

**DEVELOPMENT OF AFTERCARE GUIDELINES TO SUPPORT AND PREVENT
RELAPSE OF REHABILITATED SUBSTANCE ABUSERS IN MADIBENG SUB-
DISTRICT, NORTH WEST PROVINCE, SOUTH AFRICA**

by

MENKI ANNIDA MOEKETSI

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FACULTY OF HEALTH SCIENCES

Promoter: Prof M. Maluleke

Co-promoter: Dr N.S. Raliphaswa

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DECLARATION

I, Menki Annida Moeketsi, hereby declare that **The Development of Aftercare Guidelines to Support and Prevent Substance Abusers from Relapsing at Madibeng Sub-District, North West Province, South Africa**, submitted by me, for the Doctoral degree in nursing, has not been submitted previously for a degree at this or any other university, that it is my work in design and execution, and that all reference material contained therein has been duly acknowledged.

SIGNATURE:



DATE:04/08/2025

DEDICATION

This thesis is dedicated to my late parents, Mr Tladi Solomon Tsheola and Mrs Mmatapa Pauline Tsheola, for their encouragement to study until the attainment of a Doctoral degree. “O tsene sekolo ngwanaka. O seke wa tshwana le nna batho ba tsena ke ba ruta mosebetsi after that they are promoted to be my seniors, only because I don’t have qualifications, as my parents died while I was still small.” It is also dedicated to my children, Teboho and Kgotso, for their encouragement and support and for always wishing me luck with my studies.

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LIST OF ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
BRC	Beethoven Recovery Centre
GP	General Practitioner
NACADA	National Authority for the Campaign against Drug Abuse
PN	Professional Nurse
SOP	Standard Operating Procedures
TTO	Treatment Taken Out

ABSTRACT

Background

Substance abuse is a challenge that prevails across all ages globally today. Different drugs like cannabis, amphetamine, cocaine, methamphetamine, morphine, and alcohol are abused. Research studies have indicated an increase in relapse of rehabilitated substance abusers. Some studies revealed that 20% of admissions at rehabilitation centres are readmissions. This study aimed to develop guidelines to prevent rehabilitated substance abusers from relapsing in North West Province, South Africa.

Methodology

An interpretive paradigm informed the study; thus, a qualitative approach using explorative, descriptive, and contextual designs was adopted. This study was conducted at the Beethoven Rehabilitation Centre (BRC), North West Province, South Africa. The study population was relapsed rehabilitated substance abusers readmitted at BRC and professional nurses (PNs) caring for them. In this study, purposive sampling was used to select participants who met the selection criteria. Data were generated using unstructured, in-depth individual interviews with participants and analysed using Tesch's eight steps of analysis. Measures to ensure trustworthiness were employed. Ethical considerations were adhered to throughout the study. The six elements of practice theory; as well as the SWOT and BOEM action plan, informed the development of the guidelines. The developed guidelines were validated following Chinn and Kramer's five critical questions.

Results

Two themes and 10 sub-themes emerged from the analysed data, namely factors contributing to relapse, such as a lack of family support, physical abuse, financial abuse, peer pressure, defaulting, and hopelessness. Secondly, factors minimising relapse include motivation, positive support, medication, and aftercare. Finally, the

aftercare guidelines to prevent rehabilitated substance abusers from relapsing in North West Province, South Africa, were developed and validated.

Recommendations

It is recommended that further research be conducted to implement and evaluate the effectiveness of the developed guidelines to mitigate relapse of rehabilitated substance abusers in North West Province.

Keywords: abuse, aftercare, guideline, rehabilitation, relapse, substance

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CHAPTER 1

1.1 INTRODUCTION

This chapter presents the following content.; Background: Problem statement; Rationale; Significance of the study; Purpose; Research question; Objectives of the study; Definition of key concepts; Research paradigm; Theoretical framework; Roy's adaptation model; Dick off's six elements of practice theory; SWOT analysis approach; BOEM action plan; Chinn and Kramer criteria; Research methodology; Research approach; Research design; Study setting; Study population; Sampling method; Sampling size; Inclusion and Exclusion criteria; pre testing ,data collection, management and analysis methods. Measures to ensure trustworthiness; Ethical consideration; Development of guidelines and layout of chapters.

According to Webster (2019), abuse means using something for the wrong purpose in a way that is harmful or morally wrong. It may be the practice of drinking too much alcohol or taking illegal drugs. Substance abuse is a challenge that prevails across all ages globally today (Dada, Burnhams, Erasmus, Parry, Bhana, Timolf & Fourie 2016).

Different drugs like cannabis, amphetamine, cocaine, methamphetamine, morphine, and alcohol are abused. The South African Police (SAP) Data (2013) shows a 123% increase in drug-related crimes. A study by Swanepoel (2016) reveals that 20% of rehabilitation admissions are readmissions. These have negative effects on individuals, families, communities, and society at large. For example, the reason for more car accidents, assaults, sexually transmitted diseases, unplanned pregnancies, waste of academic opportunities, as well as damaged relationships with friends and families are caused by substance abuse and driving under the influence of alcohol. Substance abuse, driving under the influence of alcohol, and all related substance abuse can lead to criminal records that cannot be expunged (SAP Data, 2013).

Institutions have been established to rehabilitate abusers. In some instances, the abusers tend to relapse due to a lack of aftercare plans. Furthermore, aftercare plans need to be implemented after rehabilitation and discharge from rehabilitation institutions (Sue, Sue & Sue, 2010). Although treatment services and approaches

have been developed throughout the years to address substance abuse, there are still high levels of substance dependency and reoccurring relapses after being discharged from formal treatment services (Sue, Sue & Sue, 2010). Additionally, the South African National Council on Alcoholism and Drug Dependency (SANCA) provides patient services, outpatient treatment services, diversion programmes, and aftercare services, but there are still reports of relapse. Most drug abusers who enter the criminal justice system are from poverty-stricken and substance-abuse families. The abuse of substances can impact the brain's ability to function in the short-term as well as prevent proper growth and development in the long-term (Gorski, Kelly & Haven, 1993). Substance abuse sometimes leads to the destruction of relationships between the user, friends, and families (Juergens, 2019).

1.2 BACKGROUND

Substance abuse has been identified internationally and in South Africa as an escalating challenge that has harmful effects on the substance user and society (Voskuil, 2015). As a result, it is crucial to ensure that substance abusers do not relapse after rehabilitation because abusing substances has several negative effects on the life of the abuser, such as causing a disturbance in the psychological well-being of the abuser (Ngotwane, 2018). Many are admitted to the institution for alcohol and drug-induced psychosis and other substance-related mental health problems (Nursing Update, 2021). In some cases, it interferes with one's relationship with family; addiction could lead to theft. The researcher, at her workplace, Beethoven Recovery Centre (BRC), has observed that families of substance abusers frequently complain about the abuser stealing items from the house and selling them to support their addiction.

Furthermore, Swanepoel (2016) found that substance-related disorders are caused by using substances that affect the central nervous system. The use of psychoactive substances has significant social, occupational, psychological, and physical effects on the user. Marriages in which one or both partners abuse substances and relapse after rehabilitation are often characterised by fights, a lack of trust, financial problems, and emotional and physical child neglect. In many instances, such marriages end, and children tend to blame themselves for their parent's failed marriages (Nky, 2014). The

home environment in which parents use drugs or abuse alcohol may increase children's risk of future drug problems (National Institute of Drug Abuse, 2011).

The United Office on Drugs and Crime in Nigeria found that one in seven persons aged 15-64 years had used a drug (other than tobacco and alcohol) in the past year. The past year's prevalence of any drug use is estimated at 14.4% (range 14.0-14.8%), corresponding to 14.3 million people aged 15-64 years who had used a psychoactive substance in the past year for non-medical purposes (Adewole & Kale, 2018). Two-thirds of people who used drugs reported having serious problems because of their drug use, such as missing school or work, doing a poor job at work/school, or neglecting their family or children. In Nigeria, underfunding and the migration of potential researchers to the private sector in other countries have stunted what was once a growing knowledge base on alcohol issues (Adewole et al., 2018).

The physical, social, and economic well-being deteriorates, not only of substance abusers but the society at large (Sorsdahl, 2013). The cost of treating substance-related disorders places a strain on the allocation of financial resources to treat the problem. When relapse occurs in substance users who have already undergone rehabilitation, it increases the costs of treatment (Voskuil 2015). Hence, this study aimed to develop guidelines to prevent relapse.

Illegal drugs are available in Tanzania due to the transmission of drugs across the country's borders to nearby countries like Zambia, Malawi, Burundi, and Rwanda. There was a time when some of the regions were cultivating drugs like cannabis; some of those regions were Arusha, Tanga, and Mara. The government destroyed all the plantations and caught the people who were engaging in such activities of cultivating illegal drugs (Matowo, 2013). The government established a Drug Control Commission to deal with the prevention of drug abuse and trafficking. It also provides opportunities for non-governmental organisations to help prevent drug abuse in the community. The primary cause of drug abuse in Tanzania is the easy accessibility and availability of drugs among regions of the country. Year prevalence rates of cocaine use (0.7%) and opioid use (0.7%) rank third in the continent. High rates of substance use have also been reported among inpatient psychiatric populations in Tanzania and Kenya (Kambuga, 2016; Matowo, 2013).

Alcohol consumption per drinker in the World Health Organisation-defined Africa region, which includes South Africa, Ethiopia, Kenya, and other countries with similar health outcomes, compared with the United States, Canada, and Cuba. In most of sub-Saharan Africa, the beverage alcohol industry collaborates with governments to develop national alcohol policies. Ten policy documents from Botswana, Uganda, Malawi, and Lesotho drafted following the national symposia attended by government representatives and the beverage industry were nearly identical in structure and wording, reflecting the industry's dominance in policymaking across countries. A lack of public awareness also may thwart prevention efforts. In Nigeria, underfunding and the migration of potential researchers to the private sector or other countries have stunted what was once a growing knowledge base on alcohol issues (Kambuga, 2016).

As a resident of Gauteng, the researcher has observed that throughout South Africa, in townships, cities, and shopping malls, substance abusers are often seen begging for money, claiming to be looking for food, while in reality, they are seeking money to feed their addiction. Some of these individuals sleep on the pavements and no longer return home because their relationships with their families have been negatively affected by their substance abuse. Their physical, social, and economic well-being has deteriorated. There is a high rate of crime and poor economic development because of substance abuse. If they do not get money from begging, they resort to stealing and robbery; hence, the escalating crime in the country.

The effects of substance abuse are not different from social risk factors such as crime and violence. Substance-related crime in the Western Cape increased from 2004/2005 to 2013/2014 by 181%, from 30 432 to 85 463 drug-related crimes. The province's crime ratio of substance-related crimes per 100,000 is approximately three times higher than the national average. In the Western Cape, substance-related crimes account for 40% of crimes committed (Western Cape Government Community Safety, 2013; Department of Social Development Annual Performance Plan, 2013/2014; SAPS Crime Statistics, 2014). For the year 2023/2024, the number of drug-related crimes recorded by the South African Police reached 172,999 offenses, indicating an increase of 10,877 cases from the preceding year (SAPS Crime statistics, 2025).

The United Office on Drugs and Crime in Nigeria found that one in seven persons aged 15-64 years had used a drug (other than tobacco and alcohol) in the past year. The past year's prevalence of any drug use is estimated at 14.4% (range 14.0-14.8%), corresponding to 14.3 million people aged 15-64 years who had used a psychoactive substance in the past year for non-medical purposes (Adewole & Kale, 2018).

In Kenya, substance abuse is a pandemic that primarily affects youth. It destroys their future by causing school dropouts, poor health, negative financial records, social conflict, and criminal records (Njoki, 2013). The SAP Data (2013) shows a 123% increase in drug-related crimes from 2003/2004 to 2013; driving under the influence of alcohol increased by 148% in this period. Currently, the biological makeup, psychology, environmental setting, socio-economic circumstances, and culture are factors affecting substance dependency relapses by adult service users during aftercare and reintegration levels. Based on the Integrative Delivery Model (ISDM, 2006). There is a lack of research on how to account for these aspects.

When discussing substance abuse challenges at a seminar, Sorsdahl (2013) and Arun Kumar Manikandan (2024) from the University of Cape Town described several interventions but stated that a shortage of resources was a stumbling block to the possibility of scaling up these interventions and making them routinely available in all parts of the country. During the same discussion, questions arose about what happens to people after they have been treated at a facility and they return to their community. This question was posed by a pastor who pleaded for aftercare services, saying that often former drug users, severely damaged by years of substance abuse, come back into the community without any support. Hence the need for aftercare.

Many people relapse after successful detoxification and rehabilitation to the extent that the issue becomes a global public health concern. In general, 40-60% of people relapse after completing detoxification and rehabilitation treatments (Kabisa, Biracyaza & Umubyeni, 2021). According to family addiction specialists Lin and Aaron (2021), relapse rates for individuals who enter recovery from a drug or alcohol addiction are quite high. Some patients relapse within 30 days of leaving an inpatient drug and alcohol treatment centre, while some relapse within the first year. Swanepoel (2016) revealed that more than 20% of admissions into treatment centres are readmissions, with high incidences among young African adults.

Research by the National Authority for the Campaign against Drug Abuse (NACADA, 2013) stipulates that relapse is a key area that requires further investigation,

particularly among young people with the highest prevalence of drug abuse and relapse. A study conducted by Dada et al., (2013) in the Western Cape revealed that 72% of people who needed rehabilitation for substance abuse for the first time could not be admitted because the institution was occupied by readmissions who had been treated previously.

The literature cited above highlights relapse cases of substance abusers; however, not much pertains to the guidelines on aftercare. Considering the lack of information in the literature on the guidelines to address relapse, the researcher was prompted to develop guidelines on the prevention of rehabilitated substance abusers from relapsing to substance abuse following their completion of inpatient treatment. Much research has been conducted to discover the underlying causation factors for relapses. Many researchers have found that there is no single cause for experiencing relapses, but many.

Substance abuse is a global challenge, and the number appears to be the highest in countries near major substance production areas with a high income. Less evidence of substance abuse data is available for low-income countries. This is due to developed countries producing improved data while developing countries struggle with data collection (Degenhardt & Hall Armao, 2013); Arun Kumar Manikandan (2024).

. The North West Province is also facing a significant issue with alcohol and substance abuse. As an employee of BRC, the researcher found that approximately 75% of admissions for rehabilitation involve mine employees who are found to have substances in their system. At the mines, employees are tested before starting work to prevent unnecessary injuries as they operate dangerous tools.

The expectation is that if a person becomes addicted to substances, they should receive assistance at a rehabilitation centre. Upon discharge, the individual should be reintegrated into the community, with aftercare plans in place to provide support and help prevent relapse. Upon admission, the patient is to be assessed by a psychiatric nurse. Full socio-economic, cultural, family, and religious history to be obtained and recorded. The physical, emotional, and psychological status is important as well. Whereafter the multidisciplinary team, namely the physician, psychologist, social worker, occupational therapist, and psychiatrist, will all see the patient and plan their

treatment programme based on the findings. Blood and urine samples will also be sent to the laboratory for drug analysis. The programmes and duration of their stay will then be determined. During their stay at the rehabilitation centre, progress will be monitored, and aftercare is planned to be implemented from the day of discharge until the patient can withstand any temptation to substance abuse (Indianapolis Rehabilitation Hospital, 2020). In Ghana, Appiah, Boakye, Ndaa and Aziato (2017) revealed that relapse to alcohol and drug use is a global public health concern, especially in most low- and middle-income countries, with adverse physical, psychosocial, and economic implications.

1.3 PROBLEM STATEMENT

In South Africa, when substance abusers undergo rehabilitation, there should ideally be no relapses. Repeated treatment for the same condition not only impacts the country's economy but also affects the social well-being and health of its citizens. The researcher has observed at her workplace, BRC South Africa, that patients often return after relapsing into substance abuse following rehabilitation. According to the BRC's annual statistics (2018), there were 136 new admissions and 13 readmissions, representing 10% of relapsed cases. In 2019, the statistics indicated 172 new admissions, with 13 readmissions, accounting for 8% of relapsed cases. In 2020, there were 121 new patients and two readmissions, which amounted to 2% of readmissions. The 2021 BRC annual statistics reported 163 admissions and 15 readmissions. From 2018 to 2021, BRC admitted a total of 592 substance abusers, with 53 relapsing and being readmitted, which is 9%. This is concerning, as many patients return for admission multiple times a year. These statistics reveal a fluctuating pattern of relapse. There are no known guidelines regarding ongoing monitoring and prevention of relapse, that is, the gap that needs to be bridged. It is against this background that the researcher aimed to develop guidelines to support and prevent the relapse of rehabilitated substance abusers. Considering the lack of information in the literature on the guidelines to address relapse, the researcher was prompted to develop guidelines on the support and prevention of rehabilitated substance abusers from relapsing to substance abuse following their completion of inpatient treatment.

1.4 RATIONALE OF THE STUDY

Based on the body of knowledge, a scientific gap has been identified in the literature regarding the support and prevention of the relapse of substance abusers after rehabilitation. As a result, individuals continue to relapse after rehabilitation. The researcher identified two studies related to exploring the causes of relapse. However, these studies focused on different target groups related to specific drugs. They did not address the relapse of rehabilitated substance abusers in South Africa, North West Province (Mogoale, 2021; Swanepoel, 2014). This study was conducted with African adults and youth in the North West Province, South Africa. The primary issue under study is the relapse of rehabilitated substance abusers, which has detrimental effects on both the individuals affected and society as a whole.

Secondly, a study that was conducted in Cape Town by Ruschda (2015), where participants were rehabilitated, recommended that preventing the relapse of substance abusers' is significant and additional studies are required to explore the factors contributing to relapse in this patient population.

By undertaking this study, the causes of relapse were explored and described, and the aftercare support guidelines to prevent relapse were developed.

1.5 SIGNIFICANCE OF THE STUDY

The study might benefit the institution (BRC), the district, and the North West Province by potentially eliminating relapse among rehabilitated substance abusers. Additionally, the Department of Health may gain valuable insights to develop guidelines for preventing relapse. The study could also provide guidelines on aftercare for rehabilitated substance abusers, including the support they require. Families of substance abusers may benefit by gaining information on the type of support they should provide. Additionally, substance abusers may benefit from increased consistency in maintaining a substance-free life.

Moreover, the study could contribute to the body of knowledge on supporting substance abusers after inpatient rehabilitation and preventing relapse. It may also assist psychiatric staff by providing insights into improving access, engagement, monitoring, and ongoing

supportive care for individuals with substance use disorders (SUD) (The Surgeon General's Report on Alcohol, Drugs, and Health, 2016).

The findings of this study may also be used to guide aftercare services and, in turn, enhance the impact of such services (Nyambadza & Coetsee, 2017). The guidelines could potentially address the basic priority health and social ills of the North West Province, responding to the needs of people affected by substance abuse, be it individuals whose quality of life has deteriorated physically, socially, and economically. Families of substance abusers are negatively impacted by the deterioration in their loved ones' lives. If relapse can be prevented permanently, it would benefit the family, as having an abuser in the household is often associated with theft to support the addiction.

Finally, communities and society at large may also benefit from a reduction in crime and poverty caused by substance abuse, leading to increased safety. The guidelines could introduce ongoing activities that provide additional support to rehabilitated substance abusers. This may also alleviate the stress experienced by families of abusers, offering them relief from the challenges of having a family member struggling with addiction.

1.6 PURPOSE

Brink (2017) explains that the purpose of the study is to show the direction of the research project and indicate what the researcher plans to do. Therefore, the purpose of this study was to develop aftercare guidelines to support and prevent the relapse of rehabilitated substance abusers in the Madibeng sub-district, North West Province, South Africa.

1.7 RESEARCH QUESTIONS

The research questions are usually asked after formulating the problem statement (Brink, 2017). This study was guided by the following research questions:

- What are the experiences of readmitted substance abusers that led to their relapse?
- What are the perceptions of nurses regarding the causes of readmission of rehabilitated substance abusers?
- What aftercare support do rehabilitated substance abusers need?
- What aftercare guidelines can be developed to support and prevent relapse of rehabilitated substance abusers?
- How can the developed aftercare guidelines be validated?

1.8 OBJECTIVES

According to Polit and Beck (2017), objectives are the steps that will fulfil the purpose and are specific and measurable. In this study, the objectives were in two phases:

Phase one: Situational analysis

- To explore and describe the experiences of readmitted substance abusers that contributed to their relapse.
- To explore and describe the aftercare support needed by readmitted substance abusers.
- To explore and describe the perceptions of nurses regarding the causes of readmission of rehabilitated substance abusers.
- To determine the aftercare support guidelines to be developed.

Phase two: Development and validation

- To develop the aftercare guidelines to support and prevent the relapse of rehabilitated substance abusers in the North West Province.
- To validate the developed aftercare guidelines to support and prevent relapse of rehabilitated substance abusers in the North West Province.

1.9 DEFINITIONS OF KEY CONCEPTS

- **Abuse**

Abuse is the use of something for the wrong purpose in a way that is harmful or morally wrong. It may be the practice of drinking too much alcohol or taking illegal drugs (Webster, 2019). In this study, abuse referred to drinking too much alcohol and using illegal drugs in a way that may interfere with one's social life and physical well-being, including the use of illegal drugs, as mentioned in the first paragraph.

- **Aftercare**

This service is a means of continuing professional support to a service user after receiving formal treatment to “enable the individual to maintain sobriety, personal growth and to enhance self-reliance and proper social functioning in the least restrictive environment possible” (Prevention of and Treatment for Substance Abuse Act 70 of 2008). In this study, aftercare referred to continuous monitoring and support to rehabilitated substance abusers to help them maintain substance-free lives.

- **Guideline**

A guideline is a statement that aims to streamline processes according to a set routine or sound practice. An organisation may use guidelines to make activities predictable and of high quality. Guidelines are like rules (Modau, 2015). Here, the focus was on rules that need to be followed to prevent the relapse of rehabilitated substance abusers.

- **Relapse**

Relapse is the deterioration in a person's health status after treatment and improvement of the condition. Relapse can be caused by internal or external factors to the patient (Uys & Middleton, 2020). In this study, relapse referred to abusing substances after successful detoxification, individual and group therapy, and continuation of substance abuse even after treatment.

- **Rehabilitation**

Rehabilitation is the action of restoring someone to health or normal life through training and therapy after imprisonment, addiction, injury, or illness. It is the action of restoring someone to former privileges or reputation after a period of disfavour or restoring

something that has been damaged to its former condition (White Paper on Corrections, 2005). In this study, rehabilitation referred to the correction of substance abuse through individual and group therapy sessions by multi-disciplinary health professional services.

- **Support**

In this study, social support refers to any kind of support that one can get from parents, family, peer group, other close relatives, spouse, and community. Be it empathy, love, advice, guidance, or any practical assistance.

1.10 RESEARCH PARADIGM

A paradigm is a worldview or ideology. A paradigm implies the standards or criteria for assigning value or worth to both the processes and the procedures of the discipline, as well as to the methods of knowledge development within a discipline (Chinn & Kramer, 2011; Chimhundu, 2018). The purpose of this study was to develop the aftercare guidelines to support and prevent rehabilitated substance abusers from relapsing. This study draws from the three pillars of the research paradigm, namely ontology, epistemology, and methodology.

Pillar 1: Ontology/meta-theory is the study of the fundamental nature of reality and investigates the essence of the existence of reality. Brink and Van der Walt (2017) describe ontology as assumptions about reality (meta-theory). It examines if there is a single reality, multiple realities, or none at all. In this study, reality exists; it is multiple because there are diverse experiences of readmitted users regarding their relapse. Furthermore, there are a multitude of perceptions of nurses regarding the causes of readmissions. Finally, the users and nurses have various and diverse needs for support to prevent relapse.

Pillar 2: Epistemology is explained by Brink and Van der Walt (2017) as the study of knowledge about realities. How do we get to know the realities found in the ontology pillar? This study sought to explore and describe the experiences of readmitted substance abusers and what led to their relapse and explore and describe the perceptions of nurses regarding the causes of readmission of rehabilitated substance abusers. The experiences and perceptions can only be narrated in a personal capacity

and viewed through a person's cultural and specific environmental lenses. It is subjective and understood by persons experiencing it. Therefore, experiences and perceptions were explored and described through interviews.

Pillar 3: Methodology or methodological assumptions represent a specific functional approach (Botes, Nolte & Poggenpoel 2004), which implies that research should be functional and contribute to the body of knowledge and the improvement of quality of life to understanding the nature of reality (Brink & Van der Walt, 2017). It explains how knowledge will be gained. This study used a qualitative approach. Qualitative methods were appropriate to allow participants to narrate their personal experiences and perceptions regarding relapse. In-depth individual interviews were carried out to allow participants to articulate their day-to-day experiences that led to relapse. Participants also described the support needed to prevent relapse.

1.10.1 Research paradigm suitable for this study

The study was guided by the interpretivism/constructivism paradigm, as it believes in multiple realities that cannot be expressed in numbers but can be narrated subjectively in a qualitative approach. As insiders, readmitted substance users and nurses (study participants) are in the best position to understand realities within the aftercare and relapse. Each participant interpreted and constructed their different experiences/perceptions regarding the factors leading to relapse and the aftercare support needed to prevent relapse. Therefore, this study was conducted within the reality of those being studied through the constructivism paradigm.

1.11 THEORETICAL FRAMEWORK

The theoretical framework in a study is significant in guiding the argumentation, evidence generation, and conclusion process (Nkwake, 2013). This study was guided by the constructivist paradigm as the ontology has revealed multiple realities. Therefore, multiple theories were used to achieve the study purpose and multiple study objectives, which were applied in phases one and two.

- **Phase one**

In this phase of the study, the objectives were to explore and describe the experiences of substance users relating to relapse, as well as to explore and describe the perceptions of nurses regarding relapse. Therefore, two theories were adopted, which are discussed below:

- Roy's (2010) adaptation model
- Dickoff's (1968) six elements of practice theory

1.11.1 Roy's adaption model

The theory guiding this study is Roy's (2010) adaptation model, which discusses the human being under three assumptions: humans, environment, and health. It was relevant in this study because the assumptions focus on the people who abuse substances, how they think and feel, and their relationship with the environment (George, 2010). The assumptions are discussed below:

- **Humans as adaptive systems**

This area focused on human beings both as individuals and as groups from the point of view of shaping their activities. Any of these may be considered a human system, which the professional staff consider a holistic adaptive system (George, 2010). This study adopted a qualitative approach, which allowed rehabilitated readmitted substance abusers and nurses to narrate their aftercare experiences and perceptions that led to relapse and the aftercare support needed to prevent relapse.

- **Environment**

Roy (2010) defined the environment as all conditions, circumstances, and influences that surrounded and affected the development and behaviour of humans as adaptive systems (George, 2010). This study adopted a contextual design and used in-depth individual interviews to determine the perception and experiences within and around abusers and professional staff that affect the behaviour of abusers after rehabilitation and release from the institution.

- **Health**

Roy defined health as a state and a process of being and becoming an integrated and whole human being. As viewed from this perspective, rehabilitated abusers can be integrated into the community after rehabilitation with physical, emotional, or other changes (George, 2010). In this study, substance abusers are viewed as unhealthy due to their emotional changes and physical behaviours. Therefore, professional staff in the BRC promote health by promoting a healthy, adaptive, and addiction-free life.

1.11.2 Dickoff's six elements of practice theory

The six elements of practice theory outlined by Dickoff and Wiedenbach (1968) informed the theoretical framework for developing guidelines in this study. These are context, agents, recipients, procedure, dynamics and outcomes.

- **Phase two**

The findings from phase one formed the basis of phase two. Phase two was conceptualised in three theories, namely Dickoff et al., (1968) six elements of practice theory, SWOT analysis, BOEM action plan, and the methods described in the approaches by Chinn and Kramer (2013). These theories are applied and detailed in Chapters 6 and 7, respectively.

1.11.3 SWOT analysis approach

Bezuidenhout (2014) defines a SWOT analysis as a systematic analysis method that assesses and identifies strengths, weaknesses, opportunities, and threats. The internal (strengths and weaknesses) and external factors (opportunities and threats) within the SWOT analysis are important as they can positively and negatively influence relapse prevention. In this study, the application is detailed in Chapter 6.

1.11.4 BOEM action plan

The BOEM action plan was used to develop the aftercare guidelines to support and prevent relapse of rehabilitated substance users, which is described in detail in Chapter 6.

1.11.5 Chinn and Kramer's criteria

The developed aftercare guidelines to support and prevent relapse of rehabilitated substance users were validated using Chinn and Kramer's (2019) validation criteria, where the following critical questions were posed:

- How clear were the guidelines?
- How simple were the guidelines?
- How general were the guidelines?
- How accessible were the guidelines?
- How important were the guidelines?

A detailed discussion of Chinn and Kramer's critical questions is presented in Chapters 6 and 7.

1.12 RESEARCH METHODOLOGY

The study methods and the reasons they were selected are discussed in Chapter 3. The study was conducted in two phases. Phase one was the situational analysis, which adopted a qualitative approach. Phase two was the development and validation of guidelines to prevent rehabilitated substance abusers from relapsing.

1.13 RESEARCH APPROACH

This study used a qualitative approach whereby data were collected through in-depth individual interviews; sense was made of it and organised into themes that cut across the data source. The participants narrated the information, which helped provide information about what is important for preventing relapse. This study was inductive, and the researcher generally explored meanings and insights in each situation. This was in line with Roy's adaptation model (2010) and the six elements of practice theory (1968) during phase one of the study.

1.14 RESEARCH DESIGN

This study used three research design types, namely exploratory, descriptive, and contextual.

- **Exploratory**

Exploratory research is conducted when a researcher encounters an already known issue and has a description to ask why things are the way they are (De Vos, Strydom, Fourche & Delport, 2013). The study explored the aftercare needed to rehabilitate substance abusers and monitoring by professional staff as well as the support needed from families and the community through interviews and supported by the literature. Theories to guide the development of guidelines were explored. Rehabilitated substance abusers' perceptions regarding the prevention of relapse were also explored.

- **Descriptive**

A descriptive study seeks to draw a picture of a situation, person, or event or show how things are related to each other (Gray, 2009). The study allowed nurses caring for substance abusers to describe the support needed in the aftercare of rehabilitated substance abusers, which was also with rehabilitated substance abusers. The study described guidelines to prevent the relapse of rehabilitated substance abusers. The theory guiding the study was described, and guidelines were developed. Substance abusers also described their experience regarding the prevention of relapse.

- **Contextual**

Burns and Groove (2011) point out that contextual studies focus on specific events in naturalistic settings. Naturalistic settings are uncontrolled real-life situations or are referred to as field settings. The research was conducted on rehabilitated substance abusers. The focus was on the nursing staff caring for substance abusers and rehabilitated substance abusers; no other category of people was interviewed. The researcher never entertained other issues but focused only on the topic during interviews. Guidelines were developed only for rehabilitated substance abusers because they need to be permanently integrated into the community without relapse.

1.15 STUDY SETTING

According to Burns and Grove (2016), Brink (2017), and Polit and Beck (2017), a setting is a specific place, real-life situation, or environment where the data will be collected. The study was conducted in the North West Province, Madibeng sub-district, at BRC. Madibeng sub-district is divided into three townships, namely Letlhabile Damondsville and Elasrand, and 10 villages. Bethani and Jericho have a higher number of clients who have been admitted for rehabilitation. BRC is located in Brits Town, near Hartbeespoort Dam. The individuals utilising BRC services come from areas such as Brits, Rustenburg, Mafikeng, mines in the North West Province (including Marikana, Mooi-nooi, and Wonderkop), as well as Garankua, Mabopane, and Soshanguve in Gauteng Province. Due to the diverse ethnic groups residing in the area, Tswana is the primary language spoken, though other languages such as Xhosa, Zulu, Shona, and Tsonga are also common. English serves as the primary medium of communication. The population includes both educated and uneducated individuals, with the uneducated primarily consisting of mine workers from foreign countries.

1.16 STUDY POPULATION

Study population refers to a group of people the researcher may be interested in because they meet the criteria set by the researcher and have the needed knowledge and experience that the researcher may use in the research project (Burns & Grove, 2016; Brink, 2017). Therefore, this study population was substance abusers who were admitted to the BRC, including those from Gauteng. Nurses caring for substance abusers, whether qualified in psychiatric nursing or only experienced without psychiatric qualifications, were included in the study population. However, their consent was obtained before data collection.

1.17 SAMPLING METHOD

De Vos et al., (2017) and Brink (2017) define sampling as the process of choosing a group of individuals, occasions, behaviours, or other components to research. In this study, three sampling phases were done, namely sampling of the centre, sampling of

the rehabilitated substance abusers, and sampling of the nursing staff caring for abusers. The sampling methods used in this study are detailed in Chapter 3.

1.18 SAMPLE SIZE

Sample size refers to the number of participants that are examined in the research (Burns & Groove, 2011). The BRC has a maximum of 25 nurses who care for both male and female wards. The nurse participants from the BRC included some with psychiatric qualifications and others with experience but no formal qualifications. However, the actual number of participants who were included in the study was determined by data saturation. The number of rehabilitated substance abusers was also determined by data saturation; 11 rehabilitated substance abusers were envisaged to participate in the study.

Additionally, sample size refers to the number of participants examined in the research (Burns & Groove, 2011). The sample consisted of nine nurses and 11 substance users.

1.19 INCLUSION CRITERIA

The inclusion criteria consisted of rehabilitated substance abusers who were admitted to BRC, recorded in the admission register, and provided consent to participate in the study. To gather comprehensive information, nurses who cared for these substance abusers and gave consent were also included in the sample.

1.20 EXCLUSION CRITERIA

Exclusion criteria will be all rehabilitated substance abusers who do not appear in the admission register and nurses caring for substance abusers who did not give consent to participate in the study.

1.21 PLAN FOR DATA COLLECTION

Qualitative research collects data through in-depth individual interviews (Polit & Beck, 2014). Participants were interviewed individually using in-depth individual interviews.

1.21.1 Preparation

The researcher started the preparation of data collection by checking if the research question was clear and if the gadget was working properly. Management was contacted for permission to recruit participants. The researcher developed the information sheet and consent form. Furthermore, the researcher visited the BRC to recruit participants. When arriving at the BRC, permission to have a meeting with the nurses was requested from the CEO. During the meeting, the researcher introduced herself and the reason for the meeting. The researcher met the participants, gave them information on how the research would be conducted, and provided them with an information sheet.

Additionally, she explained the consent form to them, providing them with information that giving consent is voluntary and that they could withdraw from the study if they no longer wanted to continue. Information regarding the use of a tape recorder was given to the participants so they could switch it off if they no longer wanted to continue with the study. The researcher contacted the participants telephonically before scheduling an interview appointment. To minimise disruption to service delivery during data collection, the researcher scheduled interviews during participants' lunchtime, when they were free, or at a convenient time, depending on their availability and preference. Recruitment of substance abusers followed a similar process to that of the nurses. Those who did not have cell phones were contacted physically in their wards.

1.21.2 Data collection method

A research instrument is a device used to collect data in research studies (Brink, 2017). In this study, data were gathered through unstructured in-depth individual

interviews, and the researcher was interviewing participants face to face. One central open-ended question was asked during the interview, followed by probing questions:

For patients:

- *“May you kindly share your experiences regarding your relapse post-rehabilitation.”*
- *“Please share the support that you need after rehabilitation to maintain a substance-free life.”*

For nurses:

- *“As a nurse caring for readmitted substance users, what is your perception regarding relapse after rehabilitation?”*
- *“What aftercare guidelines can be developed to support and prevent relapse of rehabilitated substance abusers?”*

Effective communication skills were applied during interviews, and audio tape was used to record the interviews.

1.22 PLAN FOR DATA MANAGEMENT

The data collected were transcribed verbatim. The researcher and the supervisors should keep all transcripts and audio tapes safe and accessible. When reporting the data collected, the researcher did not use real names or participant identities; coding and pseudonyms were used. The following was considered throughout the interviews:

1.23 PLAN FOR DATA ANALYSIS

Data were analysed thematically following Braun and Clarke’s (2013) six phases of analysis.

Phase 1: Familiarise yourself with your data

After data collection, the researcher listened to the audio tape and transcribed and typed the interviews. The researcher reviewed the notes, memorised them, and identified possible shaded patterns.

Phase 2: Generating initial codes

After familiarising with the data and having a list of ideas from the data collected, the researcher started to generate the initial codes by classified phrases and words used by participants.

Phase 3: Searching for themes

This phase begins when all data have been initially coded, and the researcher has a long list of codes identified across the data set. Themes are created by identifying similarities in the data by aligning codes. The researcher aligned codes and looked for information with similar meanings to search for themes.

Phase 4: Reviewing themes

This phase involves the refinement of themes. During this phase, some themes will develop branches or sub-categories, whereas others that are not real themes collapse. In the end, the researcher had ideas on the different themes and how they fit together.

Phase 5: Defining and naming themes

The researcher defined and refined the themes. Moreover, the researcher used tables to convey the findings of the analysis. The tables were arranged according to the themes the researcher presented.

Phase 6: Producing the report

Phase 6 started when the researcher had a set of fully worked-out themes. The interpretation was based on the researcher's understanding of the topic with evidence from the literature.

1.24 PRE-TESTING

Pre-tests in qualitative research allow the researcher to test the research questions and gadgets used for recording to see if they are working, and the researcher

assesses whether she is able to use communication and probing skills. By testing the nature of the questions in an interviewing schedule, the researcher could make modifications with a view to quality interviewing during the main investigation. It also assists in estimating the time and cost involved during the interview (De Vos et al., 2014).

In this study, pre-testing was conducted using four participants who did not form part of the main study: two rehabilitated substance abusers and two nurses caring for substance abusers. This involved those who met the inclusion criteria. The researcher conducted interviews to assess whether the research question was clear to the participants and evaluated their approach to asking the question. Additionally, the researcher tested herself on how to accurately transcribe words from audio to verbatim. Pre-testing assists the researcher in eliminating challenges that may not have been foreseen when designing the research instrument (Cilliers, Davis & Bezuidenhout, 2021). Minimal activities like weekends will also be considered for easy access to the participants. However, the researcher ensured that participants were not compromising patients' care in favour of the interview.

1.25 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is the degree of confidence qualitative researcher has in their data and analyses. It is assessed using the criteria of credibility, transferability, dependability, conformability, and authenticity (Polit & Beck, 2014).

1.25.1 Credibility

Credibility refers to confidence in the truth of the data. According to Brink et al. (2014), confidence and truth can be established through the following techniques:

- **Prolonged engagement**

In this study, the researcher visited the participants to recruit them before the interview. After recruitment, those who were willing were asked to provide their phone numbers to the researcher so that the researcher could schedule an interview appointment. Maintaining contact with participants before data collection ensured familiarity

between the researcher and participants. The contact sessions between the participants and the researcher continued even after data collection for accuracy and clarity.

Data credibility was ensured by purposively selecting patients who were hospitalised for two weeks or more during the study. For all patients who are admitted, the focus is on managing the acute but transient psychotic symptoms with antipsychotics and sometimes, just a quiet and safe place is all that is needed. The symptoms are resolved in one week. To ensure that all participants are giving credible information, they should have been hospitalised for two weeks or more.

Member checks

Member checks were done through phone calls and by making appointments with the participants. The researcher and the participants verified the content of the interview throughout the interview process by deliberate probing and paraphrasing. Additionally, they were done during interviews by maintaining eye contact with the participants and using communication skills. They were also done after data collection by going back to the participants after the interview to check if what the participants said to the researcher was correct. This was done by playing the audio tape and reading transcripts. Lastly, participants were consulted after data analysis to verify the findings.

The period of interview differed from 45 minutes and more depending on the information that the participant wanted to give. The researcher listened to the participant patiently and recorded everything that the participant said.

1.25.2 Dependability

Dependability refers to the stability of the data over time and over conditions (Polit & Beck, 2014). In this study, dependability was maintained by reporting and consulting with the promoters. Data were coded and then waited for a certain period; the recorded information will be retained over time to ensure accuracy and consistency. The researcher allowed cross-checking of codes, also known as inter-coder agreement, by other qualitative research experts to see whether these experts would code the same as the researcher. It was also done by revisiting the participants to clarify what they said during the interviews.

1.25.3 Transferability

Transferability is the extent to which qualitative findings can be transferred to other settings or groups (Polit et al., 2014). In this study, transferability was ensured by a clear description of all research processes clearly from the research design, study setting, target population, sampling procedure, and data collection methods in such a way that even if other researchers repeat the same study, they will come up with the same results.

1.25.4 Confirmability

Confirmability refers to the potential for congruency of data in terms of accuracy, relevance, or meaning. Information that is recorded during interviews will be transcribed without any alteration. The researcher did not influence the responses and outcomes of the study. Confirmability was ensured by playing back the recorded audio during interviews and transcribing verbatim for verification.

1.26 ETHICAL CONSIDERATIONS

Ethics in research is a system of moral values that is concerned with the degree to which research procedures adhere to the professional, legal, and social obligations of the study participants (Polit et al., 2014). Ethics are designed to protect the rights of the participants and to define the responsibilities of the research. In this study, the following ethics were applied, which are detailed in Chapter 3: permission to conduct the study, informed consent, avoiding harm, confidentiality, anonymity, deception of the participants, and compliance with COVID-19 measures (ventilated by opening the windows).

1.27 PHASE TWO: DEVELOPMENT AND VALIDATION OF GUIDELINES

The guidelines were developed following the theoretical framework as outlined by Dickoff et al. (1968), and approaches by Chinn and Krammer (2011) and Walker and Avant (2011). These are detailed and applied in Chapter 5.

1.28 LAYOUT OF CHAPTERS

Chapter	Chapter outline	Chapter content
Chapter 1	Overview of the study	• Introduction, background of the study • Problem statement • Study purpose • Study objectives and research questions • Theoretical framework • Key theoretical and operational concepts, study paradigm • Ethical considerations
Chapter 2	Literature review	• Substance abuse • Causes of substance abuse • Effects of substance abuse • Substance use disorder • Rehabilitation programmes • Aftercare and aftercare programmes • Relapse statistics • Causes
Chapter 3	Methodology	Phase one: • Situational analysis • Study approach • Designs • Population • Setting • Sampling methods • Data collection and analysis • Ethical considerations • Measures to ensure trustworthiness
Chapter 4	Presentation of the study findings	

Chapter 5	Development of the guidelines	Phase two
Chapter 6	Validation of the developed guidelines	• Methodology • Theory • Validated guidelines
Chapter 7	Conclusion, recommendations, and limitations	

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Knowing the causes of relapse after rehabilitation of substance abusers can assist mental health professionals in offering better-individualised treatment and also predict which patients are likely to relapse and thus be able to provide individuals with effective and appropriate treatment (Ngwepe, 2016). Understanding alcohol and other drug use by recognising the contributions of the substance itself, including the individual who takes the substance and the environment where the substance is taken, is important in planning the prevention of relapse (Rickwood, Magor-Blatch, Mattick, Gruenert, Zavrou & Akers, 2008). This chapter discusses substance use disorder, substance abuse, causes of substance abuse, effects of substance abuse, rehabilitation programmes, aftercare, aftercare programmes, relapse statistics, and causes.

2.2 SUBSTANCE USE DISORDER

SUD is a treatable mental disorder that affects a person's brain and behaviour, leading to their inability to control their use of legal or illegal drugs, alcohol, or medications. Symptoms can be moderate to severe, with addiction being the most severe form. SUD

may also have other mental health disorders, and people with mental health disorders may also struggle with substance use. Other mental health disorders can include anxiety disorders, depression, attention-deficit hyperactivity disorder (ADHD), bipolar disorder, personality disorders, and schizophrenia, among others (NIDA, 2023).

It is a complex condition in which there is uncontrolled use of a substance despite harmful consequences. People with SUD have an intense focus on using a certain substance, such as alcohol, tobacco, or illicit drugs, to the point where the person's ability to function in day-to-day life becomes impaired. People keep using the substance even when they know it is causing or will cause problems. The most severe SUDs are sometimes called addictions. People with SUD may have distorted thinking and behaviours. Changes in the brain's structure and function are what cause people to have intense cravings, changes in personality, abnormal movements, and other behaviours. Brain imaging studies show changes in the areas of the brain that relate to judgment, decision-making, learning, memory, and behavioural control (Hector Colon-Rivera, CMRO, Alëna Balasanova, 2020).

Patients are diagnosed based on the primary substance that they misuse. People with substance use and behavioural addictions may be aware of their problem but not be able to stop even if they want and try to. The addiction may cause physical and psychological problems as well as interpersonal problems such as with family members and friends or at work. Alcohol and drug use is one of the leading causes of preventable illnesses and premature death globally (American Psychiatric Association, 2024). For a person with SUD to be treated successfully, one needs to be aware of their problem and accept the need for medical assistance.

2.3 SUBSTANCE ABUSE

Drug abuse is a disease that affects one's brain and behaviour. When addicted to drugs, one cannot resist the urge to use them, no matter how much harm the drugs may cause. The earlier one gets treatment for drug addiction (also called substance use disorder [SUD]), the more likely one is to avoid some of the more dire consequences of the disease (2004-2025 WebMD LLC).

Drug addiction isn't about just heroin, cocaine, or other illegal drugs. People can get addicted to alcohol, nicotine, sleep and anti-anxiety medications, and other legal substances. They can also get addicted to prescription or illegally obtained narcotic pain medications or opioids. This problem is at epidemic levels in the United States. In 2018, opioids played a role in two-thirds of all drug overdose deaths. At first, one may choose to take a drug because they like the way it makes them feel. They may think they can control how much and how often they use it. However, over time, drugs change how one's brain works. These physical changes can last a long time. They make people lose control and can lead to damaging behaviour (2005-2024 WebMD LLC).

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs (Scott,2023). One of the key impacts of illicit drug use on society is the negative health consequences experienced by its members. Drug use also puts a heavy financial burden on individuals, families, and society. A range of factors drives the evolution of the complex global illicit drug problem. Sociodemographic trends such as the population's gender, age, and the rate of urbanisation are influential. Cannabis remains the most widely used illicit substance in the African region. The highest prevalence and use increase are reported in West and Central Africa, with rates between 5.2% and 13.5% (Goldman,2023). Amphetamine-type stimulants (ATS) such as "ecstasy" and methamphetamine now rank as Africa's second most widely abused drug type. Other substances that were used by children and youth surveyed in Sierra Leone included benzodiazepines such as diazepam, chlorpromazine, and different inhalants, while 3.7% were injecting drugs. Injecting drugs carries a high risk of infection with bloodborne viruses such as HIV, Hepatitis B, and Hepatitis C, and the sharing of contaminated needles and syringes is an important mode of transmission for those viruses (WHO Regional Office for Africa, 2023).

Globally, the negative effects of psychoactive substance use can be seen. Thus, the WHO is committed to assisting countries in developing, organising, monitoring, and evaluating treatment and other services. The harmful use of alcohol results in 3.3 million deaths each year. On average, every person in the world aged 15 years or older drinks 6.2 litres of pure alcohol per year. Less than half the population (38.3%) drinks alcohol; this means that those who do drink consume, on average, 17 litres of pure alcohol annually. At least 15.3 million persons have drug use disorders. Injecting

drug use was reported in 148 countries, of which 120 reported HIV infection among this population (WHO Regional Office for Africa, 2023).

Substance-related problems represent significant health challenges, resulting in an increased interest in addiction treatment (Kvamme, Asplund & Bjerker, 2015). Some substances like alcohol are socially accepted in Western societies; however, they remain a major public health problem (Boekel, Brouwers, Weeghel & Garretsen, 2013). The problems that substance use arises are not only health problems, but other risk factors that result from substance use, like absenteeism at work, accidents, loss of productivity, and school dropout (Boekel, Brouwers, Weeghel & Garretsen, 2013).

2.4 CAUSES OF SUBSTANCE ABUSE

Causes of substance abuse are multiple factors, such as genetic vulnerability (heredity), environmental stressors, social pressure like peer pressure, physical and sexual abuse, early exposure to drugs, and stress. Additionally, parental guidance can significantly affect a person's likelihood of drug use and addiction. Development, genetic, and environmental factors interact with critical developmental stages in a person's life to affect addiction risk, individual personality characteristics, psychiatric problems, peer pressure, and physical and sexual abuse (NIDA, 2018).

It is known that addiction is a medical disorder that affects the brain and changes behaviour. Many biological and environmental risk factors have been identified, and scientists are beginning to search for genetic variations that contribute to the development and progression of the disorder. They use this knowledge to develop effective prevention and treatment approaches that reduce the toll drug use takes on individuals, families, and communities (NIDA, 2020).

It is believed that if healthcare professionals can embark on the health education of communities about the consequences of drug abuse, understanding the basics of addiction will empower people to make informed choices in their own lives, adopt science-based policies and programmes that reduce drug use and addiction in their communities, and support scientific research that improves the nation's well-being (NIDA, 2020).

2.5 EFFECTS OF SUBSTANCE ABUSE

According to Medical News Today (Peckham & Eski, 2023), using any drug can cause short-term physical effects. The following are examples of common drugs, their short-term physical effects, and potential health risks due to substance abuse:

- **Alcohol**

Alcohol may cause deficits in co-ordination, a quickened heartbeat (tachycardia), reddening of the skin or face, dizziness, nausea and vomiting, hypothermia, and coma.

- **Methamphetamines**

May cause increased wakefulness and physical activity, decreased appetite, increased breathing, increased or irregular heart rate, increased blood pressure (hypertension), and increased temperature (hyperthermia).

- **Cocaine**

It may cause narrowed blood vessels, enlarged pupils (dilatation), hyperthermia, heart rate, blood pressure, headache, abdominal pain and nausea, erratic and violent behaviour, stroke, seizure, and coma.

- **Benzodiazepines**

It is known to cause slurred speech, dizziness, problems with movement, slowed breathing, and lowered blood pressure (hypotension).

- **Heroin and other opioids**

Cause dry mouth, itching, nausea, vomiting, slowed breathing, and heart rate.

- **Tobacco and nicotine**

It causes increased blood pressure, breathing, heart rate, and risk of cancer, especially lung cancer, due to smoking. It is a trusted source of oral cancer due to chewing, chronic bronchitis, emphysema, heart disease, leukaemia, cataracts, and pneumonia.

In the USA, during 1992, treatment and prevention of alcohol and drug abuse problems and related health conditions were estimated to have cost almost \$28.8 billion in 1992, of which about \$18.8 billion was for alcohol problems, and \$9.9 billion was for drug abuse problems. Included in these estimates are the cost of speciality treatment, prevention, and support services for alcohol and drug abusers, as well as health care costs for treatment of the medical consequences of alcohol and drug abuse. The treatment of medical consequences includes inpatient and outpatient medical care, pharmaceuticals, and other services provided to persons suffering from conditions such as HIV/AIDS, infant drug or alcohol exposure, liver cirrhosis, and trauma, which are caused by irresponsible actions occurring when under the influence of substances. The findings from the analysis of healthcare costs are discussed below.

Treatment and prevention of alcohol and drug abuse disorders cost about \$9.0 billion, and training, research, and insurance administration for treatment and prevention services cost another \$1.0 billion. Treatment of the medical consequences of alcohol and drug abuse costs about \$18.8 billion. Medical consequences of alcohol and drug abuse resulted in costs of \$6.3 billion for hospitalisations and \$4.9 billion for other healthcare services. Special disease groups cost about \$6.5 billion, including about \$3.7 billion for drug abuse-related HIV/AIDS cases, \$462 million for Hepatitis, and \$407 million for drug-exposed newborns (NIDA, 2017).

Addiction in adults may cause mental conditions such as obsessive-compulsive disorder, depression, schizophrenia, anxiety, and tension. In youth, abuse of substances may cause depression, conduct problems, personality disorders, academic difficulties, suicidal tendencies, as well as attempts.

Besides personal and family distress, healthcare costs and loss of productivity place burdens on the community. Mental health problems, such as depression, developmental lags, apathy, withdrawal, and other psychosocial dysfunctions, are frequently linked to substance abuse among adolescents. A study by Appiah, Boakye, Ndaa and Aziato (2017) in Ghana revealed that relapse to alcohol and drug use is a global public health concern, especially in most low- and middle-income countries, with adverse physical, psychosocial, and economic implications.

There is an undeniable link between substance abuse and delinquency. Arrest, adjudication, and intervention by the juvenile justice system are eventual consequences for many youths engaged in alcohol and other drug use. It cannot be claimed that substance abuse causes delinquent behaviour or that delinquency causes alcohol and other drug use. However, the two behaviours are strongly correlated and often bring about school and family problems, involvement with negative peer groups, a lack of neighbourhood social controls, and physical or sexual abuse. Possession and use of alcohol and other drugs are illegal for all youth. Beyond that, however, there is strong evidence of an association between alcohol and other drug use and delinquent behaviour of juveniles. Substance abuse is associated with both violent and income-generating crimes by youth. This increases fear among community residents and the demand for juvenile and criminal justice services, thus increasing the burden on these resources. Gangs, drug trafficking, prostitution, and growing numbers of youth homicides are among the social and criminal justice problems often linked to adolescent substance abuse (Hawkins et al., 1987; Wilson & Howell, 1993).

In addition to personal adversities, the abuse of alcohol and other drugs by youth may result in family crises and jeopardise many aspects of family life, sometimes resulting in family dysfunction. Both siblings and parents are profoundly affected by alcohol- and drug-involved youth (Nowinski, 1990). Substance abuse can drain a family's financial and emotional resources (Bureau of Justice Statistics, 1992).

One of the main effects of drug abuse in South Africa is an increase in crime. Many individuals who are addicted to drugs resort to criminal activities to finance their addiction. This can lead to an increase in theft, burglary, and violent crime in communities where drug abuse is prevalent (Clearbrook Treatment Center, 2024).

Drug abuse can also affect employers and co-workers. One study found that an estimated 15% of the U.S. workforce, or 19.2 million workers, drank at the workplace or went to work while under the influence of alcohol. Although this doesn't reflect the daily rate of alcohol use at the workplace, it does suggest a problematic acceptance of drinking at work despite the risks. One study found that losses in revenue from decreased productivity due to substance abuse totalled \$510.8 billion in a year (Clearbrook Treatment Center, 2024).

When one person in a family begins to change their behaviour, the change will affect the entire family system. It is helpful to think of the family system as a mobile: when one part is in a hanging mobile move, this affects all parts of the mobile but in different ways, and each part adjusts to maintain a balance in the system. One consequence of this accommodation can be that various family members may inadvertently sabotage treatment with their own behaviours as they respond to the change in the individual using substances. For example, if an adult son tries to get sober and his retired father feels as if he has lost his “drinking buddy,” he might express to his son that he can have “just a couple of beers at the game.” This will put pressure on the son to continue his use so as not to disappoint his father. These behaviours can be seen as an attempt to maintain the comfortable equilibrium of the system because as one person changes, it upsets the equilibrium of the whole family system, including extended family relationships. Family therapy can be a useful intervention where the therapist can assist and support the son in setting limits with the father saying he does not want to drink at all and suggesting alternative non-drinking-related activities. Individual therapy can be used with the son to affirm his decision to remain sober and reinforce the importance of his establishing his own identity as a non-drinking person (Laura Lander, Janie Howsare & Marilyn Byrne, 2013).

Although active substance abuse can impair attachment and healthy modelling for affect regulation, sometimes the consequences of severe and ongoing substance abuse on the part of a parent can result in parent and child separation. This separation could be because of parental incarceration, long-term treatment, or an intervention on the part of child protective services that removes the child from an unsafe or high-risk home environment and places them in an out-of-home placement such as foster care, relative placement, or a group or residential home (Jaudes & Edwo, 1997).

2.6 REHABILITATION PROGRAMMES

Rehabilitation is the process of helping an individual achieve the highest level of function, independence, and quality of life possible. It does not reverse or undo the damage caused by disease, trauma or substance abuse, but helps restore optimal health, functioning, and well-being of the individual (WHO, 2024).

The addiction and recovery process differ based on factors such as how severe a person's addiction is, whether they have a co-occurring disorder like bipolar or depression, their medical history, support system, and more. Generally, a person who completes an addiction rehab programme may have gone through the following during the rehabilitation process: the addiction treatment process, evaluation, detox, inpatient and/or outpatient rehab, and aftercare services (Spectrum Health Lakeland, 2024).

The plan includes all the multidisciplinary health programmes, namely psychological, social work, occupational, and psychiatric. Continuous progress monitoring to determine the patient's readiness for integration with the community is also part of rehabilitation.

Rehabilitation programmes are designed to treat a person's basic medical problems and prevent complications, treat the disability and improve functioning, alter the environment and provide health education to the patient and family, enabling them to adapt to a new lifestyle. Patients undergoing rehabilitation are assisted in regaining basic skills such as:

Self-care skills, including activities of daily living (ADLs) like feeding, grooming, bathing, dressing, toileting, and sexual function. Physical care, including nutritional needs, medication, and skin care. Family support involves assistance with adapting to lifestyle changes, financial concerns, and discharge planning. Psychological counselling involves identifying problems and solutions with thinking, behavioural, and emotional issues. Pain management includes medications and alternative methods for managing pain. Vocational training focuses on developing work-related skills and socialisation abilities, such as interacting with others at home and in the community. Cognitive skills encompass areas like memory, concentration, judgement, problem-solving, and organisational abilities. Communication skills involve speech, writing, and alternative methods of communication. Respiratory care includes ventilator care, if needed, as well as breathing treatments and exercises to enhance lung function. Mobility skills cover walking, transfers, and self-propelling a wheelchair. Education involves providing patient and family education and training on the condition, medical care, and adaptive techniques (Spectrum Health Lakeland, 2024).

2.7 AFTERCARE AND AFTERCARE PROGRAMMES

Aftercare refers to the care, treatment, help, or supervision given to persons discharged from an institution (such as a hospital or correctional institution). In this study, the focus is on rehabilitated substance abusers. Substance-abusing patients need to participate in continuing care interventions, also known as “step-down care” or “aftercare,” following an initial phase of treatment. Continuing care treatment might be improved by emphasising addressing co-occurring problems and identifying and strengthening patients’ skills, interests, and talents. However, additional research would be needed to evaluate the impact of these modifications (McKay, 2021).

According to Elias (2016), rehabilitated substance abusers can benefit a lot from aftercare programmes; for example, those experiencing rejection by families or communities will experience a sense of belonging and acceptance in aftercare from their relations with other group members. They will also experience support and encouragement that positively contribute to their recovery. They will appreciate the continued sense of structure experienced in aftercare and develop the ability to cope with challenging relationships, convenience, and accessibility.

Aftercare and sober living programmes promote self-efficacy, coping skills, and relapse prevention. Effective drug and alcohol rehabilitation creates healthy and sustainable habits. Although the resulting changes in body, mind, and spirit can be profound, the person is still vulnerable to temptation and relapse in the early stages of recovery. Aftercare services help one maintain the coping skills they learnt in rehab so they can continue to build a healthy, fulfilling life after inpatient treatment from a recovery programme (Hull, 2022).

Drug or alcohol use is common, even for individuals who are dedicated to recovery. Studies show that the return to drug and alcohol use rates among adults and teenagers who have completed a rehabilitation programme are as high as 80%. Whether one is struggling with alcoholism, prescription drug abuse, cannabis use, or an eating disorder, studies show that recurrence is a common symptom of addictive behaviour. In the period after rehab, aftercare services provide valuable support to help one stay committed to their recovery goals and make sober living a reality (Wandler, 2022).

The transition from rehabilitation back to life in the community is one of the most vulnerable periods for a person in recovery. Sober living homes, or halfway houses, provide a secure, stable environment where rehabilitated substance abusers can continue to practice their coping skills in a drug- and alcohol-free setting. Sober living homes usually have strict rules, such as no substance abuse, mandatory house meetings, regular drug screening, and participation in household chores (Hull, 2022).

Many comprehensive rehabilitation programmes offer alumni organisations for their former patients. These organisations allow one to stay in touch with their treatment team and nurture the strong bonds they make in rehab. Membership in a lifelong alumni organisation can motivate one to keep up with their recovery goals long after they complete their programme (Jackson & Sartor, 2016).

Most communities have mutual support recovery groups where people in recovery can meet to share their experiences and learn new coping strategies. For those seeking more secular programmes, alternatives like Smart Recovery are available. Many communities' mental health centres offer additional groups and classes for individuals seeking a support system after rehabilitation (NIDA, 2017).

For many patients undergoing drug and alcohol rehab, recovery begins in an intensive inpatient programme or a residential facility. These structured environments provide 24-hour monitoring and supervision, making it easier to avoid stress as one focuses on detoxifying and healing their body. After completing a residential or inpatient programme, one's treatment team may recommend transferring them to a more flexible, less structured outpatient recovery centre. In an outpatient programme, they can continue to receive scheduled services like counselling, group support, and medication management while living and working in their community.

2.8 RELAPSE STATISTICS AND CAUSES

Relapse is defined as the recurrence of substance abuse after a period of abstinence. It is important to understand that relapse is not a sign of weakness or lack of willpower. Addiction is a complex disease that affects the brain, and relapse can be a natural part of the recovery process for many individuals (Relevance Recovery, 2024).

Like many chronic conditions, e.g., diabetes or heart disease, addiction can be treated, but it cannot be cured. For this reason, addiction is a struggle that many will face for the rest of their lives to varying degrees. While some people may complete an addiction treatment programme and remain sober throughout their lives, others will experience one or more relapses as they navigate the challenges that accompany lasting sobriety. Drug or alcohol use disorders are considered chronic relapsing conditions because many people will inevitably relapse at some point. There are many contributing factors to relapse, including the severity of addiction, the substance used, and the environment (Relevance Recovery, 2024). Relapse rates for rehabilitated substance abusers are high. Studies reflect that approximately 40–60% of rehabilitated substance abusers relapse within 30 days of leaving an inpatient drug and alcohol centre and 85% within the first 12 months (NIDA, 2000).

2.9 AFTERCARE PROGRAMMES

According to the National Institute on Drug Abuse (NIDA) (2007), aftercare programmes are services that help recovering drug-dependent persons adapt to everyday community life after completing earlier phases of treatment and rehabilitation. They proved to be an important component of effective treatment for substance abuse disorder, mostly for those individuals with greater problems of addiction. The research literature on continuing care for alcohol and drug abuse disorder has supported the efficacy of continuing care for both adolescents and adults. Reviews find relatively small effects when results from individual studies are combined. However, continuing care for a longer duration that includes more active efforts to keep patients engaged may produce more consistently positive results. Moreover, patients at higher risk for relapse may benefit to a greater degree from continuing care. Approaches for the provision of continuing care show promise. These include incentives for abstinence and automated mobile health interventions to augment more conventional counselor-delivered interventions. Primary care can be used to provide medications for opioid and alcohol use disorders over extended periods. However, more research is needed to determine the optimal mix of behavioural treatments and other psychosocial services in this setting. Regardless of the intervention selected for use, the status of most patients will change over time, and

interventions need to include provisions to assess patients regularly and to change or adapt treatment when warranted (NIDA, 2007).

According to the NIDA (2007), people take drugs for various reasons. Firstly, people take drugs because they want to feel good. Drugs are known to produce intense feelings of pleasure. The problem with people engaging in drug taking to make them feel good is that at first, they see it as a positive thing and they have the belief that they can control their use, but soon it becomes part of their lives, and they always need to take the drug in order feel normal (NIDA, 2007).

Some people who suffer from social anxiety, stress-related disorders, and depression start using drugs in an attempt to lessen feelings of distress. Some feel that they must have some kind of chemical enhancement for them to do well in their athletic or cognitive performance, and because of that, they can end up engaging in drug abuse. Sometimes, curiosity is the fact that other people are doing it. Here, adolescents are the ones who are primarily vulnerable because things like peer pressure play a role, and they are also more likely to engage in thrilling and daring behaviours (NIDA, 2007).

The therapist working with the relapsed substance abuser needs to start by assessing the environmental and emotional aspects of the problem that have a possibility of being associated with relapse. After the assessment, the individual's responses to these problems will be analysed, and the lifestyle factors that increase the individual's exposure to high-risk situations will be examined (Larimer, Palmer & Marlatt, 1999). In this case, the role that the therapist plays is to help the individuals identify their reasons for using the substance and also for wanting to stop using it (Jackson, 2014).

2.10 DETAILED AFTERCARE ARRANGEMENTS BEFORE DISCHARGE

Discharge planning WHO (2024), is an interdisciplinary approach to continuity of care; it is a process that includes identification, assessment, goal setting, planning, implementation, co-ordination, and evaluation, and is the quality link between hospitals, community-based services, non-government organisations, and carers.

Before starting an aftercare programme, the therapist must decide whether to 'own' the aftercare programme or 'outsource' it. Set up an 'Aftercare Team' with one or more

counsellors, a manager or member of the treatment centre's Board, and a recovering addict counsellor. The Aftercare Team will carry out the planning, implementation, and development of the aftercare programme, and plan client-by-client individualised aftercare (Jackson, 2014).

As the patients' time in treatment comes to an end, they will likely meet with therapists, counsellors, or case managers who will help them set up an aftercare plan. They can also work with an outside therapist or addiction professional to devise a plan. When creating an aftercare plan, the therapist will help them consider their particular situation, including whether they will need to find housing, employment, or continued treatment. Their plan will also depend on how far along they are in the recovery and how often or long they may need care. Discharge planning is an interdisciplinary approach to the continuity of care; it is a process that includes identification, assessment, goal setting, planning, implementation, co-ordination, and evaluation. It is the quality link between hospitals, community-based services, non-government organisations, and carers (Shenton, 2004).

Once one is aware of their needs, they can work with a therapist to find resources in their local community and online that can help them address these areas. For example, finding a sober living facility will be an important component of their plan if they lack sober housing. Moreover, the duration of their aftercare plan will be based on their needs. Some people are in aftercare for weeks or months, others for a year or more. Most programmes recommend that a person stay actively engaged in follow-up or aftercare for at least one year, and adolescents may need follow-up care for longer periods. As their needs and goals change, one can also continue to modify their aftercare plan.

Developing an aftercare plan in early recovery can help prevent relapse by supporting one and allowing them to continue to work on issues surrounding their addiction. Once they feel established in their sobriety, they can also begin to give back to others who are newly sober (American Addiction Center, 2023).

Based on the aftercare issues outlined, the programme staff should formulate a set of client goals. These should be aligned with the recovery model used in the treatment and rehabilitation services. Well-defined goals provide a focus for both the client and

the staff and also set criteria and standards for client entry into and completion of aftercare (Hustard et al., 2010).

2.11 AN INDIVIDUALISED AFTERCARE PROGRAMME

Several components can comprise a substance abuse aftercare and intervention programme. The following components are hallmarks of quality substance abuse aftercare programmes (Chassin, 2003):

Ongoing counselling can be utilised to support recovering substance abusers in identifying the underlying mechanisms for their addictions. These sessions are typically done in a group setting, but individual sessions can be available in unique circumstances. The frequency of these counselling sessions is greatest when the individual has just left rehabilitation and gradually tapers off over time. Depending on the situation, an aftercare programme may also include drop-in counselling or crisis counselling options (Ellis, 2017).

There is a tremendous variation among addiction aftercare programmes, but effective treatments share a common philosophy that the best treatments account for the entire person and all their needs. Based on this treatment principle, the best aftercare programmes offer comprehensive services that address the individual's physical and mental health, housing, finances, relationships, and more.

This system is based on the understanding that an imbalance with any of these components could lead to increased stress and a greater chance of relapse. If aftercare only focuses on one area, it may not address the root of the greater issue.

For example, Substance Abuse and Mental Health Services (SAMHSA, 2023) reports that approximately 7.7 million adults struggle with a co-occurring substance abuse disorder and some form of mental illness. By only treating one condition, there is an opportunity for the co-occurring issue to worsen, which may lead to relapse or other unwanted consequences in the future. The best addiction aftercare will take a comprehensive approach to treatment and be tailored to individual needs. Relapse prevention specialists Coll, Dumas and Haustveit (2010) identify the combination of biological, psychological and social limitations as distant and destructive patterns of

thoughts and behaviour. An individualised treatment approach would seek to locate these limitations and establish the thinking patterns that immediately precede the drinking episode. Studies have found that the utilisation of outpatient mental health aftercare following episodes of acute inpatient substance abuse treatment results in better outcomes (Walker, Donovan, Kivlahan & O'Leary, 1983 as cited in Schmitt, Phibbs & Piette, 2003). Active involvement in aftercare is also associated with reduced readmission rates (Peterson, Swindle, Phibbs, Recine & Moos, 1994 as cited in Schmitt et al., 2003).

2.12 PEER SUPPORT

According to Tracy and Wallace (2016), peer support can be defined as the process of giving and receiving non-professional, non-clinical assistance from individuals with similar conditions or circumstances to achieve long-term recovery from psychiatric, alcohol, or other drug-related problems. Recently, there has been a significant increase in the adoption of alternative forms of peer support services to assist recovery from SUDs; however, peer support has often not been separated as a formalised intervention component and tested, which makes it difficult to determine its effects. Peer support groups included in addiction treatment show much promise; however, the limited data relevant to this topic diminishes the ability to draw definitive conclusions. More research is needed in this area to further expand on this important line of research.

2.13 FAMILY SUPPORT

Researchers and treatment providers need to increase their recognition of the role that family and family functioning have in understanding the incidence and impact of substance abuse. Substance abuse is identified as a family problem by exploring its occurrence within families as well as its effects on marital relationships, family violence, and child abuse and neglect. The impact of substance abuse on the roles of spouses and parents is examined, as is the effect of substance abuse on children at various developmental stages. The role of the family as a participant in active substance abuse, as well as a valuable treatment resource, is also explored. Studies

present recommendations for increasing the focus on family in substance abuse research (Kenneth, Gruber PhD. Melissa Floyd Taylor PhD & LCSW, 2021).

In South Africa, studies were conducted on the effects of substance abuse on family well-being when the substance user is an adolescent. One particular study conducted on the infamous Cape Flats focused on the experiences of the adolescent's substance abuse (Swartbooi, Citation, 2013). Likewise, the current study also focuses on Mitchell's Plain in the Cape Flats because of its significant levels of substance abuse. The Cape Flats is regarded as a high-risk area with high crime rates and associated gang-related activities (Dolley, Citation, 2018; Dziewanski, Citation, 2020; Pinnock, Citation, 2016). The qualitative study by Asante and Lentoer (Citation, 2017) focused on the use of crystal methamphetamine widely used by coloured youth and where the participants were also mothers of users.

2.14 FAMILY INVOLVEMENT

Zimic and Jackic (2012) aver that the impact that substance abuse has on the family and the individual family members merits attention. Lander et al., (Citation, 2013) maintain that family members are affected by the individual's substance abuse; however, each individual is affected differently together with, but not limited to, having unmet developmental needs, impaired attachment, economic hardship, legal problems, emotional distress and sometimes violence being perpetrated. How a family copes with or manages the addiction issue has a profound effect on the way others experience the problem, as well as the course and severity of the problem.

The family remains the primary source of attachment, nurturing, and socialisation for individuals. According to Templeton et al. (Citation, 2007), as the course of substance abuse progresses, the emotional responses of family members are worsened in families where substance abuse is prevalent. Families tend to experience considerable stress-related difficulties, including insomnia, anxiety and depression. Orford et al., (Citation, 2010) further contend that isolation and suicidal ideation, betrayal, and resentment from family members are present. Substance abuse is regarded as an illness of the entire family, not just the substance abuser but the other family members as well. Thus, substance abuse is viewed as a 'family disease' that affects most, if not all, family members (Klostermann & O'Farrell, Citation 2013). In a

substance-affected family, functional family roles are often missing or distorted (Gruber & Taylor, Citation, 2006). According to Vernig (Citation, 2011), members of the family not only experience the effects of substance abuse, but also play an active role in supporting this pattern of behaviour.

In 2007, South Africans were transfixed by the unfolding true story of Ellen Pakkies, who strangled her 20-year-old son, who was addicted to methamphetamine (Pieterse, Citation, 2019; Walker, Citation, 2018). She related how she and her husband had been abused by their son, how he constantly stole their possessions and used violence or threats against them – all to extort money to buy drugs. Although the event might seem astonishing that a mother might kill her son, Walker (Citation, 2018) contends two underlying factors: the difficulty of living with a substance abuser and the fact that any person can be pushed beyond their limits. For Pieterse (Citation, 2019), the Ellen Pakkies story illuminates the utter vulnerability of family amid substance abuse and the lack of protection and support from community and social services.

It is a complex challenge for any parent to acknowledge or deal with their child's substance abuse. Barnard's (Citation, 2005) study revealed that families were shocked by the knowledge that one or more of their children abused substances; one parent described their experiences as "being in hell." Barnard's (Citation, 2005) findings underscored the Pakkies family experiences. In a study conducted by Jackson et al. (Citation, 2007), findings confirmed that an adolescent's substance abuse had a significant effect on family functioning, affected every member of the immediate family, and highlighted every aspect of family life. Parents found it demanding, overwhelming, and stressful. A significant theme that emerged from Mathibela and Skhosana's (Citation, 2021) study is that the parents wished that their adolescent substance abusers would die.

2.15 PATIENT ACKNOWLEDGEMENT OF THE PROBLEM

Patients with alcohol or other substance misuse disorders often withhold the truth of addictive behaviours and medical comorbidities, making these patients challenging to treat. Due to the complex nature of these patients, communication failures can lead to

missed therapeutic opportunities. Given the shift in healthcare to a more patient-centred approach and the positive association between high-quality communication with a healthcare provider and improved patient outcomes, it is essential to acknowledge and assess factors that cause abuse by the patient and the physician. Furthermore, providers can better manage interventions, referrals for treatment, and assessments of patient's willingness to change with more effective communication tools (Wu & Baker, 2023).

Sometimes, physicians do not disclose enough information to patients, which may impact a patient's involvement in their care. Proper communication allows patients to be more knowledgeable about their prognosis and to be more proactive in seeking assistance. Another issue can be non-verbal language, including facial language, body posture, and paralanguage, which may influence a patient's perception of a physician. For example, a patient may interpret a negative facial expression and a raised voice as feelings of annoyance (Wu & Baker, 2023).

Another factor to consider within the context of the problem of acknowledgement is the stigma associated with having a substance abuse problem. Stigma comprises four interrelated components: labelling, stereotypes, separation, and discrimination. Within the context of substance abuse, their stigma framework suggests that differences between persons with and without substance use problems are distinguished and labelled. Negative stereotypes are then applied to labelled persons, thereby creating separation between labelled groups, which then leads labelled persons to experience negative social consequences like prejudice and discrimination. Substance abuse problems are highly stigmatised and often regarded as a personal choice where the blame is placed on the individual (Morris, 2023).

2.16 SUBSTANCE USE TREATED SAME WAY AS CHRONIC CONDITION

Addiction is a treatable disorder. Research on the science of addiction and the treatment of SUDs has led to the development of research-based methods that help people stop using drugs and resume productive lives, also known as being in recovery. Like treatment for other chronic diseases such as heart disease or asthma, addiction

treatment is not a cure, but a way of managing the condition. Treatment enables people to counteract addiction's disruptive effects on their brains and behaviour and regain control of their lives (Morris, 2023).

The chronic nature of addiction means that for some people, relapse, or a return to drug use after an attempt to stop, can be part of the process, but newer treatments are designed to help with relapse prevention. Relapse rates for drug use are similar to rates for other chronic medical illnesses. If people stop following their medical treatment plan, they are likely to relapse. Moulin (2015) mentioned that “addiction is highly treatable, and success rates are much better than other chronic illnesses.” Unfortunately, often, patients are only given behavioural interventions. However, the best treatment is behavioural intervention combined with medications, just as we treat other diseases like diabetes or hypertension.

2.17 CHAPTER SUMMARY

This chapter involved a literature review on substance use, substance abuse, the causes of substance abuse, the effects of substance abuse on individuals and society, rehabilitation programmes, aftercare, aftercare programmes, relapse statistics, and causes of relapse after rehabilitation. The next chapter details the study methodology.

CHAPTER 3

RESEARCH METHODOLOGY

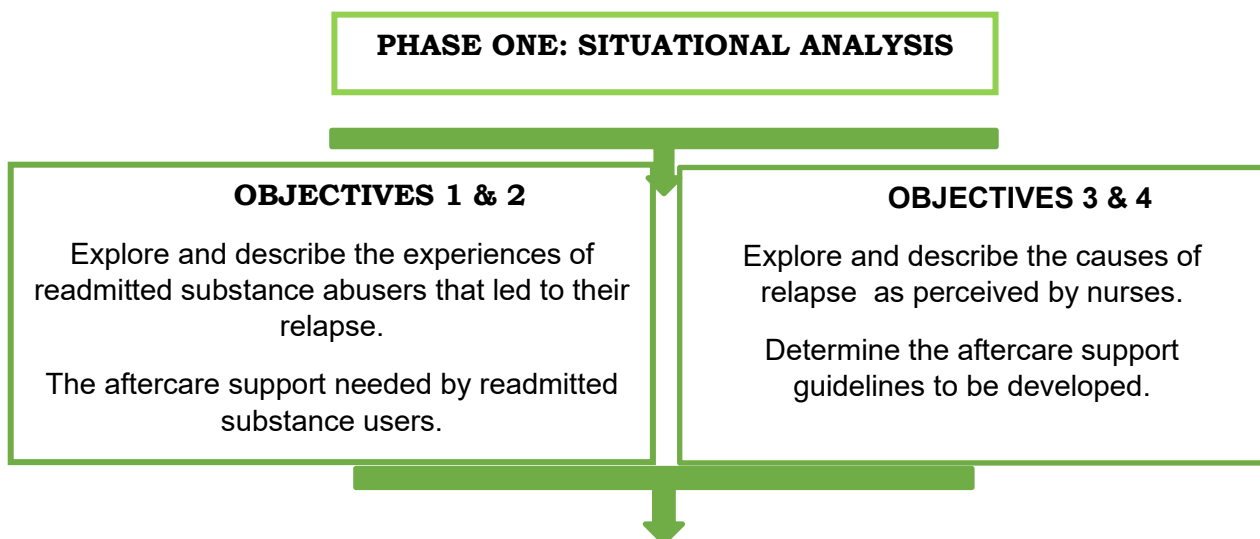
3.1 INTRODUCTION

The previous chapter presented the literature reviewed in this study. This chapter presents the research methodology, which includes the study's research approach and design, study setting, population and sampling process, inclusion and exclusion criteria, data collection instrument, pre-test study, measures to ensure trustworthiness,

data collection process, data management, data analysis, literature control, and ethical considerations.

3.2 STUDY APPROACH AND DESIGN

The purpose of this study was to develop aftercare guidelines to prevent rehabilitated substance abusers from relapsing; therefore, a qualitative approach using an explorative, descriptive, and contextual design was employed, as described by De Vos (2014) and Burns and Grove (2016). The approach and the designs are detailed below. Furthermore, this study was conducted in two phases. Phase one was a situational analysis guided by two theoretical frameworks, consisting of the setting, population, sampling methods, data collection, data analysis, ethical consideration, and measures to ensure trustworthiness. The findings from the analysed data, informed by Dickoff's six elements of practice theory, SWOT analysis, and BOEM action plan, guided phase two. Phase two involved the development of an educational programme, which was validated using Chinn and Kramer's (2019) approaches. Figure 3.1 below illustrates the research process for phases one and two adopted in this study, followed by a detailed description of the methods.



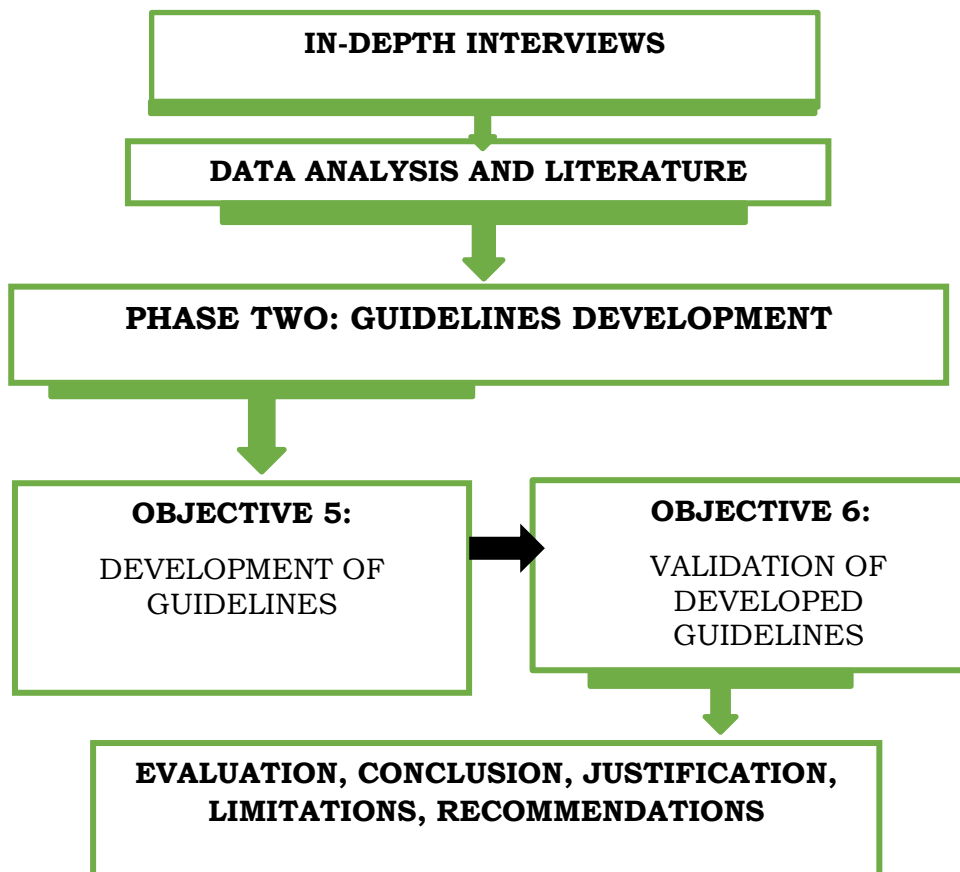


Figure 3.1: Research process

3.3 PHASE ONE: SITUATIONAL ANALYSIS

Situational analysis is a comprehensive assessment of the current and projected health situation and its determinants, which are fundamental to designing and updating national health policies, strategies, and plans according to needs (WHO, 2018). The aim of phase one (situational analysis) was to address four study objectives, namely to explore and describe the experiences of readmitted substance abusers that led to their relapse, explore the aftercare support needed by readmitted substance users, explore and describe the causes of relapse as perceived by nurses, and determine

the aftercare support guidelines to be developed. Therefore, as informed by the study paradigm detailed in Chapter 1 (constructivism), a qualitative research approach and designs were used.

3.3.1 Qualitative approach

As described by Burns and Grove (2016), qualitative research is a systemic, subjective, explorative, and descriptive approach used to describe life experiences and give them meaning. Therefore, a qualitative approach was adopted to address the study objectives and purpose as indicated in Chapter 1, which could only be achieved through a qualitative approach. Polit and Beck (2017) state that the qualitative research approach requires specific designs. In this study, the designs were explorative, descriptive, and contextual.

3.3.2 Exploratory design

Exploratory research aims to get facts, gather new data, and determine if there are interesting patterns in the data. An exploratory method is typical when a researcher examines a new interest or when the subject of the study is relatively new (Mouton & Marais, 2005; Babbie, 2015). The objectives of this study could only be achieved through exploratory design. Therefore, the experiences of readmitted substance abusers led to their relapse; the perceptions of nurses regarding the causes of readmission of rehabilitated substance abusers and the aftercare support needed to prevent relapse were explored through effective communication and probing during interviews. This is detailed in the data collection section.

Furthermore, the researcher extensively explored the literature on the available sources regarding interventions to prevent the relapse of rehabilitated substance abusers. Secondly, literature was explored in support of the study findings. Lastly, theories to guide the study, guidelines development, and an evaluation strategy were also explored.

3.3.3 Descriptive design

Polit and Beck (2017) indicate that the purpose of a descriptive design is to observe, describe, and document aspects of a situation as they naturally occur. Thus, in this study, the readmitted substance users narrated and described their experiences that led to their relapse and the aftercare support they needed. Secondly, nurses narrated and described perceptions regarding the causes of readmission of rehabilitated substance abusers as well as the aftercare support to be developed to prevent relapse.

3.3.4 Contextual design

Burns and Groove (2016) point out that contextual studies focus on specific events in naturalistic settings. Naturalistic settings are uncontrolled real-life situations or are referred to as field settings. This study was contextual because only the sub-district of Madibeng was included in the research; other districts were not included. Secondly, the study was only conducted in one specialised psychiatric/rehabilitation centre, Beethoven. Lastly, the participants were only relapsed abusers and nurses caring for them.

3.4 STUDY SETTING

The study was conducted in the North West Province, Madibeng sub-district, at BRC. Madibeng sub-district is divided into three townships, namely Letlhabile Damondsville and Elasrand, and 10 villages. Bethani and Jericho have a higher number of clients who have been admitted for rehabilitation. BRC is located in Brits Town, near Hartbeespoort Dam. The individuals utilising BRC services come from areas such as Brits, Rustenburg, Mafikeng, mines in the North West Province (including Marikana, Mooinooi, and Wonderkop), as well as Garankua, Mabopane, and Soshanguve in Gauteng Province. Due to the diverse ethnic groups residing in the area, Tswana is the primary language spoken, though other languages such as Xhosa, Zulu, Shona, and Tsonga are also common. English serves as the primary medium of communication. The population includes both educated and uneducated individuals, with the uneducated primarily consisting of mine workers from foreign countries.

3.5 STUDY POPULATION

A study population is described as the entire aggregation of respondents that meet the designated set of criteria (Burns & Grove, 2016; Brink, 2017). The study's population were readmitted substance users and professional nurses (PNs) caring for admitted substance users.

3.5.1 Target population

This sub-population was selected from the study population for the research. The target or accessible population included individuals who had relapsed after rehabilitation and were readmitted, as well as the nurses caring for them.

3.5.2 Sampling

Sampling is a selection process of a group of people or elements with which the researcher will conduct the study (Burns & Grove, 2016). In this study, sampling occurred in three stages, namely the sampling of districts, rehabilitation centres, and participants, explained below.

- **Sampling of districts**

North West has five sub-districts, namely Ngaka Modiri, Ratloy, Ruth Motati, Moses Kotana, and Madibeng. Amongst the five districts, only Madibeng has a private rehabilitation centre. Therefore, the Madibeng district was purposively selected since it met the inclusion criteria.

- **Sampling of the rehabilitation centre**

The BRC was purposively sampled since it was the only private rehabilitation centre at the time of the study.

- **Sampling of participants**

Participants were sampled through purposive sampling, a non-probability selection based on the characteristics of the population and the objective of the study (Polit &

Beck, 2014). In this study, the sampling of participants was done in two stages: the sampling of patients and the sampling of nurses.

- **Sampling of patients**

The admission register was used to select participants with the permission of the chief executive officer (CEO) of the institution. Purposive sampling was used to sample patients who were readmitted for substance use, as indicated by the admission register of the selected rehabilitation centre, whose details such as the admission date, age, and telephone numbers were complete. On the register, 15 patients had been readmitted for substance use. Of these, 13 were above the age of 18 years, had been in the hospital for more than two weeks, and had their phone numbers indicated on the register.

Initially, the researcher contacted all 13 patients by phone to schedule an appointment. Following this, the researcher visited each patient individually as per the scheduled appointments to explain the study and recruit participants. The patients voluntarily consented to take part in the study. Two patients, representing 10% of the sample, were randomly selected for a pre-test. A convenient purposive sampling method was then used to select the remaining 11 patients for the study. Those who were available at the appointment venue were interviewed.

- **Sampling of nurses**

Eleven PNs met the inclusion criteria and voluntarily consented to participate in the study. Two PNs were conveniently selected for the pre-test. Convenience sampling entails using the most conveniently available people as study participants (Polit & Beck, 2017). Since the population size is small, a total population sampling method was used to select the nine PNs to participate in the study. Secondly, it allowed the researcher to get deeper insight into the readmission of substance users and reduced the risk of missing potential insight from PNs.

3.5.3 Sample size

Sampling size refers to the number of participants examined in the research (Burns & Groove, 2011). The sample size was for PNs and patients.

- **Sample size of professional nurses**

The researcher anticipated interviewing all selected nine PNs; however, she only interviewed seven (7) because one was on night duty, and one withdrew from the study. All seven (7) were interviewed until data saturation per person, where each person was repeating information with no new information.

- **Sample size of patients**

The researcher envisaged interviewing all selected eleven readmitted patients. However, one was on leave of absence during the study period, then only 10 were interviewed. Data saturation was reached on participant 7; however, the researcher continued interviewing participants 8, 9, and 10 to ensure no information was omitted. The total sample size for this study was 17 participants.

3.5.4 Inclusion criteria

Inclusion criteria are those characteristics that the subjects or element must possess to be part of the largest population of the study (Burns & Grove, 2016). In this study, the inclusion criteria were as follows:

- A district with a private rehabilitation centre in North West Province
- A private rehabilitation centre situated in a selected district in North West Province

Inclusion criteria of patients

- Readmitted patients at a selected rehabilitation centre
- Participants aged 18 and above, as they are not minors and they can give consent to participate in the study
- Currently (during the study) admitted for two weeks and more
- Consented to participate in the study

Inclusion criteria of professional nurses

- Professional nurses working at a selected rehabilitation centre

- Professional nurse with three years of experience rendering care to readmitted substance users
- Participants aged 18 and above
- Consented to participate in the study

This will ensure data Quality and validity, they are likely to share a thoughtful and honest response. Therefore, accurate and meaningful data will be obtained.

3.5.5 Exclusion criteria

Exclusion criteria are those characteristics that disqualify subjects or elements from being part of the population in the study (Burns & Grove, 2016). The following categories were excluded in this study:

- Districts without private rehabilitation centres
- Public rehabilitation centres
- First-admission substance abusers
- Readmitted users who were less than two weeks admitted
- Other professionals

3.6 DATA COLLECTION PROCESS

Data collection is the precise, systematic gathering of information relevant to the research purpose or specific objective, questions, or hypothesis of the study (Burns & Grove, 2016). Data collection detailed how the research participants were chosen, the design, and the application. These include recruitment, preparation for data collection, pre-testing, data collection, and the role of the researcher.

3.6.1 Recruitment

The researcher visited the BRC to recruit participants. When arriving at the BRC, permission to meet the nurses and patients was requested from the CEO. During the meeting, the researcher introduced herself and the reason for the meeting. Upon

receipt of the permission, the researcher telephonically contacted participants (nurses and patients), and suitable times were set up to meet the participants.

The researcher met each participant, gave them information on how the research was to be conducted, and provided them with an information sheet. Furthermore, the researcher then clarified and explained the content in the information sheet covering the following points: aims of the study, participants' rights, possible risks and benefits of the study, the voluntary nature of the study, and that suitable assistance would be provided should anyone experience harm resulting from participation in the study.

The researcher also explained the consent form to the participants, informing them that consent is voluntary and they have the right to withdraw from the study at any time if they no longer wish to continue. Later, the researcher contacted who consented each participant to participate in this study telephonically before interviewing for an appointment. To avoid disruption of service delivery during data collection, the researcher utilised participants' lunchtime when they were free or during their own comfortable time, depending on the participants' preference.

Participants were then provided with consent forms, allowing them to give written informed consent to participate in the study. The recruitment process for patients was similar to that of PNs, as they also had phones and were listed in the register. However, those who were unreachable by phone due to technical issues were contacted in person at their respective wards.

3.6.2 Preparation for data collection

Permission was sought from related authority bodies, namely the University of Venda (UNIVEN) Higher Degrees Committee, the Provincial Department of Health, three specialised psychiatric hospitals, and the participants after approval and permission were granted. Participants' consent was requested, and appointments were made at the hospitals at a convenient time. It was also explained that an audio recorder would be used to record the conversation, and they were shown a stop button to stop the recording at any time if they wished to do so. Moreover, the participants were informed that they should feel free to explain their experiences, as there were no right or wrong

answers. They were also informed that their names would not be revealed. Permission to use a tape recorder was sought before the interviews, and data were collected until saturation (see Appendices G & H).

3.6.3 Pre-testing

Pre-tests in qualitative research allow the researcher to test the research question and whether the gadget used for recording works appropriately. The researcher also assesses whether she is able to use communication and probing skills. By testing the nature of the questions in an interviewing schedule, the researcher could make modifications with a view to quality interviewing during the main investigation. It also assists in estimating the time and cost involved during the interview (De Vos et al., 2014; Cilliers, Davis & Bezuidenhout, 2021).

In this study, pre-testing was conducted using participants who did not form part of the main study, two rehabilitated substance abusers, and two PNs caring for substance abusers. This involved those who met the inclusion criteria. The two selected patients and nurses comprised 10% of the participants and met the inclusion criteria. Secondly, the selected patients and nurses did not form the main study. The researcher conducted in-depth interviews using open-ended questions followed by probing, which was audio recorded and transcribed verbatim later. The transcribed data were presented to promoters and peer postgraduate students, who indicated that the probing was insufficient and that some questions were irrelevant to the research topic. The second pre-test was conducted with other patients and nurses, after which the promoters and peer postgraduate students commended the researcher as they could see significant improvements from probing by the researcher and that the actual study could be conducted.

3.6.4 Data collection and instrument

In-depth interviews were used with selected patients and nurses for data collection. The researcher developed both research instruments, which were pre-tested before the main data collection process. The data collection instruments were as follows:

- **Professional nurses**

The interviews were directed by the following central question, which was then followed by probing questions:

- As a nurse working at BRC, what are your perceptions of the causes of relapse in rehabilitated patients?
- What guidelines do you think should be developed to prevent relapse?

The interviews were then transcribed and analysed. The in-depth account presented a lively picture of nurses caring for readmitted patients' reality presented in words as narratives, using individual quotations. The raw data from the in-depth interviews was recorded in non-numerical form. The information from the nurses assisted in informing questions to be asked in the interview with patients. The gap left by an individual in the in-depth interviews with nurses was closed by the individual interview data from patients.

- **Patients**

Secondly, selected patients participated in individual interviews. The interview was directed by the following central questions, which were then followed by probing questions:

- As a patient readmitted to this rehabilitation centre, could you please share your experiences at home that contributed to your relapse?
- Based on your experience, what kind of support do you need to help prevent future relapse?

All interviews were audio recorded and transcribed verbatim later.

In order to abide by COVID 19 measures, during interviews with nurses and patients, there was only the participant and the researcher in the room, they were wearing masks, the distance was maintained at 1,5m, there was cross ventilation in the room and sanitisers were used.

3.6.5 The role of the researcher

The role of the researcher was akin to that of a human tape recorder. The primary instrument for data collection was the researcher, who observed, interviewed, recorded, analysed, and interpreted the participants' responses as accurately as possible during the data collection process. Rapport and trust were established, and an attitude of unconditional acceptance, respect, empathy, honesty, openness, and modesty was displayed.

Additionally, participants were encouraged to feel free to explain their experiences and that no names would be mentioned during the interview. The researcher attempted to appear relaxed and as natural as possible, and it was also explained that there is no right or wrong answer. Participants were thanked for their participation at the end of the interview. Effective communication skills to facilitate the interviews were used as described by Brink (2017):

- **Listening:** The researcher listened actively, maintained eye contact, and nodded their head throughout the interview.
- **Probing:** Probing questions were asked, emanating from the participants' answers, to allow participants to provide more clarity.
- **Clarifying:** The researcher sought clarity on statements that she would not have understood to avoid assumptions and jumping to conclusions.
- **Reflection:** Reflection was demonstrated by repeating the statement mentioned by the participant in question form, in the participant's own words, for clarity, and for the participant to expand more on the specified points.
- **Focusing:** Participants were given full attention as they expressed their needs; the focus was on the topic at hand, and any other subject apart from the topic was not entertained.
- **Paraphrasing:** The researcher rephrased the responses in the participant's own words, but with the same meaning, before asking the next question. This was to encourage the participant to provide more information.
- **Linking:** Linking information in relatively, where narrations appeared distorted.
- **Validating:** The participant was observed, and their non-verbal communication interpreted, such as vocalisation, facial expression, and body gestures, were transcribed for analysis.

- **Summarising:** Throughout the interview, the researcher summarised the important aspects of what the participant said, which could assist the participant in recalling some of the information the participant forgot to mention.
- **Using silence:** Silence was used by nodding the head and minimal verbal response, saying “mmm,” “yes,” and “continue” to allow the free flow of information and to encourage participants to open up. This aimed to make participants feel more relaxed. Eye contact is maintained, demonstrating to the participants that they are being listened to.

The data were transcribed verbatim and analysed. The in-depth account was to present a lively picture of the participants' reality presented in words as narratives, using individual quotes. The raw data from the interviews were recorded in non-numerical forms.

3.7 DATA MANAGEMENT

This study used a password-protected laptop, USB, cloud saving, printed copies, researcher and supervisor emails, and an external hard drive for data safety. The researcher transcribed the collected data verbatim within 48 hours.

3.8 DATA ANALYSIS

“Data analysis is the process of providing order, structure, and meaning to a large collection of data.” Data analysis aims to organise, arrange, and elicit meaning from data (De Vos et al., 2011; Polit & Beck, 2017). Data analysis attempts to impose order on a large amount of knowledge to draw general findings and express them in a research report. The qualitative interview data were processed using an open coding system described by Tesch (Creswell, 2016). Tesch's eight steps for data analysis are described below:

Step 1: Getting a sense of the whole

The researcher organised and prepared the data that were collected. The researcher transcribed the verbatim interviews and sorted and arranged the data into different

types depending on the sources of information. The researcher got a sense of the whole and read all transcriptions carefully. To get a sense of the transcript, the researcher attentively read the transcripts to understand the information given by non-psychiatric trained nurses, noting ideas as they occurred.

Step 2: Picking up one interview document

The researcher selected the most exciting interview, analysed and checked the meanings, and wrote thoughts that emanated on the margins. Then, the researcher read or looked at all the data. One document was picked at a time, and the researcher jotted down underlying meanings in each one; general ideas of what participants said were also documented.

Step 3: Start coding all the data

A profile of topics was developed to create themes from the data gathered, and those comparable were clustered as major, minor, or unique. Coding organises the data by bracketing chunks (text or image segments) and writing a word representing a category in the margins (Creswell, 2016). A list of all topics was made, and similar ones were grouped. Topics were grouped into columns and arranged as major, unique, and leftover. The researcher frequently used terms based on the participant's language to categorise the phrases that were differentiated from the verbatim data transcribed during data collection.

Step 4: Use the coding process to generate a description of themes

A list was taken to review the collected data. The topics were abbreviated as codes, and codes were written next to the appropriate segments of the text. Next, the researcher re-read the data to see whether new categories and codes had emerged.

Step 5: Development of themes and sub-themes in terms of qualitative narratives

The most descriptive wording for the topics was selected and turned into themes and sub-themes. The list of categories was reduced by grouping topics that relate to each other, and then lines were drawn between the themes to show interrelationships. Themes and sub-themes were written in tables, which are discussed in detail in Chapter 4.

Step 6: Interpretation and meaning-making of the data

The researcher decided on the abbreviations for each category and alphabetised these codes; the data belonging to each theme and sub-theme was assembled in one place, and a preliminary analysis was performed. The existing data were recorded to ensure that no data were missing.

Step 7: Assemble similar categories of data

The data material which belonged to each category were assembled, and preliminary analyses were performed. The researcher was able to generate themes and sub-themes from the collected data.

Step 8: Recording data

The researcher recorded existing data.

The researcher independently conducted data analysis for all transcripts before presenting them to the peer postgraduate students and promoters. The analysed data were then presented to the peer postgraduate students in the class for the recording of themes and then presented to the promoters during a class presentation for verification. The comments were effected accordingly.

3.9 LITERATURE CONTROL

The researcher conducted a literature control to contextualise and discuss the findings in relation to other studies on the experiences of readmitted patients following

discharge, the factors leading to relapse, and the perceptions of nurses regarding the factors contributing to readmission.

A literature control was done concerning the themes and related themes that emerged through the data analysis process, which were placed within the context of existing literature. The themes identified were beginning to develop as literary confirmation, literary opposition, or a developing new understanding that could add to the body of literature already in existence. The study's findings were also explored in relation to literature. Furthermore, a literature control was done to contextualise the results and increase the study's credibility. The study's findings are discussed in detail in Chapter 4.

3.10 ETHICAL CONSIDERATIONS

Ethics in research is a system of moral values that is concerned with the degree to which research procedures adhere to the professional, legal, and social obligations of the study participants (Polit et al., 2017). Ethics are designed to protect the rights of the participants and to define the responsibilities of the research. In this study, the following ethical principles were observed.

- **Permission to conduct the study**

Permission was obtained from the Nursing Department in the School of Health and the Executive Higher Degrees Committee, UNIVEN (see Appendix A). The Faculty of Health Sciences and the University Executive School Higher Degree Committee (ESHDC) granted permission for the study to be conducted (see Appendix B), and the proposal was sent to the University Research and Ethics Committee (UREC) for final approval (see Appendix C). A letter was written to the Provincial Department of Health (see Appendix E), the Department of Health at the District level (see Appendix F), and the CEOs of selected hospitals (see Appendix H), and permission was granted. The study was explained to the participants both orally and in writing. It was stressed that participation in the study was voluntary and that participants could withdraw their participation from the study at any time. However, no such withdrawals occurred. Following a thorough explanation of the study, the participants provided written informed consent (see Appendix K). Before beginning the interviews, permission for

tape recording was obtained. The data were kept private, and the results were reported anonymously.

- **The right to full disclosure about the research**

Full disclosure means that the researcher has fully described the nature of the study to participants (Polit & Beck, 2017). Participants were given information about the nature of the research. The researcher explained the purpose of the research to patients and nurses before participation and informed them of the methodology, duration of the study, nature of participation expected, how confidentiality and privacy would be upheld, and that there were no financial implications for participating in the study.

- **Informed consent**

Informed consent implies that participants have been provided with sufficient information about the research, understand the details, and can voluntarily agree to or decline participation. Participants were informed of unanticipated dangers, such as psychological distress and efforts to reduce risks (Polit & Beck, 2017). The nature of the research and its objectives were explained to non-psychiatric trained nurses in this study. They were informed that their involvement was voluntary and that they could withdraw their participation from the study at any time. Participants were informed about unforeseeable issues, such as mental distress, and that if this occurred, they would be directed to a psychologist. Participants provided informed consent after being informed about the research. Consent was given both verbally and in writing. (see Appendix K).

- **Right to privacy**

The researcher ensured that the study was not more intrusive than needed and that the participant's privacy was maintained throughout the research process. Data collected during the research were kept confidential by not sharing information collected with people who were not part of the study. Moreover, privacy was maintained by interviewing participants in a private room. The intrusion was minimised

by only asking the questions in the interview schedule and respecting participants' choice not to respond to a specific question.

- **Right to self-determination**

Self-determination implies that participants can consciously engage in the study without fear of bias. During the recruitment and briefing, potential participants were informed that they had the right to participate willingly in the study without fear of bias. This included freedom from coercion; volunteers were not threatened if they did not participate in the study. Participants were informed that they might decline or withdraw at any time without consequence. Finally, all the explanations were in writing and given to all participants as information sheets (see Appendix G).

- **Avoid harm**

The researcher should avoid harm by protecting the participants from any form of emotional discomfort that can emerge from the research project (De Vos et al., 2011). In this study, the researcher tried to minimise harm as this topic could be sensitive to other participants, explaining the lived experiences that led to their reuse of substances upon discharge. Therefore, sensitive words were avoided throughout the interviews. Secondly, the researcher constantly informed them that there were no right or wrong answers and that they must express their views freely as no one would judge them. Lastly, the researcher tried to minimise harm and discomfort by allowing participants to withdraw from the study at any time if they did not feel comfortable.

- **Anonymity and confidentiality**

Anonymity and confidentiality refer to the protection of participants so that the researcher cannot link individuals with the information provided and is not divulged in public (Polit & Beck, 2017). The researcher maintained confidentiality by conducting the interviews in a private room. Each participant was interviewed separately. Anonymity was maintained throughout the study by giving the participants pseudonyms in all reports. Only the researchers involved were granted access to the information participants provided. Furthermore, participants were coded for anonymity to prevent linking them with the data and were given pseudonyms. In this study, the

researcher kept the records safe; a copy was only made available to the study promoters.

- **Deception of the participants**

The researcher should never withhold or offer participants incorrect information (Burns & Groove, 2011). This was implemented by explaining to the participants how the interview would be conducted and that there would be no incentives for the participants.

- **Compliance with COVID-19 measures**

Although COVID-19 is no longer prominent on social media or headline news, people are still being diagnosed with COVID-19 infections. Therefore, this study complied with COVID-19 measures. The researcher wore a face mask and provided each participant with a mask to protect the nose and mouth. Social distancing was maintained (i.e., 1.5m apart), and hand sanitisers were used. Additionally, the room where the interview took place was well-ventilated by keeping the windows open.

3.11 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness is the degree of confidence the qualitative researcher has in their data and analyses. It is assessed using the criteria of credibility, transferability, dependability, conformability, and authenticity (Polit & Beck, 2014).

3.11.1 Credibility

Credibility refers to confidence in the truth of the data. According to Brink et al. (2014), confidence and truth can be established through the following technique:

- **Prolonged engagement**

In this study, the researcher visited the participants to recruit them before the interview. After recruitment, those who were willing were asked to provide their phone numbers to the researcher so that the researcher could schedule an interview appointment. Maintaining contact with participants before data collection ensured familiarity

between the researcher and participants. The contact sessions between the participants and the researcher continued even after data collection for accuracy and clarity.

- **Member checks**

Member checks were done through phone calls and making appointments with the participants. The researcher and the participants verified the content of the interview throughout the interview process by deliberate probing and paraphrasing. Additionally, they were done during interviews by maintaining eye contact with the participants and using communication skills. They were also done after data collection by going back to the participants after the interview to check if what participants said to the researcher was correct. This was done by playing the audio tape and reading transcripts. Lastly, participants were consulted after data analysis to verify the findings.

- **Independent coders**

The proposal and methodology were presented to qualitative research experts in the following platforms: peer postgraduate students, promoters, the Department of Advanced Nursing, the Faculty of Health Sciences, and the University Ethics Committee. These processes ensured that the methods were credible. Furthermore, the pre-test and study findings were consistently presented to promoters and peer postgraduate students for input and comments. Lastly, literature control was done to contextualise the findings and increase the study's credibility.

3.11.2 Dependability

Dependability refers to the stability of the data over time and under different conditions (Polit & Beck, 2014). In this study, dependability was maintained by reporting and consulting with the peer postgraduate students and promoters. The researcher also allowed cross-checking of codes, also known as inter-coder agreement, by other qualitative research experts to see whether the experts would code the same as the researcher.

3.11.3 Transferability

Transferability is the extent to which qualitative findings can be transferred to other settings or groups (Polit et al., 2014). In this study, transferability was ensured by a thick description of all research processes clearly from the research design, study setting, target population, sampling procedure, and data collection methods in such a way that even if other researchers repeat the same study, it will present the same results.

3.11.4 Confirmability

Confirmability refers to the potential for congruency of data in terms of accuracy, relevance, or meaning. Information that was recorded during the interviews was transcribed without any alteration. The researcher did not influence the responses and outcomes of the study findings. Furthermore, confirmability was ensured by playing back the recorded audio during interviews, and transcribed verbatim is kept safe for verification. Table 3.1 summarises how measures to ensure trustworthiness were applied.

Table 3.1: Measures to ensure trustworthiness

MEASURE	CRITERIA	APPLICATION
Credibility	Prolonged engagement	Participants were contacted telephonically during the introduction, giving brief information about the study, setting an appointment, and travelling to meet the participants. Sufficient time was spent with the participants during data collection. More time was spent validating data.

	Member checking	The researcher played back the recorded tape to the participants. Participants were provided to recall if there were some things that they had forgotten to mention.
	Peer examination	The research proposal was evaluated by departmental, faculty research, and university higher degree committees. Data were co-coded by peer postgraduate students. Promoters and internal and external examiners examined the thesis.
	Guidelines validation	Research experts validated the developed guidelines.
	Structural coherence	The study was guided by Roy's (2010) adaptation model. Ethical considerations were adhered to throughout the study. Data were analysed using Tech's method. The guidelines were developed using the six elements of practice theory by Dickoff et al. (1968), the SWOT analysis approach (2014), and the BOEM action plan (2013). Guideline validation was guided by Chinn and Kramer (2008).
	Researcher's authority	The researcher is knowledgeable in research.

		The promoters are also research experts. Peer postgraduate students have sound knowledge of research and the best experience in the field of mental health.
Dependability		The research proposal was presented to the departmental and school research committees. The university higher degrees committee (UHDC) examined the proposal. The developed guidelines were validated by peers, postgraduate students, promoters, and beneficiaries. The nominated external examiners examined the thesis methodology.
Confirmability		The research proposal was evaluated by the departmental and school research committees. The UHDC examined the proposal. The developed guidelines were validated by peers, postgraduate students, promoters, and beneficiaries. The nominated external examiners examined the thesis methodology.
Transferability		Theories used in the study. Qualitative methodology, study setting, and sampling process were described in detail.

Authenticity		A report indicated the experiences of readmitted substance users that led to their relapse and the aftercare support needed to prevent relapse.
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3.12 PHASE TWO: DEVELOPMENT OF AFTERCARE GUIDELINES TO SUPPORT AND PREVENT THE RELAPSE OF REHABILITATED SUBSTANCE ABUSERS IN MADIBENG SUB-DISTRICT, NORTH WEST PROVINCE, SOUTH AFRICA

The findings of phase one formed the basis of phase two. Phase two of this study comprised the development of guidelines. In developing the guidelines, certain aspects needed to be considered, such as situational analysis, as explained in phase one above, which provided information regarding readmitted patients' experiences and perceptions of PNs regarding the causes of relapse. Phase two of the study is discussed in detail in Chapter 6 after data analysis.

3.13 VALIDATION OF THE DEVELOPED GUIDELINES

Chinn and Kramer's (2008) criteria for guideline validation were selected since they are based on empirical evidence. The five critical questions necessary for the validation of the developed were as follows:

- How clear are the strategies?
- How simple are the strategies?
- How general are the strategies?
- How accessible are the strategies?
- How important are the strategies?

The validation of the developed guidelines is discussed in detail in Chapter 7.

3.14 CHAPTER SUMMARY

This chapter provides a detailed overview of the research approach and methodology used in phase one (situational analysis) of the study. This included the population and sampling process, data collection process, data management, data analysis, ethical considerations, literature control, and measures to ensure trustworthiness. The analysed study findings of phase one (situational analysis) are presented in Chapters 4 and 5.

CHAPTER 4

PRESENTATION OF STUDY FINDINGS FROM PATIENTS

4.1 INTRODUCTION

The previous chapter presented the study's research methodology. This chapter presents the results obtained from the collected data, which includes the sample description, presentation, and discussion of the findings. The study aimed to develop guidelines to prevent rehabilitated substance abusers from relapsing in the North West, Madibeng sub-district.

4.2 DESCRIPTION OF PARTICIPANTS

The study included 10 participants, consisting of seven males and three females. Four participants were admitted for the fourth time, four for the third time, and two for the second time.

4.3 PRESENTATION OF THE FINDINGS

Data were analysed using Braun and Clarke's (2013) six steps detailed in Chapter 1. The analysis revealed two themes, sub-themes, and categories. The two themes are aftercare experiences leading to relapse and readmission and the support needed by patients to prevent relapse. Tables 4.1 and 4.2 present the summary of themes, categories, and sub-categories. These themes are discussed in detail below and are supported by relevant quotations and the literature.

Theme 1: Aftercare experiences leading to relapse and readmission

Table 4.1:

SUB-THEMES	CATEGORIES
Types of Abuse experienced by patients	Physical Abuse Financial Abuse Emotional Abuse
Lack of social support	Family Friends
Lack of aftercare services	Lack of services upon discharge
Peer pressure	Old friends Stigmatisation

Theme 2: Support needed by users to prevent relapse

Table 4.2:

SUB-THEME	CATEGORIES
Aftercare support	Visit by a health professional
Strong family support	Family involvement
Medication	Adherence to medication

4.4 DISCUSSION OF THE FINDINGS

The analysed data revealed two themes, sub-themes, and categories. The themes are aftercare experiences leading to relapse and readmission and the support needed by patients to prevent relapse. Each theme is discussed below, with the relevant sub-themes.

4.4.1 Theme 1: Aftercare experiences of users leading to relapse and readmission

The following four sub-themes were identified from this theme: abuse, lack of family support, peer pressure, and stigma.

- **Type of abuse experienced by patients**

The participants' descriptions indicated that they started abusing alcohol because their spouses were abusing drugs and alcohol, and when under the influence, they would physically and financially abuse them. Furthermore, participants narrated that they went for rehabilitation and became free of drugs and alcohol. However, whenever the abuse problems start, they relapse and go for readmission, which is an ongoing cycle. The participants opined:

"...Well, the problems that I had initially brought me here are the ones that led to my relapse, the abuse from my husband, the physical abuse, financial abuse, so I ended up going back to the substance, to alcohol, to making myself feel a little bit better that's the reason I ended up relapsing because after my admission he actually tried a bit to accommodate what I was going through and then he stopped with the beating, he stopped with the financial abuse, but it was just temporary it didn't last so long, and then he went back to beating me up again in front of kids, taking my car without my permission, went back to cheating again so as a result I took a little bit of comfort which led to abuse again of the substance and the alcohol..."

"I was, I'm actually only 44 and in 2013, I used for the first time, so I was a bit older, and I didn't grow up with it at all, good family, but I was in a

relationship where Uhm my boyfriend, used Cat and Crystal but I didn't know that at that time, He was very very sneaky so when I found out I tried to get him off the drugs then one day when he came home after a week or two Uhm I said to him 'Come, empty your pockets' and he emptied his pockets and said "What? What are you going to do?" because he was hitting me as well, but I was like 'Uhm, I don't know' and I said make your lines, and he said 'What?' Must I do that in front of you?' I didn't even know how to do it. I said, 'Make four lines,' and he took two and said, 'I'll take that later,' and I said 'No, give me that,' and I rolled the note, and I took the two. I tried not to. Well, it felt like my brain was going to explode, but I was keeping my pose, and from there, I was addicted, but my relapse was more emotional."

In agreement with the above narration, Baharuddin et al., (2012) reported that the more one uses a substance, the more likely they are to become addicted and use more drugs. The participants opined:

"She kept on physically biting me, I don't know, and I said make your lines, and she said, "What? Must I do that in front of you?" I didn't even know how to do it, I said... I then feel better when drunk since I cannot care about so many things around me."

"He first began stealing my debit card out of my wallet when I was sleeping or showering and would go take care of his needs with my money while he was unemployed," wrote one user. "When he did find a job, he was even more abusive at this point and kept my debit card from me and didn't allow me to have any access to my money at all, despite having his bank account."

Financial abuse and neglect are often an invisible form of domestic violence. If one's financial stress is severe, they will experience adverse effects on their mental health and potentially their physical health. Financial stress can lead to anxiety, depression, and behavioural changes like withdrawing from social activities or physical symptoms like stomachaches or headaches (Snyder, 2022). This is in line with the findings of Can and Tannverdi (2015), who reported that financial abuse in marriage is when one partner exerts financial control over the other. It may involve fostering financial dependence by limiting the ability to work or access money. It could also involve

exploitation, like stealing the other person's credit cards or identity for purchases or loans. Financial abuse in marriage is a form of domestic violence that can have harmful and lasting consequences.

According to Snyder (2022), financial bullying tends to be covert, starting with a few minor behaviours like commenting on the high grocery bill or asking how much one's shoes cost. As the relationship progresses, it escalates into more serious behaviours like limiting one's spending to giving them an allowance as if they were a child. This can happen between parents and children and other relationships that involve financial dependence, like a sick, elderly, or disabled person who is in the care of someone else. Financial abuse can also happen in workplace settings, business partnerships, and any relationship where people fully or partially share financial assets.

Similarly, Scott (2023) reports that financial abuse in relationships doesn't only happen in marriage. Relationships and money go hand-in-hand. It can occur between non-married couples who are dating or ex-spouses. Moreover, it is common during the process of separation when determining alimony and child support. In addition, withholding resources such as access to bank accounts, credit cards, financial statements, transportation, property, healthcare, or food is an offensive and neglectful way to isolate a victim in an abusive relationship.

Scouller (2020), a financial services professional at Wealth Wave, emphasises how hard it can often be for victims to identify and decipher financial abuse red flags. She states that most research on domestic violence is within traditional cisgender male and female relationships. Financial abuse can creep into a romantic relationship in subtle, sinister ways. In one Reddit thread, users shared their experiences of partners restricting access to their own money, spending all of their money, or racking up debt in their name. Often, it took victims a long time to recognise that they were financially abused, and they had a hard time convincing others that anything was wrong.

On the other hand, Nky (2014) argues that addicted individuals experience behaviour change and end by abusing their spouse physically, and they have less self-control over the substance. Relapse is a complicated phenomenon; however, literature has been developed over the years to create an understanding of the reason that people

relapse. Investigating every aspect of a person's life, including areas like the person and the environment, plays a key role in relapse.

- **Lack of family support**

Some of the participants stated that when they leave rehab, they are judged by their family members and loved ones. The trust is completely gone, and they are always blamed for everything that goes wrong or watched in every move they take. The participants opined:

“Number one, I got to relapse because there is a poor support system at home, and by poor support system, I mean family and friends; lack of support from family and friends is a big problem.”

‘...and the use of alcohol and dagga at home causes relapse availability of resources can be another issue.’

“Yes, the support system, especially at home or where I’m staying with my relatives because most of my relatives are using drugs, and I was the only one who was not using the time when I came back from the hospital or the rehab, but then it was so weak for me to stay without them because I was influenced and also the people I mixed with, my friends will take me to drink alcohol at a pub, while we were playing snooker and sometimes when I’ve done a mistake I was afraid that people will come to me and to shy away from that because I don’t want people to blame me, alcohol or the drugs I’m using.”

“Oh okay, the first thing I experienced was at home. I didn’t have a good support system, and by that, I mean I had people at home who were using alcohol, drugs and it was so difficult for me to avoid them I know it was wrong, but I just decided to join them because most of my relatives are using it and I’m staying with them.”

“The support system, especially at home or where I’m staying with my relatives because most of my relatives are using drugs, and I was the only one who was not using the time when I came back from the hospital or the rehab, but then it was so weak for me to stay without them because I was influenced and also the people I mixed with.”

“For one to be well-rehabilitated, you need to have not a strong support system but just the support system, you need to belong somewhere, and your family should at least know these things teach maybe like a social worker or a psychologist can be invited in the family and teach the family about substance abuse and myself as I’m from rehab I need to get assistance from the social worker or psychologist so that it can build the family after being released and the family needs to be exposed to or they can come to the rehab and see what the psychologist or social workers are busy with or how are they helping when we are in rehab.”

The above narrations are supported by scientific literature. Reddy et al., (2010) reported that family factors that place adolescents at increased risk for alcohol and drug use include parental drug use. Several authors argue that there is a significant association between family status and relapse, where a user has a significantly greater risk of relapse after treatment. According to Swanepoel (2014), family perspectives on substance abuse implications from the environment are either positive or negative. Parental child-rearing, factors such as setting rules, child-centredness, and identification with the parent were also found to be protective. Parents also can buffer the negative influence of substance-using (Arteaga et al., 2010; SAMHSA, 2010).

Similarly, Baharuddin et al., (2012) allude that poor support from family members can lead to high levels of relapse. Therefore, each individual will have their own perception of recovery and relapse, and that may be a reason behind whether or not their loved ones will relapse or not. On the other hand, frequent family conflicts also increase the probability of future substance dependency (Arteaga et al., 2010). Family factors that place adolescents at increased risk for alcohol and drug use include parental drug use and frequent family conflict (Reddy et al., 2010). Positive family practices can offer protection against alcohol and other drug use (Amato & Fowler, 2002). Jay (2015) opines that family and loved ones can also contribute to prolonged addiction.

- **Peer pressure and stigma**

Some participants highlighted peer pressure as the driving force behind their relapse. Peers include their old friends and working-class friends that they hang out with. The participants opined:

“I mixed with my friends, who would take me to drink alcohol at a Pub while we were playing snooker, and sometimes, when I’d made a mistake, I was afraid that people would come to me and shy away from that because I didn’t want people to blame me, alcohol or the drugs I’m using.”

“Eish, my friends are still drinking and using drugs...we sometimes attend events, especially after tears and unweillings where alcohol is free. It's hard for me to avoid the temptation since I hang with them most of the time. I end up telling myself to drink one or two, then find myself back to square one of relapsing, then readmitted.”

“Since I do not have anything to do upon discharge, others laugh at me and call me names. I feel so lonely and frustrated that it leads me to addict back into my old habits to join my friends; they have ways of managing these emotions in any way.”

“The other thing is that I’m not working, and my friends are the ones working and for me, it was causing a lot of stress, and when they have money, they will buy for me, they won’t buy cold drinks for me like ‘Coke,’ but they will buy alcohol and drugs and will follow them.”

“... and number two is a stigma attached to mental illness that is people tend to look down on you when you are associated with the hospitals.”

According to Wada, Suto, Lee, Sanders, Sun, Le, Goldman-Hasbun and Chauhan (2019), there is a lot of peer pressure and stigma toward individuals who are highly dependent and addicted to substances. Similarly, Boekel, Brouwers, Weeghel and Garresten (2013) state that the stigma that is attached to individuals with SUD causes a loss of social functioning in individuals, which in the process results in a reduction of the quality of life and affects the systems in the patient’s life, such as family, recreational, and work.

The perception of stigma towards an individual can interfere with a patient’s treatment process. Once the patient becomes aware of the stigma, it may decrease their

intention to seek therapy, potentially leading to relapse (Can & Tanriverdi, 2015). Many participants emphasise that they relapse because, despite attending therapy, their compliance with the necessary elements for treatment success diminishes, resulting in unsuccessful therapeutic interventions (Can & Tanriverdi, 2015)

In addition, Retrieved in Government Gazette, Vol. 526, No 32150, 21 April Republic of South Africa, Department of Social Development (2013) attests that the way healthcare professionals interact with individuals who engage in substance abuse can determine the success of treatment and also influence the likelihood of relapse. In a study by (Retrieved in Government Gazette, Vol. 526, No 32150, 21 April Republic of South Africa, Department of Social Development (2013), the finding revealed that the stigma that health care professionals have towards people with substance use problems can negatively impact health care delivery, resulting in treatment avoidance and patients relapsing. The reason behind poor service delivery and relapsing is that the stigma leads to poor communication between the health care professional and the patient and misattribution of physical illness symptoms to substance use problems.

Relapse rates are high both nationally and internationally. Considering South Africa's statistics, in 2013, 22% of admissions into treatment centres were readmissions (SACENDU, 2014:15). The relapse issue is one of the most critical challenges facing the field of addiction.

4.4.2 Theme 2: Support needed by users to prevent relapse

- **Strong family support**

The study participants vocally acknowledged family involvement and emphasised the crucial role of family support in the recovery process. The participants opined:

"The first time I got treatment was when I got a close near overdoes on crystal myth, and I landed up at Sandton clinic. I was still working, so I had medical aid, and I landed in the psychiatric ward, but my mother ultimately made the decision that I should go into rehab."

‘I went into a rehabilitation centre. So, it wasn’t my decision, I was kind of forced into it. Not really, they were giving ultimatums that I do this, or I do this, and if I don’t do this, these are the consequences. So, I saw that if I kept smoking, then the school would be sacrificed, my car, I would lose everything, and that is when I said, ‘okay, let me try and change.’”

“For a long time, I didn’t, but then when I saw the physical effect and emotional effects, I went into psychosis. Like in and out of psychosis. So uhm... I realised that I had a problem when I tried to commit suicide in December of 2014, and when I came out of my coma, I pretty much took the next step, and I realised that I had a problem, I had a problem. No, you know what, it wasn’t about that. I was still naïve; I was still naughty. I knew when I came out of the clinic, I think I was there for 29 days or nearly a month, but I knew that I was not going to stay clean. When I left the clinic, my addiction got worse. My family did not care about me.”

“I didn’t get visits from my family; I only got visits from friends, and those are my friends that I left at school, and those are friends who have achieved a lot in life; they’ve heard about me and come to check on me and motivate me. Then, when discharged, it was hard for me to connect with my family since they were never involved in my treatment process. They did not understand what was going on in my life. I believe if they can be involved and support me throughout my craving struggles, I would stay sober.”

In agreement with the study participants' narrations, numerous studies have shown that the families' primary role during treatment is to provide support, and in some cases, this involves support treatment. Uys and Middleton (2014) support the view that family intervention is the most important milieu for the treatment and rehabilitation of patients living with substance abuse. Family integration and participation are crucial for users, and significant efforts are needed to support families in restoring unity and understanding the impact of addiction, not just on the individual, but on the entire family (Reddy et al., 2010).

Families can play an important role in being a supportive structure for addicts undergoing treatment and managing the recovery process. To have a successful

recovery process, the availability of support from loved ones, the family's knowledge about the relapse process, and involvement in personal programmes are more likely to reduce the chances of relapse. Jay (2015) stated that the family must be supportive. When families are provided with good direction and work together, they can become a great support structure since working together builds families. In addition, one way in which relapse can be avoided is by gaining acceptance from family members. Families can play an essential role in being a supportive structure for addicts who are undergoing treatment and managing recovery (Baharuddin et al., 2012).

On the other hand, the family also can buffer the negative influence of substance-using peers (Nky 2014). A study by Giacco, Luciano, Del Vecchio, Sampogna, Slade, Clarke, Nagy, Egerhazi, Munk-Jørgensen, Bording, Kawohl, Rossler, Zentner, Puschner and Fiorillo (2014) emphasises that patients and families have a desire for information regarding mental illness so that they should take an informed decision about the care of rehabilitated substance abusers. In agreement, Lavhelani (2022) developed a model based on the perceptions of family members regarding the reintegration of the male state.

Kurai (2013) emphasises that a successful recovery process includes the availability of support from loved ones, family's knowledge about the relapse process, and involvement in personal programmes, which are more likely to help decrease the chances of relapse. Authors alluded that relapse can be avoided by gaining acceptance and support from family members (Hazelden & Jordaan, 2013).

According to Jackson (2016), the family members and loved ones of those dealing with addiction play important roles. Family support in addiction recovery may include intervening in a crisis, finding treatment options, helping them get into treatment, and providing the right type of care. Advocating for individuals' needs and rights, supporting their adherence to treatment and aftercare plans, and monitoring for any significant behavioural changes that could indicate a potential relapse are essential roles (Moremi & Kruger, 2012). Research shows that when families actively participate in the treatment and recovery process, the individual is less likely to require hospitalisation or experience a relapse (Appiah, Danquah, Nyarko, Ofor-Atta & Aziato, 2016). Additionally, they are more likely to stick to their treatment plan and experience a successful recovery (Moremi & Kruger, 2012).

Moremi and Kruger (2020) argue that family members can also benefit from participating in the treatment process. They may receive education on addiction and learn healthy coping mechanisms to be positive contributors to their loved one's recovery efforts (Appiah et al., 2016). It is argued that many treatment programmes should invite families into the treatment process through scheduled family visits, family classes, and family therapy, a co-operative approach to lasting sobriety (Hazelden & Jordan, 2013). Jackson (2016) states that when major issues within the family are addressed, the recovering individual is more likely to maintain their recovery, and other family members are less likely to face similar challenges in the future.

- Aftercare support

Aftercare refers to services that help rehabilitated substance abusers adapt to everyday community life after completing treatment and rehabilitation. It provides an opportunity to address important issues and challenges associated with abstinence and recovery. Therefore, transitioning from treatment to recovery is a pivotal step in the journey toward overcoming substance abuse. The following are the participants' perspectives on how the transition back to the community should unfold. The participants opined:

That is the main reason: they throw you back too quickly into the real world and stress, and everything is there. Although you have been taught how to deal with them, you must practice to implement it because practice makes perfect when the stress comes, you don't know how to deal with it because you haven't practised in the outside world, and you tend to fall back but you fall back slowly, not high dosages slowly but surely until you reach a high dose so that will be my opinion."

"That way, I know I'm in safe hands. As soon as I leave, there are no safe hands; the world is there, the stresses and triggers are there, and everything is there, and you don't have that safety net. So, they must give you time to say 'baby steps', deal with this way, deal with that way, and your psychiatrist or whoever will decide that period after being discharged. If you find that some patients are staying far away from the help, they have to travel from far away, and there is not enough transportation and lack of funds to support

that. Another issue may be lack of insight about the problem, not knowing the disease, and lasting stress; stress can be another fact.”

Creswell (2010) alludes that the aftercare treatment plan aims to provide individuals with the necessary tools and strategies to navigate the challenges they may encounter post-rehabilitation. This continuum of support significantly contributes to a successful recovery journey by helping individuals stay resilient, maintain sobriety, and overcome potential relapse triggers. Recovery, one of the best rehabilitation centres in South Africa, provides specialist staff, offers detox off-site, and caters to both short- and long-term rehabilitation programmes (Baharuddin, Zakaria, Hussin, Mohamed, Sumari & Sawai, 2012). According to the National Institute of Drug Abuse, a significant percentage of individuals are at risk of relapse during the first 12 months of recovery. To promote long-term recovery, addiction places a strong emphasis on relapse prevention, recognising the critical role of ongoing support beyond the initial treatment phase.

In 2017, the WHO launched Rehabilitation 2030 to emphasise the need for health system strengthening and call for all stakeholders worldwide to work together to improve leadership and governance, develop a strong multidisciplinary rehabilitation workforce, expand financing for rehabilitation, and improve data collection and research on rehabilitation. Furthermore, the WHO launched the World Rehabilitation Alliance (WRA) to support the implementation of Rehabilitation 2030. The WRA focuses on promoting rehabilitation as an essential health service that is integral to universal health coverage (WHO, 2017). The WHO is promoting the strengthening of the health system for rehabilitation by providing technical support and building capacity in countries, increasing leadership, political prioritisation, and resource mobilisation, developing norms, standards, and technical guidance, shaping the research agenda, and monitoring progress. Finally, the WHO (2017) declares that recovery is reinforced within a safe and structured environment, enabling individuals to achieve lasting recovery and maintain their progress towards reintegration. In transitioning from a state of feeling lost to being rediscovered, the secondary programme embraces the entirety of the recovery continuum within a social context, offering a comprehensive treatment experience for individuals with stays lasting three months and more.

4.5 CHAPTER SUMMARY

Chapter 4 presented the study findings from patients, identifying two themes, three sub-themes, and three categories, all supported by the literature. The next chapter will present the findings of the study from nurses.

CHAPTER 5

PRESENTATION OF STUDY FINDINGS FROM NURSES

5.1 INTRODUCTION

The previous chapter presented individual findings from users (patients) based on in-depth interviews. This chapter presents the findings obtained from nurses' working discussions, which include the sample description, presentation, and discussion of the findings.

5.2 DESCRIPTION OF NURSES' SAMPLE

The study sample consisted of seven psychiatric nurses working at BRC, including five females and two males. All were psychiatric nurses. Of these, three had more than 10 years of experience at the centre, three had over five years of experience, and one had more than three years of experience.

5.3 PRESENTATION OF THE FINDINGS

Table 5.1 below presents the study findings, which consist of two themes: factors leading to relapse and strategies to prevent relapse. Each theme has sub-themes and categories.

Table 5.1: Themes, sub-themes, and categories of factors leading to relapse and strategies to prevent relapse

THEME	SUB-THEMES	CATEGORIES
1. Factors leading to relapse	1.1 Environmental factors	• The use of substances in the family • Dysfunctional family • Lack of family support
	1.2 Intrapersonal factors	• Unemployment • Substance use for leisure or feel-good • Coerced for treatment
2. Aftercare guidelines to prevent relapse	2.1 Before discharge	• Family involvement • Skills development
	2.2 Aftercare	• Individualised programme • Family support • Professional support • Support groups

5.4 DISCUSSION OF THE FINDINGS

Two themes emerged from the analysed data, namely factors leading to relapse and strategies to prevent relapse. Sub-themes and categories also emerged. Each theme, sub-theme, and category is discussed with quotations and supported by the literature below.

5.4.1 Theme 1: Factors leading to relapse

Two sub-themes emerged from the analysed data, namely environmental and intrapersonal factors with categories. All are presented below.

5.4.1.1 Sub-theme 1.1: Environmental factors

The study revealed that rehabilitated substance abusers are subjected to environmental factors that lead to relapse, namely, the use of substances in the family, dysfunctional family, and lack of family support. Each finding is presented with direct quotes and supported by relevant literature.

- **The use of substances in the family**

All participants highlighted that substance use dependence is episodic, with periods of abstinence, reduction of use, and relapse as the prevailing pattern, often with the course of events being influenced by external factors such as the availability of drugs and societal pressures. Furthermore, participants were vocal regarding the availability and access to drugs as the cause of relapse in the rehabilitated abuser's environment after discharge. The participants opined:

“Having been brought up in a family in which one or both parents are abusing substances, in most cases, children will also follow in the footsteps of their parents. Upon discharge from an inpatient rehabilitation centre, due to a lack of positive encouragement to stay clean, they will relapse.” Nurse 1

“When I interviewed them during admission, some users mentioned that upon release, they went to a family whose members abused substances. In addition, peer group members were also abusers; as a result, they also relapsed and started abusing substances again.” Nurse 5

This study's findings are in line with the World Drug Report (2004), which posits that factors such as drug use within the family are risk factors for substance abuse. In support, Chie, Tam, Bonn and Dang (2016) report that if, for example, someone is raised by parents who routinely abuse alcohol or have drugs around the house, it is

more likely that they will use substances. Similarly, Lian and Chu (2013) found that parental use was the most significant predictor of leading their children to engage in substance abuse. The stronger the parent-child relationship, the greater its influence on the child (Lian & Chu, 2013). At times, substance use might be seen as something normal for the child to engage in because that is the environment the child was raised in. Research by Swadi (1999) on cigarette smoking amongst families found that both maternal smoking and parent-child interaction influence the risk of lifetime smoking by the child.

- **Dysfunctional family**

Complex family dynamics and conflicted relationships with significant others were some of the factors that the participants appraised as precipitating their substance abuse. The participants opined:

“This also goes for children who grew up in families where there is physical abuse; sympathising with the abused parent may lead to substance abuse in a way that for as long as the situation remains the same, even after rehabilitation, relapse to substance abuse will still be there.” Patient 8

“This does not affect children only; even the abused parent may fall into the trap of substance abuse in an attempt to ease the mind and, despite rehabilitation, keep on relapsing.” Patient 5

“In some instances, irresponsible parents who abuse substances may fail to cater to their children’s educational needs, even if the child shows abilities to become somebody valuable in society, cannot do so because of financial constraints. Such a child looking at his peers prospering makes him frustrated to the extent of throwing himself into substance abuse, which will make him relapse even after rehabilitation.” Patient 3

According to Daley (1985), dysfunctional families can also contribute to the prolonging of addiction. In agreement, Jay (2015) found that a fragile and vulnerable family institution is one of the factors that give rise to the substance relapse case. Children

from broken families tend to be abandoned and are susceptible to destructive behaviours.

Similarly, within the present study, negative familial relationships and drug use within families were found to play a significant role in the abuse of substances. Familial risk factors for substance abuse within the family, such as rejection by parents (Jeremy, 2013), parental and sibling substance use, divorce in the family, and conflict in the family (Madu & Matla, 2003 cited in Golestan, Abdullah, Ahmad & Anjomshoa, 2010) can also contribute to substance use.

- **Lack of family support**

The findings showed that a lack of open interaction between former addicts and their family members increases relapsed addiction tendency amongst addicts. The participants opined:

“Some initiated coming here for help but relapsed after rehabilitation and discharge due to lack of support, stigmatisation from the community, frequenting places that trigger their cravings, socio-economic stressors, and peer pressure.” Nurse 1

Numerous studies have shown that the parent's primary role during treatment is to provide support. Less support from family members and the community highly promotes the relapsed addiction tendency after treatment of substance abusers (Brown et al., 1995; Miller et al., 1999; Miller, 1992; Moos & King, 1997). Weak support from family and dysfunctional families and the community can lead to high levels of relapse (Baharuddin et al., 2012). Each individual will have their perception of recovery and relapse, and that may be a reason behind whether or not their loved ones will relapse (Mohd Taib, Rusli & Mohd Khairi, 2000). Swanepoel et al., (2016) also found that many rehabilitated substance abusers relapse because of the absence of family support. Poor support from family members was identified as one of the major contributors to relapse among rehabilitated substance abusers at the microsystem level (Goldman, 2023).

In agreement, the Substance Abuse and Treatment Policy (2021) declares that for young substance abusers, this can lead to relapse after treatment due to poor support and follow-up by the family.

5.4.1.2 Sub-theme 1.2: Intrapersonal factors

In this study, some participants voiced poor socio-economic status due to unemployment as a factor leading to relapse of rehabilitated users. The participants opined:

- **Unemployment**

“For example, unemployment. A husband and a father who are the head of the family and are unable to provide basic needs for their family will have a problem with poor self-esteem and ego. These will make him abuse substances to forget about such problems. Taking him for rehabilitation, whether forced or volunteered, coming back to the same situation will drive him to relapse.”

Patient 8

This study's findings are in line with Godbey (2009) and Wegner, Flisher, Caldwell, Vergnani and Smith (2008), who found that broader economic difficulties experienced by communities due to scarce resources and lack of leisure activities are further associated with substance use and relapse of the rehabilitated users.

- **Substance use for leisure or pleasure-seeking**

Participants alluded that when at home or in the community, some rehabilitated users use substances during leisure time to manage boredom. The participants opined:

“Some people take drugs because they want to feel good. As you know, drugs are known to produce a feeling of pleasure. The problem with people engaging in drug taking to make them feel good at first, they see it as a good thing, and they believe that they can manage and control their use, but soon it becomes part of their lives, and they always need to take the drug to feel normal which is one of the reasons behind relapse.” **Patient 4**

These study findings are in line with those of Darling et al. (2005), Wegner et al. (2006), and Wegner (2011), who revealed that leisure boredom was linked to substance use in South Africa. The literature suggests that the influence of leisure activities plays a vital role in adolescent substance use. In support, Wegner (2011) reported that if a person, especially adolescents, lacks leisure skills or is constrained from participating in leisure activities, boredom results, which may lead to substance use.

- **Coerced for treatment**

Participants highlighted that some users are involuntarily admitted for treatment, which results in them not following the rehabilitation programme upon discharge.

“Those who come here because of instructions from family, in most cases, relapse shortly after rehabilitation. We have cases of patients who attempt to smuggle substances into the rehab, and tracing the root cause thereof, the findings are the patient was brought here because their family forced him to do so. Those are the patients who relapse soon after rehabilitation and discharge. Treatment cannot be successful if the individual’s mental state, physical, and emotional state is not ready for the treatment.” Nurse 2

“Forcing an abuser to go for rehabilitation and threatening him with losing some privileges requires him to be provided with the necessary support; otherwise, they become tempted to relapse after rehabilitation.” Nurse 6

“Mostly self-initiated abusers do comply with after programmes unlike those who were coerced to go for treatment.” Nurse 3

Studies examining formal coerced addiction treatment among incarcerated individuals found that it is less effective at reducing substance use and recidivism when compared to controls (Lambert, 2022). In a prospective study in a Norwegian hospital, Pilarinos (2020) revealed that voluntary participants had higher reductions in substance use frequency than coerced participants. Furthermore, a systematic review of compulsory drug treatment determined that existing evidence is inconclusive, suggesting potential harms associated with coercive interventions (Pilarinos, 2020).

5.4.2 Theme 2: Aftercare guidelines to prevent relapse

From the analysed data, two sub-themes emerged under theme two of the aftercare guidelines before discharge and aftercare programme. Each theme and sub-theme is discussed below with categories.

5.4.2.1 Sub-theme 2.1: Before discharge

Participants shared their views on how best to prepare aftercare. They indicated that it should start when the patient is still admitted to the centre and should be incorporated within the rehabilitation programme. The participants opined:

“I mean, aftercare is an outpatient service for substance abusers who have completed their inpatient treatment programme. Therefore, aftercare arrangements are to be made before discharging the client from the treatment and rehabilitation facility. Such a plan should specify the person responsible for providing aftercare, the time, frequency, place, and type of contact.” **Nurse 9**

“Aftercare arrangements are to be made before discharging the client from the treatment and rehabilitation facility. Such a plan should specify the person responsible for providing aftercare, the time, frequency, place, and type of contact.” **Patient 5**

“Family support plays a very important role in preparation for discharge. The institution’s multidisciplinary health team needs to arrange meetings with the family and discuss the support needed to prevent relapse for the rehabilitated substance abuser.” **Nurse 2**

“Detailed and well-planned aftercare arrangements must be done before discharge. This will ally anxiety and frustrations on the user since it will be clear as to what will happen from here.” **Patient 8**

- **Skills development/sport leisure activities**

“Individuals admitted to inpatient substance abuse facilities should receive treatment and rehabilitation as well as skills development.” **Patient 3**

In a study exploring school-based participation in leisure activities, Darling, Caldwell and Smith (2005) found lower substance use among adolescents involved in extra-mural activities, with boredom negatively influencing adolescent development. They further state that those who participated in non-sport extra-curricular activities reported consistently better adjustment than those who did not participate in these activities.

5.4.2.2 Sub-theme 2.2: Aftercare programmes

Participants narrated the need for aftercare activities that must be implemented to prevent relapse of the rehabilitated users. The activities include individualised programmes, family support, professional support, and support groups. Each sub-theme and category is presented below.

- **An individualised aftercare programme**

Participants indicated that the one-size-fits-all approach to aftercare does not yield the desired results; therefore, they believe that an individualised programme would be relevant and effective in preventing relapses. The participants opined:

*“A good aftercare programme also needs to be individualised. All clients differ in their problems, needs, psychological capacities, and social capacities and resources. A flexibility that allows more individual choices makes a programme more attractive and effective.”***Nurse 5**

“Programmes to suit abusers' individual needs in terms of identification of drug-craving, psychological, and other cues that trigger craving, tracking of craving urges, anticipating situations that may lead to drug use, and handling cravings according to the programme. Developing social and intimate relationships with non-drug-using people and peers, engaging them in non-drug-using ‘fun’ activities establishing healthy social activities.”

According to White Paper Correction (2015) and Mokwena (2021), rehabilitation is highly person-centred, meaning that the interventions selected for each individual are targeted to their goals and preferences. Furthermore, rehabilitation can be offered in

various places, such as inpatient or outpatient hospital settings, outpatient physio- or occupational therapy practices, and community settings, such as an individual's home, school, or workplace (Mokwena, 2021).

- **Individual responsibility**

Based on their work experience, participants alluded that a user must partake in the recovery. The participants opined:

*"It can be concluded that over and above what the significant others in the service user's environment can do to help them maintain sobriety, ... the service user also has a responsibility to make a deliberate effort to make sure that they succeed. For instance, applying effective coping skills as learned through the treatment process and attending aftercare are some of the responsibilities that are linked to the personal efforts of the affected individual."*Nurse 1

- **Family support**

This study's participants indicated that the family plays a part in the lives of substance users and relapse prevention. They state ways in which rehabilitated users would love to have support from their family members. The participants opined:

*"Family support is very important, especially in preventing relapse after rehabilitation. A strong family support can help a recovering abuser overcome the temptation of peer pressure, stigmatisation, and avoidance of any temptations."***Patient 3**

"Aftercare programmes and dates are to be agreed upon for the family to assist the rehabilitated abuser in complying with aftercare programmes." Patient 4

"Sometimes, even those who went for rehabilitation against their will, if they have the necessary family support after rehabilitation, they succeed in remaining clean permanently." **Nurse 6**

According to Daley (1985), to have a successful recovery process, the availability of support from loved ones, family knowledge about the relapse process, functional families, and involvement in personal programmes are more likely to help decrease the chances of relapse of rehabilitated substance abusers. Furthermore, when families are provided with good direction and learn to work together, they can be transformed into a great source of support because working together rebuilds families.

In line with this study, Suchman, Pajulo and Mayes (2016) indicate that drug addiction is a severe condition that even the strongest-willed individuals cannot succeed on their own. Thus, they found that most rehabilitation centres reported that it is often the mother or father who initiates treatment for their minor or adult children. Patients with substance abuse disorder are, therefore, dependent upon their families to reach out for help that contributes to their health improvement (Suchman, Pajulo & Mayes, 2016). Furthermore, families can play an important role in being a supportive structure for abusers who are undergoing treatment and managing the recovery process, if not dysfunctional. Similarly, Scott (2023) found that most participants mentioned that support from family members could help them stop relapsing. What also came up was that for the families and communities to be support systems, they need to be educated about addiction.

- **Professional support**

Participants shared that professional support is crucial when a user is at home. The participants opined:

“Counsellors need to keep close contact with rehabilitated abusers until they are satisfied that they can withstand any temptation to relapse. Regular meetings with other rehabilitated abusers may also help by sharing experiences.” **Patient 5**

“That is the reason why social workers have to arrange alternative placements for such people...regular meetings with other rehabilitated abusers may also help by sharing experiences.” **Nurse 2**

“The government needs to establish or build various treatment services in the communities. Services like inpatient and outpatient rehabilitation centres,

aftercare groups, support groups, and other community organisations to assist in the prevention and reduction of substance abuse. **"Patient 9**

The rehabilitation workforce comprises various health workers, including but not limited to physiotherapists, occupational therapists, speech and language therapists and audiologists, orthotists and prosthetists, clinical psychologists, physical medicine and rehabilitation doctors, and rehabilitation nurses. Other health workers, such as general practitioners (GPs), surgeons, and community health workers, may also play an essential role in a person's rehabilitation (Jay, 2014). Rehabilitation can be provided in different places, such as inpatient or outpatient hospital settings, outpatient physio- or occupational therapy practices, and community settings, such as an individual's home, a school, or a workplace (White Paper Correction, 2015).

5.5 CHAPTER SUMMARY

This chapter presented and discussed the findings of the study from nurses, which included themes, sub-themes, and categories that were identified and supported by the literature. Chapter six presents the development of aftercare guidelines to prevent the relapse of rehabilitated users.

CHAPTER 6

DEVELOPMENT OF AFTERCARE GUIDELINES TO SUPPORT AND PREVENT THE RELAPSE OF REHABILITATED SUBSTANCE ABUSERS

6.1 INTRODUCTION

The findings of phase one formed the basis of phase two, presented in Chapters 4 and 5. Phase two of this study comprised the development of the guidelines. In developing certain aspects, factors such as the situational analysis outlined in phase one above, which provided insights into experiences and perceptions of guidelines as contributory factors to substance abuse, needed to be considered. Phase two of the study is discussed in detail after all the data have been analysed. The six elements of practice theory outlined by Dickoff *et al.* (1968), SWOT, and BOEM informed the development of the guidelines.

6.2 THE THEORETICAL FRAMEWORK FOR THE DEVELOPMENT OF GUIDELINES

The six elements of practice theory outlined by Dickoff *et al.*, (1968) include context, agents, recipients, dynamics, processes, and outcomes. These elements are described and applied below.

6.2.1 Context

The context is viewed from the aspect of the matrix of activity; it is seen to other things, including persons and other activities, and the interrelation of these other factors as constituting an organism, unity, or total context of activity. Dickoff *et al.*, (1968) further

refer to the 'context' as the setting, location, physical structure of the ward or unit, hospital, or medical centre; time, space, or structure that constitute different elements of the situation in which the activity occurs.

In this study, the settings where the guidelines were implemented are the rehabilitation centre and the hospital, where all activities to guidelines for preventing relapse occur.

6.2.1.1 Rehabilitation centre context

A rehabilitation centre context in this study refers to the BRC used. Guidelines indicate that assessment and orientation of users should be done at the rehabilitation centre before they are allocated to the programmes so that they know what to expect and what is expected of them, such as not smoking in the room, not using drugs, what time breakfast is, and what time are they expected to be in class for the programmes (bestValueSchools.com, 2020).

6.2.1.2 Beethoven Hospital context

A rehabilitation centre refers to a specialised psychiatric hospital in the North West. For this study, it refers to the Beethoven Rehabilitation and Psychiatric Hospital. A psychiatric hospital is a health establishment that provides care, treatment, and rehabilitation services for users with mental illness (MHCA No 17 of 2002). Guidelines indicated that some activities like orientation should be done in the hospital so that the nurses are ready to face healthcare users and know how to handle those users' behaviours. The Centre is a residential establishment that provides short-term and long-term medical care consisting of observational, diagnostic, therapeutic, and rehabilitative services for persons suspected of suffering from a disease or injury and for the parturient. Its function is to provide comprehensive healthcare to the population, both curative and preventive, with outpatient services extending to the family in its environment. The hospital is also a centre for training health workers and bio-social research (Amin, 2017).

6.2.2 Agent

- An agent is any person whose activity leads to the realisation of their goal (Dickoff et al., 1968). The findings of this study revealed that there is a need for agents from centres whose activities lead to the recovery of these guidelines. Monux, Juan, Cortes, Soler and Cenia (2016) indicate guidelines are essential for the appropriate training and adaptation of participation. They teach, guide, monitor, and facilitate the integration of abusers into the community. Agents to implement the developed strategies are: Hospital management; All health workers and PNs; as well as the family.

6.2.3 Recipient

Recipients are those who receive action from agents and benefit from the activity (Dickoff et al., 1968). The findings of the study reveal that recipients of the activity that the agents will perform are the users who will receive action from the agents to mitigate relapse behaviour.

6.2.4 Dynamics

Dynamics involve the power sources for that activity. These energy sources motivate agents to pursue their activities without getting discouraged (Dickoff et al., 1968). The findings of this study reveal that the energy sources for the activity that the agents will perform to pursue their activity without being discouraged from mitigating rehabilitated users' relapse are positive attitude, professionalism, skills, and knowledge.

6.3 SWOT ANALYSIS MATRIX

A SWOT analysis matrix was developed from the study results and the discussion in Chapters 4 and 5. The matrix reflected the positive and negative internal and external factors identified in how the rehabilitation of users was rendered. Table 6.1 summarises the SWOT analysis matrix identified from the above discussions.

6.3.1 FACTORS INVOLVED IN SWOT ANALYSIS

Internal and external factors within the SWOT need attention because they negatively or positively influence abusers (Bunn & Conlin, 2013).

6.3.1.1 Internal factors

Internal factors are found within the hospitals that help the institution achieve or fail in achieving its objectives. These factors can influence how services are rendered (Bezuidenhout, 2014). They include the strengths and weaknesses of the facility. Internal factors can be manipulated to achieve the objectives of the institution. Strength is the characteristic that gives an organisation an advantage over other entities; weakness is seen as a characteristic that puts an organisation at a disadvantage (Bezuidenhout, 2014). The internal factors include human resources, competencies, financial costs, and services. Human resources are personnel needed to perform certain duties or jobs (Booyens & Bezuidenhout, 2013). In this study, the management and professionals (agents) who facilitate the orientation and implementation of the programme (processes) to the users (recipients) are available at the rehabilitation centre (context).

Financial costs pertain to adding value to a product or service; it has to do with the availability of funds, equipment, and maintenance of day-to-day functions (Booyens et al., 2013). Financial costs pertain to the availability of resources. For example, resources such as materials, human resources, and others are necessary to enable agents (PNs) to easily implement programmes for users.

6.3.1.1.1 Strengths and weaknesses

The study results revealed the strengths and weaknesses as internal factors focusing on human resources, financial costs, and services.

6.3.1.1.2 Services

- **Availability**

According to Dickoff et al. (1968), the availability of services involves the activities (processes) needed to achieve the institution's goals and outcomes. The study results indicated that the rehabilitation programmes at the centre were available, but they were few due to loitering and lack of interest in participating. In addition, participants indicated that some users have family members who are available, while others do not. As a result, only the available participants get help. Secondly, not all rehab areas are adequate. In addition, not all participants are willing to attend sessions.

- **Accessibility**

Dickoff et al. (1968) contend that the service is mainly available to the participants. This allows all participants to acquire the necessary skills. However, some of the participants lacked interest. This led to the challenge of poor skills.

- **Affordability**

Actions performed within an affordability framework were seen as the activities performed by the users and healthcare workers as a process that resulted in outcomes. In addition, the study findings indicate that rehabilitated users miss follow-up sessions due to financial constraints.

- **Acceptability**

Acceptability of the service involves agents, dynamics, processes, and terminus, as indicated by Dickoff et al., (1968). The study findings also revealed that users accepted the responsibility to attend sessions and remain substance-free. In addition, participants are responsible for availing themselves in the areas and accepting the skills and knowledge imparted to them. Therefore, the availability of participants and acceptance of the service will result in successful attendance of participants as a process and dynamics; hence, the rate of relapse as a terminus (Dickoff et al., 1968).

6.3.1.2 External factors

External factors include opportunities and threats that affect the service provided in the facility (Bezuidenhout, 2014). In this study, opportunities are characteristics that can be used to the organisation's advantage and help implement the rehabilitation programme. Threats are aspects that can negatively affect the organisation and are harmful in implementing treatment (Bezuidenhout, 2014). External factors include political, economic, socio-cultural, law, and environmental aspects.

- Political factors are the authority and powers provided by the country's constitution or government policies (Booyens et al., 2013). The centre management created vacancies for health professionals to ensure the implementation of rehabilitation programmes and sessions for all admitted users.
- Economic factors influence users to consistently attend the rehabilitation programme. They entail finances where, if a person is poor, it will determine the quality and quantity of the services offered (Booyens et al., 2013). All users use medical schemes to pay for the services provided during admission, treatment, and rehabilitation.
- Socio-cultural factors influence a person's health through their lifestyle, attitude, education, and effects of culture. According to the study findings, the rehabilitated users' relapse was influenced by social factors like living with family members who are using substances and the availability of substances around them.
- Technology entails the indications of medical advances with the provision of newly designed equipment (Bezuidenhout, 2014). This study participants (users) have cell phones, which can be used to communicate with professionals if they are not attending sessions. Nevertheless, the study findings revealed a lack of aftercare communication between users and professionals to provide support.
- Environmental factors are factors that affect the organisation and changes in the climate (Bush, 2016). The findings indicate the availability of substances at home and the unavailability of structures to keep users occupied, which play a role in user relapse.

6.3.1.2.1 Opportunities and threats

A PESTLE helps identify how factors such as opportunities and threats will influence and affect activities (process), users, and professionals (agents) implementing the aftercare rehabilitation guidelines. It is often used with the last two letters of SWOT analysis so that a person clearly understands the situation related to internal and external factors (Bush, 2016). A PESTLE is a mnemonic that, in its expanded form, denotes P for Political, E for Economic, S for Socio-cultural, T for Technological, L for Legal/Law, and E for Environmental factors that give a bird's eye view of the whole environment from many different angles that one wants to keep track of while contemplating on a certain idea/plan (<http://pestleanalysis.com/what-is-pestle-analysis>).

6.3.1.2.1.1 Political

Politics exert a negative and positive impact on the health care system, which also influences or affects aftercare of rehabilitated users. The political factor under consideration would be building an aftercare centre or allocating insufficient funds for conducting aftercare rehabilitation programmes. The study's findings revealed that a shortage of aftercare programmes, professional support, and aftercare centres hamper the provision of aftercare to rehabilitated users. Consequently, users will keep on relapsing, and readmission rates will be high.

6.3.1.2.1.2 Economic factors

Economic factors can result in a negative or positive outcome, depending on their availability and use. The users are on medical aid schemes, and due to their readmission frequency, the funds can be depleted, resulting in denied admission.

6.3.1.2.1.3 Socio-cultural factors

Some participants' values, beliefs, and culture negatively impacted their drug-free status. According to the study findings, participants' relapse was influenced by social

factors like cultural ceremonies or events where alcohol is one of the substances to be prepared. This tempts the users to drink in the name of celebration.

6.4 SWOT ANALYSIS MATRIX

From the results of the study and the discussion in section 6.4 above, a SWOT analysis matrix was developed. The matrix reflected positive and negative internal and external factors identified in the rehabilitation of users. Table 6.1 summarises the SWOT analysis matrix identified from the above discussions.

Table 6.1: SWOT analysis matrix

	STRENGTHS	WEAKNESSES
INTERNAL FACTORS	- Abusers have insight into what alcohol and drugs are doing to their lives - Participants voluntarily go to rehabilitation - Abusers have their own medical aid schemes - They know the triggers, but are unable to avoid them	- Stressful life conditions cause some weaknesses, and users resort to drugs and alcohol to ease their pain - Lack of emotional intelligence - Lack of resiliency - Some were affected by their upbringing

	OPPORTUNITIES	THREATS
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Availability	• Available mental health care workers • Availability of mental institutions • Availability of funds • Availability of families and friends	• Inadequate mental health care institutions, especially in rural areas • Most mental health care specialists are in townships • Insufficient resource • Lack of aftercare • Lack of family support • Friends using substances
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Table 6.2: BOEM action plan

INTERNAL FACTORS	STRENGTHS	BUILDING ON STRENGTH
	HUMAN RESOURCES AGENTS	ACTIONS
	Availability of health professionals and hospital management.	Management should conduct awareness through meetings, in-service training, and workshops for staff members on the aftercare guidelines.
	Availability of family.	- All health workers and PNs should implement the aftercare guidelines before and after discharge. - Professionals should continue to support users while at home. - The family should be involved in the rehabilitation of the user during admission. - The family should support the user upon discharge.
	COMPETENCIES DYNAMICS	ACTIONS
	PNs possess the knowledge and skills to empower users.	- PNs should possess the necessary skills and knowledge to support users. - Skills and knowledge should be imparted to users.
	FINANCIAL COSTS	ACTIONS
	Medical aid schemes are available for most users.	The users must be adequately supported by negotiating for funds to be released from medical aid (recipient).
	SERVICES PROCESSES	ACTIONS
	Accessibility	
	Rehabilitation centres are easily accessible to some users.	The management should improve the rehabilitation centres' accessibility process for the users' admission funding.
	Availability	
	Rehabilitation programme availability.	Aftercare guidelines and programmes should be infused into the available programme.
	Acceptability	
	Acceptance and implementation of the available rehabilitation programme.	- Management should ensure that guidelines and programmes are accepted and implemented. - The family should also accept and implement guidelines. - Users must accept the aftercare guidelines, show interest, and have a positive attitude to change.
	Affordability	

	The affordability of funds for users through medical schemes.	Management should arrange for government subsidies for those who cannot afford to pay.
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INTERNAL FACTORS	WEAKNESSES	OVERCOMING WEAKNESSES
	HUMAN RESOURCES AGENTS	ACTIONS
	Inadequate nurses at the time. Lack of professional aftercare. Lack of family support. Having friends who use substances.	- Adequate nurses' numbers of support at the time. - Professionals should continue supporting users' aftercare. - The family should be involved in the rehabilitation of the user during admission. - Users should be encouraged to change friends.
	COMPETENCIES DYNAMICS	ACTIONS
	Lack of knowledge and skills	- Management should conduct awareness through meetings, in-service training, and workshops for staff members on the aftercare guidelines. - All health workers and PNs should implement the aftercare guidelines before and after discharge. - Professionals should continue to support users while at home. - The family should be involved in the rehabilitation of the user during admission. - The family should support the user upon discharge.
	SERVICES PROCESSES	ACTIONS
	Availability	
	Lack of aftercare guidelines to prevent relapse.	Aftercare guidelines should be developed.
	Acceptability	
	The negative attitude of PNs towards readmitted users.	All professionals should display a positive attitude when they see them as their role models.
	Affordability	

	The affordability of funds for users differs from one individual to another. Lack of aftercare centres.	• Management should arrange government subsidies for those who can't afford to settle their bills. • Management should motivate aftercare.
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EXTERNAL FACTORS	OPPORTUNITIES	EXPLORING OPPORTUNITIES
	POLITICAL	ACTIONS
	Availability of funds and subsidy.	• The government should allocate sufficient funds to the rehabilitation centre and subsidise users.
	ECONOMIC	ACTIONS
	Users rely on medical aid schemes.	• Rehab management should request a subsidy from the government to assist those who can't pay.
	SOCIO-CULTURAL	ACTIONS
	Available family, friends, and community members.	• Friends, family and community members should be involved in the rehabilitation process. • Workshops and awareness should be conducted to family, friends, and the community regarding substance.
	TECHNOLOGICAL	ACTIONS
	Availability of cell phones for users, family, and professionals.	• Professionals can offer aftercare support to users and families through cell phones. • Families and users can also reach out and communicate with professionals through cell phones in times of distress. • Distant family and friends can support the user through the phone.
	LAW	ACTIONS
	Rules, regulations, and policies regarding how to remain substance-free are available.	• Professionals should be capacitated on how to support and empower users and families toward substance-free status.
	ENVIRONMENTAL CONTEXT	ACTIONS
	Family, friends, community and substance availability.	• Intensive rehabilitation centre process orientation should be done upon arrival so that the user and the family are ready for the rehabilitation programme.

EXTERNAL FACTORS	THREATS	MINIMISING THREATS
	POLITICAL	ACTIONS
	Shortage of rehabilitation centres and human resources.	• Rehabilitation centres and hospitals should motivate for sufficient funds to hire more staff.
	ECONOMIC	ACTIONS

	There are no funds for those not covered by medical aid.	The rehabilitation centre management should use appropriate negotiation when requesting subsidy funds.
	SOCIO-CULTURAL	ACTIONS
	Use of substances by participants.	Counselling of participants for social problems and substance abuse.
	TECHNOLOGICAL	ACTIONS
	Lack of communication among users, family, and friends.	Improve communications between all stakeholders.
	LAW	ACTIONS
	Inadequate orientation regarding substance use policies, rules, and regulations.	Improve the orientation process on different types of policies, rules, and regulations.
	ENVIRONMENTAL CONTEXT	ACTIONS
	The environment is not ready to promote and support rehabilitation and recovery. Users relapse immediately after being discharged.	Aftercare guidelines should be implemented.

6.5 DEVELOPMENT OF THE GUIDELINES

The information discussed under the SWOT matrix indicated the strengths, weaknesses, opportunities, and threats in mitigating relapse. Information from the SWOT matrix was used to develop the guidelines (Guillory & Galindo, 1995). To mitigate the relapse of users, the Build, Overcome, Explore, and Minimize (BOEM) guidelines were used, as outlined in Pearce (2010). Therefore, the aftercare guidelines to prevent the relapse of rehabilitated users were developed by building on strengths, overcoming weaknesses and challenges, exploring opportunities, and minimising threats. Table 6.3 illustrates the developed aftercare guidelines.

Table 6.3: The developed aftercare guidelines to support rehabilitated users

KEY FINDINGS FROM THE STUDY

KEY FINDINGS FROM THE STUDY	ACTIONS
FAMILY INVOLVEMENT	The rehabilitation centre management should: <u>During admission</u> • Involve the family in the care plan process. • Invite the family to attend some of the sessions/therapies. • Allow the family to provide input into the aftercare programme. <u>In preparation for discharge</u> • Involve the family in the aftercare plan. • Co-design the aftercare plan with the family and the user. <u>During discharge</u> • Allow the family to champion the aftercare plan.
AFTERCARE PLAN	Professions should: • Individualise the care. • The plan should specify the following: <i>a) the person responsible for providing aftercare,</i> <i>b) the time</i> <i>c) frequency,</i> <i>d) place, and</i> <i>e) type of contact.</i> • Provide a flexible care plan and allow more individual choices.
EMPOWERING	The professional and family should encourage and empower users:

	• Developing drug-free social and intimate relationships. • Establishing healthy social activities. • Identification of drug-craving. • Cues that trigger craving. • Handling cravings.
PROFESSIONAL SUPPORT	Health professionals should: • Keep close contact with rehabilitated users. • Hold climate meetings with users. • Form support groups. • Establish life coaches.

6.6 CHAPTER SUMMARY

Chapter 6 presents and discusses the development of aftercare guidelines to support and prevent relapses in rehabilitated users. The six elements by Dickoff et al., SWOT analysis, and BOEM action plan were used to develop the guidelines. The next chapter discusses the validation of the developed aftercare guidelines.

CHAPTER 7

VALIDATION OF THE DEVELOPED AFTERCARE GUIDELINES

7.1 INTRODUCTION

Chapter 6 presented the development of the aftercare guidelines to prevent the relapse of rehabilitated users at BHC. This chapter will present the validation of the developed aftercare guidelines, including methodology, sampling of validators, profile of validators, and validation of the developed aftercare guidelines by validators.

7.2 METHODOLOGY

A qualitative approach using appreciative inquiry design was adopted to validate the developed aftercare guidelines.

7.2.1 Sampling of validators

Chinn and Kramer (2011) supported the selection of validators who were health professionals. These authors reported that selecting health professionals to validate the guidelines in practice promoting health-related goals is referred to as practice-based evidence in healthcare literature. Therefore, the researcher was prompted to select health professionals who care for substance users in their daily work while others are directly involved in postgraduate supervision. Additionally, health professionals who are experts in psychiatric nursing practice gave practice-based evidence for validating the guidelines.

7.2.2 Profile of the validators

Two distinct populations validated the developed guidelines. The first were mental health care nurses working at BHC. These experts were selected considering the study's context and to ensure member checks to ascertain that the guidelines are applicable. The second population consisted of 12 mental health experts and researchers who were purposively selected with the assistance of the promoters. They were all within UNIVEN, Faculty of Health Sciences. Chinn and Kramer (2008) supported the selection of health professionals. Among the team of validators, eight held PhD qualifications and were deemed qualitative research experts, while four were registered PhD candidates.

7.3 VALIDATION OF THE DEVELOPED AFTERCARE GUIDELINES BY VALIDATORS

The developed aftercare guidelines were validated as per Chinn and Kramer's (2011) guidelines using five questions:

- How clear are the guidelines?
- How simple are the guidelines?
- How general are the guidelines?
- How accessible are the guidelines?
- How important are the guidelines?

7.3.1 Validation of the developed aftercare guidelines by academic expert validators at UNIVEN

The guidelines were presented to the validators as a PowerPoint presentation and evaluated in four sessions through Microsoft Teams, with the assistance of the promoters. The validation process was conducted by allowing the researcher to present the guidelines to the group at four different times in the presence of the promoters. The first presentation's comments by the group are highlighted in red, while the second presentation's comments are in orange, the third presentation's comments

are in blue, and the fourth presentation's comments are highlighted in green (see Appendices K1 – K4).

The validators used the criteria Chinn and Kramer (2008) outlined to validate the developed guidelines draft. Furthermore, after the inputs were made to the initial structure of the guidelines and corrections were implemented, the researcher presented the second, third, and fourth drafts of the structure of the guidelines to the group for further validation and input. All corrections were effected.

7.4 CHAPTER SUMMARY

This chapter validated the developed guidelines. The guidelines were validated based on Chinn and Kramer's (2011) approaches. Chapter 8 will present the study's evaluation, conclusion, limitations, and recommendations.

CHAPTER 8

EVALUATION, CONCLUSION, LIMITATIONS, AND RECOMMENDATIONS

8.1 INTRODUCTION

The previous chapter described the guidelines for implementing strategies to mitigate user relapse in specialised psychiatric hospitals. This chapter discusses the study's evaluation, limitations, conclusions, and recommendations.

8.2 EVALUATION OF THE STUDY

This study was evaluated based on its purpose and the objectives discussed in Chapter 1. These are detailed below.

8.2.1 Purpose of the study

The purpose of this study was to develop aftercare guidelines to mitigate the relapse of rehabilitated substance users at BHC. To achieve this aim, the experiences of readmitted users and the views of nurses regarding rehabilitation relapse and

aftercare support needed were explored and described through unstructured, in-depth individual interviews. This was fundamental in the development of the aftercare guidelines to prevent the relapse of rehabilitated users in BHC, North West, South Africa. Therefore, the study's purpose was achieved.

8.2.2 Objectives of the study

The objectives of the study are in two phases, as described below:

Phase one: Situational analysis

- To explore and describe the experiences of readmitted substance abusers that contributed to their relapse.
- To explore and describe the aftercare support needed by readmitted substance abusers.
- To explore and describe the perceptions of nurses regarding the causes of readmission of rehabilitated substance abusers.
- To determine the aftercare support guidelines to be developed.

Phase two: Development and validation of the guidelines

- To develop the aftercare guidelines to support and prevent the relapse of rehabilitated substance abusers in the North West Province.
- To validate the developed aftercare guidelines to support and prevent the relapse of rehabilitated substance abusers in the North West Province.

This study was conducted in two phases. Phase one was a situational analysis, and phase two was the development and evaluation of the guidelines. The situational analysis was conducted in phase one, adopting a qualitative approach using exploratory, descriptive, and contextual designs. Data were collected through in-depth individual interviews and analysed according to Tesch's open coding method. The study's objectives were achieved as the participants' experiences and perceptions regarding relapse; the aftercare support needed to prevent relapse were explored by the researcher and described by participants.

- **Development of the aftercare guidelines**

The findings in phase one led to phase two, which was the development and validation of the aftercare guidelines to prevent the relapse of rehabilitated users in North West Province. The development of the aftercare guidelines was informed by the six elements of practice theory outlined by Dickoff et al. (1968), namely agents, recipients, context, process, dynamics, and outcomes. A SWOT analysis was utilised to identify the strengths, weaknesses, opportunities, and threats. Finally, the BOEM action plan was used to develop the aftercare guidelines.

- **Validation of the developed aftercare guidelines**

The developed aftercare guidelines were validated by purposively sampled academics who are researchers, mental health experts, and the psychiatric nurses rendering care to users at BHC. The validation was guided by Chinn and Kramer's (2011) questions relating to the guidelines, namely clarity, simplicity, generalisability, accessibility, and importance. The validation is detailed in Chapter 7.

8.3 CONCLUSION IN TERMS OF STUDY PURPOSE AND OBJECTIVES

As described by Horny (2015), a conclusion is a last resolution or judgment that is made after a period of thought about all information connected with a situation. Therefore, the conclusions from this study's findings are presented based on the study's objectives.

This study explored and described contributory relapse factors experienced by users and nurses at BHC in North West Province. Secondly, the study also explored aftercare guidelines needed to prevent relapse of the rehabilitated users. In-depth individual interviews were conducted with participants to collect data analysed through Tesch's eight steps of data analysis (Creswell, 2014).

The themes are: Aftercare experiences of users leading to relapse and readmission and The support needed by users to prevent relapse.

- **The aftercare experiences of users leading to relapse and readmission**

Participants narrated that they underwent rehabilitation and became free of drugs and alcohol. Upon discharge, due to abuse, lack of family support, peer pressure, and stigma, they relapse and are readmitted, which becomes an ongoing cycle.

- **The support needed by users to prevent relapse**

Participants vocally acknowledged family involvement and emphasised the crucial role of family support in the recovery process. Secondly, participants reported the need for continuous visits and care by healthcare professionals.

- **Factors leading to relapse of rehabilitated users**

Participants narrated that rehabilitated substance abusers are subjected to environmental factors that lead to relapse. Namely, the use of substances in the family, dysfunctional family, and lack of family support. Secondly, intrapersonal factors such as unemployment, use of substances for leisure, and coerced treatment.

- **The aftercare guidelines needed to prevent relapse as perceived by nurses**

Theme four emerged during data analysis when participants indicated that the guidelines should start before discharge when the patient is still admitted to the centre. It should be incorporated within the rehabilitation programme. Secondly, participants narrated the need for an aftercare programme that needs to be implemented to prevent relapse of the rehabilitated users. The programme includes individualised programmes, family support, professional support, and support groups and aftercare programmes.

8.4 LIMITATIONS

This study was restricted to one institution in the North West Province. Furthermore, this study was contextual in that users were interviewed; thus, the study could not get family members' perceptions. However, the study's results and recommendations might contribute to the prevention and release of rehabilitated users.

8.5 RECOMMENDATIONS

Based on the findings of the study, the following recommendations are made:

Nursing practice

- Nurses at the rehabilitation center must emphasise and reinforce the use of developed aftercare guidelines when reviewing the institution's programmes.

Nursing education

- The centre must offer workshops for participants and nurses to implement the developed guidelines and reinforce their use.
- The rehab centre should adopt the developed guidelines as part of its programmes.
- The developed guidelines might be adopted and applied in the centre of rehabilitation.

Further research

- Further research must be conducted to evaluate the implementation and effectiveness of the developed aftercare guidelines.

8.6 CHAPTER SUMMARY

This chapter evaluated the study based on its purpose and objectives, as discussed in Chapter 1. It also outlined the conclusions of the study based on the themes and sub-themes outlined in Chapters 4 and 5. Finally, the chapter outlined the limitations of the study and made recommendations pertaining to nursing practice and further research.

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APPENDIX A: ETHICAL CLEARANCE CERTIFICATE

ETHICS APPROVAL CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms MA Moeketsi

STUDENT NO:
11621877

PROJECT TITLE: **Development of guidelines to prevent rehabilitated substance abusers from relapsing at Beethoven rehabilitation centre, Northwest province, South Africa.**

ETHICAL CLEARANCE NO: **FHS/22/PDC/09/1302**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof M. Maluleke	UNIVEN, Advanced Nursing Science	Supervisor
Dr NS Radiphaswa	UNIVEN, Advanced Nursing Science	Co - Supervisor
Prof ML Ntshikweta	UNIVEN, Advanced Nursing Science	Co - Supervisor
Ms MA Moeketsi	UNIVEN, Advanced Nursing Science	Investigator - Student

Type: **Doctoral Research**

Risk: **Minimal risk to humans, animals, or environment (Category 2)**

Approval Period: **February 2023 - February 2024**

The Human and Clinical Trials Research Ethics Committee (HCTREC) hereby approves your project as indicated above.

General Conditions

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principal investigator) must report in the prescribed format to the REC:
 - Annually (or as otherwise requested) on the progress of the project, and upon completion of the project.
 - Within 48hrs in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
 - Annually a number of projects may be randomly selected for an external audit.
- The approval applies strictly to the protocol as stipulated in the application form. Should any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the REC. Would there be deviation from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the REC and new approval received before or on the expiry date.
- In the interest of ethical responsibility, the REC retains the right to:
 - Request access to any information or data at any time during the course or after completion of the project.
 - To ask further questions; Seek additional information; Require further modification or monitor the conduct of your research or the informed consent process.
 - Withdraw or postpone approval if:
 - Any unethical principles or practices of the project are revealed or suspected.
 - It becomes apparent that any relevant information was withheld from the REC or that information has been false or misrepresented.
 - The required annual report and reporting of adverse events was not done timely and accurately.
 - New institutional rules, national legislation or international conventions deem it necessary.

ISSUED BY:

UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: February 2023

Name of the HCTREC Chairperson of the Committee: Prof MS Maputle

Signature

MS Maputle



APPENDIX B: INFORMED CONSENT

RESEARCH ETHICS COMMITTEE

UNIVEN Informed Consent

Appendix B

LETTER OF INFORMATION

Title of the Research Study: DEVELOPMENT OF AFTERCARE GUIDELINES TO PREVENT SUBSTANCE ABUSERS FROM RELAPSING AT BEETHOVEN REHABILITATION CENTRE, NORTH WEST PROVINCE, SOUTH AFRICA

Principal Investigator/s/Researcher : Menki Annida Moeketsi

Co-Investigator/s/Supervisor/s : Prof Maluleke M. and Dr Raliphaswa N.S.

Brief Introduction and Purpose of the Study: Substance abuse is a challenge that prevails across all ages globally today (Dada, Burnhams, Erasmus, Parry, Bhana, Timolf & Fourie, 2016). Different drugs like cannabis, amphetamine, cocaine, methamphetamine, morphine, and alcohol are abused. The South African Police Data (2013) revealed a 123% increase in drug-related crimes. A study by Swanepoel (2016) reveals that 20% of admissions at rehabilitation centres are readmissions. These have negative effects on individuals, families, communities, and society at large. For example, car accidents, assaults, sexually transmitted diseases, unplanned pregnancies, waste of academic opportunities, as well as damaged relationships with friends and families are caused by substance abuse and driving under the influence of alcohol. Abuse of substances, driving under the influence of alcohol and all related substance abuse can lead to criminal records that cannot be expunged (SAP data 2013). Institutions have been established to rehabilitate abusers. In some instances, the abusers tend to relapse due to a lack of aftercare plans.

Furthermore, aftercare plans must be implemented after rehabilitation and discharge from rehabilitation institutions (Sue, Sue & Sue, 2010). Although treatment services and approaches have been developed throughout the years to address substance abuse, there are still high levels of substance dependency and reoccurring relapses after being discharged

from formal treatment services (Sue, Sue & Sue, 2010). Additionally, the South African National Council on Alcoholism and Drug Dependency (SANCA) provides patient services, outpatient treatment services, diversion programmes, and aftercare services, but there are still reports of relapse. Most drug abusers who enter the criminal justice system are from poverty-stricken and substance-abuse families. The abuse of substances can impact the brain's ability to function in the short-term as well as prevent proper growth and development in the long-term (Gorski, Kelly & Haven, 1993). Substance abuse sometimes leads to the destruction of relationships between the user, friends, and families (Juergens, 2019).

Outline of the Procedures: Once approval has been granted to conduct the study, the project will be explained to the participants and relevant managers. The study objectives, aims, and benefits will be explained to participants to gain rapport, and the study will only be conducted with participants who are willing to participate. The researcher will use an in-depth individual interview to collect data. It will be a one-on-one interview between the researcher and the participants. The interviews will be conducted in a private place and will be at the participants' convenience. The interview will last approximately 30-45 minutes per participant. The researcher will go back to the field for more data if there is still some information that is useful or has been omitted.

Risks or Discomforts to the Participant: No risk

Benefits: The findings will be presented to the Department of Health in the North West Province and in workshops and national and international conferences. Moreover, the findings will be published in peer-reviewed accredited journals for possible publication.

Reason/s why the Participant May Be Withdrawn from the Study: Participants may withdraw from the study at any time with no penalties because participation is voluntary.

Remuneration: No remuneration

Costs of the Study: None

Confidentiality: The researcher will not share information gathered in the research field with anyone outside the research team, such as friends, close family members, or any unauthorised persons. When reporting the data collected, the researcher will not use names or participants' identities. Coding and pseudonyms will be used.

Research-related Injury: There will be no compensation in the study.

Persons to Contact in the Event of Any Problems or Queries:

(Dr Raliphaswa N.S.) Please contact the researcher (0791013244), my promoter (0822627809), or the University Research Ethics Committee Secretariat on 015 962 9058. Complaints can be reported to the Director: Research and Innovation, Prof G.E. Ekosse on 015 962 8313 or Georges Ivo.Ekosse@univen.ac.za.

General:

Potential participants must be assured that participation is voluntary, and the approximate number of participants to be included should be disclosed. A copy of the information letter should be issued to participants. The information letter and consent form must be translated and provided in the primary spoken language of the research population.

CONSENT

Statement of Agreement to Participate in the Research Study:

- I..... hereby confirm that I have been informed by the researcher, **Annida Moeketsi** about the nature, conduct, benefits, and risks of this study - Research Ethics Clearance Number:
- I have also received, read, and understood the above-written information (*Participant Letter of Information*) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials, and diagnosis will be anonymously processed into a study report.
- In view of the requirements of research, I agree that the data collected during this study can be processed in a computerized system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research, which may relate to my participation, will be made available to me.

Full Name of Participant Date Time Signature

I, ...
.....

I, Menki Annida Moeketsi, herewith confirm that the above participant has been fully informed about the nature, conduct and risks of the above study.

Full Name of Researcher

Annida Moeketsi Date..... Signature.....

Full Name of Witness (If applicable)

..... Date Signature.....

Full Name of Legal Guardian (If applicable)

..... Date..... Signature.....

Please note the following:

Research details must be provided in a clear, simple and culturally appropriate manner, and prospective participants should be helped to arrive at an informed decision by use of appropriate language (grade 10 level: use Flesch Reading Ease Scores on Microsoft Word), selecting a non-threatening environment for interaction and the availability of peer counselling (Department of Health, 2004).

If the potential participant is unable to read/illiterate, then a right thumbprint is required, and an impartial witness who is literate and knows the participant, e.g., parent, sibling, friend, pastor, etc., should verify in writing, duly signed that informed verbal consent was obtained (Department of Health, 2004).

If anyone makes a mistake completing this document, e.g., a wrong date or spelling mistake, a new document has to be completed. The incomplete original document has to be kept in the participant's file and not thrown away, and copies thereof must be issued to the participant.

APPENDIX C: PROPOSAL EVALUATION REPORT



University of Venda

OFFICE OF THE DVC: RESEARCH AND POSTGRADUATE STUDIES

TO : MR/MS M.A MOEKETSI
FACULTY OF HEALTH SCIENCES

FROM: PROF. N.N FEZA
DVC: RESEARCH AND POSTGRADUATE STUDIES

DATE : 19 NOVEMBER 2024

DECISIONS TAKEN BY UHDC OF 19TH NOVEMBER 2024

Application for approval of Doctoral Proposal Evaluation Report in the Faculty of Health Sciences: M.A Moeketsi (11621877)

Topic: "Development of aftercare guidelines to support and prevent relapse of rehabilitated substance abusers in Madibeng Sub-District, North-West Province, South Africa."

Supervisor
Co-Supervisor

UNIVEN
UNIVEN

Prof. M. Maluleke
Dr. N.S Raliphaswa

UHDC approved the Doctoral Proposal



PROF. N.N FEZA
DVC: RESEARCH AND POSTGRADUATE STUDIES

FHS/22/PDC/09

APPENDIX D: PERMISSION TO CONDUCT RESEARCH: NORTH WEST PROVINCIAL DEPARTMENT
OF HEALTH

P/Bag x 2068

Mmabatho

2735

Tel: (018) 391 4000

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Sir/Madam,

I, **Annida Moeketsi**, a PhD in Nursing student at the University of Venda, request permission to conduct research at the selected psychiatric and rehabilitation institution.

Title of the study: Development of guidelines to prevent rehabilitated substance abusers from relapsing at Beethoven Rehabilitation Centre North West Province, South Africa

The purpose of the study

The purpose of this study is to develop guidelines to prevent substance abusers from relapsing at the Beethoven Rehabilitation Centre in the North West Province, South Africa.

Objectives of the study

- To explore and describe the experiences of rehabilitated substance abusers and the nursing staff who care for them, focusing on the aftercare needs essential for maintaining a substance-free life.
- To develop guidelines to support substance abusers in preventing their relapse.

Significance of the study

The study could benefit the Department of Health by providing valuable insights into effective strategies to prevent relapse among rehabilitated substance abusers.

For any information, contact the researcher on 079 1533 639 or email anidamengymoeketsi@gmail.com.

APPENDIX E: PERMISSION TO CONDUCT RESEARCH: MADIBENG SUB-DISTRICT DEPARTMENT OF HEALTH

Madibeng Sub-District Department of Health

P.O. Box 5030

BRITS

0250

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Sir/Madam,

I, **Annida Moeketsi**, a PhD in Nursing student at the University of Venda, request permission to conduct research at the selected psychiatric and rehabilitation institution.

Title of the study: Development of guidelines to prevent rehabilitated substance abusers from relapsing at Beethoven Rehabilitation Centre North West Province, South Africa

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For any information, contact the researcher on 079 1533 639 or email anidamengymoeketsi@gmail.com.

APPENDIX F: PERMISSION TO CONDUCT RESEARCH: MADIBENG DISTRICT DEPARTMENT OF HEALTH

Madibeng Sub-District Department of Health

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Sir/Madam,

I, **Annida Moeketsi**, a PhD in Nursing student at the University of Venda, request permission to conduct research at the selected psychiatric and rehabilitation institution.

Title of the study: Development of guidelines to prevent rehabilitated substance abusers from relapsing at Beethoven Rehabilitation Centre North West Province, South Africa

The purpose of the study

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Objectives of the study

- To explore and describe the experiences of rehabilitated substance abusers and the nursing staff who care for them, focusing on the aftercare needs essential for maintaining a substance-free life.
- To develop guidelines to support substance abusers in preventing their relapse.

Significance of the study

The study could benefit the Department of Health by providing valuable insights into effective strategies to prevent relapse among rehabilitated substance abusers.

For any information, contact the researcher on 079 1533 639 or email anidamengymoeketsi@gmail.com.

APPENDIX G: PERMISSION TO CONDUCT RESEARCH: BEETHOVEN REHABILITATION CENTRE

CEO Beethoven Rehabilitation Centre

Beethoven Street

28 IFAFI

Hartbeespoort

0216

REQUEST FOR PERMISSION TO CONDUCT RESEARCH

Dear Sir/Madam,

I, **Annida Moeketsi**, a PhD in Nursing student at the University of Venda, request permission to conduct research at the selected psychiatric and rehabilitation institution.

Title of the study: Development of guidelines to prevent rehabilitated substance abusers from relapsing at Beethoven Rehabilitation Centre North West Province, South Africa

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Significance of the study

The study could benefit the Department of Health by providing valuable insights into effective strategies to prevent relapse among rehabilitated substance abusers.

For any information, contact the researcher on 079 1533 639 or email anidamengymoeketsi@gmail.com.

APPENDIX H: INTERVIEW TRANSCRIPTS

INTERVIEW BETWEEN THE RESEARCHER AND THE PARTICIPANT

- RESEARCHER: Good morning.
- PARTICIPANT: Good morning, colleague.
- RESEARCHER: How are you?
- PARTICIPANT: I am fine, thank you.
- RESEARCHER: Remember I called you the other day requesting an appointment for the interview?
- PARTICIPANT: Yes, I remember.
- RESEARCHER: I am a student at the University of Venda in the Department of Advance Nursing Science and I am doing a PhD. I hear you have been working for some time in this rehab centre.
- PARTICIPANT: Yes.
- RESEARCHER: About how long?
- PARTICIPANT: Three years, I think
- RESEARCHER: So, you have gathered information about rehabilitation and relapse. Can you share with me perhaps what causes rehabilitated patients to relapse?
- PARTICIPANT: Number one, these patients they got to relapse due to the fact that there is a poor support system at home, and by poor support system, I mean family and friends. Lack of support from family and friends is a big problem. Number two is a stigma attached to mental illness that is people tend to look down on you when you are associated with the hospitals' and thirdly is the use of alcohol and dagga at home causes relapse; availability of resources can be another issue, that is you find that some patient are staying far away from help they have to travel from far and there is not enough transportation and lack of funds to support that. Another issue may be a lack of insight into the problem, not having knowledge about the disease and stress; stress can be another fact.
- RESEARCHER: I can see that the following points you have highlighted:
- Poor support system
- Stigma attached to the disease
- Use of substances
- Lack of resources and stress
- RESEARCHER: So, what can be done to help the situation?

- PARTICIPANT: My dear colleague, we need a stronger support system from friends and relatives. Occupy the patient by involving them I study them so that the patient does not get bored and think of going back. Identifying the patient's friends. Attend support groups next to the village.
- RESEARCHER: I hear you say support from relatives. Do you mean they should be educated about the disease?
- PARTICIPANT: Yes, indeed.
- RESEARCHER: Thank you, colleague. I really appreciate your advice, and I know we have taken your lunch time. Thank you very much

DIALOGUE BETWEEN RESEARCHER AND PARTICIPANT

- Researcher: How are you, Popi?
- Participant: I'm fine, and you?
- Researcher: I'm fine, thank you. How is this winter afternoon holding you?
- Participant: I don't know why, but every time I'm here, it's wintertime.
- Researcher: Oh, shame.
- Participant: It's terrible, but I'm used to it now.
- Researcher: Okay, like I spoke to you earlier on Popi, I'm a student. I'm Allita Menge Moeketsi, and I'm studying towards my PhD in Nursing Science with the University of Venda.
- Participant: Wow!
- Researcher: Now I'm doing research, and it's about 'rehabilitation and relapse', so I hope you are ready. Like, I explained to you that you are not forced despite the fact that you signed the consent form, you are not forced to participate, and another thing, even if you've signed the consent, if you feel like you do not want to continue you are free to do so, and your name will never appear anywhere, and I will try as much as possible not to ask questions that will disturb you.
- Participant: Okay.
- Researcher: Popi, can you tell me how you started?
- Participant: I was, I'm actually 44 and in 2013, I used for the first time, so I was a bit older, and I didn't grow up with it at all; good family, but I was in a relationship where, Uhm my boyfriend used Cat and Crystal, but I didn't know that at that time, He was very very sneaky so when I found out I tried to get him off the drugs then one day when he came home after a week or two Uhm I said to him "Come, empty your pockets" and he emptied his

pockets and said “What? What are you going to do?” because he was hitting me as well but I was like “Uhm, I don’t know,” and I said make your lines, and he said “What? Must I do that in front of you?” I didn’t even know how to do it. I said, “Make four lines,” and he took two and said, “I’ll take that later,” and I said, “No, give me that” I rolled the note, and I took the two. I tried not to. Well, it felt like my brain was going to explode, but I was keeping my pose, and from there, I was addicted, but my relapse was more emotional.

Researcher: Okay.

Participant: When I’m very emotional or something happens or I just can’t anymore and because I’m bipolar as well. It’s difficult to live with my bipolar, but with someone hitting you as well is most difficult so I began there. Eight months later it was my first time here in bed with him, and Uhm, I was bleeding from my stomach. I was very sick.

Researcher: Is it?

Participant: So I left him. I just took my clothes and just left. Everything in the apartment was mine, but I just.

Researcher: So you left him with everything?

Participant: I was going to die. I know that, so I didn’t care. I relapsed a year later. I don’t know why. I went to the NA groups, and somebody told me I must speak them out. I didn’t know the girl then so well, but I’ve seen her at the meetings, and she said we must go and drink coffee. To cut a long story short, she was using it in the bathrooms, and she gave it to me and. I didn’t say ‘No’, and I took it, so I relapsed. I’m a binge user, so that means you hit it hard.

Researcher: If you start, you continue.

Participant: I phoned my psychologist here, and I said to her, “Listen here, I’ve got a problem I don’t think I’m going to stop” so I came in very quickly because I know myself, and yah, I was clean for two years and I relapsed again, I started off with non-alcoholic beer and thought it was okay because they said you mustn’t drink alcohol or whatever if you’ve got a substance abuse problem so I drank a non-alcoholic beer for a while maybe for a month or so, and that taste of the beer triggered me to drink.

Researcher: Okay.

Participant: So I started drinking again, and it wasn’t a few days, and when I was drunk or not drunk or if I have two or three beers in, then I want to use, then I called my dealer, and he said, “You can come.”

- Researcher: So you converted from non-alcoholic to alcoholic, and the alcoholic triggered your cravings for drugs?
- Participant: Yes, so non-alcoholic is a 'No No,' a non-alcoholic beer especially because I was always thinking beer and it triggered that feeling of that beer, the alcohol, so I drank beer and it triggered to use again, so I relapsed, and so it went on. So I think in that seven years, uhm I relapsed six times and every time is when I was in an emotional crisis for me or when something went wrong or so and then I got pregnant, so I didn't use for a long time, and then they said my son is going to be an 'Asparagus' but it's a 'High Functioning Autism' so I'm struggling to bond with him because it's a mess, luckily my mom is there and his father is not even in the picture, he doesn't even know that he is there not because of me but because the dad doesn't even want to have any contact with us. When I became pregnant, I was in a relationship, but luckily, that guy was straightforward; he didn't use it or anything, so yah, I became pregnant, and after that, I relapsed again. Like I said, I'm a binge user; I don't use in years.
- Researcher: When you start, do you use too much?
- Participant: Yes, I start where I ended. I don't start with one or two bags or whatever if you know what I'm saying; I start with five bags or whatever so I'm very, very scared now, the same thing happened, and my son really hates me he is now six.
- Researcher: Okay, he is six years old?
- Participant: Yes.
- Researcher: Okay.
- Participant: He is in a special school and I physically got sick for six years I thought I have MS and then it was actually my bipolar medication was strong, it was a high dose so I was in hospital but luckily I figured it out and they took my medication then I had to go to Denmar it's a psychiatric ward because my psychiatrist is there to sort out my medication but luckily I started walking again and all that stuff and with all this my grandmother died and it was all emotional going on and I couldn't cope, I just couldn't cope and the day I relapsed I listened to an autism summit and it triggered me, I was suicidal and was thinking about it but I wouldn't do it because my son you know, rather like a crazy mother than a dead mother, so here is my motivation for not using or staying alive but I've used for two weeks on it, you don't sleep and later you begin to hallucinate and the you're not at your senses and two weeks passed and I realised you can't do this, it's not taking away

the pain but it's making worse and worse it didn't even help anymore so luckily I came and I booked myself in, so hopefully I won't use again for a few years or forever, everybody tries forever but you know it's so difficult when you first get that that craving sometimes it's over, it gets triggered sometimes from a dealer, I must drive there every day past that place it's near my home but that's fine for me now at the moment but emotional stuff was I couldn't cope, the stress was too high I was too anxious and I couldn't cope and I was too tired.

Researcher: And the medication you got from your psychiatrist isn't working?

Participant: No, it wasn't kicking in properly so then I came here before I make a mess of it all.

Researcher: Oh, shame. I'm sorry for that, so can you share with me, in your own opinion, what is that an institution like Beethoven or the South African government can do to reduce relapse?

Participant: You know what? This Beethoven is the best programme of all psychiatric wards I've ever been and most psychiatric wards have a rehab section, but what I like about this one is that they don't break you down, if you go to a place where they treat you like you are nothing and you must clean the toilets and scrub the floors and you're already feeling so low they are not building you up, you know why they are breaking you down emotionally and building you up. That's what I have against the government and the long-term institution, long-term is good, but they mustn't be so hard on you, you already feel like a failure.

Researcher: In other words, they must have empathy with their patients?

Participant: And they must have a good schedule like in the morning have classes and they must force them to go to their classes' because their classes are actually where you learn, psychiatrists and psychologists is it? Psychologists are important for people with a drug addiction with a mental illness as well

Researcher: A what?

Participant: A mental illness, it creates a mental illness, it's a duo diagnosis. I don't think that there's anyone that I've ever met addict that doesn't have mental illness, it starts with one or maybe in the beginning it's not, but I had bipolar before I had the drugs but now it's the drugs with that and that's a mess.

Researcher: So according to you what aftercare can be done to prevent relapse of the rehabilitation?

- Participant: It's a good question, 'Groups' there are "NA" groups, "AA" groups. I'm a good Christian and there are twelve steps they do the twelve steps and they do the NA and then some other meetings because in NA there are everyday visits, so it's very good on a different place but it's very strict and the twelve steps that you must realise tht you can't do it yourself, you are actually helpless and that a higher power can help you go through this or whatever and that is actually for everybody sorry for that but that is my opinion, so if you are not a Christian you are not going to have a problem with it, if you are a Christian and don't have a problem with it it's fine, but I do but there's groups like Beethoven that has a support group for once a month for ex Beethoven relapse addicts, and the social worker is conducting us and it's pretty much the same as here, it's pretty much the same feeling. We talk and she gives a piece of lecture for us to discuss; I think if there are more places like that.
- Researcher: Relapse will be reduced.
- Participant: Yes, definitely.
- Researcher: Thank Popi, and thanks for your time.

INTERVIEW RESEARCHER AND PARTICIPANT

- Researcher: How are you this afternoon, ma'am, in this hot weather?
- Participant: I'm well, thank you. How are you
- Researcher: I am fine, thank you. My name is Annida Moekelnretsi. We spoke over the phone the other day, I made an appointment to come and interview you; there are just a few things I want to go through, although we have discussed them over the phone. I just want to remind you that you are not forced to participate here, and although you have signed the consent, any time when you decide you no longer want to continue, you are welcome to do so. Unfortunately, there's no compensation for participation. I don't expect any harm from this interview. Your name will remain anonymous.
- Participant: I do it with pleasure to contribute to medicine and society.
- Researcher: Thank you so much, so I am Annida Moeketsi like I told you on the phone, I am a PhD student at the University of Venda, and my topic is about drug abuse, rehabilitation and relapse. So, my first question to you will be how many times have you been admitted here?
- Participant: At Beethoven, this is my fourth time.

- Researcher: Your fourth time, okay? Can you share with me what were the reasons for the admission?
- Participant: Yes, of course, the reason for my admission was alcohol abuse, and to get me stabilised in a safe space, I had to identify the fact that triggers the event of falling back to alcohol, and find ways to move forward and in real life, apply what was identified as a way to mitigate.
- Researcher: That was for the first time?
- Participant: Yes
- Researcher: And the second time?
- Participant: The second time was the same also, and the first time, I'd like to add, I was working in a mining environment underground, which was extremely stressful environment. I also fell back and relapsed using alcohol.
- Researcher: Head nodding.
- Participant: The third time exactly the same. I also worked for that mining company and fell back relapsed to alcohol. The fourth time, I relapsed again due to alcohol abuse, which obviously means that I relapsed.
- Researcher: Okay can you share with me the triggers of the relapse? Can you just a little bit elaborates for me?
- Participant: Sure, I'm going to talk in general. Triggers for me would be moving in circles where alcohol is consumed, being put in a situation where I do not have a choice, decision being made for me.
- Researcher: By whom?
- Participant: For example, my husband, he went away for two months. He was afraid that I might fall back to alcohol abuse, he doesn't leave my son alone with me because he was afraid of what might happen if he is not there and he arranged for a lady to come and stay in the house with us. She is also a former patient of Beethoven; however, she was treated for depression and not for substance.
- Researcher: Nodding head.
- Participant: I didn't know the lady, really, and it's a lot of pressure on me because it's because I'm used to when you visit me or if you're a stranger, visit me get a cup of tea and a piece of cake or whatever the case may be then you leave, but now this woman is sitting in my house for two months, so a guest for two months is stressful because I feel I have no privacy, I was not consulted. To ask 'this is what I suggest, and do you agree'? So, it was just done, whilst she was living there, she didn't necessarily stick to the house rules in numerous ways like I have cooking she fed my soup to the

dogs all kinds of strange happenings whilst I told her only Ones, it was like she was deliberately doing things I asked her not to do but the mere fact that she was present the entire time for me I'm not a person that likes.

Researcher: You like your space?

Participant: I like my own space.

Researcher: I understand.

Participant: When I relapse, I want to be with people I know, I don't necessarily need to talk the whole time, I just need to be left alone and she went as far as to, I was drinking in my room because I just couldn't stand her presence anymore. I would hide my bottles somewhere in cupboards, and she would take the bottles out and take photographs, and she would send them to my husband and my therapist at Beethoven.

Researcher: Ooh.

Participant: Yes, so that was a serious invasion of my privacy, I'm a very proud person I didn't appreciate that, so in short someone invaded my space, I didn't have a choice, I wasn't respected for the house rules that were laid down and then she goes behind my back, it's almost like an undercover something.

Researcher: Investigation?

Participant: Yes, that's how I felt, so that was a huge trigger for me because you literally open my cupboards, and you don't know me, It's my stuff, it's my privacy.

Researcher: Especially your bedroom.

Participant: That's actually three more triggers. Another trigger would be when I feel I'm not being heard; for example, in a meeting at work, people would talk straight over me, and I would be saying something, but because I'm soft-spoken, they would just hammer on over me.

Researcher: And ignore your input.

Participant: Yes, it makes me feel worse, it makes me feel like I'm not contributing to the team that my knowledge and experience aren't recognised or adding any value to the company, and that makes me feel worse. I like to know that I'm contributing and making a difference, people don't have to do what I suggest because it's a suggestion as we sit together and discuss, and yet again, it's not what happens it seems that my opinion is not taken into consideration.

Researcher: I demoralised you. Or discussion, so once again, I'm left out. They discuss other people's opinions and suggestions. I don't always have the brightest

suggestions, but at least listen to it. I'm not being listened to and not appreciated.

Researcher: In my opinion, the fact that you're a qualified geologist and that meeting was work-related makes me think that they should recognise your suggestions.

Participant: I thought so; however, my manager and employer, he is a very bombastic person he has a got a he ego and he likes to feel important, so I would be busy talking or giving training for example and he would just run in over me and ravel something, his English is top I think in Afrikaans and speak in English so what I say doesn't sound correct to him so he comes and corrects my grammar.

Researcher: In front of the students?

Participant: In front of the students, he doesn't say that, 'You've said it wrong' but he would relay the same message I did but in other words which implies that he corrected my grammar, so one thing which is really bad for me is if you tell me "you must" it implies no choice, the minute I hear no choice, I become rebellious it's just a feeling that creeps up on me and immediately I think 'you don't appreciate me' so I must do what you want so let me do something I want to do so let me grab something to drink which has bad consequences it's a matter of you asking me but not an instruction there's a difference between a question and an instruction, you instruct me I have no choice so the only choice I have is I can go and drink alcohol, I'll do what you say, but then n I'm drinking alcohol.

Researcher: At work as well?

Participant: Yes, I did, like my employer didn't know, but, however I know and if I ever come into a situation like that again, I can't afford it, in short I've learned a few methods on how to approach them, if he wants to feel important, then make him feel important, like if he falls into my reasoning when he is done I can handle the situation by saying "thank you, Mr Wilson, for your contribution is there anything you would like to add?" that makes him feel important and I'm thinking about a different pattern, it's not criticising me I'm still in control of the situation and he feels important "Mr Wilson" so there's ways to perceive things coming to me, my whole problem is I don't like to be controlled, I don't like being told what to do one good example my dad would come visit us and he would throw it out there like "when last did this lavatory have water?" It's basically saying you are not taking care of your garden, and that's what I'm hearing.

Researcher: It upsets you?

Participant: Yes, it upsets me. Instead of saying, "Well, there's the bucket, and there's the tub if the lavatory needs water then do it," handle it like that instead of seeing it as criticism so I'm prone to perceive things as critic, someone is pointing at me, and one other thing is in the house there are rules for example throw your stuff in the washing basket that normal kind of things which the boys 'my husband and my son' don't do so I feel disrespected and instead of sitting next to a table discussing and saying if the stuff is not in the washing basket it's not getting washed, if the dishes aren't in the dishwasher they are not getting washed and when we eat there won't be any utensils so instead of handling it like that I'm throwing the washing into the basket, pack the washing, pack the dishwasher as usual and as a reward I'm going to have a drink, instead of handling it in a more mature way discussing it because they not going to sense what the boundaries are, they're not going to sense what I'm thinking, we married for 22 years and you still don't know this we have to communicate so I think many of the things I've brought on myself because I don't like the confrontations.

Researcher: It made you feel bad.

Participant: So pack, pack, pack and one day it will explode, and I will go on a serious alcohol binge to get that edge off, I like to do things very precise; however, there is a different way to get the results that I want by approaching. For example, with humour, I'd invent techniques which I now feel are just not hearing. It's actual stuff that empowers me to go out and apply myself to being in control because the worst thing for me is if I feel controlled and I'm like everything I can't control, let me take the edge off, and I take some alcohol.

Researcher: I understand, so now, can you share with me what do you think can be done to prevent your relapse?

Participant: Okay, what I think is very important is to know triggers first of all, be equipped with ways of dealing with your triggers, know your triggers, you must be able to identify when you are triggered and realise that you are triggered you must apply an outcome that was discussed but it's not always that easy when you do not always realise that you are triggered so it's very important to have a support network, like me it's my husband, my son, my psychiatrist, my psychologist and I have a life coach recently as well.

Researcher: A life coach.

Participant: Life coach, so those are my close support network. My husband knows when I'm edgy. He knows the signs, so he will try to mitigate whatever it is like, "Let's cook something." Take my attention off, let's go take the dogs for a walk or something like that, so a support network is extremely important, I think the other thing is medical aids; I don't think medical aids plans accommodate Beethoven specifically all medical aids don't accommodate Beethoven in their 21-day substance abuse programme. So, I think something must be done with the medical aids in collaboration with Beethoven to create at least an opportunity for someone who has a medical aid to also be able to come to Beethoven.

Researcher: For aftercare?

Participant: Yes, for aftercare, so aftercare is extremely important because I also know if I lapse my appointment with my psychologist, lapse my appointment with my psychiatrist is because I'm avoiding them, so it's important for me what I put in place, I have three appointments with each, my husband knows when those appointments are, and I also ask the relevant questions whether it's a doctor or a psychologist, I ask them to please phone me the day beforehand and remind me because it can happen that I do forget.

Researcher: You make sure you don't miss your appointment.

Participant: Also, in terms of what can be done when you go out, I think it's very important to have a follow-up with a patient after maybe a month or three weeks, I don't know what and sit down with them and get feedback like how did you find what we have given you, 21 days is not enough to recover you need to be able to apply what you were equipped with when you were here, I think Beethoven or any institution needs to sit down with patients after a certain period of time to get feedback 'were you able to apply this? How did it work for you? Is there anything you think we could have done more? What is your current situation?' It's a matter of following up. I think it's really important because when a patient gets out of the hospital, especially a psychiatrist, some people, obviously the ones that come back for appointments, you know what their situation is now, and there are those that go and never come back here and how would you know whether what you are doing here is successful or adding value to their lives if you don't follow-up, you hear that someone maybe relapsed, the hospital never interviewed that person to find out how they are doing now and is it

working? So, follow-ups are very important, and that's about what I can think of right now.

Researcher: I think that you've given me very important points, and I want to thank you I forgot to tell you that your name will not appear anywhere. Thank you so much.

Participant: It's a great pleasure, and if you have any questions later, I'd be happy to contribute.

Researcher: I'll avail the report to you after it's completed.

DIALOGUE BETWEEN RESEARCHER AND PARTICIPANT: POPI

Researcher: How are you, Popi? (Pseudonym)

Participant: I'm fine, and you?

Researcher: I'm fine, thank you. How is this winter afternoon holding you?

Participant: I don't know why, but every time I'm here, it's wintertime.

Researcher: Oh, shame.

Participant: It's terrible, but I'm used to it now.

Researcher: Okay, like I spoke to you earlier on Popi, I'm a student I'm Annida Mengy Moeketsi, and I'm studying towards my PhD in Nursing Science with the University of Venda.

Participant: Wow!

Researcher: Now I'm doing a research and it's about 'Rehabilitation and Relapse', so I hope you are ready like I explained to you that you are not forced despite the fact that you signed the consent form, you are not forced to participate, and another thing, even if you've signed the consent, if you feel like you do not want to continue you are free to do so and your name will never appear anywhere and I will try as much as possible not to ask questions that will disturb you.

Participant: Okay.

Researcher: Popi, can you tell me how you started?

Participant: I was, I'm actually 44 and in 2013, I used for the first time, so I was a bit older and I didn't grow up with it at all, good family, but I was in a relationship where, Uhm my boyfriend used Cat and Crystal but I didn't know that at that time, He was very very sneaky so when I found out I tried to get him off the drugs then one day when he came home after a week or two Uhm I said to him "Come, empty your pockets" and he emptied his pockets and said "What? What are you going to do?" because he was

hitting me as well but I was like “Uhm, I don’t know” and I said make your lines, and he said “What? Must I do that in front of you?” I didn’t even know how to do it I said, “Make four lines,” and he took two and said, “I’ll take that later,” and I said, “No, give me that,” and I rolled the note, and I took the two. I tried not to, well, it felt like my brain was going to explode, but I was keeping my pose, and from there, I was addicted, but my relapse was more emotional.

Researcher: Sorry about that

Participant: When I’m very emotional or something happens or I just can’t anymore and because I’m bipolar as well. It’s difficult to live with my bipolar but with someone hitting you as well is most difficult so I began there. Eight months later it was my first time here in bed with him, and Uhm, I was bleeding from my stomach. I was very sick.

Researcher: Is it?

Participant: So, I left him I just took my clothes and just left. Everything in the apartment was mine, but I just left.

Researcher: So, you left him with everything?

Participant: I was going to die I know that, so I didn’t care. I relapsed a year later. I don’t know why, I went to the NA groups, and somebody told me I must speak them out. I didn’t know the girl then so well, but I’ve seen her at the meetings, and she said we must go and drink coffee. To cut the long story short, she was using in the bathrooms, and she gave to me I didn’t say ‘No’ and I took it, so I relapsed. I’m a binge user, so that means you hit it hard.

Researcher: If you start, you continue.

Participant: I phoned my psychologist here and I said to her “Listen hear I’ve got a problem I don’t think I’m going to stop” so I came in very quickly because I know myself and yah, I was clean for two years and I relapsed again, I started off with non-alcoholic beer and thought it was okay because they said you mustn’t drink alcohol or whatever if you’ve got a substance abuse problem so I drank a non-alcoholic beer for a while maybe for a month or so, and that taste of the beer triggered me to drink.

Researcher: Okay.

Participant: So, I started drinking again, and it wasn’t a few days, and when I was drunk or not drunk or if I have two or three beers in then I want to use, then I called my dealer, and he said, “You can come.”

- Researcher: So, you converted from non-alcoholic to alcoholic, and the alcoholic triggered your cravings for drugs?
- Participant: Yes, so non-alcoholic is a 'No No', a non-alcoholic beer especially because I was always thinking beer and it triggered that feeling of that beer, the alcohol, so I drank beer, and it triggered to use again so I relapsed, and so it went on. So I think in that seven years uhm I relapsed six times and every time is when I was in an emotional crisis for me or when something went wrong or so and then I got pregnant so I didn't use for a long time and then they said my son is going to be an 'Asparagus' but it's a 'High Functioning Autism' so I'm struggling to bond with him because it's a mess, luckily my mom is there and his father is not even in the picture, he doesn't even know that he is there not because of me but because the dad doesn't even want to have any contact with us. When I became pregnant, I was in a relationship, but luckily, that guy was straightforward. He didn't use or anything, so yah I became pregnant, and after that, I relapsed again. Like I said, I'm a binge user; I don't use it in years.
- Researcher: When you start, do you use too much?
- Participant: Yes, I start where I ended. I don't start with one or two bags or whatever if you know what I'm saying, I start with five bags or whatever, so I'm very, very scared now; the same thing happened, and my son really hates me; he is now six.
- Researcher: Okay, he is six years old?
- Participant: Yes.
- Researcher: Okay.
- Participant: He is in a special school and I physically got sick for six years I thought I have MS and then it was actually my bipolar medication was strong, it was a high dose, so I was in hospital, but luckily, I figured it out, and they took my medication then I had to go to Denmark it's a psychiatric ward because my psychiatrist is there to sort out my medication but luckily I started working again and all that stuff and with all this my grandmother died, and it was all emotional going on, and I couldn't cope, I just couldn't cope.
- Researcher: You couldn't cope. And the day I relapsed I listened to an autism summit and it triggered me, I was suicidal and was thinking about it but I wouldn't do it because my son you know, rather like a crazy mother than a dead mother, so here is my motivation for not using or staying alive but I've used for two weeks on it, you don't sleep and later you begin to hallucinate and the you're not at your senses and two weeks passed and I realised you

can't do this, it's not taking away the pain but it's making worse and worse it didn't even help anymore so luckily I came and I booked myself in, so hopefully I won't use again for a few years or forever, everybody tries forever but you know it's so difficult when you first get that that craving sometimes it's over, it gets triggered sometimes from a dealer, I must drive there every day past that place it's near my home but that's fine for me now at the moment but emotional stuff was I couldn't cope, the stress was too high I was too anxious and I couldn't cope and I was too tired.

Researcher: And the medication you got from your psychiatrist isn't working?

Participant: No, it wasn't kicking in properly, so then I came here before I make a mess of it all.

Researcher: Oh, shame, I'm sorry for that. So can you share with me, in your own opinion, what is it that an institution like Beethoven or the South African government can do to reduce relapse?

Participant: You know what? This Beethoven is the best programme of all psychiatric wards I've ever been and most psychiatric wards have a rehab section, but what I like about this one is that they don't break you down, if you go to a place where they treat you like you are nothing and you must clean the toilets and scrub the floors and you're already feeling so low they are not building you up, you know why they are breaking you down emotionally and not building you up. That's what I have against the government and the long-term institution, long-term is good, but they mustn't be so hard on you; you already feel like a failure.

Researcher: In other words, they must have empathy for their patients?

Participant: And they must have a good schedule, like in the morning have classes, and they must force them to go to their classes because their classes are actually where you learn, psychiatrists and psychologists is it? Psychologists are important for people with drug addiction and mental illness as well.

Researcher: Mental illness.

Participant: A mental illness, it creates a mental illness, it's a duo diagnosis. I don't think that there's anyone that I've ever met addicted that doesn't have mental illness. It starts with one, or maybe in the beginning it's not, but I had bipolar before I had the drugs, but now it's the drugs with that, and that's a mess.

Researcher: So, in your opinion, what aftercare can be done to prevent relapse after rehabilitation?

Participant: It's a good question, 'Groups' There are "NA" groups, "AA" groups, I'm a good Christian and there are twelve steps they do the twelve steps, and they do the NA and then some other meetings because in NA there's everyday visits, so it's very good on different place but it's very strict and the twelve steps that you must realise that you can't do it yourself, you are actually helpless and that a higher power can help you go through this or whatever and that is actually for everybody sorry for that but that is my opinion, so if you are not a Christian you are not going to have a problem with it, if you are a Christian and don't have a problem with it it's fine but I do but there's groups like Beethoven that has a support group for once a month for ex Beethoven relapsed addicts and the social worker is conducting us and it's pretty much the same as here, it's pretty much the same feeling,. We talk, and she gives a piece of lecture for us to discuss. I think if there's more places like that.

Researcher: Relapse will be reduced.

Participant: Yes, definitely.

Researcher: Thanks, Popi, and thanks for your time.

INTERVIEW: TEBOGO

Researcher: Thank you for allowing me to talk to you like I called you the other day and said that I would like to talk to you regarding Rehabilitation and Relapse. I believe you were once admitted here in Beethoven for rehabilitation of substance abuse, and you recovered, discharged and went home. Can you perhaps share with me what led to your relapse?

Participant: Well, the problems that I had initially brought me here are the ones that led to my relapse, the abuse from my husband, the physical abuse, financial abuse, so I ended up going back to the substance, to alcohol to making myself feel a little bit better that's the reason I ended up relapsing because after my admission he actually tried a bit to accommodate what I was going through and then he stopped with the beating, he stopped with the financial abuse but it was just temporary it didn't last so long, and then he went back to beating me up again in front of kids, taking my car without my permission, went back to cheating again so as a result I took a little bit of comfort which lead to abuse again of the substance and the alcohol.

- Researcher: Okay, but did you get comfort in abusing alcohol and substances for the relief of pain that you were going through?
- Participant: Yes, it was numbing the pain, and it would make me actually sleep better at night when I was drunk, and even when he beat me, then when I was drunk, I didn't actually care as much as when I was sober; it actually made me feel as if I'm not at that situation at that time, it was a comfort for me.
- Researcher: Okay, but can I also ask you another question? What is it, in your opinion, that can be done to prevent relapse of rehabilitated substance abusers?
- Participant: Maybe if, after being discharged, if there could be a person that continues to check patients outside of the hospital to continue with the comfort and to also continue with the rehabilitation because sometimes what happens is because you're admitted, the medical aid continues to pay and then on your discharge they don't pay because it is exhausted, so you cannot go to group sessions again because you cannot afford to pay cash or something like that, so at the end of the day we relapse because no comfort anymore that we got from the group discussions or from the healthcare professionals.
- Researcher: Oh, so in other words, this needs to be brought up with people like Ministers of Health or MECs so that money can be allocated for rehabilitated substance abusers to get a follow-up or aftercare after they have been released from the hospital.
- Participant: I think that would help because if you are feeling out of place for that time and there is somebody there for you, I think it would make it a little bit easier to continue with the intent to quit the substance.
- Researcher: So, are you still with your husband?
- Participant: Yes, I currently have nowhere to go I'm unemployed. We've got three kids, so we basically depend on his money; that's why it was difficult to leave in the first place, I'm an orphan, he found me as an orphan, so I think that's the reason why he takes advantage of the fact that I don't have anyone else but him and the kids.
- Researcher: Okay, because I was of the opinion that maybe if you can separate from him and you avoid that abuse that you are faced with, it can also help you not to relapse, but now that you are saying that you rely on him financially and otherwise it means there's no way you can separate from him.
- Participant: I can't go anywhere, and I still love him.
- Researcher: I understand.
- Participant: He's the only man that I have ever known.

- Researcher: Okay, now tell me, have you ever discussed this with? Because what I know is that when you are admitted here, you have one-on-one therapy as well as family therapy. Didn't it help?
- Participant: Like I said initially, it helped a bit after my discharge, then overtime, he went back to his old ways again.
- Researcher: So he is still like that even now? That's why you are here.
- Participant: Yes, he is still like that.
- Researcher: Okay, I want to thank you for the time that you gave me, and I'm sorry about what you are going through. I hope that one day there could be a solution, maybe a social worker that is regularly visiting you especially allocated for people who have been substance abusers, just to take care of them and see the situation in which they are that can tempt them to relapse. Thank you so much.
- Participant: Thank you.

APPENDIX I: PROOF OF LANGUAGE EDITING

NIM Editorial
Bryanston, Gauteng, 2074
Cell: +27 82 587 4489
Email: info@nimeditorial.co.za
www.nimeditorial.co.za

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Editorial Certificate

To Whom It May Concern,

This certificate confirms that the thesis entitled **“DEVELOPMENT OF AFTERCARE GUIDELINES TO SUPPORT AND PREVENT RELAPSE OF REHABILITATED SUBSTANCE ABUSERS IN MADIBENG SUB-DISTRICT, NORTH WEST PROVINCE, SOUTH AFRICA”** by **MENKI ANNIDA MOEKETSI** was edited by an expert English editor with a PhD. The following issues were corrected: grammar, spelling, punctuation, sentence structure, phrasing, and formatting.

Signed on behalf of NIM Editorial by:

A handwritten signature in black ink, appearing to be 'Dr N.I. Mabidi'.

.....
Dr N.I. Mabidi

Founder & Chief Editor

