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MORALITY BEFORE KNOWLEDGE

The functionality of the family in building the resilience of narcotics abusers undergoing rehabilitation

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ABSTRACT

Background: Drug abuse remains a serious global and national issue, with South Sumatra among the provinces with the highest prevalence in Indonesia. Rehabilitation efforts often face challenges such as relapse, which is influenced by internal and external factors, particularly family support and functioning. This study aims to examine the role of family functioning in strengthening the individual resilience of narcotics abusers undergoing rehabilitation in South Sumatra Province. **Methods:** This study employed a quantitative causal design using a survey method and Structural Equation Modeling (SEM) to analyze the influence of family functioning on individual resilience among 106 narcotics abusers undergoing rehabilitation in South Sumatra. **Findings:** The findings reveal that family functionality significantly affects individual resilience (path coefficient = 0.60; t = 5.20), indicating that emotional support, parental involvement, and effective communication play a critical role in preventing relapse during rehabilitation. **Conclusion:** The research shows that family functionality plays a vital role in fostering resilience among narcotics abusers by providing emotional support, open communication, and guidance throughout the rehabilitation process. Active family involvement, especially in supervision and positive engagement, significantly aids in preventing relapse and sustaining recovery. **Novelty/Originality of this article:** The novelty/originality of this article lies in quantitatively analyzing how specific aspects of family functioning significantly enhance individual resilience and reduce relapse risk among narcotics abusers undergoing rehabilitation in South Sumatra.

KEYWORDS: family functioning; individual resilience; drug rehabilitation; South Sumatra.

1. Introduction

The issue of narcotics abuse has become a global urgency that demands swift and appropriate action due to its alarming increase year by year (United Nations Office on Drugs and Crime, 2021). The World Drug Report by the United Nations Office on Drugs and Crime (UNODC) reported a consistent rise in drug use from 2017 to 2021. In 2017, approximately 271 million people, or 5.5% of the global population aged 15–64, were drug users, increasing to 275 million people or 5.6% in 2018. In 2021, it was reported that 257 million people had used drugs in 2020 (Manurung et al., 2021). Several countries have reported increases in drug use from 2019 to 2021 (Crime, 2021). This global trend has extended to Indonesia, where narcotics have spread across all regions indiscriminately. Drug abuse does not consider age boundaries. In 2021, approximately 3,662,646 Indonesians aged 15–64 were estimated to be exposed to drugs, representing a 15% increase since 2019 (Puslitdatin BNN RI, 2022).

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Drug-related crimes threaten the productivity of human resources. In Indonesia, the number of drug abusers was 3.3 million in 2017 with 12,000 reported deaths. This figure rose to 3.5 million in 2018 and 3.6 million in 2019 among the population aged 15–64 (Manurung et al., 2021). This phenomenon has made drug abuse a serious national issue. According to a 2019 survey by the National Narcotics Agency/*Badan Narkotika Nasional* (BNN) in collaboration with LIPI, South Sumatra Province had the second-highest prevalence rate of drug abusers at 7.50% (National Narcotics Agency, 2019a). The high prevalence of narcotics and other addictive substances poses a national threat that needs to be addressed, as it hampers the development and growth of human resources in Indonesia. This threat is exacerbated by the fact that most drug abusers are within their productive age range (Anjani & Hutasoit, 2022; Bunsaman & Krisnani, 2020). Drug addicts often lose control over themselves and stop considering their future. Among the most alarming consequences is the emergence of a "lost generation" (Supratman, 2018).

In 2019, South Sumatra Province had the second-highest prevalence rate of drug use in Indonesia at 5.5%, with 5% having used drugs in the past year—significantly higher than the national average. It is estimated that around 359,363 people in the province have used drugs, with 326,694 still actively using within the past year (Puslitdatin BNN RI, 2022). In 2021, the province reported 14 regions under "danger" category, 733 under "alert," 2,374 under "standby," and 201 as "safe." In 2022, the figures shifted to 11 "danger," 703 "alert," 2,091 "standby," and 458 "safe" areas.

Table 1. Number of drug crime cases uncovered by the national narcotics agency of South Sumatra Province (2019–2023)

Year	Amount of evidence			Total number of case reports	Number of suspects
	Methamphetamine	Ecstasy	Marijuana		
2019	162,522.59 gram	58,286 Pills	500	40	55 People
2020	16,026.786 gram	30,256 Pills	67.18	33	44 People
2021	24,717.68 gram	160 Pills	198.26	32	47 People
2022	35,606.67 gram	50,000 Pills and 19.13 gram	7,300.29 grams and a cannabis plantation covering 1 hectare (1,000 plants)	31	33 People
2023 (Early semester)	117,324.58 gram	-	-	2	17

Table 1 reveals that the number of narcotics crime cases in 2022 dropped to 31 from 32 the previous year. However, in the first half of 2023, methamphetamine (shabu) seizures rose to 117,324 grams—an increase of approximately 330% compared to 35,606.67 grams in 2022. Seizures also included 50,000 ecstasy pills, 19.13 grams of Yana, 7,300.29 grams of marijuana, and a 1-hectare marijuana plantation. The disclosure of narcotics crime cases by the South Sumatra Regional Police Narcotics Directorate and its units from 2020 to 2022 is presented in table 2.

The data in table 2 show an increase in the number of suspects, from 2,370 to 2,658 individuals, with a significant rise in the quantity of confiscated evidence, particularly methamphetamine (shabu) amounting to 121,707.070 grams and 6,853 yaba tablets. This indicates an escalation in narcotics circulation. Research findings suggest that the increasing circulation of narcotics poses a serious threat to society and the surrounding environment (Wulandari et al., 2021; Zatrahadi et al., 2021).

The severe threat posed by narcotics results in substantial losses—not only physically but also psychologically, environmentally, and nationally. The impact of increasing drug dependency is particularly significant on families and surrounding communities. In 2017,

the estimated economic loss due to narcotics reached IDR 84.6 trillion (National Narcotics Agency, 2019b). The dangers of drug abuse have a profoundly disproportionate effect on mental health, public safety, and the resilience of society and the nation, thus necessitating strict regulations to protect the public from drug abuse (National Narcotics Agency, 2019a).

Table 2. Number of drug crime cases uncovered by the narcotics directorate of South Sumatra regional police and its units (2020–2022)

Year	Amount of evidence			Number of police reports	Number of suspects
	Methamphetamine	Ecstasy	Marijuana		
2020	86,511.12 gram	48,288 Pill	831,640.021	1851	2370
2021	104,039.15 gram	11,328 Pill	267,036.03	2029	2658
2022	121,707.070 grams and 6,853 yaba pills	14,157 Pill	242,511.79	1832	2279

(Narcotics Directorate of the South Sumatra Regional Police, 2023)

The government, through Narcotics Law No. 35 of 2009, Article 54, aims to carry out efforts of prevention, protection, and recovery of drug abusers from addiction through rehabilitation. The phenomenon of drug abuse necessitates both preventive and rehabilitative measures as essential strategies to curb the spread of narcotics (Supratman, 2018). This law is implemented through Law No. 24 of 2017 concerning Rehabilitation Services for Addicts and Victims of Narcotics Abuse. These provisions form the legal basis for the National Narcotics Agency to conduct rehabilitation for drug addicts. According to Article 1, point 15 of Narcotics Law No. 35 of 2009, a drug user is defined as a person who unlawfully consumes narcotics.

Improper handling of drug abusers can lead to relapse; therefore, appropriate and comprehensive intervention is necessary. The rehabilitative aspect of the Narcotics Law is a key element in addressing the problem of drug use and illicit trafficking. From a health perspective, drug users are individuals suffering from chronic narcotics dependence, while from a legal standpoint, they are perpetrators of criminal acts. Those sentenced to rehabilitation are given the opportunity to reform and avoid repeating their offenses (Iskandar, 2019). Thus, rehabilitation is considered a more effective solution for handling drug abusers compared to imprisonment. Incarceration often results in recidivism and contributes to the rise in drug abuse and illicit trafficking (Iskandar, 2019). Through rehabilitation programs, it is hoped that drug addiction can be effectively addressed, as individuals in recovery are supported in overcoming both physical and psychological health issues, ultimately shaping resilient former drug users (Iskandar, 2019).

Rehabilitation can assist drug abuse victims in recovering from their dependency or relapse; however, it does not guarantee relapse prevention, as rehabilitation is a long-term process (Kurniawan et al., 2017). Relapse remains a major challenge for drug abusers due to persistent urges to reuse, which can be triggered suddenly or under emotional distress. These urges may arise abruptly and uncontrollably, particularly when an individual's mental state becomes unstable. As a result, relapse poses a serious concern for the families of drug abusers, as it requires the affected individuals to restart the rehabilitation process from the beginning (Widyastuti et al., 2021).

According to the National Narcotics Agency, 70% of drug abusers who have undergone rehabilitation often experience relapse. Several contributing factors include low social support, situational drug use (e.g., during episodes of depression, stress, or disappointment), the length of time a person has abstained from drug use, and family conflicts (Kurniawan et al., 2017). Environmental factors and internal stimuli, such as mood and emotional state, also play a role in triggering relapse (Wijaya & Ghozali, 2021; Wuryantari & Ghozali, 2020).

According to data released by the Indonesian National Narcotics Agency in 2013, the relapse rate among drug addicts who had undergone rehabilitation remained relatively high, with approximately 40% relapsing or engaging in repeated drug use (Kurniawan et al., 2017). In 2018, BNN data showed that 70% of former drug addicts who had completed the

recovery phase returned to drug use. Relapse is defined as the act of returning to drug use after a period of recovery and is characterized by the recurrence of addictive thoughts, behaviors, and feelings following the withdrawal phase. Efforts to reduce relapse rates among substance users must focus on relapse prevention strategies. The risk of relapse increases when individuals exhibit low personal resilience (internal factor) and receive inadequate family support (external factor), both of which are crucial for maintaining sustained recovery. The National Narcotics Agency provides rehabilitation facilities in both inpatient and outpatient settings. The Compulsory Reporting Institutions (IPWL) operated by BNN serve as designated facilities for drug abusers to report and receive rehabilitation services, primarily in outpatient settings. BNN's IPWL clinics are located at the national level (BNN RI), provincial level (BNNP), and city/regency level (BNNK).

South Sumatra Province is one of the five provinces with the highest prevalence of drug abuse, based on the 2019 BNN survey (BNN, 2020). In this province, there are nine BNN-affiliated IPWL clinics, including IPWL BNNP South Sumatra, IPWL Ogan Komering Ilir, IPWL Prabumulih, BNNK Lubuk Linggau, BNNK Ogan Komering Ilir, BNNK Prabumulih, BNNK Muara Enim, BNNK Pagar Alam, BNNK Musi Rawas, and BNNK Empat Lawang. The following data presents the number of clients who participated in rehabilitation programs at the nine IPWL BNN clinics in South Sumatra Province from 2018 to 2022.

Table 3. Data on drug users undergoing rehabilitation in South Sumatra Province (2018–2022)

Institution	Year	Number of clients	Program completed	Percentage (%)
BNNP South Sumatra	2020	311	253	81
	2021	547	417	76
	2022	245	186	75
BNNK Prabumulih	2020	59	49	85
	2021	74	61	82
	2022	26	21	80
BNNK Pagar Alam	2020	72	60	83
	2021	71	59	83
	2022	45	38	84
BNNK Lubuk Linggau	2020	33	26	78
	2021	93	71	76
	2022	79	58	73
BNNK Empat Lawang	2020	25	18	72
	2021	31	28	90
	2022	20	15	75
BNNK Musi Rawas	2020	21	17	80
	2021	64	51	79
	2022	27	19	70
BNNK Muara Enim	2020	110	94	85
	2021	79	61	77
	2022	42	35	73
BNNK OKU Timur	2020	41	39	95
	2021	52	39	75
	2022	37	29	78
BNNK OKI	2020	30	27	90
	2021	84	74	88
	2022	128	108	84
BNNK Ogan Ilir	2020	46	40	87
	2021	109	89	81
	2022	43	39	90
Total		3,484	2,121	60.87

(National Narcotics Agency, 2023)

Based on the aforementioned data, over the past three years, only 60.87% of drug abusers who accessed outpatient rehabilitation services at the ten IPWL BNN clinics in South Sumatra from 2020 to 2022 remained in the program according to the prescribed

treatment plan. This figure is significantly lower than the total number of individuals who initially accessed rehabilitation services.

Outpatient drug rehabilitation requires a greater level of family involvement compared to inpatient rehabilitation. One of the main challenges in outpatient rehabilitation is the client's compliance with the treatment process, particularly attendance at counseling sessions. Therefore, family support is essential to encourage participation. The lack of family support has been identified as a contributing factor to the low participation rate of drug abusers in rehabilitation programs (Hartini & Samputra, 2021), along with the general lack of awareness among families about the importance of supporting drug abusers throughout the rehabilitation process (Fitri & Yusran, 2020).

Treatment dropout is one of the major issues encountered in rehabilitation programs. Therefore, the application of motivational techniques can help keep patients engaged, thereby improving treatment outcomes. Viewing addiction as a chronic disease necessitates continuous care and monitoring to ensure program success, which often involves multiple treatment episodes and a readiness to re-admit relapsed clients (National Institute on Drug Abuse, 2014). The success of rehabilitation is often linked to the duration an addict remains in the program, as sustained participation is critical to achieving the therapeutic benefits. Consequently, developing strategies to retain individuals in treatment programs is of paramount importance. Rehabilitation can serve as an indicator of program success, particularly through the level of resilience an individual possesses in protecting themselves from drug abuse. Personal resilience refers to an individual's ability to cope with life's challenges, to persist in the face of adversity, and to recover and grow into a better version of themselves (Mufidah, 2017).

The family plays a central role in shaping individual resilience (BNN, 2019). It serves as a crucial factor in fostering personal resilience against drug abuse. Key aspects include increased frequency of communication between parents and children, democratic parenting styles, and the cultivation of warm family relationships—all of which are vital for building strong resilience among adolescents. The family is one of the most powerful and influential social institutions; it represents the foundation of early education, and evidence shows that positive parenting practices are strong protective factors in preventing substance use, adolescent violence, and behavioral disorders.

Prevention efforts must start within the family, as many challenges stem from internal issues such as poor family communication, lack of effective discipline, inadequate supervision of children, limited stress-management skills, failure to build children's self-esteem, and susceptibility to peer pressure. Families must also be equipped to understand drug addiction—including its definitions, behavioral characteristics, symptoms, and transmission channels—so they can recognize early signs of vulnerability at home and in the neighborhood. In addition, they must implement effective prevention strategies and adopt a 'family united' approach through systems of early detection and response.

The challenges faced by families in the recovery process include negative perceptions and mindsets toward drug users, low levels of religious values within the family, emotional distance between family members and the resident, insufficient attention and support from families, and dysfunctional family interactions where roles and functions are not properly fulfilled. Additionally, there is a lack of balance within the family system, unclear boundaries, and an absence of clearly defined family tasks and roles. Families often lack a shared vision and mission, and their active participation in Family Support Groups (FSG) remains low.

Therefore, to strengthen the resilience of individuals who misuse narcotics, it is necessary to identify the influence of family functioning. A review of various studies reveals that no prior research has specifically examined the relationship between family functioning and individual resilience among drug users. This study aims to fill that gap by focusing on rehabilitation institutions under the National Narcotics Agency (BNN), including provincial (BNNP) and municipal/regency-level (BNNK) offices in the South Sumatra region. Based on this background, the present study is titled: 'Family Functioning

in Building Individual Resilience Among Narcotics Abusers Undergoing Rehabilitation in South Sumatra Province'.

1.1 Theoretical framework

The purpose of this study is to identify the factors that influence the resilience of narcotics abusers in the province of South Sumatra, to examine the relationship of each family functioning factor with the resilience of narcotics abusers, and to analyze the impact of family functioning factors on the resilience of narcotics abusers undergoing rehabilitation in South Sumatra Province.

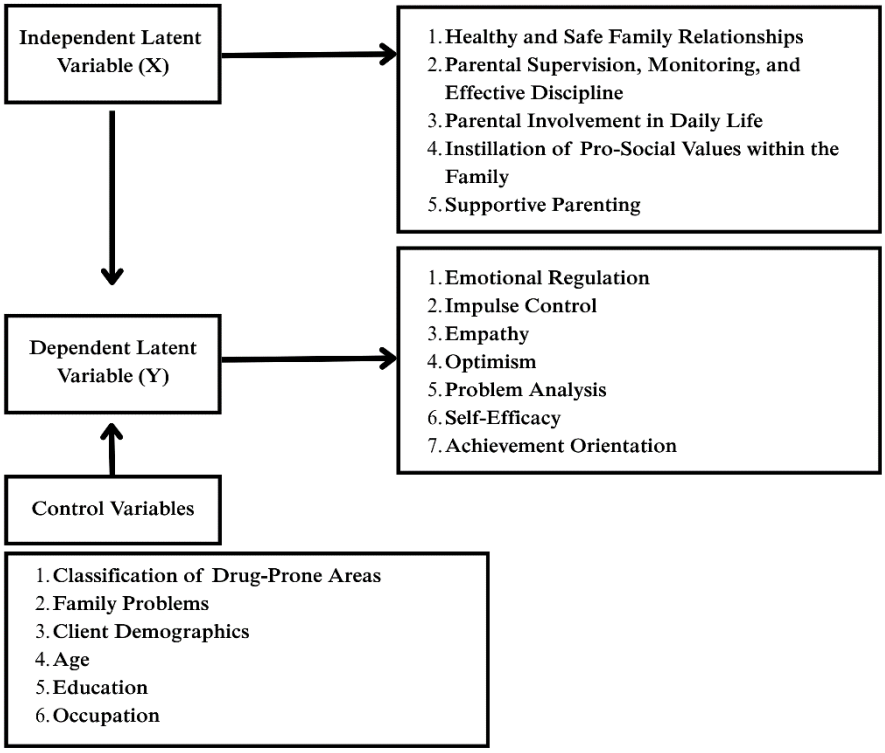

Fig. 1. Theoretical framework

2. Methods

2.1 Research design

This study employs a quantitative research design, as the data obtained are numerical and processed using statistical methods before being interpreted (Sugiyono, 2019). The rationale for using this method is that it fulfills scientific principles, namely being "concrete, empirical, objective, measurable, rational, and systematic" (Semiawan, 2017). The research utilizes a causal approach with a survey method and applies the Structural Equation Modeling (SEM) technique (Majeed et al., 2021). Causal research aims to analyze the influence or relationship between one variable and another. This study seeks to examine and identify the influence of family functionality on the individual resilience of narcotics abusers. The type of data used in this research is quantitative data.

2.2 Research subjects and samples

The population in this study refers to a group of individuals or phenomena with specific characteristics. The members of the population are referred to as population elements (Sugiyono, 2019). The population of this research consists of former narcotics abusers who

have participated in rehabilitation programs in South Sumatra Province. The total population for this study is 692 individuals.

The sample in this research refers to a subset of the population that is selected for observation and analysis. The results derived from measuring the sample are referred to as "statistics." The sampling method used in this study is non-probability sampling, specifically purposive sampling, where the selection of respondents is based on specific objectives and criteria. The respondents in this study are individuals who have abused narcotics and their family members, all of whom are enrolled in rehabilitation programs organized by the National Narcotics Agency of South Sumatra Province. These programs are conducted at various facilities, including the Pratama Clinic of BNNP South Sumatra, BNNK Ogan Ilir Rehabilitation Clinic, BNNK Ogan Komering Ilir Rehabilitation Clinic, BNNK Ogan Komering Ulu Timur Rehabilitation Clinic, BNNK Ogan Ilir Rehabilitation Clinic, BNN Empat Lawang District Rehabilitation Clinic, BNN Lubuk Linggau City, BNN Musi Rawas District, BNN Pagar Alam City, and BNN Muara Enim District.

The research subjects are male and female clients aged over 18 years who reside in South Sumatra Province and are currently or have previously undergone rehabilitation therapy at one of the mentioned facilities. Participation is voluntary, with respondents required to complete an informed consent form. Given that this study employs Structural Equation Modeling (SEM) for statistical analysis, sample selection must consider proportionality (Foldnes & Grønneberg, 2022). An excessively large sample may hinder the development of a good model fit; therefore, a sample size between 100 and 200 respondents is recommended (Putra, 2018). Based on Slovin's formula and the size of the population, the final number of respondents selected for this study was 100 individuals, in accordance with the following criteria:

$$n = \frac{N}{1 + N(e)^2} \qquad \text{(Eq.1)}$$

Based on Slovin's formula, with a population size (N) of 692 individuals and a margin of error (e) of 10%, the required sample size for this study was determined to be 100 respondents. According to the Slovin formula as cited in Muchlis (2015), a 10% margin of error is considered an acceptable level of sampling inaccuracy for research in the social sciences. This study employed a non-probability sampling technique using purposive sampling. As stated by Sugiyono (2019), purposive sampling is a sampling technique in which the selection of data sources is based on specific considerations. The use of purposive sampling is appropriate when not all members of the population meet the criteria relevant to the research phenomenon. Therefore, the researcher applied this technique by establishing specific criteria that the research sample must fulfill.

Table 4. Research sample

Rehabilitation Clinics	Population	Sample
BNNP South Sumatera	245	50
BNNK Prabumulih	26	4
BNNK Pagar Alam	45	5
BNNK Lubuk Linggau	79	10
BNNK Empat Lawang	20	3
BNNK Musi Rawas	27	3
BNNK Muara Enim	42	5
BNNK OKU Timur	37	5
BNNK OKI	128	16
BNNK Ogan Ilir	43	5
Total	692	106

(IPWL clinics of the National Narcotics Agency South Sumatra region, 2023)

2.3 Research time and location

The research was initiated in December 2023. The study was conducted within the jurisdiction of the National Narcotics Agency of South Sumatra Province, specifically at the following rehabilitation centers: Pratama Clinic of BNNP South Sumatra, BNNK Ogan Ilir Rehabilitation Clinic, BNNK Ogan Komering Ilir Rehabilitation Clinic, BNNK Ogan Komering Ulu Timur Rehabilitation Clinic, BNNK Ogan Ilir Rehabilitation Clinic, BNN Empat Lawang District Rehabilitation Clinic, BNN Lubuk Linggau City, BNN Musi Rawas District, BNN Pagar Alam City, and BNN Muara Enim District.

2.4 Research variables

The variables examined in this study consist of latent variables, observed variables, and control variables. The first is the Exogenous Latent Variable (Independent), which refers to a variable that influences the values of other variables in the model. In the SEM model, exogenous variables are indicated by arrows originating from the variable pointing towards the endogenous variable (dependent variable). The exogenous variable in this study is family functioning. The independent variable comprises factors of family functioning as stated by UNODC (2009), which include healthy and safe family relationships, parental supervision and monitoring along with effective discipline, parental involvement in life, the instillation of prosocial values from the family, and supportive parenting.

In this study, a family functioning questionnaire instrument was used, consisting of five dimensions: healthy and safe family relationships, parental supervision and monitoring along with effective discipline, parental involvement in life, the instillation of prosocial values from the family, and supportive parenting. This questionnaire was used to identify family functions. The scale items were constructed by the researcher based on the family function components according to the UNODC (2009) theory. The scale is a Likert-type scale ranging from 1 to 4. A score of 1 indicates that the client strongly disagrees with the statement item; a score of 2 indicates disagreement; a score of 3 indicates agreement; and a score of 4 indicates strong agreement. The higher the score on the scale, the stronger the individual resilience against drug abuse.

The second is the Endogenous latent variable (dependent), referring to variables that are directly or indirectly influenced by exogenous variables. The dependent variable used in this study is individual resilience. Individual resilience is the ability to endure the problems experienced by the client. Resilient clients are better able to withstand pressure, so that no stressors cause behavioral or emotional disturbances, thus allowing them to undergo rehabilitation and recovery more effectively.

In this study, a Resilience Scale questionnaire was adapted from the Resilience Quotient Test (RQ Test) by Reivich & Shatte, consisting of 56 items. It includes the seven factors proposed by Reivich & Shatte, namely: emotional regulation, impulse control, empathy, optimism, causal analysis, self-efficacy, and reaching out. This test was adapted because, according to Werner & Smith (2001), resistance initially aimed to identify the damage experienced by clients in facing life risks, but it was found that one-third of those living such lives were actually capable of adapting to the various problems they encountered. The individual resilience questionnaire for drug abuse was used to identify factors influencing the resilience of drug-abusing clients undergoing rehabilitation at BNN in South Sumatra, along with examining the relationships and effects of these factors and measuring the level of individual resilience. The scale is a Likert-type scale ranging from 1 to 4, with a score of 1 indicating strong disagreement, 2 indicating disagreement, 3 indicating agreement, and 4 indicating strong agreement. The higher the score, the stronger the individual's resilience against drug abuse. In this study, the data processing stages using LISREL include the normality test, confirmatory factor analysis (CFA), and second-order confirmatory factor analysis (2nd CFA), due to the observed variables not being directly measurable. In the 2nd CFA, the endogenous latent variables—family functioning and the observed variables from

the exogenous latent variable of individual resilience—as well as the control variables, consisting of the categorization of drug-prone areas and family problems, are assessed.

2.5 Data collection procedure

2.5.1 Data source

Primary data, which is obtained directly from the subjects under investigation by the individual or organization conducting the research. This data is collected through direct observation and by distributing questionnaires to respondents, specifically former drug users and the families of drug users who are currently participating in rehabilitation programs at the National Narcotics Agency of South Sumatra Province. Secondary data, which refers to pre-existing data intentionally collected by the researcher to complement the research data needs. The secondary data used in this study includes data related to drug users undergoing rehabilitation at the National Narcotics Agency of South Sumatra Province.

2.5.2 Data collection methods

The data collection techniques used in this study are observation and questionnaires. The following are data collection methods that significantly support research utilizing these techniques. Observation is conducted at the initial stage where the researcher has not yet identified specific issues to investigate. As a result, the researcher carries out a broad and comprehensive inquiry, documenting everything observed, heard, and experienced. To draw conclusions from observations conducted under unspecified conditions, all data are recorded in detail. Field research, observation, and questionnaires are the methods employed for data collection in this study. This research uses a research instrument in the form of a questionnaire distributed to respondents. A closed-ended questionnaire with a Likert scale ranging from 1 to 4 is applied, allowing respondents to select responses that best reflect their opinions.

Table 5. Likert scale

Scale	Description
1	Strongly disagree
2	Disagree
3	Agree
4	Strongly agree

2.6 Data analysis techniques

2.6.1 Descriptive analysis

Quantitative descriptive analysis is a research method that involves collecting data as it actually exists, then organizing, processing, and analyzing the data to provide a depiction of the existing problem (Sugiyono, 2018). Descriptive statistics describe the demographics and responses of the participants. Descriptive analysis is used to present an overview of respondents' demographics and perceptions based on the questionnaire.

2.6.2 Structural Equation Modeling (SEM) test

Once the SEM assumptions are fulfilled, the next step is to test for model fit. In the SEM procedure, the evaluation of the goodness-of-fit between the data and the model is carried out through several stages. The first stage of this test aims to evaluate the overall Goodness of Fit (GOF) between the collected data and the proposed model. GOF indicates the extent to which the specified model matches the covariance matrix among the indicators or

observed variables. If the GOF results are good, the model can be accepted; otherwise, it should be rejected or modified. A comprehensive evaluation of SEM cannot be conducted using a single best-fit statistic to explain the predictive power of the model. Instead, several GOF indices have been developed, which can be used jointly or in combination. Based on this, Hair et al. (2014) categorized the GOF measures into three groups: Absolute Fit Measure, which assesses the degree of prediction of the entire model (structural and measurement model) toward the correlation and covariance matrix; Incremental Fit Measure, which compares the proposed model with a baseline or null model (a model with all correlations among variables set to zero); and Parsimonious Fit Measure, which refers to models with relatively fewer parameters and greater degrees of freedom. A summary of fit indices and model fit assessments is therefore needed.

Once the overall model fit is found to be acceptable, the next step is to evaluate or test the fit of the measurement model. This evaluation is conducted for each construct or measurement model separately, through the assessment of both validity and reliability. Validity evaluation involves examining whether a variable accurately represents its latent construct. A variable is said to have good validity if the t-value exceeds the critical value (≥ 1.96). A t-value of the factor loading that exceeds the critical threshold indicates that the observed variable adequately represents its underlying construct and simultaneously verifies the relationship between the variable and the defined construct. Furthermore, the standardized factor loading must be ≥ 0.70 to demonstrate the strength of the relationship between the variable and its construct. Reliability evaluation involves measuring the internal consistency of the measurement model. In SEM, reliability is measured using the Composite Reliability (CR) and the Variance Extracted (VE) measures, which are calculated accordingly.

$$Construct\ reliability = \frac{(\sum_i^n standardized\ loading\ factor)^2}{(\sum_i^n standardized\ loading\ factor)^2 + (\sum Standard\ Errors)} \quad \text{(Eq.2)}$$

$$Variance\ extracted = \frac{\sum_i^n standardized\ loading\ factor^2}{\sum_i^n standardized\ loading\ factor^2 + (\sum Standard\ Errors)} \quad \text{(Eq.3)}$$

Construct reliability is considered acceptable if the construct reliability value is ≥ 0.70 and the variance extracted value is ≥ 0.50. In addition, Confirmatory Factor Analysis (CFA), as the measurement model, consists of two types of measurement: the measurement model for exogenous variables (independent variables), and the measurement model for endogenous variables (dependent variables). The general equation for the measurement model of exogenous variables is: $X = \lambda x\ \xi + \zeta$, then the general equation for the measurement model of endogenous variables is: $Y = \lambda y\ \eta + \zeta$.

The third stage is structural model fit, also referred to as the latent variable relationship, is generally expressed through a specific equation: $\eta = \gamma\ \xi + \delta$, $\eta = B\ \eta + \gamma\ \xi + \zeta$ The assessment of the structural model includes the evaluation of the significance of the estimated coefficients. This evaluation is carried out by examining the t-values of the estimated coefficients. If the t-value is greater than or equal to 1.96, the coefficient is considered statistically significant. In addition, the maximum value of the standardized solution coefficient should not exceed 1. Similarly, the R^2 value must also be assessed to provide an indication of the relative goodness-of-fit for each structural equation.

3. Results and Discussion

3.1 Overview of rehabilitation implementation at the National Narcotics Agency of South Sumatra province

The Pratama Clinic of the National Narcotics Agency of South Sumatra Province (BNNP Sumsel) has been officially operating since October 22, 2014, based on the Mayor of

Palembang's License No. 503/KLK/021/KPPT/2014 regarding the Permit for Medical Center Operation. The establishment of this clinic within the BNNP Sumsel is intended to support and enhance the government's performance in providing rehabilitation services for victims, addicts, and drug abusers, in line with the BNN's Prevention and Eradication of Drug Abuse and Illicit Trafficking Strategy (P4GN) and Government Regulation No. 25 of 2011 concerning the Implementation of Mandatory Reporting for Drug Addicts.

The clinic currently operates under the latest permit issued by the Mayor of Palembang through License No. 440/IPSPMD/0020/DPMPTSP-PPK/2020 concerning Clinic Operation Permit. Since being designated as a Mandatory Reporting Institution in 2015, as stated in the Minister of Health Decree No. HK.01.07/MENKES/701/2018 on the Appointment of Mandatory Reporting Institutions and Methadone Maintenance Therapy Service Facilities, the clinic has actively provided services. Although it holds the status of a primary clinic, its main function is to offer outpatient rehabilitation services for victims, addicts, and drug abusers. For inpatient rehabilitation services, BNNP Sumsel refers clients to rehabilitation institutions within or outside the city.

South Sumatra faces significant challenges in addressing narcotics-related issues. According to a 2019 survey conducted by the National Narcotics Agency in collaboration with the Research Center for Society and Culture, LIPI, the province ranked second nationwide in terms of annual drug abuse prevalence, with 5% or approximately 326,694 individuals identified as users. Meanwhile, the lifetime prevalence rate reached 5.5%, equivalent to 359,363 individuals. Therefore, the Pratama Clinic of BNNP South Sumatra, as a service unit under the rehabilitation division responsible for providing rehabilitation services to victims, addicts, and drug abusers, is expected to carry out its duties optimally.

The Province of South Sumatra has nine National Narcotics Agency offices operating at the city and regency levels, namely BNNK Ogan Ilir, BNNK Prabumulih, BNNK Ogan Komering Ilir, BNNK Muara Enim, BNNK Lubuk Linggau, BNNK Pagar Alam, BNNK Empat Lawang, BNNK Musi Rawas, and BNNK OKU Timur. BNNP South Sumatra provides assessment services for victims, drug users, and addicts, as well as outpatient rehabilitation counseling services.

The outpatient rehabilitation service process follows a structured flow, starting from admission to program termination. The initial admission stage occurs when a client begins the rehabilitation process. At this stage, staff will collect data, assess the client's readiness, and obtain their commitment to the service. This phase includes filling out registration forms and submitting necessary documents. The screening process follows, using the ASSIST instrument to identify potential substance abuse issues. The results categorize clients into low, moderate, or high risk, each requiring different interventions. Low-risk individuals receive brief education on substance abuse and prevention, while moderate to high-risk clients undergo further urine tests and ASI assessments.

Once this is completed, clients sign an informed consent agreement, are briefed on facility rules, receive orientation on the rehabilitation program, and undergo initial urine tests to help establish a clinical diagnosis. The early assessment phase is conducted to determine the client's condition due to substance abuse, including physical examinations, ASI interviews, placement criteria observation, and WHO-QoL assessments. These assessments are repeated mid-treatment to evaluate therapeutic effectiveness, typically at least 30 days after the initial ASI. Placement criteria follow ASAM (American Society of Addiction Medicine) instruments to determine appropriate service duration and frequency. Mental health assessments are also conducted using ASI and ASAM data, followed by further screening if needed using SRQ-29, PANSS–EC, and MMSE tools. WHO-QoL measures the client's quality of life across physical, psychological, environmental, and social domains.

The treatment planning phase begins with a case conference involving multi-disciplinary professionals who provide input on complex cases. Treatment plans are developed based on assessment findings, considering the client's strengths and weaknesses, and adhere to SMART principles (Specific, Measurable, Attainable, Realistic, Time-bound). Drug use monitoring is done through periodic urine tests to detect early relapse signs.

Telemedicine services are also available, allowing clients to consult healthcare professionals and receive prescriptions without face-to-face meetings.

Medical services include withdrawal management, tailored to the type of substance used and symptoms experienced during detoxification, and comorbidity management for clients with concurrent physical or mental illnesses. Psychosocial interventions target motivational, psychological, social, and environmental factors contributing to substance use, supporting abstinence, and enhancing adherence to therapy and pharmacotherapy. These interventions include individual counseling, group counseling, education, relapse prevention, family or partner approaches, and crisis intervention.

Individual counseling helps clients resolve personal issues and mobilize behavioral change through basic counseling, motivational interviewing, and cognitive behavioral therapy (CBT), combining behavioral, cognitive, and social learning strategies to reshape thought patterns and behaviors. Group counseling is delivered to multiple clients with similar issues to improve their physical, psychological, and social well-being. Family/partner approaches involve educating, reconciling, or reintegrating family members to support recovery.

Relapse prevention equips clients with skills to recognize relapse triggers, cravings, and refusal techniques. Crisis intervention is provided to clients overwhelmed by situations beyond their coping abilities. Psychological assessments are offered as preventive and curative outpatient services within BNN rehabilitation centers. Post-rehabilitation services (aftercare) are extended activities following outpatient treatment. The final stage, termination, is conducted once the client completes all aftercare services. This includes a final evaluation using urine tests, WHOQoL–BREF, and URICA assessments, followed by issuing a certificate of rehabilitation completion.

3.2 Description of narcotics-prone areas in South Sumatra province

Narcotics-Prone Areas are regions identified based on the presence of drug use culture within the community, narcotics markets, and evidence of drug trafficking revealed through law enforcement operations. These operations provide indicators such as crime scenes or loci, distribution methods, trafficking routes, and narcotics-related crimes occurring in those areas, whether in urban centers, rural villages, river routes, coastal zones, or border regions. Prior to 2018, the loci of these areas were not specifically defined and referred to general locations such as airports, seaports, terminals, river routes, prisons, detention centers, street names, local red-light districts, or district names. However, since 2019, the loci have been designated more specifically, down to the village or sub-district level. Through systematic categorization efforts of Narcotics-Prone Areas, community participation has steadily increased. This approach plays a crucial role in achieving the collective goal of creating drug-free environments and realizing the vision of a drug-free Indonesia.

The categorization of narcotics-prone areas consists of four levels, each indicating a different degree of vulnerability and the corresponding types of intervention required. The first category, known as the danger zone, includes areas with 5 to 8 primary factors and 4 to 5 supporting factors. In this category, comprehensive efforts under the Prevention, Eradication, Abuse, and Illicit Drug Trafficking (P4GN) program are implemented, covering eradication, rehabilitation, alternative empowerment, community participation, and prevention strategies. The second category, referred to as the alert zone, comprises areas with 3 identified factors. P4GN efforts in these zones include rehabilitation, alternative empowerment, community engagement, and preventive measures. The third category, the standby zone, involves areas with 2 supporting factors, with a primary focus on rehabilitation, community participation, and prevention. Lastly, the safe zone consists of areas with only one supporting factor, yet P4GN efforts are still carried out, particularly through community involvement and preventive actions.

The primary characteristic indicators of narcotics-prone areas consist of eight indicators that reflect the main vulnerabilities of a region to drug abuse and trafficking.

These indicators include the occurrence of drug-related crimes, high levels of criminal activity or violence, the presence of drug dealers, and active narcotics production. In addition, the number of drug users, the existence of drug-related evidence, narcotics entry points, and the presence of drug couriers also serve as core indicators. Meanwhile, the supporting characteristics of narcotics-prone areas are comprised of five indicators that further reinforce the region's potential vulnerability. These include the presence of numerous entertainment venues, lodging or housing with high levels of privacy, high poverty rates, the lack of adequate public facilities, and low levels of social interaction within the community.

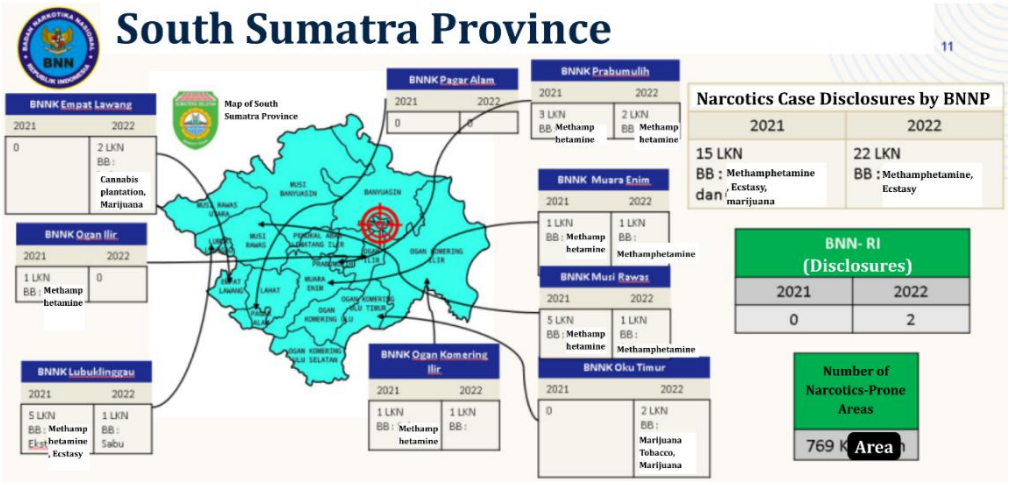

Fig. 2. Distribution of narcotics-prone areas in South Sumatra province

3.3 Description of respondents' sociodemographic characteristics

This study employed a quantitative research design because the data collected were in the form of numerical values, which were subsequently processed using statistical methods and interpreted (Sugiyono, 2019). The rationale for using this method lies in its adherence to scientific principles, namely being "concrete, empirical, objective, measurable, rational, and systematic" (Semiawan, 2017). The sociodemographic characteristics of respondents who were narcotics abusers are presented in table 6. The table provides information on the respondents' age, gender, occupation, education, and marital status. This research was conducted on a total of 107 respondents. Of these, 75 individuals (70.09%) were aged between 15 and 25 years, while 32 individuals (29.90%) were aged between 26 and 38 years.

Table 6. Characteristics of respondents

Characteristics		N	%
Age	15-25	73	70.09
	26-38	32	29.90
Gender	Male	93	86.91
	Female	14	13.08
Education	No formal education	2	1.86
	Elementary school	8	7.47
	Junior high school	21	19.62
	Senior high school	64	59.81
	Higher education	12	11.21
Occupation	Unemployed	35	32.7
	Student	12	11.21
	Laborer	25	23.36
	Self-employed	35	32.71
Marital status	Single	104	97.1
	Married	0	0
	Previously married	3	2.8

Based on gender, the majority of respondents were male, totaling 93 individuals or 86.91%, while female respondents numbered 14 individuals or 13.08%. In terms of education level, most respondents were high school (SMA/MA) graduates, totaling 64 individuals or 59.81%, followed by junior high school (SMP) graduates with 21 individuals or 19.62%, university graduates with 12 individuals (11.21%), elementary school (SD) graduates with 8 individuals (7.47%), and those with no formal education totaling 2 individuals (1.86%). Regarding employment, the highest number of respondents were self-employed or unemployed, each comprising 32.71%, followed by 25 individuals (23.36%) working as laborers, and lastly, 12 individuals (11.21%) were students. In terms of marital status, most respondents were unmarried, accounting for 104 individuals or 97.1%, while 3 individuals (2.8%) had previously been married. Therefore, the majority of respondents were characterized as males aged 15–25, with a high school education, unmarried, and either self-employed or unemployed.

3.4 Description of characteristics of narcotics abusers living with their parents

The characteristics of narcotics abusers who live with their parents can be seen in Table 7, which presents the relationship between the narcotics abuser and their relationship with their parents.

Table 7. Characteristics of narcotics abusers living with their parents

Characteristics		N	%	Ranking
Parental presence	Every day	71	65.42	1
	Once a week	7	6.54	3
	Once a month	9	8.4	4
	More than once a month	20	18.69	2
Frequency of communication with family	More than 3 hours	48	44.85	1
	1–3 hours	25	23.36	2
	Less than 1 hour	23	21.49	3
	Never	11	10.28	4
Parental living arrangement	Living with both parents	66	61.6	1
	Not living with parents	12	11.21	3
	Living with one parent	25	23.36	2
	Living with other family members	4	3.73	4

Based on the category of daily parental presence at home, 71 individuals (65.42%) reported that their parents are present every day, while 7 individuals (6.54%) stated that their parents are present once a week. A total of 9 individuals (8.4%) reported parental presence once a month, and 20 individuals (18.69%) reported parental presence less than once a month. Regarding the frequency of daily conversations with family, 48 individuals (44.85%) talked with family for more than three hours per day, 25 individuals (23.36%) for one to three hours, 23 individuals (21.49%) for less than one hour, and 11 individuals (10.28%) reported never or rarely having conversations with their parents. In terms of living arrangements, 66 individuals (61.6%) still live with their parents, 12 individuals (11.21%) live alone or not with their parents, 25 individuals (23.36%) live with one parent, and 4 individuals (3.73%) live with other family members.

3.5 Description of family problem characteristics

Based on the characteristics of family-related problems, 45 respondents (42%) identified debt as the main family issue, ranking it first. Seventeen respondents (15.9%) reported coming from broken homes, while approximately 5 respondents (4.67%) mentioned family stigma as a problem. Only 2 respondents (1.9%) cited economic issues, and 38 respondents (35.5%) reported having no family problems.

Table 8. Characteristics of family problem

Characteristics		N	%	Ranking
Family problems	Debts	45	42	1
	Broken home	17	15.9	3
	Family stigma	5	4.67	4
	Economic issues	2	1.9	5
	None	38	35.5	2

3.6 Description of characteristics of narcotics-prone areas

Based on the environmental characteristics of the areas where narcotics abusers reside, 9 individuals (8.41%) were found to be living in high-risk (danger) zones, 72 individuals (67.2%) in alert zones, and 26 individuals (24.29%) in watchful (caution) zones. No respondents were reported to be living in safe zones.

Table 9. Characteristics of narcotics-prone areas

Characteristics		N	%	Ranking
Drug-prone area	Dangerous	9	8.41	3
	Alert	72	67.2	2
	Standby	26	24.29	1
	Safe	0	0	4

3.7 Research findings analysis

This chapter presents an overview of the research findings based on respondents' answers and the processed data. These data serve as the foundation for analyzing and addressing the research objectives as well as testing the proposed hypotheses (Sugiyono, 2019). The initial section presents the results of descriptive data analysis, which illustrates respondents' responses to each indicator of the main research variables. This analysis is then used to identify the tendencies in respondents' answers for each variable. Subsequently, to analyze the proposed research model, Structural Equation Modeling (SEM) is employed using Confirmatory Factor Analysis (CFA) on the dimensions of this study. The evaluation of the SEM model is conducted through a model fit test. Once model fit is confirmed, the structural model in SEM is applied to test the hypotheses and draw the final conclusions of the study.

3.7.1 Data test and analysis

First, the Causal Relationship Path Diagram. The theoretical model constructed based on the hypotheses will be illustrated in a path diagram. This diagram facilitates the researcher in observing the causal relationships intended to be tested. The following figure is the path diagram used in this study:

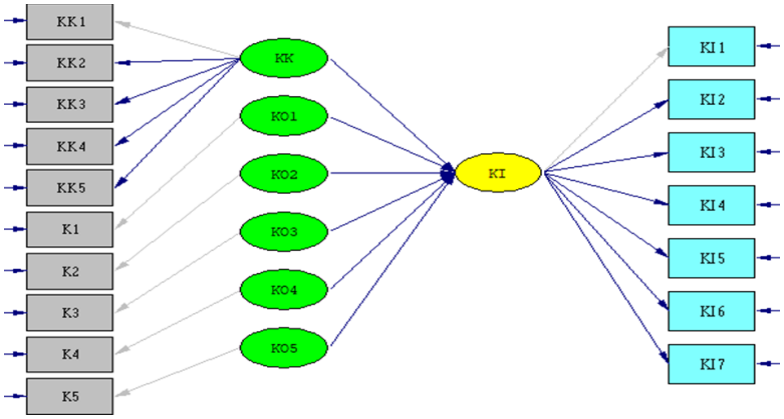

Fig. 3. Conceptual diagram

From the conceptual diagram above, it can be observed that all variables are reflective, as all arrows point from the variables to the indicators. The structural model is expressed through the following equations:

$$Individual\ resilience = Family\ functionality\ +\ e_1 \quad \text{(Eq.4)}$$

The structural model used in this study is explained through two types of models: the outer model and the inner model. In the outer model, the manifest variables consist of two main latent constructs: family functionality, measured by 20 indicators, and individual resilience, measured by 21 indicators. Meanwhile, the inner model illustrates that the individual resilience variable is influenced by family functionality. Using the LISREL 8.8 application, this causal relationship is visualized through a path diagram, which is then translated into programming syntax to generate the mathematical equations and subsequently estimate the model parameters.

The second step is conducting a Confirmatory Factor Analysis (CFA), which aims to test the validity of the indicators used to measure latent variables. The factor loading value serves as the reference for determining this validity. An indicator is considered valid if it has a factor loading value of 0.5 or higher. CFA is used to assess unidimensionality, which refers to the extent to which each indicator consistently measures a single construct or specific latent variable. This analysis is carried out separately for each latent variable model. In the Confirmatory Factor Analysis of the exogenous variable, the validity of indicators in forming the latent variable is tested by examining the standardized loading factor of each indicator. If the test result is highly significant, the indicator is deemed valid and appropriate for constructing the latent variable. The outcome of this analysis demonstrates the contribution of each indicator to the exogenous construct, which, in this case, is family functionality.

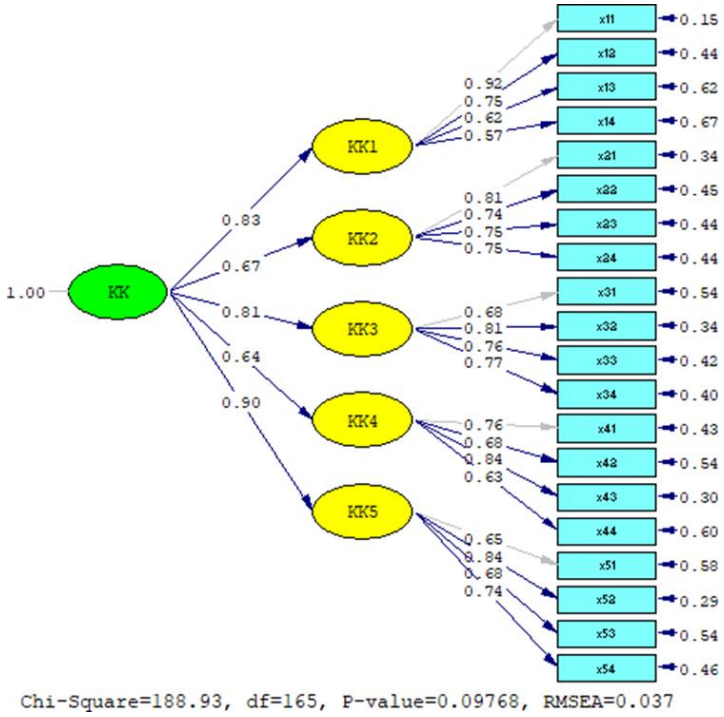

Fig. 4. Confirmatory factor analysis (CFA) diagram – Exogenous variable

Table 10 of the factor analysis also presents the test values for each indicator forming a construct. The results indicate that all indicators of the latent variable demonstrate favorable outcomes, where the t-values exceed 1.96. In addition, the standardized loading factors for all indicators are greater than 0.5. Based on these findings, it can be concluded that the indicators forming the exogenous latent variable exhibit unidimensionality (valid).

Consequently, based on this confirmatory factor analysis, the research model can be utilized for further analysis without requiring model modification.

Table 10. Confirmatory factor analysis (CFA) results – Exogenous variable

Level		Indicator	Loading factor	T-values	Remarks
Variable	Family functionality	FF1	0.83	8.75	Valid
		FF2	0.67	6.00	Valid
		FF3	0.81	6.29	Valid
		FF4	0.64	5.43	Valid
		FF5	0.90	6.42	Valid
Dimension	Family functionality 1	x11	0.92	-	Valid
		x12	0.75	9.00	Valid
		x13	0.62	6.93	Valid
		x14	0.57	6.29	Valid
	Family functionality 2	x21	0.81	-	Valid
		x22	0.74	7.75	Valid
		x23	0.75	7.88	Valid
		x24	0.75	7.88	Valid
	Family functionality 3	x31	0.68	-	Valid
		x32	0.81	7.13	Valid
		x33	0.76	6.80	Valid
		x34	0.77	6.86	Valid
	Family functionality 4	x41	0.76	-	Valid
		x42	0.68	6.59	Valid
		x43	0.84	7.82	Valid
		x44	0.63	6.10	Valid
	Family functionality 5	x51	0.65	-	Valid
		x52	0.84	6.95	Valid
		x53	0.68	5.93	Valid
		x54	0.74	6.33	Valid

Third, Confirmatory Factor Analysis (CFA) of the Endogenous Factor. The significance testing of the extracted indicators in forming the latent variable can be derived from the standardized loading factor values of each indicator. If the test values obtained are highly significant, this indicates that the indicators are sufficiently valid to be extracted in forming the latent variable. The following results present the significance testing of each indicator in constructing the endogenous latent variable.

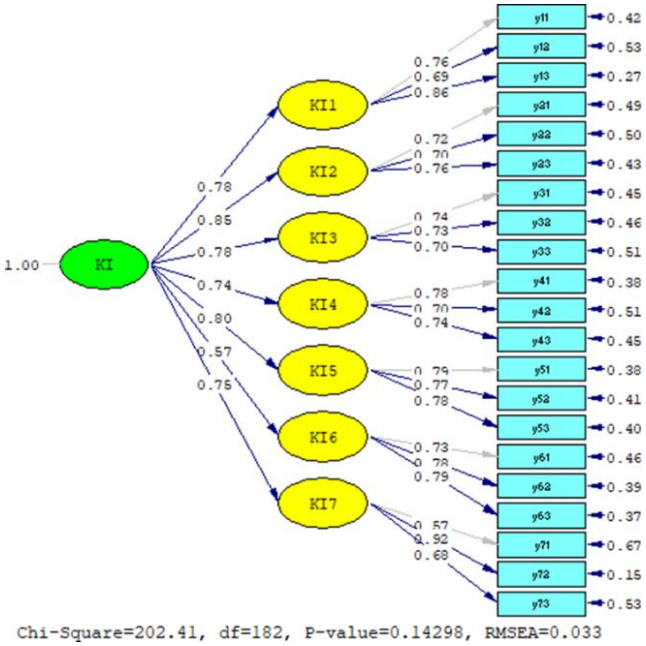

Fig. 5. Confirmatory factor analysis (CFA) diagram – Endogenous variable

Table 11 of the factor analysis also presents the test values for each construct-forming indicator. The results indicate that all indicators forming each latent variable show good results, with t-values exceeding 1.96. Moreover, the loading factor values (standardized estimates) for all indicators are greater than 0.5. Based on these results, it can be concluded that the indicators forming the endogenous latent variable demonstrate unidimensionality (valid). Consequently, based on this confirmatory factor analysis, the research model can be used for further analysis without requiring any model modifications.

Table 11. Confirmatory factor analysis (CFA) results – Endogenous variable

Level		Indicator	Loading factor	T-values	Remarks
Variable	Individual resilience	IR1	0.78	6.58	Valid
		IR2	0.85	6.70	Valid
		IR3	0.78	6.37	Valid
		IR4	0.74	6.35	Valid
		IR5	0.80	6.97	Valid
		IR6	0.57	4.74	Valid
		IR7	0.75	4.95	Valid
Dimension	IR1	y11	0.76	-	Valid
		y12	0.69	6.76	Valid
		y13	0.86	8.04	Valid
	IR2	y21	0.72	-	Valid
		y22	0.70	6.32	Valid
		y23	0.76	6.69	Valid
	IR3	y31	0.74	-	Valid
		y32	0.73	6.52	Valid
		y33	0.70	6.27	Valid
	IR4	y41	0.78	-	Valid
		y42	0.70	6.56	Valid
		y43	0.74	6.92	Valid
	IR5	y51	0.79	-	Valid
		y52	0.77	7.67	Valid
		y53	0.78	7.73	Valid
	IR6	y61	0.73	-	Valid
		y62	0.78	6.94	Valid
		y63	0.79	6.98	Valid
	IR7	y71	0.57	-	Valid
		y72	0.92	5.82	Valid
		y73	0.68	5.35	Valid

The fourth step is the Reliability and Average Variance Extracted (AVE) Test. One approach to evaluating the measurement model is by calculating the composite reliability and variance extracted for each construct. Reliability refers to the internal consistency of the indicators of a construct. High reliability results provide confidence that all individual indicators are consistent with their measurements. A commonly accepted threshold for reliability is greater than 0.70. However, it should be noted that reliability does not guarantee validity. Validity refers to the extent to which an indicator accurately measures or reflects what it is intended to measure. Another measure of reliability is the variance extracted, which complements the construct reliability metric. The recommended threshold for the variance extracted value is greater than 0.50. The following formulas are used to calculate construct reliability and variance extracted.

$$Construct\ reliability = \frac{(\sum std\ loading)^2}{(\sum std\ loading)^2 + \sum \varepsilon j} \quad \text{(Eq. 5)}$$

$$Variance\ extracted = \frac{\sum std\ loading^2}{\sum std\ loading^2 + \sum \varepsilon j} \quad \text{(Eq. 6)}$$

After the validity test has been conducted, the next step is to calculate or analyze the reliability of the research variables. Following the calculations performed using Microsoft Excel based on the formulas mentioned above, the resulting values of construct reliability and variance extracted are presented as follows:

Table 12. Reliability and average variance extracted (AVE) results – Exogenous variable

Level		Indicator	λ	λ^2	e	CR	VE
Variable	Family functionality	FF1	0.830	0.689	0.311	0.882	0.603
		FF2	0.670	0.449	0.551		
		FF3	0.810	0.656	0.344		
		FF4	0.640	0.410	0.590		
		FF5	0.900	0.810	0.190		
Dimension	Family functionality 1	x11	0.920	0.846	0.154	0.813	0.530
		x12	0.750	0.563	0.438		
		x13	0.620	0.384	0.616		
		x14	0.570	0.325	0.675		
	Family functionality 2	x21	0.810	0.656	0.344	0.848	0.582
		x22	0.740	0.548	0.452		
		x23	0.750	0.563	0.438		
		x24	0.750	0.563	0.438		
	Family functionality 3	x31	0.680	0.462	0.538	0.842	0.572
		x32	0.810	0.656	0.344		
		x33	0.760	0.578	0.422		
		x34	0.770	0.593	0.407		
	Family functionality 4	x41	0.760	0.578	0.422	0.820	0.536
		x42	0.680	0.462	0.538		
		x43	0.840	0.706	0.294		
		x44	0.630	0.397	0.603		
	Family functionality 5	x51	0.650	0.423	0.578	0.820	0.535
		x52	0.840	0.706	0.294		
		x53	0.680	0.462	0.538		
		x54	0.740	0.548	0.452		

Based on Table 12 above, the results show the construct reliability (CR) and average variance extracted (AVE) values for each research variable. It is found that the latent variables have construct reliability coefficient values greater than or equal to the critical value (CR ≥ 0.7), and the variance extracted values exceed the critical threshold (0.5). This indicates that the exogenous variables exhibit a good level of reliability.

Table 13. Reliability and average variance extracted (AVE) results – Endogenous variable

Level		Indicator	λ	λ^2	e	CR	VE
Variable	Individual resilience	IR1	0.780	0.608	0.392	0.903	0.573
		IR2	0.850	0.723	0.278		
		IR3	0.780	0.608	0.392		
		IR4	0.740	0.548	0.452		
		IR5	0.800	0.640	0.360		
		IR6	0.570	0.325	0.675		
		IR7	0.750	0.563	0.438		
Dimension	IR1	y11	0.760	0.578	0.422	0.816	0.598
		y12	0.690	0.476	0.524		
		y13	0.860	0.740	0.260		
	IR2	y21	0.720	0.518	0.482	0.771	0.529
		y22	0.700	0.490	0.510		
		y23	0.760	0.578	0.422		
	IR3	y31	0.740	0.548	0.452	0.767	0.524
		y32	0.730	0.533	0.467		
		y33	0.700	0.490	0.510		
	IR4	y41	0.780	0.608	0.392	0.784	0.549

	y42	0.700	0.490	0.510		
	y43	0.740	0.548	0.452		
IR5	y51	0.790	0.624	0.376	0.823	0.608
	y52	0.770	0.593	0.407		
	y53	0.780	0.608	0.392		
IR6	y61	0.730	0.533	0.467	0.811	0.588
	y62	0.780	0.608	0.392		
	y63	0.790	0.624	0.376		
IR7	y71	0.570	0.325	0.675	0.775	0.545
	y72	0.920	0.846	0.154		
	y73	0.680	0.462	0.538		

Based on Table 13 above, the results show the construct reliability and variance extracted values for each research variable. It is found that the latent variables have construct reliability coefficient values greater than or equal to the critical value (CR ≥ 0.7), and the variance extracted values exceed the critical threshold (0.5). This indicates that the endogenous variables exhibit a good level of reliability.

3.7.2 Hypothesis test

First, evaluation of model fit criteria (Goodness of fit model). The model's suitability is assessed by examining various goodness-of-fit criteria. The initial step involves evaluating whether the data meet the assumptions required for Structural Equation Modeling (SEM) analysis. Once these assumptions are satisfied, the model can be tested. Several key indicators are used to evaluate the goodness-of-fit criteria, along with their respective cut-off values, as follows:

Table 14. Model fit test (Goodness of fit model)

No.	Goodness of fit indices	Cut-off value	Research findings	Fit level
Absolute Fit Indices				
1	Probability	≥ 0.05	P=0.77	Good fit
2	RMSEA	≤ 0.08	0.000	Good fit
3	RMR	≤ 0.10	0.067	Good fit
4	SRMR	≤ 0.08	0.08	Good fit
5	Nor. Chi Square (X^2/DF)	< 2	0.799	Good fit
6	GFI	≥ 0.90	0.92	Good fit
7	AGFI	≥ 0.90	0.88	Marginal fit
Incremental Fit Indices				
8	NFI	≥ 0.90	0.97	Good fit
9	TLI (NNFI)	≥ 0.90	1.01	Good fit
10	CFI (RNI)	≥ 0.90	1.00	Good fit
11	RFI	≥ 0.90	0.96	Good fit
12	IFI	≥ 0.90	1.00	Good fit
Parsimony Fit Indices				
13	PNFI	≥ 0.50	0.74	Good fit
14	PGFI	≥ 0.50	0.62	Good fit

Absolute fit indices: The table shows that the Chi-square significance probability is 0.77, indicating a good model fit, as the ideal value for Chi-square significance probability is ≥ 0.05. The Root Mean Square Error of Approximation (RMSEA) value is 0.000, which falls within the good fit category, since the acceptable threshold is ≤ 0.08. The Root Mean Square Residual (RMR) value is 0.067, also indicating a good fit, as the ideal value for RMR is ≤ 0.10. The Standardized Root Mean Square Residual (SRMR) is 0.08, which is classified as a good fit, meeting the criterion of ≤ 0.08. The Normed Chi-Square value is 0.799, which is considered a good fit, as the recommended threshold is < 2. The Goodness of Fit Index (GFI) is 0.92, indicating a good fit, as the ideal value is ≥ 0.90. However, the Adjusted Goodness of

Fit Index (AGFI) is 0.88, which falls within the marginal fit category, since the acceptable value for a good fit is ≥ 0.90.

Incremental Fit Indices: The Normed Fit Index (NFI) is 0.97, indicating a good fit, as the recommended threshold is ≥ 0.90. The Non-Normed Fit Index (NNFI) is 1.01, which meets the good fit criteria (≥ 0.90). The Comparative Fit Index (CFI) is 1.00, also indicating a good fit. The Relative Fit Index (RFI) is 0.96, which is considered a good fit. The Incremental Fit Index (IFI) is 1.00, which likewise falls within the good fit category, as the ideal value is ≥ 0.90.

Parsimony Fit Indices: The Parsimony Normed Fit Index (PNFI) is 0.892, indicating a good model fit, as the recommended threshold is ≥ 0.50. The Parsimony Goodness of Fit Index (PGFI) is 0.651, which also meets the criterion for a good fit (≥ 0.50). Based on Table 14 and the explanation above, it can be concluded that the model yields 12 fit indices within the good fit category, and 2 within the bad fit category. However, as the majority of indices indicate a good fit, it can be inferred that the model employed in this study demonstrates an acceptable level of fit.

Second, Structural Model. In this structural equation, the researcher has established a structural model aligned with the path diagram developed based on theoretical review and the proposed hypotheses. This study includes a single structural equation model, which examines the effect of family functionality on individual resilience. The results of the structural model in this study are presented in Figure 6.

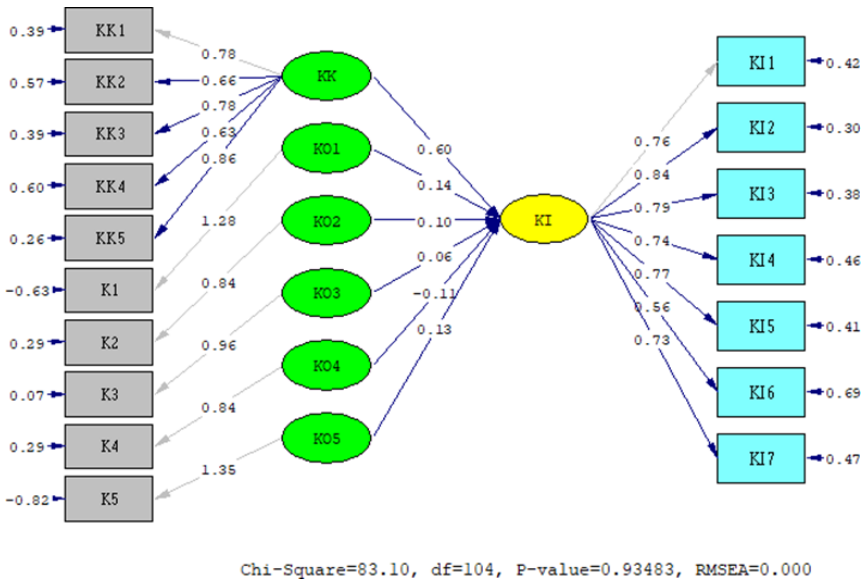

Fig. 6. Estimated standardized coefficients

The figure above illustrates the strength of the relationships between the variables used in this study, where each variable demonstrates a positive influence. The following presents the results of the structural model equation:

$$KI = 0.60 * KK + 0.14 * KO1 + K0.10 * O2 + 0.06 * KO3 - 0.11 * KO4 + 0.13 * KO5, Errorvar. = 0.42, R^2 = 0.58 \quad \text{(Eq. 7)}$$

Based on the structural model equation, the following can be explained the Family Functionality variable has a positive effect on Individual Resilience with a path coefficient of 0.60. This indicates that the exogenous variable has a positive influence on the endogenous variable—in other words, the better the functionality of the family, the higher the level of individual resilience. The control variable KO1 (Narcotics Vulnerability) has a positive effect on individual resilience with a path coefficient of 0.14. This implies that an improvement in KO1 corresponds to an increase in individual resilience. The control variable KO2 (Family Problems) has a positive effect on individual resilience with a path

coefficient of 0.10, indicating that better conditions in KO2 also lead to stronger resilience. The control variable KO3 (Age) has a positive effect on individual resilience with a path coefficient of 0.06, suggesting that higher age is associated with greater resilience. The control variable KO4 (Education) shows a negative effect on individual resilience with a path coefficient of -0.11. This means that higher levels of KO4 are associated with lower levels of individual resilience. The control variable KO5 (Occupation) has a positive effect on individual resilience with a path coefficient of 0.13, indicating that improved occupational status contributes to increased resilience. The coefficient of determination (R^2) obtained from the model is 0.58 (58.0%). This means that 58.0% of the variance in individual resilience is explained by family functionality, while the remaining 42.0% is influenced by other unobserved factors in this study.

Next is the hypothesis test, which examines the direct effect of the exogenous variable on the endogenous variable—namely, the effect of family functionality on individual resilience. Based on figure 7 below, the results of hypothesis testing using the t-value are presented to determine whether the proposed hypothesis—namely the effect of the exogenous variable on the endogenous variable—is accepted or rejected. The hypothesis testing was conducted using Structural Equation Modeling (SEM), processed with LISREL 8.8.

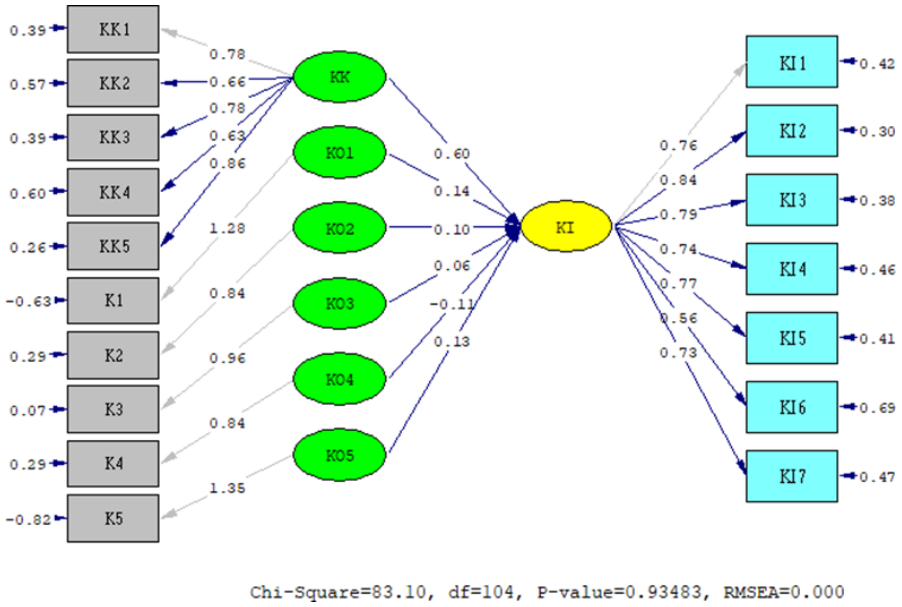

Fig. 7. Estimated T-values

Based on Figure 7 and Table 15 above, the results of the hypothesis testing and the path coefficient values are presented. The criterion for significance testing in SEM is based on a critical value of 1.96 at a 5% error rate, where a t-value greater than or equal to the critical value (t-value ≥ 1.96) indicates that the parameter is statistically significant. Referring to Figure 7, it can be seen that the variable of family functionality (KK) has a positive effect on individual resilience (KI) with a standardized coefficient of 0.60 and a t-value of 5.20 (Significant: t > 1.96). This result indicates that family functionality has a positive and significant influence on individual resilience, supporting Hypothesis 1 (H1).

The variable KO1 (Vulnerability) has a positive effect on individual resilience with a coefficient of 0.14 and a t-value of 1.99 (Significant: t > 1.96). This suggests that KO1 positively and significantly affects individual resilience, supporting Hypothesis 2 (H2). The variable KO2 (Family Problems) has a positive effect on individual resilience with a coefficient of 0.10 and a t-value of 1.10 (Not significant: t < 1.96). This indicates that KO2 has a positive but not statistically significant effect on individual resilience, thus Hypothesis 3 (H3) is rejected. The variable KO3 (Age) has a positive effect on individual resilience with a coefficient of 0.06 and a t-value of 0.75 (Not significant: t < 1.96). This shows that KO3 has a positive but not significant effect on individual resilience, resulting in the rejection of

Hypothesis 4 (H4). The variable KO4 (Education) has a negative effect on individual resilience with a coefficient of -0.11 and a t-value of -1.08 (Not significant: t > -1.96). This finding suggests that KO4 negatively and insignificantly affects individual resilience, leading to the rejection of Hypothesis 5 (H5). The variable KO5 (Occupation) has a positive effect on individual resilience with a coefficient of 0.13 and a t-value of 2.07 (Significant: t > 1.96). This result confirms that KO5 positively and significantly influences individual resilience, supporting Hypothesis 6 (H6).

Table 15. Estimated effects results

Effect	Standardized coefficient	t-value	Conclusion
H1 : FF-> IR	0.60	5.20	Significant
H2 : KO1-> IR	0.14	1.99	Significant
H3 : KO2-> IR	0.10	1.10	Not significant
H4 : KO3-> IR	0.06	0.75	Not significant
H5 : KO4-> IR	-0.11	-1.08	Not significant
H6 : KO5-> IR	0.13	2.07	Significant

Note: FF: Family functionality
IR : Individual resilience
KO1: Vulnerability
KO2: Family problems
KO3: Age
KO4: Education
KO5: Occupation

3.7.3 Dimensions of family functionality among narcotics abusers

First, a healthy and safe relationship within the family. As discussed in the research article Integrating Family Resilience and Family Stress Theory (Patterson, 2002), using the Family Adjustment and Adaptation Response (FAAR) model to link family stress theory with family resilience, four main constructs are involved. Families work through shared meaning to adjust their needs and capabilities. Family demands may include normative and non-normative stress, chronic family strains (unresolved and harmful tensions), and daily hassles. Family capabilities refer to resources and psychosocial strengths (what the family has) and coping strategies (what the family does). These capabilities and demands originate from three levels of the ecosystem: individual family members, the family unit, and the wider community. Second, parental monitoring and effective discipline. A cohesive family unit plays a crucial role, as parental direction, guidance, and value systems shape children's attitudes and behavioral patterns (Nisfiannoor & Yulianti, 2005). Ongoing family interaction involves each member's effort to understand challenges, and their interpretations determine the coping strategies they employ.

Third, parental involvement in family life. Families play a key role in passing on cultural values (Zahrok & Suarmini, 2018). When family functions are well-implemented by parents, this significantly influences other members, particularly children (Herawati et al., 2020). Research conducted by Supriyati & Pangesti (2021) at the National Narcotics Agency (BNN) in Lampung Province found that outpatients who received social support from their families were more likely to stop using drugs, especially when they received greater family support. Economic and social needs within the family during outpatient rehabilitation are typically met by spouses, parents, or siblings.

Fourth, instilling prosocial values through parenting. The success of a family in embedding prosocial values depends heavily on the parenting style applied. Authoritarian parenting prioritizes control over the child, democratic parenting encourages cooperation, and permissive parenting emphasizes granting autonomy to the child (Subianto, 2013). A study by Yuris et al. (2019) on the role of fathers and peer social support in the self-determination of adolescent drug addicts at Medan Plus Addiction Recovery Clinic involved 54 adolescents. Regression analysis showed a significant correlation between self-determination and both fatherly involvement and peer support, with these variables

accounting for 30.3% of self-determination. Woititz (1992), as cited in Sunarti (2021), emphasized that parenting style influences family health. Parents are responsible for clarity of communication, loving unconditionally, respecting others, allowing emotional expression, setting boundaries, offering age-appropriate care, and reinforcing children consistently and intentionally.

Fifth, supportive parenting. Effectively managing family members with substance use issues involves identifying the problem and its causes, discussing solutions, focusing on goals, taking concrete actions, and learning from past mistakes. According to research responses, problem-solving approaches varied depending on the respondent. Those still living with their families preferred discussing issues directly, while others adhered to addiction counselor recommendations. Informal and professional support is essential for family members of drug users to mitigate feelings of guilt, shame, and stigma. Creating a context for families to meet others with similar experiences and increasing professional support is crucial, as guilt and isolation often prevent families from seeking help. Professionals should actively explore the needs of these relatives and include them in treatment when possible. Early detection and support for parents of drug-using children can prevent a negative cycle of guilt and shame. Evidence-based methods now exist to support families affected by drug addiction, and these should be more widely implemented in social and healthcare services. These support strategies should be grounded in empathy and inclusiveness, aiming to reduce feelings of guilt and shame.

Future outlooks within families also influence resilience. Families that believe adversity can lead to growth are better equipped to cope with challenges, especially in drug abuse cases (Siahaan, 2012). These findings suggest that family functioning significantly enhances individual resilience; approximately 90 out of 107 respondents stated that family functioning improved the resilience of drug abusers. Other factors that contribute to individual resilience beyond family functioning include internal personal factors and external elements such as family and environmental support. Families are expected to adapt constructively when dealing with a drug-using member by offering support, guidance, and supervision.

4. Conclusions

Based on the research findings, family functionality in building the resilience of narcotics abusers undergoing rehabilitation in South Sumatra Province demonstrates that the family plays a crucial role not only in enduring times of crisis but also as a space for healing and growth. A well-functioning family can create a warm, supportive, and hopeful environment, enabling them to accompany a member struggling with substance abuse through appropriate and compassionate approaches. By offering motivation, fostering open communication, and planning a shared future, families can strengthen the rehabilitation process and support the sustained recovery of their members.

Moreover, family functionality is also evident in efforts to build individual resilience through advice, supervision, and effective discipline, particularly from parental roles. Active family involvement in the daily life of the abuser—both during and after outpatient rehabilitation—significantly contributes to relapse prevention. This form of support includes severing ties with negative environments and encouraging participation in positive activities that can redirect individuals away from substance abuse.

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Author Contribution

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