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CAUSES OF RELAPSE POST TREATMENT FOR SUBSTANCE DEPENDENCY WITHIN THE SOUTH AFRICAN POLICE SERVICES

by

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DECLARATION

I hereby declare that I, **Mahendhree Chetty** (ID number: 680118 0169 083), submitted my original dissertation to the University of Pretoria, without any plagiarism and all sources have been acknowledged by means of comprehensive referencing.

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MAHENDHREE CHETTY

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DATE

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I hereby wish to express my sincere gratitude to the following individuals who contributed directly or indirectly towards the completion of this study:

- To the almighty God for giving me strength to complete this study.
- My supervisor, Dr. Florinda Taute, for her guidance and support.
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- My colleagues in the SAPS Employee Health and Wellness Unit-KZN Province for their support and assistance in identifying the participants and administering of the questionnaires.
- My family and friends for their love, support and encouragement.

DEDICATION

This work is dedicated to my children, Sandrika and Sachin Chetty for their unwavering love, patience and encouragement during my studies.

ABSTRACT

The aim of this research was to explore the causes of relapse post treatment for substance dependency within the South African Police Services (SAPS). "Alcoholism is a chronic relapsing brain disease, so individuals with substance abuse disorders face the possibility of relapse once they stop using alcohol even if they have had a successful treatment" (Perkinson, 2004:180). According to Connors, Maisto and Donovan (1996:5) research revealed that relapse rates among persons treated for alcoholism were approximately 35% and 58% at two weeks and three months after treatment, respectively. A relapse or uncontrolled return to alcohol or other drug use following competent treatment, is one of the greatest problems substance abusers and their counselors face (Lewis, Dana & Blevins, 2002:105; Johnson, 2003:271).

The objective of the study was to explore the challenges that members in the South African Police Services (SAPS) experience or are exposed to causing them to relapse post treatment for substance dependency. The findings are intended to provide recommendations to the management of SAPS to develop a relapse prevention programme in the workplace to prevent relapse post treatment.

The researcher utilized a quantitative research approach to identify the causes of relapse among SAPS members post rehabilitation for substance dependency. The type of research is applied research as the focus of the study is on identifying the causes for members within the SAPS to relapse post treatment for substance dependency and to address a specific practical issue in the workplace.

The literature review focused on understanding the relapse process. The cognitive-behavioural Model of relapse was discussed at length including the prevalence of substance abuse among police members and concluded with information on the relapse prevention programme.

A self-administered questionnaire was used as a research tool to collect data from the respondents (See annexure C). The population of this study was the members of the SAPS who had undergone treatment for substance dependency from January 2008 to April 2009. The researcher concentrated on those members in the KZN Province. Consultation with the social workers revealed a population size of 50 members. Due to the small size of the population, no sampling procedure was necessary as the whole population was selected as the sample. The findings of the study were based on 44 questionnaires that were returned by the respondents. The findings were analyzed and presented using tables and graphs which were then interpreted in words.

The study revealed that the majority of the respondents attributed their main cause for relapse due to Intrapersonal determinants - they experienced a negative emotional state (for example, feelings of anger, frustration and anxiety) that initially triggered their need to taking that first drink. Secondly respondents identified exposure to peer pressure and boredom as also being a cause for their relapse. They disclosed that at times their peers would pressurize them to consume alcohol. The temptation, urges and cravings and being in the presence of other people consuming alcohol proved too difficult to resist. Alcohol being the recreational drug of choice proved to be tempting to members especially when socialising with colleagues.

Based on the findings of the study conclusions and recommendations were made to the development of the relapse prevention programme to assist members post treatment to maintain their sobriety.

KEY CONCEPTS

- **RELAPSE**
- **SUBSTANCES**
- **SUBSTANCE ABUSE**
- **SUBSTANCE DEPENDENCY**
- **TREATMENT**
- **EMPLOYEE ASSISTANCE PROGRAMMES (EAP)**
- **EMPLOYEE HEALTH AND WELLNESS (EHW)**
- **SAPS EMPLOYEE (MEMBER)**

TABLE OF CONTENTS

DECLARATION i
ACKNOWLEDGEMENTS ii
DEDICATION iii
ABSTRACT iv

CHAPTER ONE: INTRODUCTION AND GENERAL ORIENTATION 1
1.1 CONTEXTUALISATION AND RATIONALE OF THE STUDY 1
1.2 PROBLEM FORMULATION 3
1.3 GOAL AND OBJECTIVES OF THE RESEARCH STUDY 6
1.3.1 GOAL OF THE STUDY 6
1.3.2 OBJECTIVES OF THE STUDY 6
1.4 RESEARCH QUESTION OF THE STUDY 7
1.5 RESEARCH APPROACH, DESIGN AND METHOD 7
1.6 FEASIBILITY OF STUDY 7
1.7 ETHICAL ASPECTS 8
1.8 DEFINITION OF KEY CONCEPTS 11
1.9 CONTENTS OF THE RESEARCH REPORT 14
1.10 LIMITATIONS OF THE STUDY 14
1.11 SUMMARY 15

CHAPTER TWO: UNDERSTANDING THE RELAPSE PROCESS 16
2.1 INTRODUCTION 16
2.2 DEFINITIONS OF RELAPSE 16
2.3 UNDERSTANDING THE RELAPSE PROCESS 17
2.4 RELAPSE PREVENTION MODEL: A COGNITIVE-BEHAVIOURAL APPROACH 20
2.5 DETERMINANTS OF RELAPSE 22
2.6 PREVALENCE OF SUBSTANCE ABUSE AMONGST POLICE MEMBERS 26

2.7	RELAPSE PREVENTION PROGRAMME	27
2.8	SUMMARY	29
CHAPTER THREE:	RESEARCH METHODOLOGY, DATA ANALYSIS AND INTERPRETATION	30
3.1	INTRODUCTION	30
3.2	RESEARCH APPROACH, DESIGN AND METHODS	30
3.2.1	Research Approach	30
3.2.2	Type of Research	31
3.3	RESEARCH DESIGN AND METHOD	31
3.3.1	Research Design	31
3.3.2	Research Population, Boundary, and Sample	32
3.3.3	Data Collection Method	33
3.3.4	Data Analysis	35
3.4	RESEARCH FINDINGS	37
3.4.1	Section 1: Biographical Details	37
3.4.2	Section 2: Treatment Process	43
3.4.3	Section 3: Reasons for Drinking after treatment	52
3.4.4	Section 4: Proposed Interventions and Services	59
3.5	SUMMARY	61
CHAPTER FOUR:	CONCLUSION AND RECOMMENDATIONS	62
4.1	INTRODUCTION	62
4.2	CONCLUSIONS	62
4.3	RECOMMENDATIONS	63
4.4	SUMMARY	65
4.5	RECOMMENDATION FOR FURTHER STUDIES	6

REFERENCES 67

ANNEXURES

Annexure A: Letter of Approval to Conduct Research 74
Annexure B: Informed Consent 75
Annexure C: Research Questionnaire 76

LIST OF TABLES

Table 1: Provincial Statistical Report 5
Table 2: Reliability Statistics 36
Table 3: Rank of Respondents 43
Table 4: Reason for Treatment 44
Table 5: Reasons for Drinking again 54
Table 6: Measures of Central Tendency 57
Table 7: Proposed Intervention and Services 59

LIST OF FIGURES

Figure 1: A Cognitive-Behavioral Model of the Relapse Process 21
Figure 2: Age Distribution 37
Figure 3: Race Distribution 38
Figure 4: Gender Distribution 39
Figure 5: Marital Status 40
Figure 6: Highest Qualification 41
Figure 7: Years of Service 42
Figure 8: Reason for Treatment 44
Figure 9: Length of Treatment 45
Figure 10: Relapse after the last treatment 46
Figure 11: Frequency of treatments before the last relapse 47
Figure 12: Duration of sobriety before the last relapse 48
Figure 13: Support received after treatment 50

CHAPTER 1

INTRODUCTION AND GENERAL ORIENTATION

1.1 CONTEXUALISATION AND RATIONALE OF THE STUDY

The abuse of alcohol and other drugs is one of the most serious problems facing the world today. The abuse of alcohol and drugs, not only does it affect the physical and psychological well-being of the drug users themselves, but it threatens the social and economic stability of the entire country (Mendelson & Mello, 1992:19). “Our country is faced with a growing problem of substance abuse. This has implications for millions of citizens because it contributes to crime, domestic violence, family disintegration and other social problems” (Nelson Mandela, National Drug Master Plan……., 1999).

In South Africa, it has been estimated that the use of alcohol costs the country about 1% of its Gross Domestic Product (Weich, 2006:436). Recent studies indicate that adults can become physically addicted to drugs or alcohol within five to 15 years (Meyer & Viljoen, 2005:4). According to Perkinson (2004:11) alcoholism develops slowly over a patient’s lifetime, and it can begin at any age. It often occurs in individuals with no history of psychological problems. He states that when the substance causing addiction is readily available, inexpensive, and rapid acting, abuse increases. Further, when the individual is ignorant of healthy alcohol use, susceptible to heavily using peers, or has a high genetic predisposition to abuse or to antisocial personality disorder, abuse may increase. Perkinson (2004:11) mentions further that this is also true if the person is poorly socialized into the culture, in pain, or if the culture makes the substance the recreational drug of choice. The researcher’s experience is that within the South African Police Services (SAPS) alcohol use often resulting in abuse is viewed as an acceptable part of the SAPS culture.

Despite the resources in terms of rehabilitation centers, hospitalization detoxification programmes and self-help groups such as AA group meetings, available to patients to seek assistance with their dependency problems, the challenge facing them is to

maintain sobriety. The outcome of treatment may be abstinence or relapse. This may be attributed to the fact that “substance use disorders have long been recognized as chronic relapsing conditions” (Connors et al., 1996:5). Perkinson (2004:180) states, “Alcoholism is a chronic relapsing brain disease, so individuals with substance abuse disorders face the possibility of relapse once they stop using alcohol even if they have had a successful treatment”. According to Connors et al. (1996:5) research revealed that relapse rates among persons treated for alcoholism were approximately 35% and 58% at two weeks and three months after treatment, respectively. A relapse or uncontrolled return to alcohol or other drug use following competent treatment, is one of the greatest problems substance abusers and their counselors face (Lewis et al., 2002:105; Johnson, 2003:271).

The researcher’s own experience has been that members abusing alcohol often relapse from three months to one-year post treatment. Jeewa and Kasiram (2008:44) acknowledge that it has become increasingly difficult to assist an individual to maintain long-term recovery from substance abuse, irrespective of which treatment centre the individual had been to, as none guarantees a successful recovery.

According to Naidoo (2009) at Jullo Rehabilitation Centre, one of the most frequently used treatment centre by SAPS members in the Durban area, patients relapse because they often forget what they had been through resulting in their admittance to the rehabilitation centre. Patients leave the rehabilitation centre with the belief that they can sort out their own problems. This belief is especially significant amongst members of the SAPS. These members’ views are based on their “macho image” of being a member of the police. Members return to SAPS post rehabilitation and although they have undergone change, their work environment remains the same. They continue to experience lack of support from their senior managers; their salaries remain the same/no promotions as well as the stressful nature of their jobs.

Kistensamy (2009) at South African National Council Alcoholism and Drug Dependence (SANCA) Durban, views relapse as related to a lack of commitment on the part of the abuser to continue with aftercare post treatment. The abuser does not apply the life skills he/she developed during treatment thus failing to cope

effectively when faced with challenges. She emphasized the importance of the abuser remaining committed to the aftercare programme and attendance of support groups to assist them in maintaining sobriety.

The researcher's personal experience has been that not all members referred to the rehabilitation centre for treatment were able to maintain their sobriety. According to Perkinson (2004:183) about two-thirds of patients coming out of addiction programs relapse within three months of leaving treatment. Lewis et al. (2002:105) reported that 90% of all clients treated for substance abuse relapse within 1 year after their discharge.

This study will assist the SAPS to identify the causes of relapse post treatment for substance dependency and to render the necessary supportive services in assisting members to maintain sobriety thus reducing the relapse rate amongst members post treatment.

1.2 PROBLEM FORMULATION

Creswell (1998:94) defines the problem statement as a problem leading to the study. Problem formulation according to Bless and Higson-Smith (2004:26), introduces the necessity of clearly defining all the concepts used and of determining the variables and their relationships. The researcher's view of problem formulation is that it identifies the aspect that is seen as a problem and thus discovers ways of addressing that problem.

According to Kilian (2008:13) substance abuse at work is a hidden disease. He states further that this is a short-sighted omission on the part of employers. The researcher agrees with this statement. Despite the SAPS having in place an Employee Assistance Programme (EAP) to assist members with personal problems including substance dependency problems, there does not appear to be a decrease in abuse of substances by members. The consequences of substance abuse in the workplace are low productivity, absenteeism, failure to meet deadlines, poor performance and criminal activity such as theft or fraud, as well as disputes with

managers or supervisors (Kilian, 2008:15). The researcher would like to include placing colleagues, members of the public and themselves at risk to the above -mentioned consequences.

The Employee Health and Wellness Unit (EHW) within the South African Police Services, consists of a multi-disciplinary team that provides Social Work, Spiritual and Psychological services to all employees of the SAPS and their immediate families. These services include assisting members with substance dependency problems namely alcohol and or drug dependency. The predominant referrals received for services are alcohol related. This may be due to the fact that a dependency to alcohol is easier identified in terms of the physical effects like drinkers nose (puffy and red); eyes are bloodshot and puffy; trembling hands as well as a distinct smell of alcohol in the breath as opposed to chemical substances like cocaine or heroin. Despite the fact that members are often referred to rehabilitation centres for treatment, they often relapse shortly following their discharge from the treatment centre.

It has been the researcher's observation that there is a high incidence of substance dependency amongst the members of the SAPS. The reasons for members abusing substances and subsequently becoming dependent on it could be attributed to the following scenarios.

- Members are exposed to traumatic incidents on a daily basis. Some find it easier to cope with their trauma by abusing substances.
- Some abuse substances due to pressure from their colleagues.
- Most of the stations have a bar within their premises that makes alcohol more accessible.
- Members go on detached duties, with nothing to do after hours and they entertain themselves by abusing substances. Alcohol is the number one recreational drug of choice for members.

Despite the high incidence of substance dependency, only a few members or their families seek the services of Employee Assistance Services for treatment. The Provincial Statistical Report for Employee Assistance Services (EAS) interventions

in Kwa-Zulu Natal (KZN) for the period April 2008 to March 2009 for members requesting counseling regarding substance dependency issues are as follows:

TABLE 1: Provincial Statistical Report

PERIOD	NO. OF PERSONNEL REACHED
1ST QUARTER(APRIL-JUNE 08)	110
2ND QUARTER(JULY- SEPT. 08)	187
3RD QUARTER (OCT – DEC. 08)	42
4TH QUARTER (JAN – MAR. 09)	38

(Source: KZN: EAS Reactive Intervention report: April 08 – March 09)

The above statistics reveal a significant increase in the need for services especially in the 2nd quarter of 2008. The decline noted in the 3rd and 4th quarter could be attributed to the fact that the members were involved in special duties over the festive period, exam leave or on vacation leave. During these periods members often work long hours as well as enjoying all that the festive season has to offer, and do not focus on their problems thus not seeking the services of EAS. It could also be because the services are not easily accessible to members and their families thus many cases go unassisted. Members fear being stigmatized for seeking services and the belief that seeking help will result for an example, in the postponement of their promotion. Families may not be aware of the services offered thus do not call for help. Some members who do consume alcohol in excess justify their abuse, as being a part of the SAPS culture and that consuming alcohol is their number one stress reliever. The researcher has observed Commanders to be failing in their duty to refer members with substance dependency problems to EHW for help. Instead, they are seen as enablers since they make excuses for these members and turn a blind eye when their behaviour affects their productivity. The abuser thus experiences no consequences for his abuse of substances and will continue to do so.

According to Perkinson (2004:180) recovery from alcoholism involves:

> Gaining information, increasing self- awareness, developing skills for sober living, and following a program of recovery. The programme of recovery may include ongoing counseling/therapy, participation in self-help groups as well as self-management approaches. The alcoholic may also need help with family, work or legal problems. Thus, the patient is dependent on external as well

as professional support. As their recovery progresses the patient begins to work a self-directed program of recovery where the person relies on themselves to handle the challenges of living a sober lifestyle.

The researcher has decided to embark on this research because the South African Police Service (SAPS) who are responsible for the protection and safety of all citizens of South Africa are not immune to the negative impact of substance abuse and dependency in terms of absenteeism and resultant loss of productivity, ineffective working hours and loss or damage to property. It has been further noted, that members who do seek treatment for their dependency to substances, relapse shortly thereafter. This study will focus specifically on relapse in relation to alcohol abuse/dependency. The EHW unit do not collate their statistics according to the different categories of substances but rather group all categories under one heading. However EHW members informed the researcher that the majority of the members seeking assistance is with regard to alcohol abuse/dependency.

1.3 GOAL AND OBJECTIVES OF THE RESEARCH STUDY

1.3.1 Goal of the study

The goal of this study was to explore the causes of relapse post treatment for substance dependency within the South African Police Services.

1.3.2 Objectives of the study

The objectives of this study were:

- To conceptualize theoretically the impact of relapse on a person post treatment for substance dependency.
- To undertake an empirical study to explore the challenges that members experience or are exposed to causing them to relapse post treatment for substance dependency.
- To make recommendations to the management of the South African Police Services on developing a prevention of relapse programme in the workplace to prevent relapse of members post treatment.

1.4 RESEARCH QUESTION OF THE STUDY

According to Neuman, (2000:142) research questions refer to "the relationships among a small number of variables". According to Fouché (2005:111), a research question comes from real-world observations, dilemmas and questions. It takes the form of wide-ranging enquiries reflecting complex situations. Hypotheses primarily arise from a set of "hunches" that are tested through a study. The researcher used a research question instead of a hypothesis, as the researcher wanted answers to real-world situations as opposed to testing of hypotheses.

For this study, the research question was as follows:
What are the causes of relapse amongst members of the South African Police Services post treatment for substance dependency?

1.5 RESEARCH APPROACH, DESIGN AND METHOD

The research approach, type of research, design and methods used in conducting this research study will be discussed in detail in chapter 3.

1.6 FEASIBILITY OF THE STUDY

According to Strydom (2005b:209) feasibility of the study can "alert the researcher to possible unforeseen problems that may arise during the main study. It will also assist the researcher in the practical planning of the research in terms of transport, finance and time."He mentions further that a feasibility study "is a very valuable way of gaining practical knowledge of and insight into a certain research area" (Strydom, 2005b:209).

The researcher is employed at the SAPS as a social worker. Permission to conduct the research was granted by the relevant authorities within SAPS to conduct the research (See attached Annexure A). The researcher had access to respondents via her own caseload as well as with colleagues in the EHW KZN Province. The

researcher did not anticipate high costs for the study and all costs incurred was the researcher's responsibility.

1.7 ETHICAL ASPECTS

Strydom (2005c:57) defines ethics as "a set of moral principles which is suggested by an individual or group, is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards all role players". *The Oxford Advanced Learner's Dictionary* (2000:395) defines ethics as the "moral principles that control or influence a person's behaviour.To the researcher ethics, related to what is right and wrong when conducting research. The following ethical issues were taken into consideration:

- **Avoidance of Harm**

According to Babbie and Mouton (2005:522), when conducting social research there is always a threat of subjects being emotionally or psychologically harmed. Thus, it is the responsibility of the researcher to prevent such harm. In this study, the researcher noted the fact that respondents may not feel comfortable disclosing information regarding their dependency problem. The respondents were informed before hand of the purpose of the research and that their participation was strictly voluntary and they were given the opportunity to withdraw from the study if they wished to (See Annexure B).

In view of the fact that the researcher elicited the help of EHW members from the different clusters to administer the questionnaires to their members, the members themselves felt more comfortable to participate as opposed to the researcher whom they may not have had contact with previously.

- **Informed Consent**

Brynard and Hanekom (2006:86) state that researchers must communicate to the respondent the aims of the study, the anticipated consequences of participating in such a study and their signed consent should be obtained. According to Strydom (2005c:59) informed consent implies that all possible information on the goal of the

study, procedures to be followed, the possible advantages and disadvantages that participants may be exposed to must be made available to the respondents.

The researcher provided a written informed consent form to all respondents that indicated explicitly the goal of the study, procedures, the possible advantages and disadvantages (including possible harm), as well as the credibility of the researcher. Every respondent was requested to sign the relevant informed consent form and a copy was handed to each of the respondents (See Annexure B).

- **Deception of Subjects**

Strydom (2005c:60) defines deception as "deliberately misrepresenting facts in order to make another person believe what is not true, violating the respect to which every person is entitled to". Strydom (2005c:61) states further that a distinction must be made between deliberate deception and deception of which the researcher was not aware of. In such cases, the incidents must be discussed with the respondents immediately after or during the debriefing session.

The researcher took all necessary precautions to ensure that participants were not deceived in any way.

- **Violation of Privacy/Anonymity/Confidentiality**

According to Neuman (2000:98) researchers violate the privacy of respondents when they probe into beliefs, backgrounds, and behaviours in a way that reveals intimate private details. Anonymity means that subjects remain anonymous or nameless. Neuman (2000:99) states that whilst anonymity protects the identity of specific individuals from being known, confidentiality means that information may have names to it but the researcher keeps it secret from the public. A researcher may provide anonymity without confidentiality or vice versa.

The researcher guaranteed confidentiality of information obtained from the participants. The identity of the research participants was not disclosed on the questionnaire but their social workers were able to identify them. The data will be reported collectively with no individual names being identi

- **Actions and Competence of Researcher**

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation (Strydom, 2005c:63).The researcher has completed course work in research methodology thus; she is competent to conduct the proposed research under the supervision of the Department of Social Work and Criminology.

- **Cooperation with Contributors**

According to Strydom (2005c:65) when a researcher relies on sponsors or colleagues to assist with the study it is important that the researcher draws a contract that clarifies everyone's role and thus avoids any misunderstanding. The researcher has gained the support and cooperation from her colleagues and other experts in the field of treatment of substance dependency. Thus, the researcher will guard against any form of prescriptive action that may jeopardize the outcome of the study.

- **Release or Publication of the Findings**

Babbie and Mouton (2005:526) express the ethical obligation of the researcher to the ethics of analysis and reporting. The researcher must in her report indicate the limits of the findings and methodological constraints and include any shortcomings or errors. Strydom (2005c:66) further states that participants should be informed about the findings in an objective manner without violating the principle of confidentiality. The researcher will inform participants about the findings in a written report as well as information about all the people who will have access to the report.

- **Debriefing of Respondents**

Debriefings are sessions during which respondents get the opportunity to work through their experiences following the study. According to Strydom (2005c:66) debriefing also affords the researcher the opportunity to assist respondents and thereby reducing harm as well. According to Babbie as cited in Strydom (2005c:66) problems generated by the research experience can be corrected during debriefing sessions. In this study the self-administered questionnaires was coordinated by EHW members in the respective clusters, and debriefing services were made

available to the respondents on completion and returning of the questionnaires by EHW members who are trained debriefers. Verbal feedback received on completion of the questionnaires was that no debriefing was requested from the respondents.

1.8 DEFINITION OF KEY CONCEPTS

- **Relapse**

Perkinson (2004:180) defines relapse as “a breakdown in the person’s attempt to change substance abuse behaviour”. According to Connors, Donovan and DiClemente (2001:194) relapse is defined as “a return to pretreatment levels of drinking”. Relapse can be defined as “the return to substance abuse after a period of sobriety” (Mendelson & Mello, 1992:25). Marlatt and Gordon as cited in Lessa and Scanlon (2006:275) define relapse as “a breakdown or setback in a person’s attempt to change or modify any target behaviour”. The researcher’s understanding of relapse is a return to some previous behaviour pattern for example, substance abuse following a sincere desire to discontinue that behaviour pattern.

- **Substances**

Substances refer to both legal and illegal drugs. Substances are categorized accordingly: Depressants (alcohol, sedatives, hypnotics. and inhalants); Cannabinoids (dagga), Opiods (heroin, morphine, and codeine), Hallucinogens (LSD, mescaline, psilocybin and PCP); Stimulants (amphetamines, cocaine and caffeine; Nicotine and Steroids) (Johnson, 2003:11-37). Due to the fact that alcohol is abused more than any other substance (Johnson, 2003:19; Connors et al., 2001:2), in this study substance abuse will specifically focus on alcohol abuse.

- **Substance Abuse**

Lewis et al. (2002:4) define substance abuse as when a client’s use of alcohol or another mood-altering drug has undesired effects on his or her life or on the lives of others. The negative effects of the substance may involve impairment of physiological, psychological, social or occupational functioning. According to the DSM IV, as cited in Johnson (2003:6) substance abuse is when there is a maladaptive pattern of substance use resulting in significant impairment-distress.

The researcher's understanding of substance abuse is when any use of alcohol or drugs causes physical, psychological, legal or social harm to the individual or to others affected by the substance abuser's behaviour. The researcher's experience has been that alcohol is found to be among others, the most abused legal recreational substance in the South African Police Services by its members.

- **Substance Dependency**

Chemical/substance dependency is a disease that causes a person to lose control over the use of alcohol or other drugs (Gorski, 1989:3). This loss of control causes physical, psychological, social and spiritual problems. The total person is affected. According to Miller (2005:8) to meet the criteria for dependence, the client must have a maladaptive use pattern causing some type of impairment with at least three of the following occurring within one year: tolerance; withdrawal; more or longer use than planned; desire without ability to cut down or control usage; time spent on obtaining it, using, or recovering from the substance; impact on activities that are social, occupational, or recreational; and continued use in spite of physical or psychological problems related to use. The researcher's understanding of substance dependency is when the body becomes accustomed to having alcohol/drugs present, and when it is not present, you get a craving for it. Substance dependence refers to the psychological or physical compulsion to use substances in order to experience an altered state.

- **Treatment**

Connors et al. (2001:4) define treatment as an "application of planned procedures to identify and change patterns of behaviour that are maladaptive, destructive, or health injuring; or to restore appropriate levels of physical, psychological or social functioning". According to Johnson, (2003:168) treatment is defined as "the result of collaboration between the client and therapist. It is based on the desired outcome. Once the destination has been clarified, work is initiated on the best way for that individual to get there". The researcher's understanding of treatment is a plan of clinical interventions mutually agreed by the client and the therapist/counselor to decrease or cessation of substance abuse. Treatment in the context of this study

will refer to the in-patient treatment that the member undergoes at a rehabilitation centre for the treatment of substance abuse.

- **Employee Assistance Programmes (EAP)**

EAPA SA (2005:6) defines EAP as:

> A worksite-based programme designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns, but not limited to: health, marital, family, financial, alcohol, drug, legal, emotional, stress or other personal concerns which may adversely affect employees' job performance.

Employee assistance programmes are defined as counseling programmes designed for employees in their work settings (Lewis et al., 2002:23). Clients in need of treatment are referred to resources outside of the employing organization. EAP counselors, counsel employees, with the goal being temporary support and assistance so that clients can gain or regain self-responsibility. The essence of the EAP programme is seen as a work based strategic intervention to address productivity issues, identify and resolve employees' work/personal concerns that can affect performance.

- **Employee Health and Wellness (EHW)**

The EHW within the SAPS comprises social workers, psychologists and spiritual services (chaplain). These professionals are employed by the SAPS to provide support services to all their members and their immediate families.

- **SAPS Employee (member)**

"Employee" means a person in the permanent employment of the South African Police Service appointed in terms of either the South African Police Service Act or the Public Service Act (National Instruction/2005).

1.9 CONTENTS OF THE RESEARCH REPORT

The research report will be divided into the following chapters:

Chapter 1: Introduction and general orientation.

Chapter 2: Understanding the relapse process.

Chapter 3: Research methodology, data analysis and interpretations.

Chapter 4: Conclusion and recommendations.

1.10 LIMITATIONS OF THE STUDY

The limitations of the research study were as follows:

- The study was limited in terms of sample. The study focused only on members who relapsed post treatment for substance dependency in the KZN Province; hence generalizations cannot be made based on the findings.
- The degree to which the respondents could accurately retrospectively identify the precipitants of relapse is questioned.
- In South Africa limited research has been done on the issue of relapse, thus recent literature on the subject is limited.
- A few EHW members experienced difficulty in contacting and getting the respondents to complete the questionnaires due to unavailability of the respondents.
- The researcher experienced apathy on the part of some of the EHW personnel to reach out to members who relapsed during the specified period for completion of questionnaires.

1.11 SUMMARY

This chapter contained the general orientation of the study, which included the context of the study, problem formulation, the ethical aspects, definition of key concepts and the limitations of the study.

Chapter two will focus on understanding the relapse process. A discussion will follow on a relapse prevention model. For the purposes of this study the researcher has focused on the work done by Marlatt (in Marlatt & George, 1984:261) on a Cognitive-behavioural approach. A central feature of this model is the detailed classification of factors or situations that can precipitate or contribute to episodes of relapse. The prevalence of substance abuse amongst police members and a relapse prevention programme will also be discussed.

CHAPTER TWO

UNDERSTANDING THE RELAPSE PROCESS

2.1 INTRODUCTION

Individuals who struggle with substance dependence did not start out with their dependence being part of their goal but with them wanting to relax, engage in experimentation and to experience a sense of belonging (Johnson, 2003:53). According to Johnson (2003:53) some theories may suggest that an individual may possess a hereditary predisposition to the disease of substance dependence, referred to as a "disease concept". One of the factors inherent in the disease concept is the acknowledgement that substance dependence is a disease of relapse. Thus relapse is always a possibility and confirmation of the need for total abstinence. According to Litman, Stapelton, Oppenheim, Peleg and Jackson (1983:381) treatment of substance dependency in the short term may be quite effective, but ensuring abstinence in the long term is a challenge. According to Litman et al. (1983:381) one of the factors resulting in relapse is the fact that treated substance abusers return to a world that "holds many dangers both internal and external" precipitating the return to abuse of substances.

The rationale behind this chapter is to present the treatment of substance dependency and relapse from a theoretical point of view. The definition of relapse will be reflected in this chapter. The emphasis will be placed on the nature and extent of relapse theoretically as well as the determinants of a relapse.

2.2 DEFINITIONS OF RELAPSE

Connors et al. (1996:5) indicate that substance use disorders have long been recognized as "chronic relapsing conditions and thus relapse is seen as a common outcome following the initiation of abstinence". Marlatt, Parks and Witkiewitz (2002:2) state that individuals wanting to change health–related behaviours (e.g., lose weight, stop smoking, taking less alcohol) will experience set-backs or slips (lapses) that will sometimes worsen and become relapses. Miller (2005:153) views

relapse "as an experience from which a client can learn and a chance to intervene on the relapse process as opposed to it being viewed as a treatment failure". According to Lewis et al. (2002:105) most people who make behaviour changes do relapse and they state that it is common for people to recycle through earlier stages several times before they achieve long-term success. Thus a relapse or an uncontrollable return to alcohol or other drug use following competent treatment is one of the greatest problems substance abusers and their counselors face (Connors et al., 2001:194; Miller, 2005:157; Walter, Gerhard, MacFarland, Weijiers, Boening & Wiesbeck, 2006:100).

2.3 UNDERSTANDING THE RELAPSE PROCESS

Research has found that approximately 35% and 58% of persons relapse at two weeks and three months respectively following treatment for alcoholism, and as high as 90% when relapse has been defined as the consumption of a single drink after treatment (Connors et al., 1996:5; Miller, Westerberg, Harris & Tonigan, 1996:155).

Lewis et al. (2002:106) differentiate among three different states an individual may experience post treatment for substance dependency.

- A return to non-problematic drinking. The individual has not relapsed because use is not really problematic.
- A slip, which is temporary relapse. It is neither a catastrophe nor regressive impetus for learning.
- A relapse, which is return to uncontrolled substance use. This is seen as serious and occurs when a client resumes an abusive pattern of use after a period of treatment – induced abstinence or controlled use. Thus a relapse occurs.

According to Marlatt as quoted in Lewis et al. (2002:106) a slip if not managed correctly and redefined as a learning experience, may be termed as the abstinence-violation effect (AVE). Clients who believe that absolute abstinence and utter loss of control are their only options often have reactions to what could have been minor

lapses. They experience great confusion, profound guilt, decreased self-esteem, extreme embarrassment and a pervasive sense of shame. These powerful negative emotions lead to pessimism about the possibility of recovery and a resumption of substance abuse to manage the resultant negative emotional states.

The researcher's experience has been that due to the term "relapse" having a negative connation to it, meaning one is either "cured" (abstaining) or relapsed (violation of abstinence), that, often whilst in treatment patients are taught the importance of abstaining and if they relapse it reinforces the belief that the individual is a helpless victim of circumstances beyond his or her control. Further during their treatment patients interact with other patients and often discover that it may be the individual's second or third attempt to seek treatment. In view of this, patients almost expect a relapse. Thus in reality when a member returns from a treatment centre he may experience a "slip" or "lapse" and any "slip" is seen as a relapse and a return to pre-treatment abuse of substances. Therefore relapse needs to be seen as a challenge and opportunity for learning to occur rather than an indication of failure.

Many therapeutic interventions have been developed to assist individuals with addiction problems. These interventions include a range of therapies as well as detoxification programmes, drug treatments, rehabilitation, twelve-step programmes (example, Alcoholics Anonymous, Narcotics Anonymous) and therapeutic communities. However according to McMurrian (1994:97) "levels of success in intervention are modest" and that two-thirds of clients either do not improve at all or improve temporarily, slipping back into previous behavior. She found that not all individuals with alcohol problems or addictions seek assistance. Often, people can change addictive behaviours on their own. In society generally, not everybody with addiction problems seek professional help. Research (McMurrian, 1994:98) has found that large numbers of people successfully change their behavior from uncontrolled use to moderation or abstinence without receiving any help.

This unassisted change has been termed as "maturing out" or "spontaneous remission". In "maturing out" the belief is that alcohol or drug abusers are somehow "immature" and that as time passes on they develop "maturity" and are able to control their use of alcohol or drugs. The term "spontaneous remission" refers to the

notion that "change is in the nature of a miracle cure" (McMurrian, 1994:98). Other researchers namely Tuchfeld (as cited in McMurrian, 1994:99) found that other people resolved their drinking problems without formal treatment because they did not want to be labeled "alcoholic". Their reasons for initiating change were, "experiencing an illness or having an accident; extraordinary events such as humiliating experience; a suicide attempt, or seeing other heavy drinkers and thinking 'that could be me'; religious conversion; financial problems; direct intervention by family or friends; alcohol-related death or illness of another person; education about alcoholism and alcohol related legal problems" (McMurrian, 1994:99; Gorski, 1989:11). This resolution of alcohol problems involved a process of change, acknowledging the problem, disengaging from alcohol related social and leisure activities and the seeing oneself as a worthy, confident and competent person. The researcher's experience has been that there is relatively a small percentage of the population who are able to resolve their alcohol or drug addiction problem without professional help. As mentioned above these individuals experience a life threatening incident and are able to make the decision to quit their habit. Individuals with a positive self-image and a good supportive network are able to maintain their sobriety for many years without any professional intervention.

Relapse has a connotation of failure, weakness and shame. Relatedly, the dichotomous nature of the term "relapse" may contribute to a self-fulfilling prophecy (Miller, 1996:25). Marlatt's relapse prevention model emphasizes the potentially detrimental impact of such thinking. Simply believing that there are only two states of drinking, abstaining or out–of-control drinking may create the expectancy that a single behavioural slip is equivalent to a full blown relapse. A study done by Miller (1996:25) supports this view.

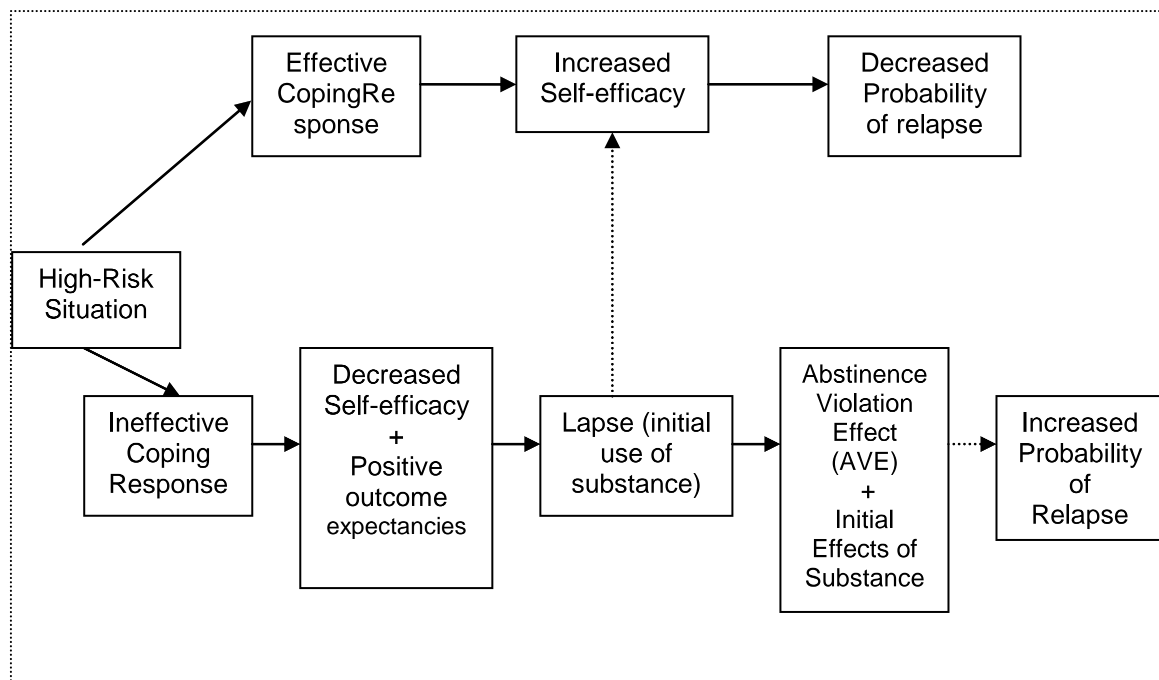
2.4 RELAPSE PREVENTION MODEL: A COGNITIVE-BEHAVIOURAL APPROACH

The most discussed model of the relapse process is by Marlatt (Marlatt & George, 1984: 261). The Marlatt model sees the relapse process as involving a number of cognitive processes. Marlatt hypothesized that "the initiation of abstinence engenders a sense of personal control and self-efficacy, self-perceptions that become strengthened as the period of abstinence lengthens" (Connors et al. 2001:199). During this period the substance abuser is likely to be faced with situations that put him/her at risk to again use alcohol or drugs. These "high-risk" situations are a central feature of the Marlatt model. A "high-risk" situation is defined as any situation which poses a threat to the individual's sense of control and increases the risk of potential relapse (Marlatt & George, 1984:264). When a person is placed in such a situation, the ideal response would be an effective coping behaviour. When this behaviour is emitted and is successful, this experience enhances the person's self-efficacy (Bandura as cited in Connors et al., 2001:200). This, in turn will decrease the probability of relapse in similar situations. However if the person is unable to emit an effective coping response, then this will lead to a decreased level of self-efficacy and an increase in the attractiveness of the substance use for dealing with the situation, especially if the person maintains positive outcome expectancies regarding the effects of the substance use. Often a person will anticipate the immediate positive effects of the activity, ignoring the negative consequences. They focus on the immediate gratification. According to Marlatt and George (1984:265) positive outcome expectancies are a primary determinant of alcohol dependency and other forms of substance abuse.

The combination of being unable to cope effectively in a high-risk situation coupled with positive outcome expectancies for old habitual coping behaviour greatly increases the probability that an initial lapse will occur. Thus the initial lapse may be accentuated by a sense of helplessness or hopelessness that undermines control or reactivates the alcohol-taking attitudes and beliefs. According to Marlatt and George (1984:264) unless a last minute coping response or sudden change of circumstances occurs, the individual may move from abstinence (or controlled use) to relapse. It is further hypothesized that as the attractiveness of the substance

increases (in conjunction with decreased self-efficacy); it is most likely that the person will use the substance. If a substance is used, an abstinence violation effect (AVE) will result, where the person experiences feelings of guilt and low self-esteem, which can trigger the initial use of substance into a full blown relapse (Marlatt & George, 1984:264). This scenario is illustrated in figure 1.

Figure 1: A Cognitive-Behavioral Model of the Relapse Process



Source: Marlatt et al., (2002:7).

Miller (2005:157) explains “self-efficacy consists of the self-judgments made about a person’s competency to adequately perform in a particular task situation”. Thus the longer the period of successful abstinence a person achieves, the greater the individual’s perception of self-control. In a study conducted by Ibrahim and Kumar (2009:40) found that self-efficacy is the factor identified as the main contributor towards relapsed addiction tendency amongst addicts in Malaysia. Substance abusers following treatment often lack the self-confidence to overcome problems and easily give up and resort to relapsed addicts. Studies have also shown an improvement in self-esteem positively leads to success in rehabilitation programs and assists in curbing addictions (Ibrahim & Kumar, 2009:41).

2.5 DETERMINANTS OF RELAPSE

According to the Marlatt model "high-risk situations often serve as precipitants to relapse to substance use" (Marlatt & George, 1984:264). A hallmark feature to the Marlatt Model is a detailed classification of factors or situations that can precipitate or contribute to episodes of relapse. They are explained as follows:

- **Intrapersonal – Environmental Determinants**

This category includes all determinants that are primarily associated with intrapersonal factors (within the individual), and or reactions to non-personal environmental events (Marlatt & George, 1984:264). Intrapersonal factors include emotional states (moods and feelings) of both positive and negative for example feelings such as frustration, anger, anxiety, depression and boredom. These are conditions internal to the individual that were probably previously dealt with through the use of alcohol. Intrapersonal determinants are defined as high-risk events internal to the individual e.g. negative emotional states. These internal events may function as triggers for the addicted individual's return to alcohol use (Strowig, 2000:469).

Life-skills deficits are also commonly associated with relapse (Spurgeon, McCarthy-Tucker & Waters, 2000:171). These deficits include the inability to manage anger and inappropriate reactions to stress. Stressors may include a feeling of being overwhelmed by the transition from a highly structured environment of a treatment facility to a less structured environment upon release. The individual upon release may enter environments which offer little support and frequent exposure to drug-related cues.

The intrapersonal-environmental determinants category is further divided into five subcategories namely; coping with negative emotional states, coping with negative physical-physiological states, enhancement of positive emotional states, testing personal control and giving in to temptations or cravings/urges (Marlatt, Parks & Witkiewitz, 2002:11-12).

Tiffany & Conklin (2000:145) describe craving as “aversive, confusing, intrusive, frustrating and exasperating”. It is commonly assumed that craving is central to all alcohol use in the alcoholic. That is, certain stimulus conditions for example the sight of a bar may trigger a state of craving (Tiffany & Conklin, 2000:145) in turn generating a compulsion to consume alcohol. Tiffany & Conklin state that, firstly, the assumption is that craving is responsible for the maintenance of all alcohol use in the ongoing alcoholic and secondly craving provides the necessary trigger for relapse in the alcoholic wanting to abstain. According to Lewis et al. (2002:120) Urges and craving result from external cues (example seeing a syringe, passing a favourite bar and seeing the alcohol) and are common experiences following abstinence.

Support for the Marlatt model of relapse determinants is found in the work of Strowig (2000:471). Research conducted by Stowig (2002:471) highlighted that 72% of relapses occurred as a result of intrapersonal factors. A study conducted by Cummings as stated in Strowig (2000:470) reported that among participants, intrapersonal determinants accounted for an average of 52% of all cases of relapse, whereas interpersonal determinants accounted for 48%. A study by Wallace as cited in Connors et al. (2001:202) found that the most frequent precursors to relapses were “painful emotional states (40% of relapses), failure to enter aftercare following treatment (37%) and encounters with conditioned environment stimuli (34%).

- **Interpersonal Determinants**

This category includes determinants that are defined as high-risk events external to the individual (e.g. fights, arguments, peer pressure, conflict associated with any interpersonal relationship, such as marriage, friendship, family members, or employer-employee relations). These high-risk situations pose a general threat to the client’s sense of self-control and increase their return to substance use (Lewis et al., 2002:111; Broome, Simpson & Joe, 2002:58). These external events involve interpersonal interaction and they function as triggers for the addicted individual’s return to the use of alcohol or drugs. Strowig (2000:471) in his study found that only one relapse determinant was classified as interpersonal, in particular social pressure 8.6%. According to Stowig (2000:469) research has offered support for the impact of relapse determinants on recovery from alcohol addiction. Interpersonal relationships

accounted for 33% of all episodes of relapse, whereas 33% related to work events, 20% to health events, and 14% to changes in residence.

The subcategories within this group were coping with interpersonal conflict, social pressure, and enhancement of positive emotional states (Connors et al., 2001:201). In a study by Connors et al. (2001:201) found that 39% of their participants reported interpersonal conflicts and social pressure. According to Marlatt and George (1984:264) social pressure may either be "direct (direct interpersonal contact with verbal persuasion) or indirect (example being in the presence of others who are engaging in the same target behaviour, even though no direct pressure is involved)".

Community support is also a factor that contributes towards a relapse (Ibrahim & Kumar, 2009:40). Communities often view substance abusers as negative influences and distance themselves leaving the recovering substance abuser feeling rejected and isolated. Communities should therefore change their thinking and embrace the substance abuser following treatment as a new member into their fold and guide the person and prevent further abuse. Communities should embark on Substance awareness programmes and participate in events organized by drug prevention agencies and other non-governmental organizations.

A study by Broome et al. (2002:58) found that the support of family and friends can have positive effects. He adds that strong social support is "associated with greater treatment retention and behavioural improvement during treatment as well as better outcomes" (Broome et al. 2002:58). On the other hand, the lack of family support is also seen as a major factor contributing to the relapsed addiction tendency (Ibrahim & Kumar, 2009:40). This is often due to a lack of communication and ineffective interaction between the substance abuser and his/her family. Employers are also very skeptical when a substance abuser returns to work following treatment. (Ibrahim & Kumar, 2009:41). They are prejudiced and have no confidence that the employee has the ability to contribute to the productivity of their workforce following treatment.

The above lends support to the findings of Marlatt and George (1984:265) that if an individual uses an effective coping response in the high-risk situation (for example assertive in counteracting social pressures, the probability of relapse decreases

significantly. A study by Miller, Westerberg, Harris and Tonigan (1996:169) on predictors of relapse to drinking found that a lack of appropriate coping resources of clients to particularly stressful events proved to be most predictive to relapse (85%).

- **Covert Antecedents of Relapse**

According to Marlatt and George (1984:266) although high-risk situations are viewed as the immediate determinants of relapse, a number of less obvious factors also influence the relapse process. These covert antecedents include lifestyle factors such as overall stress levels, as well as cognitive factors that may serve "to set up" a relapse, such as rationalization, denial and urges and craving.

According to Lewis et al (2002:113) lifestyle imbalances occur when "people's balance between external demands (their shoulds) and pleasure and self-fulfillment (their wants) is inordinately weighted to the side of the "shoulds". They state further that when this happens patients may feel "imposed on" and "deprived" and may begin to believe that they deserve indulgence and gratification and will become intoxicated. Marlatt and George (1984:266) state that these people would follow their desire for indulgence and gratification, begin to have increasingly strong urges and cravings for alcohol or their preferred substance. As these cravings and urges grow stronger, the client thinks positively about the immediate effects of the substance, the desire for indulgence increases, client will rationalize ("I owe myself") and begin to deny any possible negative outcomes that could be associated with returning to using substances. The client then begins to move closer and closer to the high-risk situation.

Whilst studies described above identify specific categories of determinants to relapse it is important to note that relapses are not only precipitated by particular factors but instead that multiple influences can operate simultaneously in leading to a relapse. This is supported by research conducted by Wallace as cited in Connors et al., (2001:202). He reported that 86% of his participants' causes for relapse were "multi-determined".

2.6 PREVALENCE OF SUBSTANCE ABUSE AMONGST POLICE MEMBERS

In a study conducted by Gorta (2008:90) to determine why police members abuse substances some of the reasons quoted were “stress, either at work or in their personal lives or as a result of lifestyle choices”. Stress is also seen as an important trigger for relapse after a period of abstinence. However, a study conducted by Walter et al. (2006:100:101), found significant predictors of relapse were social factors related to living situation (living alone), marital status and pretreatment frequency of alcohol intake. They state further that “alcohol-dependent individuals have learned to drink heavily to reduce stress and are likely to relapse if they are faced with stressors” (Walter et al., 2006:101).

In the South African context, police members are challenged by various potential stressors, such as high crime level, organizational transformation, continuous exposure to death and injury, a lack of resources, inadequate salaries, the negative public image of police officers and the organization as a whole (Meyer, Rothmann & Pienaar, 2003:881). To cope with these stressors some members often resort to inappropriate coping strategies for example, the abuse of alcohol and other illegal substances. Research indicates that police officers utilize coping mechanisms that increase rather than alleviate their stress (Meyer et al., 2003:883). Police work is seen not only as a job but a way of life for officers. A study conducted by Kohan and O’Connor (2002:315) confirmed the finding that alcohol consumption is associated with job stress among police.

Illegal drug use by police officers is a concern for many countries, not only the use of drugs but also the risk of corruption among police officials (Gorta, 2008:85). The illegal use of drugs and alcohol by police officials is seen as a huge problem, not only does it affect the professionalism and effectiveness of the police official but also the health and integrity of the official, including the safety of the colleagues and the community (Gorta, 2008:88; Davey, Obst, & Sheehan, 2000:206).

The police play an important role in protecting and serving the public, thus to render an effective service the force requires effective police officers. Thus the effects of police stress and the use of alcohol as a coping mechanism may have an adverse

affect not only to the public but to the individual themselves (Meyer et al*.,* 2003:886). This is supported by a study by Ovuga and Madrama (2006:19), who found that when police officers who suffer from various forms of psychosocial impairment related to alcohol use are entrusted with security issues and are not able to perform optimally, "the security of the public will be seriously undermined and the trust of the public in the force will be seriously eroded". Therefore the need to establish measures to provide services to those affected, and a further need to establish preventative measures against alcohol dependence in the police force.

2.7 RELAPSE PREVENTION PROGRAMME

The main goal of a relapse prevention programme is to focus on the problem of relapse and to identify and develop skills for preventing and managing it. Within the cognitive-behavioural frame-work a relapse prevention programme "seeks to identify high-risk situations in which an individual is vulnerable to relapse and to use both cognitive and behavioural coping strategies to prevent future relapses in similar situations" (Marlatt & Witkiewitz, 2005:1). The Relapse prevention treatment begins with the assessment of the interpersonal, intrapersonal, environmental and physiological risks for relapse and the situations or factors that may precipitate a relapse (Marlatt & Witkiewitz, 2005:4). Once the potential relapse triggers and high-risk situations are identified specific interventions including teaching effective coping strategies, enhancing self-efficacy and motivation are exposed to the client. Whilst the educational component of the relapse prevention programme will provide clients with opportunities to make more informed choices in high-risk situations, discussing and preparing clients for lapses may also serve to prevent a major relapse episode (Marlatt & Witkiewitz, 2005:4). According to Marlatt & Witkiewitz (2005:5) in addition to providing clients with the educational and intervention strategies to the high-risk situation, the relapse prevention programme should include life-style self-management strategies such as "relaxation training, stress management, time management and mindfulness techniques like meditation". This exercise of identifying and role-playing possible high-risk situations and effective coping strategies can enhance the clients self efficacy and prevent a relapse.

To assist members within the South African Police Services to cope, the EHW Unit comprising of social workers, psychologists and spiritual services render both proactive and reactive services. One of the many proactive programmes is the substance dependency programme aimed at creating an awareness regarding the abuse of substances and the negative impact it has on the individual, employment and family. In terms of reactive services members are referred to rehabilitation centers. However it is the researcher's experience and as research indicates above the challenge facing many substance abusers and police officers are no exception, is the ability to maintain sobriety post treatment for substance dependency.

Despite aftercare services being offered by all treatment centre's for substance dependency, many patients fail to return for after care services. Thus many are not ready to deal with the challenges facing them and a relapse is inevitable. According to Marlatt and George (1984:261) many treatment programmes' main focus is on the cessation of the target behaviour for example, smoking or alcohol consumption overlooking the maintenance of change once it's being induced. By teaching members behavioural self-management skills, members would be able to anticipate and cope effectively with problems as they arise during post treatment. A relapse prevention programme is a "self- control programme designed to teach individuals who are trying to change their behaviour how to anticipate and cope with the problem of relapse" (Marlatt& George, 1984:261).

Whilst relapse is seen as the most common outcome following substance abuse treatment, there are individuals who achieve abstinence and maintain it for long periods of time. According to Connors et al., (2001:204) the methods for maintaining abstinence most frequently used was "avoiding risky people and places, recalling drinking-related problems, aftercare treatment and self-help groups". They included "strategies of staying in alcohol-free environments, using treatment skills, avoiding thinking about alcohol, recalling the benefits of sobriety, and remembering sobriety as a top priority (Connors et al., 2001:206).

2.8 SUMMARY

In this chapter the literature review focused on understanding the relapse process. As indicated above relapse remains to be a challenge that all substance abusers face post treatment. In an attempt to fully understand this process the researcher focused on the Cognitive-behavioural Model of the relapse process by Marlatt (Marlatt & George, 1984:261). This approach focused on the immediate precipitating circumstances of relapse as well as identifying events that may set-up a relapse. The literature review also focused on the prevalence of substance abuse amongst police members. Research has shown that police members abuse substances due to stress, either at work or in their personal lives. Despite police members having access to workplace support in the form of the Employee Health and Wellness unit who also refer members to rehabilitation centers, maintaining sobriety remains a challenge for many members.

Throughout the discussion in this chapter it is evident that central to preventing relapse following treatment for substance dependency is identifying those high-risk situations that a member maybe faced with and to teach members effective coping skills to prevent a relapse.

Chapter three explains the research design and methodology that was used in the study and the statistical analysis and interpretation of the data.

CHAPTER 3

RESEARCH METHODOLOGY, DATA ANALYSIS AND INTERPRETATION

3.1 INTRODUCTION

In this chapter the researcher deals with the empirical findings derived from the study. The research methodology is briefly discussed, as a detailed discussion is provided in chapter one of this report. This study focused on identifying the causes of relapse post treatment for substance dependency. The population for this study is the members of the South African Police Service who have undergone rehabilitation for substance dependency from January 2008 to April 2009. The researcher concentrated on those members in the KZN Province including the Provincial Office, as well as the following cluster stations namely; Durban Central, Phoenix, Inanda, Pinetown, Newcastle, Ladysmith, Chatsworth, Eshowe, Ulundi, Empangeni, Port Shepstone and Pietermaritzburg. After consultation with the EHW members from these clusters, it was determined that the sample will comprise of the whole population of 50 members.

3.2 RESEARCH APPROACH, DESIGN AND METHODS

3.2.1 RESEARCH APPROACH

There are two well-recognised approaches to research, namely the qualitative and the quantitative approach. Fouché and Delport (2005:74) define a quantitative study as “an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers and analyzed with statistical procedures in order to determine whether the predictive generalizations of the theory hold true”. According to Brynard and Hanekom (2006:37) in quantitative methodology, “the researcher assigns numbers to observations. By counting and measuring “things” or “objects”, data is produced”.

The researcher’s understanding of the quantitative approach is that it sees reality as objective and it aims to objectively measure the social world. Thus in the context of this study, the researcher made use of the quantitative approach to identify the

causes of relapse among SAPS members post rehabilitation for substance dependency. Relapse is a practical problem; therefore, a quantitative approach enabled the researcher to numerically measure the impact of relapse within the SAPS.

3.2.2 TYPE OF RESEARCH

Fouché and De Vos (2005a:105) regarded the goals of research as either basic or applied in nature. They defined basic research as "research that seeks empirical observations that can be used to formulate or refine theory" and applied research as the "scientific planning of induced change in a troublesome situation". The distinction between these two goals thus can be seen that basic research has been viewed as providing a foundation for knowledge and understanding, whereas the applied research has been viewed as responsible in solving specific problems. According to Neuman (2000:23) basic research focuses on using research to advance general knowledge also regarded as pure research. Applied researchers "want to apply and tailor knowledge to address a specific practical issue" (Neuman, 2000:23).

The type of research for this study was applied research as the researcher's focus in this particular study was on identifying the causes for members within the SAPS to relapse post treatment for substance dependency and to address a specific practical issue in the workplace.

3.3 RESEARCH DESIGN AND METHODS

3.3.1 Research Design

The research design refers to the strategy or plan the researcher intends using to conduct the study. There are namely two basic methods or methodologies that can be used: qualitative and quantitative methodology. Quantitative research is underpinned by a distinctive theory as to what should pass as warrantable knowledge and requires methods such as experiments and surveys to describe and explain phenomena (Brynard & Hanekom, 2006:37).

Fouchè and De Vos (2005b:137) state that the survey designs are more of a quantitative nature, requiring questionnaires as data collection methods. This design will enable the researcher to ask numerous questions to many respondents in a short period of time. This information will give the researcher an idea of what are some of the causes of relapse of members post treatment for substance dependency.

In this study the researcher utilized the quantitative-descriptive (survey) research design in gathering data from the participants. The rationale behind utilizing this approach was to enable the researcher to gain a better idea of what are some of the causes of relapse of members post treatment for substance dependency. A structured method of data collection was utilized by means of a questionnaire. The questionnaire was written in English and the aim of the research and the motivation for completion of the questionnaire were highlighted on the front page of the questionnaire (See Appendix B and C of this report).

3.3.2 Research population, boundary of the sample and the sampling method

Strydom (2005a:194) defines a population as "the totality of persons, events, organization units, case records or other sampling units with which the research problem is concerned". Seaberg (in Strydom, 2005a:193) defines population as "the total set from which the individuals or units of the study are chosen. A population therefore, is that group of people about whom we want to undertake the study.

The population for this study is the members of the South African Police Service who have undergone rehabilitation for substance dependency from January 2008 to April 2009. The researcher concentrated on those members in the KZN Province specifically in the following cluster stations namely; Durban Central, Phoenix, Inanda, Pinetown, Newcastle, Ladysmith, Chatsworth, Eshowe, Ulundi, Empangeni, Port Shepstone and Pietermaritzburg. After consultation with the social workers from these clusters, it was indicated that the population will consist of 50 members.

Since the population of the study is 50, no sampling procedure was necessary as the researcher selected the whole population as the sample, including both males and

females irrespective of race and culture, who have sought rehabilitation for substance dependency problems during January 2008 to April 2009.

3.3.3 Data Collection Method

Several methods of collecting data are available. Delport (2005:166) mentions the following methods of data collection for a researcher working from a quantitative approach namely, questionnaires, checklists, indexes and scales. In this study, the researcher developed a questionnaire. "A questionnaire is a list of questions compiled by a researcher to be completed by respondents" (*New Dictionary of Social Work*, 1995:51). There are different types of questionnaires available, namely, mailed questionnaires, telephonic questionnaires, self-administered questionnaires, questionnaires delivered by hand and group-administered questionnaires.

The researcher used a self-administered questionnaire as a means of collecting data. This type of data collection method is less time consuming, less expensive and allows for the immediate clarification of any doubts the respondents may have regarding any of the questions. The researcher developed the questionnaire, using open and close-ended questions, with the assistance of other specialists in the field of treatment for substance dependency as well as consulting with literature on the subject. The questionnaire developed for the purposes of this study, aims to identify the factors, which may impact on an individual causing them to relapse post treatment for substance dependency.

According to Delport (2005:171), it is important that newly constructed questionnaires be thoroughly tested prior to being used in the main study. This will ensure that errors can be rectified immediately at little or no cost. She mentions further that it is better to ask people to complete the questionnaire themselves opposed to reading through and looking for errors. The researcher pilot tested the questionnaire on two SAPS members post treatment for substance dependency, who did not participate in the main study. The purpose of conducting this pilot test is to improve the reliability of the research.

The researcher pilot tested the questionnaire on two SAPS members post rehabilitation, who did not participate in the main study. The purpose of conducting

this pilot test is to improve the reliability of the research. Both members who participated in the pilot study were males and were Warrant Officers in the SAPS. The one Warrant Officer was Indian in the 36-49 age group and the second Warrant Officer was African in the 26-35 age group. Both members completed the questionnaire with little effort. Thus the questionnaire was then used in the main study.

The respondents for the main study were the members who had undergone treatment at a rehabilitation centre for substance dependency during January 2008 to April 2009.

The questionnaires were hand-delivered to the respective social workers in the SAPS within the KZN Province to be administered to the respective respondents.
The researcher was assisted by the members of the EHW Unit (psychologists and social workers) to administer the questionnaires. The self-administered questionnaires were completed by the respondents, who are members who had undergone treatment at a rehabilitation centre for substance dependency from January 2008 to April 2009. The psychologists and social workers were available to the members whilst completing the questionnaires. The researcher received verbally a positive report from the EHW members that the respondents completed the questionnaire with no difficulties.

A month was allocated for the questionnaires to be administered and the respondents to submit the completed questionnaires. The researcher distributed 50 questionnaires to the respective cluster stations participating in the research, however only 44 questionnaires were returned. This indicates a response rate of 88%. Data collected will be safely stored at the Department of Social Work and Criminology at the University of Pretoria for 15 years.

3.3.4 Data Analysis

Once the data is collected, it needs to be analyzed. According to Kruger, De Vos, Fouché and Venter (2005:218), analysis means:

> The categorizing, ordering, manipulating and summarizing of data to obtain answers to the research questions. The purpose of analysis is to reduce data to an intelligible and interpretable form so that the relations of research problems can be studied and tested and conclusions can be drawn.

In this study data analysis will focus on determining the relationship by correlating between variables measured and establishing frequencies and percentages of the responses. The data were analyzed using the SPSS statistical package for windows. The data gathered are presented graphically using pie charts, histograms as well as numerical formats such as tables. The use of open-ended questions gave the respondents the opportunity to respond in-depth on certain questions. This data will be reflected through frequencies.

SPSS version 15.0 (SPSS Inc., Chicago, Illinois, USA) was used to analyze the data. A p value <0.05 was considered as statistically significant.

- **Descriptive Statistics**

Descriptive statistics in the form of frequency and percentage were computed for the variables. Mean and Standard deviation were computed for each question. Frequency distribution for the variables were graphically presented using bar and pie charts.

- **Cross tabulation**

Cross tabulation tables were computed using Q2.3 (Relapse/No relapse) – these tables reflect the frequency distribution according to those who had a relapse and those who did not.

- **Reliability**

Table 2: Reliability Statistics

Cronbach's Alpha	N of Items
.793	11

Reliability is the degree to which measurements are free from random errors. Although many types of reliability exist internal consistency reliability is vital to surveys. Internal consistency indicates the extent to which the items in the measurement are related to each other. There are several statistical indexes used to estimate the degree of internal consistency. The most commonly used is Cronbach's alpha coefficient (Pallant, 2005:90). Basically, this alpha coefficient indicates the degree to which items are interrelated to each other. This index can range from 0 to 1. A reliability of 0 indicates that the observed score is not related to the underlying true score; a reliability of 0.7 indicates that the observed score is a perfect indicator of the underlying true score. Generally, a reliability of 0.7 or greater is an acceptable level of reliability.

Cronbach's alpha coefficient was computed to determine reliability of the data in this study Table 2 reflects that the Cronbach's alpha is 0.793 which shows a high degree of internal consistency and stability amongst the Lickert scale items in Question 3.2. This reflects a high degree of reliability.

3.4 RESEARCH FINDINGS

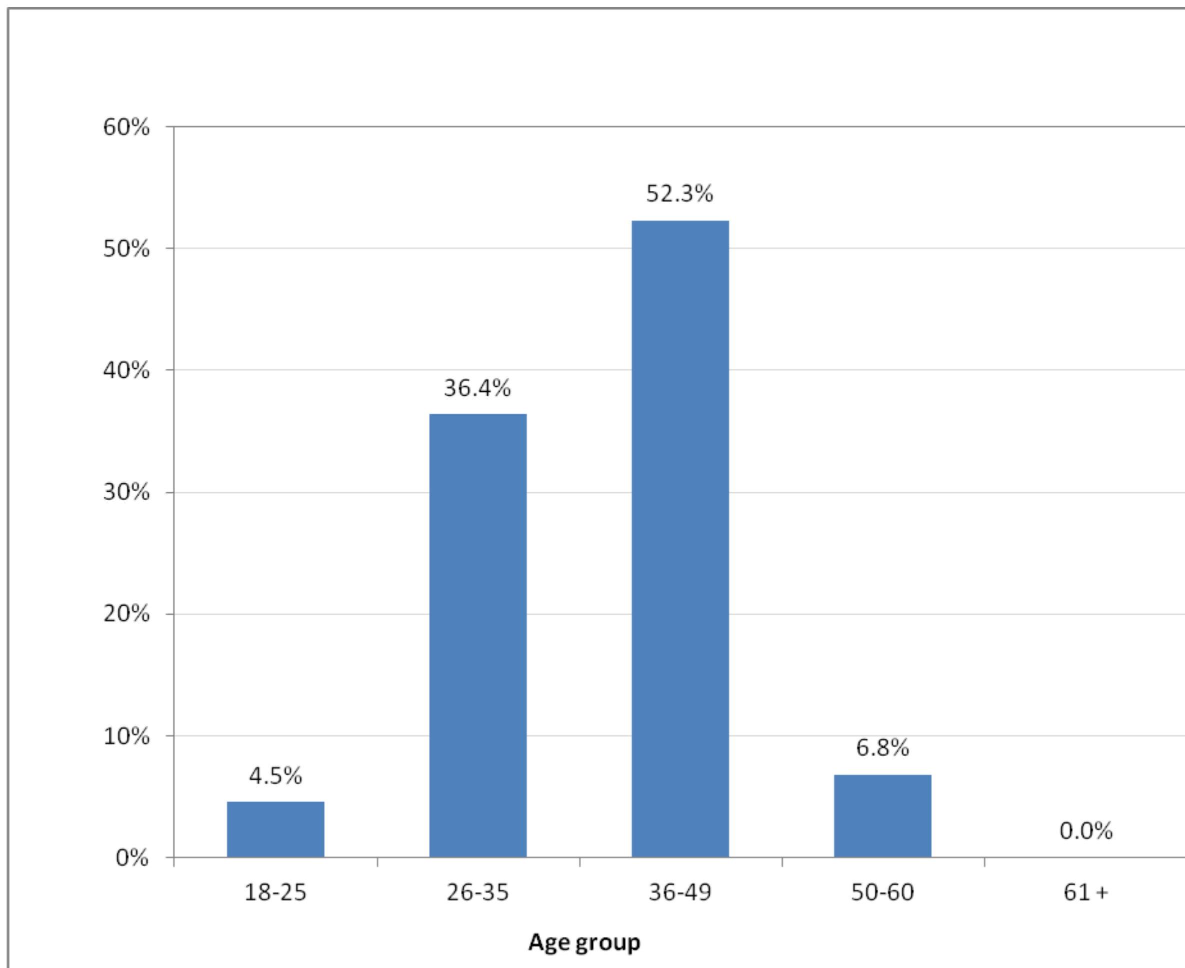
The questionnaire was divided into four sections; hence the research findings are presented as such.

3.4.1 Section 1: Biographical details

In this section the researcher presents the biographical information of the respondents, showing the respondents' distribution in terms of age, race, gender, marital status, highest qualification, years of service and rank.

- **Age**

Figure 2: Age Distribution

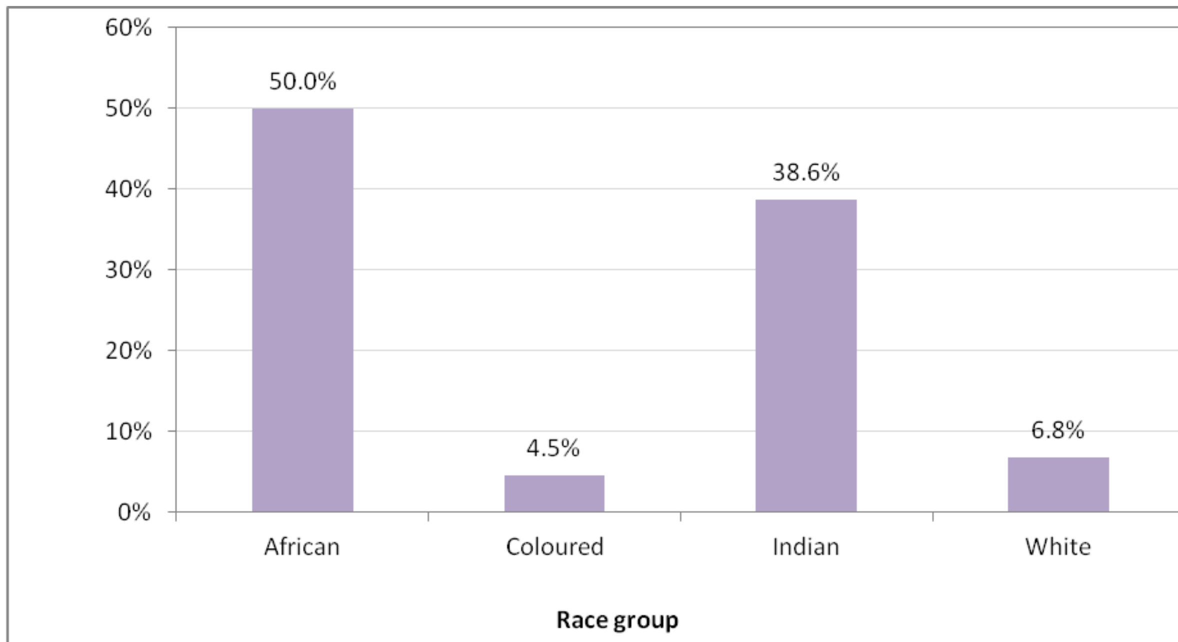


The data in Figure 2 reflect that the majority of respondents were between 26 and 49 years with 36.4% in the 26-35 age group and 52.3% of respondents in the 36-49 age

group. The majority of the employees taken in this sample fall within the 36-49 age group.

- **Race**

Figure 3: Race Distribution



The data in Figure 3reflect that a total of 50% of the respondents were African and 38.6% were Indian. This could be attributed to the fact the African race group is the majority in Kwa Zulu Natal followed by the Indian population, white and coloured race groups respectively.

- **Gender**

Figure 4: Gender distribution

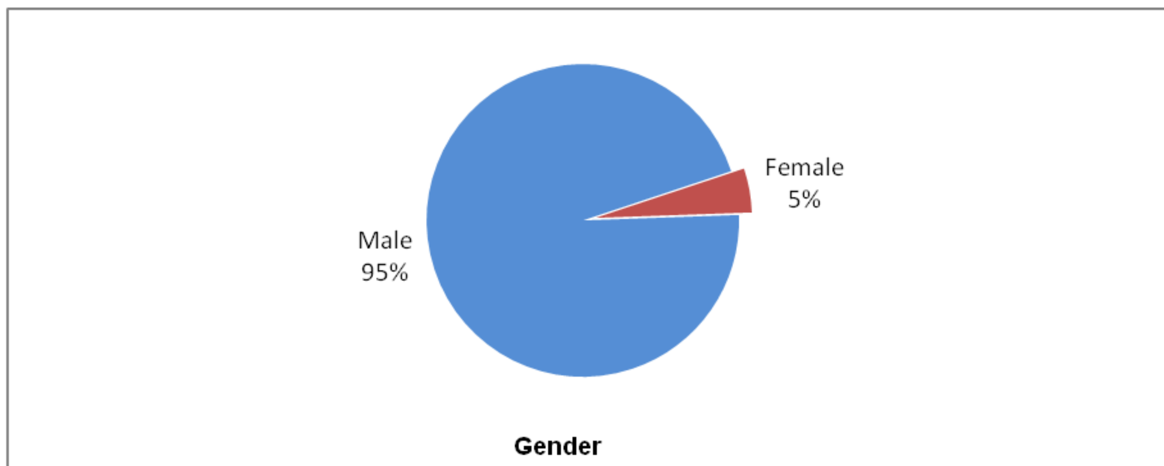


Figure 4 illustrates that the sample was not evenly distributed. A total of 95.5% of the sample were male. This is due to the fact that the South African Police Services (SAPS) is traditionally a male dominated environment thus the majority of participants were male.

- **Marital Status**

Figure 5: Marital Status

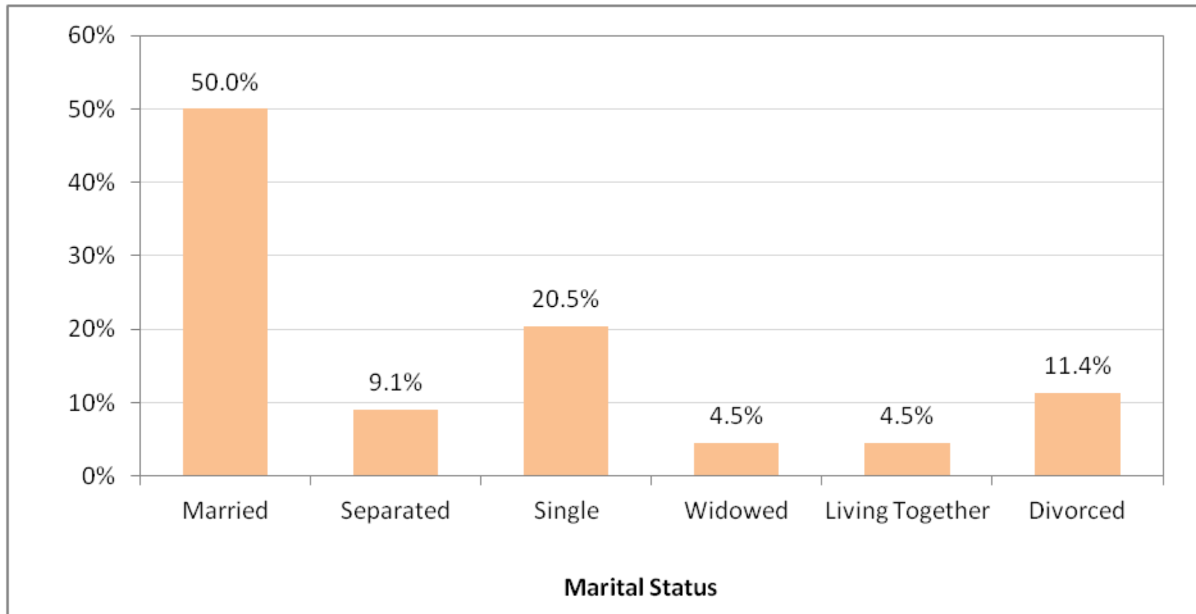


Figure 5 illustrates that 50% of the participants were married, 20.5% were single and 11.4% were divorced.

- **Highest Qualification**

Figure 6: Highest Qualification

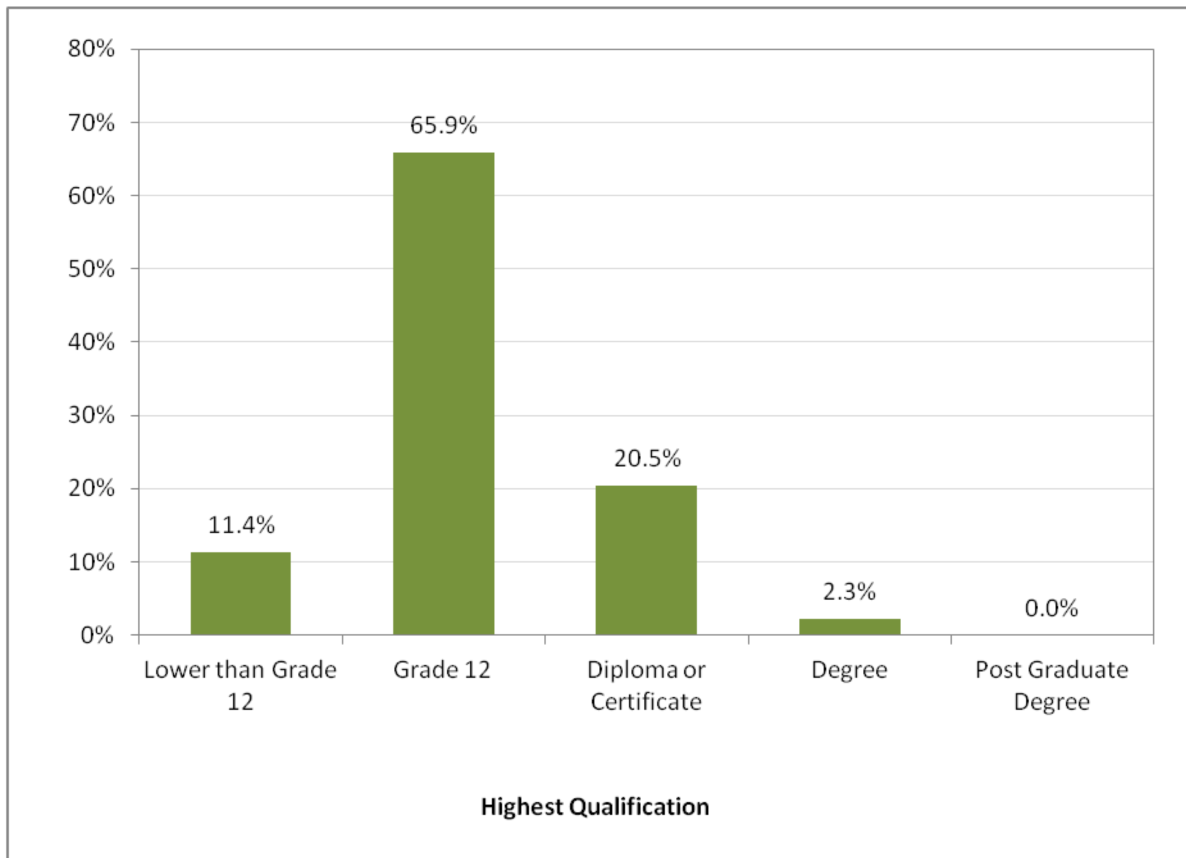


Figure 6 reflect that the majority of the participants (66%) possess only a Grade 12 qualification while 20.5% had a Diploma/Certificate.

- **Years of Service**

Figure 7: Years of service

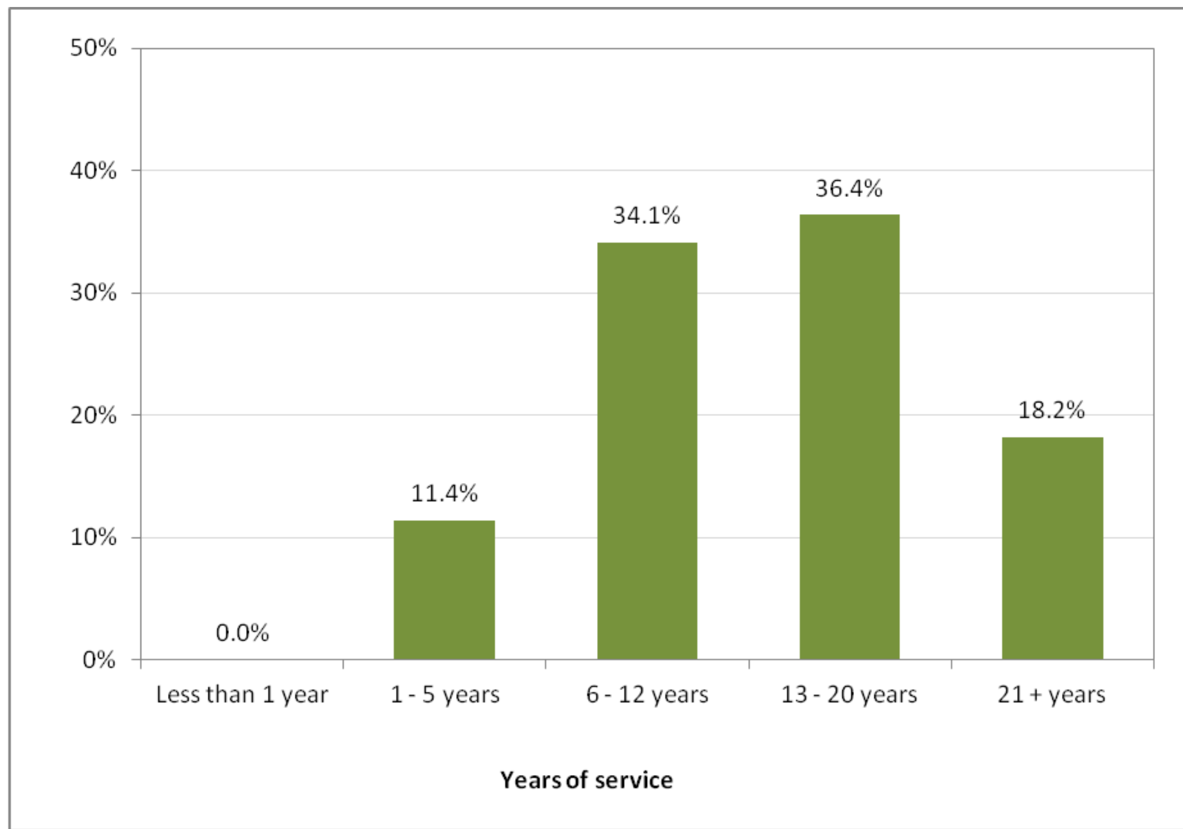


Figure 7 illustrates that a total of 11% of the respondents were employed for 1-5 years while 36% of the respondents were employed for 13-20 years. The findings indicate that the long serving members of the SAPS sought treatment as opposed to the younger serving respondents. It is the researcher's observation that Commanders often turn a blind eye to those members whose alcohol abuse directly impacts on their work performance. The Commander will often wait for years indirectly enabling the member to continue with the abuse of alcohol before referring the member to EHW for services. These respondents are by this stage, older and have been abusing alcohol for a longer period and their productivity and performance at work is negatively affected and they are often pressurized to seek treatment.

- **Rank**

Table 3: Rank of respondents

Rank	N	%
Police Trainee	0	.0%
Constable	9	20.5%
Sergeant	7	15.9%
Warrant Officer	20	45.5%
Lieutenant	0	.0%
Captain	1	2.3%
Major	0	.0%
Lieutenant Colonel	1	2.3%
Colonel	0	.0%
Brigadier	0	.0%
General	0	.0%
Admin Clerk	3	6.8%
Senior Admin Clerk	1	2.3%
Chief Admin Clerk	0	.0%
Personnel Practitioner	0	.0%
Cleaner	2	4.5%
Telkom Operator	0	.0%

The data in Table 3 reflect that 45% of the respondents were Warrant Officers while 21% were Constables and 16% were Sergeants. The findings of the rank of the respondents are consistent with the number of years of service of the respondents. However it is the researcher's experience that often the rank of constable and sergeant are also held by older serving members. Due to their abuse of alcohol and poor work performance these members are often denied promotion.

3.4.2 Section 2: Treatment Process

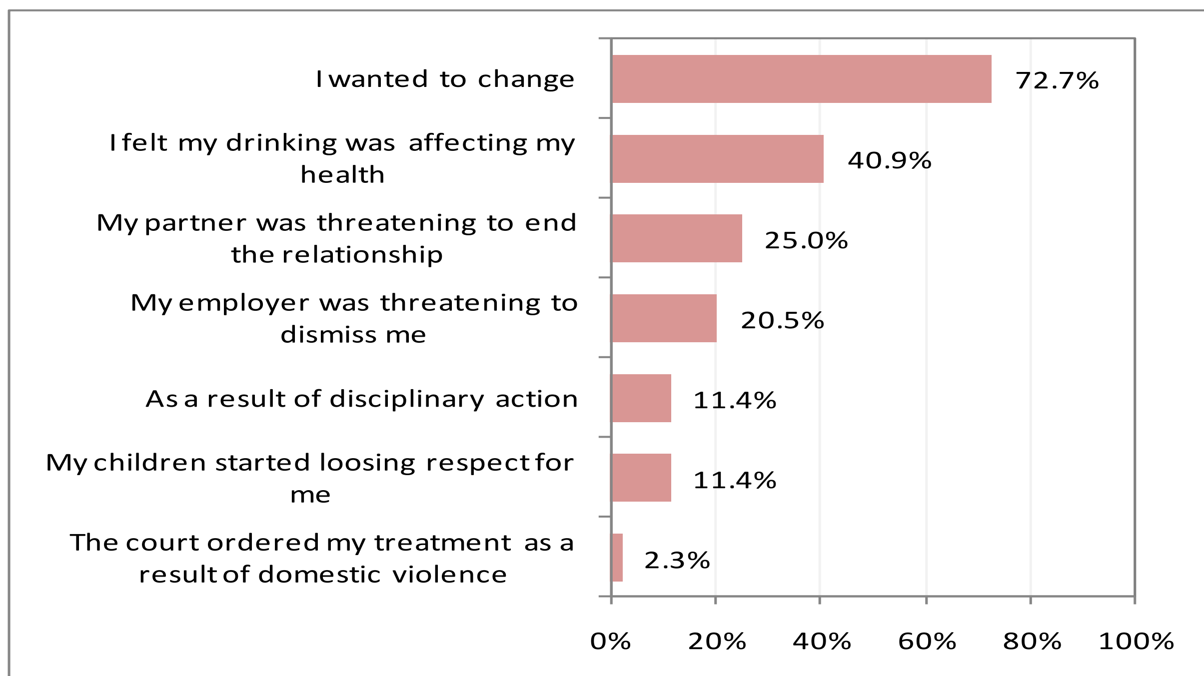
In this section the researcher wanted to ascertain as to the reasons as to why respondents went for treatment, the period of the treatment, whether the respondent experienced a relapse and how many times the respondent did go for treatment. The researcher also wanted to know the period of sobriety maintained following the last relapse as well as the positive and negative experiences during treatment. Respondents were also asked to indicate the support they received and to describe their experience upon their return home and work following their treatment.

- **Reason for treatment**

Table 4: Reason for treatment

REASON FOR TREATMENT	Yes		No	
	n	%	n	%
Q2.1.1 I felt my drinking was affecting my health.	18	40.9	26	59.1
Q2.1.2 My partner was threatening to end the relationship.	11	25.0	33	75.0
Q2.1.3 My children started losing respect for me.	5	11.4	39	88.6
Q2.1.4 My employer was threatening to dismiss me.	9	20.5	35	79.5
Q2.1.5 As a result of disciplinary action.	5	11.4	39	88.6
Q2.1.6 The court ordered my treatment as a result of domestic violence.	1	2.3	43	97.7
Q2.1.7 I wanted to change.	32	72.7	12	27.3

Figure 8: Reason for treatment



Data in Figure 8 and Table 4reflect that 73% of respondents indicated that the reason for treatment is that they wanted to change. The decision to seek treatment is often taken when the abuser of substances realizes that his/her life problems are being caused by their alcohol or drug use (McMurrian, 1994:99; Gorski, 1989:11). They recognize their need for help and actively seek out this assistance. The

researcher's experience has been that members would request referral to a substance dependency treatment facility citing their "need to change" and unhappiness regarding their present lifestyle as their main reasons for seeking assistance. Forty one percent of the respondents indicated that drinking was affecting their health. The researcher's experience has been that some members who abuse alcohol often disclose having medical problems for example diabetes and liver cirrhosis. The abuse of alcohol does impact negatively on an individual's health. Parry (2000:218) found that the abuse of alcohol is a contributing factor to chronic conditions such as heart disease, liver cirrhosis and malignancy. According to Beuster and Arnott (2007:55) patients with serious health problems might be more motivated to seek treatment for their dependency on alcohol.

- **Duration of treatment**

Figure 9: Length of treatment

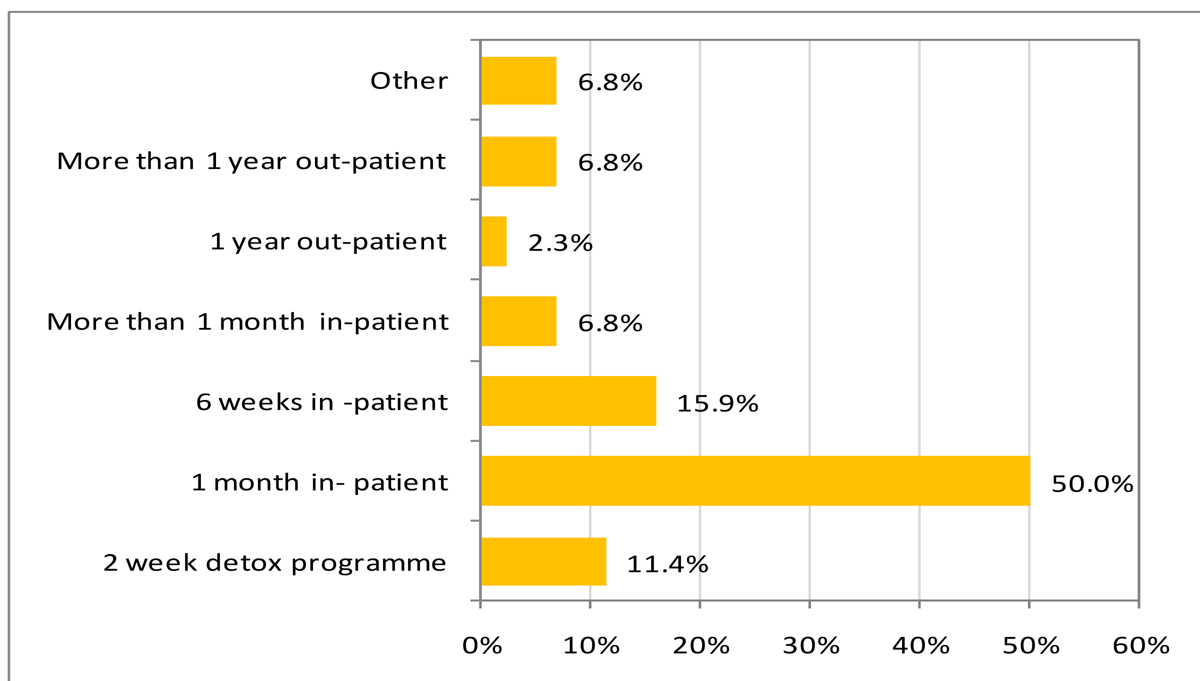


Figure 9 reflects that 50% of respondents went for a one month in-patients treatment. Sixteen percent attended a six weeks in-patient programme and11% participated in a two-week detoxification programme.

- **Relapse after the last treatment**

Figure 10: Relapse after the last treatment

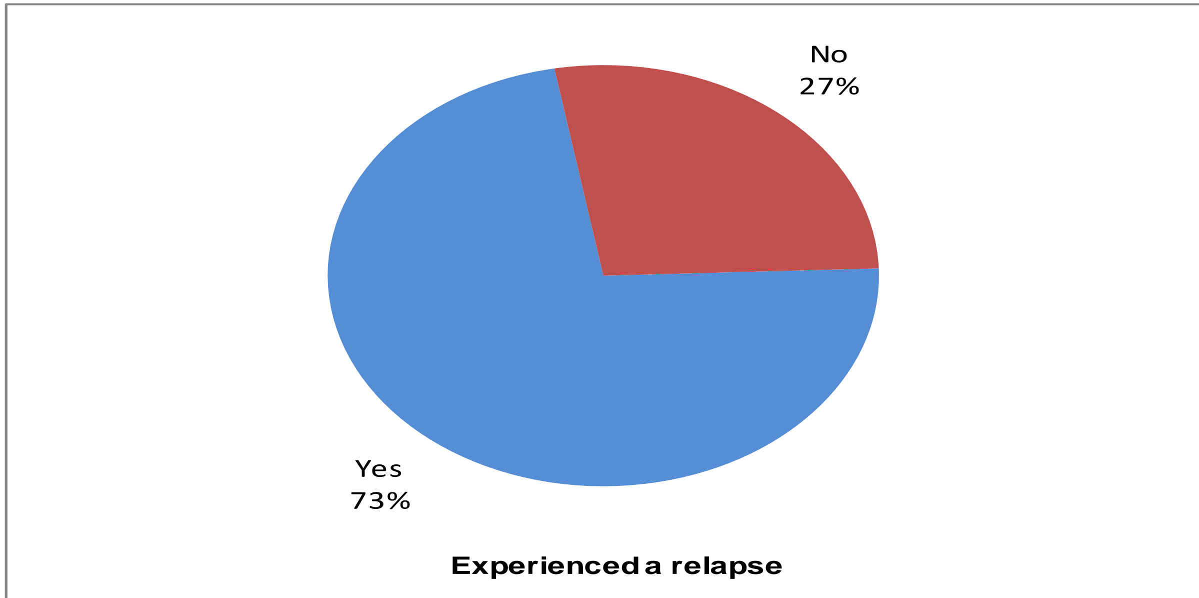


Figure 10 reflects that the majority (32) of respondents (73%) had experienced a relapse following treatment whereas only 12 of the respondents (27%) stayed sober. These findings are consistent with research (Connors et al., 1996:5; Miller et al., 1996:155; Perkinson, 2004:180; Lewis et al., 2002:105; Johnson, 2003:271) that the problem of relapse remains to be a challenge to many substance abusers post treatment for substance dependency.

- **Number of treatments before the last relapse**

Figure 11: Frequency of treatments before the last relapse

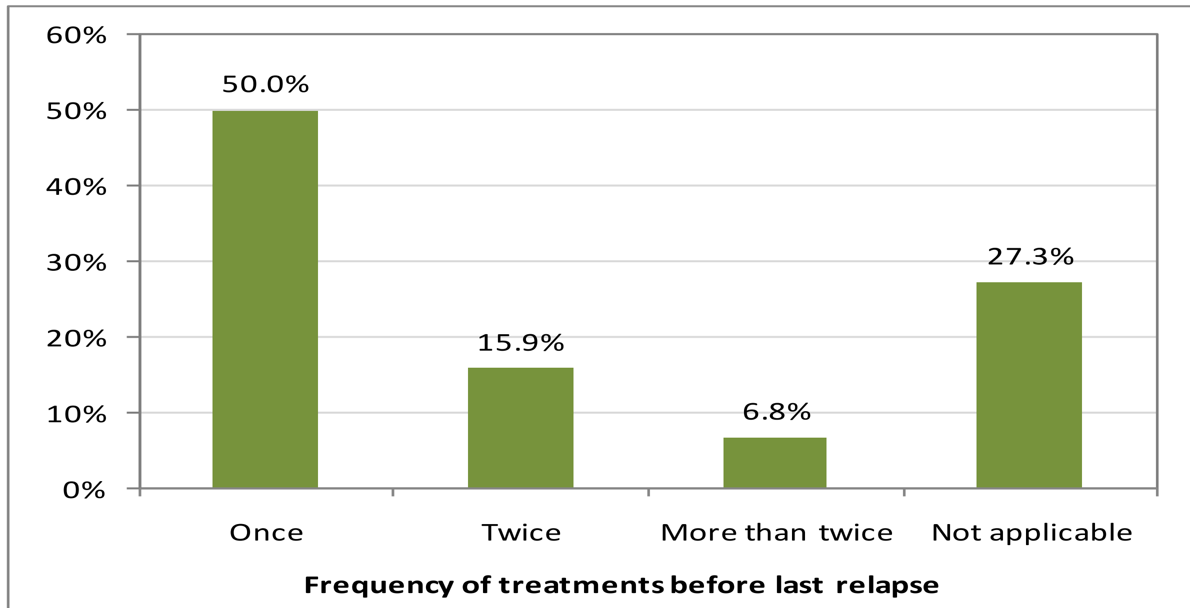


Figure 11 shows that 22 of respondents (50%) had treatment at least once before the last relapse whereas 7 respondents (16%) indicated that they went twice and 3 (7%) went more than three times for treatment. In 27% of the responses, this was the first time that respondents went for treatment. The decision to return for treatment following a relapse will depend on the individual's self esteem and self efficacy about the relapse, as well as the support available to the individual (Marlatt & Witkiewitz, 2005:4; Stowig, 2000:469).

In the treatment of substance dependency, research has found that the proportion of cases who relapse at least once during a year after treatment may be as high as 90% (Connors et al., 1996:5). These findings are consistent with the views held by researchers (Brownell, Marlatt, Lichtenstein & Wilson, 1986:765; Marlatt & George, 1984:263; Stout, Longabaugh & Rubin, 1996:99) that individuals may enter a treatment facility more than once following a relapse.

- **Duration of sobriety before the last relapse**

Figure 12: Duration of sobriety before the last relapse

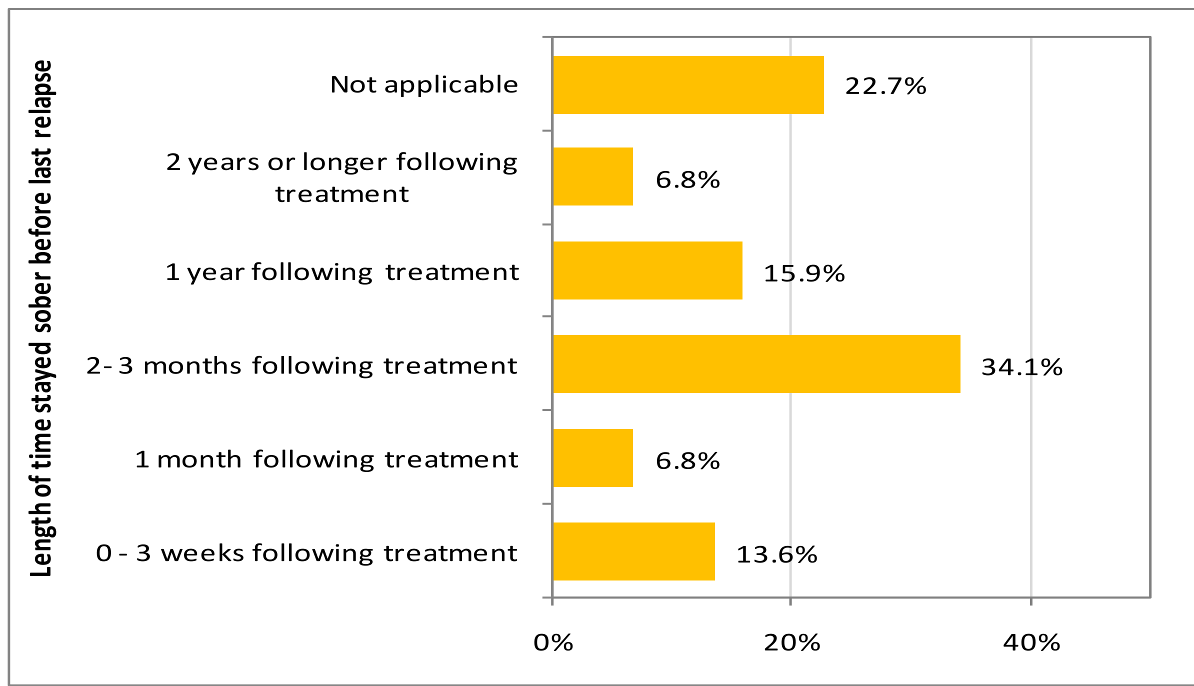


Figure 12 shows that 15 of the respondents (34%) stayed sober for two to three months before their last relapse. Ten respondents (23%) maintain that they are maintaining sobriety. Seven respondents (16%) stayed sober for one year following treatment and 6 respondents (14%) stayed sober for a period up to three weeks following treatment. Maintaining sobriety post treatment for substance dependency is a challenge facing many individuals. The high rates at which individuals return to substance after abstaining for a period of time supports the views held by counselors and clients that although it is difficult for a client to give up his/her dependency to substances it is even more difficult to remain abstinent (Connors et al., 1996:5; Brownell et al., 1986:765; Witkiewitz & Marlatt, 2007:1).

- **Positive experiences during treatment**

The following analyses were in response to an open-ended question. The overall comments made by the respondents regarding positive experiences during treatment was on the education they received at the rehabilitation centers on how alcohol/drug abuse affects the person physiologically and psychologically (f=18). They found the lectures to be informative and stimulating (f=14). According to Perkinson (2004:180)

recovery from alcoholism involves gaining information, increasing self awareness and developing skills for sober living. Therefore whilst attending the lectures the information about substance dependence overwhelms and instills a desire within the respondents to abstain from abusing substances. Respondents felt energetic, relieved and a renewed sense of hope for the future (f=10). Respondents also enjoyed good relationships with their family, friends and colleagues (f=7).

The researcher's experience has been when visiting members' during their stay at the treatment centre they are positive about wanting to change. For many the lectures are an eye-opener to understanding alcoholism as a disease. The sense of hope for the future comes with their understanding of the "disease" of alcoholism and that although there is no cure it is treatable (Gorski, 1989:16). When members decide to enter into a treatment programme, many spouses/partners/family members are relieved that there is help for their loved ones and are prepared to do whatever it takes to support their loved one during his/her treatment programme. This family support is seen as much needed to ensure the success of the rehabilitation process (Ibrahim & Kumar, 2009:38; Marlatt & Witkiewitz, 2005:20).

- **Negative experiences during treatment**

The following analyses were in response to an open-ended question. The general comments made by the respondents focused on missing their families (f=5) and being away from home (f=3). Respondents mentioned the loss of friends with whom they abused alcohol with (f=3) and the emotional difficulty (f=10) and physical illness they experienced during the detoxification period (f=3).The initial challenge facing members on entering the treatment centre is adjusting to the period of induction or adaptation to the treatment situation before the therapeutic intervention begins (Broome et al., 2002:58). During this period the member has no contact with their family; he/she experiences withdrawal and literally feels physically ill. This initial period is often seen by the respondents as the only negative experience during their treatment. Eventually the member is allowed contact with family and friends and the family becomes a part of the treatment process.

- **Support received after treatment**

Figure 13: Support received after treatment

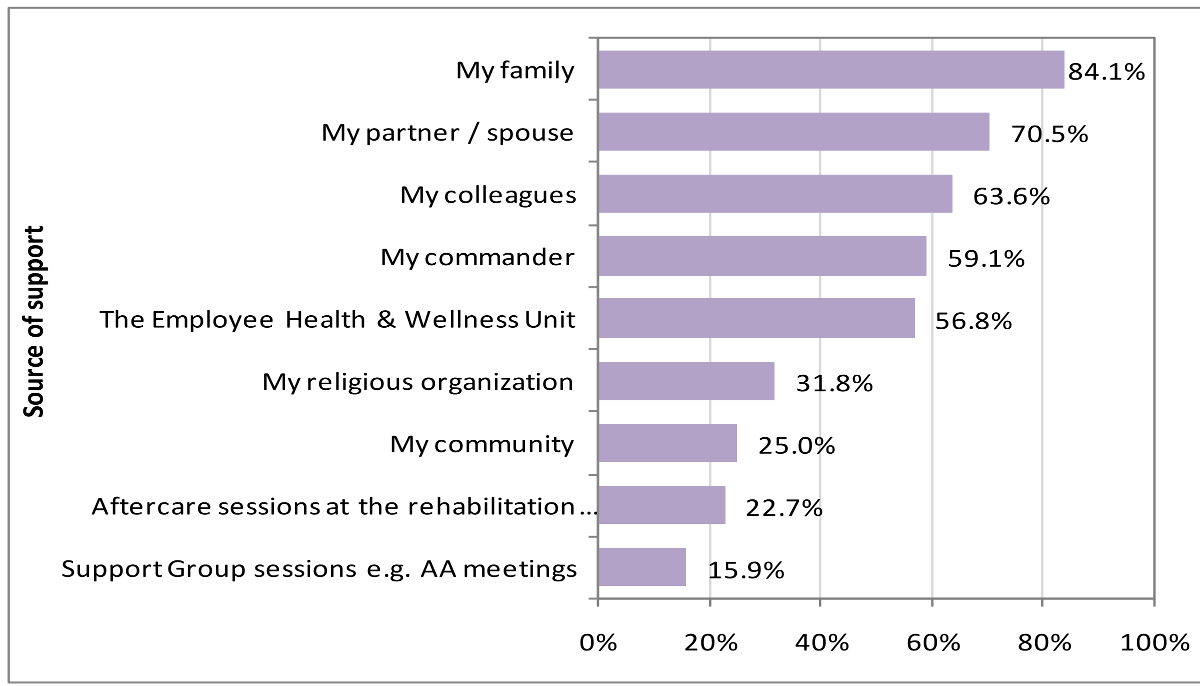


Figure 13 above shows that 37 respondents (84%) identified their family as their source of support and 31 respondents (71%) identified their partner/spouse. Studies have found that family and friends can have positive effects and that strong social support is linked to better outcomes post treatment (Brownell et al., 1986:771; Broome et al., 2002:58; Marlatt & Witkiewitz, 2005:20). Twenty eight respondents (64%) identified their colleagues and 26 respondents (59%) identified their commanders as being supportive post treatment. Only 10 respondents (23%) attended aftercare sessions at the rehabilitation centre and 7 respondents (16%) attended support group sessions. Interestingly 37 respondents (84%) did not attend support group sessions and 34 respondents (77%) admitted to non-attendance at aftercare sessions at the rehabilitation centre's.

The researcher has experienced that when respondents return from the treatment centre they are motivated and are willing to return to the treatment centre for aftercare services. However as mentioned by Naidoo (2009) patients leave the rehabilitation centre with the belief that they can sort out their own problems and this

belief is especially significant amongst members of the SAPS. The members are feeling confident and have a strong belief in themselves that they can cope. They tend to make excuses for not attending, respondents mentioned their reasons for non-attendance to aftercare sessions and support group meetings was due to firstly a lack of time and/or unavailability of transport to go to the rehabilitation centre's for aftercare and support group meetings. Seven respondents stated that there were no support groups available in their communities. Thirty three respondents (75%) received no support from their community. The EHW Unit was identified by 25 respondents (57%) as a source of support and 19 respondents (43%) did not receive support after their treatment. The researcher's experience has been that often respondents do not see a need to maintain contact with the EHW workers post treatment as they see the EHW worker's role only as a referral agent to the treatment centre.

- **Experience back home after treatment**

The following analyses were in response to an open-ended question. Respondents reported a positive interaction with their partner/spouse and families (f=7). They experienced an improved self-esteem (f=34) and the confidence to deal with life's challenges (f=3). They indicated further that initially there was uncertainty (f=4), since the alcohol caused lots of problems within the home. Families did not know how to interact with now a "sober" member (f=3).

According to Marlatt & George (1984:265) a successful recovery from an addictive behavior is based on a high motivation to change and a high degree of self-efficacy. Self-efficacy is defined as "the individual's expectation concerning the capacity to cope with an impending situation or task" (Marlatt & George, 1984:265). Marlatt hypothesized that the initial abstinence results in the individual experiencing a sense of personal control and self-efficacy. This is consistent with the findings above where the respondents experience back home after treatment was an improved self-esteem and the confidence to deal with life's challenges.

- **Experience back at work after treatment**

The following analyses were in response to an open-ended question. The findings reflect that for some of the respondents their experience back at work after treatment was positive (f=27) in terms of support they received from their colleagues and commanders. However some respondents (f=16) indicated that their commander and colleagues did not provide them with a supportive environment, but instead they criticized them. The researcher's experience has been that often members return to the same negative work environment prior to their treatment. Whilst the member has undergone a process of change the work environment hasn't. According to the respondents (f=16) some commanders lack the skills to reintegrate the member returning from treatment into the workplace, thus the work environment is often found stressful to the member and this directly impacts on the member's ability to maintain sobriety. The researcher views this lack of integration skills on the part of commanders and colleagues due to their limited understanding of substance abuse and dependency and the treatment thereof. A study by Ibrahim and Kumar (2009:41) found that employers are not supportive to employees post treatment and that they lack the confidence in the employee's ability to make a positive contribution.

3.4.3 Section 3: Reasons for drinking after treatment

- **The main reason for you taking the first drink**

The following analyses were in response to an open-ended question. The respondents (f=15) indicated that their first drink was due to peer pressure, as a result of their emotional state at the time of their first drink (f=13), craving/urges (f=7) and boredom (f=6). In terms of Marlatt's (1984:264) categorization of determinants of relapse, there are two classes of relapse determinants, namely intrapersonal and interpersonal determinants. Intrapersonal factors refer to factors within an individual and or reactions to non-personal environmental events for example emotional states, moods and feelings, frustration, anger, anxiety, depression and boredom. Interpersonal determinants are defined as high-risk situations external to the

individual for example, fights/arguments, peer pressure and conflict associated with interpersonal relationship such as marriage/friend.

Firstly the results in this study in terms of emotional state at the time of their first drink, as well as craving/urges and boredom fall within the category of intrapersonal determinants. These findings are consistent with the negative emotional states that Marlatt (1986:264) identified as characteristic that the person experiences prior to relapse. The "experience of negative-emotional states and exposure to social pressure constitute high-risk situations for relapse to alcohol and substance use" (Marlatt, 1996:41; Brownell et al., 1986:769; Zywiak et al., 1996:125).

Secondly, the results of the study also reflect that some of the respondents' main reason for taking the first drink is due to peer pressure which falls within the interpersonal category of determinants. The findings are consistent with research by Broome et al. (2002:59) that the social context can serve either as a resource or an obstacle for behavior change by the patient post treatment. For example "negative peer influences have been noted in the development of substance use behavior and the promotion of relapse" (Broome et al., 2002:59; Ibrahim & Kumar, 2009:38). Marlatt's (1996:41) study found that patients were unable to resist either direct or indirect attempts by others to engage them in drinking. In this study the respondents confirmed that one of the main reasons for taking the first drink was due to peer pressure. As mentioned by Perkinson (2004:11) when an individual is ignorant of healthy alcohol use and is susceptible to heavily using peers, abuse of substances may increase. Perkinson (2004:11) mentions further that when a person is poorly socialized into the culture, or if the culture makes the substance the recreational drug of choice, it is difficult for the patient to maintain sobriety. Further within the SAPS there exists this culture of drinking, when members want to relax following a stressful day or if they plan to socialize, the recreational drug of choice is alcohol. This view is consistent with the findings by Corelli as cited in Madu and Poodhun (2006:216) that policemen to handle stress of their work would often get together and their favourite pastime is drinking alcohol.

The researcher is of the view that when the respondents were confronted with the high-risk situation, post treatment and following a period of abstinence, and for

example experienced a negative emotional state namely anger or frustration, the respondent failed to exhibit effective coping skills and the resultant decrease in self-efficacy led to the initial lapse. This initial lapse may have lead the respondent to experience guilt or self-blame (abstinence violation effect) (Marlatt & George, 1984:265) and a return to pre-treatment use of alcohol.

- **Reasons for drinking again**

Table 5: Reasons for drinking again

	Strongly Disagree		**Disagree**		**Neither agree nor disagree**		**Agree**		**Strongly Agree**	
	n	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Q3.2.1 I felt angry with myself because things were not going my way.	14	31.8%	9	20.5%	4	9.1%	13	29.5%	4	9.1%
Q3.2.2 I felt frustrated with myself because things were not going my way.	14	31.8%	7	15.9%	4	9.1%	13	29.5%	6	13.6%
Q3.2.3 I felt bored.	11	25.0%	9	20.5%	8	18.2%	10	22.7%	6	13.6%
Q3.2.4 I felt anxious.	13	29.5%	10	22.7%	6	13.6%	11	25.0%	4	9.1%
Q3.2.5When I saw alcohol I just had to give in.	10	22.7%	8	18.2%	6	13.6%	8	18.2%	12	27.3%
Q3.2.6 I felt sad.	14	31.8%	15	34.1%	3	6.8%	8	18.2%	4	9.1%
Q3.2.7 I felt physically ill.	20	45.5%	14	31.8%	5	11.4%	3	6.8%	2	4.5%
Q3.2.8 I felt pain.	19	43.2%	16	36.4%	2	4.5%	4	9.1%	3	6.8%
Q3.2.9 I was in a good mood and felt like getting high.	13	29.5%	7	15.9%	7	15.9%	8	18.2%	9	20.5%
Q3.2.10 I wanted to see what would happen if I tried one drink.	15	34.1%	16	36.4%	5	11.4%	7	15.9%	1	2.3%
Q3.2.11 I just felt tempted to drink out of the blue and went off to get a drink.	15	34.1%	13	29.5%	2	4.5%	10	22.7%	4	9.1%
Q3.2.12 Someone	14	31.8%	13	29.5%	4	9.1%	6	13.6%	7	15.9%

offered me a drink.										
Q3.2.13 I felt frustrated because of my relationship with someone else.	15	34.1%	15	34.1%	2	4.5%	6	13.6%	6	13.6%
Q3.2.14 I was with others having a good time and we felt like getting drunk together.	14	31.8%	10	22.7%	1	2.3%	9	20.5%	10	22.7%
Q3.2.15 I felt ill or in pain but this was not due to withdrawal from alcohol.	18	40.9%	19	43.2%	3	6.8%	2	4.5%	2	4.5%
Q3.2.16 I felt others were being critical of me.	16	36.4%	16	36.4%	5	11.4%	4	9.1%	3	6.8%
Q3.2.17 I saw others drinking.	12	27.3%	13	29.5%	3	6.8%	12	27.3%	4	9.1%
Q3.2.18 I discovered I have a terminal illness/ my health began to deteriorate due to my health status.	22	51.2%	15	34.9%	5	11.6%	1	2.3%	0	.0%
Q3.2.19 I felt I could not cope with my stressful work environment.	16	36.4%	14	31.8%	3	6.8%	7	15.9%	4	9.1%
Q3.2.20 I was transferred to another more stressful department at work.	15	34.1%	19	43.2%	3	6.8%	3	6.8%	4	9.1%

Table 5 reflects the frequency distribution of questions relating to reasons for drinking again after treatment. Twenty respondents (45%) agreed/strongly agreed to question 3.2.5, that the main reasons for drinking again was due to the fact that when they saw alcohol they just had to give in ((intrapersonal determinants – giving into temptations).The above results is consistent with research by Zywiak et al. (1996:125) as their results indicated that the predominant factor was negative emotions from both the intrapersonal and interpersonal domains, followed by social pressure and lastly wanting to get high, testing control, substance cues and urges to drink. However, 45% of the respondents strongly disagree/disagreed that they felt like getting high as a reason for drinking again and 24 respondents (55%) disagreed/strongly disagreed to question 3.2.14 that they were with others having a

good time and felt like getting drunk together. These findings thus contradict Zywiak et al. finding as discussed above.

Twenty one respondents (48%) disagreed/strongly disagreed to question 3.2.2 to feeling frustrated and 23 (52%) disagreed/strongly disagreed to question 3.2.1 to feeling angry (intrapersonal determinants) with themselves as things were not going their way. These findings are contradicting with a study done by Marlatt (1996: 41) where respondents experienced frustration and anger rather than dealing with these emotions constructively would choose taking a drink. Twenty respondents (46%) disagreed/strongly disagreed to question 3.2.3 that they felt bored (intrapersonal determinant – negative emotional state).

Thirty seven respondents (86%) disagreed/strongly disagreed to question 3.2.18 that they discovered that they had a terminal illness or their deterioration of their health led them to drink again. Thirty seven respondents (84%) disagreed/strongly disagreed to question 3.2.15 to having felt physically ill and 35 respondents (80%) disagreed/disagreed to question 3.2.8 that they felt pain as a reason for drinking again. These findings contradict what Marlatt and Witkiewitz (2005:3) say that if an "individual views a lapse as an irreparable failure or due to chronic disease determinants, and then the lapse is more likely to progress to a relapse".

In question 3.2.19, 30 respondents (68%) strongly disagreed/disagreed that they could not cope with their stressful environment and 77% strongly disagreed/disagreed that they were transferred to another more stressful department at work (question 3.2.20). This findings contradict what Marlatt (1996:41) indicates with the early social learning theory that problem drinking can be considered as a maladaptive attempt to cope with stress that an individual may find himself/herself in due to environmental demands. An alcoholic may fail to exercise an effective coping response when experiencing a stressful situation following treatment may turn to alcohol as a response especially if in the past the person relied on alcohol as a means of coping with stress (Marlatt, 1996:41).

The researcher noted further that although respondents identified their main reason for taking the first drink in question 3.1 was due to peer pressure, emotional state,

cravings/urges and boredom respectively, their responses to question 3.2 were inconsistent. This finding could be due to the fact that the respondents misunderstood the question or interpreted the scale incorrectly. Another factor may be the opportunity to mark neither agree nor disagree with statements. That leads to an average of 9% of respondents who opt for this option. If this percentage would be taken into consideration with the agreed/strongly agreed percentages, the outcomes would have been according to the literature in most cases.

Table 6: Measures of central tendency

MEASURES OF CENTRAL TENDENCY	Mean	Std. Deviation
Q3.2.5 When I saw alcohol I just had to give in.	3.091	1.552
Q3.2.9 I was in a good mood and felt like getting high.	2.841	1.539
Q3.2.3 I felt bored.	2.795	1.407
Q3.2.14 I was with others having a good time and we felt like getting drunk together.	2.795	1.622
Q3.2.2 I felt frustrated with myself because things were not going my way.	2.773	1.508
Q3.2.1 I felt angry with myself because things were not going my way.	2.636	1.432
Q3.2.4 I felt anxious.	2.614	1.385
Q3.2.17 I saw others drinking.	2.614	1.385
Q3.2.12 Someone offered me a drink.	2.523	1.470
Q3.2.11 I just felt tempted to drink out of the blue and went off to get a drink.	2.432	1.404
Q3.2.13 I felt frustrated because of my relationship with someone else.	2.386	1.434
Q3.2.6 I felt sad.	2.386	1.351
Q3.2.19 I felt I could not cope with my stressful work environment.	2.295	1.357
Q3.2.10 I wanted to see what would happen if I tried one drink.	2.159	1.140
Q3.2.16 I felt others were being critical of me.	2.136	1.212
Q3.2.20 I was transferred to another more stressful department at work.	2.136	1.231
Q3.2.8 I felt pain.	2.000	1.220
Q3.2.7 I felt physically ill.	1.932	1.129
Q3.2.15 I felt ill or in pain but this was not due to withdrawal from alcohol.	1.886	1.039
Q3.2.18 I discovered I have a terminal illness/ my health began to deteriorate due to my health status.	1.651	0.783

Table 6 reflects the mean and standard (STD) deviation of the questions relating to reasons for drinking after treatment. The mean was calculated by averaging the scores for each question. Strongly agree was coded 5, Agree was coded as 4, Don't

know was coded as 3, Disagree was coded 2 and Strongly disagree was coded 1. The large STD deviation values indicate a deviation of responses from the mean – respondents answers ranged widely between strongly agree and strongly disagree. The mean values are mostly under 3 which indicate that most respondents selected strongly disagree or disagree.

The above findings specify that the factors indicative of negative emotions/Intrapersonal environment, namely, frustration(f=19), anger(f=17), boredom(f=16) and anxiety(f=14), substance cues and non-cued urges and interpersonal conflict; namely, watching others drinking (f=16), respondents were in a good mood and wanted to get high(f=17), being in the company of others and wanting to have a good time (f=19)were identified by the respondents as being some of the reasons for drinking. This finding is in support of Marlatt's taxonomy of relapse (Marlatt et al., 2002:11). According to Zywiak et al. (1996:121) this cluster of lapse precipitants may facilitate the continuation of the drinking episode into a full blown relapse. This is consistent with Marlatt's abstinence violation effect (AVE) (Marlatt & George, 1984:264) where he hypothesized that if a person experienced conflict, guilt and or self-blame regarding an initial lapse this would lead the person to drink even more. He added that the negative emotions of anger, frustration, sadness and anxiety could also be present making future lapses more likely.

- **Circumstances at work that can prevent a relapse**

The following analyses were in response to an open-ended question. The responses reflect a co relational analysis between the work place/environment and the member's ability to maintain sobriety. Respondents indicated that support from management and colleagues (f=8) as well as a change in their work environment (f=11) would have prevented them from relapsing. According to Kilian (2008:15) substance abuse does negatively impact on the workplace. He mentions low productivity, absenteeism and poor performance as some of the consequences of substance abuse in the workplace. Therefore it is important for management to take cognizance of this fact and to make concerted efforts in the early identification of members abusing alcohol and referring members to EHW for assistance. Further it is important that management and colleagues are exposed to the substance

dependency awareness programme so that they can firstly identify early signs and symptoms of substance abuse and can refer the member for treatment as well as being able to assist in reintegrating the member into the workplace as effectively as possible upon his return from treatment.

Respondents also indicated that having a support group at work would be most beneficial to their aftercare treatment. Career sessions to temporarily and alternatively place members post-treatment, would allow members the opportunity to re-orientate themselves to the work environment and to adjust to their new lifestyle of maintaining sobriety. As mentioned earlier support to the member from the employer and colleagues post treatment is paramount to the member's ability to maintain sobriety, as strong social support is linked to better outcomes post treatment (Brownell et al., 1986:771; Broome et al., 2002:58; Marlatt & Witkiewitz, 2005:20).

3.4.4 Section 4: Proposed Interventions and Services

Table 7: Proposed Interventions and Services

PROPOSED INTERVENTIONS	Yes		No	
	N	%	N	%
Q4.1.1 Participation in Aftercare services (development of life skills, example conflict management, financial and stress management).	42	95.5	2	4.5
Q4.1.2 Participation in a health education and fitness Programme.	43	97.7	1	2.3
Q4.1.3 Participation in support groups.	43	97.7	1	2.3
Q4.1.4 Establishment of Peer (Buddy) Support.	40	90.9	4	9.1
Q4.1.5 Education of management and colleagues on substance dependency thus creating a supportive working environment.	43	97.7	1	2.3
Q4.1.6 Attendance for debriefing following exposure to traumatic scenes	43	97.7	1	2.3

Table 7 reflects that the majority of respondents support the proposed interventions and services. Ninety five percent of the respondents agreed that participation in aftercare services including the development of life skills would assist in them maintaining sobriety. Forty three respondents (98%) were in agreement that they would participate in a health education and fitness programme, support groups and utilize the trauma debriefing services offered to members following their exposure to

traumatic incidents. Despite 91% agreed to the establishment of Peer (Buddy) support, 9% of the respondents indicated that they were of the view that colleagues would not supply positive inputs (f=3), they are negative (f=3), respondents will learn from other professionals and other people's example (f=3), businessmen/women who are struggling with the same problem. According to Ibrahim and Kumar (2009:38), positive peer support could assist substance abusers to maintain sobriety.

A study by Connors et al., (2001:205) reported that "cognitive coping skills, positive thinking and a number of available coping skills" are all related to post treatment abstinence. A key factor to avoiding relapse is identifying situations in which the client is at a greater risk for relapse (Connors et al., 2001:2006).

- **Added beneficial interventions/services**

The following analyses were in response to an open-ended question. The responses indicate a dire need for the organization to play an integral role in the whole treatment process, both during the treatment (f=14) and especially when the member returns to work (f=16). Respondents identify the workplace as playing a crucial role in enabling them to maintain sobriety. The request is that the organization be involved in their treatment in terms of commanders supporting them during treatment and especially upon their return to the workplace. Ibrahim and Kumar (2009:41) suggest that family, employers and the community should work in partnership with the treatment centers so that they can take over the role played by the treatment centre's when members return post treatment.

3.5 SUMMARY

In this chapter various aspects of the research methodology, pertaining to this study was explained. This included an explanation of the research design, the data collection method, a description of the research instrument (questionnaire), including the statistical analysis of data. The data analysis focused on determining the relationship by correlating between variables measured and establishing frequencies and percentages of the responses. The chapter had 4 sections which indicated biographical details, the treatment process, and reasons for drinking after treatment and proposed interventions and services.

The information provided by the respondents, the members of the South African Police Services (SAPS), indicated that like many substance abusers globally, they too experienced a challenge in maintaining sobriety post treatment for substance dependency. The majority of the respondents identified (intrapersonal determinants) experiencing a negative emotional state (example anger, frustration and anxiety), exposure to peer pressure and boredom, constituting a high-risk situation for their relapse to alcohol. A significant number of respondents indicating that they experienced positive support from their colleagues and commanders. There were a small percentage of respondents mentioning a lack of support from their commander and colleagues. The feeling was that there is a lack of reintegration of the member into the workplace following treatment and the member often returns to a stressful environment leading to relapse.

Chapter 4 will focus on the concluding remarks on the study and future recommendations.

CHAPTER 4

CONCLUSION AND RECOMMENDATIONS

4.1 INTRODUCTION

In this chapter the researcher will provide a summary of the research process, in order to draw conclusions from the findings of the study and to make recommendations. The type of research that was used in this study is applied research as the researcher's focus in this particular study was on identifying the causes for members within the SAPS to relapse post treatment for substance dependency.

The researcher therefore presents the final evaluation of the research process in accordance to conclusions, recommendations and summary.

4.2 CONCLUSIONS

Based on the findings of the study, the following conclusions are made with careful consideration due to the possibility of the respondents choosing the option of neither agree nor disagree in the scale for reasons for taking the first drink following treatment, which has impacted on the outcome of the study.

- A significant number of respondents experience a challenge in maintaining sobriety post treatment for substance dependency.
- The main reason for relapse is due to their exposure to a high-risk situation for which they did not have an effective coping skill.
- Intrapersonal determinants example, factors internal to the individual like frustration, anger, anxiety, peer pressure and boredom posed to be significant high-risk situation for which respondents lacked an effective coping skill resulting in a relapse.
- Respondents' failure to continue with aftercare services contributes to the relapse process.

- Social support both in terms of family and the workplace can either aid in the members treatment and in a lack thereof may impact negatively on the members' treatment.
- Attendance of support groups can assist members in their ability to maintain sobriety.
- The workplace (for example, management, colleagues and especially the EHW Unit), do play an integral role in providing the necessary supportive services to members post treatment for substance dependency.

4.3 RECOMMENDATIONS

The following recommendations are made:

- The South African Police Services' National Office to develop a relapse prevention programme to be implemented by the EHW Unit, throughout the country.
- This treatment programme should be a step down from the respective treatment centre and should support and not replace the aftercare programme at the treatment centre.
- The goal of this programme should be to teach clients how to anticipate and cope with relapse by increasing their awareness about choice of behavior, coping and self-control.
- The treatment programme should encourage the education and identification of high-risk situations. An important component of the programme should include a return-to-work strategy that would ensure the smooth transition for the member from the treatment centre to the workplace. This would better equip members to deal with these high-risk situations and aid them in maintaining sobriety.
- The focus of the programme should include reintegration into the workplace; interventions should focus on teaching effective coping strategies and enhancing self-efficacy and participation in a support group. The workplace programme is not meant to replace the aftercare programmes at treatment

centre's but to support and supplement the members functioning at work to maintain sobriety.

- Support groups (the concept of Buddy (Peer) support) at the stations should be established and members returning from treatment should attend. In this way the member is aware that support is available, he/she may feel more comfortable discussing such confidential issues with a peer. Through this system members would not have excuses of time and transport for their non attendance.
- The members' family to be included as a part of the treatment process.
- The concept of Buddy (Peer) support to be developed. Every member especially management in the employ of the SAPS should be exposed to the Substance Awareness training programme. This programme gives an overview of substance dependency, signs and symptoms and most importantly, how to refer a member/colleague for professional assistance and how to provide support to the member.
- The South African Police Services to re-introduce the holding of alcohol boards for members which will encourage members to realize the seriousness of their decision to seek treatment and the progress reports from the social worker would be a good monitoring tool to assess the members' progress following treatment.
- The South African Police Services – EHW units to develop partnerships with Department of Health, Department of Social development and other Non Governmental agencies dealing with substance dependency issues. The purpose would be to keep abreast with current legislation and treatment trends.

4.4 SUMMARY

The goal of this study to explore the causes of relapse post treatment for substance dependency within the South African Police Services has been established. The following objectives of the study outlined were achieved.

- To conceptualize theoretically the impact of relapse on a person post treatment for substance dependency.

The literature review focused on understanding the relapse process. The term relapse is defined as an uncontrollable return to drug or alcohol use following competent treatment. Relapse is seen as a challenge facing many dependents following their treatment. It is believed that there are certain high-risk situations that often serve as precipitants to relapse to substance use. These high-risk situations are divided into categories, example, Intrapersonal determinants; Interpersonal determinants and Covert antecedents of relapse. It is believed that if an individual on completing his treatment for substance dependency is faced with a high-risk situation, will relapse if he/she does not have effective coping skills. The literature also looked at the Prevalence of substance abuse amongst police members and the need for a relapse prevention programme. This objective has been accomplished through chapter two in this research report.

- To undertake an empirical study to explore the challenges that members experience or are exposed to causing them to relapse post treatment for substance dependency.

The empirical study was carried out by means of a quantitative descriptive survey design. The data was collected by using a self-developed questionnaire and then analysed and interpreted. The main conclusion drawn from the finding is that when members leave the security of the treatment centre, they return to a world full of challenges. The members disclosed that their main challenge was the maintenance of their sobriety following treatment. The majority of respondents stated that they experienced a relapse shortly after their treatment. This objective was attained in chapter 3; where the empirical findings are presented in detail.

- To make recommendations to the management of the South African Police Services on developing a prevention of relapse programme in the workplace to prevent relapse of members post treatment.This objective was attained in chapter 4; where the necessary recommendations were made.

4.5 RECOMMENDATIONS FOR FURTHER STUDIES

Future research is recommended to investigate the effectiveness of the relapse prevention programme within the South African Police Services in assisting members with substance dependency problems to maintain sobriety.

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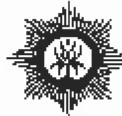
ANNEXURE A

G P S 002-0222 SAP 21

SUID-AFRIKAANSE POLISIEDIENS  SOUTH AFRICAN POLICE SERVICE

UMBUTHO WAMAPHOYISA ASENINGIZIMU-AFRIKA

Privaatsak/Private Bag 1965, DURBAN, 4000
Posbus/Post Office Box

Verwysing Reference	3/34/2 3/34/2(6)2009-5495898
Navrae Enquiries	Dir. NG Govender S/Supt. A D vd Linde
Telefoon Telephone	031 - 3254925
Fax number Faksnommer	031 - 3254841 031 - 3256022

The Provincial Commissioner
Die Provinsiale Kommissaris
KwaZulu-Natal

2009-09-07

The National Commissioner
Strategic Management
Pretoria
0001

Att: S/Supt. J Schnetler/ Supt. GP Joubert

RESEARCH REQUEST: CAUSES OF RELAPSE POST REHABILITATION FOR SUBSTANCE DEPENDANCY WITHIN THE SAPS: MASTERS DEGREE IN EMPLOYEE ASSISTANCE PROGRAMMES(EAP): UNIVERSITY OF PRETORIA: RESEARCHER: M CHETTY.

1. Your evenly numbered minute dated 2009/08/14 have reference. Research request from M Chetty, Masters Degree in employee assistance programmes: University of Pretoria.

2. This office herewith grants permission for the above mentioned research to be conducted.

3. For any further assistance and support the researcher can contact Supt. H T Olkers at the following numbers:
   Office: 031 3254914
   Mobile: 0730771577

4. Thank you.

P/PROVINCIAL COMMISSIONER: KWAZULU - NATAL
B A NTANJANA

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ANNEXURE B

18/01/2012
Our Ref: 27406891
Tel: (012) 420-2827
E-mail: florinda.taute@up.ac.za

Participant's Name: ……………………………………………

Dear Participant,

Informed consent

Title of the study: Causes of relapse post treatment for substance dependency within the South African Police Services.

Purpose of the study: To assist the SAPS to identify the causes of relapse post treatment for substance dependency.

Procedures: I will be requested to complete a questionnaire. The time estimated for completion of the questionnaire will be half an hour.

Risks: If there is a possibility of potential harm, debriefing services will be offered to me on completion and returning of the questionnaires by EHW members who are trained debriefers.

Benefits: I understand that there are no direct benefits to me for participating in this study. However, the results of the study may provide feedback and recommendations to management of SAPS on developing the post treatment Prevention of Relapse programme in the workplace.

Participants' rights: Participation in this study is voluntary and I may withdraw from participating in the study at any time without any negative consequences.

Confidentiality: The information received from me will be treated confidential and my identity will not be revealed. Should I withdraw from the study, my data will be destroyed. Only the researcher and the supervisor have access to the data before it is published. The results of this study may be published in the researcher's final research document, professional journals or presented at professional conferences, but my records or identity will not be revealed unless required by law.

If I have any queries or concerns, I can call Mandy Chetty at (031) 510 9979 or 083 786 4561 any time during the day. I understand my rights as a research subject, and I voluntary consent to participation in this study. I understand what the study is about and how and why it is being done. I am aware that the data will be stored for 15 years at the Department of Social Work and Criminology at the University of Pretoria and if necessary may be used later for future research. I will receive a copy of this consent form.

Respondent: ______________________ Date_________________
Researcher: ______________________ Date _________________
Supervisor: _______________________ Date_________________

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ANNEXURE C

18/01/2012
Our Ref: Mandy Chetty
Tel: Work: (031) 510 9979/ Cell: 083 786 4561

Dear Sir/madam,

To all respondents

I am registered for the MSW (Employee Assistance Programme) degree at the University of Pretoria. The title of research is “Causes of relapse post treatment for substance dependency within the South African Police Services”. I need some of your time to complete the attached questionnaire. Your response to this questionnaire is very important as it will produce results of interest to managers and in the South African Police Force (SAPF) to render the necessary supportive services in assisting members to maintain sobriety thus reducing the relapse rate amongst members post treatment.

The completed questionnaires will be securely stored for a minimum of 15 years at the Department of Social Work and Criminology according to the policy of the University of Pretoria.

Thank you for your participation.

Mandy Chetty
Researcher

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QUESTIONNAIRE

SECTION 1: BIOGRAPHICAL DETAILS

Instructions

- Please **mark with a cross (X)** next to the appropriate answer.
- Do not omit any question

1. AGE GROUP

18-25	
26-35	
36-49	
50-60	
61 +	

2. RACE

African	
Coloured	
Indian	
White	

3. GENDER

Male	
Female	

4. MARITAL STATUS

Married	
Separated	
Single	
Widowed	
Living Together	
Divorced	

5. HIGHEST QUALIFICATION

Lower Than Grade 12 / Std 10	
Grade 12/Std10	
Diploma / Certificate	
Degree	
Post Graduate Degree	

6. YEARS OF SERVICE

Less than 1 year	
1 - 5 years	
6 – 12 years	
13 - 20 years	
21 + years	

7. RANK

SA Police Service Act		SA Public Service Act	
Police Trainee		Admin Clerk	
Constable		Senior Admin Clerk	
Sergeant		Chief Admin Clerk	
Warrant Officer		Personnel Practitioner	
Lieutenant		Cleaner	
Captain		Telkom Operator	
Major			
Lieutenant Colonel			
Colonel			
Brigadier			
General			

SECTION 2: TREATMENT PROCESS

1. I went for treatment because…………

		Yes	No
1	I felt my drinking was affecting my health.		
2	My partner was threatening to end the relationship.		
3	My children started losing respect for me.		
4	My employer was threatening to dismiss me.		
5	As a result of disciplinary action.		
6	The court ordered my treatment as a result of domestic violence.		
7	I wanted to change.		

2. How long was your last treatment?

2 week detox programme	
1 month in- patient	
6 weeks in –patient	
More than 1 month in-patient	
1 year out-patient	
More than 1 year out-patient	
Other	

3. Did you experience a relapse after the last treatment?

Yes	No

4. How many times did you go for treatment before the last relapse?

Once	
Twice	
More than twice	
Not applicable	

5. How long did you stay sober/ clean before the last relapse?

0 – 3 weeks following treatment	
1 month following treatment	
2- 3 months following treatment	
1 year following treatment	
2 years or longer following treatment	
Not applicable	

6. Briefly explain any positive experiences during your treatment?

……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………

7. Briefly explain any negative experiences during your treatment?

……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………
……………………………………………………………………………………

8. Kindly indicate either Yes or No by **marking a cross (X)** regarding the support you received after treatment?

I received support from

	Yes	**No**
My commander		
My colleagues		
My partner / spouse		
My family		
Aftercare sessions at the rehabilitation centre		
Support Group sessions e.g. AA meetings		
The Employee Health & Wellness Unit		
My community		
My religious organization		

9. Substantiate reasons for the **"NO"** responses.

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10. Describe your experience back home after treatment.

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11. Describe your experience back at work after treatment.

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SECTION 3: REASONS FOR DRINKINGAFTER TREATMENT

1. What was the main reason for you taking that first drink?

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……………………………………………………………………………………………
……………………………………………………………………………………………
……………………………………………………………………………………………

2. The following questions are a list of reasons why people may begin to drink again after they have given up drinking/went for treatment. Please rate these on how important each reason was for you when you began to drink again. Indicate the extent to which you agree or disagree with each statement by **marking a cross (X)** alongside the appropriate response. Use the following scale.

1	**Strongly disagree**
2	**Disagree**
3	**Neither agree nor disagree**
4	**Agree**
5	**Strongly agree**

	Reasons for Drinking Again	**1**	**2**	**3**	**4**	**5**
1	I felt angry with myself because things were not going my way.					
2	I felt frustrated with myself because things were not going my way.					
3	I felt bored.					
4	I felt anxious.					
5	When I saw alcohol I just had to give in.					
6	I felt sad.					
7	I felt physically ill.					
8	I felt pain.					
9	I was in a good mood and felt like getting high.					

10	I wanted to see what would happen if I tried one drink.					
11	I just felt tempted to drink out of the blue and went off to get a drink.					
12	Someone offered me a drink.					
13	I felt frustrated because of my relationship with someone else.					
14	I was with others having a good time and we felt like getting drunk together.					
15	I felt ill or in pain but this was not due to withdrawal from alcohol.					
16	I felt others were being critical of me.					
17	I saw others drinking.					
18	I discovered I have a terminal illness/ my health began to deteriorate due to my health status.					
19	I felt I could not cope with my stressful work environment.					
20	I was transferred to another more stressful department at work.					

Source: Adapted from the reasons for drinking questionnaire by Zywiak*et al.* (1996:130).

3. What do you think could have been different at work that would have prevented you from a relapse?

………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………

SECTION 4: PROPOSED INTERVENTIONS AND SERVICES

1. Choose from the following interventions that can be implemented in the workplace to assist employees to maintain sobriety?

Interventions	Yes	No
1. Participation in Aftercare services (development of life skills, example conflict management, financial and stress management).		
2. Participation in a health education and fitness Programme.		
3. Participation in support groups.		
4. Establishment of Peer (Buddy) Support.		
5. Education of management and colleagues on substance dependency thus creating a supportive working environment.		
6. Attendance for debriefing following exposure to traumatic scenes		

2. Substantiate reasons for the **"NO"** responses.

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Other suggested interventions/services.

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……………………………………………………………………………………………
……………………………………………………………………………………………
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Thank you for your participation

Mandy Chetty
Researcher