term residential programmes mainly focuses on controlling co-morbid disorders such as medical and psychiatric conditions which co-exist with the substance use problem (Makuyana 2018; Balistreri 2013). Diaper, Law and Melichar (2014) specifically note that most residential drug treatment centres offer pharmacological detoxification as the first-line intervention.

According to Kasiram and Jeewa (2008), short-term residential programmes generally give holistic solutions to patients with substance use disorders as they engage the person in total including his/her environments. Among a range of specialised interventions, short-term residential programmes offer types of psychotherapy like cognitive-behavioural therapy (Balistreri 2013), multidimensional family therapy (Liddle, Dakof, Rowe, Henderson, Greenbaum, Wang & Alberga 2018) motivational interviewing, and motivational incentives (Jiang, Wu & Gao 2017).

The physical exercise programme implemented in short term rehabilitation proves to assist in reducing cravings and produce improvements in fitness and different aspects of quality of life, such as mental health, psychological benefits, vitality, physical function, social function, and general health (Giménez-Meseguer, Tortosa-Martínez, & Remedios Fernández-Valenciano 2015). Lennox and Cecchini-Sternquist (2018) mention that some withdrawal symptoms last months or years after

drug cessation, and this usually precipitates a return to substance misuse. These authors mention that sauna therapy and exercise programmes help to reduce withdrawal symptoms including cravings, low-level physical discomfort, disturbances in sleep, and mood and reduced cognitive function.

Pruett, Nishimura and Priest (2007) note that the meditation programme is an important component in addiction recovery, they mention that the success of addiction recovery is often based on the individual's ability to develop and use a repertoire of coping behaviors. Meditation helps individuals in addiction to refocus and it provides a consistent means of preparing for the inevitable. It also helps to overcome addiction-related life challenges and enhances coping skills that can help maintain equilibrium in living with ever-present peril.

More to that Golestan, Namayandeh, and Anjomshoa, (2011) mention that the life skills programme is important in prevention of relapse amongst opiate users and that the lack of life skills is an operative factor to relapse. Developing life skills is a way one can master how to avoid relapses, rehabilitation centres teach life skills with the hope that they can assist individuals in the long run (Barr & Parrett 2001).

The philosophy behind these interventions is that psychosocial interventions are critical for enhancing drug users' readiness and willingness to receive pharmacological treatments which usually constitute the main thrust of short-term residential programmes (Jiang et.al 2017). Towards enhancing the therapeutic environment, some short-term residential programmes are luxuriously designed to suit those who can afford and also offer treatment at a more comfortable level, at most this is what differentiates government rehabilitation centres from private ones (Rouche 2014).

More to that there are residential programmes that are based on the belief that anyone can change given the correct environment these are known as Therapeutic communities. Therapeutic communities were formed in 1958 (Drug and Alcohol Rehab Asia (DARA) 2016). Mainly these are designed for patients with long-standing or persistent addiction history. These are long-term residential programmes that usually can go up to a year or longer. The therapy programmes that are offered at short and long-term residential rehabilitation centres are the same, the only difference is the period the therapies are administered to the individuals. More to that therapeutic communities may fall under long-term residential treatment, also the approach is quite different. These use participative, group-based approaches; and halfway houses, which provide a combination of treatment and housing support (Chiu, Ho, Lo & Yiu 2010). These communities are designed to create environments that will foster the desired change of behaviour. A minimum of a year is required to maintain a healthy lifestyle, saying that people need adequate time in treatment to adjust to the healing process if they are to sustain improvement.

2.4.2 Long term Residential Programmes

The second commonly used approach geared towards rehabilitating and preventing substance use relapse is long-term residential programmes. These programmes are generally long-term in nature ranging between six up to twelve months in length. According to Manuel, Yuan, Herman, Svikis, Nichols, Palmer and Deren (2017), long-term residential programmes provide care 24 hours per day in non-hospital settings. Decker, Peglow, Samples and Cunningham (2017), write that Therapeutic Communities (TCs) are some of the most common and most effective approaches used in curbing recidivism in substance use treatment. The focus of long-term residential programmes, particularly TCs is to re-socialize the drug user after long-

term substance use (Manuel et. al. 2017). Long-term residential programmes underscore that whereas professionals are important in reforming drug users, particularly those with a history of repeated relapse, such persons can best learn from each other (Cutcliffe, Travale, Richmond & Green 2016). In this sense, Vergara-Moragues and González-Saiz (2020) mention that the interaction between residents in a long-term residential programme and the concomitant environment is therapeutic on their own. Residents provide moral guides to each other and learn from each other's mistakes (Decker et.al 2017). The overarching philosophy driving long term residential programmes is that addiction to substances is an outcome of social and psychological deficits in the individual and thus programming emphasizes socially grounded treatment approaches whose focus are pinned on improving personal and relational accountability and also help foster capacity for productivity in the individual (Decker, Peglow, Samples & Cunningham 2017; Manuel et. al. 2017).

Long-term residential programmes offer highly structured interventions whose goals are to reinvent and refine a sense of routine and predictability in the lives of drug users (Kasiram & Jeewa 2008). Cutcliffe et. al. (2016) adds that long-term residential programmes such as TCs encourage amicable confrontation between and among residents and programmes staff towards promoting helpful self-introspection and examination of negative beliefs, self-concepts behaviours. The grounding belief is that some of the drug users may not be aware of their negative behaviours and beliefs, thus confrontation brings such beliefs and behaviors to their conscious awareness and they can start to work on changing such behaviours (Barnard 2006)

Long-term residential programmes also construe that addressing the behavioral, cognitive and physiological aspects of addiction is not enough (Cutcliffe et. al. 2016).

According to Manuel et. al. (2017), these long-term residential programmes advocate for comprehensive services which can enable recovering drug users to successfully reintegrate into their families and communities after their discharge (Jiang, Wu & Gao 2017). Among other services, long-term residential programmes such as training centres offer vocational training, linking substance users with actual or potential employers, and family reunification (Makuyana 2018).

2.4.3 Twelve steps programme

A Twelve-Step Program is a set of guiding principles outlining a course of action for recovery from addiction, compulsion, or other behavioral problems (Jannasz 2018). The twelve steps program was initially started by the Alcoholics Anonymous (AA) as a method of recovering from alcoholism, specifically was founded by Dr. Bob Smith and Bill Wilson around 1935 in Akron, Ohio. Around 1839 about one hundred men and more had recovered from addiction, this was later adopted for Narcotics addiction after its proven success (Orrok 1989; Jannasz 2018). However, it was only in 1853 when the AA gave the NA official permission to adopt its steps. Most rehabilitation centres use the twelve steps programme which can be classified as a form of cognitive behavioural therapy, because of the nature it has of transforming the mind and the individuals' behaviour.

NA was formed by individuals who had substance use disorders, who did not relate to the specifics of the AA. Similar demographic preferences related to their' drug of choice have led to the creation of Cocaine Anonymous, Crystal Meth Anonymous, Pills Anonymous, and Marijuana (Jannasz 2018).

Table 4: Twelve Steps Programme Outline

Programme Step	Focal Activity
1	Acceptance of powerlessness over addiction,
2	Believing higher power's ability to restore sanity,
3	Dedication of lives to a higher power,
4	Fearless moral inventory.
5	Admission of wrongdoing to everyone,
6	Allowing higher power to remove defects of character,
7	Request higher power to remove shortcomings,
8 & 9	8 and 9. Making a list of people wronged and making amends
10	Continuation of taking personal inventory
11	Prayer and meditation
12	A Spiritual awakening as a result of all the steps

Muskin, (2015)

Above all these steps have been adopted for most dependency problems. This treatment approach has been employed by rehabilitation centres for substance use patients who suffered from several relapses. In most cases, where the twelve steps have been adapted as guiding principles, they were altered to emphasise principles vital to the fellowships like suiting the steps for all genders.

2.4.4 Outpatient Programme

Generally, outpatient services can be construed as medical procedures or tests which do not involve the detainment/admission of patients in a medical facility (Wilson 2017). Precisely, outpatients receive treatment and go back to their homes (Wilson 2017). The general philosophy behind outpatient programmes is the need to provide interventions to clients in the context of their natural environments (Wallace & Weeks 2004). Outpatient treatment programmes are designed to support mostly the patients mostly released from the residential treatment (McCarty et. al. 2014). Makuyana (2018) notes that, in many instances, outpatient drug treatment programmes target recovering drug users who would have been discharged from the residential treatment programmes and assist them to reintegrate and adjust post-residential

care. These are community-based programmes facilitated by rehabilitation centres, to help the patients of recovery maintain their sobriety and reintegrate well back into society. According to McCarty et. al. (2014), when substance users undergo rehabilitation for addiction in residential facilities, they get accustomed to the protected environments of the institutions and upon discharge into natural environments they face the risk of relapse. To this end, outpatient programmes capitalise on this deficit of residential programmes and advocate for the treatment of substance users within their natural contexts (Makuyana 2018; McCarty et. al. 2014). Concurringly, Rouche (2014) underscores that in the context of outpatient programmes, substance users get the chance to be treated and supported for real-life challenges as opposed to more theoretical interventions offered in residential programmes.

Wilson (2017) observes that in many instances, persons who are admitted into outpatient programmes are perceived to be at low risk. Wilson (2017) mentions that outpatient drug treatment programmes offer several advantages including lower costs, improved continuum of care, better patient experience, and ability to absorb higher numbers and reduced waiting periods before admission.

More to that outpatient programmes are also conducive for those who have substance use disorders but cannot be institutionalised due to diverse life commitments (Wallace & Weeks 2004). According to Jules-Macquet (2015), outpatient programmes are the most preferred drug treatment modality in South Africa. This scholar postulates that the popularity of outpatient programmes in South Africa derives from two main factors including that they are cheaper and offer flexible schedules which suit the work and family commitments of many drug users. In South

Africa, outpatient programmes are largely championed by the South African National Council on Alcohol and Drug Dependence (SANCA) (Sibanda 2019).

2.4.5 Pharmacotherapy Programmes

Substance use relapse is increasingly being managed through different types of pharmacotherapy including nicotine replacement, bupropion, and varenicline used for tobacco use disorders; naltrexone and acamprosate used for alcohol use disorders and methadone and buprenorphine mainly used for opioid use disorders (Klein 2016). According to Kranzler and Soyka (2018), pharmacotherapy relates to the treatment of a disorder or disease through the use of medication. Sharma, Kelly, Mitchell, Gryczynski, O'Grady and Schwartz (2017); Klein (2016) underscore that pharmacotherapy in substance use treatment has several fundamental functions including treating comorbid disorders or conditions, reducing the intensity of withdrawal symptoms, reducing the craving for the substance and reducing the likelihood of relapse by blocking their effect of specific drugs.

While pharmacotherapy has been widely hailed for its effectiveness, analysts have warned that the modality possesses several dangers to substance users (Ostadi, Zamani, Hassanian-Moghaddam, Khosravi & Shadnia 2019). Makuyana, (2018) writes that medications such as naltrexone which work by blocking the effect of a drug of choice by a drug user can result in fatalities as it may induce one to overdose by continuing to use substances while not getting the effect they are looking for.

2.5 This section discusses the second objective: to determine the extent to which selected therapy programmes assist in the prevention of substance use relapse.

One of the major discourses straddled across the many centuries and decades of substance use interventions has been the issue of determining the extent of the efficacy of therapeutic programmes. Coming from a background characterized with some therapeutic missteps, such as the usage of amphetamines and cocaine as a treatment for opiate addictions, substance use researchers have become more concerned about ensuring that all interventions are evidence-based and have higher efficiency both in terms of treating current symptoms and stemming out the probability of future relapse. Also, inspiring debates on the effectiveness of drug use therapy programmes is the acknowledgement by global leaders including leading research and development organizations that the substance use problem is exponentially growing and thus upsetting global public health systems and outcomes (Musto & Korsmeyer 2008). This has raised some pertinent questions regarding if the current interventions being offered are serving the purpose they were designed for. Demographers have warned that without urgent and decisive remedial action by authorities, the disease burden associated with substance use will soon overtake the impact of HIV/AIDS. Analysts have noted that the substance use problem is costly to the global economy in terms of lost productivity at the workplace, costs associated with establishing and maintaining drug treatment facilities, premature deaths and costs related to the prosecution and incarceration of those who commit crimes while intoxicated. Given the foregoing, it has become pertinent to ensure that all therapeutic programmes geared towards treating substance use disorders are effective and responsive to the unique needs of drug users (Copeland & Martin 2004).

2.6 Issues around the efficacy of various drug use therapy programmes used in South Africa and other parts of the world.

This section discusses issues around the efficacy of various drug use therapy programmes used in South Africa and other parts of the world. Literature aptly demonstrates that there is no cure for substance use disorders. Research communities agree that substance use is often a lifelong phenomenon for which one has to continually maintain personal mindfulness for them to retain recovery and well-being. The general understanding is that there is no specific timeframe post-treatment after which a drug user may be certified as being cured of a drug use disorder. Rather, experts in the field underscore that each drug user has to live by the universal rule of “one day at a time” which simply means that one is only guaranteed of being sober just for the current moment, Olitzky and Copans (2009) write that even after several decades of abstinence, one can fall back into the vicious cycle of addiction. To better comprehend the subject of the effectiveness of substance use therapy programmes, it suffices to start with a presentation of the universal principles of effective drug use treatment as per the National Institute on Drug Abuse (NIDA 2020).

2.6.1 Principles of Effective Substance Use Treatment

For therapy to be effective it has to be guided by principles, the table below lists the principles of effective substance use treatment provided by the National Institute on Drug Abuse (2020), and provided detailed explanations to each one.

Table 5: Principles of Effective Substance Use Treatment

No//	Principle	Explanation
1.	*Addiction is a complex but treatable disease that affects brain function and behaviour*	*Substances after abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why substance users are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences (National Institute in Drug Abuse 2020)*
2.	*No single treatment is appropriate for everyone*	*Treatment varies depending on the type of substance and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.*
3.	*Treatment needs to be readily available*	*Because individuals with substance use disorders may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.*
4.	*Effective treatment attends to multiple needs of the individual, not just his or her drug abuse*	*To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture*
5.	*Remaining in treatment for an adequate period is critical*	*The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most individuals with substance use disorders need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment*

		prematurely, programs should include strategies to engage and keep patients in treatment.
6.	*Behavioural therapies—including individual, family, or group counselling—are the most commonly used forms of drug abuse treatment*	*Behavioural therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.*
7.	*Medications are an important element of treatment for many patients, especially when combined with counselling and other behavioural therapies*	*For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioural treatment program.*
8.	*An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.*	*A patient may require varying combinations of services and treatment components during treatment and recovery. In addition to counselling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.*
9.	*Many drug-addicted individuals also have other mental disorders*	*Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.*
10.	*Medically assisted detoxification is only the first*	*Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and*

	stage of addiction treatment and by itself does little to change long-term drug abuse	*can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.*
11.	*Treatment does not need to be voluntary to be effective*	*Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.*
12.	*Drug use during treatment must be monitored continuously, as lapses during treatment do occur*	*Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signalling a possible need to adjust an individual's treatment plan to better meet his or her needs*
13.	*Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counselling, linking patients to treatment if necessary.*	*Typically, drug abuse treatment addresses some of the drug-related behaviours that put people at risk of infectious diseases. Targeted counselling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviours. Counselling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receives their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.*

Adapted from: National Institute on Drug Abuse NIDA, (2020)

The principles of effective drug use treatment outlined above provide a grounding environment within which the efficiency of substance use therapy programmes can be understood, interpreted and applied.

2.6.2 Effectiveness of drug use therapy programmes

2.6.2.1 Effectiveness of Short Term Inpatient/Residential Programmes

According to Meier (2005), short-term residential drug treatment programmes are some of the most common drug treatment modalities used across the world. The popularity of these drug treatment programmes is largely based on their immediate benefits of including removing the drug user from a toxic environment and placing him/her in a safe and well-moderated environment wherein he/she receive holistic care. According to Monteiro (2002), short-term residential programmes have in recent times remodelled to encompass different services such as medically assisted detoxification, psychosocial counselling, spiritual awakening and reconnection, sauna therapy, physical exercises, cognitive behavioural therapy (CBT) and the 12 Steps programme. Mbulayi and Makuyana (2017) mention that the agglomeration of these services has proved to be very effective in many residential drug treatment programmes. Their study found that at least 47% of all participants who had received services in an inpatient/residential drug treatment programme they were assessing managed to retain sobriety for at least one year from the date of their discharge. These scholars reported that their study participants who have remained sober after one year attributed their ability to remain abstinent from substances to the introspective counselling they had received while they were admitted at the residential facilities. Similarly, Kelly, Brown, Abrantes, Kahler, and Myers (2008) found in their study that participants believed that the structured environments in

residential drug treatment facilities were an essential component of these programmes and aided to their overall effectiveness. Precisely, Bain (2004) mentions that structured environments help to ensure that clients only focus on their substance use problems and do not get distracted by other issues which are common if they were to use outpatient programmes.

Furthermore, short-term residential programmes are more effective due to their intensive intervention. By providing multifocal services, residential drug treatment services have a better chance of holistically addressing the foundational factors responsible for causing one to use substances. Additionally, according to Solbakken and Abbass (2015), short-term residential/inpatient drug rehabilitation programmes emphasise the uniqueness of the individual and they assist each client to design an appropriate treatment plan which suits their unique needs and circumstances. The fundamental philosophy underlying residential drug treatment programmes is that notwithstanding similarities in terms of the drug of choice, individual ages, socioeconomic background and other demographic variables, no two individuals can have the same treatment plan.

Greenfield, Venner, Kelly, Slaymaker and Bryan (2012) pose that another success factor associated with short-term residential drug treatment plans is that in many instances, these programmes are privately owned and thus they often have less bureaucracy. For example, Makuyana (2018) found that privately-owned short-term residential treatment facilities had shorter waiting periods before they can admit a drug user. This goes a long way in reducing fatalities during the waiting period.

However, there are some significant challenges associated with short-term residential drug treatment programmes. According to Solbakken and Abbass (2013),

one of the major drawbacks of short-term residential programmes -is that they tend to be unaffordable, especially to low-income earners. Secondly, another setback is that in many instances, these programmes tend to be located in affluent places where the majority of the poor cannot sustainably access them.

From a programming point of view, Makuyana (2018) mentions that due to the growing demand for residential treatment services, some programme managers are shortening their admission periods thus resulting in ill capacitated drug users being sent back to communities thus exposing them to the inevitable fate of relapse. In a sharp deviation from the traditional admission period of six weeks, a study by Makuyana (2018) found that there were short-term residential drug treatment programmes ranging from as little as 3 days up to the traditional six weeks. While this perhaps may mean that there is now more convenience associated with drug treatment in residential programmes, the quality and eventual outcomes of these programmes become questionable.

2.6.2.2 Effectiveness of Outpatient Programme

In terms of geographical coverage, outpatient programmes are the most common drug treatment modality used across the world. Swanepoel et. al. (2016) add that outpatient programmes have the benefit of convenience as they allow drug users who may have other personal, familial and professional responsibilities to concurrently receive treatment while also undertaking their other functions. According to Doweiko (2006) notwithstanding that outpatient drug and substance use treatment programmes are the most subscribed, their success rates are dependent on several factors. Dos Santos, Rataemane, Fourie and Trathen (2010) notes that the effectiveness of outpatient programmes is undercut by several factors including those

drug users who receive treatment in these programmes do so under difficult circumstances of going back to sometimes negative environments which negate their gained coping skills. More so, in many instances, outpatient programmes are often publicly owned and they often have a perennial challenge of poor funding. Furthermore, in her study of the contributions of selected drug treatment programmes to the vision of ameliorating the drug problem in South Africa Makuyana (2018) established that outpatient programmes had the weakness of trying to solely provide psychotherapy and group work activities without any attempt to manage the client withdrawals. This scholar noted that due to lack of medically assisted detoxification, many drug users who attend outpatient programmes tend to run away and revert to drug use citing that the withdrawals will be painful.

However, on the brighter side, Carroll and Onken (2005) found out that outpatient drug use treatment programmes in South America which combined Cognitive Behavioural Therapy (CBT) and methadone maintenance programmes were yielding positive outcomes for those who were addicted to opiates. Similarly, the UNODC (2017) notes that drug treatment facilities in various countries across the world, where there was good administration, regular attendance by participants, constant and objective monitoring and evaluation, outpatient programmes were yielding success rates exciding 60% over an intervening period of six months.

2.6.2.3 Effectiveness of Pharmacotherapy Programmes

Although pharmacotherapy as a modality for drug treatment has been in existence for so long, Carroll (1997) admits that these programmes are still not very much understood. Critiques of the modality advance the view that medication only addresses the physical symptoms of addiction and does nothing or very little towards

resolving the causative factors behind the problem. However, analysts have noted that on their own, medication is largely important as a first step in the recovery process to assist with detoxification. Furthermore, Elias and Kleber (2017) write that it is difficult to fully tell the effectiveness of pharmacotherapy as this modality is often used as a complementary strategy to help manage the often disorientated states of drug users when they enter treatment. More so, Ayanga, Shorter, and Kosten (2016) pose that in many instances, drug users often present with other co-morbid diseases and disorders such as anxiety, psychosis, HIV/AIDS and many other conditions which require medical treatment. In their study, Ayanga et.al (2016) found that substance users who were admitted for opiate addiction in short and long-term residential programmes and were not on medically assisted detoxification programmes tended to abscond from treatment as compared to their counterparts who received medically assisted detoxification. In this sense, Elias and Kleber (2017) underscore that while pharmacotherapy cannot be perceived as a truly stand-alone drug and substance treatment approach, it is a necessary pre-condition for other behavioural interventions.

2.7 Recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use relapses.

The last objective of this study was to formulate recommendations for improving the outcomes of substance use relapse prevention and treatment programmes. It thus suffices to explore some literature on the nature of recommendations and conclusions reached by other scholars who contributed to this discourse. As already illustrated, in this chapter, substance use relapse is a complex phenomenon and

there is no singular intervention that is guaranteed to eliminate possibilities of relapse. By and large, experts suggest that the best substance use relapse prevention and treatment modalities are those which are tailored according to individual needs and circumstances (Braciszewski, Wernette, Moore, Tran, Bock, Stout & Vose-O'Neal, 2018). Rolland, D'Hondt, Montègue, Brion, Peyron, de Ternay and Maurage (2019) write that blanket approaches to substance use relapse interventions are dangerous and at most unfair to substance users who are put into straitjackets which may not be relevant to their circumstances. The ensuing section provides an overview of what other studies recommend as pre-requisites for effective and sustainable substance use relapse prevention programming.

2.7.1 Use of Cognitive Therapy Approaches

Literature abounds showing that many researchers concur that cognitive therapy approaches are effective and more sustainable in combating the problem of substance use relapse (Fortuna, Porche & Padilla, 2018; Vujanovic, Meyer, Heads, Stotts, Villarreal & Schmitz, 2017; Priddy et.al 2018). As discussed earlier in this chapter, cognitive therapy is a form of psychotherapy that is premised on the conviction that psychosocial problems emanate from the way people perceive and interpret their situations which in turn inform how they feel about such situations (Vujanovic et. al 2017). As such, increasingly many substance use relapse researchers believe that the best way of helping people with substance use relapse problems is by way of challenging how they perceive their problem and the subsequent meanings they give to the symptoms and outcomes of their drug-using problems (Priddy et. Al 2018). In his study Melemis, (2015), found a plurality of negative thoughts and beliefs such as:

1) My problem is because of other people; 2) I don't think I can handle life without using; 3) Maybe I can just use occasionally; 4) Life won't be fun — I won't be fun — without using; 5) I'm worried I will turn into someone I don't like; 6) I can't make all the necessary changes; I can't change my friends; 7) I don't want to abandon my family; 8) Recovery is too much work; 9) My cravings will be overwhelming; I won't be able to resist them; 10) If I stop, I'll only start up again; I have never finished anything; 11) No one has to know if I relapse; and 12) I'm worried that I have been so damaged by my addiction that won't be able to recover.

*(*Adopted from: Melemis, 2015; 327*)*

According to Melemis (2015), the negative undertones in these beliefs and self-actualisations undercut a drug user's self-efficacy and desire to achieve and retain long-term recovery. Accordingly, Cherkin, Anderson, Sherman, Balderson, Cook, Hansen and Turner (2017) suggest that to unravel these belief systems and negative thinking, there is a need for deliberate programming which seeks to overturn these negatives and replace them with positive beliefs and thought patterns. Challenging negative beliefs and thought patterns require that substance use therapists take their time to understand every one of their clients and confront them about ill thoughts (Makuyana 2018). Melemis (2015) notes that cognitive therapy requires that substance use therapists hold a psychological mirror through which substance users can reflect and introspect and realise where they will be going wrong and adjust themselves accordingly.

Sprague Martinez, Walter, Acevedo, Lopez and Lundgren (2018) add that for effectiveness, social workers and other psychosocial professionals who work with substance users ought to be genuine in their approach to their clients. Forman and Moyers (2020) write that in their study of the effectiveness of cognitive therapy as a

modality of substance use treatment and relapse prevention, found that many practitioners were failing their clients by failing to be genuine. According to these scholars, many therapists lose their clients when they try to be prescriptive and directive of which elements in the thoughts and behaviour of the client will be causing them to relapse. Hawke, Mehra, Settipani, Relihan, Darnay, Chaim and Henderson (2019) note that naturally, substance users come from backgrounds where they feel misunderstood by everyone trying to tell them what to do, this makes them resistant. Accordingly, Forman and Moyers (2020) suggest that it is imperative that cognitive therapy sessions be non-directive but rather allow the drug user to realise and make a personal and conscious decision to change without necessarily being pressured or told how to live their lives. Precisely, cognitive therapists should manipulatively direct a client to identify and acknowledge their problems by themselves, this makes intervention more sustainable.

2.7.2 Ensuring adequate programme length and intensity

There seems to be growing currency among different research communities that one of the major contributing factors to the growing phenomenon of substance use relapse pertains to the issue of poor programming with special regard to programme length and intensity. In her study, Makuyana (2018) found that in South Africa, substance use rehabilitation programmes were increasingly becoming short-lived. Scholars such Schmidt, Bojesen, Nielsen and Andersen, (2018); Campbell, Alexander and Lemak, (2009) underscore that short-lived interventions are not effective for mitigating the substance use problem and predispose drug users to high risk of relapse. Schmidt et al., (2018) write that short-lived substance use rehabilitation programmes only address the external symptoms of drug use and they

seldom venture into the foundational psychosocial factors responsible for the individual's initiation and maintenance of drug use behaviour. These scholars add that short-term interventions do not equip substance users with relapse prevention skills. Makuyana (2018) describes programmes of less than one week as money making schemes designed to fleece people of their hard-earned money without offering any significant treatment.

While there is still no universal agreement of the standard length of substance use treatment and relapse prevention programmes, there seems to be a consensus that the duration of treatment should be discussed and agreed on based on individual circumstances (Schmidt et.al 2018). Secondly, there is general convergence among research communities that short-term residential treatment programmes should have a basic duration of 28 days (Jordan & Andersen, 2017). Researchers also agree that no yardstick can be used to measure the intensity/dosage strength of interventions (Daughters, Magidson, Anand, Seitz-Brown, Chen & Baker 2018). However, general perceptions are that interventions should be applied daily in respect of the agreed treatment plans and durations (Schmidt et.al 2018). More so, there an admission that for effectiveness, there is a need to combine pharmacotherapy and psychosocial interventions in a singular intervention plan to ensure holistic interventions (NIDA, 2020). Precisely, NIDA (2020) writes that pharmacotherapy should be viewed as an essential component of a drug use treatment plan and not a standalone treatment on its own. Additionally, Beetham, Saloner, Gaye, Wakeman, Frank and Barnett, (2020) add that drug treatment interventions should be a multi-stakeholder process in which each stakeholder determines the intensity of interventions based on individual client needs.

2.7.3 Improving the competencies and support available to drug use therapists

One of the key outcomes of research on substance use studies has been the finding that many substance use rehabilitation programmes were being implemented by people without requisite competencies to effectively execute their mandates (Fanucchi, Walsh, Thornton & Lofwall 2019). Available literature notes that some programmes are manned by former drug users who attempt to force their personal experiences to inform interventions and disregard individual uniqueness (McKay, 2017). More so, in her study, Makuyana (2018) found that the managerial positions of the substance use rehabilitation facilities which they were assessing were occupied by personnel without any psychosocial or medical backgrounds. This scholar noted that this situation means that important decisions about programme refinement are being taken by those who may are not well equipped to deal with the multifaceted problems of substance use. Given the foregoing, Englander, Weimer, Solotaroff, Nicolaidis, Chan, Velez and Hartnett (2017) mention that social work education institutions should infuse specific modules on substance use treatment in their degree programmes. Similarly, McKay (2017) calls for the growth of specialist substance use treatment postgraduate qualifications which can equip personnel with requisite competencies. Perhaps these programmes ought to be designed and offered in a manner that is flexible and sensitive enough to cater to the sometimes busy schedules of those working in drug rehabilitation facilities. Another important recommendation towards the improvement of the outcomes of substance use treatment and relapse prevention has been that there is a need for local substance use rehabilitation institutions to develop knowledge sharing platforms (Fanucchi et.al 2019; NIDA, 2020). The general idea is that if professionals working in rehabilitation

centres can come together and share their practice experiences and challenges, they can be able to help each other in developing fail-proof interventions.

2.7.4 Ongoing Monitoring and Evaluation of Drug Use Therapies

Research communities also seem to be converging on the acceptance that effective substance use treatment and relapse prevention is incumbent on regular programmes monitoring and evaluation (Englander et.al. 2017; Babor, Del Boca, & Bray, 2017). There are growing calls for strict monitoring and evaluation of substance use treatment and relapse prevention programmes (Babor, Del Boca & Bray, 2017). According to Park-Lee, Lipari, Hedden, Kroutil and Porter (2017) objective monitoring and evaluation of substance use and relapse prevention therapies allow rehabilitation facilities to ground their interventions on credible evidence of what has been proven to work as opposed to following blind intuition. Babor, Del Boca and Bray (2017) note that monitoring of the effectiveness of drug use and relapse-prevention interventions ought to follow substance users after their discharge and determine their challenges and establish success factors at different designated timeframes. Such knowledge can be used in informing programming which can be sensitive to identified post treatment challenges and also emphasise the success factors associated with recovery in community settings (Englander et.al. 2017; Park-Lee et.al. (2017).

2.8 Conclusion

This chapter explored literature to respond to the central research objectives and research questions upon which the study was premised. The chapter opened with an in-depth analysis of the historical terrain associated with the evolution and development of substance use treatment up to modern interventions. The section on

the history of substance use treatment also highlighted the origins of the phenomenon of substance use relapse, debates surrounding the phenomenon and the subsequent interventions designed to curb its occurrence. Key in this debate is the Relapse Prevention Model which was deliberately left out from this chapter as it is exclusively discussed in the following chapter (Chapter 3). The chapter also dealt with issues of conceptualizing the key variables of the study including substance use, substance use relapse and outlining the criteria used in assessing substance use disorders. Towards consolidating the comprehension and subsequent place of the notion of substance use relapse in the grand scheme of the change process associated with substance use rehabilitation, Prochaska and DiClemente's (1983) change model was discussed and illustrations of how and when relapse occurs were made. Comprehensive discussions which directly addressed themselves to the core objectives of the study including the nature of substances on which drug users commonly relapse on and the subsequent intervention programmes designed to curb relapses were made. Furthermore, the literature on the extent to which the identified therapy programmes that were being used in helping relapsed substance users was also identified and extensively discussed. To provide a generic framework and build a much-needed context for understanding and measuring the effectiveness of therapy programmes designed to deal with relapsed substance users, an apt outline of the Principles of Effective Drug Use Treatment was provided.

3 CHAPTER THREE: THE THEORETICAL AND LEGISLATIVE FRAMEWORK

3.1 Introduction

The previous chapter largely concentrated on reviewing the literature on the discourse of substance use relapse and establishing the philosophical underpinnings of this phenomenon. This chapter establishes the theoretical foundations of the phenomenon of substance use relapse towards developing a context within which its variables were perceived, interpreted and applied in this study. However, before delving into the theoretical framework of the study, an introduction of the legislative environment surrounding the prevention, treatment and care of those afflicted by the scourge of substance abuse is provided.

3.2 Policy Environment Surrounding Substance Use Relapse Treatment and Prevention

Generally, a policy can be construed as a course or principle of action adopted or proposed by an organisation or individual to regulate or guide certain operations. From administrative and programming points of view, policies constitute decision making guidelines on resource allocation, responsibility delegation, procedures and processes of monitoring and evaluation as well as acceptable professional conduct by employees and other stakeholders. Concurringly, the Central Drug Authority (CDA) in the National Drug Master Plan 2019 – 2024 writes that although policies offer a wide range of benefits, their (policies) primary goals are to put into writing the expectations which an organisation/institution/government have regarding the workforces' behaviour, actions, and processes they take in specific scenarios. It is in

this light that a discussion of the policy environment surrounding substance use prevention and treatment in general and relapse prevention, in particular, became an important undertaking in this study. The ensuing section explored the various drug and substance control systems and policies. An attempt is also made to articulate the challenges, gaps and opportunities associated with the drug control system and their concomitant implications on relapse prevention.

3.3 Drug use Policy Environment: A Global Glance

There is no specific global legislation that speaks about drug and substance use relapse. Issues around relapse after a supposedly successful treatment intervention are dealt with under the auspices of generic drug and substance use prevention, treatment, harm reduction legislation and policies. Drug and substance use is a major public health threat and a significant security concern in many countries across the world. Indications are that the phenomenon of drug and substance use haemorrhages global economies in devastating ways.

Globally, drug and substance trafficking, usage and prevention of its abuse are controlled through three fundamental conventions namely, the Single Convention on Narcotic Drugs of 1961, the 1971 Convention on Psychotropic Substances and the United Nations Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances of 1988 (Moise 2018; Carpentier, Niaz & Tettey, 2018). The focus of these instruments is on slowing, reducing, stopping and possibly thwarting the proliferation of the drug problem around the world (Carpentier, Niaz & Tettey, 2018).

The section that follows disseminates information on conventions held and Acts that were put in place concerning the use of substances.

3.3.1 The Single Convention on Narcotic Drugs (1961)

The Single Convention on Narcotic Drugs of 1961 is the first global committal by world leaders towards dealing with the bane of substance use in the world (Knöss, van de Velde, Sandvos & Cremer-Schaeffer 2019). The Convention was conceptualized to replace the many bilateral agreements between and among countries by providing a single universal framework within which issues of drug and substance trafficking, use and disposal were to be dealt with. The Convention laid the groundwork for controlling the movement and usage of drugs (Moise 2018; Knöss et. al. 2019). Precisely, the Convention recognized that unregulated usage and movement of substances pose serious health and economic hazards in countries and that there was a need to develop an international drug control system. The convention specifically identified that while not all drugs/substances are harmful to the well-being of the global citizenry, some required some stringent control measures. According to Note (2014), the convention was not necessarily designed to make the manufacturing, sale and usage of drugs illicit, rather it advocated that narcotic drugs and psychotropic substances should be put under control and be made available exclusively for medical and scientific purposes. The Convention required all member states to guarantee adequate but restricted supply of protected narcotic and psychotropic drugs and substances solely for medical and scientific inquiry purposes.

3.3.2 Convention on Psychotropic Substances (1971)

The Convention on Psychotropic Substances was adopted in 1971. The Convention specifically expanded the list of regulated drugs and substances which were to be put under surveillance and whose movement was to be controlled (Bayer & Reform 1989). The Convention specifically produced two main resolutions including

extending an invitation to all member states to continue with their sterling work in regulating the manufacturing, trafficking and usage of regulated substances including the new drugs which were added to the list. Secondly, the Convention specified the need for research on the usage of Amphetamine drugs with the view of limiting its medical usage because it was highly addictive yet it give limited medical value (Khan 1979). Member states to the Convention were encouraged to discourage or discontinue usage of amphetamines for medical purposes and consider alternatives in its place. The Convention further developed an international drug scheduling model which member states where to adhere to in regulating drug and substance use and regulation (Bayer & Ghodse 1999). Other issues discussed in the schedule related to the need for adequate labelling of drugs and substances in ways that give adequate information to potential consumers.

3.3.3 United Nations Convention against the Illicit Trafficking of Narcotic Drugs and Psychotropic Substances (1988)

The 1988 Convention largely concerned itself with the management of the physical movement of substances between and among member states. The 1988 Convention broadly gives outlines on how members' states should deal with the production, and trafficking of regulated drugs and substances. Among other issues, the Convention details how member states should react to the possession, purchase or cultivation of controlled drugs for personal consumption (Chatterjee 1981). The Convention specifically calls for punitive measures in respect of unauthorized possession or production of illicit drugs and substances. The Convention however falls short of specifying how member states should apply the law, it only specifies that member states should deal with the offense within the scope of their domestic constitutions

and legal instruments. The 1988 Convention also bequeaths the responsibility of developing measures for treatment, education aftercare, rehabilitation or social reintegration to member states. The Convention sees these curative efforts as part of the drug and substance use control measures. In several sections of the Convention including Article 3 paragraph 4. (c), proffer statutory treatment of small scale drug dealers and users as an alternative punishment.

3.3.4 Drug and Substance Legislative and Policy Environment in South Africa

South Africa is a member of all global drug control Conventions. This obligates the country to take reasonable measures towards regulating the cultivation, processing, prescription, sale and ultimate consumption of drugs and other regulated substances. In bolstering its membership to various global conventions, South Africa moved to craft several domestic legislation and policies geared towards ensuring strict control of highly addictive drugs and substances (Out 2011). The domestic legislation on drug and substance use in South Africa gives legal and operational effect to international protocols and conventions on drug and substance control. The major domestic drug control instruments in South Africa include the National Drug Master Plan, the Medicines and Related Substances Control Act (No. 59 of 2002), the Drugs and Drug Trafficking Act (No. 140 of 1992), the Prevention of Organized Crime Act (No. 121 of 1998), the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992), the Road Traffic Amendment Act (No. 21 of 1998) and the Tobacco Products Control Amendment Act (No. 12 of 1999). These specific instruments find support from other subsidiary legislations and bills including:

- Liquor Act (No. 53 of 1989)
- Child Care Act (No. 74 of 1983)

- Domestic Violence Act (No.116 of 1998)
- South African Schools Act (No. 84 of 1996)
- Extradition Act (No. 67 of 1962)
- Health Act (No. 63 of 1977)
- Witness Protection Programme Act (No. 112 of 1990)
- Medicine and Related Substance Control Act (No. 59 of 2002)
- Occupational Health and Safety Act (No. 85 of 1993)
- Sexual Offences Act (No. 23 of 1957)
- South African Constitution Act (No. 108 of 1996)
- Mental Health Care Act (No.17 of 2002)
- Pharmacy Act (No. 53 of 1974)
- Promotion of Equality and Prevention of Unfair Discrimination Act (No. 52 of 2002)
- Road Transportation Act (No. 74 of 1977)
- Road Traffic Act (No. 93 of 1996)
- Extradition Act (No. 77 of 1996)
- Financial Intelligence Centre Act (No. 38 of 2001)
- International Co-operation in Criminal Matters Act (No. 75 of 1996)
- Institute for Drug-Free Sport Act (No. 14 of 1997)
- Child Justice Bill, 2003
- Criminal Law (Sexual Offences and Related Matters) Amendment Bill, 2006

(Extracted from the NDMP, 2006 – 2011)

3.3.5 The National Crime Prevention Strategy (NCPS)

In addition to the above legislative framework, substance abuse South Africa initiated the National Crime Prevention Strategy (NCPS) in March 1996 (Rauch 2001). The

primary goals of the NCPS are to create conditions that promote the reduction of crime or motivation for it as well as improve the capacity of the criminal justice system in the country. Seven key crimes have been prioritised by the NCPS which are (i) crimes involving firearms, (ii) organized crime, including the organized smuggling of illegal migrants and narcotics, and gangsterism, (iii) white collar crime, (iv) gender violence and crimes against children, (v) violence associated with intergroup conflicts, such as political conflicts, taxi violence and land disputes, (vi) vehicle theft and hijacking, and (vii) corruption within the criminal justice system (Rauch 2001). Interestingly, all these crimes have strong lings to substance use and abuse. It suffices to provide in-depth analysis and discussion of some of the profound domestic legal instruments used in controlled drug and substance production, trafficking and consumption in South Africa.

The above mentioned Acts and policy initiatives towards drug supply control seemingly can be effective in reducing the outcomes of substance use and repeated relapses. This can be backed up by several evidence based interventions across South Africa, although the problems associated with substance use are still there and far from ending. The number of illegal drug supply spots has decreased, pharmaceuticals are less accessible due to the strict regulations in place, this reduces their misuse. Also, it leads to a reduced population that has access to substances and who deal with consequences of established use, this also reduces the number of young people who can be initiated into addiction. However, opportunities always exist for the policymakers to think innovatively towards new pathways to achieving all intended outcomes in relation to substance use.

3.3.6 Prevention of and Treatment of Substance Abuse Act (70 of 2008)

This Act was then developed to solve the challenge of the use of substances that had become a national problem. This was vital with the substance use problem which had seemed to spread like wildfire in South Africa and these had negative implications on the economy and livelihoods. The mechanisms that the Act stipulated aimed at harm reduction through improving prevention, intervention, reintegration programmes and treatment (South Africa 2008). More to that this Act made it possible for the establishment and registration of treatment facilities as well as halfway houses and the voluntary and involuntary commitment of persons with substance use disorders by qualified persons. This Act provides a platform for the development of the Central Drug Authority with catered for most substance use related national matters and interventions (South Africa 2008).

3.3.7 The Central Drug Authority (CDA)

The CDA was established as an advisory body in terms of the Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008) and is mandated to assist in the fight against substance abuse in the country (Department of Social Development (DSD) 2013). The CDA's participants create sector-based responses to the country's substance use problem and contribute to the final output that is put into the National Drug Master Plan (South Africa 2008). The CDA developed the NDMP as a national strategy for managing the substance use situation in the country and also to facilitate an integrated approach to service delivery and the coordination of programmes on the management of the drug problem in all spheres of government and civil society (Scheibe, Shelly, Versfeld, Howell & Marks 2017).

It also uses the National Drug Master Plan to drive the drug control legislation with the aim of lowering the numbers of individuals whose lives are ruined by substance use. It is thus imperative to provide a concise discussion of the NDMPs as they relate to the vision of ameliorating drug use in South Africa.

3.3.8 The National Drug Master Plan (NDMP)

The National Drug Master plan is one of the mainstream health care frameworks which specifically guides interventions and strategies for combating the problem of substance abuse in the country. The NDMP has been designed to serve as the basis for holistic and cost-effective strategies to reduce the supply and consumption of drugs and limit the harm they cause to people (NDMP 2006-2011). When the NDMP was drafted all stipulations of the Prevention and Treatment of Drug Dependency Act (No. 20 of 1992) were considered. It was also drafted to show the country's responses to the substance abuse problem as set out by UN Conventions and other international bodies (NDMP 2006-2011). The administrative unit of the Act is the Central Drug Authority (CDA) whose secretariat is located in the Department of Social Development. The NDMP allows cooperation amongst various stakeholders, government departments and agencies in the prevention of drug use, such as traditional healers, traditional institutions, religious organisations, healthcare professionals, schools, sports groups, parents, the media and the private sector (Howell & Couzyn 2015).

A concerted effort is required from the government and the different sectors of society to make South Africa a country less infested by drugs. The late former President of South Africa Mr Nelson Mandela in his first opening address to parliament in 1994, singled out substance use as a social pathology that needed prompt action to restore

the social and health detriments such as poverty, dysfunctional family life crime, political instability, reduced productivity, unemployment and the escalation of chronic diseases such as Hepatitis, HIV/AIDS and Tuberculosis (Peltzer, Ramlagan, Johnson & Phaswana-Mafuya 2010).Twenty five years down the line the South African government still fights this social vice which has since aggravated. The United Nations Drug Control Programme (UNDCP) described the NDMP as covering most of the national concerns such as drug control and others in a single document that is a national strategy in resolving this national quagmire. It involves operational plans of all departments and government entities involved in the reduction of the demand for and the supply of drugs in a country (Pienaar & Savic 2016).

3.4 Theoretical Framework

According to Braidotti, (2019) a theoretical framework constitutes the philosophical environment within which a study's constructs are located. It provides a basis for the interpretation, definition and application of variables in a particular study. Hatch (2018) adds that a theoretical framework includes all literature or discourse specific words, ideologies or perspectives which are considered paramount in understanding a particular phenomenon of interest. This study was underpinned by the philosophies and principles of the Relapse Prevention Model (RPM) as coined by Marlatt and Gordon in 1985 (Hendianti & Uthis 2018) and the Utilization Focused Evaluation (UFE) approach/framework (Anderson, 2018). The Relapse Prevention Model will be discussed in the next section.

3.4.1 The Relapse Prevention Model (RPM)

The Relapse Prevention Model is one of the highly acclaimed cognitive behavioural models which explain the phenomenon of substance use relapse including its

process, outcomes, implications and possible interventions (Abdoli, Farnia, Salemi, Tatari, Juibari, Alikhani & Basanj 2019). The model is one of the most widely applied intervention frameworks in substance use treatment environments (Roos, Kober, Trull, MacLean & Mun 2020). According to Niknam, Madahi and Shafiabadi (2017), the Relapse Prevention Model is premised on the Cognitive Behavioural Therapy (CBT) approach and the Social Cognitive Theory. Precisely, Heather, Raistrick and Godfrey (2006) note that relapse prevention is a skills-based, cognitive-behavioural approach that requires drug users and their clinicians to identify situations that place them (drug users) at greater risk for relapse and establish ways through which these can be mitigated. These scholars add that relapse prevention emulates to address both internal experiences such as positive thoughts related to substance use or negative thoughts related to sobriety (automatic thoughts) and external factors such as persons or environments which prompt a drug user to reminiscent his/her past drug use.

The relapse prevention explains the recalcitrant disposition of some substance users who regress to substance use after a supposedly effective treatment intervention (Abdoli et. al. 2019). The model describes relapse as the return to addiction after undergoing a series of treatments aimed at reforming the drug user (Marlatt & Witkiewitz 2005). The model is founded on the conviction that addictive behaviours are attained and or over-learned habits which have psychological, biological and social determinants and consequences (Marlatt, 1985; Marlatt & Witkiewitz 2005). These habits serve some functional roles such as assisting the individual to withstand some social, psychological, biological, emotional and economic hurdles (Marlatt & Witkiewitz 2005). According to Nabi, Masud, Humaira, Hussain, Naz, Chakraborty and Hawlader (2020), it is these functional roles that weaken an individual's ability to

stay drug free. Precisely, the perceived benefits of abstaining from drug use are perceived as less attractive than the benefits of using substances (Gonzalez-Cuevas, Martin-Fardon, Kerr, Stouffer, Parsons, Hammell & Weiss, 2018). Marlatt and Witkiewitz 2005, explain that in many instances, people who relapse into drug use often do so based on some vicarious positive memories associated with drug use or associations made between past drug use and lessening of conscious painful memories. Concurringly, Galacgac and Tarroja (2019) posit that relapse is associated with negative beliefs of personal abstinence self-efficacy. To this end, Gonzalez-Cuevas et. al. (2018) underscore that it is crucial for interventions targeted at reducing incidents of relapse to foster personal belief in the substance user that he/she has all that it takes for him/her to retain his sobriety regardless of the many perceivable challenges (abstinence self-efficacy).

The Relapse Prevention Model underscores that relapse is a multi-staged process that involves several social, behavioural and cognitive processes, such as coping skills and they are articulated below (Miller & Heather 2013).

3.4.1.1 Lack of Coping Skills

The model explains that multiple substance use relapse is a product of the lack of adequate and competent coping skills in an individual which force him/her to resort to substances when faced with difficult situations. The model suggests that naturally, some people lack coping skills and the discomfort which comes with this deficiency is temporarily overcome with the numbing effect of substances. The numbing effect becomes firmly imprinted in the functional memory of the individual such that whenever such person encounters discomfort associated with the issues which they lack coping skills they turn to the drug which help them to cope. According to (Braun-

Harvey 2009) situations that trigger multiple substance use relapse are usually highly traumatic and frightening situations such as being a victim of fatal disasters such as car accidents, rape, and extreme violence. However, Wallace (1989) adds that in some instances, even minor and seemingly trivial things such as job loss, failure in an examination, death of a loved one and or divorce can create an enduring sticking point and become a cause of repeated drug use. The relapse prevention model, therefore, suggests that to effectively help substance users and prevent them from relapsing post-treatment, there is a need to design a social skills programme that instils coping skills and capacities in the individual which will help him/her in coping with future challenges. The model underscores that interventions that do not identify residual problems and equip the individual with counter skills, will only provide short-term recovery.

3.4.1.2 High risk situations

One of the key interventions in the relapse prevention model is of identifying high-risk situations and setting coping mechanisms of how to deal with unexpected and unwelcome circumstances. The relapse prevention model helps by showing how to identify high risk situations and relapse triggers. Adding to that, relapse prevention presents specific interventions such as behavioural, cognitive techniques and global strategies which can be implemented to avoid lapses, manage relapses and address lifestyle balance.

This model puts light on how cognitive distortions, cravings present the temptations of failure to manage high risk situations in strategic ways which prevent relapses. Hence the initial step in Relapse Prevention Therapy (RPT) is to identify each individual's unique profile of high-risk situations for relapse and evaluate the client's

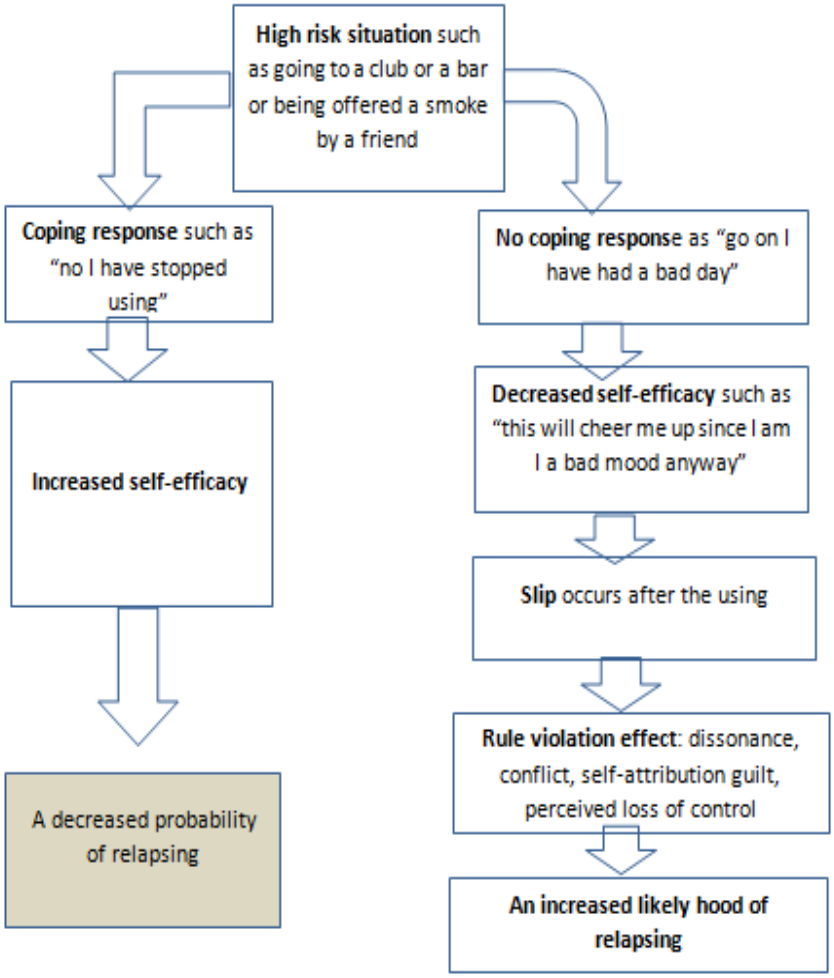
ability to cope with these high-risk situations without having a lapse (Braun-Harvey 2009).

In cases where individuals exhibit no capability to manage lapses and inability to adopt any coping mechanisms for relapse sequence, the therapists need to recognise the cause of the deficit and suggest coping mechanisms that can aid a successful refrain from a relapse down the road.

However, several determinates threaten successful management of high risk situations, some of these are anxiety, low self-esteem, low motivation, low self-efficacy or utter lack of knowledge and skills on how to handle situations that threaten relapses. Cognitive behavioural therapy for substance dependence provides a wide overview of coping skills training that may be adopted for substance dependence. This is conducted through capacity assessments, training on developing missing coping skills or addressing factors that interfere with the performance of skills already in the client's repertoire.

The figure below illustrates how lack of coping skills degenerates into substance use relapse according to Ibitoye and Nwosu (2021).

Figure 4: Illustration relapse vs sobriety.



Source: Melemis, (2015)

Most treatment approaches on relapse often hypothesize relapse as an end-state which is viewed as a failure of treatment or equivalent to a negative outcome. Thus, this perspective considers only a dichotomous treatment outcome that is, a person is either abstinent or relapsed (Larimer, Palmer & Marlatt 1999). However, there are other models of relapse which are based either on behavioural or social-cognitive theories that emphasize relapse as a transitional process, a series of events that unfold over time (Annis 1986; Marlatt & Gordon 1985).

This relapse prevention model is based on social-cognitive psychology which incorporates a conceptual model of relapse a set of behavioural and cognitive strategies to avoid relapse episodes. Relapse prevention is a vital component of addiction treatment, it suggests covert antecedents such as urges and lifestyle, and immediate determinants as outcomes expectancies, coping skills, high-risk situations may be highly contributing factors to relapse once or multiple times. Global intervention and several specific strategies are incorporated in relapse prevention as they make it possible for individuals with addiction to go through all steps of the relapse process during their treatment. The Majority of the treatment centres adopt this model to inform their treatment approaches.

The relapse prevention model adopts a cognitive approach that involves specific interventions which include guiding clients to identify their high-risk situations and enhance their coping skills such as management of lapses, improvement of self-efficacy and the shaping of thoughts and perceptions on how to restructure the client's perceptions.

According to numerous studies precipitants of relapse of clients who would have to go through inpatient treatment, attributed environmental, biological, emotional and interpersonal characteristics of relapse-inducing situations (Marlatt, 1996). According to this classification, numerous types of situations can play a role in relapse episodes, as the disease model of addiction explains it.

The disease model of addiction is a model that describes addiction as a disease with different sources of origin such as genetic, neurological, biological and environmental. The disease model of addiction defines addiction as a disease. Addiction was termed a disease because it fits the traditional medical model of

“disease”, which requires that an abnormal condition be present in a person that causes discomfort, dysfunction or distress to the afflicted individual (Volkow & Koob 2015). According to the Centre on Addiction (2019) an estimate of 25-50% of the individuals with substance use disorders appear to have a progressive disease that needs intensive treatment with continual strict aftercare.

3.4.2 The Biopsychosocial Model of Addiction

The biopsychosocial model of addiction posits that biological/genetic, psychological, and sociocultural factors contribute to substance use and all must be taken into consideration in prevention and treatment efforts (Skewes & Gonzalez 2013). The biomedical model of addiction had long dominated addiction studies until criticism arose and models like the biopsychosocial model came up.

A psychiatrist George Engel in 1977 developed the argument that individuals of the same genetic deposition can be exposed to the same illness and have different results meaning that susceptibility to illnesses is not entirely due to biological factors. The author argues biological factors cannot be considered in isolation when explaining addiction problems, social, psychological and cultural influences also contribute significantly. Engel (1977) surmised that psychological and sociocultural factors must explain the differences in the disease state among people with the same biochemical abnormalities psychological, social, and cultural influences on illness (Skewes & Gonzalez 2013). The authors note that evidence available from research suggests that biological, genetic, personality, psychological, cognitive, social, cultural, and environmental factors interact to produce the substance use disorder and is the core tenet of the biopsychosocial model of addiction. Hence according to this, addiction treatment should be multi-dimensional to address all the different factors in prevention and treatment programmes.

3.4.3 Biological Factors

Another contributing factor to substance use is biological influences that are encapsulated in genetic factors and brain changes due to changes caused by any chemical dependence. Genetic factors are based on the hypothesis that addiction problems can be inherited due to certain genetic composition. An example is family studies of alcohol use disorders, which suggest that such disorders show traces of being inherited in cluster families (Kessler, Davis, & Kendler 1997; Merikangas,1990; Merikangas, Stolar, Stevens, Goulet, Preisig and Fenton, & Rounsaville, 1998). However even though family studies suggest that substance use can be common in cluster families, it is very difficult to separate the effects of environmental and genetic influences. This is because dependency on substances can be found amongst several family members, but the cause can be due to social learning rather than any factors of genetic inheritance. The separate contribution of genes and environment can be teased apart in studies of adopted children and monozygotic and dizygotic twins. Research examining the gene for the brain's cannabinoid system (CNR1) found that variants of the CNRl gene were associated with cannabis, cocaine, and heroin dependence (Comings et al., 1997). This indicates that genetic and biological predispositions may aggravate the substance use and problems that are associated with it if a bad environment is present (Skewes & Gonzalez 2013). For example, individuals who suffer from impulse disorders, gambling and substance use problems statistically are more likely to have the dopamine D2A1 gene and if same like individuals are presented with high risk situations, due to their genetic make-up they are likely not to be able to resist the temptations.

This genetic polymorphism is associated with reduced D2 receptor density and deficits in the dopaminergic reward pathway. According to Braun-Harvey (2009) research found that individuals with low D2 receptor density are more likely to seek out pleasurable activities including alcohol use, drug use, and gambling. However biological factors may contribute to the outputs of human behaviour but not in isolation. Hence biological facts should be incorporated with other determinates to substance abuse. For example, there remain uncounted cases where individuals with a genetic risk of becoming a person with a substance use disorder did not indulge in substance use but on the other hand, those with no known genetic risks became hooked on substances. This is when factors explored by the biopsychosocial model must be counted as a catalyst to furthering substance use behaviour. The biopsychosocial model of addiction acknowledges that psychosocial variables also are needed to explain these occurrences and that these variables may interact with genetic and biological risks to cause addiction (Braun-Harvey 2009).

3.4.4 Genetic Theories and Relapse

Genetic theories attribute addictive and relapse behaviour to having some genetic relationship e.g. family addiction history. Offspring of a parent in active addiction or who have an addiction history have a very much increased risk of developing the same dependency on substances. This occurs even when there is a relationship that holds even when the children are raised separately from each other and the biological parents (Schuckit 1985). The theory assumes that genetically transmitted biochemical abnormality predisposes individuals with relations to those, in addition, to following suit if there are exposed to it. This abnormality is not identified although there have been many cases of individuals who had a family history of addiction

ending up with substance use disorders. The genetic theory explains why not everyone who drinks (alcohol) heavily develops alcoholism and why people who have the abnormality are more likely to relapse. Goldstein (2001) hypothesized that some individuals are more likely to develop narcotic dependency than others, due to an endorphin deficiency. Endorphins are a type of hormone that gives pleasure when basic needs such as hunger, thirst and sex are satisfied. These feelings of pleasure are triggered by the release of endorphins and the use of drugs can also give the same increased effect. Hence individuals who inherit this endorphin deficiency may seek ways to balance the imbalance by using psychoactive drugs (Sussman 2012). This author hypothesizes that those with the deficiency, when they use narcotics, would discover a “normalizing” or euphorigenic effect in excess than when taken by those without the abnormality. Hence this imbalance is the major contributing factor to relapse in certain individuals.

3.4.5 The thinking behind the Relapse Prevention Model

Relapse prevention is primarily based on the observation that many people are encountering many challenges in their lives for which they have limited or no known solutions or coping strategies (Marlatt & Gordon 1985). Faced with these challenges, people turn to drug use which enables them to momentarily escape the painful realities of their misery (Marsch, Campbell, Campbell, Chen, Ertin, Ghitza & Jacobs, 2020). Drug use, in this case, is perceived as a coping strategy in the face of a daunting situation or sensation for which the individual believes or perceives to lack control (Barnard 2006). It is against this background that people with substance use addictions are not able to cease using as they anticipate that stopping their usage would result in them becoming overwhelmed and or possibly killed by the prompting

challenges. To this end, relapse prevention advances the view that substance use treatment takes as its point of departure the need to not only resolve the symptoms of drug use but primarily to offer relapse prevention skills which involve capacitating the individual with a wide range of skills that enable one to cope with foreseeable as well as unforeseen challenges (Marlatt & Gordon 1985; Marsch et. al. 2020; Galacgac & Tarroja, 2019). The fundamental thinking behind the model is that recovery is cumulative such that as the drug user starts to accumulate successful recovery experiences; their confidence in recovery grows (Galacgac & Tarroja, 2019). In this case, “recovery experiences” entails the accumulation of positive and drug-free skills which replace the negative coping strategies to life stressors (Liddle et. al. 2018). The relapse prevention views that drug users are rational beings who when faced with a stressful situation for which they have the requisite capacity to resolve without resorting to drug use they would choose to do the right thing of using an alternative coping strategy other than reverting to drug use (Marlatt & Gordon 1985).

The fundamental assumption in the model is that drug users always have the motivation for abstinence but they are failed by the lack of a substitute way of dealing with risky situations and other life stressors which in the first place pre-dispose them into drug use. In this sense, each successful attempt of resolving challenges without resorting to drug use strengthens the drug user’s ability and desire to retain sobriety (Marlatt & Gordon 1985). As a response, relapse prevention advances a plethora of evidence informed interventions aimed at equipping drug users with the requisite skills to improve their readiness for change (Galacgac & Tarroja, 2019). The following is an extract from (Letourneau, McCart, Sheidow & Mauro, 2017) detailing some of the key strategies used in relapse prevention. Building awareness around the

potential negative consequences of encountering high-risk situations and thoughts that associate substance use with good outcomes (i.e., it challenges positive expectancies surrounding substance use).

- Helping the patient to develop and expand their repertoire of coping skills that address specific high-risk situations for relapse (often called “triggers”), whether those situations lead to drug use-related thoughts, feelings, or bodily sensations.
- Skills range from techniques to communicate with others when in a risky situation (e.g., how to confidently and comfortably say “no” to a drink if it is offered, called “assertive drink and drug refusal”), to “urge surfing,” a technique to help individuals cope with the intense longings to consume the substance that occurs during cravings.
- Planning for “emergencies.” That is, unexpected situations where the patient finds themselves suddenly struggling to abstain from drinking or using other drugs
- Assessing and reinforcing the patient’s confidence in his/her ability to abstain from substance use, even in the face of challenging situations (e.g., self-efficacy).
- Finding alternative ways of thinking about positive thoughts related to substance use, and negative thoughts related to abstinence, sometimes called “cognitive restructuring.” This activity includes discussing the thinking “traps” (sometimes called cognitive distortions, or unhelpful thinking styles) that can develop after years of drinking and using other drugs.

3.4.6 Learning Theories

Learning theories makes it better to understand what causes addiction and how it can be managed. Through the conditioning theory and the social learning theory, the anatomy behind is explained below.

3.4.6.1 Conditioning Theory

Wikler (1961, 1965, 1973) explained relapse using conditioned withdrawal syndrome, he explains how after the physical dependency is gone and a complete addiction treatment the formally addicted persons find themselves back in addiction again. The environmental and social stimuli formerly associated with drug use become classically conditioned for the substance addictive behaviour.

Wikler and Pescor (1967) gave an illustration of the influence of environmental and social stimuli, rats previously physically dependent on morphine when brought back to the cage where it had been exposed to the dependency, began to show signs of narcotic withdrawal (e.g. ‘wet shakes’). This is to say the phenomena of drug use become conditioned to the environmental and emotional stimuli through temporal continuity (Ludwig & Wikler 1974) More evidence of conditioned abstinence in intravenous heroin users was discovered by (Sideroff & Jarvik 1980). After an experiment showing patients who had completed treatment and were no longer dependent on heroin a video of individuals being injected the drug. These patients showed an increase in heart depression, anxiety, cravings and galvanic skin resistance.

Cue exposure theory falls under the behaviour theories and is explained from a classical conditioning point of view that cues play a vital part in the development and

maintenance of addictive behaviour (Drummond, Tiffany, Glautier, & Remington 1995; Heather & Greeley 1990). A cue that has previously been present when drugs were administered was more likely to elicit a conditioned response (cue reactivity), the reason why an individual can experience overwhelming cravings even after maintaining abstinence for a while (Heather & Greeley 1990). Human beings' intentions are largely dominated by emotions, the decisions they make about their lifestyles and choices are hugely motivated by emotions. So the types of choices made are determined by the kind of emotions behind, in addiction negative emotional states such as anxiety, anger, frustration, depression and boredom are termed intrapersonal high-risk situations. Intrapersonal high-risk situations are situations that present an almost irrevocable temptation to return to addiction, these are associated with the highest rate of relapse (Marlatt & Gordon 1985). Intrapersonal perceptions of certain situations such as loneliness, boredom can cause negative emotional states hence during treatment clients are encouraged to be around supportive environments always in recovery.

According to the explanations of these theories certain individuals are more prone to susceptibility to addiction than others. These individuals are termed to have addictive personalities, according to the psychological resource model, dependence on drugs was serving a particular angle of an individual's personality profile (Eysenck 1997). Eysenck (1997) notes that the three main independent personality dimensions namely N (neuroticism), E (extraversion) and P (psychoticism) facilitate an individual's vulnerability to drug addiction problems. Deep research on the relationship between drug dependence and personality dimensions has been done without complete conclusions

3.4.6.2 Social Learning Theories

The role of operant and classical conditioning is acknowledged by social learning models of addiction and relapse. These focus on cognitive-mediated processes in the acquisition, maintenance, and modification of behaviour (Sherman 2017). The conditioning theory is complemented by learning theories by focusing on the cognitive processes which occur between stimulus and behaviour. In the social learning framework, the relapse model has three steps which are, firstly to face a temptation of a high-risk situation, secondly, expectations of handling the situation without any drug use arise and lastly there appears a limited repertoire of behaviours and skills to cope with the high-risk situation (Shafiei, Hoseini, Bibak, Azmal 2014).

Treatment that is aimed at addressing social learning theories, makes an effort to prevent relapse by intervening at different points in the chain of behaviours, beginning with antecedents to the high-risk situation and extending through actual relapse (Brandon, Vidrine, & Litvin, 2007).

3.4.7 Psychological theories

Diverse explanations explain the psychological causes of substance use, such as behavioural models, models of rational choice, and cognitive theories (Miller &Taylor 1980).

The theories mentioned above attribute sociocultural, genetic, psychological factors to being responsible for stirring dependency on psychoactive substances in individuals, and all mentioned have been supported by empirical research. Authors as Anthony, Warner and Kessler (1997), Hall, Johnston and Donnelly (1999), believe that mainly individuals who end up with substance use problems are either those who

would have performed badly in school or those who would have completed a few years of education. This argument is based on the premise that these individuals lack the foresight to weigh the unprecedented consequences dependency on substances can bring, it is subject to debate, however.

3.5 Utilisation Focused Evaluation (UFE) Approach

As already alluded, this study was also premised on the principles, philosophies and operational provisions encompassed within the Utilization-Focused Evaluation (UFE) approach/framework (Anderson, 2018). The framework was coined by Michael Quinn Patton (1978) and is based on the conviction and principle that an evaluation should be judged according to how useful it is for different users of such knowledge (Anderson, 2018; Alkin & King 2016). The approach strongly condemns the commissioning and implementation of evaluations without a purpose and without a plan of how the evidence generated from a study will be consumed towards improving policy and practice (Alkin & King 2016). The UFE underscore that the utility of research or more specifically and evaluation process should be examined and judged in terms of how its findings are relevant, applicable and accessible to its primary intended users (Butts & Roman 2018). The overall view is that a UFE process and outcome should be premised on the need to capacitate the evaluated to transform, scale and or decommission certain activities on the strength of credible evidence (Alkin & King, 2016). In some instances, the usefulness of a UFE may also be judged on the process itself, by exploring the extent to which such a process empowers marginalized groups to participate and engage with decision-makers towards giving their voices effect in programming (Butts & Roman 2018).

According to Alkin and King (2016), a programme or project evaluation is only useful to the extent to which the intended users of such evaluation understand and feel ownership of such evaluation process and its outcomes. Patton (2008) underscores that consumers of evaluation findings can only feel ownership of the process and its outcomes if they are allowed to actively participate in the decision-making process of the evaluation including guaranteeing them the opportunity to decide how they want to use the evaluation outcomes. Specifically, Patton (2008) writes that by involving primary intended users of evaluation findings, evaluators and by extension researchers lay the groundwork for the adoption and utilization of evidence towards informing policy and performance. The application of UFE follows seventeen fundamental steps namely: Assessing and building program and organizational readiness for utilization-focused evaluation

1. Assessing and enhancing evaluator readiness and competence to undertake a utilization-focused evaluation
2. Identifying, organizing, and engaging primary intended users: the personal factor
3. Situation analysis conducted jointly with primary intended users
4. Identifying and prioritizing primary intended uses by determining priority purposes
5. Considering and building process uses if and as appropriate
6. Focusing priority evaluation questions
7. Check that fundamental areas for evaluation inquiry are being adequately addressed: implementation, outcomes, and attribution questions
8. Determine what intervention model or theory of change is being evaluated

9. Negotiate appropriate methods to generate credible findings that support intended use by intended users
10. Make sure intended users understand potential methods controversies and their implications
11. Simulating use of findings: evaluation's equivalent of a dress rehearsal
12. Gathering data with ongoing attention to use
13. Organizing and presenting the data for interpretation and use by primary intended users: analysis, interpretation, judgment, and recommendations
14. Preparing an evaluation report to facilitate use and disseminate significant findings to expand influence
15. Following up with primary intended users to facilitate and enhance use
16. Meta-evaluation of use: be accountable, learn, and improve

Adopted from: Patton (2008).

3.5.1 Application of Utilisation Focused Evaluation (UFE) in Substance Use Treatment Programme Evaluations

According to Onyura (2020), the UFE approach is a dynamic and versatile framework that can be applied in different evaluation scenarios including formative, process, impact and summative evaluations. The approach can also be utilised in the context of different research designs and data typologies (Kennedy & Crowley 2020). In this study, the UFE played a pivotal role in maintaining focus not only on the narratives of substance use treatment as per service providers (rehabilitation centres), service consumers (relapse substance use relapse patients) and key stakeholders (caregivers of substance use relapse persons) but to also gave these different constituencies a voice as regards how best substance use relapse programming

ought to take place. The endeavour in this process was to ensure that this study would not only end up as an academic accomplishment but could also contribute to tangible changes and reconfigurations in current and future substance use relapse prevention and treatment programming.

Additionally, the UFE approach was adopted in this study to provide philosophical lenses through which the subject of inquiry was gleaned, interpreted and applied. The approach enabled a focused study that sought to measure the real issues affecting the effectiveness and success of substance use relapse therapy programmes in the two selected rehabilitation centres. This enabled the research to generate relevant, applicable and adaptable data which can be used in transforming how the selected rehabilitation centres and by extension other facilities in South Africa and beyond conduct their businesses. This was crucial as authorities, families, and substance users themselves are continually calling for effective and sustainable therapy programmes which not only extinguish the symptoms of the substance use but also prepare and strengthen the resolve of treated drug users to retain sobriety even in the face of strong physical and emotional compulsions to re-use after treatment.

The UFE approach was also crucial in this study as it provided all philosophical and practical scaffolding requisite for undertaking a truly participatory research process as underscored in the research design and approach. This enabled a grounded research process whose outcomes are located with the realm of programmers and key stakeholders who are best placed to affect care and treatment changes for substance use relapse patients.

3.6 Conclusion

In conclusion, this chapter covered the legislative environment around the prevention and care of individuals who are involved in substance use. The theoretical foundations of the phenomenon of substance use relapse which were the UFE and relapse prevention were explored, articulating all theories around drug dependency.

The following chapter will present the methodology applied to this study.

4 CHAPTER FOUR: RESEARCH METHODOLOGY

4.1 Introduction

The previous chapters provided a critical review of the background issues on the phenomenon of substance use in general and more specifically substance use relapse. The current chapter discusses methodological processes, procedures and considerations which underpinned this study. Among the key issues discussed in this chapter include the research approach, research design, study population, sampling, sampling techniques, methods of data collection, data analysis and ethical considerations. Before delving into the specifics of the methodology used in this study, it is crucial to illuminate the socioeconomic and environmental issues in the Gauteng Province of South Africa which was the study domain of the current inquiry.

4.2 Study Domain

This study took place in the Gauteng Province of South Africa. Gauteng is home to 12,272,263 million people and this makes it the most populated Province in the country (Wanda, Nyoni, Mamba & Msagati 2017). Despite being the most populated, Gauteng is the smallest of the country's nine provinces in terms of the total landmass (Ramokgopa 2018). The Province is located at the centre of the country, sharing borders with Limpopo, North West, Free State and Mpumalanga Provinces (Mubiwa & Annegarn 2013). Historians record that Gauteng evolved from being a small village which evolved into becoming a formidable economic hub both in the country and the entire African continent (Elbra 2017). According to Mubiwa and Annegarn (2013), before the demise of Apartheid, Gauteng was known as the Transvaal that included

Pretoria-Witwatersrand-Vereeniging (PWV), it only changed in 1994 after the country gained independence and the installation of the new democratic government. Makuyana (2018) states that the name “Gauteng” is of Sisotho origins and is understood to mean a “Place of Gold”. The name derives from the region’s natural rich gold deposits (Mubiwa & Annegarn 2013).

Gauteng is home to Pretoria which is the country’s administrative capital (Wanda, Nyoni, Mamba & Msagati 2017). The Province is subdivided into three metropolitan and eight local municipalities (Mokgosi, Shai & Ogunnubi 2017). Available data shows that Gauteng is the most urbanised of all the country’s Provinces (Mubiwa & Annegarn 2013). Socioeconomically, indications are that just like all other Provinces, Gauteng is plagued by widespread poverty, social inequalities, substance abuse and crime (Isaac 2019).

Data collection sites in this study were located under Mohale City and in Vereeniging municipalities. Specific details of the study sites are not provided as these were deemed to undermine the principle of anonymity.

Figure 7 below presents the geographical map of Gauteng with the two focal areas highlighted in red circles.

Figure 5*:* Map of Gauteng Province showing the position of the study sites

Source: https://www.sa-venues.com/maps/gauteng/physical.php

The reason why these two areas in Gauteng were selected for data collection was their accessibility to participants, diversity, gender balance and registration with the Department of Social Development.

4.3 Methodology

Generally, research methodology refers to a systematic approach towards purposive investigation, which entails collecting data on relevant variables, analysing and

interpreting results and reaching conclusions either in the form of a solution, or a generalisation (Dagnino & Cinici 2015). Alternatively, De Vaus and De Vaus (2013) pose that research methodology can be understood as a blueprint that spells out the various steps followed in undertaking an empirical investigation. According to Creswell (2014), three fundamental methodologies are used in conceptualising empirical investigations and these include the qualitative, quantitative and mixed methods research approaches (Fetters, Curry & Creswell 2013). The current study used a mixed-methods methodology to explore the perceived success of selected drug therapy programmes in mitigating the relapse of patients with substance abuse disorders in the Gauteng Province of South Africa. To better comprehend the nature, principles, applications and implications of the mixed methods methodology, it is crucial to first gain an appreciation of the qualitative and quantitative methodologies in whose constituencies the mixed methodology is located (Creswell 2014).

4.3.1 Qualitative Approach

The qualitative research approach/methodology/strategy can be conceptualised as a type of research that takes the insider perspective of social action as its point of departure (Alase 2017). The approach is concerned with establishing the social meaning of phenomena in their natural environment (Carsten, Uhl-Bien, West, Patera & McGregor 2010). In qualitative research, the reality is socially constructed and thus no two scenarios regardless of their commonalities can be viewed as being truly the same (Alase 2017; Creswell, 2014). To this end, the qualitative approach engenders the view that the true essence of social phenomena can be generalized or predicted, rather it can be understood in-depth and suggestions developed (De Vaus & De Vaus, 2013).

Mbulayi and Makuyana (2017) cites Welman, Kruger and Mitchell (2006) in articulating that qualitative research constitutes an umbrella research approach that integrates interpretive techniques, towards describing, decoding, translating, and understanding the meaning of naturally occurring phenomena in the social world. The qualitative research strategy takes as its point of departure a commitment to deducing meaning from how people construct meaning out of their circumstances and experiences (Creswell 2014). The foundational philosophy behind qualitative research is in the plurality of meaning as perceived by different individuals and groups (Peck & Mummery 2018). These multiple realities constitute the blood life of social inquiry as informed by the qualitative research approach (Carsten et. al. 2010).

4.3.2 Quantitative Approach

The quantitative research methodology/approach/strategy constitutes a direct opposite extreme of the qualitative approach (Apuke 2017). The approach is rooted in the positivist paradigm which underscores the importance of using data to describe and predict phenomena (Panhwar, Ansari & Shah 2017). The quantitative approach is grounded in a firm conviction that the true meaning of a phenomenon can only be achieved through objective measurement (Creswell 2014; De Vaus & De Vaus 2013). The approach underscores that due to meticulous and objectivity in measuring phenomenon, findings can be generalised and trends of such phenomenon can be predicted based on prior measurements (Shekhar, Prince, Finelli, Demonbrun & Waters 2019). Creswell (2014), adds that whereas qualitative approaches use narratives to capture meaning, quantitative approaches use statistics and other numerical values to demonstrate the significance of data and its meaning.

4.3.3 Mixed Methods Approach

According to Tashakkori and Creswell (2007), mixed methods is a “research approach in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative methods in a single study or programme of enquiry.” The approach lies at the centre of the qualitative and quantitative approaches (Almalki 2016; Creswell 2014). Doyle, Brady and Byrne 2016, McKim 2017 pose that the integration of the qualitative and quantitative approaches in mixed methods is premised on the recognition that all methods have limitations hence biases inherent in any single method can be neutralized or cancelled when integrated with the biases of other methods. Precisely, Creswell (2014) writes that when the qualitative and quantitative approaches are fused, they become mutually reinforcing with one method’s strength overlapping to cover the weaknesses of the other.

4.3.4 Why a Mixed Methodology?

As already underscored above in this chapter and the thesis as a whole, the primary aim of this study was to explore the perceived success of drug therapy programmes in mitigating the relapse of patients with substance abuse disorders, in some selected rehabilitation facilities in Gauteng Province of South Africa. Accordingly, the phenomenon which formed the core of the study had several convoluted dimensions whose scope and significance could not be captured within the means and confines of a unitary methodology and that necessitated the adoption of a mixed methodology. According to Tashakkori and Creswell (2007), the choice of a viable and efficient research methodology in a study is premised on a few selected considerations including, the conviction which the researcher holds about the form of knowledge,

how such knowledge is generated and interpreted, the researcher's training, psychological attributes, nature of the problem to be investigated and the nature of the targeted audience who will use the findings of the study.

The subject of inquiry demanded the mixing of methods to effectively measure the success of therapeutic programmes on curbing recidivism among substance users. According to Creswell (2014), methodological triangulation is best suited for exploring problems that include human experiences while also having a large sample base. Under these conditions, qualitative techniques are used to gain an appreciation of how the people associated with the problem under investigation interpret their circumstances and also establish the corresponding meaning attached by participants to their experiences (De Vaus & De Vaus 2013; Tashakkori & Creswell, 2007; Clarke 2005). On the other hand, quantitative methods allowed for the recruitment of larger samples which permits for greater precision in terms of establishing trends, testing the validity and reliability of the findings and eventually creating room for making generalisations (Creswell 2014). In lieu of the above, the qualitative component of the study enabled the measurement of the perceived success of relapse prevention therapy from the experiential perspectives of relapse patients and programme administrators who acted as key informants. The qualitative component of the inquiry also facilitated the identification of the nature of therapy programmes that were being used by the selected rehabilitation centres. This was in line with De Vaus and De Vaus (2013) assertion that social action and social action cannot be extricated from or understood outside its natural context.

On the other hand, the quantitative component of the study allowed the study to reach as many samples towards gaining an appreciation of the problem from a statistical

point of view (Creswell 2014). Precisely, the quantitative component of the study concerned itself with measuring the perceptions of primary caregivers of recovering relapse substance abusers on the success of selected drug therapy programmes on recovery and the ability of substance users to maintain long term sobriety. Quantitative methods were also crucial as they allowed for statistical testing of the study' hypothesis towards ensuring objectivity in determining the success of treatment programmes on long term recovery.

An integrative methodology in this study was paramount in understanding the phenomenon of substance use relapse from a plurality of angles and therefore helps to develop a well-rounded solution to the recalcitrant problem of recidivism after a supposed successful treatment regimen. The philosophies and techniques espoused in the qualitative and quantitative methods used in tandem provided helped to overcome methodical weaknesses embedded in singular methodologies and emboldened their mutual strengths (Creswell 2014, Denzin & Lincoln 2011).

4.4 Research Paradigm

Tracy (2019) define a research paradigm as a philosophical framework that guides the interpretation of social action. Concurringly, Creswell (2009) underscore that the research paradigm which is also known as epistemologies/ontologies/world views constitute knowledge formulation and interpretation frameworks. Furthermore, Padgett (2016) writes that a research paradigm constitutes a general orientation or philosophical conviction of how phenomena operate and exist. Research paradigms are informed by a researcher's belief system, experiences, disciplinary orientation and training (Denzin and Lincoln 2011; Clarke 2005).

Table 6: Criteria for choosing a suitable and viable research methodology

Criteria	Quantitative Paradigm	Qualitative Paradigm
Researcher's World View	A researcher's comfort with the ontological , epistemological, axiological, rhetorical and methodological assumptions of the quantitative paradigm	A researcher's comfort with the ontological, epistemological, axiological, rhetorical and methodological assumptions of the qualitative paradigm
Training and Experience of the researcher	Technical writing skills, Computer statistical skills and Library skills	Literary writing skills, Computer texts analysis skills and Library skills
Researcher's Psychological Attributes	Comfort with rules and guidelines for conducting research, Low tolerance for ambiguity, Time for a study of short duration	Comfort for lack of specific rules and procedures for conducting research, High tolerance for ambiguity, Time for lengthy study
Nature of the Problem	Previously studied by other researchers so that the body of literature exists, is known, along with the variables and existing theories	Exploratory research, variables unknown, context important, may lack theory base for study
Audience for the study, (e.g. journal editors and readers, graduate committees)	Individuals accustomed to/supportive of quantitative studies	Individuals accustomed to/supportive of qualitative studies

Source: Clarke (2005)

This study used methodological triangulation which fused both qualitative and quantitative methods (Creswell 2014; Denzin & Lincoln 2011). Implicitly, this means that the study was informed by both the positivist and constructivist/interpretivist epistemologies and ontology (Creswell 2009). Notably, the researcher has a good understanding of both ontological and epistemological bases of knowledge from positivist and interpretivist/constructivist perspectives. Technically, this prior knowledge positioned the researcher in a comfortable space to be able to adopt a mixed methodology (Creswell 2014).

4.4.1 Constructivist/Interpretivist Paradigm

According to Wiltshire (2018), the constructivist/interpretivist paradigm advances the notion that social reality is socially constructed. To this end, the paradigm underscores the importance of gaining access to subjective experiences and interpretations of the social worlds of those who engage in social action (Creswell, 2014). According to Denzin and Lincoln (2011), the constructivist/interpretivist paradigm is informed by hermeneutic and phenomenological perspectives which underscore that the primary focus of research is to explain social action and human nature. The grounding belief in the interpretivist perspective is that social reality cannot be objectified nor can it be extricated from social contexts including backgrounds, history and beliefs of those who participate in the social action which forms the core of the study (Denzin & Lincoln 2011). A constructivist paradigm was suited for this study as it enabled for in-depth analysis of the selected drug therapy programmes and also facilitated the identification of nuances associated with these programmes (Hennink, Hutter & Bailey 2020).

4.4.2 Positivist Paradigm

Positivism is a research paradigm premised on a deterministic philosophy about research in which causes probably determine effects or outcomes (Kivunja and Kuyini 2017; Corry, Porter and McKenna 2019). The paradigm underscores the importance of objectivity (Wiltshire 2018); empirical observation and measurement, (Hennink et. al. 2020); reductionism, (Kivunja and Kuyini 2017); and theory verification as forming the core of knowledge (Corry et. al. 2019). In this study, positivism underlay the quantitative component of the study. The rationale for positivism in this study was that it allowed for objective inquiry into the success of

drug use therapy programmes, their application and outcomes in terms of thwarting the phenomenon of relapse post-treatment (Kivunja and Kuyini 2017; Wiltshire 2018).

4.5 Research Design

Creswell (2014) conceptualises research design as a strategic framework for action, which guides the arrangement of conditions for the collection and analysis of data. Concurringly, Denzin and Lincoln (2011) posit that research designs constitute plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection and analysis. In sync with its multi-methods approach, this study adopted a concurrent mixed methods design. According to Creswell (2014), a concurrent mixed methods design merges quantitative and qualitative data to provide a comprehensive analysis of the research problem. In this design, data collection for both the quantitative and qualitative components of the study is done simultaneously and then integrates the information in the interpretation of the overall results. Precisely, quantitative data collection and analysis was nested on a broad qualitative design (Denzin & Lincoln 2011). The qualitative component of the study will have enabled a conceptual and process evaluation of the drug therapy programmes while the quantitative component facilitated an outcome evaluation process of the selected drug therapy programme. In lieu of the combined designs, this study made use of the following specific designs.

4.5.1 Exploratory Design

Creswell, (2014) conceptualizes exploratory research design as used in an inquiry in which the key variables of the problem under investigation are not fully defined. The focus of the inquiry will therefore be on establishing operational definitions and or conceptualizations. In this study, an exploratory design was considered paramount

as it enabled the researcher to gain an appreciation of the relapse prevention sector including its associated therapy modalities which are not very much known, especially in the context of South Africa. The focus was on answering the “what”, “why” and “how” questions associated with substance use therapy programmes designed to curb relapse in the selected rehabilitation centres in Gauteng, South Africa (Hay, Duffy, Grealy, Tahsiri, McTeague & Vuletic 2020).

4.5.2 Descriptive Design

Generally, put, a descriptive research design can be construed as a method of inquiry that concerns itself with describing the characteristics of the population or phenomenon studied (Doyle, McCabe, Keogh, Brady & McCann 2020). The primary function of the design is on answering the “what” of a research problem (Cuneen & Tobar 2017). Given the foregoing, a descriptive design was pertinent in this study because it permitted for qualitative conclusions of the perceptions of primary caregivers of substance use relapse patients and also of the success of selected therapy programmes.

4.6 Population

Population in research is generally construed as including all individuals about whom a research project is meant to generalize or to draw inferences (Largent & Lynch 2017). Alternatively, Mohajan (2018) defines a study population as all subjects who bear characteristics about which the researcher intends to investigate. In this study, the population included all substance abusers who were admitted into the selected rehabilitation centres between August 2019 to November of the same year. Additionally, the population included the primary carers of substance users who were discharged from the two selected rehabilitation centres within an intervening period

of six months dating back from the 31st of July to February 2019. The population also included key informants including social workers and directors working at the selected rehabilitation facilities.

4.7 Sampling

According to Neelankavil (2015a) sampling involves a process of choosing a representative selection of the population on whom tests and observations are applied towards answering central research questions. The logic behind sampling is to cut the costs associated with applying tests and observations to every member of the study population hence, only a few representatives of the population are tested and findings are then generalised to the wider population with some degree of certainty and accuracy. Denzin and Lincoln (2011) write that there are two approaches to sampling in research and these include probability and non-probability sampling strategies. This study used both probability and non-probability sampling strategies with the non-probability approach used for sampling participants for the qualitative component of the study while probability sampling was carried out for the quantitative component of the inquiry. These sampling strategies are elaborated below. The inclusion criteria were important in getting relevant information for this study and it entailed: Caregivers/parents who have stayed with individuals who were admitted at the rehabilitation centres, the social workers who had experience in working with individuals with substance use disorders and were registered with the South African Council for Social Service Professions (SACSSP). The directors who were heading the rehabilitation centres and the individuals who suffered from substance use disorders and were admitted at the centre. The exclusion was participants who were not willing to give consent to participate in the study, consent

needed to be given especially considering this type of sensitive study. The criteria of the focus groups and key informants' interviews were that both groups needed to be at the selected rehabilitation centres.

4.7.1 Probability Sampling

According to Creswell (2014) probability sampling is an approach of selecting samples for a study that use methods that give an equal chance to all members of the sampling frame to be selected and included in the sample (Neelankavil 2015b). All members of the sampling frame have a non-zero probability of being selected. Probability sampling is generally used in selecting samples in quantitative studies (Hibberts, Johnson & Hudson 2012). Probability sampling use techniques such as random and stratified random, systematic and cluster sampling (Neelankavil 2015b). In this study, probability sampling was used in selecting samples for the mini-survey involving the primary carers of substance users who had been discharged from the selected drug therapy programmes. This study utilised random sampling as its specific probability sampling strategy. Below is a discussion of the random sampling strategy used in this study.

4.7.2 Random Sampling

According to Creswell (2009), random sampling is a sampling technique that gives all participants in a study an equal opportunity of being selected from the population group for inclusion into a study sample. Random sampling allows the researcher to select a truly representative sample as it removes all bias that may be imported if other methods are used (Taherdoost, 2016). In this study, random sampling followed several processes including firstly securing a list of all persons into whose custody the selected rehabilitation facilities had discharged recovering substance abusers

within the people extending from February 2019 up to July of the same year. The lists were then subjected to a computer programme that randomised the names and then selected a total of one hundred names (Creswell 2009). The selection process was designed to ensure that a total of 50 samples were drawn from the list of each corresponding rehabilitation facility.

4.7.3 Non probability sampling

Non-probability sampling involves a sampling approach in which samples are selected in a process that does not give all members of the population equal chances of being selected (Creswell 2009). According to Neelankavil (2015b), non-probability sampling methods are relatively cost-effective although they do not entirely permit objectivity in the sampling process. In this study, non-probability sampling was used in selecting samples for the qualitative component of the study. More specifically, purposive sampling was used in this study. The purposive sampling strategy is discussed below.

4.7.4 Purposive/Judgemental Sampling

Purposive sampling is generally understood as a non-probability sampling technique that uses the discretion of the researcher to select samples that fit the description and criteria of the study (Etikan, Musa & Alkassim 2016). Concurringly, Taherdoost (2016) writes that purposive sampling constitutes a sampling technique in which samples are selected strictly based on the characteristics of the population and objective of the investigation. The rationale behind judgemental sampling is hinged on the conviction that the researcher as the vehicle through which the research process is mobilised is best placed to be able to select samples from which the study can benefit (Etikan et al 2016; Neelankavil (2015b). Taherdoost (2016) adds that

while purposive sampling is premised on the discretion of the researcher, it is crucial to retain the understanding that in many instances the discretion is exercised within the confines of predetermined exclusion and inclusion criteria. The researcher has the responsibility to select only samples which provide the greatest learning opportunity and are best suited for the description, criteria and demands of the research topic, questions and objective (Creswell 2014).

In this study, purposive sampling was used in selecting samples for key informant interviews and focus group discussions. The researcher enlisted the assistance of social workers who were working in the selected drug treatment facilities to help in the process of purposively selecting potential participants who were being treated for substance use relapse after having attempted recovery and failed. The inclusion criteria in the study was that individuals needed to have received treatment in the programme at least twice or more times. Other parameters for inclusion and exclusion included the need for intra sample variation in terms of age, gender, socio-economic background, level of education, employment status, and marital status among other factors.

4.8 Sample Size

According to Denzin and Lincoln (2011), one of the important processes in research is determining the sample size. The importance of sample size derives from the fact that a study's validity, reliability and trustworthiness are dependent on the use of a correctly sized sample size. Inopportunely, Boddy (2016) writes that the sizing of study samples is one of the contentious issues in research circles. Saunders (2012) underscore that while the issue of sample size is a contentious subject, the general view is that samples for qualitative studies should range between fifteen and fifty

samples. Contrarily, some scholars hold that good sample size should constitute at least one-third of the total sampling frame (Vasileiou, Barnett, Thorpe & Young 2018; Turner, Paul, Miller & Barbey 2018). Another school of thought suggest that sampling in research should only stop when the data collection process reaches what is known as the saturation point (Braun & Clarke 2019). According to Sim, Saunders, Waterfield and Kingstone, (2018), a study's saturation point refers to a stage during data collection and analysis when the addition of new cases stops producing new insights. Given the mixed methodology, this study used the saturation point approach in determining the sample size for the qualitative component of the study. For the quantitative component, the sample size was calculated based on one-third of the sampling frame.

This resulted in the qualitative component of the study making use of 46 participants in the sample, while the quantitative made use of 100 respondents out of the total sampling frame of 308. The total sample in the study was 146 people. Access to the population sample was requested from the rehabilitation centres, who further communicated the information to all the participants who were willing to take part in the collection of data of the study. The caregivers/parents were requested by the directors of the rehabilitation centres and only allowed those who were willing to participate in the survey during a series of the weekend when they had come to visit their family members who were admitted. The same was done on the qualitative data, which was recorded using a voice recorder. Appointments were set up and the interviews with the social workers and the directors were conducted during weekdays. The participants of the focus groups had a timetable of the different programme sessions, those who volunteered to take part in the focus group sessions used one of their slots on the timetable for the focus groups, all slots that were

allocated to this research by the facilitators at the rehabilitation centres were during weekdays.

The table below graphically captures the distribution of samples in the study.

Table 7: Sample structure and size

Research Approach	Method	Sample type	Sample size
Quantitative	Mini-Survey	Primary carers of discharged patients from the selected drug treatment centres.	100
Qualitative	Focus group discussions	Recovering substance users	40
Qualitative	Key informant method	Directors Social workers	2 4
Total samples			146

4.9 Data collection Methods and Instruments

Generally, data collection is defined as the systematic collection of information from relevant sources towards understanding a particular subject of inquiry (Creswell, 2014). Correspondingly, data collection methods constitute the various strategies used in collecting data which is consistent with different research ontologies and epistemologies (Neelankavil 2015b). According to Denzin and Lincoln (2011), data collection constitutes an important phase of the research process. If wrong or incomplete data is collected, the entire research process can be ruined with the result that findings can lose credibility while the entire research process loses reliability, trustworthiness and validity (Creswell 2014). It is therefore crucial for a researcher to design data collection instruments that effectively capture relevant and adequate information which comprehensively answer the central research questions. To this end, Neelankavil (2015b) suggests that it is important for a researcher to design the

most efficient data collection instruments (*devices used to collect data such as questionnaires and interviews*) (Creswell 2009). It must be noted that this study used a mixed methodology; this means that data triangulation was used. Specifically, the study made use of three fundamental data collection methods including focus group discussions, key informant interviews and lastly a mini-survey. The ensuing sections discuss the specific data collection methods, instruments and processes used in this research. The mentioned data collection techniques were chosen because they allowed to get in-depth information of the research questions from multiple sources which included the individuals with substance use disorders, their caregivers, their social workers and the directors of the rehabilitation centres. This was very vital as it lead to the collection of quality data which informed the main themes that came out.

4.9.1 Focus Group Discussion Guide

Focus groups generally consist of a one-time meeting of persons who do not know one another, who have a common experience to share their understanding and experiences associated with a particular subject of inquiry. Concurringly, Hennink (2014) writes that focus group interviews constitute a data collection method that uses a group of people who share common knowledge on the topic of interest as a launchpad to understanding both consensus and divergent views on such a topic. Focus groups present the advantage that a researcher can easily reach a relatively larger sample within a short period and with limited resources (Woodyatt, Finneran & Stephenson, 2016). To allow a focus group facilitator to effectively coordinate interactions within the focus group and ensure his/her ability to record proceedings, Woodyatt, Finneran and Stephenson, (2016), suggest that a focus group should have at least six to twelve participants.

In this study, four focus group discussions of ten members each were conducted with repeated relapse substance users who were admitted and were undertaking drug use therapy programmes in the selected rehabilitation facilities. All discussions were conducted within the confines of a pre-designed interview schedule which consisted of twelve discussion topics. Discussion topics largely revolved around process evaluation of the selected therapy programmes with a special inclination towards understanding whether or not the participants believed that the programmes were helpful or not in their fight against relapsing into drug use. Among other issues, the focus group discussion schedules sought to understand whether the participants understood what they were supposed to gain from their participation in the programmes, whether or not they believed that these goals were achievable given the dosage, consistency, duration and overall quality of the programmes.

The structure of the focus group discussion schedule was in such a way that it began with an introduction of the facilitator, an outline of the group rules, followed up by an opening question, transition questions and closing questions. Probe questions were also posed as and where necessary. In the end, the facilitator paraphrased the findings towards confirming whether or not the core ideas were expressed during the discussions. On average, each focus group discussion lasted for 45 minutes.

4.9.2 Key informant method

The key informant method entails drawing information from those fully knowledgeable on the phenomenon being investigated. It entails gathering together key informants or experts to provide input for a particular situation or phenomenon. This study gathered key informants from individuals who were qualified social workers and also the directors of the rehabilitation centres who were knowledgeable about substance

use as well as substance use prevention. There were six key informants in total, consisting of three from each rehabilitation centre. This availed detailed qualitative information about impressions and experiences the individuals had with repeated substance use relapses at the rehabilitation centres. The interviews were conducted to obtain vital information about the contribution of rehabilitation centres towards repeated substance use, through their various therapy programmes. In this regard, professionals from different categories who were interviewed were four social workers approved by the Department of Social Development (DSD) and the two directors from the rehabilitation centres. These key informants were deemed to be full of experiential knowledge in substance use rehabilitation. They provided relevant information and knowledge that was vital for the study.

4.9.3 Mini-Survey

Vaske (2019) conceptualises a survey as a quantitative research method used in collecting primary data based on verbal or written communication with a representative sample of individuals or respondents from the target population. Creswell (2009) adds that a survey design provides a quantitative or numeric description of trends, attitudes, or opinions of a population by studying a sample of that population. In this study, a cross-sectional/transverse/prevalence survey design was used. According to Queirós, Faria and Almeida (2017) cross-sectional /transverse/prevalence survey design is a research type that analyses data of variables collected at one given point of time across a sample population.

The mini-survey in this study was carried out with the primary carers of substance users who had accessed treatment from selected treatment programmes. The mini-

survey was based on a questionnaire designed to elicit perceptions of the utility of selected drug use therapy programmes in curbing relapse among substance users.

The mini-survey developed was knowledge and attitudes one, this helped to capture self-reported observations of the participants. Questions were identified in accordance with the study objectives, the questionnaire contained both open-ended and closed-ended questions which were primarily designed to elicit information on the outcomes of the relapse prevention programmes in which the loved ones of the carers were admitted. The mini-survey was conducted with a total of 100 respondents. The survey consisted of 25 questions. The questionnaire The responses were converted to numerical values to get the meaning through statistical analysis.

4.9.4 Data Analysis

Data collection can be understood as the process of breaking down collected data sets and transforming them into meaningful and logical findings from which conclusions about the subject matter can be drawn (Wang, Kung & Byrd, 2018). Denzin and Lincoln (2011) add that the process of data analysis is largely concerned with either upholding or refuting the hypothesis initially held by their researcher. Having used a mixed-methods design, this study collected both quantitative and qualitative data and this means that both statistical and interpretive data analysis methods were used (Creswell 2014). Qualitative data analysis was therefore done through the thematic analysis approach and quantitative data was analysed using statistical analysis (Creswell 2014). It suffices to note that despite having gathered both qualitative and quantitative data in this study, the research was quantitative heavy, implying that the qualitative component including its analysis carried more

value in comparison to the quantitative component (McKim 2017). Ensuing below are discussions of how both thematic and statistical analysis in the study was carried out.

4.9.5 Qualitative Data Analysis

As already indicated, the collected qualitative data sets were analysed using the thematic data analysis method (Creswell 2014). Nowell, Norris, White and Moules, (2017) write that Qualitative Data Analysis (QDA) can be understood as a process of organizing collected raw data and identifying its embedded meaning and establishing conclusions. Creswell (2009) writes the process of thematic data analysis usually focuses on making interpretations of the perceptions, attitudes and beliefs captured in the collected data sets towards making explicit the lessons learnt, comparing findings with the general knowledge from past literature and theory, posing questions, suggesting new research focus and advocating for a new agenda for reform.

In this study, the process of thematic data analysis followed Creswell's (2009) criteria and also employed an inductive approach to analyse the data The collected data sets were firstly subjected to a process of transcription in which the audio clips and handwritten notes which were produced during in-depth key informant interviews and focus group discussions were transcribed into Microsoft Office Word format (Creswell 2014). When all the data sets were transcribed, the researcher engaged in a process of data cleaning which primarily involved manually reading through each transcript to become familiar with the data and also remove meaningless words and sentences (Creswell 2014). After the data was cleaned, the transcripts were then uploaded into ATLAS. Ti version 8.0 qualitative data analysis software to commence the process of analysis.

The actual process of qualitative data analysis involved firstly reading each transcript that was uploaded into the ATLAS. Ti 8.0 software and identifying the major ideas presented by each participant (Soratto, Pires & Friese 2020). The major ideas were coded using the “open coding” function embedded within the ATLAS. Ti 8.0 software (Friese, 2019).

4.9.5.1 Description of how ATLAS. Ti was used in this study

The interview and focus group recordings were transcribed and the transcription was done verbatim to ensure meaning and context was not lost. Thereafter, the data from the transcriptions were coded to make reorganizing easy, occurrences were identified, and connected to different variables, to ease the process to describe the data. Lastly, thematic analysis was carried out which involved the development of code groups, importing code neighbours, identifying patterns in the data to allow rigorous analysis. The codes were exported along with some verbatim quotes into a word document which was used in writing the research report which is the findings chapter in this thesis.

4.9.6 Quantitative Data Analysis

According to Babbie (2008), analysis means categorising, ordering, manipulating and summarising the data to obtain answers to research questions. In this study, data collected quantitatively was captured, coded and entered for scientific analysis with the help of the Statistical Package for Social Science (SPSS). Descriptive statistics were used for the study, the analysis focused on central tendencies. The SPSS package helped analyse the data to develop trends, graphs, tables and other variations.

4.10.1.1 *Description of how SPSS was used in this study*

The surveys of the study were captured in SPSS and codes were assigned to the Likert scale responses and the variables were labelled. Thereafter values were assigned to categorical valuables and graphs were pulled out using descriptive statistics.

4.10 Validity, Reliability, Trustworthiness and/or Authenticity

According to Rubin and Rubin (2011), all research has to conform to some standard of practice that guarantees that the outcome of investigations is a true or close reflection of the subject of inquiry. In this study, several considerations and undertakings were carried out towards safeguarding the validity, reliability, trustworthiness and or authenticity of findings. Mixed methods that were employed aided the validity and reliability as they ensured that the methodological weaknesses that could be found in linear approaches were eliminated.

4.10.1 Credibility

The primary measure of credibility is the degree to which testimony could be probable or improbable when judged by common experience (Braun and Clarke 2006). This means that the credibility of a study serves as a function of how such a study can be believed and relied upon (Creswell 2009). In this study, credibility was achieved through member checking (Lincoln & Guba 1985) and maintaining an audit trail of the research process at every stage (Shenton 2004). In this study member checking the results report was shared with some focus group participants and the social workers from the rehabilitation centres, and all confirmed the report reflected the views of the participants.

4.10.2 Transferability

The importance of transferability is vital as each study should provide room for future studies Bryman (2012). To ensure transferability in this study the objectives were declared, as well as the research design and the analysis. Also to ensure transferability, recommendations were also made based on the results of the study,

4.10.3 Dependability

Dependability in research is a function of the trustworthiness of a study's findings. Dependability subjects a study to a litmus test to demonstrate whether or not the findings of an enquiry can be consistent when the study is replicated using similar methods (Malterud 2001; Creswell 2009). Towards ensuring dependability an elaborate and concise methodology that provides specific details about the processes and procedures and subsequent justification for each undertaking was developed. This gives room for future replication of the study to generate and measure its dependability. In this study the qualitative data was also shared with two other researchers in the social work field to also analyse so that the results may be assessed, to ensure the dependability of the analysis.

Dependability refers to the consistency and reliability of the research findings and the degree to which research procedures are documented, allowing someone outside the research to follow, audit, and critique the research process (Sandelowski 1986, Polit & Beck 2006, Streubert 2007). As a quality measure, dependability is particularly relevant to ecological and conservation science applications that are in the early stages of testing findings in multiple contexts to increase the confidence in the evidence. Detailed coverage of the methodology and methods employed allows the reader to assess the extent to which appropriate research practices have been

followed (Shenton 2004). Researchers should document research design and implementation, including the methodology and methods, the details of data collection (e.g., field notes, memos, the researcher's reflexivity journal), and reflective appraisal of the project (Shenton 2004, Polit & Beck 2006, Streubert 2007). Reflexivity, for example, a self-assessment of subjectivity, can reduce bias (when appropriate to do so) and increase dependability by increasing transparency of the research process (Malterud 2001).

4.10.4 Conformability

The ethical requirement of conformability constitutes a requirement for researchers to demonstrate a clear link between their conclusions and the collected data. A study's methodology and methods of analysis are required to demonstrate a realistic link between the research outcome and its relationship to the original theory (Creswell 2009). Among other factors, conformability in this study was achieved through grounding the findings of the study in a thick layer of supporting literature related to substance use and relapse. Two more researchers went through the qualitative data analysis process to ensure the accuracy of the data. More so, the study made several inferences between the study's findings and the principles of the theories which informed the study (Denzin & Lincoln 2011; Creswell 2009).

4.11 Ethical Considerations

Ethical considerations in a social work research are vital, to avoid any physical, psychological, legal repercussions (De Vos, Strydom, Fouche, & Delport 2011). The ensuing subsections provide a rundown of specific ethical considerations upon which this study was built.

4.11.1 Confidentiality and Anonymity

According to De Vos et. al. (2011), confidentiality implies that the personal information and privacy of participants is protected. In this study, confidentiality was achieved by ensuring that all participants took part in the study as anonymous individuals. No names or pictures of the participants were attached to the results and presentation of the data. This helped to ensure that none of the personal information was divulged. More so, confidentiality was achieved by ensuring that all materials which contained participant information were kept in a secure place that was always locked.

4.11.2 Reduction of harm

Reducing harm is making sure that adverse consequences or any form of harm is prevented from the participants (Lo 2012). The participants were not subjected to any pain and won't be hurt physically, socially, emotionally, or psychologically.

4.11.3 Informed Consent and Voluntary participation

According to Lo, (2012) researchers have the ethical obligation to ensure that their participants and or participants agree to take part in their study after acquiring all relevant information that can help them to make intelligible decisions of whether to participate or not. True voluntary participation in a study is incumbent on having access to knowledge about rights and potential dangers associated with being involved in a study (Denzin & Lincoln 2011). In this study, participants were informed of their right to choose whether or not they wanted to participate. They were also made aware that should they initially choose to participate and then decide to withdraw their participation, they could do so without any hindrance or negative

consequence to them or anyone affiliated with them. Participants of the study were asked to read and sign a written informed consent form which was dated and signed with a declaration that their decision to participate was voluntary (De Vos et al., 2011).

4.11.4 Human Rights of the participants

Human rights of participants entails allowing them right to the, privacy confidentiality and expression of what they would have revealed during a study (Gavin 2008). The researcher protected the human rights of participants by ensuring their anonymity. More so, the physical, psychological and emotional wellbeing of participants were safeguarded by ensuring that their participation was voluntary and they had rights to withdraw at any time.

4.11.5 Intellectual property concerns

The use of other people's work without due acknowledgement was tantamount to academic theft (Talili 2017). Accordingly, due acknowledgement in the form of proper referencing and citations were done towards avoiding plagiarism.

4.11.6 Conclusion

This chapter discussed the methodology of the study, the two methods of data collection were explained as well as the description of their analysis and how it was conducted. The accuracy of the data was discussed and lastly, all ethical considerations were explained.

5 CHAPTER FIVE: RESULTS AND DISCUSSION

5.1 Introduction

Previous chapters laid a strong and compelling case for exploring the efficacy of selected therapy programmes in mitigating the problem of relapse of substance users in the Gauteng Province of South Africa. Chapter four specifically dealt with methodological processes, procedures and considerations which formed the bedrock of this study. The current chapter presents and discusses the findings of the study. In lieu of the study's mixed methods design and approach, the study generated both qualitative and quantitative findings. Towards ensuring clarity and better structure, this chapter will start by presenting and discussing qualitative findings and then close off with quantitative findings for each objective one at a time. However, before delving into a comprehensive presentation and discussion of findings, it suffices to restate the fundamental objectives in respect of which findings are being presented. Below are the research objectives which underpinned this study.

A. To establish the nature of selected therapy programmes and examine the extent to which they are meeting their objectives.

B. To determine the extent to which selected therapy programmes assist in the prevention of substance use relapse.

C. To formulate recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use relapses.

5.2 Results and discussion of qualitative findings

5.2.1 Demographic Qualities of Study Participants

As already illustrated in chapter four of this thesis, was constituted by two categories of qualitative sources which included, focus group discussions and key informants. The total sample size for the qualitative component of the study was forty-six. This section presents findings pertaining to the demographic qualities of all qualitative study participants.

5.2.2 Demographic Data of Focus Group Discussion Participants

The second category of qualitative data in this study was extracted through four focus group discussions constituted by ten participants each. The total sample size (Combined *Rehabilitation Centre A and B)* was twenty participants (N=40). The two tables below summarise the individual demographic qualities of the participants from all the focus group discussions.

Table 8: Demographic Qualities of Focus Group Discussion Participants (Rehabilitation Centre A)

Pseudo name	Gender	Age	Marital status	Highest Level of education	Occupation	Number of children	Substance addicted to	Number of times admitted in the rehabilitation centre
Focus Group 1								
David	Male	28	Single	Completed Matric	None	0	Crystal Meth	7
Mobil	Male	34	Divorced	Completed Matric	None	3	Heroin and Cocaine	9
Fadel	Male	24	Married	Did not complete matric	None	1	Cocaine	2
Michel	Male	21	Single	Did not complete matric	None	0	Crystal Meth	2
Gadesh	Male	44	Married	University Degree	Medical doctor	4	Cocaine and Benzodiazepines	12
Lamer	Male	57	Divorced	Completed Matric	Business	5	Benzodiazepines	42
Sam	Male	27	Single	Did not complete Matric	None	1	Heroine, whoonga	9
Pradel	Male	39	Married	College diploma	Cook	2	Cocaine, benzodiazepines	12
Kristod	Male	26	Divorced	Did not complete matric	None	1	Cat, Alcohol	6
Kumla	Male	29	Divorced	Completed Matric	None	2	Crystal Meth, Mandrax	7
Focus Group 2								
Dominic	Male	21	Single	Did not complete matric	None	0	Cocaine	3
Keith	Male	24	Married	Completed diploma	Marketing Manager	1	Alcohol, Cocaine	2
Given	Male	33	Married	University Degree	Medical doctor	2	Benzodiazepines, Cocaine	6
Ovidad	Male	34	Married	University Degree	Dentist	2	Benzodiazepines	5
Simon	Male	20	Single	Did not complete matric	None	0	Crystal Meth	2
Peiter	Male	28	Married	Completed Matric	None	1	Cat, Crystal Meth	3

Alan	Male	38	Divorced	Did not complete matric	None	2	Heroin	4
Johan	Male	40	Single	Completed Matric	None	0	Heroin,	12
Colin	Male	48	Married	Completed Matric	Business	5	Mandrax, Alcohol	18
Edgar	Male	42	Divorced	Completed Matric	None	3	Cocaine, Alcohol	12

Table 9: Demographic Qualities of Focus Group Discussion Participants (Rehabilitation Centre B)

Focus Group 3								
Pseudonym	Gender	Age	Marital status	Highest Level of education	Occupation	Number of children	Substance addicted to	Number of times admitted in the rehabilitation centre
Tia	Female	22	Single	Completed Matric	None	0	Mandrax, Alcohol	2
Chanel	Female	30	Married	University Degree	None	2	Crystal Meth	3
Fadel	Female	24	Married	Completed matric	None	1	Heroin, Whoonga	2
Joy	Female	39	married	Did not complete matric	None	0	Crystal Meth	4
Chrystal	Female	21	Married	Did not complete matric	None	4	Crystal Meth	1
Michel	Female	29	Divorced	College diploma	Administrator	2	Cocaine,	3
Sameya	Female	22	Single	Did not complete Matric	None	0	Crystal Meth,	2
Gladys	Female	25	Divorced	Did not complete matric	None	0	Benzodiazepines	2
Gracious	Female	26	Divorced	Did not complete matric	None	1	Heroine, Whoonga	3
Donna	Female	33	Divorced	Completed Matric	None	1	Crystal Meth,	5
Focus group 4								
Aisha	Female	24	Single	Did not complete matric	None	0	Alcohol, Cat, Mandrax	3
Atika	Female	29	Married	Completed certificate	Secretary	1	Cocaine, Cat	2
Romana	Female	23	Single	Did not complete matric	None	0	Whoonga, Herion	1

Mary	Female	33	Married	University Degree	Biophysicist	2	Benzodiazepines	5
Lirikka	Female	20	Single	Did not complete matric	None	0	Crystal Meth	1
Vinesha	Female	22	divorced	Completed certificate	Administrator	0	Crystal Meth,	1
Leona	Female	34	Divorced	Completed Matric	None	0	Heroin, Whoonga	3
Portia	Female	28	Single	Completed Matric	None	0	Benzodiazepines,	2
Princess	Female	33	Single	Did not complete matric	None	0	Cat,Ecstacy, Heroin	4
Florence	Female	42	Divorced	Completed Matric	None	2	Benzodiazepines ,Alcohol	6

5.2.3 Gender

As shown in the above tables, there was gender equilibrium within the focus group discussion sample. Notably, twenty males (Rehabilitation Centre A) and twenty females (Rehabilitation Centre B) participated in four separately convened focus group discussions. The equal number of males and females was more of a technical outcome and not a dynamic because the study specified the need to ensure gender balance in terms of focus group discussion participants. However, the fact that the study managed to achieve this feat of ensuring gender parity for the focus group discussion sample vindicates assertions that the problem of substance use relapse is gender blind. Tuchman (2010) supports this by noting that the use of substances was considered as a male problem primarily but recent substance use research indicates significant gender differences in the substance-related epidemiology, social factors and characteristics.

5.2.4 Age

Findings of the study noted that the minimum age of the focus group discussions sample was 20 years and the maximum age was 58 years. The average age within the focus group discussions sample was 30.4 years. The average and the minimum age of focus group discussion participants explicitly demonstrate that the phenomenon of substance use is relatively youthful. However, the expansive range of ages allowed the study to tap insights from people of different social, economic and maturational backgrounds. Ramlagan, Peltzer and Matseke (2010) conducted a study using the treatment demand statistics from the South African National Council on Alcoholism and Drug Dependence, and the South African Community Epidemiology Network on Drug Use records. The findings indicated that individuals who sort treatment for substance use at the time in South Africa ranged from 11 to 60 with the mean of 29 years. This study's mean was not far off with 30.4 years, this indicating the age range of individuals who use substances.

5.2.5 Marital Status

For the marital status structure within the focus group discussions sample, the 'married' status was predominant with 14 participants, the 'divorced' and 'single' statuses were not far off with each status recording 13 participants. There were no other statuses recorded. Perhaps the distribution of marital statuses within the focus group discussion sample is reflective of how recurring substance use relapse is inimical to one's inability to forge and sustain a strong and stable personal and interpersonal relationship and thus many opt to stay out of marital commitments or enter and opt-out. Masiko and Xinwa (2017) mention that research in South Africa indicate that intimate-partner violence is five times higher in relationships where one

or both partners use substances. The two authors also note that the relationship between substance use and gender-based violence is undeniable and acknowledged in South Africa. This might be one of the factors that have bearings on the family unit. Relapse prevention and cognitive behavioural therapy focus on helping individuals to develop or strengthen capabilities of maintaining interpersonal relationships. However, what the results of the marital statuses stimulate inquiries of, is whether these therapy programmes were being effectively delivered at these rehabilitation centres or whether the patients themselves decided the outcome.

5.2.6 Level of Education

With astounding similarity findings from all the focus group discussions, it was noted that the bulk of focus group participants generally had lower levels of educational attainment. Notably, findings showed that slightly above half (n=27 out of 40) of the total focus group discussion sample had educational levels which ranged from Matric certificate and below. Whilst the other few ones had equivalent to a college qualification and above. Ramlagan et.al. (2010) in their study also noted that the majority of the individuals that were using substance use had studied up to high school only and higher substance use prevalence was generally seen in lower- to middle-income households. Crum, Helzer and Anthony (1993) in their study mention that individuals who had dropped out of high school were 6 times more likely to develop a substance use disorder than individuals who completed their education to college level. This serves to embolden the view that early departure from academic processes elevates the risk of initiating substance use while low educational attainment reduces the capacity to break the substance use habit.

5.2.7 Occupation

Demographic data on the occupational statuses of the participants from the focus group discussions indicated that the majority of two-thirds were unemployed (n=31 out of 40). Only nine were either running a business or employed. The unemployed status of the bulk of substance use relapse persons could be an insignia of the low levels of education which makes them unattractive on the job market or could be effectively mean that these people lose their jobs due to repeated relapses. On the other hand, the number of unemployed participants could have been higher because of the addiction problems that would have made them unemployable at the time.

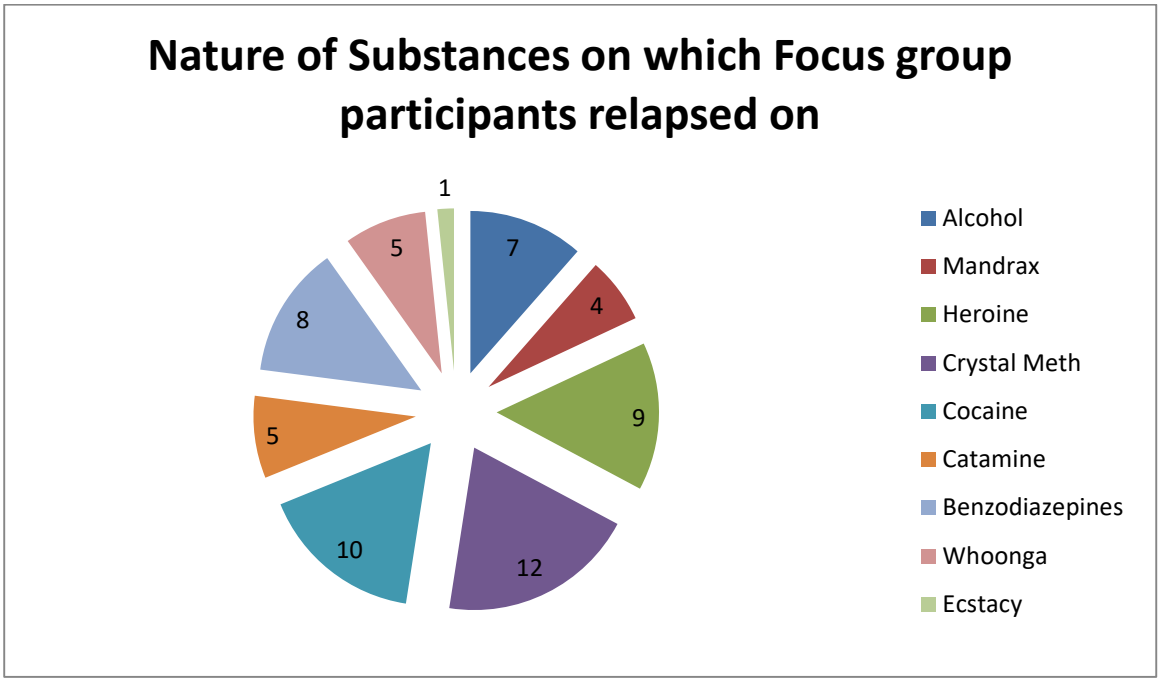
5.2.8 Nature of substance of Dependence

Demographic findings on the nature of substances on which focus group discussion participants were relapsing revealed that substance use relapse was largely affiliated with poly-drug use, use of stimulant drugs such as crystal meth, cocaine, ecstasy as well as the use of depressant substances including heroin, whoonga, alcohol among others. Perhaps this places stimulants, depressants and poly-drug use as major impediments to successful and sustainable recovery

5.2.8.1 Distribution of types of the substance of dependence among the participants of the focus groups

One of the key demographic findings of this study pertains to the nature of substances on which participants were repeatedly relapsing. Figure 7 below graphically summarises the distribution of the nature of substances on which participants had reportedly relapsed.

Figure 6: Distribution of types of Substances of Addiction among the Focus group discussions sample



*N=Does not add to 20 due to poly drug use

As shown in figure 7, Crystal Meth is the drug on which the bulk of participants had relapsed from. Perhaps this indicates that the drug (Crystal Meth) is highly potent and difficult to recover from. Ramlagan et.al. (2010) mentions that in South Africa polydrug use of alcohol, tobacco and cannabis begins at 12 years old, and cocaine and heroin from the age 16 or 17 years old. Other drugs which seemed to cause many of the participants of this study to relapse include Cocaine, Heroin and Benzodiazepines. Additionally, it was noted that just less than half of the sample (*19 out of 40 participants*) were poly-drug users. This perhaps suggests that repeated substance use relapse tends to be high among poly-drug users.

5.2.9 Previous Relapse Incidents

Study participants were asked a question on how many times they had previously been admitted into a rehabilitation facility for substance use rehabilitation. Findings

showed that previous incidents of substance use relapse ranged from a minimum of 1 time to a maximum of 12 times. The average relapse rate among focus group participants was 3.05 times for each individual. When aggregated by gender, the relapse rate for females was 2.7 times while that of males stood at 3.4 times. This implied that in terms of frequency, substance use relapse has a significant gender dimension which is male-dominated. At the treatment facilities in South Africa males present substance use problems more than females (Ramlagan et.al. 2010).

5.2.10 Demographic Data of Key Informants

The last category of qualitative data in the study was that of key informants. This category constituted a total of six participants including two directors (*one from each*) of the selected rehabilitation centres and four social workers (*two from each*) who worked at the selected rehabilitation centres (N=6).

5.2.10.1 Demographic qualities of Directors

Table below summarises the individual demographic qualities of interviewed directors of the selected rehabilitation centres.

Table 10: Demographic Qualities of Directors (Key Informants)

Characteristic	Rehabilitation Centre A	Rehabilitation Centre B
Gender	Male	Male
Age	48	50
Level of Education	Bachelor of Accounting	Bachelor of social work
Years of Work Experience	18	11

As shown in table 8 above, the two directors who participated in this study were both males aged 48 and 50 years respectively. In terms of the levels of education, they both had university degrees, with one from Rehabilitation Centre A, having a

bachelor's degree in Accountancy while the other one from Rehabilitation Centre B had a bachelor of social work degree. Generally, in terms of work experience related to substance use rehabilitation, both directors were well experienced with one having 18 years and the other one 11 years respectively.

5.2.10.2 Demographic qualities of Programme Social workers/Therapists

This study also tapped into the perceptions and experiences of social workers/programme therapists regarding the phenomenon of substance use relapse.

Table 11: Demographic Qualities of Social workers/Therapists (Key Informants)

Characteristic	Rehabilitation Centre A	
Gender	Male (social worker 1)	Female (social worker 2)
Age	29	37
Level of Education	Bachelor of Social work Master of Social work	Bachelor of Social work
Years of Work Experience	3	7
Characteristic	Rehabilitation Centre B	
Gender	Male (social worker 1)	Female (social worker 2)
Age	35	44
Level of Education	Bachelor of Social work	Bachelor of Social work
Years of Work Experience	8	11

As shown in Table 13 above, the therapists from 'Rehabilitation Centre A' in terms of their educational qualifications, both had a bachelors' degree in social work and the male therapist also had a Master's of social work degree. In terms of work experience in the field of substance abuse treatment or rehabilitation centres, one had 3 years of work experience while the other one had 7 years. The therapists from 'Rehabilitation Centre B' also both had a bachelor's degree in social work, one male with 8 years' work experience while the other female had 11 years. The demographic qualities of the therapist inspire confidence that the work of substance use

rehabilitation in the selected rehabilitation centres was being handled by relevant professionals.

5.3 Findings related to Objective 1: The nature of selected therapy programmes and examine the extent to which they are meeting their objectives.

The above section presented findings on the demographic characteristics of participants to the qualitative component of the study. This section presents qualitative findings to the first objective of the study which sought to establish the nature of relapse prevention programmes that were being used in selected rehabilitation centres and establish the extent to which they met their objectives.

5.3.1 Types of Relapse Prevention Programmes used in the selected Rehabilitation Centres

Study findings revealed that generally, the selected rehabilitation centres considered relapse as part of the overall treatment drug treatment programme hence issues relapse prevention programming was integrated into all programmes and activities. In this regard, there were no specific or standalone relapse prevention interventions, rather, services towards mitigating relapse post-treatment were infused in generic drug treatment programmes. To this end, the selected rehabilitation centres had a considerable range of relapse therapy programmes which included, The 12 steps programme, life-skills training, psychotherapy, pharmacotherapy, sauna, pastoral, physical exercises, and aftercare support and care. Findings pertaining to what each of the programmes entailed is discussed below.

5.3.2 The Minnesota 12 Steps Programme

Study findings revealed that one of the key relapse prevention programmes which were being used by the two selected rehabilitation centres was the Minnesota 12 Steps Programme. Interviewed key informants from both participating rehabilitation centres averred that the Minnesota 12 Steps Programme was their foundational intervention programme. Indications by the interviewed social workers were that the 12 Steps Programme helps substance users to learn new adaptive coping strategies with which they can handle problematic aspects of addiction such as the urge to reuse after rehabilitation. Social worker 1 from 'Rehabilitation Centre A' noted that their 12 Steps programme is infused with critical skills which help the individual to identify their vulnerability to certain environments, objects or people which reawaken the desire to reuse substances.

Concurringly, social worker 1 from 'Rehabilitation Centre B' noted that their 12 Steps programme helps their clients to locate themselves within a context of complex social, economic, cultural, spiritual and chemical vulnerabilities. According to this social worker,

> *"the 12 Steps programme facilitates a purposeful process of deep self-introspection through which the individual recognises his/her powerlessness over the drug. Similarly, according to the director of 'Rehabilitation Centre B', recalcitrant substance use relapse is product of denial. (Rehab B-sws01)*

The director from the same Rehab centre mentioned that:

> *"Our relapse prevention programme is primarily based on the ideology that continued relapse is an outcome of denial. The individual will be hooked on the belief that if they can bring their other problems under control, then they will be able to control the drug. This belief prevents the individual to realise that most of his/her problems are an outcome of chemical dependence.... We therefore use the 12 Steps programme to induce realisation and acceptance which is vital for successful recovery"*

The above captioned quotation explicitly demonstrates that the 12 Steps programme was being used as an instrument to induce realisation among substance users to realise that in their natural capacities they cannot control drugs.

Additionally, study findings established that key informants from the two selected rehabilitation centres construed that the 12 Steps programme was critical in relapse prevention through its ability to rekindle spiritual awakening among substance abusers. Notably, the social worker from Rehabilitation Centre B said:

> *"Our experience with substance abuse is that the drug users slowly lose their spiritual connection with their creator and with others. They start to lead a life of loneliness even though they are fully surrounded by others. They live lead carefree lifestyles and this dissociation from the social and spiritual realm makes them to feel inept, useless, unloved and unlovable and the drug becomes their only reason for living. Our 12 Steps programme is therefore designed to facilitate spiritual reawakening among the drug users." (Rehab B-sws02)*

Social worker 1 from 'Rehabilitation Centre A' added that:

> *"The idea in our 12 Steps programme is to reinstitute purpose and accountability in the lives of the drug users. You would see that most recurring relapse drug users end up giving up on themselves. The Twelve Steps programme therefore help them to change their methodology to recovery which in many instances will be based in the faith that medicines, psychotherapy or any other modality will help them. Instead in 12 Steps we encourage them to look up to a higher power which can be greater than themselves....although we don't prescribe what a higher power for a drug user should be, we often talk of "God as you understand him." (Rehab A-sws01)*

Given the two quotations above, it is unequivocal that the two selected rehabilitation centres utilised the 12 Steps programme to foster spiritual awakening among substance abusers. It is also clear that the rationale behind spiritual awakening is to

facilitate social reintegration of substance abusers and also develop a sense of accountability not only to the individual him/herself but to others and a higher power or Providence.

Study findings also showed that the 12 Steps programme as administered by the two selected rehabilitation centres was also construed as a strategy of bringing about the realisation of past wrongdoings and facilitating controlled emotional response. Indications by key informants were that one of the factors which lead substance users to relapse is the heavy burden of feeling guilty. Another social worker said, from 'Rehabilitation Centre A' said:

> *"You will notice that most of these substance users did some really bad things during their days of active addiction, so when we treat them here, those people who were hurt are seldom treated, this results in substance users going back to very hostile environments. So through the 12 Steps programme we help the drug users to reflect on their past action and account for all the people who might have been hurt. We then assist them to realise and accept the pain of others and prepare them to voluntarily make amends either physically or just be willing to make amends if the opportunity to do so avails itself". (Rehab A-sws02)*

Concurringly, the director of Rehabilitation Centre A said:

> *"In our programme we view that substance use is associated generalised negative energy. Therefore, out task as a rehabilitation facility is to avail opportunities to the individual to dispense of those negative energies. You would see that while in active addiction, a drug use would normally have attracted all sort of bad friends who encourage him or her to continue on this self-destructive path. As part of treatment we endeavour to release all negative energy within the individual.... for example, guilty of past wrong doings is negative energy and self-blame among other things"*

A Social worker from 'Rehabilitation Centre B' added that:

> *"Most substance abusers who seek treatment often want the easy way out; they want what we call a quick fix. They want to make*

everyone believe in the blink of an eye that they are changed and thus wholly blame the drug and not the individual.... However, in many instances people still want you to account for your mistakes even if you are coming from a rehab... We therefore use the 12 Steps programme to bring about this realisation and prepare the drug users for reintegration which is based on accountability. I personally believe failure to be accountable is the root cause of relapse". (Rehab B-sws02)

In lieu of the above statements, it is evident that the 12 Steps programmes as conceptualised by the two selected rehabilitation centres were considered pivotal to the successful social reintegration of drug users. The overriding perception was that failure to accept own misdeeds would result in social rejection of recovering drug users and this pushes them into relapse.

5.3.3 Psychotherapy

Study findings also established that one of the integral substance use relapse prevention modalities which were being used by the selected rehabilitation centres was psychotherapy. This programme was successful in assisting the prevention of substance use relapse to a greater extent. Key informants who included the directors and social workers were considered to be best placed to define and explain what the psychotherapy programmes entailed in their respective institutions. The social worker from 'Rehabilitation Centre A' described their psychotherapy programme as:

Generally, substance abusers are people who experienced some traumatic events in their past and due to this trauma they feel some level of physical and mental discomfort or emptiness. In their search for a means to fill this void, they may stumble on substances which offer temporary relief. In such persons, the substance creates a firm and vicarious impression in the memory of the drug user such that whenever he/she feels discomfort he/she goes to look for the drug for its relief effects. This process happens with or without the conscious awareness of the drug user.... Psychotherapy therefore helps the drug user to identify his/her primary source of pain and to comprehensively deal with it without resorting to drug use." (Rehab A-sws02)

Additionally, the director of 'Rehabilitation Centre A' said:

> *''Our social workers are equipped to conduct introspective psychosocial assessments on substance abusers and to assist the client a suitable recovery plan which is informed by his/her personal circumstances and resources''*

The director of Rehabilitation Centre B mentioned that:

> *''Psychotherapy is all about understanding the client from his/her cradle to present. It (psychotherapy programme) forces the client to look into what we call a "psychosocial mirror" and identify themselves, particularly their weaknesses and then with the help of the social worker, they then plan a strategy of how to circumvent the identified hurdles''*

Given the foregoing, it can be noted that in generally, the selected rehabilitation centres defined their psychotherapy programmes as constitutive of talk therapy with the express goal of helping substance users to identify residual psychosocial fixations which might be predisposing them to drug use.

5.3.4 Cognitive Behavioural Therapy

Study findings also found that in addition to generic psychotherapy, the two selected rehabilitation centres were also using Cognitive Behavioural therapy as a stand-alone relapse mitigation strategy. The social worker from Rehabilitation Centre B had the following to say:

> *"My experience is that many substance users prefer to dwell on issues of the past and seldom want to engage with their current issues, they often seek to explain the current problems in terms of past experiences and this exempts them from taking responsibility for their active contribution to the current problem of substance use... it is therefore necessary to use CBT as a modality which help to focus therapy on the presenting problem and assisting the client to change their way of viewing their problem and attitude towards their problem." (Rehab B-sws02)*

A Social worker from Rehabilitation Centre A said:

"We use CBT as a complimentary tool in our psychotherapy programme. Basically, CBT in our therapy rooms imply that the social worker has to be alive to both past and present circumstances of the client and helping the client to design appropriate treatment plans which are holistic and not only focus on the past fixations at the expense of present enabling beliefs, attitudes and lifestyles of the client.'' (Rehab A-sws01)

In respect of the above captioned quotations, it is unequivocal that CBT was considered as important in the grand scheme of substance abuse treatment and more specifically in terms of averting incidents of relapse. The general perception seems to be that Cognitive-Behavioural Therapy enabled the therapist to shift the focus of the therapy processes from past traumas to the here and now moments and realities of the clients. One participant in relation to this said:

"How the therapy programmes help is by teaching all the new stuff, my problems were just that I didn't have safe house to stay in. My thinking changed I let go of my anger which used to make me use all the time, to escape. I should say though what I think has changed to be more positive from the first time I was admitted." (FG3-09)

The general belief was that relapse is a product of incomplete psychosocial intervention provided through generic psychotherapy programmes which tend to focus on past issues at the expense of the present realities of the client. In this sense, CBT was being embraced as a framework for exclusively focusing on the presenting problem and helping in reframing narratives about it and thus changing beliefs and attitudes towards the problem. The approach was noted to be empowering.

5.3.5 Enforced Meditation

Study findings also revealed that the participating rehabilitation centres also had enforced meditation as part of their psychotherapy interventions. The following sentiment by the social worker of "Rehabilitation Centre A" aptly demonstrates the role and importance of meditation in substance use-relapse prevention matrix:

In many instances, substance users who relapse are people who usually lack self-awareness; they feel inept and have all sorts of negative perceptions about themselves. They usually thrive on external validation, so our mandatory and enforced meditation helps the substance users to develop a culture of self-introspecting and appraising. This is vital for improving the self-esteem and general awareness of the individual and it help them to sustain their recovery. (Rehab A-sws01)

One social worker from "Rehabilitation Centre B" said:

"Substance use relapse is a process, it takes time and processes before an individual relapse. We therefore require all our clients, both those attempting recovery for the very first time and those with multiple to wake up every day and find a place where they can sit quietly and validate their thoughts, actions and motives for their previous day. This helps them to identify possible relapse urges and rectify them before they gain more strength". (Rehab B-sws02)

Some focus group participants shared their opinions on this programme:

"I faced challenges with the meditation and the forgiving step, I still don't know how to do it" (FG4-p04)

'" Meditation and reading Surahs help me each time, I know I am back here but if I try had I think what they teach in the programmes help us not to go back to using over and over again" (FG3-p01)

"All the programmes are not bad I think, you see there are just these evil thoughts that come and sent me to those drugs, the programme that teaches us to meditate helps me to take that devil away, its only bad when I get home because at times I fail to keep doing it alone" (FG2-p05)

"I do not agree with him because for meditation does not work, I only feel better when I run, I forget those drug thoughts" (FG2-P06)

Notwithstanding the universality of meditation in the two selected programmes, it was evident that in Rehabilitation Centre A, meditation was construed as a process of self-realisation and a mechanism for developing the self-perception of drug users towards developing their resolve to achieve recovery. However, in "Rehabilitation Centre B", meditation was specifically conceptualised as an ongoing motive

validation process that helps to recover substance users to detect early signs of relapse and adjust their lifestyles accordingly.

5.3.6 Pharmacotherapy

It was further established in this study that the selected rehabilitation programmes also embraced medical treatment of their clients as part of their holistic drug treatment programmes designed to mitigate the phenomenon of relapse. The general overview of pharmacotherapy as per the interviewed programmes personnel was that pharmacotherapy involved a range of medical drugs used to help drug users during their recovery processes. The following sentiment was shared by the director of Rehabilitation Centre B:

> *"Substance use could result in or could be as a result of some underlying medical problems. So here as a first port of call, all patients undergo a professional assessment with our medical doctor and psychiatry nurse who determine the medical needs of each client and prescribe them accordingly. The medication is concurrently taken along with various psychosocial interventions."*

The social worker from "Rehabilitation Centre A" also said:

> *"We have a medical component to our programme, you would see that in many instances, substance abusers, especially those who repeatedly relapse after will be having a co-morbid condition which in many instances is responsible for recalcitrant substance use problems...we therefore try to ensure holistic treatment of substance users to make sure that upon discharge, not only their substance use problem will have been resolved but also other underlying conditions should be under control so as to minimise chances of relapse." (Rehab A-sws02)*

As shown in the quotations above, pharmacotherapy was used as adjunct relapse prevention strategies in the two selected rehabilitation centres in Gauteng. Notably, pharmacotherapy was being used for treating co-morbid conditions which occurred alongside substance abuse.

5.3.7 Spiritual Reawakening

Study findings revealed that alongside spiritual reconnection under the 12 Steps Programme, the investigated rehabilitation facilities were also using stand along spiritual reawakening programmes to buffer against relapse. Indications were that spiritual awakening was critical in supporting substance users who are prone to relapse. The following expression by the social worker of "Rehabilitation Centre A" vividly captures the essence of spirituality in substance use relapse prevention:

> *"Spiritual reawakening is invaluable in the process of recovery from multiple relapse, it helps to foster a sense of self awareness, can be relied upon by the recovering drug user to cope with physical and psychological challenges.." (Rehab A-sws02)*

Similarly, the social worker from Rehabilitation Centre B said:

> *"Our spiritual programme is mainly premised on the view that spiritual connection helps the individual to maintain some level of presence, builds and operates a moral compass within the individual...We therefore implore our clients to become spiritual.." (Rehab B-sws01)*

Concurringly, the director of "Rehabilitation Centre B" mentioned that:

> *"Routine reverence to the higher power means that the substance abuser develops certain moral codes which then guide him away from substance use and its associated ills. Our view is that families should encourage substance abusers to continue with their new found spirituality even after they exit from the rehab..."*

Adding to that another said:

> *"Yes I can say all our programmes help give our patients greater chances of equipping them to prevent relapses but I think the best is our spiritual programme, Moolana helps them develop so much discipline you will not believe how much it works." (Rehab A-director01)*

Some participants in their focus group added:

> *"For me I do not know what to say because I have been here 7 times but step 6 continues to give me hope each time and I know that my higher power will rescue me one day" (FG1-p01)*

> *"Our religions are different so at times I really get confused when their priest starts teaching us that the higher power is their God, but I believe some force out there helps me because I would have died soon." (FG1-p02)*

> *"I do not know all the therapy programme although the sessions we are taught about the higher power seem to help me think straight and I also feel better after talking to Amed'' (Amed is the social worker). (FG3 -p01)*

In line with the above quotations, it is unequivocal that spiritual reawakening was considered a paramount modality in the treatment and management of recurring substance use relapse problems.

5.3.8 Physical Exercises

Study findings also revealed that one (Rehabilitation Centre B) of the two selected rehabilitation centres was using daily physical exercises as one of their relapse mitigation strategies. According to the director and social worker 1 of Rehabilitation Centre B, substances that are consumed tend to be deposited in visceral fat wherein they sometimes tend to be released back into the blood system. Specifically, the social worker from Rehabilitation Centre B said:

> *"Once the stored up residue of substances in visceral fat get released into the blood stream, the recovering drug user start to feel as if he has used and this triggers strong physical cravings which can result in eventual relapse. So our strategy is that we introduce physical exercises which burn the visceral fat so that it also discharges the stored up drug residue." (Rehab B-sws02)*

The director of Rehabilitation Centre B added that:

"One thing about substance abusers is that they have very low stress threshold such that even a minor stressful situation can easily push them over into a relapse. We therefore introduce them to physical exercises as a strategy for stress relief.."

As shown in the quotation above, physical exercises were embraced as a proactive strategy of releasing toxic residues of substances in the body thus helping to eliminate the possibility of their slow release into the system thereby causing cravings and relapse. Additionally, it was also indicated that physical exercises were crucial in helping substance abuse in releasing stress which in many instances push substance users into seeking relief through using narcotics.

5.3.9 Sauna Therapy

Whereas Rehabilitation Centre A indicated that they were using physical exercises to facilitate detoxification of their clients, findings revealed that Rehabilitation Centre A used what they called "sauna therapy" to facilitate the detoxification processes of substance users. Indications were that sitting in a dry sauna was crucial and was more or less the same as doing physical exercises and help substance users to detoxify. The director of Rehabilitation Centre A said:

"All our patients spend some time in the sauna to help them detoxify.... we couldn't enforce physical activities but sauna is easy for everyone, they can sweat out all toxins"

Correspondingly, the social worker from the same rehabilitation facility mentioned that:

Sauna generally refreshes and reinvigorates the body and the mind....(Rehab A-sws02)

The statements noted above demonstrate that, unlike Rehabilitation Centre B which used physical exercises to achieve detoxification, Rehabilitation Centre A was using

the sauna. It is unequivocally clear that the two rehabilitation facilities mutually believed that detoxification either through manual exercises or through technology in the form of a sauna was critical in mitigating against possibilities of relapse post treatment of substance use disorders.

5.3.10 Life Skills Training

The last but not least relapse mitigation strategy which was being implemented by the two selected rehabilitation centres was life skills training. According to reviewed programme documents, life skills were defined as follows:

Rehabilitation Centre A: The skills needed to deal well and effectively with the challenges of life

Rehabilitation Centre B: Skills needed to make the most out of life

Furthermore, reviewed programme documents showed that among a range of life skills prioritised for clients with a history of substance use relapse included those summarised in the table below.

Table 12. Life skills

Life Skill	Explanation
Self-care	The practice of taking an active role in protecting one's own well-being and happiness, in particular during periods of stress
Mindfulness meditation	The ability to set apart time to focus on the self towards gaining objective self-awareness
Knowing your triggers	Ability to discern factors which predispose your to cravings and wanting to use substances
Play the tape through	Ability to visualise not only the pleasurable effects of using substances but also imagining the after effects of the usage
Developing an emergence list	Having a list of persons or places you can go to absolve urges without using

Indications by key informants from the two participating rehabilitation centres were that as a general observation, substance users are persons who lack certain requisite life skills which are needed in negotiating their way out of situations. The social worker from Rehabilitation Centre B said:

> *"In most instances, those who succumb to relapse after treatment will be lacking basic life skills such as negotiation, self-care and impulse control and this elevates their vulnerability to relapse.."*
> *(Rehab B-sws01)*

In light of the above statements, it is notable that life skills were some of the crucial relapse prevention strategies which were being used to buffer recovering substance users against possible relapse.

5.4 Findings related to Objective 2: To determine the extent to which selected therapy programmes assist in the prevention of substance use relapse

The first objective of this study has unequivocally established that the nature of substance use relapse therapy programmes used in the two selected rehabilitation programmes and examined if they met their goals. It also made explicit how the therapy programmes were believed to aid the process of preventing the occurrence of substance use relapse, which is one of the main aims. According to Patton (2008), utilisation focused evaluations (UFEs) are based on the principle that an evaluation should be judged according to how useful it is to its primary intended users. The current section presents findings of the second study objective which sought to establish the extent to which the identified therapy programmes were believed to be effective and reliable in achieving their intended purpose (which is to prevent

substance use relapse post-treatment). Towards holistically answering this objective, it was necessary to tap into the perceptions of the service providers (rehabilitation centre personnel), service users (substance users who were in treatment after the previous relapse/s) and key informants (in this case families of recovering substance users who were treated in the selected rehabilitation centres). Additionally, secondary data sources including programme documents and registers were used. For clarity and better presentation, qualitative findings to this objective are given first while insights from the caregivers of recovering substance use relapse patients will be provided under the section of quantitative findings.

5.4.1 Findings from the Mini-Survey related to objective B

As already indicated in the methodology chapter, this study also had a quantitative component which was nested on top of a mainly qualitative inquiry. The quantitative component of the study sought to explore perceptions of 100 people who were the recovering relapse patient's caregivers on the effectiveness of therapy programmes that were used to treat their family members (patients). Understandably, the caregivers did not have much understanding of the therapy programmes which were used in treating their loved ones; however, they had first-hand experience of the behavioural and lifestyle changes in their loved ones which they attributed to treatment in the selected therapy programmes. To this end, the survey questionnaire which was used was designed in such a way that it asked questions that addressed the success of specific therapy programmes as administered by the two selected rehabilitation centres. The ensuing section presents findings from the mini-survey combined with like themes results from the qualitative data. However, before delving

into the perceptions of caregivers, it suffices to provide an overview of the demographic details of the survey respondents.

5.4.1.1 Representation of selected rehabilitation centres

To ensure that specific rehabilitation facility data was collected and therefore ensure objective analysis, it was necessary to recruit an equal number of caregivers for recovering substance use relapse patients treated in the two selected rehabilitation centres. The study managed to achieve parity in terms of rehabilitation centre representations. Figure 9 below graphically show that there was an equal representation of rehabilitation centre A and B caregivers who took part in the study.

Figure 7: Distribution of caregivers between the focal rehabilitation centres

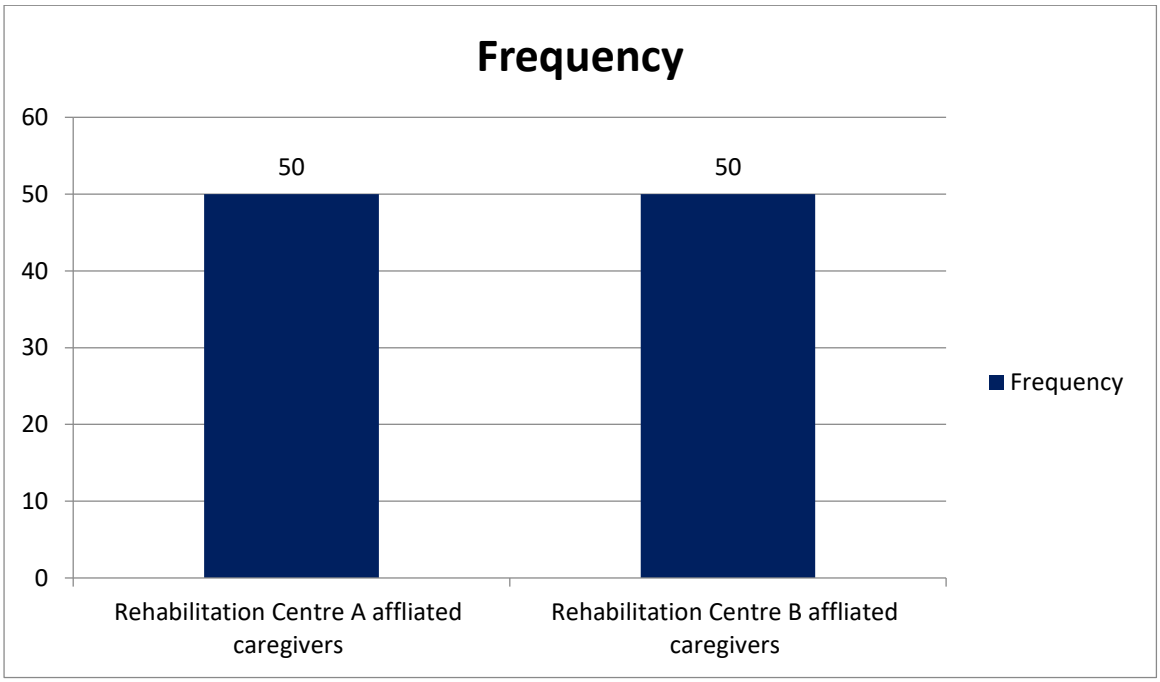


Figure 9 aptly shows that the perceptions which formed the basis of this qualitative component of the study were equally distributed between caregivers who had their loved ones in both the focal rehabilitation facilities. Equal representation was

considered paramount in ensuring a fair analysis of the core therapy programmes which were being run by the selected rehabilitation centres.

5.4.2 Demographic characteristics of mini-survey respondents

5.4.2.1 Gender

As shown in figure 10 below there were more female caregivers than males who participated in this study. Precisely, a total of 67 females took part in the study against a total of 33 males.

Figure 8: Gender Distribution in the survey sample

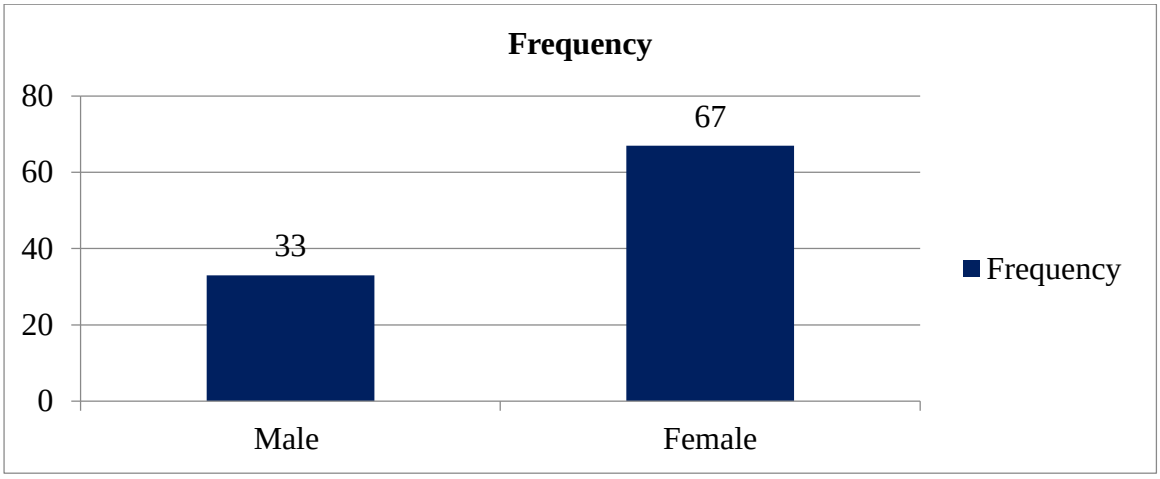


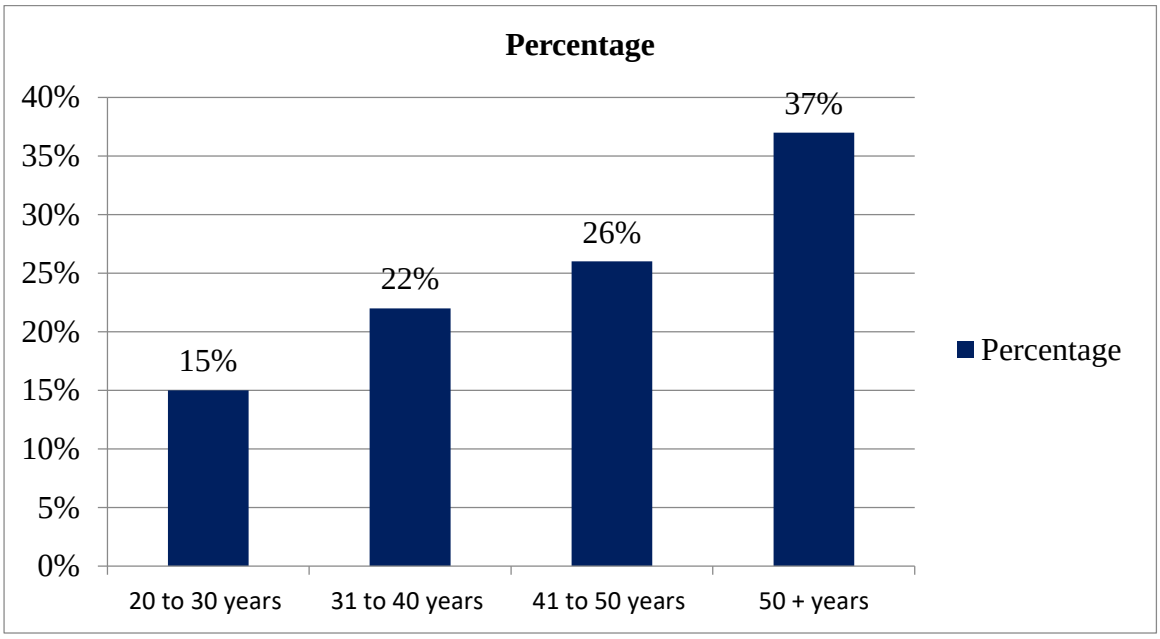
Figure 9 aptly demonstrate that females are highly involved in caregiving for substance use relapse persons in Gauteng. At face value, it seems inconsequential that more females than males were involved in the caregiving of substance use relapse persons. However, if viewed from the viewpoint of the distribution of resources between genders which show that more females than males live in poverty, it becomes concerning that perhaps these women lack adequate resources to effectively and sustainably support their recovering loved one. This is supported by the 2021 Global Gender Gap Report which indicates that fewer women participate in

the labour market, hence the uneven distribution (Schwab, Samans, Zahidi, Leopold, Ratcheva, Hausmann & Tyson 2021).

5.4.2.2 Age

Findings from the mini-survey showed that the sample of caregivers of recovering substance use relapse patients was highly diverse in terms of their ages. The minimum age in the sample was 23 years and the maximum 74. Figure 11 below demonstrate the categorical distribution of the ages of study respondents.

Figure 9: Distribution of Age among Caregivers of recovering substance use relapse patients



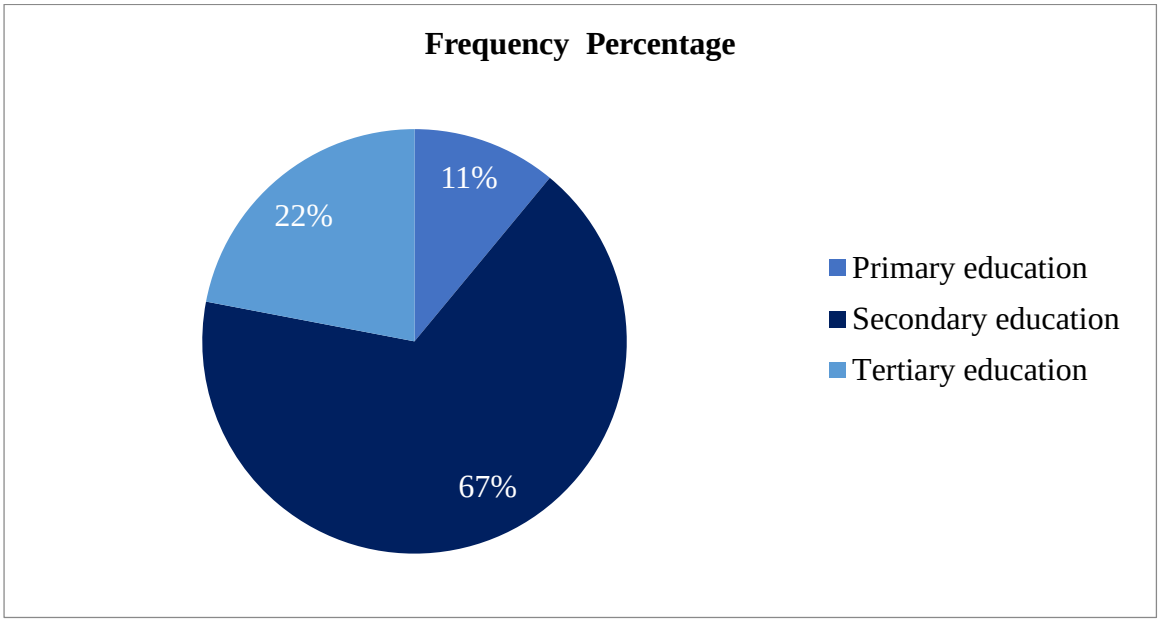
Depictions in figure 10 explicitly show that the responsibility for caregiving to substance use relapse patients increases with age with older persons (those above 50 years) being the most involved age category. This finding casts a negative outlook on the prospects of effective and sustainable care for recovering substance use relapse patients post their treatment. Notably, the preponderance of older persons in caregiving for recovering substance use relapse patients raise prospects of lack of adequate supervision of recovering drug users which may elevate their risk for

relapse. This is because older persons may lack the requisite energies, resources and competencies to attend to all the psychosocial, emotional and physical needs of recovering substance users.

5.4.2.3 Education

Findings of the study appositely demonstrated that caregiving for recovering substance use relapse patients in Gauteng was mainly in the hands of persons with lower educational qualifications. Figure 10 below graphically illustrates the distribution of educational qualifications among the sampled caregivers.

Figure 10: Distribution of educational qualification among caregivers of recovering substance use relapse persons

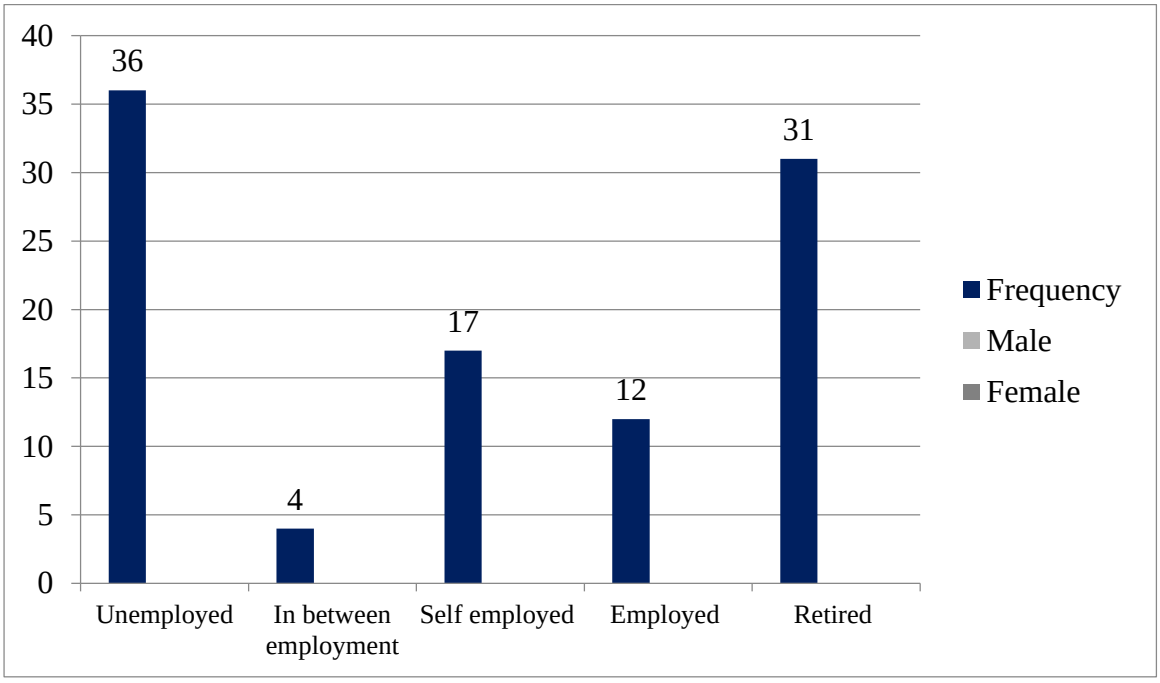


As shown in figure 10 above, the majority 67%(N=67) of the caregivers of recovering substance use relapse patients had achieved secondary school education and the least had primary education 11% (N=11). This finding inspires the hope that caregiving to recovering substance users in Gauteng is in the hands of people with significant education which positions them to be able to provide good quality care to their loved ones.

5.4.2.4 Employment Statuses

The employment status of the caregivers of recovering substance use relapse persons was considered paramount as an indicator of the potential affordability of post-treatment recovery accessories and services. To this end, participants in the mini-survey were asked to share information on their employment statuses. The figure depicted below effectively demonstrate that the bulk of the caregivers were unemployed and or retired.

Figure 11: Distribution of Employment Statuses among caregivers



The findings indicated that the bulk of caregivers of recovering substance use were persons who were unemployed, in-between jobs and retired evokes a sense of ambivalence. 36% (N=36) caregivers were unemployed, while 31% (N=31) were retired, 4% (N=4) in-between employment, 17%(N=7) Self-employed and 12%(12) employed. This propagates that the caregivers have ample time to provide requisite support to their loved ones. However, being out of employment may mean that they may lack disposable incomes with which they could help to meet their welfare and

that of their care recipients who may be dependent on them. Several individuals with substance use disorders face challenges in maintaining or committing to one job (Jemberie, Stewart Williams, Eriksson, Grönlund, Blom Nilsson & Lundgren 2020).

5.4.2.5 Gender/Employment split

The figure below indicates the number of caregivers who had some sort of income from either being employed or self-employed according to gender.

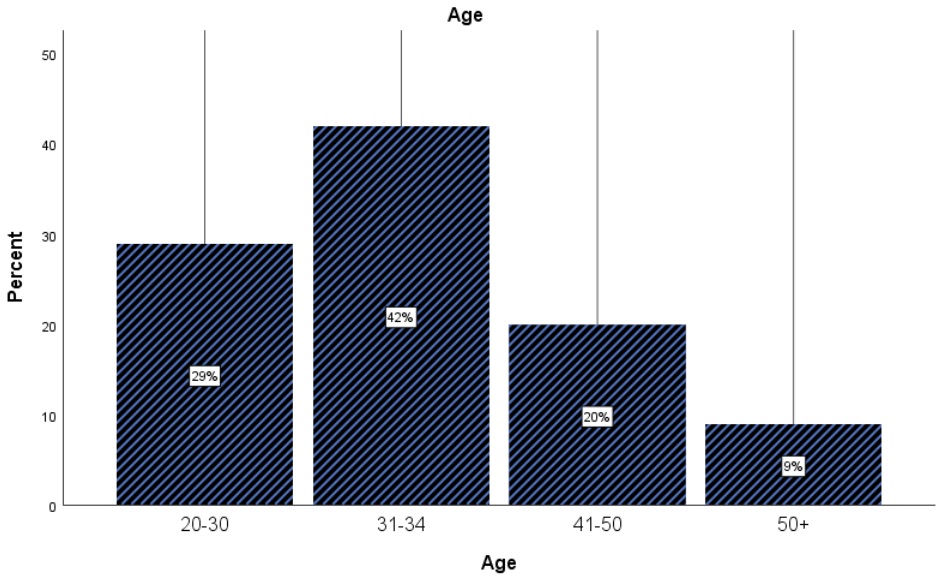
Figure 12: Gender/Employment split

5.4.3 Demographic characteristics of the substance use patients

5.4.3.1 Gender

As shown in the figure below there were more female caregivers than males who participated in this study. Although the split of the patients who were represented was 50% female and 50% male.

Figure 13: Patients Gender Distribution in the survey sample

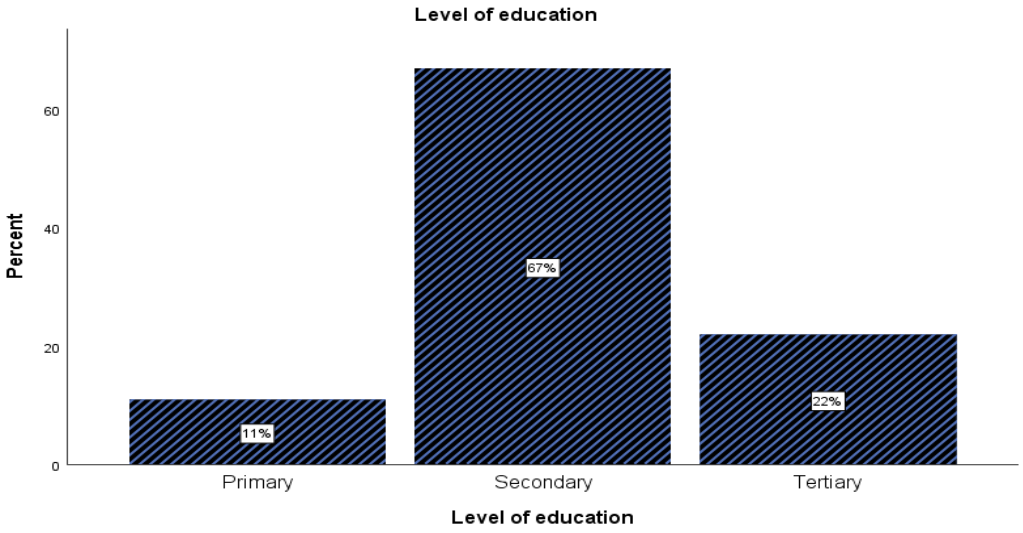


The figure above shows that the majority of the patients who had their caregivers complete the survey were between the ages of 31-34 (42%). The patients who were between the ages of 20-30 had the next higher percentage (29%), the ones between 41-50 (20%) and more than 50 years (9%) were the fewer ones. There are similarities of the age groups of the participants showing that the majority of individuals who battle the substance use relapses are in their prime years.

5.4.3.2 Education

These findings indicated that most of the patients only had reached secondary school or did not have any sort of education. The figure below graphically illustrates the distribution of educational qualifications among the patients.

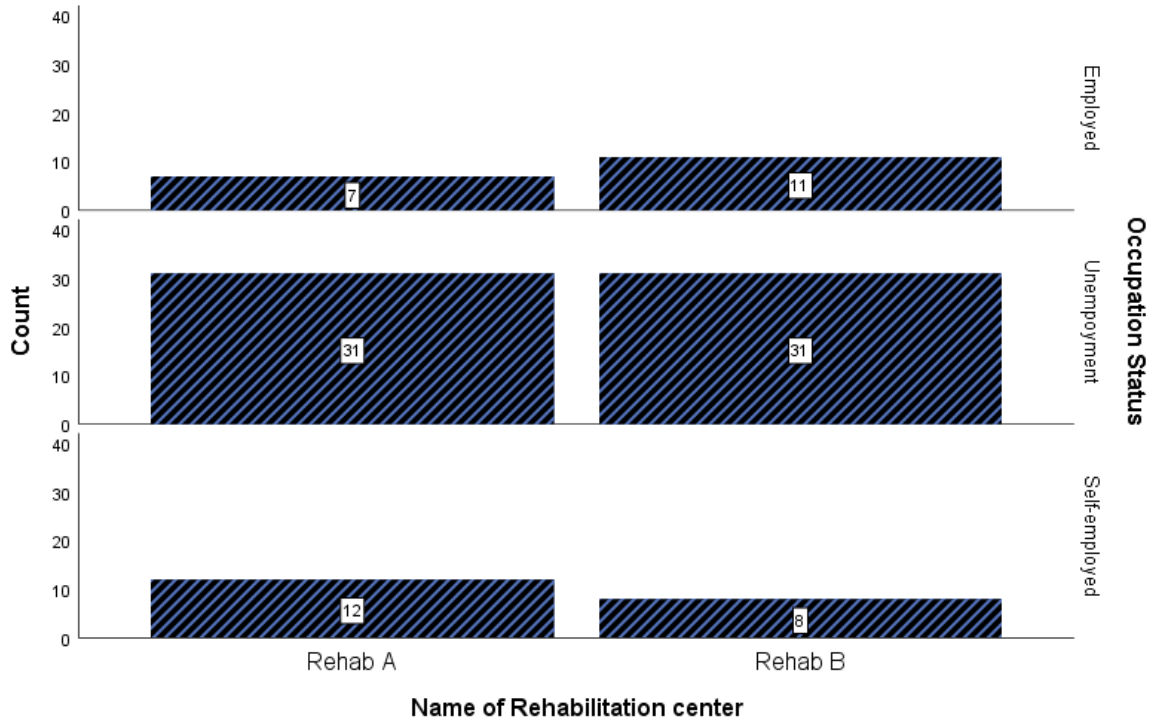
Figure 14: Level of Education



5.4.3.3 Employment Status

The employment statuses of the patients were relevant as it could show the relationship between unemployment and repeated relapses. The figure below illustrates the distribution.

Figure 15: Distribution of Employment Statuses among the patients



The findings indicated that the majority of the patients were unemployed from both rehabilitation centres followed by self-employed and employed. Both the survey and focus group indicated that most of the patients were not employed. The cycles of relapse the patients go through are probably the reason they cannot secure steady employment. Unemployment could also be a trigger for relapses or could have been due to the reasons that the patients had become unemployable.

5.4.4 Effectiveness of the Minnesota 12 Steps Programme

5.4.4.1 A Service Provider Perspective

Findings of the study demonstrated that the Minnesota 12 Steps Programme was generally considered as the key therapy strategy for relapse prevention efforts in the two selected rehabilitation facilities. Specific findings pertaining to the effectiveness of the programme from a service provider perspective showed that both therapists and the management of the selected rehabilitation centres were strongly inclined towards the belief that the 12 Steps programme was highly effective in mitigating substance use relapse. From a service provider perspective, the 12 Steps Programme was described as the “heart” and “blood life” of all substance use relapse prevention efforts. The social worker from Rehabilitation Centre A said:

> *“Before they introduced the 12 Steps programme in 2007, treatment for substance use relapse in this organisation used to be primarily based on a moral blackmailing programme, in which religious scripts were used to scare substance users against reusing after exiting treatment. It was not effective; our internal research showed us that since the time when the 12 Steps programme was adopted, we are seeing less of previously treated clients.’’ (Rehab A-sws01)*

The director of the same Rehabilitation Centre A concurred and said:

"I can authoritatively tell you that this 12 Steps programme is very effective. At one point in time, a student from an overseas university came to conduct her research using our data. Here findings showed that since the beginning of the 12 Steps programme, the duration survived by most of our recurring substance use relapse patients after treatment significantly improved from an average of 9 days to 43 days post treatment. This is a great improvement and an indication that the programme is effective.."

Similarly, the director of Rehabilitation Centre B intimated that, the 12 Steps programme was the most important and results bearing programme in their facility. He said:

"In all honesty, there is no substance abuse treatment, let alone relapse prevention without the 12 Steps programme. The programme is globally acclaimed to be the fundamental basis of substance use treatment."

The social worker from Rehabilitation Centre B also said:

"For me, the extent of this programme's effectiveness cannot be quantified, it's in its utility, you would see that the 12 Steps is pivotal in bringing about self-awareness, assisting the substance user to realise his/her trigger factors and also proactively equip drug users on how to deal with their trigger factors. These are critical factors in relapse prevention." (Rehab B-sws01)

As demonstrated above, service providers concurred that the 12 Steps Programme was to a greater extent useful and effective in assisting drug users to curb the occurrence of relapse. Indications were that the 12 Steps Programme was critical in helping the rehabilitation process by providing a technical framework within which therapists can provide holistic interventions.

5.4.4.2 Psychotherapy

The findings of the study revealed that both service providers and consumers believed that psychotherapy interventions were playing significant roles in preventing the occurrence of relapse after treatment. Among the notable credits of psychotherapy, interventions were that long term psychotherapy interventions which were provided by Rehabilitation Centre A helped to support substance users to deal with the hostile social and economic challenges faced by recovering substance users post their treatment. The effectiveness of the psychotherapy programme was also confirmed through a comparative analysis of the relapse rates and patterns between the selected rehabilitation centres. Notably, a review of the re-admission registers over six months showed that repeated relapse substance users from Rehabilitation Centre A, were on average spending 19 days longer in recovery than their counterparts from Rehabilitation Centre B. While there could have been many other variables that could be responsible for this anomaly, enforced post-treatment psychotherapy seemed to be the main difference between the two selected rehabilitation facilities hence it is possible that this difference in relapse periods could be as a result of this ongoing intervention.

When study participants were asked to share their perceptions and experiences on how the ongoing psychotherapy programme in Rehabilitation Centre A assisted with long term recovery, participants expressed the following sentiments:

Rehabilitation Centre A, Focus Group 2 participant:

> *"I agree, this programme of continuously having professional counselling even after leaving the rehab is very good. As my colleagues have already said, real recovery starts the very moment you step out of this gate (rehabilitation centre entrance), that were the most support is needed." (FG2-01)*

Another participant from rehabilitation Centre A, Focus Group 1 said:

> *"Of all the programmes here, I really liked this after care programme of ongoing therapy. Unlike the counselling which is provided inside the rehab, the counselling which is provided after discharge I found it more practical and supportive as it deals with real life situations.." (FG1-p05)*

Additionally, the social worker 2 from Rehabilitation Centre A said:

> *"You would notice that when we provide counselling during the admission period, the bulk of issues discussed are in retrospect, its issues which happened from birth up until the problem of substance use commenced.." (Rehab A-sws02)*

The above noted sentiments appositely demonstrate that psychotherapy was considered to be highly efficient in mitigating the phenomenon of relapse. Perhaps there is a need to ensure that all rehabilitation programmes embrace both long and short term psychotherapy programmes.

5.4.5 Perceptions on behavioural changes related to specific treatment goals

5.4.5.1 Changes in personal and interpersonal relationships

Findings from the qualitative component of the study astutely demonstrated a strong conviction among both service providers and substance abusers that effective substance use relapse therapy should bring about positive changes in clients' personal and interpersonal relationships. The study sort to determine through the perceptions of the caregivers of recovering substance use relapse patients if they had noticed any significant changes in the patient's relationships. The conviction was that perceptions of caregivers provided an indirect means of testing the efficacy of the various therapy programmes which among other goals emulates to restore and

improve peaceful co-existence between substance use relapse patients and their significant others in different contexts.

The figure below presents findings pertaining to the quality of personal and interpersonal relationships of recovering substance use relapse patients from the viewpoint of their caregivers.

Figure 16: Perceptions on the success of recent rehabilitation on personal and interpersonal relationships

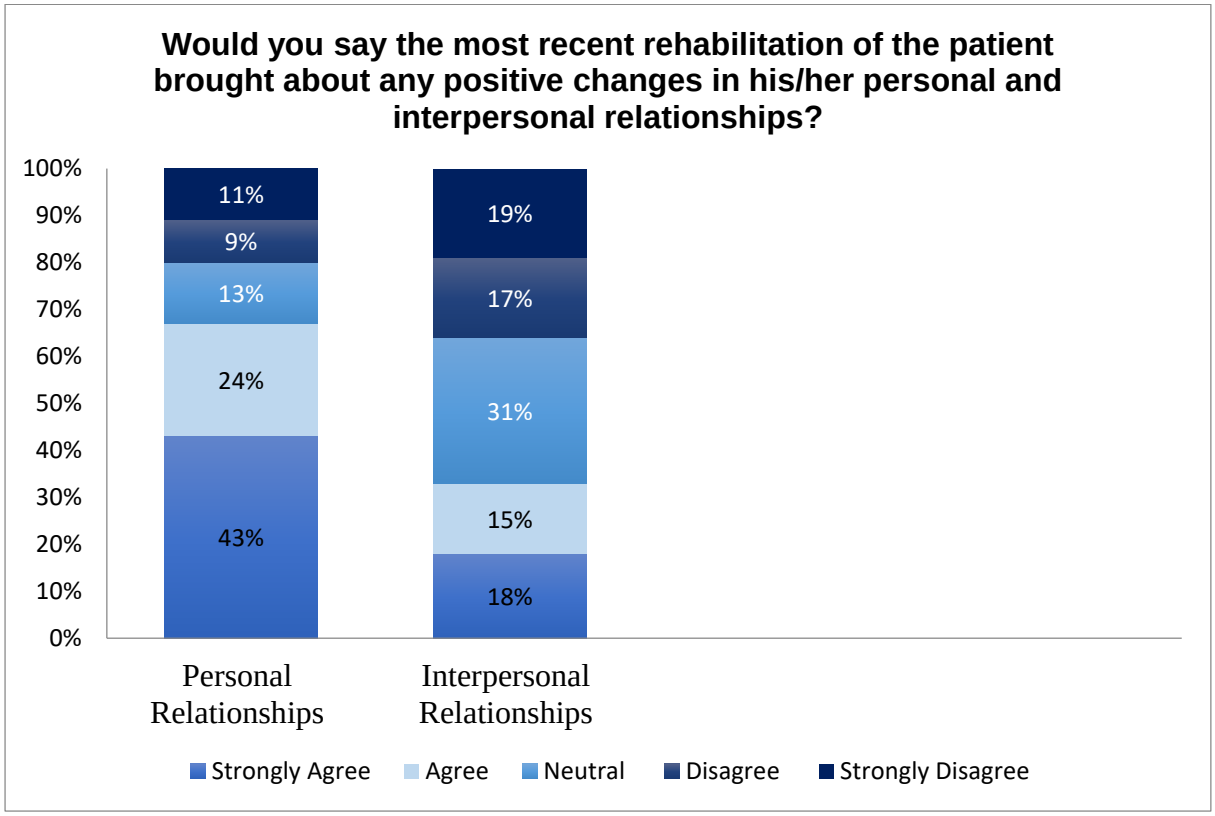
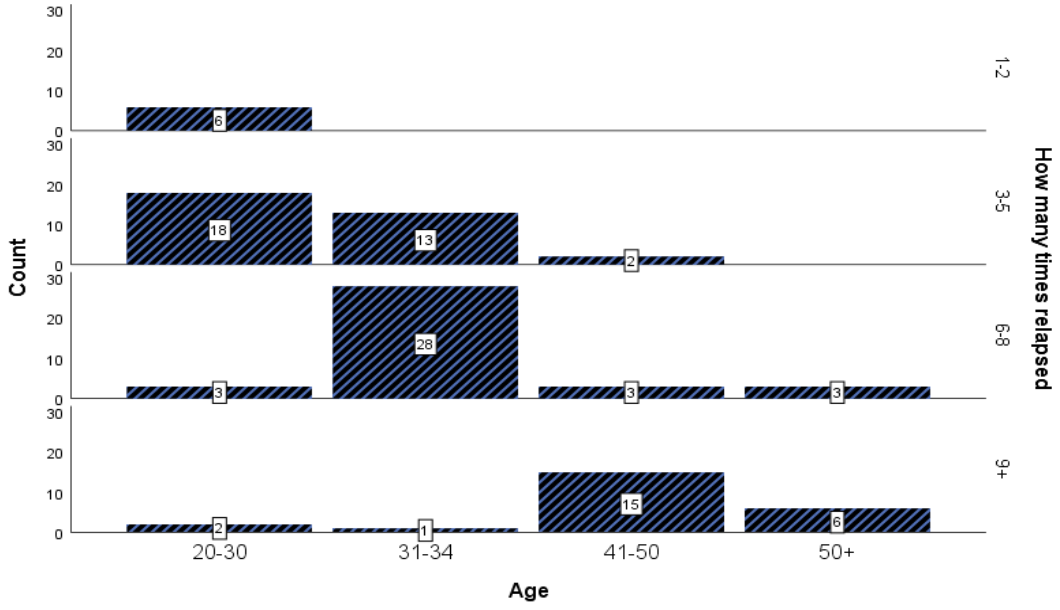


Figure 17 above demonstrates that post recent treatment of their loved ones, the bulk of the surveyed caregivers reported major improvements in the personal relationships of the recovering substance use relapse patients. Precisely, 43% and 24% of the respondents strongly agreed and simply agreed respectively that there was a positive change in the personal relationships of their loved ones. Fewer caregivers, 11% and 9% strongly disagreed and disagreed respectively that there were positive changes in the patient's relationships.

On the contrary, findings on the opinions of the caregivers of recovering substance use relapse persons regarding the quality of their interpersonal relationships with others indicated that the bulk 31% of the caregivers were neutral. Other opinions were moderately equal differing with 1 percentage point between those who strongly agreed 18% and those who strongly disagreed 19%. Still, on the same notion, 15% of the respondents simply agreed that there was a positive change in the interpersonal relationships of their care recipients while 17% simply disagreed.

The preponderance of positive validation of improvements in the personal relationships of recovering substance use relapse persons may mean that the therapy programmes in the two selected rehabilitation centres were highly effective in their goal of aiding relapse patients to be more compassionate towards others. However, the disaggregate outcomes in terms the interpersonal relationships seem to suggest that there is a major gap in the programming of the two rehabilitation facilities towards ensuring that their clients acquire requisite skills for forging and maintaining relationships with others. However, it may also mean that after rehabilitation in treatment centres, substance use relapse persons are discharged into adverse communities where they are shunned and their efforts to reintegrate despised. The figure below indicates the number of times the patients have relapsed according to the caregivers.

Figure 17: Number of times the patients have relapsed

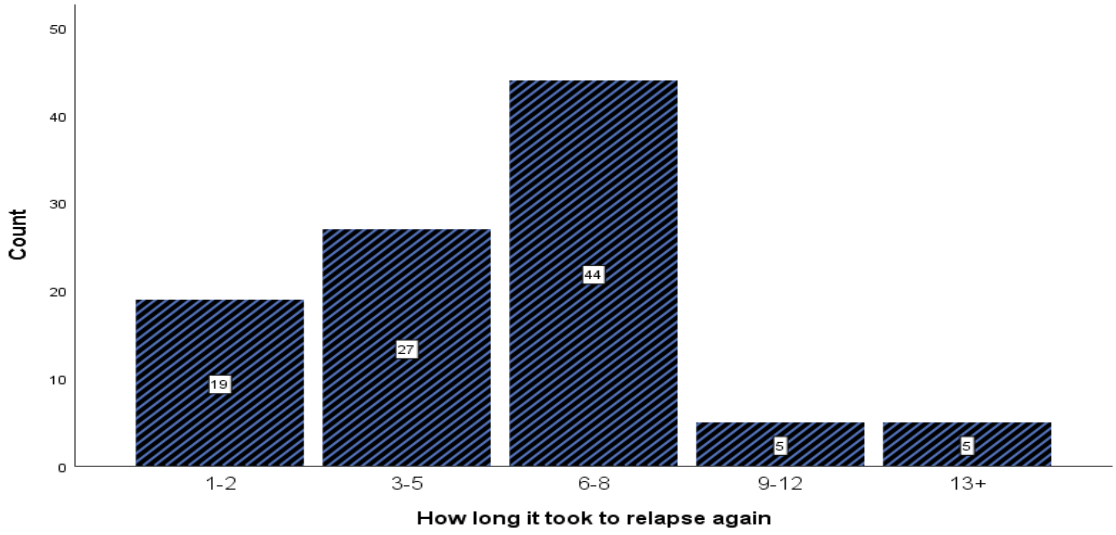


From the families that answered the 100 questionnaires representing their family member who was admitted at either of the rehabilitation facilities, 6% of the respondents indicated that their family members had relapsed 1-2 times in their lifetimes, 33% indicated 3-5 times, 37% indicated 6-9 times and 24% more than 9 times. Comparing the age groups and the number of times the patients had relapsed, 6 indicated that they have relapsed once or twice within the 20-30 years age group. 33 patients indicated that they had relapsed 3-5 times, 18 being of the 20-30 age group, 13 of the 31-34 age group and 2 of the 41-50 age group. 37 individuals of the rehabilitation centres were said to have relapsed about 6-8 times, with 3 being of the 20-30 age group, 28 being of the 31-34 age group, 3 of the 41-50 age group and the

other 3 of more than 50 years old. The patients who had relapsed more than 9 times were 24 and of those, 2 were of between 20-30 years, 1 was between 31-34 years old, 15 were of the 41-50 age group and 6 were above 50 years old.

The figure below shows how long it took for the patients to relapse after they had been discharged from the rehabilitation centre.

Figure 18: Number of weeks it took the patients to relapse

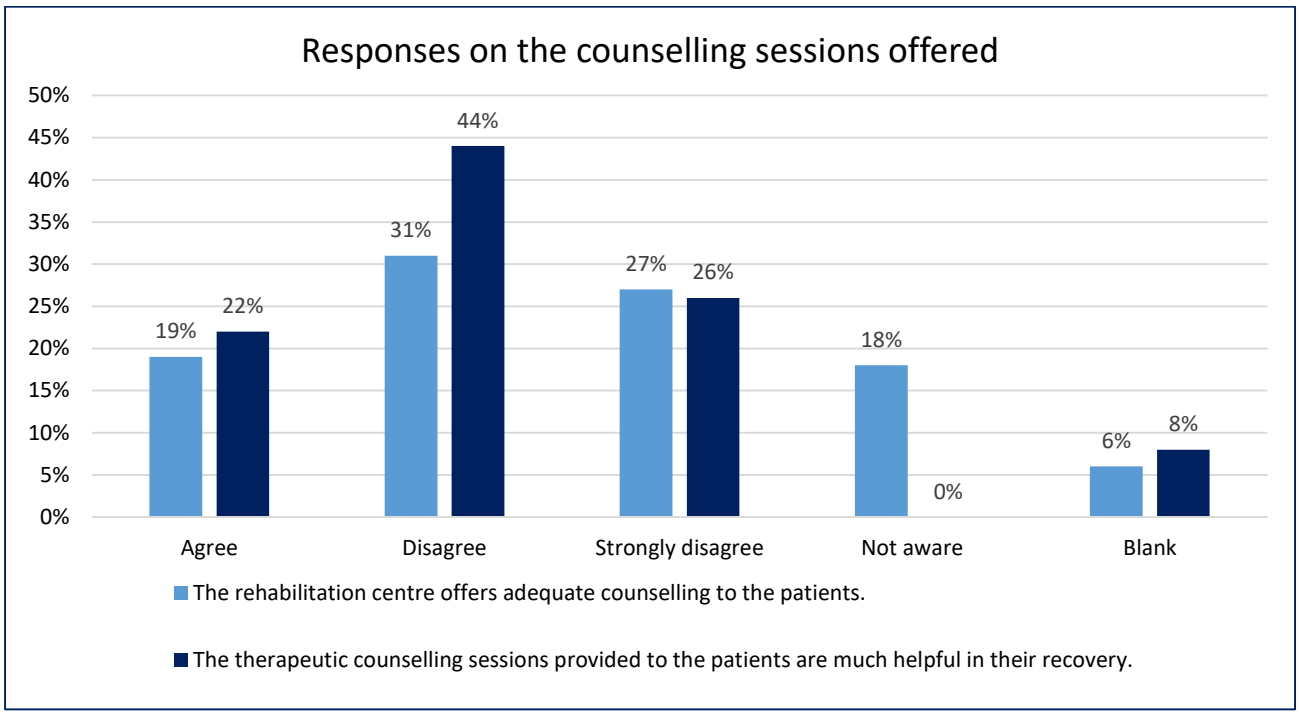


The results indicate that the majority of the patients relapsed within the first 8 weeks after being discharged from the rehabilitation centre. It is however difficult to rule the ineffectiveness of the therapy programmes offered at rehabilitation centres. There could be other factors that contributed to the outcome.

5.4.5.2 If patients received adequate counselling and whether it was adequate

The main objective for psychotherapy was to set specific treatment goals with the patient, work towards them, and assess the outcomes at termination. This was facilitated by social workers to help patients abandon their fixed delusional system. The social workers through CBT ensure that all psychotherapy sessions are individualised according to the patient's persona and experiences. To enhance optimal effectiveness, although the sessions are mandatory client's free will is respected and their values and right are upheld. Figure 20 below indicates the caregivers' views of the counselling sessions.

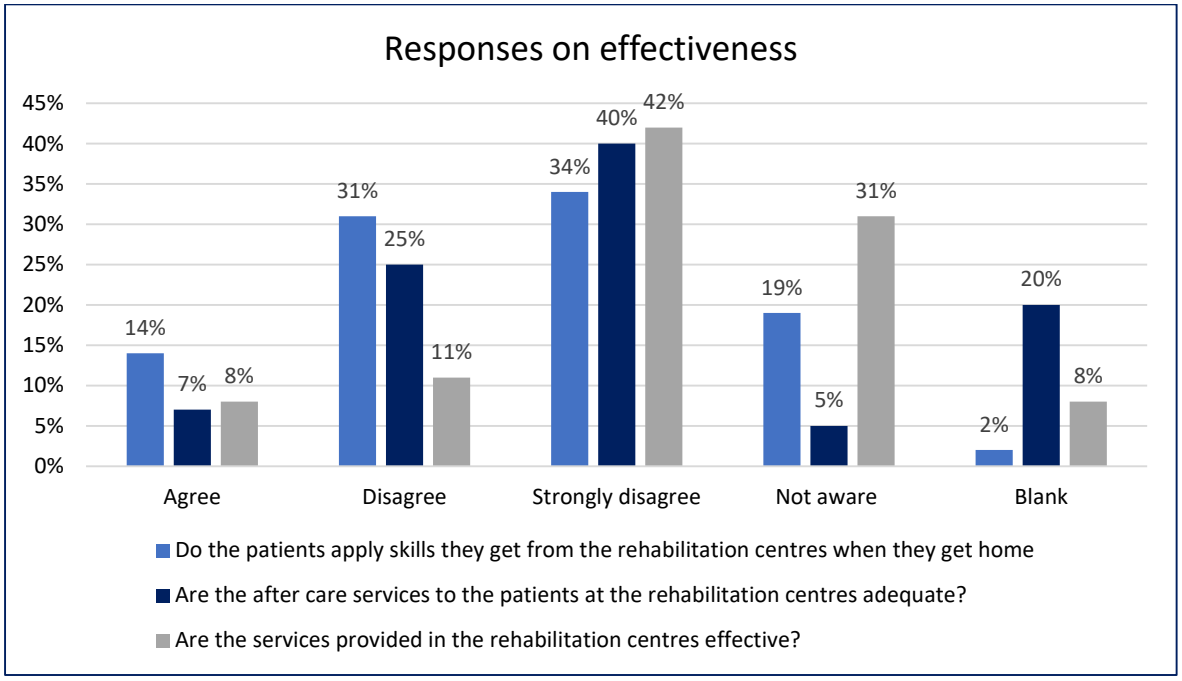
Figure 19: Responses on the effectiveness of counselling sessions



The survey showed that 19% of the caregivers strongly agreed that the rehabilitation centres offered adequate counselling to the patients, and 31% agreed on the same. The social worker before setting treatment goals with the patient, try to learn of any patient's potentially self-destructive behaviour and strategize how that part can be addressed during the treatment. The sessions help patients to become aware of any self-destructive, thoughts, habits and work on transforming them, this is perhaps why a total of 50% of the caregivers perceive that the counselling offered at the rehabilitation centre was adequate. However, 27% disagreed and 18% strongly disagreed, while 6% were not aware whether the counselling was adequate. More to 22% strongly agreed that counselling was helpful to the patients, 44% agreed and 26% disagreed and 8% were just not aware if it was helpful. This shows that most caregivers thought the counselling services provided by the rehabilitation centres were adequate and helpful.

5.4.5.3 If services provided by rehabilitation centres are effective

Figure 20: Responses on effectiveness



In response to the question if the services offered by the rehabilitation centres were effective, the survey results showed that 8% of the caregivers strongly agreed, 42% agreed, while 40% disagreed,5% strongly disagreed and 20% were not aware. This indicates that 45% disagreed probably due to the results they saw, of the patients who kept on relapsing repeatedly regardless of the number of times they got admitted at the rehabilitation centres.

However, one key informant shared their sentiments and they believed that the services their rehabilitation centre offered were effective if facilitating sobriety.

These were his words below:

> *'Our programmes are top notch, like every rehabilitation centre in this country uses the twelve steps programme, we also have it here but the boys just don't want to leave these drugs man. I get calls from companies complaining that good employees are using drugs, they give them one chance and send them here but what do the boys do? They come here not serious, waste their 6 weeks and go*

back to work and start using again at work, the companies call me that they have no option but to fire them, I mean at least they would have tried, sending them to a private rehabilitation centre, no addict from the street can afford this place, (sigh) they all go and get crowed at free government rehabilitation centres' (Rehab A-director01)

The key informant indicated that the services were effective but sobriety was dependent on the patients. On the other hand, some participants thought the programmes were helpful, like the 12 steps programme.

The importance of the twelve-step programmes is supported by a participant from rehabilitation centre B focus group:

'The twelve steps have helped me on helping me to move from denial and officially accept my weakness and to start putting efforts in my recovery journey'(FG4-p08)

However, most participants from the focus group discussions felt the therapy programmes there were being offered after a series of several relapsing cycles, where the same and no longer proving to be effective to them anymore since they kept on relapsing multiple times.

The extracts from the focus groups below show the direct quotations.

Rehabilitation centre A Focus group:

'See I agree with what Edgar (psydo) has just said, what they teach us doesn't work, every time I am discharged to go home, I don't even last for a week, I fail to overcome the cravings and the next thing I just see myself at the merchant's house'(FG1-p09)

Rehabilitation centre A Focus group:

*'am so *** up, all I think of is crystal meth, my parents bring me to this jail thinking my love for meth will go but, this place is just like another holiday resort where I can be clean for 12 weeks and back again to my habit, I don't stuff if what they teach us here works because am going to die with meth…hahaha (laughs). Other participants also supported the similar notion by stating the following statements" (FG2-P04)*

Rehabilitation centre B Focus group:

'when I came I was given methadone for a few days to deal with my withdrawals that helped me, but I don't think I got much from the classes, maybe the one on one sessions helped a bit in trying to convince me, but when it comes to real life cravings are real and so hard to overcome, I guess that's why I am always in rehab' be consistent with labelling names"(FG4-08)

Rehabilitation centre A Focus group:

'I think the therapy programmes don't do much , to tell the truth…hahaha (laughs) I think the only thing this rehab helps with is a protective environment which is free from all civilization and all drugs… when I am in here I can't smoke my weed because where will I find it , the classes I don't know , but when I talk to the social worker I think I feel a bit better , I offload my stress and the social worker really makes sense most of the time and changes my perspective on a lot of things in my life which leads to my relapse all the time"(FG2-p06)

Rehabilitation centre B Focus group:

'maybe some of the other programmes work and others don't work, like for me the I wish like I could have access to methadone for a long time I think my problems of cravings and withdrawals will be solved, like my previous rehab I was at used to give us these pills that would help us to cope with addiction but now it's hectic here because it only classes and no medication…. of course the 12 steps are beneficial but if medication was there it would be awesome and maybe help me not to relapse.' (FG3-p01)

Participants gave various responses to how they viewed the effectiveness of the therapy programmes. Most of the patients noted that they're being admitted in the rehabilitation centres was just a form of religious formalism or a way of fulfilling the wishes of their employers or family members.

Rehabilitation centre A Focus group:

> *'I really am not sure if these programmes in rehabs work because this is my fourth time being admitted, so tell me if it works why do I keep coming back, I don't think what they do with us here is beneficial' (FG2-p03)*

Rehabilitation centre A Focus group:

> *'I think rehabs are just out to make money, this is a business for real, the amount that we pay is a lot …. just for me to relapse and come for admission again. (FG1-p04)*

The sentiments and views of the participants from the rehabilitation centres demonstrated by the findings of this research might mean that most treatment programmes at the rehabilitation centres do not adequately equip individuals against relapsing over and over again. Most views from the focus groups indicated that the offering of the same treatment programmes to first-time patients and also those who would have relapsed and been admitted again in the rehabilitation centres were not effective.

Another participant from rehabilitation centre B Focus group had this to say:

> *'The lessons never changed, still the same as the first time I was admitted here, now I have actually lost count how many times I have relapsed and come back again. No wonder why at times the supervisors ask me to give classes because they know that I now know most of it by heart.'(FG3-p04)*

Nonetheless, some individuals stated that the same twelve steps programmes are effective when it comes to ensuring sustainable recovery. This is supported by the following statement from a participant receiving assistance for addiction.

Rehabilitation A Focus group:

> *'guys don't be so negative minded, sis… when I was first admitted in was on almost everything, tjhoooo… it was bad man …. like I would buy the cheapest and when I score some more money then get the expensive stuff, but when I went home I managed to cut down of some of the drugs … these 12steps are amazing they helped me change my thinking, although I am still on Heroin now, I know that eventually I will leave it.'(FG2-p02)*

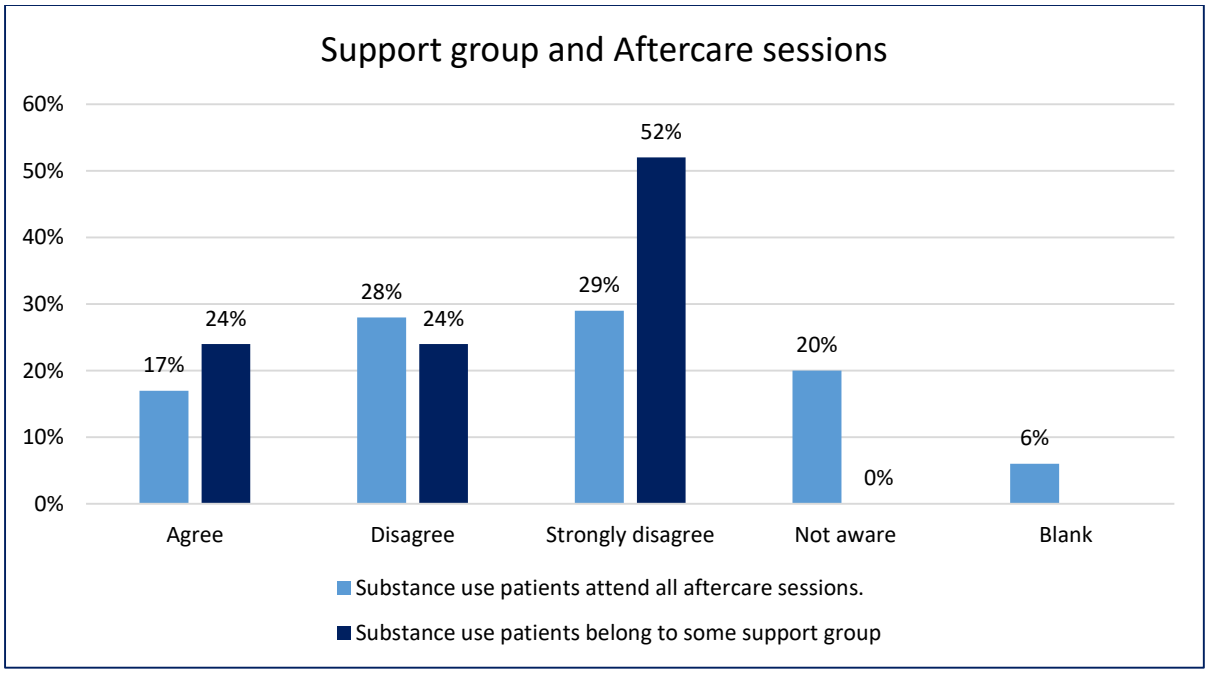
Generally, therapy is aimed at helping individuals to stop or reduce harmful substance abuse, improve their health and social function, and minimize their risk of recurrence. However, the success of therapy in combating substance use disorder, depends on numerous issues. These underlying issues should be addressed by the therapist during the therapy sessions.

5.4.5.4 If patients committed to the After Care program by belonging to a support group

The rehabilitation centres in the research have aftercare programmes that are set for the patients for when they are discharged. These aftercare programmes are to provide continued support to prevent any lapses that could lead back to substance use. At the aftercare program, a patient joins a support group and gets allocated to a sober ex substance user (a sponsor) that motivate them and help them throughout their sobriety journey or when they experience craving or when they lapse. The role of peer support is also supported by quantitative data, the caregivers admitted that some of the patients belonged to an aftercare support group. The figure below

presents the responses from the survey pertaining to the commitment of the patients after being discharged.

Figure 21: If Patients committed to a support group after residential rehabilitation



The survey results indicated that 24% of caregivers strongly agreed, 24% agreed that the patients belonged to some support group, and 52% disagreed. This shows that a huge percentage (52%) of the patients after they were discharged from the rehabilitation centres, would not commit to a support group and access aftercare services. Relapses in such cases are very common, in the absence of any informed support system. Miller (1992) that at times the commitment to follow through the rules of sobriety and surrounding oneself with support from aftercare sessions can only be a personal decision, which many fail to keep.

5.4.5.5 The effectiveness of the therapy programmes at the rehabilitation centres

The figures below show the responses that were given by the caregivers towards the effectiveness of the therapy programmes at the rehabilitation centres, and the adequacy of the knowledge shared with the patients.

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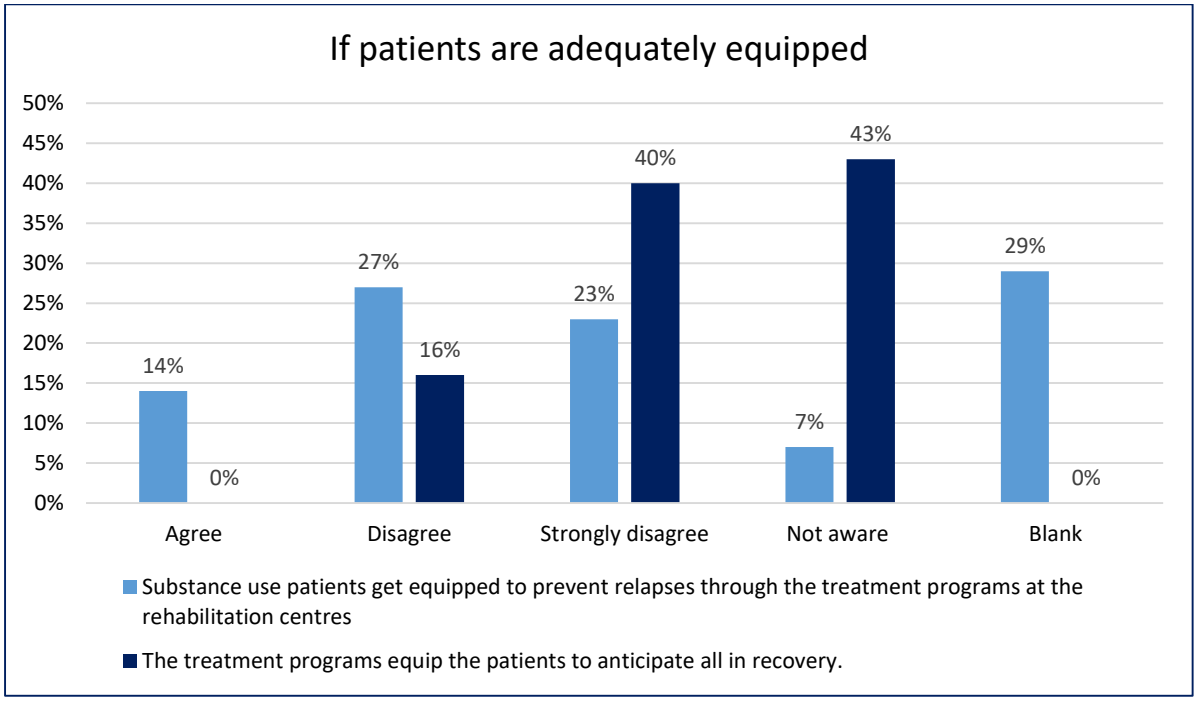
Figure 22: The effectiveness of the therapy programmes at the rehabilitation centres



According to figure 24 above a large percentage of the participants either did not know (43%), disagreed (16%) and strongly disagreed (40%) that the patients were adequately equipped to prevent relapses at the rehabilitation centres. In some cases, individuals are given all the tools they can need to prevent relapses but the decision to use the tools always lies with the individuals (Tucker, Vuchinich, & Gladsjo 1991).

Figure 23: If knowledge shared is adequate to prevent relapse

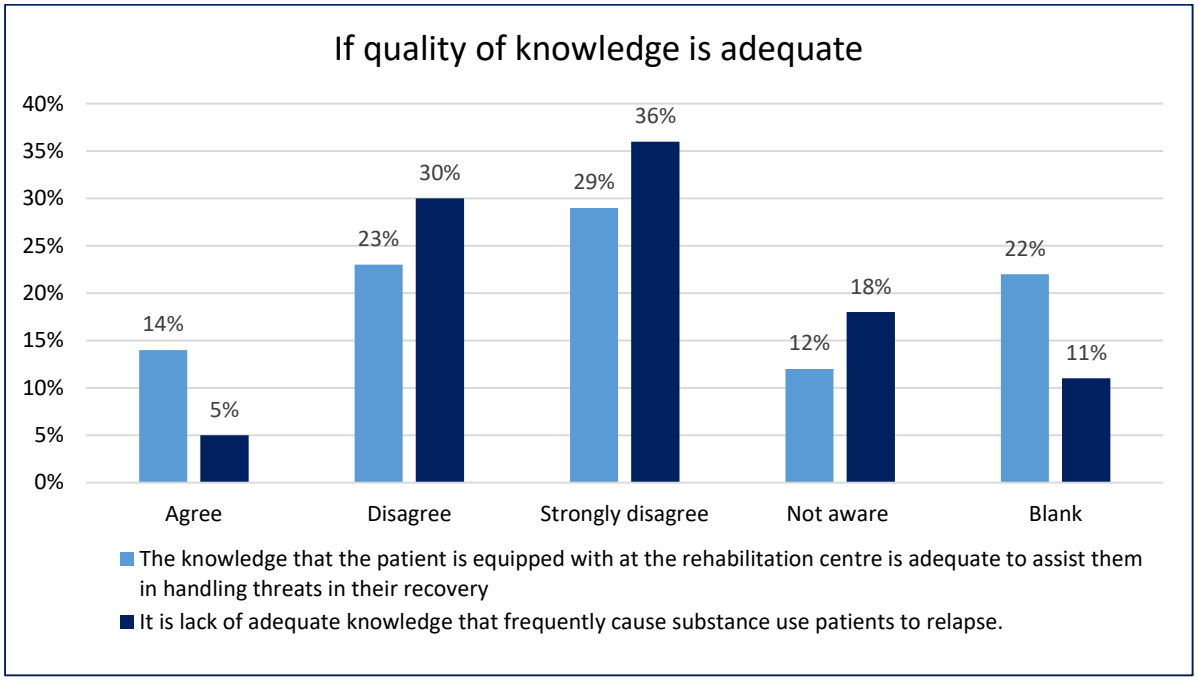
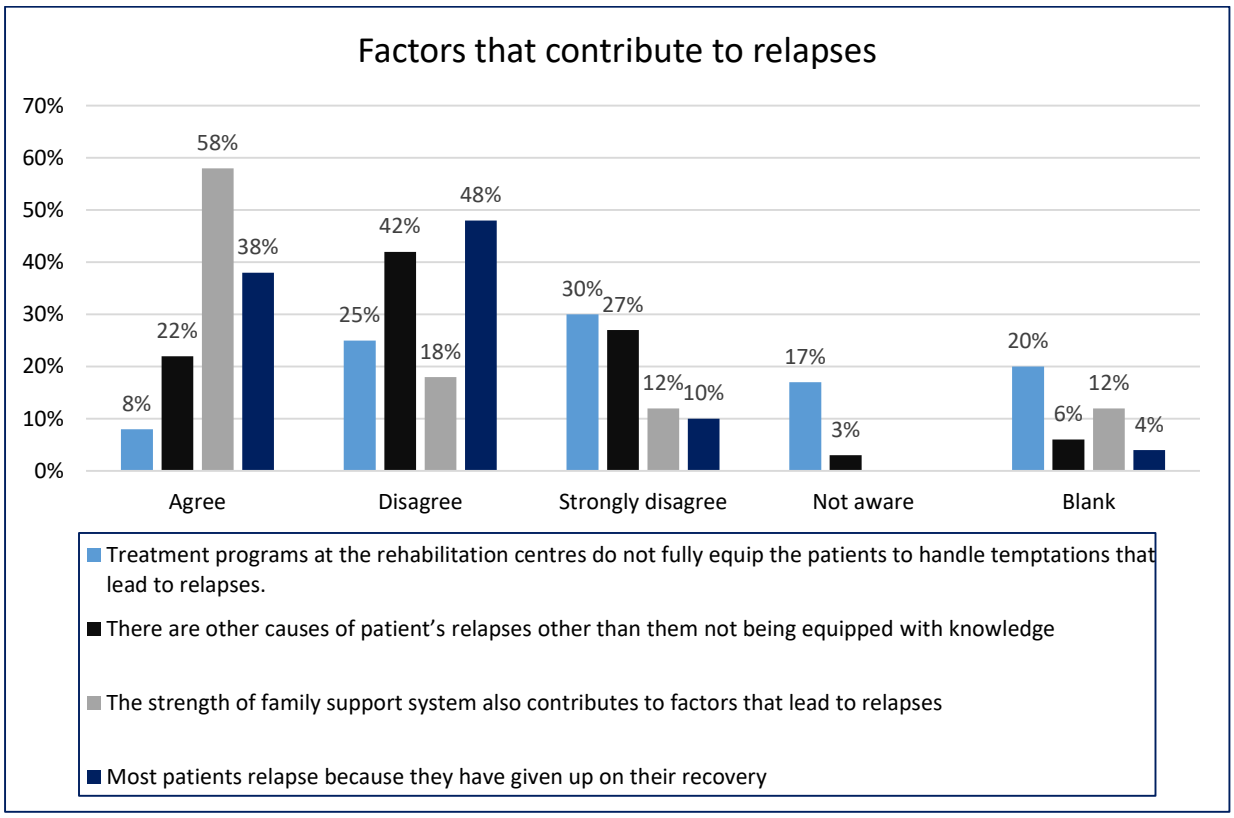


Figure 23 above shows that only 5% agreed while 30% disagreed, 36% strongly disagreed and 18% were not aware of individuals' relapse because of inadequate information that the treatment programmes offered. Katz and Higgins (2003) mention in their study that, there is no justification and explanation for relapses no matter the reasons that come up.

5.4.5.6 Other causes of patient's relapses (External)

The rehabilitation centres provide the patients with programmes that equip them to maintain sobriety. However, there are external factors that contribute to or lead to relapses.

Figure 24: Level external factors contribute to relapses



The findings of this study are consistent with previous studies that have been conducted with regard to relapsing. They showed that 22% strongly agreed, 42% agreed, other external factors contribute to patients' relapse, while 27% disagreed, 3 % strongly disagreed and 6% were not aware if there were other external factors that trigger relapses. Golestan et.al (2011) also found out in their study that external factors play a huge part in the sobriety journey of individuals with substance use disorders.

5.4.5.7 Family factors triggering relapses

The family environment is vital and emphasis should be put on it to make sure that it is safe for the patient's sobriety interests. There could be cases where either the family members do not understand how to relate with someone in recovery or when they are substance users themselves. If family therapy is not conducted adequately

or at all and a patient is discharged to such an environment (toxic or ignorant), the desire to go back into addiction can easy grow due to the surrounding triggers and pressure. So treatment should not be limited to patients only, but extended to their families so that they can be able to offer relevant support to their family member the patient). Family therapy is also vital as it identifies family dynamics that could facilitate relapses and attempts to help the families resolve them.

Some participants indicated that their immediate environments were the main problems, as one mentioned below:

Participant from rehabilitation centre A Focus group notes:

> *'I don't want to lie, every time I am at hope and making it in my recovery, if my brother relapses he makes sure he does something to make me also relapse, so that he is not the only one who goes back to rehab, I could move but I don't have anywhere to stay.' (FG2-p01)*

Other participants had this to say:

> *'My Father is a dealer, so what do you want me to do, I try but he sells drugs and he has the nerve to send me to rehab, I know he wants me to finish high school but it's difficult' (FG2-p09)*

> *'well the 12 steps definitely helped me a lot, relapse only because my husband who I stay with is also an ex addict and every time he relapses he makes sure I relapse also…. am going to deal with that idiot, I think when I leave he am going to divorce him, because we cannot both be in rehabs, who will take care of our kids?'(FG4-p06)*

Environmental factors such as toxic families or neighbourhoods have a significant part in the relapse process. The participant's responses indicated that their family environments party contributed to their relapses. The rehabilitation centre offers individual, group and family therapy to the patients, however only to those who are

willing. The majority of the families believe only the patient (their family member) should receive therapy and not them too, hence if the therapy is not holistic the patient's sobriety is compromised.

However, other external factors may tempt individuals to relapse, like locations or memorabilia connected with early drug use, and overcoming these is entirely up to the individual (El Sayed, Ali, Ahmed, & Mohy 2019). Some places and routes can be hard to avoid especially in the event of an individual using public transport, so their ability to overcome will be purely on the individuals.

The findings indicated that several interpersonal circumstances lead to relapses. Interpersonal circumstances are connected to the individual's being and their relationships with others. Individuals who are in recovery at times struggle to have meaningful connections with people around them including their families, except those they either use substances with or buy from. The life skills the patients are equipped with at the rehabilitation centres recommend them to have a clean social network, which reduces their chances of being hooked on to the old habits again.

Interpersonal relations can either be supportive and moulding or the total opposite. The twelve steps and the life skills treatment programmes emphasise the importance of relationships, any people from a social network that are linked to substance use can promote new toxic behaviour, hence the emphasis of keeping away from them is made. Dunn (2018) postulates that the individual's exposure to good social support systems during recovery, help individuals face triggers, overcome cravings and high-risk situations.

5.4.5.8 If patients get equipped to prevent relapses through the treatment programmes at the rehabilitation centres and if there are effective

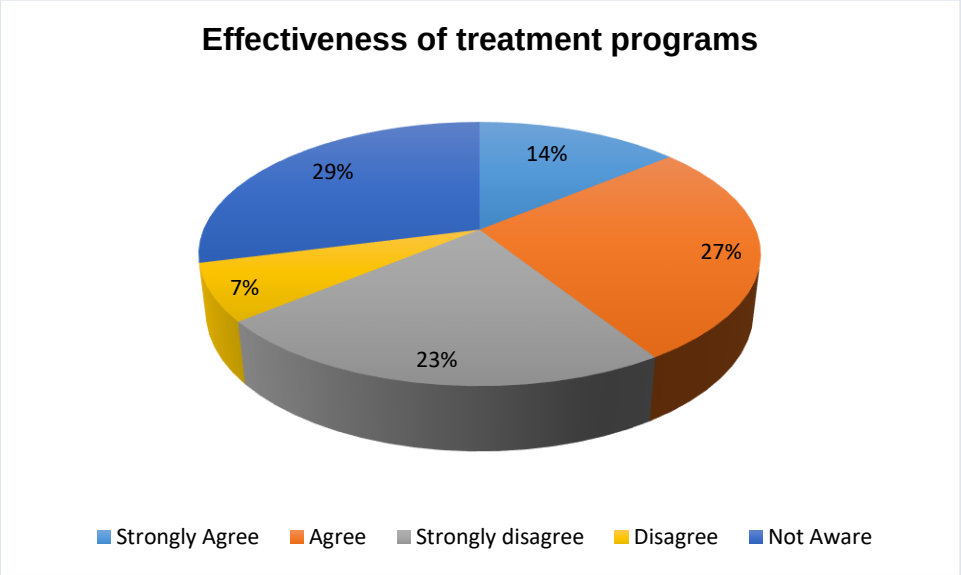


Figure 25: Effectiveness of treatment programmes

The figure above indicated that 14% Strongly agreed that patients were equipped by treatment programmes, 27% agreed, but 23% disagreed and 7% strongly agree and 29% were not aware if patients get equipped with life skills through the treatment programmes. 14% Strongly agreed, 23% agreed, this showing a total of 37% believed that the knowledge patients received at the rehabilitation centre was successful while 23% disagreed, and 7% strongly disagreed and 29% were not aware if patients get equipped with life skills through the treatment programmes. Sereta, Amimo, Ouma, and Ondimu (2016) in their study on the effectiveness of treatment programmes in rehabilitation centres noted that the greater responsibility lies with the individuals with substance use disorders themselves.

The focus group discussions also brought the perceptions of the participants on the treatment programme's effectiveness.

A participant from rehabilitation centre A focus group said:

'you see I only come here because my dad forces me all the time, this is my 7th time in rehab, and every time it's the same things that I am told, the classes the same, counselling sessions a bit different but those twelve steps I know them by heart now, and nothing is helping, maybe something new might help me, a miracle maybe'(FG2-p08)

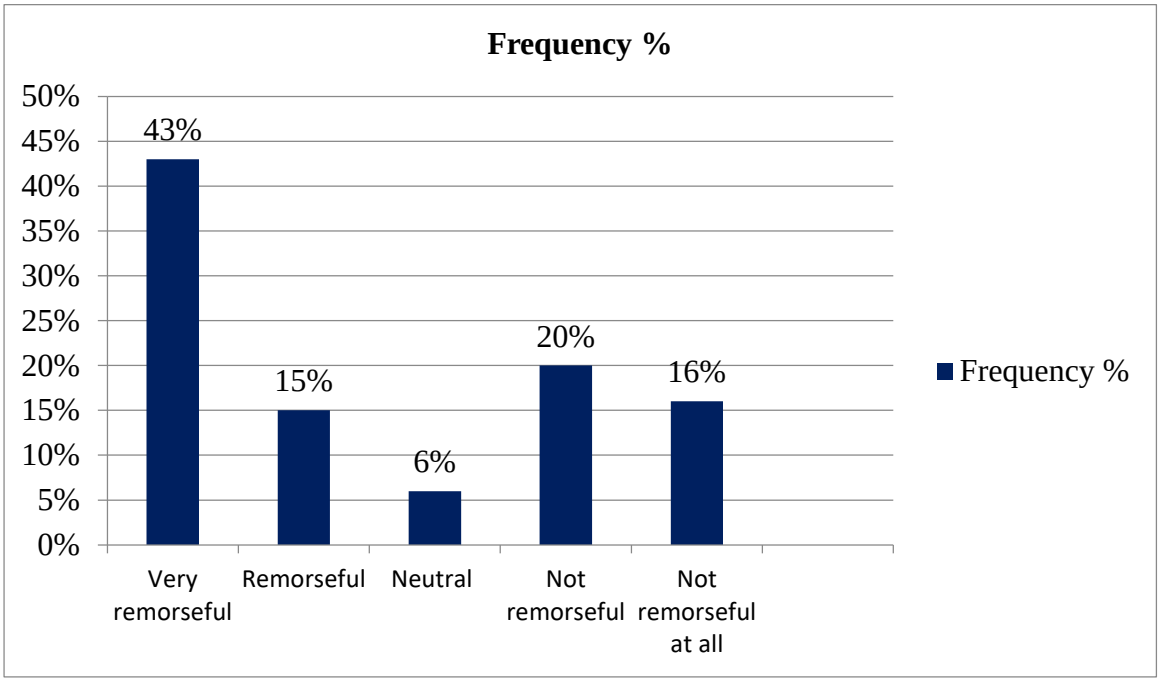
Another participant from rehabilitation centre B focus group:

'What he is saying is true, like I only relapsed twice, but I now feel like the twelve steps don't work for me, I mean I heard them, how many times now? and nothing, when you go into the world it real ha! Not these silly things of homework stuff that I have learnt since my very day one.' (FG4-p03)

5.4.5.9 Remorsefulness of the patients

Qualitative findings of this study claimed that one of the key goals of substance use relapse treatment was to enable the drug user to realize and accept that his continued drug use affects not only him but others around him. To this end, it was crucial to pose a question to measure caregiver perceptions and experiences regarding whether the patients were demonstrating remorse in their post-treatment recovery. Participants were therefore asked to rate the perception of remorse among their loved ones post their most recent treatment. Figure 26 below summarizes the perceptions of caregivers on the remorse of their recovering loved ones.

Figure 26: How best can you describe the patient's remorsefulness?



Findings of the study demonstrated that the bulk 43% of the caregivers were convinced that the patients were remorseful regarding how their addictions had affected others around them. On the other hand, an accumulative 36% were disposed to the view that the patients were 'Not remorseful' 20% and 'Not remorseful at all 16%. This gives credence to the view that the therapy programmes in the two selected rehabilitation centres were effective in promoting self-awareness and remorse which was construed to be central to recovery from substance use relapse. However, remorsefulness is not the only factor that curbs relapse.

5.4.5.10 Most patients relapse because they have given up on their recovery

For the treatment programmes to produce desired results, the patients in rehabilitation need to be willing to change. However, at times patients only get admitted in rehabilitation centres, either because they are forced by their families or employers and given ultimatums. Of the 100 respondents surveyed 38% of the

caregivers strongly agreed that patients end up relapsing repeatedly due to loss of hope and 48% agreed to the same. On the other hand, 10% strongly disagreed that the other reason patients kept on relapsing was due to loss of hope and 4% were not aware if loss of hope was a contributing factor to the multiple relapses or not.

The key informant the director from rehabilitation centre B shared the same sentiments:

> *'am telling you some of the patients we have don't want to learn at all, they get forced with their families to come to rehab. Some of them only come because they don't want the social workers to take their children to foster care, and not because they really want to change, some because their husbands threatened them divorce. So that's why they relapse because our programmes are perfect but they don't want to change their lives, it's like these demons don't want to leave, it's sad' (Clicks tongue)*

The social worker from rehabilitation centre B noted the following.

> *'a challenge of commitment to the programme sessions, for the programmes to show results, the patients should be willing also to learn from the group therapy, even from the support groups when they leave the rehabilitation centre' (Rehab B-sws02)*

Adding to that the director from rehabilitation A said:

> 'these boys are playing with their lives man, I mean look at Uncle Zee (pseudo name) he came he when he was 22 years old, and now look how old he is, he is now an old man with grandchildren he is 64 years old now. So it's sad there is no commitment to the programmes at all in most of these boys especially when they start this game of relapsing a million times"

Rehabilitation A social worker had this to say:

'Just something I noticed in the group sessions when having discussions with patient's, a huge number of them seem to stay in the denial stage for the whole six weeks, some never accept that they have weaknesses and should not tolerate any form of temptation that might led them back to addiction. I do not know if it is stubbornness or what but, I would hear some say they still would want to go and party with their friends, but they will just not drink and alcohol or take any drug…that is like walking in to a hungry lion's den and not expect to be eaten.' (Rehab A-sws02)

This shows that some patients relapse repeatedly due to a lack of commitment or interest in exerting effort towards their sobriety. The treatment programmes might be effective in delivering skills and coping strategies that help to prevent relapses, but the patients also need to be willing to work their recovery to attain sobriety.

5.4.6 Gaps Identified

The literature argues that the basis of relapse prevention in therapy programmes comprises three essential ideologies. These are that firstly **relapse is a gradual process** with different stages and the main goal of treatment is to assist an individual to identify all the stages, most importantly the early stages so that they can be able to avoid the relapses (Woolard 2019).

Secondly, that **recovery is a process of personal growth** marked by achieving certain developmental milestones, which are tempted by high-risk situations at every relapse process stage (Melemis 2015). The third ideology is that **the essential mechanism of relapse prevention is cognitive therapy** and mind-body relaxation, which help an individual to transform negative thinking and facilitate them to develop healthy coping skills (Melemis 2015; Roos et.al 2020).

The findings in this study reveal that there are four processes in the treatment programmes, patients are equipped to prevent relapses through illumination on the

importance of **self-efficacy**, **outcome expectancy**, **attributions of causality**, and **the decision-making processes** (Zemestani & Ottaviani 2016).

The treatment programmes aimed to successfully equip patients with coping skills that would help them to prevent future relapses, but whether the programmes achieve this satisfactorily remains a debatable point. The treatment programmes such as the Life skills programme, twelve steps programme and psychotherapy equip individuals/patients to be able to identify high-risk situations and can promptly apply the relevant coping skills to prevent relapses or handle them. The recovery programme gives patients time to introspect and reform, and the Aftercare programme supports patients after they are released from rehabilitation facilities.

However, results from this study indicated that treatment programmes that were offered to first-time relapse patients were the same as those that were offered to patients who had also relapsed multiple times. It could be that the patients who relapsed multiple times required different or additional unique treatment programmes, to help them stop relapsing. Each individual/patient at the rehabilitation centre should be provided with treatment that is unique to his needs, especially those who are not first time relapse patients. In this context a social worker from rehabilitation centre B noted the following; concerning the role of treatment programmes in preventing substance use relapse:

> *'There is no alternative to treatment programmes, when it comes to prevent substance abuse relapse, this is because treatment programmes, does correspond individual needs with the treatment programmes, include the duration of the programme., such expertise entail that treatment programmes are the best in relapse prevention.' (Rehab B-sws02)*

Another social worker from the same rehabilitation centre said:

'The fact that those who work here are individuals with specific important skills is important in combating substance abuse and relapse prevention, their experience and knowledge cannot be easily match, and centres ensure that the best individuals are recruited in the institution.' (Rehab B-sws01)

The ability of treatment programmes to equip the patients so that they can be able to prevent relapses in any environment is based on the experience and knowledge that should the patient religious employ all the tools there can create around themselves an environment which is conducive for recovery.

The social worker from rehabilitation centre A stated the below:

'The most important aspect with regards to treatment provided at therapy centres is that they are provided with the knowledge that specific conducive environment should be created for the process to be successful. There are some cases that trigger craving, hence therapy programmes ensures such environments are avoided and the individual is equipped with the suitable skills' (Rehab A-sws02)

Another social worker from the same rehabilitation centre noted the following:

'These programmes assist individuals suffering with addiction by equipping them with the capacity to cope within specific situations that lead to relapse, not every individual is equipped with self-efficacy however the inclusive nature of these programmes ensures that everyone acquires the skills associated with self-efficacy' (Rehab A-sws01)

Since self-efficacy is essential to relapse prevention, therapy is vital in equipping individuals with such skills, to prevent relapsing (Lac and Luk 2018). Therapy programmes are also vital at outcome expectancy, in this instance therapy programmes helps an individual to carefully predict the psychoactive impact of addictive substances. Therapy programmes are essential in enhancing self-efficacy skills in individuals. However, self-efficacy levels are very different in individuals, due to various reasons. The research found out that a greater percentage of the participants think that the patients keep on relapsing several times because they have

given up on their ability to be ever free from addiction in their lives. The goal of treatment programmes should be to increase self-efficacy across all areas of the patient's life meaning that an effective treatment should not only increase the capacity of an individual to sustain sobriety when he experiences specific situations that put him at risk but should be able to build every aspect of weakness in his persona (Giordano, Prosek, Loseu, Bevly, Stamman, Molina & Calzada 2016).

Now having such patients who have that mindset takes a lot especially when they witness other patients whom they thought were going to succeed in staying clean, come back to be rehabilitated in the same institution a week or two weeks after there were discharged. A patient might have their problems but witnessing this, especially for an individual who doesn't have self-efficacy, also the fact that the rehabilitation centres do not separate the patients who would have been discharged and brought back after relapsing with those who were about to finish their six weeks' cycle. By the time the patient who was about to be discharged sees a patient whom they think was strong and was going to maintain sobriety at least for a longer time, return within two weeks after failing on the outside world. Their confidence in the effectiveness of the treatment programmes and even the aftercare could drop.

The twelve steps encourage patients to have sponsors (individuals who had suffered from addiction before but managed to be sober for a period of more than at least 3 years). Individuals can even have sponsors assigned for them at specific aftercare even before they are discharged from the rehabilitation centre, but the same way a patient can lose hope after seeing another patient they knew and trusted being rehabilitated again. If a patient's sponsor relapses, there are high chances of patients who would be under them to also relapse, and it seems the treatment programmes

do not fully prepare the patients on how to manage these specific unfortunate situations.

The research however shows that there are several simulations that are conducted in the life skills and recovery group sessions, that help the patients to know possible situations and to prepare how to likely act in the situations.

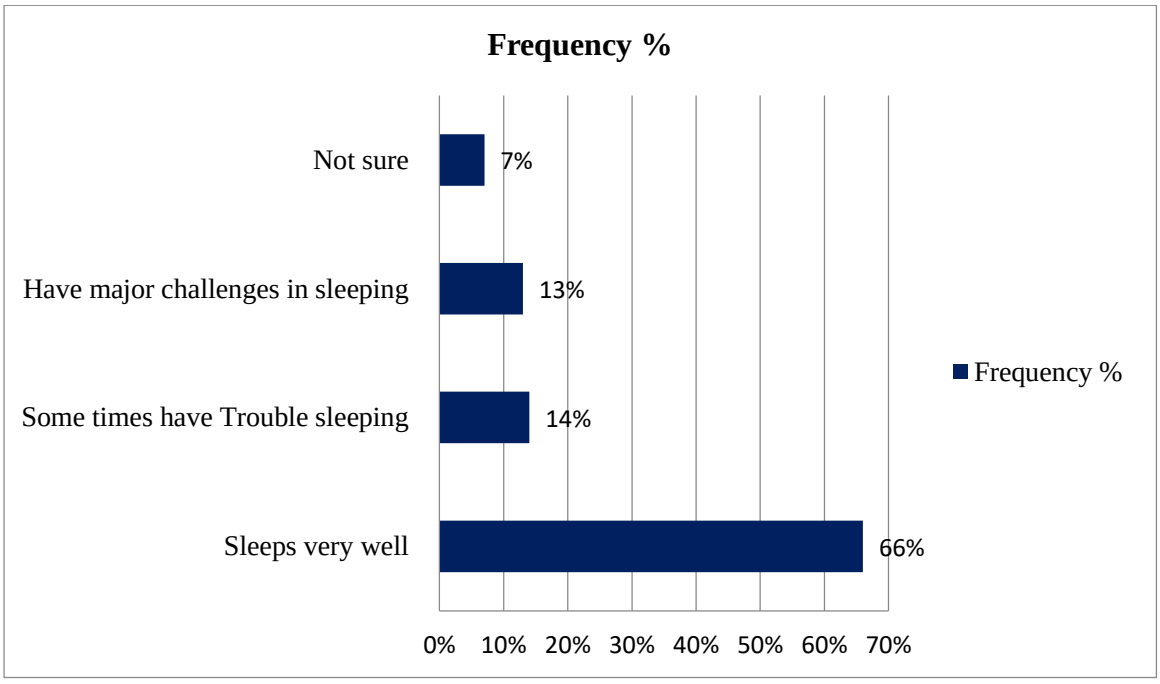
5.4.7 Changes in other problematic areas

This study took as its point of departure the conviction that caregivers of recovering former relapse patients in the selected rehabilitation centres were best placed to commend on therapy induced behavioural and lifestyle changes associated with their loved one. One of the major establishments in the qualitative segment of this study which mainly focused on mapping the nature and scope of therapy programmes offered by the two selected rehabilitation centres revealed that one therapy that was provided was not solely meant to provide respite to the drug problem alone but to also help the drug user to institute changes in other problematic areas of his/her life. The belief was that substance use in general and relapse after treatment in specific were mere symptoms of trouble that require intervention. To this end, caregivers were asked to validate changes in some specific and more generalized physiological aspects of the loved one. In general, quantitative findings demonstrated that from the viewpoint of caregivers, therapy programmes which sought to effect holistic changes to the lives of their recovering substance use loved ones were fruitful and effective. This is because there was a preponderance of positive perceptions regarding changes in identified physiological aspects of their loved ones. Specific findings to changes in generalized client problematic areas are presented under the following sub-themes. The sub-themes are as follows sleep patterns, eating habits, domestic violence and violence in general, financial discipline and sharing emotions.

5.4.7.1 Sleep Patterns

A review of the literature including programme documents from the two selected rehabilitation centres and findings from the qualitative interviews showed that apart from the physical re-usage of substances, relapse patients tend to experience severe insomnia problems. Indications were that relapse in some instances is triggered by this insomnia as the individual will be trying to find sleep and thus use depressant drugs to achieve this end. It was in this light that a question on whether the caregivers had noticed any significant changes in their loved one's sleep patterns. The figure below graphically presents findings on the responses of caregivers of recovering former relapse patients in the two selected rehabilitation centres.

Figure 27 : How you rate the sleep patterns of the patient when discharged from rehabilitation centre?



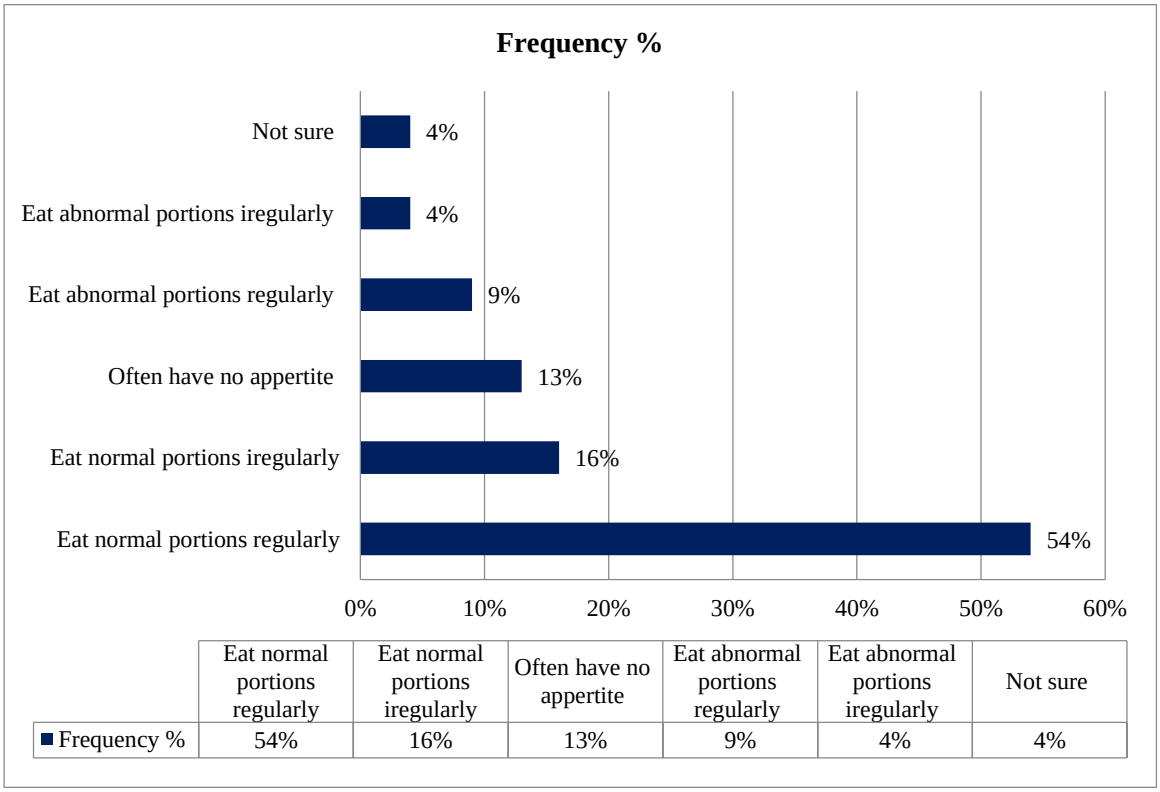
As shown in figure 29 above, there was a statistical preponderance of caregivers who were disposed to the view that post their treatment in the selected rehabilitation facilities, their loved ones were sleeping very well. This perhaps vindicates that the therapy programmes aimed at assisting substance abusers to adjust their sleep

patterns were effective. However, the fact that 13% of the total survey sample believed that their loved one were having major challenges in sleeping is worrisome and would require interventions.

5.4.7.2 Eating Habits

Furthermore, findings from literature review and utterances captured during focus group discussions and key informant interviews proved that substance use in general and relapse in specific occur with poor eating habits. Indications were that erratic eating habits including gluttonous eating or not eating at all was indicative of impending relapse or active addiction. Nutritious diet and the Life skills programmes in the selected rehabilitation programmes were noted to have as one of the goals they need to reinstitute proper eating habits in substance abusers. Accordingly, it was considered prudent to measure the effectiveness of these therapy programmes in the context of improving the eating habits of recovering substance use relapse patients. Figure 28 below summarizes perceptions of caregivers pertaining to changes in their loved one's eating habits.

Figure 28 :How are the patients eating habits of the patient when discharged from the rehabilitation centre?

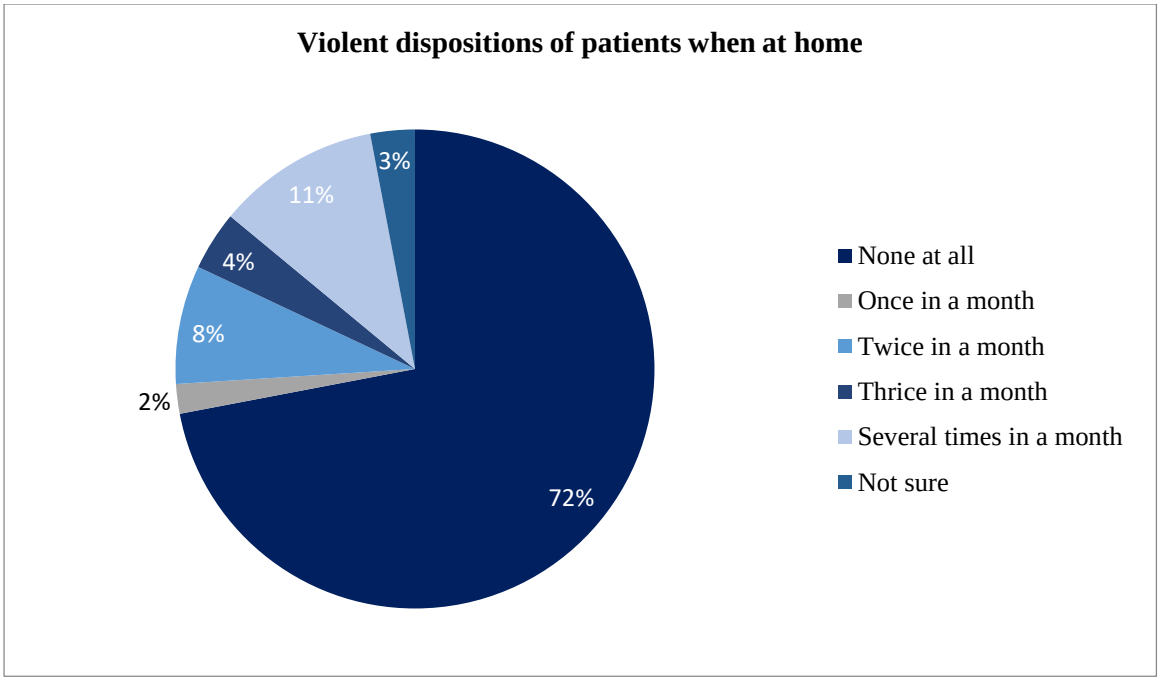


Study findings showed that from the viewpoints of their caregivers, the majority (54%) of recovering substance use relapse patients were eating normal portions regularly. There was concern among 9% of the caregivers who indicated that their loved ones were eating abnormal food portions regularly while another 4% indicated that they had noticed that their loved ones were eating abnormal meal portions irregularly. The consumption of abnormal meal portions either regularly or irregularly could be concomitant with the phenomenon of subconscious cravings being substituted with overeating. It is concerning that at least 4% of the caregivers were not sure of changes in their loved one's eating habits; this could be suggestive of laxity in the caregiving of recovering substance use relapse which can cause another relapse.

5.4.7.3 Domestic Violence and Violence in General

Literature shows that substance use and relapse to drug usage after a period of abstinence is concomitant with violent dispositions at family and society level. Relapse prevention therapy programmes, therefore, seek to equip clients with alternative conflict resolution skills to enable peaceful co-existence between substance users and their significant others. The caregivers of recovering substance use relapse patients were asked to share their opinions and experiences pertaining to changes in the patients in terms of violent predispositions. Figure 29 below outlines the findings from the mini-survey.

Figure 29: If at all how often does the patient exhibit violent dispositions?



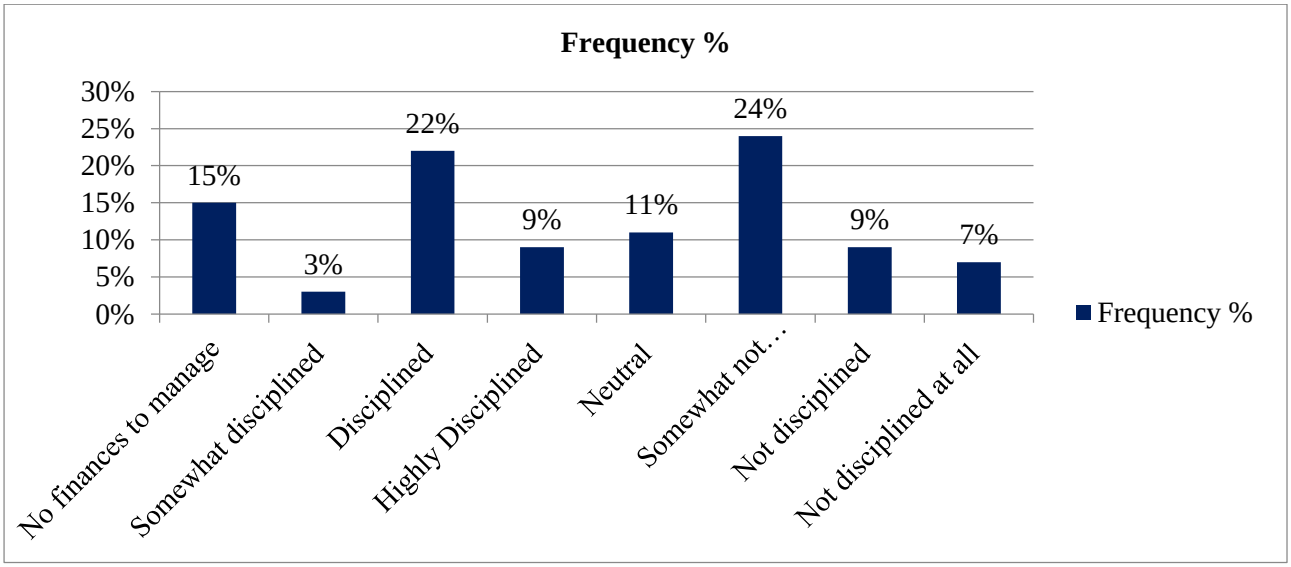
As shown in the pie chart (Figure 29) above, the bulk of the caregivers 72% (can't see the blue text in the chart) reported that they had not witnessed any or much violent dispositions. This suggests that interventions which were provided to mitigate against violence among substance use relapse patients were effective. However, the

11% who reported that they had the patients being violent on several occasions in the preceding week are a cause for concern.

5.4.7.4 Financial Discipline

Substance use and more specifically repeated relapse confound with an individual's ability to efficiently manage their finances. Under the influence of substances, drug user can blow away their incomes sometimes at the expense of their families' well-being. Psychotherapy programmes in the two selected rehabilitation centres were noted to have as part of their goals, they need to increase the self-awareness of the substance abusers in terms of their past harmful practices and assist them to adopt new sustainable lifestyles. The caregivers of recovering former substance use relapse patients in the two selected rehabilitation centres were asked about their perceptions and experiences pertaining to improvements in financial management among their loved ones. The following graph summarizes the opinions of the caregivers on this subject.

Figure 30: How would you describe the patient's handling of finances when discharged from the rehabilitation centre?



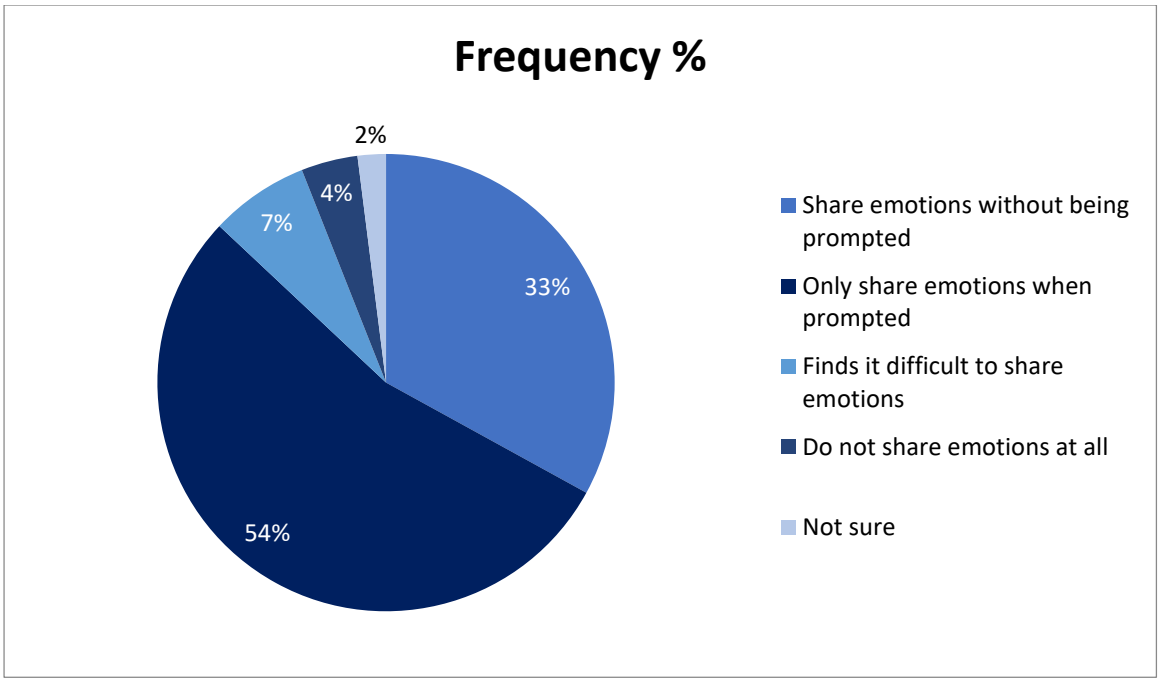
The caregivers of the substance recovering relapse persons concurred that patients had challenges in handling their finances whenever they are discharged from the rehabilitation centre. Precisely, an accumulative 40 % were of the view that their loved ones were somewhat not disciplined, not disciplined and not disciplined at all. On the other hand, 34% of the total sample were in the affirmative that their loved ones were somewhat disciplined, disciplined and highly disciplined respectively. The rest being 11% of those who were neutral and 15% who had no finances to manage. Suggestively, this positions all interventions in the two selected therapy programmes as only somewhat instituting discipline and character reformation in substance use relapse patients.

5.4.7.5 Sharing Emotions

The study also sought to determine the efficiency of the therapy programmes in the two selected rehabilitation centres in instituting changes associated with assisting relapse clients to share and simultaneously deal with their emotions. The qualitative component of this study established that the various therapy programmes which were being utilized in the selected rehabilitation centres stated, “Capacitating substance abusers to be able to share their emotions” as one of the major goals of their interventions. Indications were that where substance use relapse is an operation of lack of skills of dealing with negative emotions. This would result in substance abusers bottling up emotions to the extent of being overwhelmed and without a solution for these bottling emotions, drug users will revert to drug use as a means to calm themselves and feel better. It was therefore, important to validate through the perceptions and experiences of caregivers of the recovering drug users if they had

noticed any significant improvement in terms of their loved one sharing their emotions.

Figure 31: Which statement would you say best describes how the patient shares their emotions?



As shown in figure 31 above, the bulk 54% of the caregivers reported that the patients only share their emotions when prompted and 33% without being prompted. On the other hand, an accumulative 11% were reportedly finding it difficult or were totally not sharing their emotions. This finding suggests that interventions that were being provided by the selected rehabilitation centres to promote purposeful expression of emotions were not entirely effective for their intended purposes. The bottling of emotions could contribute to relapses, especially if a patient lapses and does not share the guilt which eventually led to a relapse.

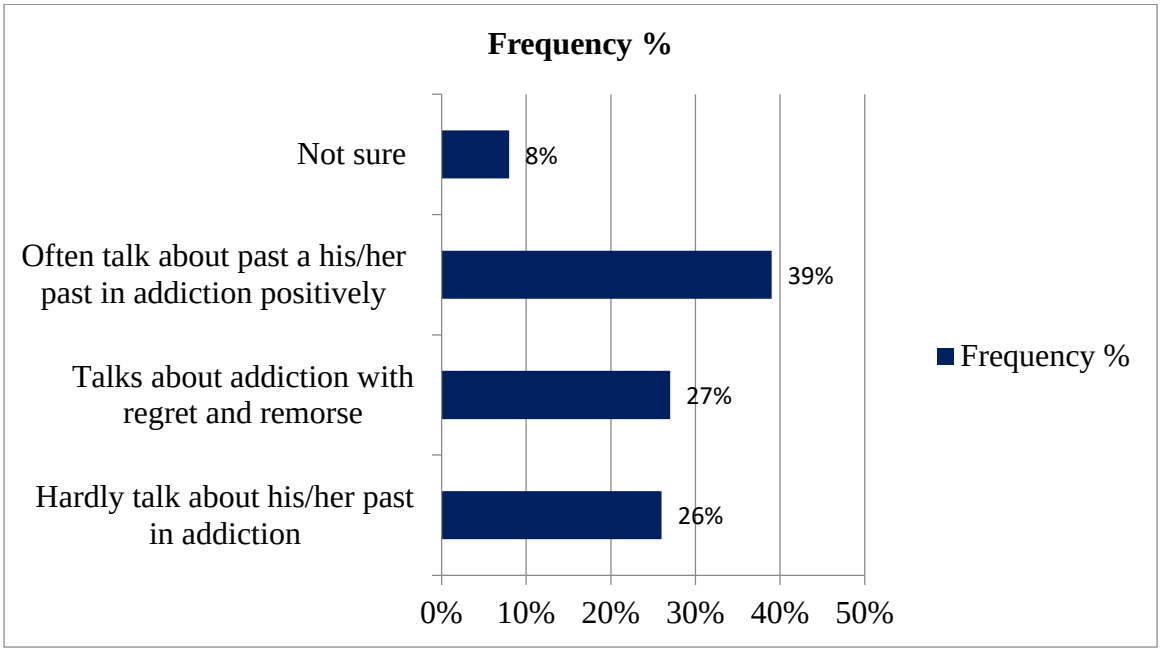
5.4.7.6 Changing Narratives of Past Drug Use – From glorifying Drug use to Regret

Another imperative underscored in the qualitative component of the study was that effective therapy programmes should assist drug users to move from a point of positively talking about their past drug use habits and experiences to regretting such

experiences. Indications were that in situations where drug user glorify their past drug use, they were likely to relapse. It was therefore prudent to test through the experiences and perceptions of primary caregivers of recovering substance use relapse patients who were treated in the selected therapy programme to determine if the treatment they had gotten had assisted them to transition from a point of glorifying/celebrating drug use to a point of abhorring past drug related memories.

Figure 32 below summarizes findings on the perceptions of caregivers of whether their loved one had transitioned to regretting past memories of substance use or were still positively identifying with them.

Figure 32: Which of the following statements, would you say best described the patient?



Findings established that the bulk 39% of the surveyed caregivers reported that contrary to the therapy goal of helping relapse patience to change their perception and narrative of their former addictions, relapse substance use patients were still positively conversing about their past addiction experiences. More so, of concern is the finding that 26% of the caregivers reported that their loved ones would hardly talk

about their past addiction. This may mean that they are ashamed of their past and not necessarily remorseful nor regretful about it. This may count and bottling of emotions which were noted to also contribute to the possibility of relapse.

5.5 Findings related to Objective 3: To formulate recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use relapses.

This section provides recommendations that can be adopted for policy development and for improving outcomes of treatment and rehabilitation centres.

5.5.1 Counselling

The counselling sessions are tailored to resolve any area in a patient's life that poses to be triggered, it could be low self-esteem, anger management, stress management or grief counselling. Patients are equipped with coping techniques to help improve their ability to exercise self-control and apply any best approach that aids them to remain clean in their recovery journeys. The social workers supported this by noting the below,

The social worker from rehabilitation centre A:

> *'Through Psychotherapy we health to transform the patient's mind sets, of how they view themselves and how they reason when presented with different situations. Although from the way I view it, whether these counselling sessions are helpful to the patients or not should not be judged with the percentage that relapsed after they leave the centre, it should actually be assessed by, the quality of sessions the social worker had, and what she offered to the client...' (Rehab A-sws01)*

Social worker from rehabilitation centre B:

> *'Counselling sessions are helpful, but another problem we have at this centre, is other patients who are forced to come to the centre and are not willing or interested in participating in anything, others*

become choosy when assigned to a social worker whom they don't want, others if assigned to a black social worker and there are of a different race, refuse to cooperate or open up during therapy session. The patients can just choose not to cooperate for different reasons, at the end of the day the success of the psychotherapy is a joint effort of both the social worker and the patient." (Rehab B-sws02)

The research showed that most families agreed that most counselling sessions were able to suitably prepare patients how to maintain their sobriety once the program is completed. Al-Tayyib, Koester, and Riggs (2017) noted that a comprehensive plan for the treatment of drug use must adapt its services to patients and their special, ever-changing needs.

5.5.2 How counselling can be applied to yield better results

Counselling at all times is dependent on the patient's willingness to change or open up in sessions, should there be unwillingness, the patients fail to get equipped with the necessary coping mechanisms. This leads to relapses in the long run. Counselling is also not effective if applied in isolation on cases of dual diagnoses, split personalities, schizophrenia or any other cases that need additional specialist treatment other than general social work practitioners. Different individuals in recovery programmes and therapies have specific aspects that are inherent and more significantly deep-seated, complicated aspects that might not have arisen prior to the substance abuse problem (Loggins & Tyson 2017). These aspects might include physical and mental conditions, difficulties with living situations, damaged interpersonal or family relationships.

5.5.2.1 Family therapy compulsory for every admitted patient.

Family therapy should be core the same way counselling for patients is at the rehabilitation centres. Since the patients do not leave in isolation but with their families, these families need to understand the recovery process and how to respond and handle their family members. Family problems that may trigger relapses may be resolved through counselling, hence it is vital that the rehabilitation centres consider making the holistic approach mandatory.

5.5.3 The need to diversify treatment programmes for relapse patients

The social workers noted that after an individual relapse they become used to the same sessions and will end up knowing all the programmes by heart, to the extent that the routines at the rehabilitation centres become repetitive for them, that's why at most times they show no dedication and the effort of being rehabilitated end up being futile.

One social worker noted the following concerning the content of the treatment programmes.

The social worker from rehabilitation A:

> 'It can be in the model the programmes are delivered, it can be boring and monotonous to the extent that assimilation can be difficult." (Rehab A-sws02)

Some participants from the focus group discussions also noted that every time they got admitted to the rehabilitation centres, they were presented with the same content, which they thought didn't help them overcome relapses the previous times. It is

debatable however whether it is the content or the patients that lead them themselves to relapsing repeatedly.

It is however recommended that the rehabilitation centre diversify the content of the programmes especially for returning patients.

5.5.4 If Patients had Individual Care Plans to prevent relapsing

Out of the 100 respondents, the results indicate that 14% of them strongly agreed that patients had Individual care plans, 24% agreed, however, 45% disagreed and 17% strongly disagreed that patients had individual care plans. This shows that a total of 62% of the caregivers indicated that the patients didn't have any recovery plans of their own written down. This might explain why there were several cases of repeated relapses as well. The recommendation is that patients need to draw a road map for their recovery and the rehabilitation centres must not make this optional but mandatory before every patient is discharged.

5.5.5 After Care programme (support groups)

The aftercare programmes which are supported by the rehabilitation centres are conducted at different locations, so patients who are discharged can attend any one near to their residential area. Regular meetings are conducted, the same syllabus of the treatment programmes in the rehabilitation centres are used. Random drug tests are conducted and necessary support is given to the patients. The aftercare is important as it also provides a ground for peer support as individuals with similar experiences get a chance to interact and support each other. Although it is possible for some of the interactions to turn toxic.

One participant had this to say, in line of the above:

'the treatment programmes taught me a lot, but I just think it's not wise to make friends at the support group, even though our addiction problems are similar. I was enticed for me to relapse the 3rd time, that guy noticed he had already slipped, he deceived me into believing that two slips were fine, but it leads me back to a worsen situation, I learnt about how to avoid high risk situations but not one like this one. (FG1-p06)

This shows that patients could actually be at risk if they met such kind of sponsors from the aftercare programme.

5.5.6 How After Care programmes more effective

The survey results showed that not all patients attend aftercare programmes when they get discharged from the rehabilitation centres. It is recommended that the rehabilitation centres should make attending aftercare programmes compulsory and enforce various measures or rules to ensure all patients continue receiving guidance and support. More to that the rehabilitation centre should be responsible for tracking the patients' sponsors to ensure that there is a positive influence at all times. If a sponsor lapses they should be immediately replaced before they relapse and discourage other patients.

More so rehabilitation centres always re-admit old patients (patients who relapse more than once). This study recommends some form of consequences to be enforced on those patients so that they try to stay sober and avoid being re-admitted.

5.5.7 Recommendation of employing or outsourcing other mental health specialists

The participants also mentioned that intrapersonal factors contributed to their constant relapses. Also the rehabilitation centres in the study indicated that only psychosocial assessments and psychotherapy was offered at the centres (social workers). Other mental health specialists' services like psychiatrists or psychologists

were not offered. This shows that the treatment offered at these centres was not holistic.

In this context a participant from rehabilitation centre B Focus group noted the following:

> *'I felt I always relapsed when am feeling down, I don't know it just happens my mood just changes and drops, and every time the happens, yes I try to exercise but at times I do not have the patience for it, using again will be the quickest option for me to fix this feeling of sadness which I leave with' (FG3-p01)*

It is possible that this participant suffered from an undiagnosed and untreated bipolar disorder, if the rehabilitation centres had mental health specialists, such illnesses that trigger relapses would be treated and possible relapses prevented.

Menon and Kandasamy (2018) note that the most common high-risk relapse situations are when dysfunctional, negative emotions are encountered. There are various solutions to mental health problems, but in the absence of a proper diagnosis, conditions may continue to aggravate and manifest in several ways such as substance use. The use of substances gives temporary satisfaction while the underlying problems or diagnoses remain unknown in some cases. It is therefore recommended that the rehabilitation centres avail services of psychiatrists and psychologists to patients who need them.

The theoretical framework gave the study structure and made the vision clear, it provided a blueprint for the build-up. The analysis of how both theoretical frameworks (the relapse prevention model and utilization focused evaluation) were applied will be discussed in the section below.

5.5.8 The Relapse prevention model

The Relapse prevention model incorporates cognitive behavioural techniques in relapse prevention efforts. Not only does the model explain the relapse process but it also shows how ways of overcoming high-risk situations and preventing relapses. The relapse prevention model suggested by Marlatt and Witkiewitz (2005) show that imminent determinants such as high-risk situations and covert antecedents like desires, lifestyle variables are the main contributors to relapsing. The relapse prevention model also integrates various unique and global methods of intervention that allow the therapist/social worker and patient to tackle each phase of the relapse.

Particular approaches include recognizing specific high-risk circumstances for each client and improving the ability of the patient to deal with those circumstances, improving the self-efficacy of the client and removing misconceptions about the effect of substance use (Polaschek 2016). The Relapse prevention model empowers patients to identify high-risk situations and equip them with skills to use when faced with similar situations in the outside world. However, it is always up to the patients to either utilize what they would have been equipped with or not, regardless of the situations they encounter.

One participant from rehabilitation centre B Focus group noted:

> *'I knew facing my temptations, was my high-risk situation, but I went ahead anyway to the club with my old friends and that's how I relapsed again'(FG3-p03)*

This indicates that the patient was aware of the high-risk situation but they choose to ignore it and it resulted in another relapse. In addition, another participant from rehabilitation centre A Focus group also noted the following:

'the counselling really helped me and my in-laws, like they would really drive me crazy that I would just think of smoking crack, but since we talked things out and we decided I no longer staying the main house with them and my husband, things became better…. I only relapsed after 11 months when I went to a new year's eve party with my friends, that why am back here, if I sort that out I don't think I will have issues with drugs again. (sigh). (FG2-p07)

Another participant from rehabilitation centre A Focus group noted:

*'I wanted to like complete my high school but I guess me and my friends where busy selling drugs to get more money to get more drugs to use …(laughs)… then afterwards I wasn't really interested in any school stuff and all. When I came here the life skills classes really felt like I was in school that's why I never paid that much attention, I would listen a bit though, if the topic was interesting, but when I saw Mohammed returning I was like this **** is real, you know how much he participated in class? I never knew that his parents were going to bring him back just after a few days after he left this place, I don't know where my mind is sorry' (FG1-p10)*

The therapy programmes focused on equipping the patients with mechanisms to help them cope with high-risk situations as a way to equip patients to prevent relapses.

One participant from rehabilitation centre B Focus group noted:

'I think life skills help a lot, like all that we learnt about triggers, how to cope with high risk situations and avoiding toxic people, I was the one who thought after 8 months I was strong enough to hang out with my old friends, that is what made me relapse after 8 months, it was my carelessness, so I don't agree with what others are saying that the programmes here are crap, I think we are the crap that's why our families don't want us at home and come and dump us here at any cost.'(FG4-p03)

The above sentiments show that the patients have quite different views on whether the treatment programme equips adequately to be able to overcome relapses or not. How each patient may handle high-risk situations may be predominantly emotional, behavioural, or interpersonal, and the presence or absence of an individual's coping strategies will often decide how they respond to the situation (Grant, Colaiaco, Motala, Shanman, Booth, Sorbero & Hempel 2017). For example, individuals

respond differently to negative emotional stress such as anger, anxiety, boredom, and sadness because of their temperaments, perspective or belief. Hence even though all of them can be equipped with coping mechanisms, they might not all apply them in the same manner. Other research states that humans have different hormonal balances, and some naturally do not produce enough dopamine in their bodies hence there are more susceptible to conditions like chronic depression and may indulge in addictions of different kinds. If such individuals do not take any sort of supplements or medication, the hormonal imbalance will always be present and affect the normal functioning of the individual. This is when some individuals seek substances to temporarily raise their dopamine levels and become addicted to them since their bodies have deficiencies. If one-sided treatment is offered to such a person they will probably relapse many times until maybe their hormone deficiently is addressed, this is the reason why rehabilitation centres should have all kinds of specialists full-time on the premises so that all-round assessments may be conducted and all-round treatments may be administered to the patients. A one-sided treatment approach might only work for the minority.

However, the life skills and recovery programme does dwell on some natural ways of raising dopamine levels like meditation and exercise, but it is not exhaustive patients should be presented with as many options as there are to address any problem. Like diet can also be used to address such deficiencies should there be present, but a nutritionist must be present to recommend what can be best for such patients. But the rehabilitation centres of this research did not have specialists who could even give such a diagnosis or similar.

The social workers noted various challenges that could be attributed to the seemingly increasing numbers of patients who relapse repeatedly. One of the social workers from rehabilitation centre A during the interview noted:

> *'there are so many challenges, I mean so many, but I think the major one is a high turnover of the specialists, hence at time some programmes end up being run by those who are not qualified, hence affecting the quality of the services rendered.' (Rehab A-sws01)*

In addition, social workers also noted that there was a general lack of qualified individuals within therapy centres. Some individuals are not trained and lack substance abuse training, a social worker from rehabilitation centre B also noted the following:

> *'it obvious, if a person who is not qualified is given a service to render to the patients, the outcomes will definitely be sub-standard, relapsing of patents should actually not be a surprise' (Rehab B-sws02)*

In addition, social workers also noted that there was a general lack of commitment from the individuals who relapse more than once, it could be a sign of totally giving up to putting effort into their recovery journeys. This lack of commitment entails the individuals just religiously availing themselves for all therapy programmes but without showing any dedication and interest from the heart. Hence substance use programmes end up being a mere formality rather when they are meant to at least facilitate the transformation of the patients' lives from addiction.

5.5.9 Utilization Focused Evaluation

The UFE underscore that the utility of research or an evaluation process should be examined and judged in terms of how its findings are relevant, applicable and accessible to its primary intended users (Butts & Roman, 2018). The overall view is that a UFE process and outcome should be premised on the need to capacitate the evaluated to transform, scale and or decommission certain activities on the strength of credible evidence. The intended use for the study was to provide recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use, relapse patients. The perceptions of the service providers (rehabilitation centre personnel), service users (substance users who were in treatment after the previous relapse/s) and informants (the patient's family members) were collected for such purpose. More to that, secondary data sources including programme documents and registers were used to provide more information and context.

5.5.10 Effectiveness of the Psychotherapy Programmes

As already established under the findings on the nature of therapy programmes that were being used by the selected rehabilitation centres, psychotherapy was noted to be one of the key relapse prevention interventions employed. It was, therefore, necessary to determine the extent to which psychotherapy programmes in the two selected rehabilitation centres were considered viable and effective in sustaining recovery among persons with a history of multiple substance use relapse.

5.5.10.1 Utility of counselling in mitigating substance use relapse: A service provider perspective

Findings of the study demonstrated a strong conviction between the selected rehabilitation centres that counselling played pivotal roles in supporting recovery and diminishing chances of post-treatment relapse. It was indicated that little attention was given to family therapy even though family counselling should have been valued the same as individual counselling. However, reviewed programme documents and interviewed programme personnel showed that the two selected rehabilitation centres were differentially conceptualising these two concepts of counselling and psychotherapy.

Notably, in a programme document of "Rehabilitation Centre A", counselling was conceptualised as:

> *'.... the short term professional relationship between a therapist and substance users and their significant others towards accomplishing better states of mental wellness and promoting abstinence from substances use."*

Conversely, during an interview, the social worker from Rehabilitation Centre B noted that:

> *'Counselling involves face to face engagement between a social worker and a substance user with the aim of setting therapeutic and recovery goals.... this usually happens over a long period of time...recovery is not an event but process so, the counselling is usually long term." (Rehab B-sws02)*

This contradiction means that while the two selected rehabilitation centres were amenable that counselling work as a strategy, they differed in terms of their interpretation of the timeframes of the process. In Rehabilitation Centre A,

counselling was construed as a short term process geared towards maintaining better state of mental welfare. The same rehabilitation centre (A) further indicated that they used what they term as psychotherapy which constitutes long term and holistic engagements with substance users and their social environments towards sustaining recovery. On the other hand, Rehabilitation Centre B construed counselling and psychotherapy as the same thing which concerns itself with "ensuring holistic assessment and interventions by social workers" (Director of Rehabilitation Centre B).

Notwithstanding these differential conceptualisations, study findings showed that both service providers and service users concurred that counselling played critical roles is supporting effective and sustainable long term recovery. The social worker from Rehabilitation Centre B said:

> *Counselling offers a golden highway to the inner thoughts, feelings, experiences and challenges of the substance user.... It is also invaluable in setting up treatment and recovery goals and it also offer a mechanism of appraising these goals. (Rehab B-sws01)*

Social worker from Rehabilitation Centre A indicated that:

> *'We offer both counselling and psychotherapy and these approaches are very important to any functional and result bearing programme. Counselling usually help us to gain an appreciation of the problem at hand and help the client in setting the treatment goals and objectives. Our experience is that real recovery start immediately when the client exits our facility, we therefore have an ongoing therapy programme in which our clients either come back here or we visit them in the community and offer long term psychotherapy in which we mainly focus on validating a client's progress in recovery, reviewing goals in the light of the prevailing situation and realities.' (Rehab A-sws02)*

Notwithstanding the general positive findings from the service providers, outcomes from the convened focus group discussions revealed a state of mixed feelings and perceptions regarding the utility of counselling and psychotherapy as strategies of

curbing recidivism. On a positive note, participants to the two focus groups intimated that counselling was good as it enabled them to have a full-spectrum and objective view of their problem including gaining an understanding of assistive factors which they seldom think of on their own. Following are some of the key outcomes of the focus group discussions pertaining to the utility of counselling as a substance use relapse prevention strategy:

Participant from rehabilitation centre B Focus group 3:

> *'I agree with her that counselling is boring, but ultimately, it is really helpful, every time I go for counselling, I come back with a new perspective to my life, I get new revelation of what I could have possibly missed which caused me to relapse.'(FG3-p05)*

Another participant from the same rehabilitation centre B Focus group noted:

> *'Personally, I like those counselling sessions, they challenge me to think differently, the counsellors often give you many options to choose from and it is helpful'(FG4-p06).*

And another in the same focus group noted:

> *'When you are in a situation, your mind doesn't think through things and counselling has been helpful for me to think beyond my current situation and it energises me, I really like and appreciate my counsellor.'(FG4-p07)*

However, on the contrary, some participants indicated their dislike and therefore dismissed the utility of counselling in supporting sustainable recovery:

Participant from rehabilitation centre A Focus group:

> *'As always talk is cheap, these counsellors tell you things which on paper sounds good but in reality, it's not helpful personally I am tired of these counselling sessions.'(FG2-p07)*

Another participant in the same group said:

'You see these counsellors have their own perspective of what works unfortunately everyone's circumstances are different and their methods with him (another participant) cannot work on me, it wastes our time.' (FG2-p08)

A participant from the same rehabilitation centre B Focus group:

'The problem is they want to ask too many and most of the time personal information, I was never raised to tell people about my family secrets.' (FG3-06)

In light of the above utterances, it is clear that some participants were strongly opposed to the usefulness of counselling as a strategy of curbing post substance use treatment relapse. It is evident that those who indicated their dislike and pessimism regarding the viability of counselling as a relapse prevention strategy argued that counsellors were using one approach to assist different clients. It was also noted that counselling was too intrusive to the extent of infringing on the client's privacy, social and cultural beliefs. Perhaps, there is a need to rethink models of counselling towards embracing approaches that promote free association. It is retrogressive and unhelpful to use approaches that force information out of clients.

5.5.10.2 A Service User Perspective

Relapse substance users who were undertaking treatment were considered as an invaluable constituency that could provide insightful information regarding the extent to which selected therapy programmes were instrumental in preventing substance use relapse. Findings from the two focus group discussions illustrated that substance users as the service consumers of the various therapy programmes in the selected rehabilitation centres were inclined towards the belief that to a larger extent, the Minnesota 12 Steps Programme was vital in supporting long term recovery. Participants in the two focus groups were strongly opined that the 12 Steps

Programme was assistive to them in various ways. Following are some of the prominent extractions from the focus group discussions:

Rehabilitation centre A, Focus group participant:

'Not sure about others, personally, my experience is that whenever I work all my 'Steps' well, it takes me long to relapse...'(FG1-p07)

Another participant from the same focus group added:

'I agree with him, the 12 Steps is the most important part of this programme, the steps help you to deal with real life situations which cause relapse...'(FG1-p08)

And another participant from the same focus group added:

'The 12 Steps programme provide real life solutions....' (FG1-p09)

In addition to that participants from Rehabilitation centre B, also shared the same thoughts:

Rehabilitation centre B, Focus group 4 participant:

'I personally know what helped me in me previous rehabilitation was step number eight and nine, it helped me to accept that I caused pain to my family and I was slowly mending my relationships using the steps but I fell because my husband suddenly died and I couldn't bear it.'(FG4-p05)

Rehabilitation centre B, Focus group 3 participant:

'The 12 Steps Programme helped me to understand myself, it helped me to physically understand my relationship with God, myself and with other people.'(FG3-p03)

As shown in the expressions above, the bulk of the focus group participants concurred with service providers that the Minnesota 12 Steps Programme was by far the most important component of the therapy programmes offered in the two selected rehabilitation centres. As a general overview, participants indicated that the 12 Steps

programme was crucial for them because it was providing practical steps through which they confront the hurdles associated with substance use recovery.

In a nutshell, this chapter provided presentations and discussions of the study results and a summary of the application of the two theories at the rehabilitation centres. The following and last chapter will focus on the conclusions and recommendations of the study.

5.6 Conclusion

This chapter presented and discussed the findings of the study according to each objective. The quantitative data was presented in graphs and tables and descriptions of the graphs were given. In the same manner, the qualitative data was grouped into themes and discussed, direct quotations from focus group discussions and interviews were added. The study aimed to evaluate the perceived success of selected therapy programmes in mitigating the relapse of patients with substance use disorders. The researcher believes that the study successfully investigated this phenomenon and that the aim of the study was achieved. The following, last chapter will present the conclusions and recommendations of the study.

6 CHAPTER SIX: CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

The previous chapter provided a detailed discussion of the research conclusions and recommendations of the study. The first section of the chapter will discuss the conclusions related to the objectives of the study and theoretical framework. The second section will furnish recommendations for the study, as well as recommendations for social work practice, social work training and curriculum, recommendations for policy development and those linked to the theoretical framework. Ultimately the last section will provide a discussion on the recommendations for future research, which might be conducted on similar issues, especially on specific gaps within drug abuse policy and research.

This study aimed to evaluate the perceived success of selected therapy programmes on mitigating the relapses of patients with substance use disorders. To achieve this, the following objectives guided the study:

A. To establish the nature of selected therapy programmes and examine the extent to which they are meeting their objectives.
B. To determine the extent to which selected therapy programmes assist in the prevention of substance use relapse.
C. To formulate recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use relapses.

Different perceptions towards evaluating the success of selected therapy programmes on mitigating the relapses of patients with substance use disorders were given by the different sample categories, namely, the patients, their care givers, the social workers and the directors of the rehabilitation centres.

6.2 Conclusion of the perceptions that emerged

Based on the findings of this research and other available literature, substance use disorder is perceived as a disease that affects the body and the brain leading to compulsive use of substances regardless of its negative effects. The social workers in this study alluded that as much treatment is given for this disease through various programmes, a greater responsibility of success lies on the individuals suffering from substance use disorders. As mentioned below:

> *'greater chances yes but at times it is up to the patients themselves'(Rehab B-sws01)*

> *I can say the objectives are met partly, because some patients end with success stories and some patients after they get, they just relapse so many times" (Rehab A-sws01)*

However, in answering objective A, the therapy programmes that were presented in this study proved to be effective in meeting their objectives to a greater extent. Although, the responses given by some of the participants towards objective B indicated that the selected therapy programmes did not fully assist in the prevention of substance use relapses. The conclusion made for objective B be would justify why the rehabilitation centres of this study had high numbers of readmissions, due to patients who would have relapsed.

There were both negative and positive perceptions towards the success of selected therapy programmes on mitigating the relapses of patients with substance use disorders which are discussed below.

6.2.1 Positive perceptions

The positive perceptions that were given indicated that the treatment programmes at the rehabilitation centres were and are successful in mitigating relapses amongst individuals with substance use disorders.

The Key informants shared their views when there were asked if the treatment programmes covered all areas of relapse causes. The responses alluded that the programmes were fairly meeting their objectives:

> *'the programmes themselves are good programmes, but treatment has to be holistic for the patients to be fully assisted, but of course the programmes which are there do address, how to avoid relapses, how to cope with triggers, stress etc…. (Rehab A-sws01).*

> *Well that is difficult to answer because some of the patients' relapse, the objectives all aim at transforming the lives of the clients so they won't go back to their old life styles (Rehab A-sws02)*

During the focus groups some patients indicated that they learnt how to control their will, which is very important in sobriety. The application of Cognitive Behavioural Therapy (CBT) assisted them to recognise their emotions and mastering the ability to control them and assess their consequences. One participant says:

> *"My thinking changed I let go of my anger which used to make me use all the time, to escape. I should say though what I think has changed to be more positive from the first time I was admitted." (FG3-09)*

66% of the respondents who were the caregivers of the patients also seemed to believe that the CBT was helpful to the patients in their recovery journeys. The Key informants also viewed CBT as helpful to the patients as well:

Cognitive Behavioural Therapy focuses mainly on an individual's mind and thought process, that is how the patients are helped in transforming the way they think to led a constructive life' (Rehab A-sws01)

The twelve steps programme seemed to be successful in equipping patients with skills to avoid relapsing, ranging from acceptance of the addiction problem to making amends and being accountable. The key informants perceived this as a key and vital programme that helped the patients, in these words:

''We therefore use the 12 Steps programme to induce realisation and acceptance which is vital for successful recovery'' (Rehab B-director)

'The 12 steps programme is basically the foundation for the treating addictive behaviour' (Rehab A-sws01)

So through the 12 Steps programme we help the drug users to reflect on their past action and account for all the people who might have been hurt (Rehab A-sws02)

We therefore use the 12 Steps programme to bring about this realisation and prepare the drug users for reintegration which is based on accountability. I personally believe failure to be accountable is the root cause of relapse". (Rehab B-sws02)

The participants of the Focus groups also shared the same thoughts on the 12 Steps programme, that it was successful in equipping them with skills to avoid relapsing. Few selected quotes of the many alluding to this are below:

"I agree with him, the 12 Steps is the most important part of this programme, the steps help you to deal with real life situations which cause relapse..."(FG1-p08)

The twelve steps have helped me on helping me to move from denial and officially accept my weakness and to start putting efforts in my recovery journey'(FG4-p08)

of course the 12 steps are beneficial but if medication was there it would be awesome and maybe help me not to relapse.' (FG3-p01)

More to that the social workers shared that one of the programmes helped the patients with self-awareness. Self-awareness is mentioned as key in the Relapse Prevention Theory and having one of the treatment programmes focusing on that at the rehabilitation centres is helpful in efforts to prevent relapses amongst the patients.

They said:

> *In many instances, substance users who relapse are people who usually lack self-awareness; they feel inept and have all sorts of negative perceptions about themselves. They usually thrive on external validation, so our mandatory and enforced meditation helps the substance users to develop a culture of self-introspecting and appraising. This is vital for improving the self-esteem and general awareness of the individual and it help them to sustain their recovery. (Rehab A-sws01)*

Also, meditation programme seemed to help the patients to re-centre and focus on recovery and maintaining their sobriety. Although some of the patients had relapsed, they still thought this programme was successful in helping them to avoid thoughts that could trigger or lead back to relapse. In support of this some patients shared in focus groups saying:

> *Meditation and reading Surahs help me each time, I know I am back here but if I try had I think what they teach in the programmes help us not to go back to using over and over again" (FG3-p01)*

> *'. the programme that teaches us to meditate helps me to take that devil away, its only bad when I get home because at times I fail to keep doing it alone" (FG2-p05)*

On the other hand, some participants thought the Lifeskills programme which was guided by the Relapse Prevention approach also helped them to be able to identify the areas to work on. Such as realising their triggers and mastering how to handle them and avoid risky situations.

I think life skills help a lot, like all that we learnt about triggers, how to cope with high risk situations and avoiding toxic people"(FG4-p03)

It was my carelessness, so I don't agree with what others are saying that the programmes here are crap' (FG4-p03)

"I might to be answering your question correctly but I think the life skills are the real deal, they told us association was important...' (FG1-p08)

The physical exercise programme did not only help the patients to stay fit, make use of idle time but it also helped their brains to produce endorphins that are necessary for recovery. Some of the participants shared that this programme helped them to shift their thoughts.

I only feel better when I run, I forget those drug thoughts" (FG2-P06)

The key informants shared the same sentiments of the programme helping the patients to shift from potentially destructive thoughts that could lead to relapses.

We therefore introduce them to physical exercises as a strategy for stress relief.." (Rehab B-director)

So our strategy is that we introduce physical exercises which burn the visceral fat so that it also discharges the stored up drug residue." (Rehab B-sws02)

The respondents also indicated that the success of the treatment programmes in mitigating relapses was dependent on other factors as well, at least 64% of them agreed to that. This highlights that other external factors such as the strength of family support or support play a big role in one's recovery as well, 76% of the respondents agreed that the strength of the family support system also contributes to factors that lead to relapses. This goes in line with the other participants who have mentioned that their family environments were toxic and were part of the reasons they had relapsed in the past. One of the social workers also highlighted how important it was for the patients to be in environments that encouraged their sobriety.

I think not everything is addressed, such as, them sorting out their external environments to be conducive for recovery (Rehab A-sws02)

However, in as much as these various categories had positive views on the success of the treatment programmes on mitigating the relapse of patients with substance use disorders. There were others who viewed it quite differently.

6.2.2 Negative perceptions

The rehabilitation centres had several readmissions due to the relapsing of patients. The patients shared this during the focus group sessions, some mentioned that they thought rehabilitation centres were more of a business scheme than them being facilities of assisting individuals suffering from addiction. The quote below shows that:

'I think rehabs are just out to make money, this is a business for real, the amount that we pay is a lot …. just for me to relapse and come for admission again. (FG1-p04)

Another patient only just highlighted that if someone had not paid for her she would have not been able to get admitted to receiving treatment at the rehabilitation centre. Indicating the high costs of rehabilitation fees.

Thank Allah for finding me a sponsor otherwise where was I supposed to get R40 000 for staying here." (FG3-p07)

Another participant shared their thoughts and explained multiple admissions as evidence of failure for the programmes :

'I really am not sure if these programmes in rehabs work because this is my fourth time being admitted, so tell me if it works why do I keep coming back, I don't think what they do with us here is beneficial' (FG2-p03)

On the other hand, another participant shared that the lessons are not individualised but generalised for everyone. This participant mentioned he had mastered most of

them to the extent that some staff at the rehabilitation centre request him to lead those classes. This participant indicated that despite knowing all from the programme lessons he still has relapsed several times.

> *'The lessons never changed, still the same as the first time I was admitted here, now I have actually lost count how many times I have relapsed and come back again. No wonder why at times the supervisors ask me to give classes because they know that I now know most of it by heart.'(FG3-p04)*

> *like I only relapsed twice, but I now feel like the twelve steps don't work for me, I mean I heard them, how many times now? and nothing, when you go into the world it real ha! Not these silly things of homework stuff that I have learnt since my very day one.' (FG4-p03)*

Moving on, particularly to the enforced meditation and physical exercises programmes, other participants of the focus groups had positive feedback but not all shared those same sentiments:

> *"I do not agree with him because for meditation does not work" (FG2-P06)*

> *'yes I try to exercise but at times I do not have the patience for it, using again will be the quickest option for me to fix this feeling of sadness which I leave with' (FG3-p01)*

Some participants of the focus groups mentioned earlier viewed the treatment programmes to be successful in mitigating relapses. However, some had other thoughts about the support groups that were held at the After Care centres. These centres are set by the rehabilitation centres in order to continue in providing support to the patients post them being discharged. These participants thought the support groups presented temptations of meeting bad company that could encourage relapsing.

the treatment programmes taught me a lot, but I just think it's not wise to make friends at the support group (FG1-p06)

Although one of the social workers mentioned that if anything should be attributed to the low success rate of the After Care programme in mitigating relapses, it should be attributed to the lack of commitment of the patients. The respondents to the survey also indicated that not all patients committed to the After Care. Only 45% indicated that the patients attend the After Care sessions when they are discharged and only 48% committed to a support group and only 32% thought that the services provided by the After Care programmes are enough.

'a challenge of commitment to the programme sessions, for the programmes to show results, the patients should be willing also to learn from the group therapy, even from the support groups when they leave the rehabilitation centre' (Rehab B-sws02)

I personally believe failure to be accountable is the root cause of relapse (Rehab A-sws01)

.. but I mean at times the patient also has to be willing to also abandon the lifestyle of using substances... (Rehab A-sws01)

Adding to that one of the directors also indicated that the success of the treatment programmes in assisting patients not to relapse is also dependent on the level of commitment of the patients. This shows that this director perceived the treatment programmes to be successful in mitigating relapses but some of the patients were the ones who hindered their sobriety.

'am telling you some of the patients we have don't want to learn at all, they get forced with their families to come to rehab. Some of them only come because they don't want the social workers to take their children to foster care, and not because they really want to change, some because their husbands threatened them divorce. So that's why they relapse because our programmes are perfect

but they don't want to change their lives, it's like these demons don't want to leave, it's sad' (Rehab B-director)

Another focus group participant indicated they were in the rehabilitation centre only because they were forced to be there, this shows that commitment to be in recovery lacked from the part of the patient. Meaning that measuring the success of the treatment programmes with like-minded individuals would not be justifiable.

you see I only come here because my dad forces me all the time, this is my 7th time in rehab, and every time it's the same things that I am told, the classes the same, counselling sessions a bit different but those twelve steps I know them by heart now, and nothing is helping, maybe something new might help me, a miracle maybe'(FG2-p08)

The respondents of the survey agreed that skills development programmes are useful for financial independence and preventing relapses, 71% of them attested to this. However, only 9% indicated the existence of these types of programmes at the rehabilitation centres, indicating that the caregivers supported the programmes that would empower some sort of skills on the patients to avoid idle minds and enable their independence and sustenance when they are discharged from the centres. This is one of the gaps that existed in the holistic model of transformation.

Some participants attended a Life skills programme at the rehabilitation centres, although some saw them as just uninteresting classes, one focus group participant expressed how it felt like there were back to school, saying:

*When I came here the life skills classes really felt like I was in school that's why I never paid that much attention, I would listen a bit though, if the topic was interesting, but when I saw Mohammed returning I was like this **** is real, you know how much he participated in class? (FG1-P10)*

The social workers during the interviews had their views on the success of the treatment programmes towards mitigating substance use relapse. Indicating that a more holistic approach could perhaps produce cumulative success from treatment programmes the rehabilitation centres offer. More to that another social worker mentioned that the success of the treatment programmes could be low due to the fact that they seemed inadequate. Quotes from the social workers are below:

'I can say not entirely, there could be more added in equipping the patients to help them not to relapse after they are discharged' (Rehab A-sws02)

Another social worker from the same Rehab shared

'well the package of the programmes if it were holistic, the chances of preventing relapses woud have been higher' (Rehab A-sws01)

But after the first relapse I don't know if these programmes actually help, because they are taught the same things over and over again'(Rehab B-sws02)

'ummm , that's a hard one but effectiveness as I said is seen when there are various programmes that compliment each other in helping patients, we have a few here that's why maybe success rate is low'(Rehab B-sws02)

Other social workers adding to the view that a treatment approach which is not holistic and individualised is not successful in mitigating relapses amongst patients with substance use disorders.

They said:

' I do no think there are that effective on patients who have relapsed several times , but on the patients that do not have a history of relapsing the programme can be effective.' (Rehab B-sws01)

' they are effective to the first time clients admitted I think but once a client begin the relapsing trend I do not think these programmes penetrate through them'(Rehab A-sws02)

..well the package of the programmes if it were holistic, the chances of preventing relapses wouldn't have been higher (Rehab A-sws01)

'the best way could be to employ all specialists to help the patients with their problems from medical, spiritual, psychological and so on. (Rehab B-sws04)

It can be concluded from the different views that the selected therapy programmes that were discussed in this study were able to meet their objectives, however, their success seemed to be linked to the application of a holistic approach, which lacked in both of the rehabilitation centres as presented. The main gap that was found out indicated that if one area of a patient's life is not attended to, even if treatment programmes would have covered other areas that could potentially be the constant loophole that causes relapses to always occur.

6.3 Conclusions related to objective A: To establish the nature of selected therapy programmes and examine the extent to which they are meeting their objectives.

Kumar and Vedpuria (2018) note that it should be understood that the success of therapy programmes in meeting their objectives is mainly dependent on certain elements and factors. These are some of the essential aspects that are important with regards to the ability of the therapy programmes to meet their objectives (Chetty 2012). The common objective in all therapy programmes is to ultimately equip individuals who have substance use disorders, to prevent any future lapses and or relapse. However, although many treatment approaches demonstrate some success, relapse rates for substance use problems remain high (Thakker & Ward 2010).

Although through the information collected by the study and literature review, it can be said that substance use disorders do not have a cast and stone cure, therefore the success of the treatment programmes can be determined by a lot of variants. Patients who adhere to the treatment programmes regimens may have better desirable outcomes than the others, thus making it difficult to rule judgement solely on the effectiveness of the treatment programmes alone, in reaching their objectives. Some participants from the focus groups attributed their sobriety adhering to the takeaways from some treatment programmes.

> *"I might not be answering your question correctly but I think the life skills are the real deal, they told us association was important and I noticed that my first slip incident happened when I went to my toxic girlfriend's house and that was after I had not touched anything from the time I was discharged from here." (FG1-p08)*

> *"Like as I said before I would go back to using after pulling away from my higher power, it's the guilt I think that made me fall deeper" (FG1-01)*

> *"We therefore use the 12 Steps programme to induce realisation and acceptance which is vital for successful recovery" (Rehab B-director)*

Below is the list of the therapy programmes that formed the treatment of the rehabilitation centres of this study.

6.3.1 The Minnesota 12 Steps Programme

Objective: To establish guidelines for the best way to overcome an addiction to alcohol or drugs.

The director of rehabilitation centre B has this to say about the programme,

> *''We therefore use the 12 Steps programme to induce realisation and acceptance which is vital for successful recovery'' (Rehab B-director)*

The effectiveness of this programme was further endorsed by one participant from rehabilitation centre B,

''The twelve steps have helped me on helping me to move from denial and officially accept my weakness and to start putting efforts in my recovery journey'' (FG4-p01)

Another participant from Rehabilitation centre A focus group, has this to say as well,

"I agree with him, the 12 Steps is the most important part of this programme, the steps help you to deal with real life situations which cause relapse..."(FG1-p08)

The results of this study indicate that the patients at the rehabilitation centres were helped by the Minnesota 12 Steps Programme through its focus on spiritual reawakening. The purpose of spiritual reawakening is to understand the purpose in life through higher power (Galanter 2007). Participants said it helped them to induce realisation and acceptance, which is vital for successful recovery. Discussions at the focus groups and interviews showed that the programme helped the patient to realise and accept their addiction problem, make an inventory of their wrongdoings and make amends.

This helped the patients to accept their powerlessness and realise that there is a higher power that can help them overcome their fears and challenges. The Director of the rehabilitation centre B said this about the Spiritual reawakening,

''Routine reverence to the higher power means that the substance abuser develops certain moral codes which then guide him away from substance use and its associated ills. Our view is that families should encourage substance abusers to continue with their new found spirituality even after they exit from the rehab...'' (Rehab B-director)

"Our spiritual programme is mainly premised on the view that spiritual connection helps the individual to maintain some level of presence, builds and operates a moral compass within the individual...We therefore implore our clients to become spiritual" (Rehab B-sws01)

Above all the 12 steps programme along with the Spiritual programme helped the patients to connect with their higher power, whom they could ask for guidance and assistance in life. The patients of this study attested to how what they learned through these programmes helped them during the time they managed to maintain their sobriety.

> *"For me I do not know what to say because I have been here 7 times but step 6 continues to give me hope each time and I know that my higher power will rescue me one day" (FG1-p01)*

It is interesting to note that the patients indicated that each time they relapsed, they would have disconnected from all that they would have been taught at the rehabilitation centres, the answer to what motivates this disconnection is yet to be found.

6.3.2 Psychotherapy

Objective: To have the collaboration of a client and a therapist towards goals to be achieved in psychotherapy and for clients to solve problems that made their lives difficult and that they tried, but failed to solve (Tryon 2018).

The rehabilitation centres employed one type of psychotherapy namely Cognitive Behavioural Therapy (CBT). It helps to change patterns of thinking or behaviour that are behind people's difficulties and to change the way they feel (Wright & Davis, 1994).

The study results showed that psychotherapy and cognitive-behavioural therapy (CBT) provided support and behavioural encouragement to mainly the patients who suffered from substance use disorders and partly to their families as well. The

patients who were part of the focus groups indicated that having therapists (social workers) to talk to, give them the platform to share about their secret struggles in addiction without any fear of judgement, that they would have gotten from friends or family. The CBT helped with basic behaviourism encouragement, change of distractive thought patterns to constructive ones, establishing external control and learning how to handle triggers and high-risk situations that lead to relapses. The results of this study indicated that patients acquired knowledge from both the group and individual therapy sessions, which helped them to master coping skills and set goals.

One of the social workers' described their psychotherapy programme as:

> *'Generally, substance abusers are people who experienced some traumatic events in their past and due to this trauma they feel some level of physical and mental discomfort or emptiness. In their search for a means to fill this void, they may stumble on substances which offer temporary relief. In such persons, the substance creates a firm and vicarious impression in the memory of the drug user such that whenever he/she feels discomfort he/she goes to look for the drug for its relief effects. This process happens with or without the conscious awareness of the drug user.... Psychotherapy therefore helps the drug user to identify his/her primary source of pain and to comprehensively deal with it without resorting to drug use.' (Rehab A-sws02)*

During the focus group sessions, the participants had various opinions on how effective psychotherapy was to them:

> *"I think for me talking to the social worker made me realise the areas of my weakness, I had never sat to think that for myself." (FG1-p10)*

Another participant from the same focus group indicated that:

> *"Of all the programmes here, I really liked this aftercare programme of ongoing therapy. Unlike the counselling which is provided inside the rehab, the counselling which is provided after discharge I found it more practical and supportive as it deals with real life*

situations."(FG1-p02)

The findings indicated that this programme was successful in assisting the prevention of substance use relapse. It cannot be dismissed that these treatment programmes worked in accordance to achieve their objectives. However, these rehabilitation centres seemed to have their main focus only on the CBT approach under psychotherapy, whereas in the history of substance use treatment not everyone responds positively to it, like clients with emotional dysregulation or anything similar. Rehabilitation centres should have various approaches for different personalities.

6.3.3 Pharmacotherapy

Objective: To reduce the intensity of withdrawal symptoms, reduce cravings, and reduce the likelihood of use or relapse for specific drugs by blocking their effect and for the patient to achieve fully-sustained remission.

Pharmacotherapy is helpful when done properly, the results found out that it helped patients with heroin addiction when they experience withdrawals. However, it was also found out that pharmacotherapy mostly was administered at a cost at these centres, and patients who could not afford this extra therapy would not have access to it. This in the long run affects the notion of holistic treatment to patients who cannot afford it. Therefore, the rehabilitation programmes were successful to a lesser extent in assisting the prevention of substance use relapse through this programme.

6.3.4 Enforced Meditation

Objective: To enhance resilience against stressors that may lead to substance use (Christopher, Hunsinger, Goerling, Bowen, Rogers, Gross & Pruessner 2018).

Participants during focus group discussions mentioned that meditation helped them to change their attitudes towards their thoughts and feelings which were addiction related and helped them to become more aware of those thoughts and feelings without necessarily acting on them.

> *"" Meditation and reading Surahs help me each time, I know I am back here but if I try had I think what they teach in the programmes help us not to go back to using over and over again" (FG3-p01)*

Social worker 1 from Rehabilitation Centre B in light of the above said that:

> *"those attempting recovery for the very first time and those with multiple to wake up every day and find a place where they can sit quietly and validate their thoughts, actions and motives for their previous day. This helps them to identify possible relapse urges and rectify them before they gain more strength. (Rehab B-sws01)*

However, some participants had different views on the effectiveness of the programme:

> *"I do not agree with him because for meditation does not work, I only feel better when I run, I forget those drug thoughts" (FG2-p06)*

This programme helped the patients to become aware of character defects that could lead back to substance use, meaning that it was successful in equipping the participants to avoid substance use relapse.

6.3.5 Physical Exercises

Objective: To help individuals learn new patterns of motivation, and also to change behaviour through increased body awareness and self-confidence (Donaghy & Ussher 2005).

Physical exercises help to increase the availability of brain tryptophan and the synthesis of serotonin, which in combination with changes in other monoamine

neurotransmitter systems mediates the behavioural sensations of fatigue and subsequently positive mood changes.

Participants from Focus group 3 said the below on how physical exercises helped them:

> *"Exercising is hard but I noticed that after each session I become calmer..." (FG3-p08)*

> *"The craving for using for me it disappears after intense workouts although it's difficult to do it daily. The social worker made it look so simple that I should friend an hour daily to exercise but it is such a mission…" (FG3-p09)*

Another participant from Focus Group 1 indicated that:

> *"I dedicated time to exercise and it really kept me out of trouble most of the time, maybe if I hadn't given up on the routine exercising would have helped me use my time wisely." (FG1-p03)*

This indicates that patients attested to physical exercises being beneficial to them and helpful in terms of diverting their attention from the use of substances. However, some mentioned motivation for consistent physical exercises was difficult to maintain.

6.3.6 Life Skills Training

Objective: To provide the groundwork for effective stress management and presentation of positive behaviours (Moshki & Aslinejad 2013).

The key informants revealed that the life skills activities enable empowered patients to cope with anxiety, be more aware of risky behaviours and increase their knowledge of immediate consequences of substance use and help them master better alternative behaviours. Patients indicated that the life skills helped them to enhance their cognitive and behavioural competencies to reduce and prevent different health risk behaviours.

"I might to be answering your question correctly but I think the life skills are the real deal, they told us association was important and I noticed that my first slip incident happened when I went to my toxic girlfriend's house and that was after I had not touched anything from the time I was discharged from here." (FG1-p08)

"Yes I generally think the treatment programmes are effective, we learn a lot in the daily classes but I guess I will be tested once I leave this place." (FG4-p02)

"Challenges that I think are that we are just taught in the life skills classes but we are not given the practical experience, for me I saw that it is a different environment." (FG2-p01)

"Yes that's true, here is a controlled space we are protected, the gate is always locked but outside there is so much freedom that affects following all those dos and don'ts." (FG2-p02)

It is however worth mentioning that the manner (operational) in which the programmes are carried out by the rehabilitation centres have an effect on the success of their effectiveness.

6.4 Conclusions related to objective B: To determine the extent to which selected therapy programmes assist in the prevention of substance use relapse.

Murthy (2017) in the American Surgeon General's Report on Alcohol, Drugs and Health notes that substance use disorders are chronic, and affected individuals may have difficulty in complying with the prescribed treatment. Sinha (2011) in her research noted that 85% of individuals relapse and return to drug use within their first year after the rehabilitation. Hence it is difficult to utterly rule out whether the high numbers of repeated relapses are due to failure of treatment programmes or due to the individual's ability to resist temptation and remain resilient.

The rehabilitation centres in this research focused on psycho-social intervention approaches and through various treatment programmes aimed to improve the patients' emotional regulation, cognitive distortions and equip them with coping

strategies on how to handle cues and triggers and how to overcome high-risk situations to maintain their sobriety. In the recovery journey, high-risk situations are anticipated hence the twelve steps programme, through different steps raise awareness of the individual's character defects, help them to understand their triggers, cues, and how to work on overcoming them, reconnecting with their higher power, their families, sponsors or people around them and led a clean life.

The life skills programmes at the rehabilitation centres are aimed at helping the patients to be alert of their cues, weaknesses, and triggers that facilitate their return to addictive behaviours. This programme also creates scenarios of escaping or falling back into addiction, so that the patients can apply the life skills in real life. Lastly, the life skills programme is focused on equipping patients with, skills, tools, strategies that they could use to avoid relapses. However, whether these were sufficient or not is subjective, because looking at the results of the mini-survey, question 8 indicate that 90% (N=90) of the patients who had been admitted more than once at a rehabilitation centre, indicated that it took them only between 1-8 weeks to relapse each time they had been discharged from the rehabilitation centres.

Furthermore, the aftercare program consisted of support groups set up by the rehabilitation centres to support their patients after they are discharged from the centres. Through weekly meetings, and random drug tests at these support groups patients access some sort of supervision and support from that aftercare programme. However, 45% (N=45) of the respondents in this research disagreed with the effectiveness of these aftercare services. At the aftercare programme, one relapse could affect the entire group our majority of it and this could be one of the reasons the families of the patients didn't completely agree on the effectiveness of this

programme. While on the other side some patients completely abandoned attending aftercare programmes, as the results indicated that 52% (N=52) of the patients would not even bother to attend aftercare programmes after being discharged from the rehabilitation centres.

Family therapy aimed to address relapse prevention with the involvement of the family since family plays a pivotal role in patients' lives. It is also essential that the family environment becomes sensitive to the needs of the family member in recovery or else they could be the ones to facilitate a relapse. Research shows that treatment programmes involving family therapy have better success levels of recovery than those that do not include any family member therapy. However, not all families were interested in any therapy because several believed that only the individuals with substance use disorders needed to be "fixed by therapy''.

A toxic family environment has higher chances of facilitating a relapse than a supportive one. This is supported by what one participant from focus group 2 noted:

> *"My Father is a dealer, so what do you want me to do, I try but he sells drugs and he has the nerve to send me to rehab, I know he wants me to finish high school but it's difficult" (FG2-p09)*

It was observed in this study that family therapy was not prioritised as should have been. If the families are not equipped on how to support their family member after rehabilitation, they could be the first ones to lead the individual back to his triggers, the very moment they are discharged.

However, the commitment and willingness of the individuals in recovery also matter, because not all patients admit themselves at the rehabilitation centres willingly, at sometimes it would be their families, workplace or religious or community leaders.

In light of the above mentioned one participant from Focus group 3 noted:

'I knew facing my temptations, was my high-risk situation, but I went ahead anyway to the club with my old friends and that's how I relapsed again'(FG3-p03)

This indicates that recovery is a complex task that requires stern discipline, the treatment programmes aim to equip individuals with everything so that they can be successful in their recovery journeys. However, various external factors can pose a threat to one's recovery, but if the self-discipline is in check relapse will only be an active decision. In this context, therapy programmes were designed to ensure sustainable relapse prevention with the realisation of the unique nature of individuals, implying that relapse prevention efforts should focus on the unique needs of the individuals.

6.5 Conclusions linked to the Relapse Prevention Theory

There is no doubt that it has been debated that relapse prevention has several strengths as a treatment model and theory. Relapse prevention as a cognitive-behavioural therapy should not be the sole approach for effective rehabilitation. The NIDA (2020) notes that in reality, drug addiction is a complex disease, and quitting usually takes more than good intentions or a strong will.

Thus even though relapse prevention can help identify high-risk situations, employ behavioural and cognitive strategies to prevent any relapse in the future due to the same or alike situations, there is no guarantee that the approach can be effective on all individuals in the same way. Hence as mentioned earlier in this chapter a multifaceted approach should be employed in rehabilitation centres for optimum results. Thakker and Ward (2010) note that one of the key weaknesses of relapse prevention is that it takes a generally unconstructive approach to the therapeutic

process through the use of negative concepts and avoidance goals. the aforementioned two authors recommended that a ‘good lives’ framework of psychological wellbeing can provide a means of remedying these weaknesses of the traditional relapse prevention model. However, arguably, in terms of both the theoretical and the practical application of relapse prevention, there is room for improvement.

6.6 Recommendations

The following section will provide recommendations for the study based on the findings from the rehabilitation documents review, the questionnaire results, focus group discussions and the key informant interviews. These recommendations will be related to social work practices, social work training and curriculum, recommendations for policy development, rehabilitation centres and theoretical framework.

6.6.1 Multidisciplinary Approach

This study recommends that the use of a multidisciplinary approach be mandatory in all rehabilitation centres in South Africa. A multi-disciplinary approach that employs holistic, biopsychosocial-spiritual assessments. The application of this approach will be to determine diverse problem areas, possible solutions and recommend treatment programmes that yield lasting results. The information collected from the document review and key informants’ interviews indicated that the intake processes of the rehabilitation centres were not in-depth as described above and all the patients were recommended the same treatment programmes.

Based on that information this could mean that the initial assessment at these rehabilitation centres was not comprehensive. Employing a holistic assessment model will allow individuals to be prescribed treatment programmes according to their temperaments, medical history, psychiatric conditions, social functioning, and spiritual beliefs. The Department of Social Development should enforce and ensure that all rehabilitation facilities government and private-owned offer a holistic multidisciplinary approach before their operating licences are granted or renewed.

6.6.2 Diversify treatment programmes

The study discovered that all patients at the rehabilitation centres were offered the same treatment plans, irrespective of the substance or whether there were first time admissions or readmissions. The relapse rates are likely high because re-admitted patients got familiar with the same information they would have learnt before their relapse.

Some focus group participants in light of this mentioned that:

> *'I really am not sure if these programmes in rehabs work because this is my fourth time being admitted, so tell me if it works why do I keep coming back, I don't think what they do with us here is beneficial' (FG2-p03)*

> *'On challenges I just need a miracle because I have been here four times and I know everything by heart now, but I still go back to using'(FG1-p07)*

Therefore, rehabilitation centres should diversify their treatments according to the type of substance or drug and according to the severity of the substance use disorder to prevent familiarity that can inhibit their effectiveness. Like treatments for individuals who would have relapsed a couple of times could focus on the causes of the relapses

and how to avoid them. While treatment for first-timers can focus on how to avoid even a first relapse. Several factors should be considered per individual when it comes to the type of treatment that could work for them and rehabilitation centres are encouraged to put such into consideration.

6.6.3 Individualised Client Centred treatment

It is recommended that rehabilitation centres in South Africa emphasize offering individualised treatment to help unique patients effectively. One proto-psychological theory suggests that individuals are divided into four main temperaments, namely phlegmatic, choleric, sanguine, and melancholic (Vorkapić 2011). The theory differentiated personalities according to the dominant bodily fluids, this should mean that the effect of substance use on individuals is different according to their specific temperaments, their treatment should be different, specific according to the needs of their temperaments and substance of use. Perhaps this was one of the reasons why some treatment programmes seemed not to be 100 per cent effective on all the patients.

6.6.4 Alternative Behaviour Therapies

The results of this research showed that Cognitive Behavioural Therapy (CBT) was enforced on every patient who was admitted in either of the rehabilitation centres, however, it is unknown whether it was effective on every patient, due to the high relapse percentages at these centres.

In light of that one focus group participant said:

> *'The lessons never changed, still the same as the first time I was admitted here, now I have actually lost count how many times I have relapsed and come back again. No wonder why at times the*

supervisors ask me to give classes because they know that I now know most of it by heart.' (FG3-p04)

It is therefore recommended that rehabilitation centres have alternative therapies to cater for patients who do not respond positively to CBT or any other kind of behavioural therapies due to different factors. Some individuals may have distresses that are triggered by CBT, while others who are emotionally raw may feel invalidated by CBT. In the absence of alternative therapies for such individuals, CBT might be ineffective for them.

Instead of employing CBT only, rehabilitation centres could consider using Mindfulness-based cognitive therapy (MBCT) as well. Also, other therapy programmes such as Dialectical Behavioural therapy can help such individuals in several ways, like mindfulness which helps individuals to get out of the emotional rational mind and helps with distress tolerance, emotional regulation, personal effectiveness (to help them with self-validation) and problem-solving.

6.6.5 Psychoeducational Therapy

The documents that were reviewed at the rehabilitation centres did not provide any information on class activities that were under psychoeducational therapy, nor did any participant mention anything about it during the focus group discussions.

It is recommended that rehabilitation centres invest more in psychoeducational therapies to help patients become familiar with various personality disorders and their personality disorders if they are diagnosed. Also for them to be familiar with other self-help programs while teaching them about critical issues of addiction and relapse. During the psychoeducational therapies, the function of the therapist or social worker

may be to simultaneously coach and teach, fostering a positive and encouraging relationship with the patient.

With the advancing world of technology even after the patients are no longer at the rehabilitation centres, they should be able to access psychoeducational therapy pre-recorded material online.

6.6.6 Increase minimum weeks of rehabilitation

The rehabilitation centres of this study had a minimum admission period of 6 weeks and a maximum of 8 weeks, as indicated in their document review and the key informants' interview.

> *'The 12 steps programme is basically the foundation for the treating addictive behaviour, I think that's why the programme designers made sure they can be completed in the one and a half months of admission.' (Rehab A-sws01)*

The results indicated a high relapse percentage amongst the patients who were admitted at the centres. Generally, in South Africa, the period for residential rehabilitation ranges from 6-8 weeks, except for a few private rehabilitation centres that extend the period for up to 32 weeks for long-term rehabilitation. A period of six to eight weeks for rehabilitation might just be primarily adequate for detox, removing all traces of drugs, and treating any withdrawal symptoms.

However other underlining issues which cause substance use dependency might need a longer period to resolve. Early or premature discharge of patients from the rehabilitation centres, leave them with several unresolved issues and this could be one of the factors that lead to relapses soon after rehabilitation.

Domínguez-Salas, Díaz-Batanero, Lozano-Rojas, and Verdejo-García (2016), also noted that the treatment of substance use disorders requires a much longer period than just a basic few weeks, depending on the type of individual. Therefore, it is recommended that the minimum period of admission be extended to at least a minimum admission period for 90 days in all rehabilitation centres unless it is for sorely detox purposes.

More to that, rigorous pre-admission and pre-discharge assessments should be conducted on patients before they are admitted and discharged to ensure that all threatening issues are identified and resolved. In cases where after pre-discharge assessments are conducted and a need for an extension is identified. There should be some sort of admission fee discounts in place so that the patients can afford to stay for the extended period, or there should be some form of government subsidy that could cover these expenses for individuals who are keen to recover and be admitted for a longer period but cannot afford.

6.6.7 More subsidized Private Non-Governmental Rehabilitation centres

In South Africa, due to the high rates of substance use, the state-owned rehabilitation centres at most times cannot admit all individuals who need treatment. The private rehabilitation centres in such cases became the alternative for individuals in need of rehabilitation, however, due to the exorbitant admission fees, only those who can afford to pay can resort to it. In most cases, individuals who suffer from addiction would have used all their finances to feed their habit and will be in no position to afford any fees for rehabilitation.

"Operational gaps I see none but of cause its costs a lot for the patients to be here but still we are not liquid enough." (Rehab A-director 01)

Other Focus Group participants had this to say in light of the rehabilitation centre fees being unaffordable:

'I think rehabs are just out to make money, this is a business for real, the amount that we pay is a lot …. just for me to relapse and come for admission again.' (FG1-p04)

"The life skills taught me how to control my habits, I will try. Thank Allah for finding me a sponsor otherwise where was I supposed to get R40 000 for staying here." (FG3-p07)

This shows that the private rehabilitation centres are pricey for an ordinary citizen in South Africa, those who can afford to be rehabilitated in the private institutions, are either those who come from wealthy families and or those who have their admission fees paid by their employers or well-wishers. Only a few individuals remain with jobs when they use substances, hence only a small fraction of those who are admitted get financial support from their employers, this same applies to well-wishers unless they are sponsors or individuals who have a personal understanding of addiction battles. In a nutshell rehabilitation centres in South Africa are not easily accessible due to them either being full or not affordable. At most times patients who cannot afford to pay rehabilitation fees on their end up stuck because even the government facilities which are free, are always full.

One focus group participant in light of this said:

'Challenges I face is getting sponsors, if I had not found a sponsor at the aftercare group, I would be probably in the street using right now, because I couldn't go back to Hospital they had told me they didn't have beds.'(FG2-p01)

It is therefore recommended that the Department of Social Development should consider increasing their annual budgets targeted to curb the use of illicit substances in South Africa. Also, a portion of this budget can be directed towards subsidizing or reducing fees at private rehabilitation centres.

The Department of Social Development already subsidizes several private rehabilitation centres across all provinces. However, there are many more private rehabilitation centres that do not receive these subsidies, including the centres that were used for this study. So these rehabilitation centres end up charging exorbitant fees to cover several expenses of operating the facilities.

6.6.8 Accredited Specialists mandatory at all rehabilitation Centres

Most rehabilitation centres outsource specialist services from psychiatrists, psychologists and medical doctors. Other financially stable facilities including the government-owned rehabilitation centres have these specialists on a full-time basis. The review of the information from the rehabilitation centres of this study indicated that the only professionals who were at the facilities were the nurse and the social workers. Access to other specialised professionals such as medical doctors, psychiatrists and psychologists was limited and only available at an extra cost which was not included in the rehabilitation fees.

Most patients who get admitted to non-governmental rehabilitation centres cannot afford the pricy specialists' rates, hence they end up being rehabilitated without receiving adequate assessments and specialist services. This precisely does not have a positive effect on the expected treatment outcomes.

Having said that, it is recommended that every licensed facility should at least offer services from the specialists aforementioned to all patients. Since the services might be unaffordable to many, it is recommended that the annual budget for supporting rehabilitation centres by social development be increased enough to cover the costs of specialists services.

6.6.9 Dual Diagnosis be treated accordingly

In addition, cases of either severe or acute mental health issues are common, it is very important how the addiction and mental health problems are separated and addressed as prescribed by the different specialists. The rehabilitation centres of this study did not have any specialists to conduct assessments soon after intake except for the social workers, neither psychologists nor psychiatrists were present.

One of the social workers mentioned the below as one of the challenges that affect the effectiveness of the whole treatment of the patient at the rehabilitation centres

> *"under challenges, we try I must say but I think it would be better if a psychiatrist would come and help do that first assessment, they can recommend other treatments too. (Rehab A - sws 02)*

> *"Well I presume that out therapy programmes are indeed effective. Yes, some patients would be better if they consulted psychiatrists though, because in my own opinion most need medication but there are on none at all. (Rehab B- sws 01)*

The social workers would only recommend suspected cases for outsourced psychiatric or psychologist evaluation at their own cost, meaning if these services were only accessible to those who could afford them. The availability of specialists to conduct evaluations after intake assessments is an effective way to make sure that

no case of dual diagnoses is missed or neglected. That way all diagnoses can receive the attention they require.

It is recommended that rehabilitation centres should ensure close monitoring and necessary treatments are given to patients with dual diagnoses. Also, the centres could consider including Peer workers in the dual diagnosis team as they are useful for experiential learning. Relapse prevention in isolation will not be effective for patients who have mental illnesses that are not treated, like multiple personality disorder, schizophrenia and bipolar disorders. These would also require specialised treatment and medication in some cases.

6.6.10 Integrating Psychological treatments with Medication-Assisted Treatment (MAT)

Research that demonstrates that addiction is driven by changes in the brain has helped to reduce the negative attitudes associated with substance use disorders and provided support for integrating treatment for substance use disorders into mainstream health care (The Surgeon General's Report on Alcohol, Drugs, & Health 2016). NIDA (2020) notes that substances cause chemical imbalances that change the brain patterns in a way that creates addiction over time. Hence integrating psychosocial services with any medically assisted therapy will be effective in restoring the imbalances created by any substance use. It will also help stimulate the relevant behavioural and cognitive changes. The rehabilitation centres of this study offered medically assisted therapy, unfortunately not to all the patients but only those who could afford to cover their medication expenses.

Therefore, it is recommended that the Department of Social Development Funds Medication-Assisted Treatments (MATs) and make it mandatory for all treatment

centres in South Africa to integrate them with psychosocial interventions. Especially amongst individuals who are dependent on opioids.

6.6.11 Increase Prevention initiatives

The Rehabilitation centres of this study, only focused on treatment according to their operation models, however different types of stakeholders including these centres must invest and be involved in substance use prevention initiatives. These initiatives should involve the target groups from the planning to implementation phase to stimulate high involvement of the same age groups. More to that the prevention initiatives should be informed by research and address the problems specific to each type of substance problem in each local community. These initiatives should be tailored to address risks specific to the audience or population characteristics such as age, gender and ethnicity to improve the effectiveness of the programme.

In addition to that Family-based prevention programmes should also form part of these initiatives. They have to be designed in a way that enforces the strengthening of family bonds, providing substance use education and equipping them with parenting skills. These prevention services can be extended to schools, targeting key transition points such as, **pre-school to primary school**, **primary school to secondary school**, **high school to college or universities**. These could address risk factors for substance use such as academic frustration, failure and improve their social competence and academic performance.

6.6.12 Prioritise family based interventions

The treatment programmes offered by the rehabilitation centres are mainly focused on the individuals suffering from substance use disorders, family counselling

sessions are conducted occasionally. One quote below from the focus group participants indicates that family therapy is important because in some cases some of the family members will be indeed of therapy themselves too.

> *"My Father is a dealer, so what do you want me to do, I try but he sells drugs and he has the nerve to send me to rehab, I know he wants me to finish high school but it's difficult" (FG2- p09)*

A social worker said the below:

> *'For challenges that affect the treatment of the patients, I would say it's when the families do not want to come and be part for their sons' progress, we end up not having family sessions even though they are a very important part of ones' recovery.' (Rehab A- sws01)*

However, the family environment is vital when it comes to recovery, a supportive environment can facilitate a longer sobriety period. Therefore, it is recommended that family behavioural therapy be prioritised as well, as it investigates the family system and its environment to help identify weak links, triggers points that lead to the substance use problem. It also helps the family to acquire new skills to improve the environment at home and the interpersonal environment of a person.

6.6.13 Upgrade outpatient programmes to include Telehealth Technologies

When individuals are discharged from rehabilitation centres, outpatient programmes are there to provide support and motivation. However, due to various reasons such as distance, work commitments, pandemic outbreaks leading to lockdowns, patients may not be able to attend all of these programmes in person. The results from the survey (section 4) indicated that only nearly half (45%) of the patients when they are discharged attend all the in-person sessions. There are so many ways to encourage

participation at the aftercare. This study recommends that outpatient programmes should also explore the options of hosting virtual support groups, online video education for patients, if possible on zero data platforms which make the services readily accessible to everyone at no cost. These virtual platforms could also provide 24hr support lines for emergencies as well.

6.7 Recommendations for social work practice

Social work practice with regards to substance use treatment is vital through various ways such as academic research and practice. In practice, the role of the social workers is to conduct comprehensive assessments on individuals, offer to counsel and recommend appropriate treatment programs.

Handing mental health and substance use issues require specific training. That is why it is important for social workers who are placed in rehabilitation facilities to receive continuous specialised training. Although the basic social work degree includes substance use education. Further training that will equip the social workers to be able to accurately assess involuntary, self-referred or mandated patients, and conduct relevant counselling is required.

Social workers should be responsible for connecting individuals in recovery with services or resources that contribute positively in their lives, during and after any sort of rehabilitation.

The contribution of social work practice in substance use treatment cannot be overemphasized. Social workers contribute to the prevention and intervention initiatives, they act as educators on substance use in the communities, schools or

any outreach centres. More to that they can connect individuals with substance use disorders with relevant rehabilitation centres.

Social work practice should be more suitably positioned to monitor the service delivery of chronic illnesses treatment, such as substance use disorders. Social workers in the academic field should increase their participation in substance use prevention and intervention through dynamic research. This research would help to develop empirically-validated intervention and treatment strategies. These should continually be formulated, implemented and always updated according to contemporary research.

6.8 Recommendations for social work training and curriculum

It seems as if the field of social work does not sufficiently provide training for social workers whose skills are suitable and essential for sustainable recovery and relapse prevention. Social workers upon their first graduations are usually not well informed on how to handle addiction counselling, this is due to a lack of in-depth knowledge on how to handle patients with substance use disorders (Krull, Salas-Wright, Amodeo, Hall, Alford & Lundgren 2018). This is also due to an absence of education, training and field placements related to substance use in most instances. The courses provided for social work do not directly educate on how addiction or substance use is addressed. In most instances, limited information is provided on the aforementioned, (Salas-Wright, Amodeo, Fuller, Mogro-Wilson Pugh Rinfrette & Lundgren 2018). This is an indication that there should be major shifts and changes concerning social work training and education on substance use.

In addition, social work training should constantly change and evolve with the trends enough to respond to every social problem presented. Any societal changes

influence human behaviour therefore any significant transformations should inform social work training and curriculum (Minnick 2019).

Adding on to the recommendations, education and training for social work should include taking into consideration mandate related substance use education within the qualifying and post-qualifying criteria (Estreet, Archibald, Tirmazi, Goodman & Cudjoe 2017). Often, there is an assumption that social work training is essential and can be universally applied to all situations including, substance use. However, education to ensure sustainable treatment and recovery requires knowledge from multiple fields (Putney, O'Brien, Collin & Levine 2017).

Hence in this context emphasizing improving education and training on substance use for social workers is essential (Sacco, Ting, Crouch, Emery, Moreland, Bright & DiClemente 2017). It means that social workers need to be well-equipped with knowledge and better-positioned to handle address substance use cases, immediately after obtaining their qualification.

Though social work graduate programmes do not offer substance use education as part of their curriculum, knowledge is absent on the various settings in which treatment will be provided (Wodarski 2020). For instance, counselling can be provided in various settings that include hospitals, drug treatment facilities and mental health clinics. The social work curriculum should diversify and provide various education on training that is related to such different environments. The training should be linked with substance use counselling, to allow the entry-level social workers to be adequately equipped when they start practising.

Lastly, a recommendation for social work training is that it should focus more on supervisor training. In this context, supervisors need to undergo relevant training to

support social workers on ways to deal with patients with substance use disorders. This should also enable them to track and encourage the further growth of interpersonal and relationship building skills of social workers (Dupper 2017). There is a gradual shift to a more holistic approach integrated treatment, social work training and curriculum should accommodate such knowledge and skills that will be relevant when providing treatment for substance use disorders and other co-occurring mental health disorders at the same time (Hanley, Bereket, Tuchman, More, Naegle, Kalet & Gourevitch 2018).

6.9 Recommendations for policy development

The current policies and strategies towards reducing substance use in South Africa seemingly continue to produce unexpected outcomes (Howell & Couzyn 2015). It has been stipulated by various sources, that the techniques adopted in prohibiting the use of illicit substances are not successfully eliminating the drug problem. Hence the suggestion in this context is that recommendations to improve policy for substance use should focus on human rights approach to the drug problem. This should also include decriminalising individual substance use in the context of specific boundaries to understand and address the drug problem in South Africa (Pereira & Scott 2017).

In South Africa, policies relating to substance use should constantly be reviewed and formulated according to the trends. The policies should always strategize how to limit the use of substances by starting and supporting programmes centred around action areas of harm reduction, demand reduction and supply reduction.

Harm reduction strategies seemingly have proved effective in other countries such as Ukraine, Israel, Canada, France, Netherlands (Bonny-Noach 2019). As much of the harm reduction strategies may still be controversial in Africa, South Africa must

at least consider employing the strategies in-depth, given how it might help in reducing the spread of infections related to substance use such as hepatitis C, STIs and HIV, overdose deaths and any deaths connected to substance use.

The integration of the South African economy with the global economy, made the country vulnerable to drug trafficking, which increased supplying of illicit drugs. Recommendations for policy development should take into consideration the current weakness of policies for drug prohibition (Csete, Kamarulzaman, Kazatchkine, Altice, Balicki, Buxton & Byre 2016). The priority should be on combating drug trafficking to ensure that there is a limited constant supply of illicit drugs into the country. As explained, earlier, one of the ‘’failures’’ of South Africa, relates to the fragile policy on combating the movement of illegal drugs into the country. South Africa must formulate new and stricter policies that make border controls tighter and enforce severe punishments on any culprits caught.

Combating drug trafficking is the foundation of substance use prevention policy, without stifling trafficking of illicit drugs, it will be difficult to improve policy for substance use prevention. However, for effective formulation and implementation of these policies, there should also be sound coordination between all essential Stakeholders such as the Department of Social Development, Non-Governmental organizations, Police(SAPS), communities, municipalities and other various levels of government.

It should be a priority that these stakeholders collaborate to collectively combat the use of substances in South Africa. The current approach is lethargic and stakeholders are usually isolated in the course of implementing policy, being isolated from other

stakeholders creates a deficit in terms of specific resources which could be filled when stakeholders combine and function collectively.

Furthermore, policy development and formulation is supported by research, although there might not be enough research in South Africa or current research to guide these. There should be more and diverse research conducted on substance use to avoid policies being implemented on little or unreliable information.

Quite a number of years have passed since some of the substance use-related Acts that have a direct bearing on policy were formulated or reviewed i.e. The Drugs and Drug Trafficking Act, No 140 of 1992 and Prevention of and Treatment for Substance Abuse Act, No 70 of 2008. The role of research should be to inform these on any new developments, changes and suggest more new ways to combat the social vice.

There is a definite need for more treatment centres in South Africa and this can be implemented if the policy is adequately and accurately informed.

6.10 Recommendations linked to the theoretical frameworks

The arguments of the relapse prevention model can be essential for recommendations on substance use addiction and efforts to implement recovery. However, to provide these recommendations, it is important to understand the basis and the main premises of the Relapse prevention theory (Cook 2016). Relapse prevention demonstrates that the drug user encounter high-risk conditions that mostly encourage a relapse (Witkiewitz & Marlatt 2011). High-risk conditions such as inadequate reaction to coping, diminished self-efficacy, perceived drug consequences pose a threat to the individual's sense of control and increased likelihood of recurrence (Hendershot, Witkiewitz, George & Marlatt 2011).

A core principle of the relapse prevention model posits that high-risk conditions sometimes act as the imminent triggers following abstinence of initial substance use. As shown by the model, an individual who has undertaken a transformation in behaviour, such as abstinence from alcohol, should begin to experience increased self-efficacy or mastery of his or her actions, which should develop as he or she continues. In this context therapy programmes and various treatment, approaches should have a clear understanding of these factors and implement informed strategies per individual. Such strategies include how to act and behave in specific situations that pose risks of relapsing.

Relapse prevention also should emphasize ensuring that every individual who receives treatment on addiction acquire such skills since there are essential with regards to coping in high-risk situations. Some individuals can cope in specific situations and are inherently able to cope, whilst others have a natural weakness. The role of treatment in this instance is ensuring each patient obtains skills and capacity to cope in diverse individuals.

Relapse prevention has specific essential strategies, for instance assessing the current motivation and willingness of the client to deal with specific high-risk circumstances and then helping the client develop more effective coping skills (Abdoli, Farnia, Salemi, Tatari, Juibari, Alikhani & Basanj 2019). Relevant behavioural or cognitive skills can include all strategies for dealing with specific high-risk circumstances. In this context, those who provide treatment and therapy should also include these suggestions.

Therapists/social workers should also adopt the self-efficacy strategy suggested by the relapse prevention model. Self-efficacy is a technique designed to enhance the

sense of competence of a patient and to be able to manage challenging situations without running out. One of the most critical efficacy-enhancing strategies that should be employed in relapse prevention, is the focus on communication between patient and therapist. Rather than a more traditional "top-down" partnership between the therapist and patient. This ensures that the patient has a voice with regards diagnosis of his self-behaviour. This is contrary to imposing treatment approaches and techniques within the individual. This method can be employed within treatment centres that use relapse prevention. Patients suffering from addiction should be provided with a platform to express their views on their condition. The most important recommendation here is that the patient and the therapist should collaborate to find a common effective solution for the patient`s condition.

6.11 Recommendations for future research

This study identified several areas for future research. The study aimed to evaluate the success of treatment programmes employed by residential rehabilitation centres. However, this study unambiguously established that there is also a need for improvement by the local city municipalities. More efforts need to be directed towards improving services and treatments that are offered at non-residential rehabilitation centres and that are also offered to the homeless in city centres. Therefore, the need to research the success of treatment programmes that are offered at inner-city, non-residential rehabilitation centres stridently remains.

This research stimulated much that lead to finding out that a multidisciplinary treatment approach is not only effective for inpatient rehabilitation centres but could be also for the outpatient rehabilitation centres in South Africa. As indicated in the conclusion of this study, the lack of individualised treatments and a multidisciplinary

approach seems to be on top amongst the many reasons why rehabilitation seem not to be as successful as expected or does not achieve the expected outcomes.

To have the research of this nature in the future, at the other type of rehabilitation centres (non-residential), would be useful and provide an opportunity to compare the results with this study. It will also provide an opportunity to evaluate and assess effective types of substance use rehabilitation. More to that studies of this same nature should not only be conducted in the Gauteng province, it should be extended to the other provinces of South Africa, as well as other surrounding countries of the Southern African region. This study was conducted at private-owned rehabilitation centres in the Gauteng province, it would be valuable as well if the same research would be conducted in state-owned rehabilitation centres, to deduce which sector is impactful, and perhaps make future decisions, plan or form useful policies based on that premise.

6.12 Limitation of the study

A limitation that was observed in this study was selection bias since it was the rehabilitation centres that selected the sample for the survey, interviews and focus group discussions. The possibility of biased information was there, especially with the interviews with the key informants, who were staff at the rehabilitation centre. In efforts to present their rehabilitation centres in a positive light, the responses might have been tailored to give such a picture. However, since the participants were informed of the anonymity, there might have been no bias, but it is important to note the possibility. Lastly, during the focus groups some participants rarely contributed anything and also it seemed the participants would have preferred individual interviews to discuss more and their personal experiences. The nature of this study

was sensitive hence the limitation of divulging in-depth information in a group setting was observed during and after conducting the focus group discussion.

6.13 Chapter Conclusion

Due to the transnational nature of substance use, there is still much that needs to be done globally and in South Africa particularly in exerting efforts to eliminate this social vice and problems associated with it. This chapter provided conclusions of the study and showed that treatment programmes offered at rehabilitation centres are effective in equipping individuals with addictive behaviours to somewhat extent. Recommendations on improving the effectiveness of treatment of individuals were given, although the study also found out that there are no quick fixes or one size fits all treatment approaches.

6.14 Thesis Conclusion

Tshitangano and Tosin (2016) note that substance use is a catalyst to social problems such as gender-based violence, dysfunctional homes, child abuse, health issues particularly mental health problems, crime, and all these negatively affect lives that could give a meaningful contribution to the society and the nation at large.

High percentages of deaths each year are linked to substance use and this has proved to be a global challenge for several decades. South Africa remains on top of the list amongst the countries which struggle to curb this social vice. To date, however, the South African response to the drug problem has been disjointed, fragmented, and uncoordinated (UNODCCP 1999). The South African Government above the laws in place to reduce both the supply and demand of illegal drugs, have to innovate and come up with more ways to improve programmes that aim to

rehabilitate and reduce the detriments caused by substance use at micro and macro levels.

The below were the objectives of the study:

A. To establish the nature of selected therapy programmes and examine the extent to which they are meeting their objectives.
B. To determine the extent to which selected therapy programmes assist in the prevention of substance use relapse.
C. To formulate recommendations and or interventions for improving the selected programmes used by rehabilitation centres to treat substance use relapses.

It can be concluded that all the objectives of the study were met.

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8 ADDENDUMS:

8.1 ETHICAL CLEARANCE

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ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	NYA011SCHA01
Project title:	**The perceived impact of selected therapy programmes on mitigating the relapses of patients with substance use disorders in Gauteng, South Africa.**
Nature of Project	Doctor of Philosophy: Social Work
Principal Researcher:	Nyasha Chatikobo
Supervisor:	Dr R. Nyanhoto
Co-supervisor:	Dr J. V. Rautenbach

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above. This certificate is valid for a year from the date of approval; thereafter, the Principal investigator/s will be expected to apply for renewal.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document;

- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

Special conditions: *Research that includes children as per the official regulations of the act must take the following into account:*
Note: The UREC is aware of the provisions of Department of Health Charter of Ethics in Health Research Principles, Processes and Structures; DOH 2015, signed by the Minister of Health in March 2015. This certificate is granted in terms of the provisions of the above-mentioned document.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected;
  - Relevant information has been withheld or misrepresented;
  - Regulatory changes of whatsoever nature so require;
  - The conditions contained in the Certificate have not been adhered to.
- Request access to any information or data at any time during the course or after completion of the project.
- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office.

The Ethics Committee wished you well in your research.

Yours sincerely

22/11/2018

Professor Pumla Dineo Gqola
Dean of Research

12 November 2018

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8.2 FOCUS GROUP DISCUSSION GUIDE

(Patients with substance use disorders from both rehabilitation centres)

Dear Participants

My name is Nyasha Chatikobo and I am the principal researcher on a topic focusing on the perceived success of selected therapy programmes on mitigating the relapses of patients with substance use disorders in Gauteng, South Africa. Our focus group will provide information that is relevant to this study and all of your input is valuable.

Participation is voluntary and confidential in this group, information collected will only be for research purposes. Ethical considerations guiding social work research will be adhered to. During the focus group sessions, I will take notes and place a recorder in order not to lose any information. This discussion will be for approximately 45 minutes and will be kept confidential. All participants welcome to ask questions and everyone is free to express themselves.

This academic research intends to gather data the perceived success of selected therapy programmes on mitigating the relapses of patients with substance use disorders in Gauteng, South Africa. This research maybe be published, no individualised information may be released. Participation is voluntary and your honest responses will improve the accuracy of the study.

Section One: Biographical information

1. Age	
2. Marital status	
3. Level of education	
4.Skills acquired	
5. Number of children	
6.Reason for relapsing	
7.Number of relapsed times	
8.Name of Rehabilitation centre	

Section Two: What are the factors that prompt patients with substance use disorders to relapse repeatedly?

- What factors lead to repeated relapses
- How the therapy programmes at rehabilitation centres help patient who relapse repeatedly?

Section Three: What are the various therapy programmes provided by rehabilitation centres in helping patients suffering from substance use disorders?

- What are the therapy programmes offered to you at the rehabilitation centre?
- How do the therapy programmes contribute in equipping patients to be able to prevent relapses?

- What are the different services that rehabilitation centres offer in empowering patients with substance use disorders?

Section Four: What are the operational gaps in the therapy programmes offered to patients with substance use disorders

- What are the challenges faced while delivering these therapy programmes?
- What challenges do patients face in getting assistance at the rehabilitation centres?
- What do you think can be done to improve the possible gaps within the therapy programmes offered by rehabilitation centres?

Section Four: How effective are the services of rehabilitation canters in empowering patients with substance use disorders

- Are the services provided effective in empowering patients with substance use disorders?
- Do you think the services you are receiving at the rehabilitation met your problems?
- What else can be done in order to meet all the needs of patients with substance use disorders?

Section Six: Suggestions

- What do you think can be done to improve the programmes run to help patients with substance use disorders?
- Do you think generally the substance use treatment programmes are effective?

8.3 DATA COLLECTION TOOL: INTERVIEW GUIDE WITH KEY INFORMANTS

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Interview Guide for key informants

Dear participant

A perfidious effect of multiple substance use relapse entails many of the addicts attending treatment centres with the hope of coming up with recovery resolutions, but instead the users get prompted to continue abusing the same substance as before, or even becoming worse addicts (Sanders, 2016). Perhaps the phenomenon raises many questions of whether these clients have fallen victim of poor treatment, ineffectiveness of the treatment interventions, or the wrong approach towards the treatment generally. The relapse of patients who have completed therapy programmes have been attributed to possible glitches in the rehabilitation treatment programmes, or mere failure to observe treatment protocols by the patients (Watson, 2013). Hence, this study seeks to evaluate the environment pertaining or underpinnings relapsing among those who have undergone treatment modalities in selected rehabilitation centres in Gauteng.

The researcher (Nyasha Chatikobo) is kindly requesting for your valuable input. This is academic research which is under the University of Fort Hare. This research will ensure there is no harm to you as a person or anyone related to you. During this interview, you will be requested to respond to a number of questions about your perception and experience of the rehabilitation programmes run for patients with substance use disorders. At most the interview will take 20-35 minutes. Your

voluntary contribution and valued input will be useful in this research. You have the right to withdraw from further participation without any questions asked. No information that may be linked to you may be published or be seen by a third party apart from my supervisors. In case of any questions please do not hesitate to contact me via this mobile phone number: 0785971832 200909466@ufh.ac.za

Section One

1. Age	
2. Gender	
3. Qualification	
4.Experience in years	
5. Marital status	
6.Name of Rehabilitation centre	

Section Two: What are the various therapy programmes offered by rehabilitation centre to patients

- What kind of therapy programmes do patients access in rehabilitation centres?
- To what extent does the rehabilitation centre met the objectives of these therapy programmes?
- How do these programmes assist the patients psychologically?
- How do these programmes assist the patients psychosocially?

- Are the therapy programmes adequately addressing the patient's relapse causes?
- Do you think the programmes provided are meeting the patient's individual needs?

Section Three: What are the operational gaps associated with rehabilitation centre in running the therapy programmes?

- What challenges do rehabilitation centre in running the therapy programmes often encounter?
- What do you think are the main operational gaps?
- How do these challenges faced affect the treatment of the patients?
- What do you think can be the best way to overcome such challenges?

Section Four: How effective are the rehabilitation centres therapy programmes

- What can you say concerning the effectiveness of the therapy programmes offered to patients with substance use disorders?
- Are the patients being equipped in any way? If so in what way?
- Do these treatment programmes meet the individual needs?
- Can you confidently say the therapy programmes offered to patients has greater chances of equipping them to prevent relapses?

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8.4 QUESTIONNAIRE (FOR THE PATIENTS FAMILY MEMBERS)

Letter to the respondent

Dear respondent,

I would like to evaluate the perceived success of selected therapy programmes on mitigating the relapses of patients with substance use disorders in Gauteng province.

This survey has a number of questions, kindly answer them precisely and as honestly as possible. The questions are about the factors prompting patients with substance use disorders to relapse repeatedly, the treatment programmes offered by rehabilitation centres, the effectiveness of these treatment programmes and the operational gaps within these treatment programmes.

Participation in this research is voluntary, and you have the right to withdraw from it any time. All responses and comments will be handled with confidentiality and anonymity. The questionnaire will take from about 15-20 minutes

Your participation in this research project would be greatly appreciated. There is no form of remuneration for completing this questionnaire. In case of any questions, my contact details are 200909466@ufh.ac.za , +27 78 5971 832

Nyasha Chatikobo Principal Researcher

Thank you

Please answer the following questions according to your knowledge by choosing the best appropriate answer that represent your opinion.

Section 1: Biographical data of the respondents.

Please tick in the box provided []

1. What is your gender? 1.Male [] 2. Female []

   1b. What gender is your family member? 1.Male [] 2. Female []

2. What is your age? 1 14-19 2. 20-30 [] 3.31-40 [] 4.41-50 []. 5.Above 50 []

   2b. What is your family member's age? 1 14-19 2. 20-30 [] 3.31-40 [] 4.41-50 []. 5.Above 50 []

3. What is your level of education? 1.Primary [] 2. Secondary []3. Tertiary []

   3b. What is your family member's level of education? 1.Primary [] 2. Secondary [] 2. Tertiary []

4. Where do you live?1. In Gauteng [] 2. Outside Gauteng []

   4b. Where does your family member live?1. In Gauteng [] 2. Outside Gauteng []

5 What is your employment status? 1. Employed [] 2. Unemployed []
   3. Self-employed []

   5b. What is your family member's employment status? 1. Employed [] 2 Unemployed [] 3. Self-employed []

6 Name of The Rehabilitation Centre son/daughter's? A [] B []

Section 2: Number of times the patients with substance use disorders have relapsed

(Please Tick the answer that best suits your opinion)

7. Do you know how many times your family member has relapsed? Yes [] No []

7b. If yes, how many times has your family member relapsed? 1-2times [] 3-5times [] 6-8times [] 9&more times []

8. After how long from the rehabilitation centre did your family member take to relapse? 1-2weeks [] 3-5weeks [] 6-8weeks [] 9weeks-12weeks [] 13weeks and more []

Section 3: To what extent do selected therapy programmes assist in the prevention of substance use relapses (Please tick the answer that best suits your opinion: strongly agree; agree; disagree; strongly disagree; not ware.

9. Substance use patients get equipped to prevent relapses through the treatment programs at the rehabilitation centres. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
10. The knowledge that the patient is equipped with at the rehabilitation centre adequate to assist them in handling threats in their recovery. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
11. It is lack of adequate knowledge that frequently cause substance use patients to relapse. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
12. The treatment programs equip the patients to anticipate all in recovery. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
13. Treatment programs at the rehabilitation centres do not fully equip the patients to handle temptations that lead to relapses. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
14. There are other causes of patients' relapses other than them not being equipped with knowledge. Strongly agree [] agree [] Disagree [] strongly Disagree [] Not aware []

15. The strength of family support system also contributes to factors that lead to relapses. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []

16. Most patients relapse because they have given up on their recovery Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []

17. How are the patients eating habits of the patient when discharged from the rehabilitation centre? Not sure [] Eat abnormal portions irregularly [] Eat abnormal portions regularly [] Often have no appetite [] Eat normal portions irregularly [] Eat normal portions regularly []

18. If at all how often does the patient exhibit violent dispositions? Not sure [] Once in a month [] Twice in a month [] Thrice in a month [] Several times in a month [] None at all []

19. How would you describe the patient's handling of finances since when not admitted at the rehabilitation centre? No finances to manage [] Somewhat disciplined [] Disciplined [] Highly Disciplined [] Neutral [] Somewhat not disciplined [] Not disciplined [] Not disciplined at all []

20. Which statement would you say best describes how the patient shares their emotions? Not sure [] Share emotions without being prompted [] Only share emotions when prompted [] Finds it difficult to share emotions [] Do not share emotions at all []

21. Which of following statements, would you say best described the patient? Not sure [] Often talk about their addiction positively [] Talks about addiction with regret and remorse [] Hardly talk about their past in addiction []

22. How best can you describe the patient's remorsefulness?

Very remorseful [] Remorseful [] Neutral [] Not remorseful [] Not remorseful at all []

The various psychosocial services offered by rehabilitation centres to the patients.

17. The rehabilitation centre offers adequate counselling to the patients. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
18. The therapeutic counselling sessions provided to the patients are much helpful in their recovery. Strongly agree [] Agree [] Disagree [] strongly disagree [] Not aware []
19. Substance use patients attend all aftercare sessions. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
20. Substance use patients belong to some support group. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
21. Substance use patients have their own individual care plan. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
22. Substance use patients access to skills development at the rehabilitation centres. Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
23. The skills development programmes are useful for financial independence and preventing relapses. Strongly agree [] Agree [] Disagree [] strongly disagree [] Not aware []
24. Do the patients apply skills they get from the rehabilitation centres when they get home? Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []
25. Are the after care services to the patients at the rehabilitation centres adequate? Strongly agree [] Agree [] Disagree [] Strongly disagree [] Not aware []

26. Are the services provided in the rehabilitation centres effective? Strongly agree [] Agree [] Disagree [] strongly disagree [] Not aware []

THANK YOU FOR YOUR PARTICIPATION

8.5 INFORMED CONSENT FORM

CONSENT FORM FOR PARTICIPATING IN THE STUDY

I,……..…(Name) consent to participate in the study of the perceived success of selected therapy programmes on mitigating the relapses of patients with substance use disorders in Gauteng, South Africa.

The use and purpose of this research have been explained to me. I understand I may withdraw at time with no consequences.

I understand that my name, details and responses will be kept anonymous at all costs and times

Name of the Participant…….

Signature …….

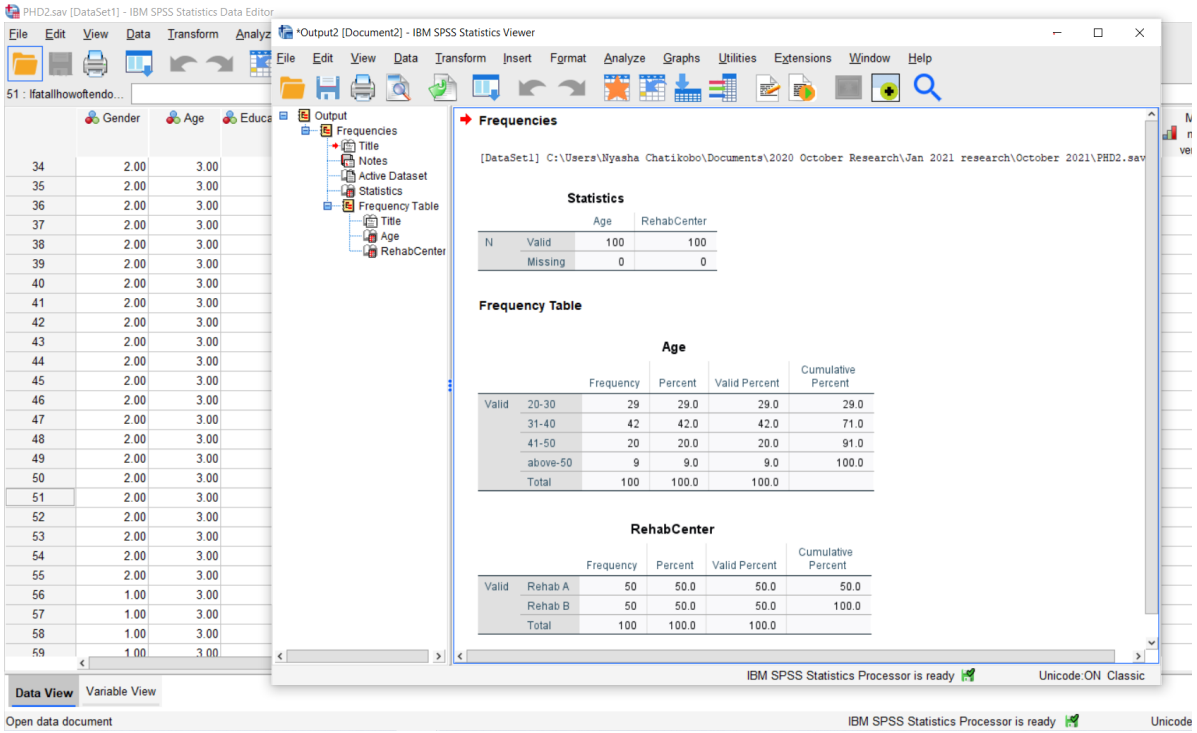
Date: …….

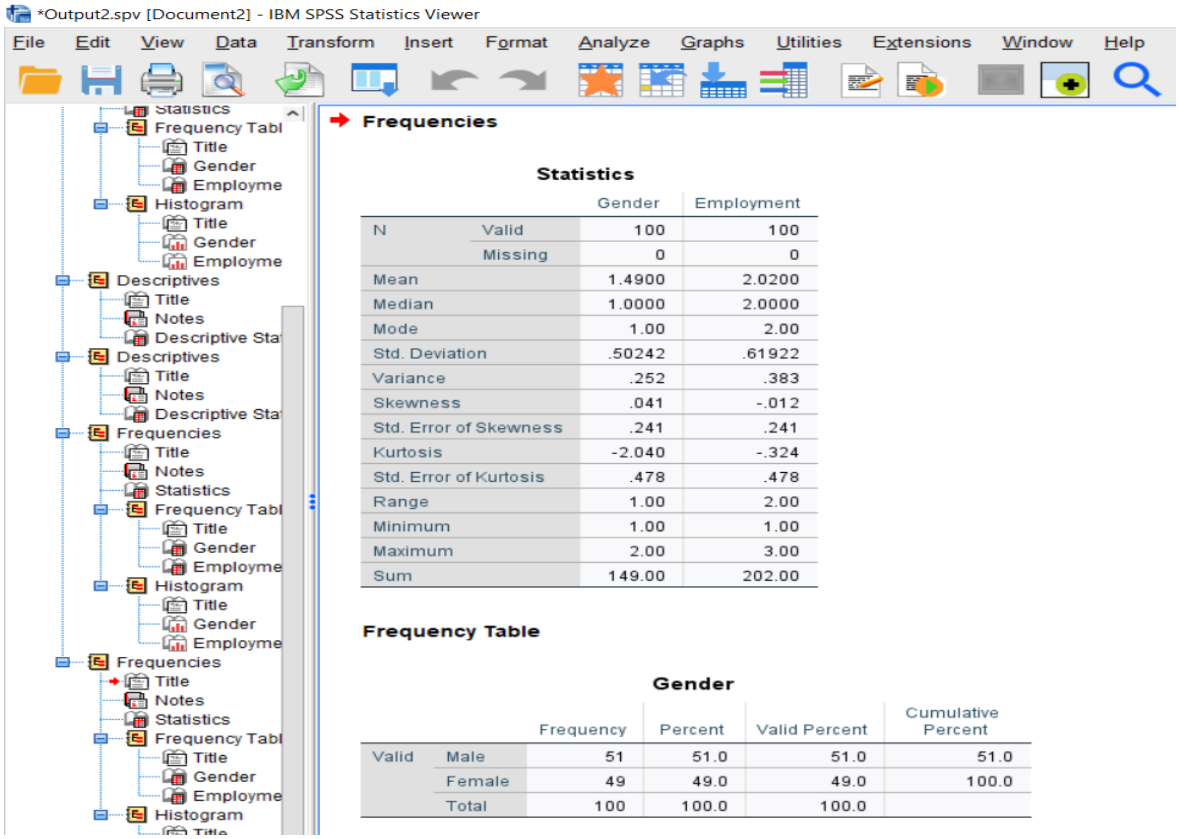
Name of Researcher …….

Signature …….

Date: …….

8.6 SPSS Snippets





8.7 Atlas Ti Snippets