The role of community-led support groups in facilitating relapse prevention to young adults with a substance use disorder

Luvuyo Teko

s214096513

Submitted in fulfilment of the requirements for the degree
Master of Social Work Research (Dissertation)

In the

Department of Social Development Professions,

Faculty of Health Sciences

Nelson Mandela University

Supervisor: Prof. V. Goliath

Co-Supervisor: Dr Z. Abdulla

Date: December 2021

NELSON MANDELA
UNIVERSITY

DECLARATION

NAME: Luvuyo Teko

STUDENT NUMBER: s214096513

QUALIFICATION: Master of Social Work Research

TITLE OF PROJECT: The role of community led support groups in facilitating relapse prevention to young adults with a substance use disorder

In accordance with Rule G5.6.3, I hereby declare that the above-mentioned thesis is my own work and that it has not previously been submitted for assessment to another University or for another qualification.

SIGNATURE

10 November 2021

DATE

ACKNOWLEDGEMENTS

The people who were instrumental in my research journey must be properly recognised and acknowledged.

Firstly, I would like to give all the glory to the Almighty God for giving me the strength to complete this journey. Without Him, this would not have been possible.

I would like to thank myself for always believing in myself, I would like to thank myself for always motivating myself and I would like to thank myself for not giving up and choosing to complete this journey.

I would like to extend my gratitude and thanks to my two supervisors, Prof. Veonna Goliath and Dr Zurina Abdulla, for their unlimited academic support throughout the research process and for supporting me during difficult times.

I would like to extend my thanks to my brother, Mr. SIyabulela Teko, for supporting me and always reminding me why I should continue with this journey.

I would like to acknowledge my late mother, Mrs. Nobahle Sylvia Teko, who during her time on earth always told me to study further and not rest in one place. It was her constant motivation and reminder to study further that inspired me to undertake this project.

I would like to acknowledge Ms. Asanda Solani, my life partner, who has been with me all the way, supporting me, motivating me and always telling me that I can do it.

I would like to extend my thanks to the Feni family, highlighting the late Mr. Khumbulani Feni and Mr. Mbasa Feni, who offered their support and motivation during my research journey. They played a role in my conviction to continue with my study.

I would also like to acknowledge the NRF for funding this research project. Without their support, this project would not have been possible.

ABSTRACT

Substance use disorder (SUD) is a cause of great concern globally and in South Africa. Epidemiological studies in South Africa indicate that the age of onset of substance use is rapidly decreasing with time from the age of 17 to as young as 10 years of age. Research confirms that early identification and treatment of harmful substance use reduce the chances of developing a substance use disorder. This study focused on young adults whose harmful use of substances escalated into a substance use disorder. Aftercare is an integral component in addressing risk factors to facilitate ongoing recovery. This study focused on community-led support groups as an aftercare strategy for SUD recovery. The aim of this qualitative, exploratory, descriptive, and contextual study was to develop an in-depth understanding of how community-led support groups can facilitate relapse prevention in the aftercare of young adults with substance use disorders. Non-probability purposive and snowball sampling were employed to recruit members from community-led support groups between 18 and 35 years of age who had been in recovery for a substance use disorder for six months and longer. A total of nine participants were sampled from three different community led support groups in the Nelson Mandela Bay Metro. Data was collected through individual, online, semi-structured interviews. The data was analysed by means of thematic analysis. The findings showed that community led support groups are viable vehicles for recovery in the aftercare. What was unique was the employment of strategies of needs identification and active responses that improved the recovery potential of young adults. What was further noted was how Community-led support groups can tailor their assistance to the unique needs of their members who take ownership of the group instead of relying on professional interventions. In conclusion, the community-led support groups in this study served as a viable strategy for the ongoing recovery in the aftercare of the participants in this study. Data verification strategies were employed to ensure the trustworthiness and rigour of the study. There was strict adherence to all ethical considerations.

Keywords

Aftercare, community led support groups, continuum of care, prevention, relapse, risk factors, social cognitive theory, social support, support group, substance use disorder young adult.

TABLE OF CONTENTS

DECLARATION .... **i**

ACKNOWLEDGEMENTS .... **ii**

ABSTRACT .... **iii**

LIST OF ANNEXURES .... **xi**

LIST OF FIGURES .... **xii**

LIST OF TABLES .... **xiii**

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND 1

1.2 PROBLEM FORMULATION AND MOTIVATION FOR THE STUDY 3

1.3 THEORETICAL FRAMEWORK UNDERPINNING THE STUDY 5

1.3.1 Social Support 5

1.3.2 Social Network as a Concept Incorporated in Social Support 6

1.3.3 Social Cognitive Theory 6

1.3.4 Modes of Agency and the Learning Process 8

1.4 DEFINITIONS OF KEY TERMS 10

1.5 RESEARCH QUESTION 11

1.5.1 Research Aim 12

1.5.2 Research sub-questions and objectives 12

1.6 RESEARCH METHODOLOGY 12

1.6.1 Research Paradigm 13

1.6.2 Research Design 13

1.6.3 Sample 13

1.6.4 Method of Data Collection 14

1.6.5 Gaining Entry into the Research Site 14

1.6.6 Data Analysis 15
1.7 ETHICAL CONSIDERATIONS 15
1.7.1 Justice 15
1.7.2 Respect for Persons 16
1.7.3 Beneficence 16
1.7.4 Informed Consent 16
1.7.5 Confidentiality, Privacy and Anonymity 17
1.8 DATA VERIFICATION: ENSURING RIGOUR AND TRUSTWORTHINESS . 17
1.8.1 Credibility 17
1.8.2 Transferability 17
1.8.3 Dependability 18
1.8.4 Confirmability 18
1.9 OUTLINE OF THE RESEARCH REPORT 18
1.10 DISSEMINATION OF RESULTS 18
1.11 CHAPTER SUMMARY 19

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION 20
2.2 CONCEPTUALISING SUD 20
2.3 CURRENT SUD INCIDENCE 21
2.4 NATIONAL POLICIES AND LEGISLATION IN SOUTH AFRICA 23
2.5 PHYSIOLOGICAL AND PSYCHOSOCIAL IMPACT OF SUBSTANCE USE DISORDER 27
2.5.1 Physiological Impact 27
2.5.2 Psychological Impact 28
2.5.3 Social Impact 29
2.6 RISK AND PROTECTIVE FACTORS ASSOCIATED WITH SUD 30

2.6.1 Intrapersonal Risk and Protective Factors 31
2.6.2 Interpersonal Risk and Protective Factors 33
2.6.3 Environmental Risk Factors 38
2.7 CONTINUUM OF CARE FOR TREATMENT OF SUD 40
2.8 FOCUS ON AFTERCARE AS PART OF RELAPSE PREVENTION 43
2.9 GROUP WORK AS TREATMENT AND AFTERCARE METHOD 45
2.10 SUPPORT GROUPS 46
2.11 CHAPTER SUMMARY 49

CHAPTER THREE

APPLICATION OF RESEARCH METHODOLOGY

3.1 INTRODUCTION 50
3.2 APPLICATION OF THE RESEARCH APPROACH 50
3.3 RESEARCH PARADIGM 51
3.4 INTEGRATION OF EXPLORATORY-DESCRIPTIVE AND CONTEXTUAL RESEARCH DESIGN 52
3.4.1 Exploratory Design 52
3.4.2 Descriptive Design 53
3.4.3 Contextual Design 53
3.5 SAMPLE AND SAMPLING PROCEDURE 54
3.6 ENTERING THE RESEARCH SITE AND THE RECRUITMENT PROCESS 56
3.7 DATA COLLECTION PROCESS 58
3.8 PILOT STUDY 60
3.9 DATA ANALYSIS 62
3.10 DATA VERIFICATION - ENSURING RIGOUR AND TRUSTWORTHINESS 65
3.10.1 Credibility 65
3.10.2 Transferability 66
3.10.3 Dependability 67

3.10.4 Confirmability ... 68
3.11 ETHICAL CONSIDERATIONS ... 69
3.11.1 Justice ... 69
3.11.2 Respect for persons ... 71
3.11.3 Beneficence ... 72
3.11.4 Informed consent ... 73
3.11.5 Confidentiality, Privacy and Anonymity ... 74
3.12 DISSEMINATION OF RESULTS ... 74
3.13 CHAPTER SUMMARY ... 75

CHAPTER FOUR

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION ... 76
4.2 DEMOGRAPHIC PROFILE OF SUPPORT GROUPS AND PARTICIPANTS 76
4.3 DATA ANALYSIS ... 77
4.4 PRESENTATION OF FINDINGS ... 78
4.5 DISCUSSION OF THEMES ... 80
4.5.1 The needs of young adults with SUD who are active in community-led support groups ... 80
4.5.1.1 Require assistance with longstanding addiction recovery 81
4.5.1.2 Need assistance with identified intrapersonal factors that may impact the level of social support conferred ... 82
4.5.2 How community-led support groups respond to the needs of young adults active in support groups ... 91
4.5.2.1 Religious faith as a key component of support groups ... 92
4.5.2.2 Connecting through online media during lockdown when face-to-face contact was not possible ... 94
4.5.2.3 Providing individual and group-based support ... 95

4.5.3 Benefits of community-led support groups to young adults in recovery 101

4.5.3.1 Place for intrapersonal growth..... 101

4.5.3.2 Social Support..... 103

4.5.3.3 Safe platform to share life stories and learn from one another's experiences..... 104

4.5.3.4 Social support group - a safe environment for fostering acceptance and care..... 105

4.5.3.5 The support group facilitated the restoration of family relationships and thus helped with relapse prevention... 107

4.5.4 How community-led support groups assist young adults address risk factors of relapse..... 109

4.5.4.1 Assists in the identification of triggers..... 110

4.5.4.2 Implement behavioural strategies in response to triggers 111

4.5.4.3 Religiosity as an intervention to combat triggers..... 115

4.5.5 Recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention..... 116

4.5.5.1 Motivate for consistent attendance..... 117

4.5.5.2 Long-term attendance and support required for long-term recovery..... 118

4.5.5.3 Support groups provide structure..... 119

4.5.5.4 Filling time by remaining busy..... 121

4.5.5.5 Homogeneity in the Social Network (remain connected to positive people who have overcome addiction)..... 122

4.5.5.6 Facilitating attendance by creating support groups that are easily accessed..... 124

4.6 CHAPTER SUMMARY..... 125

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION 126

5.2 SUMMARY AND CONCLUSION 126

5.3 SUMMARY AND CONCLUSIONS DRAWN FROM THE RESEARCH FINDINGS 127

5.3.1 The needs of young adults with SUD who are active in community-led support groups 127

5.3.1.1 Requiring assistance with longstanding addiction 128

5.3.1.2 Require assistance with intrapersonal factors that may impact the level of support required 128

5.3.2 How community-led support groups respond to the needs of young adults that are active in support groups 129

5.3.2.1 Religious faith as a key component of support groups ... 129

5.3.2.2 Connecting through online mediums during lockdown when f2f contact was not possible 129

5.3.2.3 Providing individual and group support 130

5.3.2.4 Gaining coping skills and guidance 130

5.3.3 Benefits of community-led support groups to young adults in recovery 131

5.3.3.1 Place for intrapersonal growth 131

5.3.3.2 Social Support 131

5.3.3.3 Safe space to share life stories and learn from one another's experiences 131

5.3.3.4 Social support group a safe environment for fostering acceptance and care 131

5.3.3.5 The support group facilitated the restoration of family relationships and thus facilitated relapse prevention 132

5.3.4 How community-led support groups help young adults to deal with the cravings and triggers for relapse 133

5.3.4.1 Assist in the identification of triggers 133

5.3.4.2 Implement behavioural strategies in response to the triggers 133

5.3.4.3 Religiosity as an intervention to combat triggers 134

5.3.5 Recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention..... 134

5.3.5.1 Motivate for consistent attendance................................ 135

5.3.5.2 Long-term attendance and support required for long-term recovery 135

5.3.5.3 The support group as a structure 135

5.3.5.4 Filling time by keeping busy 135

5.3.5.5 Homogeneity in the Social Network (remain connected to positive people who have overcome addiction).......... 136

5.3.5.6 Facilitating attendance of meetings by creating support groups that are easily accessible. 136

5.4 SUMMARY OF METHODOLOGY AND RESEARCH DESIGN 136

5.4.1 Summary of research methodology 136

5.4.2 Data verification - Trustworthiness 137

5.4.3 Ethical Considerations 137

5.5 VALUE AND LIMITATIONS OF THE STUDY 138

5.6 RECOMMENDATIONS FOR PRACTICE 139

5.7 FUTURE RESEARCH 139

5.8 CHAPTER SUMMARY 141

REFERENCES... 142

LIST OF ANNEXURES

APPENDIX 1: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH THE SUPPORT GROUP 162

APPENDIX 2: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH THE SUPPORT GROUP 164

APPENDIX 3: INFORMATION AND INFORMED CONSENT FOR PARTICIPATION IN THE STUDY.. 166

APPENDIX 4: INTERVIEW SCHEDULE.. 171

APPENDIX 5: TRANSCRIPT 172

APPENDIX 6: ETHICS APPROVAL.. 187

APPENDIX 7: PROOFREADING CERTIFICATE.. 189

LIST OF FIGURES

Figure 2.1: Continuum of care model 40

Figure 2.2: Treatment levels of care 42

LIST OF TABLES

Table 1.1: Research sub-questions and objectives 12

Table 2.1: Types of groups... 45

Table 4.1: Presentation of findings 78

CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION AND BACKGROUND

Substance use disorder (SUD) is a cause for great concern and epidemiological studies in South Africa indicate that the onset age of the harmful use of substances is rapidly decreasing with time. The Diagnostic Statistical Methods 5 (DSM-V) defines SUD as "a cluster of cognitive, behavioural, and physiological symptoms depicting that the individual continues using substances despite significant substance-related problems" (American Psychiatric Association, 2013:483). It has been particularly noted that substance use disorder ranges from mild to moderate and severe and the determinants are based on the number of symptoms present within the diagnostic criteria (American Psychiatric Society, 2013:484). In this study, the concept use will be to refer to the non-problematic use of substances and the commonly connoted stigmatising terminology of misuse and abuse of substances will be referred to as the harmful use of substances. Ramlagan, Peltzer and Matseke (2010:44) reported that the onset of illicit substance use was at age 16. A study conducted by Groenewald (2018:1) concurred, highlighting that the common onset of illicit substance use was between the ages of 13 and 17 and has also been noted to be as young as 10 years old. The South African Community Epidomolgocal Network in Drug Use statistics indicated that of the 515 individuals who sought treatment from July to December 2017, 23% were adolescents who ranged between 13 and 19 years of age (Dada, Burnhams, Erasmus, Parry, Bhana, Pretorius, Wiemann & Kitshoff, 2018:32). These findings support the observation in treatment statistics that substance use peaks during late adolescence and continues into young adulthood (Alicia, Merline, O'Malley, Schulenburg, Bachman & Johnston, 2004:96). Stone, Becker, Huber and Catalano (2015) posit that substance use problems peak during adulthood, which correlates with the increase in substance use. The early onset of engagement in substance use elevates the risks associated with substance use and other long-term impairments and behavioural problems (Poudel & Gautam, 2017:2). These treatment centre statistics confirm the research evidence that early-onset substance use increases the risk of developing a substance use disorder and a poorer prognosis for treatment (Del Mar Capella & Adan, 2017:2). To support the aforementioned statement, 42% of the 515

who sought treatment for moderate to harmful substance use during the same period in 2017 were young adults between the ages of 20 and 34 (Dada et al., 2018:32). The statistics show that the frequent use of harmful substances is relatively high in young adults, which necessitates a focus on young adults (Merline, O'Malley, Schulenberg et al, 2004:100). For this study, a young adult is a person between 18 and 35 years of age. This is in accordance with two legislative mandates that define the social constructs of a *youth* and a *child*. The National Youth Commission's Act (1996:7) defines a youth as a person aged from 14 to 35, whilst the Children's Act 38 of 2005 (2005:24) states that the legal age of adulthood begins at age 18. This study uses the term young adult as opposed to youth and thus includes participants whose ages ranged between 18 and 35. The focus on young adults was important because within this age range are many young adults who are expected to work towards achieving sustainable livelihoods. Unemployment is rife in South Africa and De Lannoy, Swartz, Lake and Smith (2015:53) recommend that a key intervention in increasing employability in youth is through skills development educational programmes so that they can take care of their homes and sustain their livelihoods. Substance use affects paradigms relevant to education and careers. If a large percentage of youth are battling recovery from SUD, it will exacerbate the rising level of unemployment. From this view, urgent and collective mechanisms must be implemented to respond to their needs, both in the interest of the society and young adults so that they can participate in employability-related programmes.

The relapse potential amongst young adults with substance use disorder in the United States of America was reported to be between 40% and 60% (National Institute on Drug Abuse (NIDA), 2018:15). South African statistics mirror these concerning trends with SACENDU reporting that 15% of young adults during the same period in 2017 were re-admitted for moderate to severe substance use disorder treatment (Dada et al, 2018:32). Factors that exacerbate the relapse potential include peer group influence, the accessibility of substances, stress, family dynamics and conflict (Kabisa, Biracyaza, Habaguseng & Umubyeyi, 2021:4). An essential aspect in minimising the relapse rate and addressing risk factors is the focus on aftercare as a component of the continuum of care. Relapse in this context refers to resuming the use of substances. In this study, aftercare is described as ongoing, long-term support with no defined end date to prevent relapse (Prevention of and Treatment for Substance

Abuse Act, No. 70 of 2008, 2008:8; Popovici, French & McKay, 2008:4). The focus is thus on young adults with SUD who are working to avoid the onset of substance use.

The continuum of care model is a conceptual model involving the classification of different types of interventions that track clients' progress over time through a comprehensive integrated model with clear identification of actions appropriate to each level of care (Springer & Phillips, 2007:3-4). These include primary intervention (prevention and early intervention), secondary intervention (treatment) and tertiary intervention (aftercare). The National Drug Master Plan (NDMP) (2013:73) refers to strategic approaches to dealing with substance use disorder problems that involve aftercare interventions with society utilised as a means of enabling the population to deal with the problem. Community-led support groups are a strategic approach to aftercare that is used to minimise relapse and promote recovery. Millet and Cort (2013) posit that it is important to introduce an individual to the most appropriate level of the continuum. This implies that an individual can enter the continuum at any point to foster recovery and support. Several studies (Chetty, 2011; Millette & Cort, 2013; Van der Westhuizen, 2010) are in agreement with support groups as an aftercare intervention strategy, as attendance of support groups can assist members in their ability to maintain sobriety and prevent relapse. The NDMP (2013:49) advocates for the establishment of community-led support, as this is in line with the above-mentioned strategic approach of employing community-driven approaches to address substance use disorder at a communal level. Community-led support is an intervention that addresses problems and includes the support of members of a community without the presence of a professional. The reliance on support from a professional is reduced but raised from members of the community. What is not entirely understood is how community-led support groups aid in the prevention of relapse. Therefore, the focus of this study was on exploring how existing community-led support groups facilitate relapse prevention amongst young adults who have been struggling with the harmful use of substances.

1.2 PROBLEM FORMULATION AND MOTIVATION FOR THE STUDY

It is broadly acknowledged that substance use disorder can be conceptualised as a chronic relapsing brain disorder that requires a long-term recovery support intervention (Menon & Kandasamy, 2018:473) and young adults in recovery are at a high risk of

relapse while trying to remain drug-free (Melemis, 2015). Aftercare is an integral component in addressing risk factors to facilitate recovery. According to Van Der Westhuizen (2013), the goal of aftercare is to prevent relapse. The NDMP (2013:57) proposed community-led support groups as an aftercare intervention in addressing problems related to substance use disorder. This is in line with one of the eight key outcomes set out in the NDMP and relevant to the proposed study, namely "the ability of all people in South Africa to deal with problems related to substance use disorder within communities" (NDMP, 2013:35). Although several community-led support groups in Nelson Mandela Metropole identify with the above-mentioned key outcome, what is unclear is how community-led support facilitates relapse prevention. Tracy and Wallace (2016:145) identified in their review of articles that peer support groups are effective, as they demonstrated increased treatment retention and reduced relapse rate. What is unclear is how the support group facilitated the above-mentioned outcomes, and how this was achieved at communal grass roots level. The motivation for the study came as a result of my volunteering experience at a SUD support group. Despite the benefits it had for the members, there was an obstacle of transport in getting to the location of the support group meetings. This experience motivated me to conduct the study in seeing the benefits of community led support groups being facilitated within people's respective communities. I was not involved in any support during the period of the research study. It is worth noting that there is limited literature in the South African context describing how support groups facilitate relapse prevention in aftercare (Van Der Westhuizen et al., 2013). Shifting the focus to community-led support groups will offer the opportunity to explore practice-based evidence to understand what occurs, what works and what can be improved (Fisher, 2014). The present study aimed to address the gap in the literature by exploring the role of community-led support groups in facilitating relapse prevention and in the process respond to a recommendation in the NDMP (2013:131) that research is undertaken to explore how people in South Africa have been dealing with the problems related SUD through existing community-based interventions such as community led support groups, and further exploring the role it plays in reducing the harm related to substance use disorder in our country.

1.3 THEORETICAL FRAMEWORK UNDERPINNING THE STUDY

This section focuses on describing the theoretical framework that underpinned the study. A theoretical framework explains the path of a research paper and grounds it in a theoretical construct (Adom, Hussein, Agyem, 2018:438). A theoretical framework utilises existing theories as a foundation for building a theoretical construct or hypothesis that underpins a study and explains the phenomena thereof from a specific perspective (Adom et al., 2018:438). A theoretical framework makes the research findings more credible and acceptable to the theoretical constructs in the field and ensures that the findings can be generalised (Adom et al., 2018:438). The theoretical framework that underpinned this study was an integration of social support and social cognitive theory to explain how social support occurs in support group settings and the process thereof through the lens of social cognitive theory (SCT). The applicability of SCT is based on the theory’s assumption that we learn from one another through observation and this was evident in the modes of agency where collective agency translated into social support.

1.3.1 Social Support

Social support can be described as the experience of being cared for and loved by others in a mutually supportive social network (Taylor, 2011:192). A social network can be briefly described as social relationships that link an individual to other people and groups (Taylor, 2011:293). The social support theory proposes that characteristics of one's social network are beneficial for abstinence and substance use disorder recovery (Stevens, Jason, Ram & Light, 2015:1). Social support is crucial to young adults because there is a link between recovery and being part of a social network (Stevens et al., 2015:4). Yang, Xia, Han and Liang (2018:2) hypothesised that social support serves as a mediator between stress and life satisfaction. It was noted that the life satisfaction of people with SUD can be enhanced by reducing stress and the mechanism for reducing stress is by increasing their social support (Yang et al., 2018:4). The Canadian Institute of Health Information (2012:1) found that social support is a consistent protective factor for populations experiencing high levels of distress. This indicates a link between recovery and being part of a social support network and how having a high level of social support reduces the likelihood of using substances (Yang et al., 2018:2).

1.3.2 Social Network as a Concept Incorporated in Social Support

In the foregoing section, a social network was described as the social relationships that connect an individual with significant others. Song, Son and Lin (2011:9) posit that the network properties can be either objective or subjective and differ in strength, relational content and structural attributes. The latter refers to the size and characteristics of the network members that all have a role in conferring effective social support (Song et al., 2011:9). This includes attributes such as strength and relational content; structural attributes such as network size and compositional attributes such as network members' characteristics (Song et al., 2011:9). Subjective network properties include network norms (Song et al., 2011:9). Other concepts are derived from the network and empirically explain the dynamics of a social network. These concepts are social cohesion, social integration and the aforementioned social support (Song et al., 2011:9). Social cohesion is the degree of attraction of members to one another and the group as a whole, as indicated by trust and the norms of reciprocity (Forsyth, 2006:123). Social integration is the extent of participation in a social network guided by active engagement in social roles and social activities (Song et al., 2011:9). Social cohesion and social integration tie in with social support and depict characteristics evident in a social network and consequently also serve as cues indicating an effective social support network. Community-based social support interventions such as support groups offer important opportunities for peer-to-peer interaction to facilitate relapse prevention and enhance the health of individuals recovering from SUD (Fleury, Keller & Perez, 2009:1). Taylor (2011:192) posits that providing social support confers the same benefits as receiving social support. Melemis (2015:330) posits that joining a support group offers the benefits of learning what other people have done in recovery and what coping skills have been successful. Taylor (2011:192) explains that offering social support interventions may have the potential to provide emotional, informational and instrumental support to people who might otherwise lack social support.

1.3.3 Social Cognitive Theory

Social learning theory was the forerunner of social cognitive theory, which can be viewed as an expansion of the social learning theory (Nabavi, 2012). This latter theory hypothesises that we learn new patterns of behaviour either deliberately or

inadvertently from one another through observation of others and noting the consequences of their behaviours (Bandura, 1979:3). This resonates with the view that we learn from our interactions with others in social contexts, such as in support group settings (Nabavi, 2012:5). According to the theory, this is achieved through observational learning; specifically verbal modelling (Bandura, 1979:10). The social cognitive theory expanded on the social learning theory by including cognitive concepts in the processes of observational learning, which emphasises the social origins of cognitive processes.

The process of learning from how others have been able to cope and offer social support in a social network can be understood from the social cognitive theory (Bandura, 1989). The basic assumptions of this theory are that we learn new patterns of behaviour from one another through observation within our social environment and that thought processes (cognition) are central to understanding personality and behaviour (Nabavi, 2012:12; Bandura, 1989). The social cognitive theory further assumes that the capacity to exercise control over the nature and quality of one's life is the central aspect of humanness, mainly referred to as human agency (Bandura, 2001:1). Agency refers to deliberate actions (Bandura, 2001:6). Human agency foregrounds four core features that are instrumental in the learning process, namely intentionality, forethought, self-reactiveness and self-reflectiveness (Bandura, 2001).

Intentionality refers mainly to acts performed intentionally and future courses of action (Bandura, 2001:6). Forethought refers to planning, anticipating the likely consequences of prospective actions, identifying courses of action that will likely produce desirable outcomes and avoiding those that are detrimental (Luszczynskal & Schwazer, 2015:128; Bandura, 2001:7). With forethought, people can motivate themselves and guide their actions in anticipation of future events or acts (Luszczynskal & Schwazer, 2015:128; Bandura, 2001:7). Self-reactiveness refers to the ability to construct and shape an appropriate course of action and motivate and regulate the execution thereof (Bandura, 2001:8). Lastly, self-reflectiveness deals with self-examination and reflecting upon one's actions and behaviours (Bandura, 2001:10). People can evaluate their motivation, values and the meaning of their life pursuits to assess their soundness of thinking (Nabavi, 2012; Bandura, 2001:10). These four core features have significant roles in behaviour depiction on a cognitive

level and as such, function simultaneously in depicting desired outcomes within the social environment.

1.3.4 Modes of Agency and the Learning Process

Bandura (2001) highlights three modes of agency, namely individual, proxy and collective agency. The type that applied to this study was collective agency, as it draws on the value of social interdependence. Bandura (2001:13) argues that as people do not live in isolation, they give effect to their social interdependence by coordinating their efforts in a social group with others to secure what they cannot accomplish on their own. Collective agency can be described as working together as a collective to achieve what cannot be achieved alone (Bandura, 2001:13). People's shared belief in collective power to produce beneficial outcomes is a key feature of collective agency and group attainment is the product of not only the shared intentions, knowledge and skills of its members but also the interactive, co-ordinated and synergetic dynamics of their shared patterns of behaviour in a social group (Bandura, 2001:13). These support group members' shared intentions, knowledge and skills are operationalized through the exchange of emotional, informational and social support in support group meetings with the view to foster further recovery and prevent relapse (Sari, Wahyuni & Wibowo, 2018:65-66; CSAT, 2008:1). The concept of knowledge is evident in support groups through the sharing of information pertaining to experiences of recovery and the challenges encountered with preventing relapse. Members' skills are evident in their sharing of experiences and their application of strategies to prevent relapse.

Social learning occurs either deliberately or inadvertently by observing the behaviour of others, the consequences of behaviour being modelled through verbal means and being aware of the effects thereof on the social environment (Bandura, 1989:21). What is distinct about observational learning as opposed to learning by doing is that a single verbal model can transmit new ways of thinking and behaving simultaneously to numerous people within a social network (Bandura, 1989:22). As mentioned, we learn new behaviour patterns from one another through observation and this resonates with the view that we learn from our interactions with others in social contexts, such as in support group settings (Nabavi, 2012:5). Observational learning is governed by four sub-processes, namely the attention, retention, behaviour production and motivational processes (Bandura, 1989:23-24).

When applying the four sub-processes, we are more likely to attend to models to which we have an interpersonal attraction and that we find interesting. We then retain these preferred observations by storing them in our memory and reproduce the observed behaviours through our actions. The behaviours that we reproduce are largely influenced by three types of incentive motivators, namely direct, vicarious and self-produced (Bandura, 1989:24). In learning, we are more inclined to focus on things that we find beneficial to us and more likely to remember the actions that we observe and replicate. The motivation for us to replicate the learnt behaviour is either direct, indirect or self-produced. Abstract modelling facilitates learning new skills through observation (Bandura, 1989:25) and utilising those skills in future situations in which those skills are required. Components that influence learning and the expression of learnt behaviour include one's past experiences within the social environment and how one's social environment shaped one's views or perceptions (Bandura, 1989:26). One's environment and exposure perform a significant role in one's learning of new skills. Considering young adults struggling to resist triggers and cravings for substance use within their environment, they may gain valuable advice from their fellow members who are struggling with similar issues by sharing their testimonies and offering social support. Observing their self-efficacy may inspire hope and motivation in young adults who lack belief in their abilities to cope with such triggers and cravings. The opposite can be said in instances in which others may feel disheartened by their own "inability" to have the same level of self-efficacy that they observe and hear from others in the group. We learn within our social networks through observation of the benefits of providing social support to other young adults so that those young adults can, inter alia, provide the same support to others (Bandura, 1989:22; Taylor, 2011:192). The integration of social support and social cognitive theory is based on the understanding that mental and physical wellbeing is in part achieved through social support and social support is learnt through observational learning and modelling in social settings (Uchino, 2009; Bandura, 1989). Uchino (2009:377) found a link between social support and physiological health, arguing that social support appears to be related to more positive "biological profiles" across disease-relevant systems. The internal reward of gaining social support from members of the group results in motivating individuals to open up in the meetings and the rewards of sharing and conferring support include physical and mental health and emotional, informational and instrumental support (Taylor, 2011; Uchino, 2009; Bandura, 1989). The value of the collective agency

gained from these social networks is seen in increased life satisfaction and reduced stress (Song et al., 2011; Bandura, 1989). Support groups are a facet of the recovery-oriented, systems-of-care approach to substance recovery and the emotional, informational and instrumental support that is provided assists individuals to manage their substance use problem and achieve sustained health, wellness and recovery (Sari, Wahyuni & Wibowo, 2018:65-66; CSAT, 2008:1). To further understand the focus and direction of this research paper, one must have an understanding of the key terms that were utilised throughout the research paper.

1.4 DEFINITIONS OF KEY TERMS

Addiction - is conceptualised as a chronic brain relapsing disorder that requires a long-term recovery support intervention (Menon & Kandasamy, 2018:473).

Substance Use Disorder - is a cluster of cognitive, behavioural and physiological symptoms depicting that the individual continues using substances despite significant substance-related problems (American Psychiatric Association, 2013:483). This is the description that was inferred when this term was used in the preceding sections and explains the range of substance use disorder.

Support Group - Support groups are voluntary mutual aid groups whose members share a common problem and meet to exchange social support (Forsyth, 2014:483).

Community led support group- are mutual aid groups that offer support services within a community setting with the view of exchanging social support to each other to improve their recovery rate (Meiring, Visser & Themistocleous, 2017:308; Forsyth, 2014:483).

Continuum of Care - is a conceptual model involving the classification of various types of interventions that track clients' progress over time through a comprehensive integrated model with clear identification of the actions that are appropriate at each level of care (Springer & Phillips, 2013:3-4).

Risk Factors - are individual, interpersonal and environmental factors that increase the probability of using substances (Burkholder, Schensul & Pino, 2007:25).

Protective Factors - are factors that inhibit or reduce the probability of substance use despite the presence or absence of risk factors (Burkholder et al., 2007:25).

Aftercare - is ongoing, long-term support with no defined end to prevent relapse (Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008, 2008:8; Popovici, French & McKay, 2008:4).

Relapse - is a gradual process that leads to relapse and it is categorised by emotional, mental and physical relapse (Melemis, 2015:325).

Relapse Prevention Strategies - are intervention strategies employed to reduce the likelihood and/or severity of relapse after the cessation of substance use (Hendershot, Witkiewitz, George & Marlatt, 2011:1).

Young Adult - a person from the age of 18 to 35. This is in line with the National Youth Commission's Act (1996:7), which defines a youth as a person from 14 to 35 years of age. The study referred to young adults rather than youth.

Social Support - described as the experience of being cared for and loved by others as part of a mutually supportive social network (Taylor, 2011:192).

Social Cognitive Theory - is a theory that focuses on learning through observation and integral to this theory are the cognitive processes involved in learning observed behaviour (Nabavi, 2012:11).

Social Network - refers to social relationships that connect a person with other people and groups (Taylor, 2011:293).

The ensuing section presents a discussion of the research methodology.

1.5 RESEARCH QUESTION

How can community-led support groups facilitate relapse prevention in the aftercare of young adults with substance use disorder?

1.5.1 Research Aim

To develop an in-depth understanding of how community-led support groups can facilitate relapse prevention in the aftercare of young adults with substance use disorder.

1.5.2 Research sub-questions and objectives

Table 1.1: Research sub-questions and objectives

Research sub-questions	Research objectives
What are the needs of young adults with SUD who attend community-led support groups?	To explore and describe the needs of young adults who are active in community-led support groups.
How do community-led support groups respond to the needs of young adults with SUD?	To explore and describe how community-led support groups respond to the needs of young adults active in support groups.
What are the benefits that young adults with SUD derive from attending community-led support group meetings?	To determine what benefits community-led support groups offer to young adults in recovery.
How do community-led support groups assist young adults with SUD in dealing with cravings and triggers of relapse?	To explore and describe the role of community-led support groups in helping young adults to deal with the cravings and triggers of relapse.
What recommendations can be made on how the role of community-led support groups can be improved to facilitate relapse prevention?	To identify recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention.

1.6 RESEARCH METHODOLOGY

The study employed a qualitative research approach. The rationale for the use of a qualitative research methodology was to gain first-hand experience and a holistic understanding of the phenomenon under investigation (Delport, Fouche & Shrunik, 2007:74). The approach was rooted in the interpretive paradigm and its broad sense is referred to as "research that elicits participant accounts of meaning, experiences, stories or perceptions" (Delport et al., 2007:74). The qualitative research approach gave the participants a voice, which coheres with the aim of the study.

1.6.1 Research Paradigm

An interpretive paradigm was employed because it was best suited to the qualitative research approach and the exploratory, descriptive and contextual research design where the ideal outcome was to understand the meaning behind human behaviour, social relationships, interactions and society in the context of their social and physical environments (Pulla & Carter, 2018:9). I was interested in how young adults made sense of the world around them when fighting daily to avoid substance use and how they made sense of their engagement with like-minded individuals in a community-led support group (Pulla et al., 2018:10).

1.6.2 Research Design

The study employed an exploratory, descriptive and contextual research design. The rationale for this design was aligned to the aim of the study, which was exploratory and focused on enhancing our understanding of community-led support groups' role in facilitating relapse prevention. The inclusion of descriptive research was to further describe how community-led support groups function to facilitate relapse prevention. The utilisation of a contextual research design was to facilitate the generation of data through the members' understanding of the role of their support group in their context. The design focused on what they did, why they did it and learnt patterns of behaviour and talked about them within the context of social support during recovery from a substance use disorder (Wixon, Holtzblatt & Knox, 1990:332).

1.6.3 Sample

The population from which the sample was drawn included young adults with SUD who were members of various active community-led support groups. At the onset of the conceptualisation of the study, active community-led support groups meant support groups that convened face-to-face meetings. During the height of the national lockdown due to the COVID-19 pandemic, the support groups resorted to connecting on social media platforms to sustain the support offered to their members (Bergman, & Kelly, 2020:1-2). These community-led support groups had been active for longer than six months and were open to new members, some leaving and occasionally some returning (Center for Substance Abuse Treatment, 2005:21). Organisation-based support groups such as AA, the Nationwide Support Group, the St Marks Support

Group and Narcotics Anonymous were excluded from the population as they are non-profit organisations and not community-led. The qualitative study employed a non-probability, purposive sampling technique, as the research participants were required to meet specific sampling criteria to qualify for inclusion in the study. Purposive sampling was complemented by snowball sampling as the participants had contact with their fellow support group members whom they could refer to participate in the study. I proceeded with this process until data saturation was reached with a sample of nine participants.

1.6.4 Method of Data Collection

The primary tool that would have been used for data collection was focus group interviews, which involve a facilitator and several participants meeting to discuss a specific topic or issue of interest (Mack, 2005:56). Due to the COVID-19 pandemic and lockdown regulations, the proposed method of data collection was not feasible and an application was made to the REC-H committee to change the data collection tool from focus group interviews to online one-on-one semi-structured interviews. This offered a viable alternative where social distancing was practised and the spread of the virus was prevented. This change did not impact the quality of the data that was collected. The interviews were conducted via ordinary telephone calls, WhatsApp or Zoom depending on the platform the participants felt most comfortable utilising and to which they had access.

1.6.5 Gaining Entry into the Research Site

Permission to enter the research site was requested from the gatekeepers, primarily the Nelson Mandela Metropole community activist and longstanding rehabilitated user of substances, who took it upon himself to collate information about resources and the key stakeholders involved in support groups for substance use disorder. He established his support group and a social networking platform for sharing key resources for SUD recovery. Secondly, a request for permission to address the support group directly would have been distributed to the convenors of the identified support groups requesting 10 minutes at the end of a support group session to introduce the proposed study and explain all aspects of the proposal. To prevent pressure and coercion, I planned to leave my contact details so that individuals could decide for themselves whether or not to contact me if they wished to participate in the

research. Due to COVID-19 and the lockdown regulations, the method of recruitment was amended. The new recruitment method entailed requesting the gatekeeper to post the invitation to participate in the study (refer to the amended Appendices 1 and 2) on the support group's WhatsApp virtual support group platform.

1.6.6 Data Analysis

Data was analysed using thematic analysis guided by the research question. The rationale for the utilisation of thematic analysis stemmed from the premise that this method aimed to pinpoint, examine and record patterns or themes across the data that was collected and was useful for the description of the researched phenomena (Maguire & Delahunt, 2017:3355). Five themes were derived from the data analysis and these are described in detail in Chapter 4.

1.7 ETHICAL CONSIDERATIONS

Ethical issues in a research study should not be perceived as a once-off activity but an ongoing monitoring and evaluative component of the research process. Five key ethical principles were observed during the study and these are described briefly hereunder.

1.7.1 Justice

This principle was addressed through an inclusive criterion for sampling that was directly related to the problem that was studied. To avoid manipulation and exploitation, clear plans were highlighted to gain entry into the research site and these were implemented. Justice was guided by the 5 formulations that took into consideration each individual's equal share, individual needs, individual efforts and societal contributions and on merit (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). In further promoting justice, the findings and recommendations that emanated from the study sought to benefit the members involved in community-led support groups. The community-led support groups were given access to the final report. The participants were not compensated for participating to avoid undue influence.

1.7.2 Respect for Persons

The participants were respected in that they were supplied with all the relevant information and could choose whether or not to participate without coercion. To ensure that their judgement was considered, I disclosed in full all information related to the study so that they could make an informed decision (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). During data collection, I provided the research questions before the interview, which promoted the freedom to act on their judgement in terms of answers (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979).

1.7.3 Beneficence

Beneficence was achieved by listing all the benefits and risks that could accrue from the study and by putting harm reduction strategies in place to reduce the risks and maximise the benefits (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). These benefits included giving voice to the community members that were directly and indirectly involved, gaining insights and knowledge regarding the functions of other support groups and advancing recommendations that could be implemented to enhance their support groups. Other benefits included the sharing of their experiences and bringing about awareness of the milestones achieved. The risks the data collection could foreseeably cause were discomfort in finding a quiet place for the interview and transference of feelings. The latter would have been addressed through a debriefing after the interview by applying Kolbs Experiential Learning Cycle (Kolb, Boyatzis & Mainemelis, 1999:3).

1.7.4 Informed Consent

The study was explained in a way that the community in question could understand and the members were informed that they could withdraw from the study at any time without implications. A consent document detailing all the information relating to the inquiry was handed to each participant for their signature to confirm their voluntary participation in the study. Further consent was requested for audio recording.

1.7.5 Confidentiality, Privacy and Anonymity

A research participant's right to privacy should not be violated. As a researcher, it was important to establish an agreement with the participants, in this case, the support groups, about whether or not they were comfortable with the information being shared in various media and engaged the individual members on the technicalities related to the extent of the information to be published. Another strategy that was used to promote privacy was removing the participants' identifying details during data collection and the academic reporting phase. The data was to be stored for a maximum of 5 years for verification on a laptop and cloud and the interviews were erased from recording devices. I appealed to the participants to refrain from mentioning identifying details of themselves or others during the recording of the interview.

1.8 DATA VERIFICATION: ENSURING RIGOUR AND TRUSTWORTHINESS

Trustworthiness in a qualitative inquiry is necessary to support the argument that the inquiry's findings are "worth paying attention to" (Guba & Lincoln, 1981:290). In any qualitative research, four criteria of trustworthiness demand attention, namely credibility, transferability, dependability and confirmability.

1.8.1 Credibility

Credibility argues that there are multiple truths or realities to be explored and the strategies that were employed to ensure credibility were prolonged engagement in the research field (Anney, 2015:276); the adoption of well-established research methods (Shenton, 2004:64); the utilisation of peer debriefing; iterative questioning that involved asking probing questions and voluntary participation to ensure that the participants answered the questions truthfully.

1.8.2 Transferability

Transferability was ensured by a nominated sample that was achieved through purposive sampling to generate in-depth findings (Anney, 2015:278). Another strategy was providing thick, rich descriptions of the research processes, data collection and context of the study for the compilation of the final report (Anney, 2015:278).

1.8.3 Dependability

Strategies included an audit trail that focused on the examination of the inquiry process and product to validate that data was collected from the interviews, recorded and analysed (Anney, 2015:278), which entailed keeping the raw data that emanated from the interviews, reflective journals, consent forms and other descriptive documents; coding the same data twice with a gestation period between analyses; employing an independent coder and peer examination in conjunction with supervisors to discuss aspects of the research project.

1.8.4 Confirmability

Confirmability was addressed through the strategy of maintaining an audit trail as described in the preceding section. A reflexive journal was another strategy that entailed reflecting on field practice by highlighting the "aha" moments during interviews, reflecting on the implementation of the research process and lastly, personal reflections about the study (Anney, 2015:279). In compiling the reflective journal, the 7c's method was employed. Another strategy was prolonged engagement in the field.

1.9 OUTLINE OF THE RESEARCH REPORT

Chapter 1 - Overview and introduction to the study
Chapter 2 - Literature review
Chapter 3 - Research methodology
Chapter 4 - Discussion of the findings with literature control
Chapter 5 – Conclusions and recommendations

1.10 DISSEMINATION OF RESULTS

The findings of the study will be disseminated in the form of a formal research dissertation, presentation at a research conference and preparation of a manuscript for publication for the academic community. For the general public and support groups, dissemination will be in the form of a short research report prepared for the support groups from which participants were recruited, as well as an educational manual for support groups.

1.11 CHAPTER SUMMARY

This chapter served as an introduction and explained the context of the overall study, which was aimed at gaining an in-depth understanding of the role of community-led support groups in facilitating relapse prevention in the aftercare of young adults with a substance use disorder. Chapter 1 also focused on the theoretical framework and the key concepts of the study and briefly introduced the research methodology that was employed, with a detailed discussion of each aspect of the methodology reserved for Chapter 3. The chapter concluded with an outline of the research project and how the findings will be disseminated.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A literature review is more than a summary of articles; it is an exposition of existing knowledge and reasoning that leads to the analysis of current literature on the relevant topic to assist in identifying a researchable gap (Hart, 1998:1). A literature review can be viewed as a description of the literature relevant to the topic under investigation. According to Ramdhani, Ramdhani and Amin (2014:2), the purpose of the literature review is to provide an overview and appraisal of existing literature relevant to the topic by touching on aspects such as the key writers in the field of study, key conversations, looking for similarities and differences in the relevant literature, reporting and synthesising the findings of various authors with the view to justify the need for further research into support groups in facilitating relapse prevention in aftercare. The literature review explores themes of substance use disorder, risk and protective factors associated with SUD, the consequences of SUD, the continuum of care for the treatment of SUD, group work as treatment and aftercare methods and support groups as part of aftercare in alignment with the scope of the study.

2.2 CONCEPTUALISING SUD

Addiction also referred to as the severe form of substance use disorder, is a well-known concept within the field of substance use. Various authors (Menon & Kandasamy, 2018:473; APA, 2013:483; Bettinardi-Angress & Aggress, 2010:31) view SUD as a chronic brain relapsing disease. This view is based on the understanding of substances as mind-altering substances due to the chemicals having adverse neurological effects and changing the brain's circuitry and functioning (Satel & Lilienfeld, 2014:17; APA, 2013:483). It is further characterised by uncontrollable urges and the craving for substances and can include compulsively seeking the desired substance despite the known consequences (NIDA, 2018:3). SUD has several effects on the brain's circuits that include reward and motivation, learning and memory and inhibitory control over behaviour, hence being referred to as a chronic brain relapse disease (NIDA, 2018:3). Substance use disorder does not occur overnight; it is a process that occurs in stages (Sussman & Sussman, 2011:4026). This is influenced

by several factors such as the duration, quantity and frequency of the use of substances, as well as the type of substances and the prevalence of addictive behaviour. The long-term use of substances results in changes in the brain that persist long after cessation (NIDA, 2018: 8). These substance-induced changes give rise to several behavioural, interpersonal and other consequences that are discussed in this chapter. The high incidence of SUD across continents warranted the development of several key policies to guide the treatment of SUD.

2.3 CURRENT SUD INCIDENCE

The West Africa Commission on Drugs reported that the highest prevalence of cannabis use in the world is in West and Central Africa and this remains the most popular illicit substances in the world (Obot, 2013). The current pattern of substance use in West Africa is evident with cannabis being the most prevalently used substance, followed by the low but increasing use of methamphetamine and heroin (Obot, 2013). Looking at the treatment of SUD in Africa, what has been reported in surveys is that the services currently offered in African countries include purely western orthodox medicine (in psychiatric hospitals); syncretic approaches; purely religious and traditional healing methods and self-help groups such as Narcotics Anonymous using the Minnesota 12-step model (Obot, 2013). Countries in West Africa respond to substance use disorder mainly with underdeveloped policies that entail the use of law enforcement, while other aforementioned methods have not been given particular attention. This implies that West Africa is the least developed region in the prevention and treatment of substance use (Obot, 2013). In South Africa, the NDMP of 2013-2017 addressed this aspect by incorporating other forms of intervention such as treatment centres for substance use disorders and aftercare services, as endorsed by the Prevention of and Treatment for Substance Abuse Act 70 of 2008, which incorporates community-based interventions such as support groups in dealing with the problem at the grassroots level (NDMP, 2013:31).

In 2012, the World Health Organisation reported that 15% of South Africa's population had an SUD problem, giving it a reputation as one of the drug capitals of the world (Ettang, 2017:157). No country-wide surveys have been conducted in South Africa since 2012, however, it can be inferred that there has been an increase since then. SACENDU reported a slight increase in the number of admissions to specialist

treatment centres country-wide from 8486 to 9268 persons since Phase 45 of the reporting on substance use and treatment in South Africa (Dada et al., 2020:2), which can indicate that the substance use disorder problem in South Africa is on the rise. Cannabis was reported to be the most commonly utilised partially illicit drug reported by young adults who attended specialist treatment centres (Dada et al., 2020:2). 33% of the 9268 reported cannabis as their primary substance in the Eastern Cape (Dada et al., 2020:2). 39% of patients who were in specialist treatment in the Western Cape reported methamphetamine (MA) as their primary substance, while in other regions such as the Eastern Cape (EC), 35% of patients reported MA as their primary or secondary substance of use (Dada et al., 2020:2). The most commonly reported substance of secondary use amongst young adults in the Eastern Cape was cannabis at 51%, followed by cannabis/mandrax at 15% (Dada et al., 2020:39). These statistics indicate the prevalent substances that contribute to the ever-rising problem in the EC. SACENDU also reported a slight increase in re-admissions in 2019; 19% as opposed to 17% in 2018. One may then ask what contributing factors led to the increase in re-admissions and one would also wonder if not attending support group meetings had an impact on the slight increase or an increase of exposure to risk factors (Dada et al., 2020:34). The rationale for this focus on statistics was to indicate the importance of focusing on young adults to reduce relapse and focusing on children as a primary prevention method. The aforementioned statistics were mostly related to the EC. A total of 475 people were treated from January to June 2019 (Dada et al., 2020:34). Of the total, youths younger than 20 comprised 25% of the population and the remainder were adults. While the adults included those older than 35, these numbers indicate that the prognosis for recovery from substance use disorder is low beyond the youth stage. The rate of re-admission that was highlighted earlier reinforces this stance. Of the 475, 240 were young adults within the age range of 20 to 34, accounting for approximately 42% of the total population (Dada et al., 2020:35). From the statistics mentioned, it is important to reiterate that the focus was on young adults and that in the subsequent sections the focus was on the risk and protective factors against relapse for young adults.

2.4 NATIONAL POLICIES AND LEGISLATION IN SOUTH AFRICA

In South Africa, substance use disorder is regarded as a national problem that requires attention and this problem is addressed through the establishment of the Prevention of and Treatment for Substance Abuse Act 70 of 2008. The purpose of the act as it relates to the study is:

- to provide for a comprehensive national response for the combating of substance use disorder and to provide for mechanisms aimed at demand and harm reduction in relation to substance use disorder through the prevention, early intervention, treatment and reintegration programmes.

To achieve the first point of the purpose as stated, The Prevention of and Treatment for Substance Abuse Act of 2008 makes provision for the treatment of SUD. The implementation of the interventions referred to in the act is operationalized through a policy that was devised by the Department of Social Development known as the National Drug Master Plan (2013-2017). The admission of an individual to a treatment centre should be in accordance with Section 18, which states that "A service user is admitted to a public treatment centre for the purposes of receiving or undergoing treatment and rehabilitation, including skills development" (Prevention of and Treatment for Substance Abuse Act, 2008:27). The Prevention of and Treatment for Substance Abuse Act (2008:27) further states that the voluntary admission of a substance user to a treatment centre should be in accordance with subsection (1) and (2), which states that -

- The service user must access the centre voluntarily
- Any person acting on behalf of the voluntary service user may request the admission
- The person that submits himself or herself voluntarily to a treatment centre for treatment, skills development and rehabilitation is entitled to appropriate treatment, rehabilitation and skills development services.

The service user receives treatment and at some point, as stated by Millet and Cort (2013), is required to move out of a particular intervention and on to the next. This is when the individual accesses outpatient aftercare services. In reference to the second

purpose stated in the Act, which was of particular relevance to this study, are reintegration programmes for treatment and the specific guidelines are highlighted under Chapter 7 on aftercare and re-integration services and Section 30(1) & (2) prescribe the availability of integrated aftercare and reintegration services that work towards successful reintegration of a young adult into their respective society, employment, family and community (Prevention of and Treatment for Substance Abuse Act, 2008:38). Section 30(2) outlines that the services contemplated in subsection 1 should:

1. allow opportunity for service users to interact with one another, their families and communities
2. allow for the opportunity for recovering service users to share and deliberate about their long term sobriety experiences
3. encourage group unity amongst service users;
4. allow service users to maintain sobriety from substance use disorder
5. must focus on the successful reintegration of a service user into society and family and community life and
6. prevent the recurrence of problems in the family environment of the service user that may contribute to substance use disorder.

These elements, as prescribed in the Act, describe a service that includes the meeting of service users in a defined group setting. The service recommended in the Act is a support group. Section 31 (1) states that service users and persons affected by substance use disorder may, as needed establish support groups that focus on integrated, ongoing support to service users in their recovery (Prevention of and Treatment for Substance Abuse Act, 2008:38). Section 31 (2) outlines the purpose of the support group as contemplated under subsection 31 to:

- provide a safe and substance-free group experience where service users can practice re-socialisation skills;
- facilitate access for service users to persons in recovery or that have recovered from substance use disorder who can serve as role models to service users who are in the beginning or middle stages of the recovery process and

- encourage service users to broaden their support system beyond the persons contemplated in paragraph (b).

The current study sought to explore how community-led support groups facilitate relapse prevention. Section 31(3) explains that support groups may be established at the community level by a professional, non-governmental organisation or a group of service users or persons affected by substance use disorder (Prevention of and Treatment for Substance Abuse Act, 2008:38). This study focused on support groups established by service users or persons affected by substance use thus making these community-led support groups (Prevention of and Treatment for Substance Abuse Act, 2008:38). The NDMP (2013-2017:2) realised that the use of substances has an impact on the individual, family, community and society at large. Based on this view and the continued increase in the abuse of substances, strategies for combating substance use had to be developed and were realised through the policy outcomes. The most applicable to the intervention and this study was the ability of all people in South Africa to deal with problems related to substance use disorder within communities (NDMP, 2017:4). The policy further states that it was formulated by the Central Drug Authority in terms of the aforementioned Act and amended to meet the needs of international bodies and South African communities (NDMP, 2013-2017:4).

The Prevention of and Treatment for Substance Abuse Act of 2008 further mandates the establishment of a Local Drug Action Committee (LDAC) that consists of interested persons and stakeholders who are directly involved in organisations that address the problem of substance use disorder in the Nelson Mandela Metropole Municipality (Prevention of and Treatment for Substance Abuse Act, 2008:59). The function of the committee is to ensure that effect is given to the National Drug Master Plan in the relevant municipality and compile an action plan to combat substance use disorder in the relevant municipality in cooperation with provincial and local governments (Prevention of and Treatment for Substance Abuse Act, 2008:59). Based on these two functions that refer to the establishment of an action plan that is aligned with the NDMP, the action plan formulated by the LDAC facilitates the emergence of support groups as community-based interventions that strive to fulfil one of the key outcomes of the National Drug Master Plan. It is important to note that the LDAC in the Nelson Mandela Metro was inactive during the time of this study.

The illegality of substances in South Africa was made possible through the Drugs and Drug Trafficking Act of 1992, which could be viewed as a catalyst for the establishment of the above-mentioned Act and policy as a treatment approach to the ever-rising substance problem in South Africa. The rationale of the Act is to prohibit the use or possession of or the dealing in substances and of certain behaviours related to the manufacture or supply of certain illegal substances or the attainment or alteration of the profits of other crimes; for the obligation to report certain information to the police (Drugs and Drug Trafficking Act, 1992:1). The rationale for including this policy was to highlight why substances are deemed illicit in South Africa, foregrounding the root and catalyst for the establishment of the above-mentioned Act and policy as a treatment approach to the ever-rising substance problem and also to explain why it is deemed to be a criminal activity to deal or be in possession of such.

The use and possession of substances were made illegal through the enforcement of Sections 4 and 5 of the Drugs and Drug Trafficking Act of 1992, which state that:

1. no individual shall use, concur dealings or have in his possession (a) any addictive substance or
2. any dangerous addictive substance or any undesirable addictive substance,

unless the substance in its purest form is registered and the person is a patient who has acquired or bought any such substance and uses these under the instruction of a medical practitioner *(*Drugs and Drug Trafficking Act, 1992:9-11). Despite legislation implementing provisions, numerous individuals do not comply with these rules. Individuals sell and use substances that harm their lives to a point at which a different intervention approach is required. The non-adherence to the Act by young adults brought about various physiological and psychosocial impacts on their substance use disorder.

2.5 PHYSIOLOGICAL AND PSYCHOSOCIAL IMPACT OF SUBSTANCE USE DISORDER

Engaging in substance use at any point leaves a trail of psychosocial consequences in and around the user. These consequences are so profound that they at times require problem-specific interventions. It is important to explore these impacts on the individual and surrounding environment.

2.5.1 Physiological Impact

The physical effects of SUD vary according to the type of substance the individual consumes because their chemical compositions have several side effects on the body (Schulte & Hser, 2014:2). As mentioned, the most widely used substance in the EC is cannabis and its effects include respiratory tract cancers and chronic bronchitis (Dada et al., 2020:2; Shazzad, Abdal, Majumder, Sohel, Ali & Ahmed, 2013:87). There are however common and similar bodily or physiological effects that are caused by continued substance use and these include breathing problems, stomach pains, vomiting, constipation, diarrhea, kidney and liver damage, seizures, strokes, brain damage, changes in appetite, constant changes in body temperature and inconsistent sleeping patterns (Jabeen et al., 2018:3). With a high consumption of substances, a person's body enters a point of physical dependence that is described as the physical tolerance of the body, when large amounts of substances are needed to achieve the desired euphoric effect (Shazzad, Islam, Ahmed, Fatema, Azad, Salimula, Haider & Haq, 2013:84). The by-product of this physical tolerance is withdrawal symptoms that a person experiences during abstinence or cessation of consumption (Shazzad et al., 2013:84). These withdrawal symptoms occur with abrupt cessation of substance use and common symptoms experienced during this period are restlessness, insomnia, nausea and body aches and other symptoms that are substance specific (Singh & Gupta, 2017:187). To correlate the prevalence of the physical effects of substances, a study was conducted among people in the Pulwama District of Jammu and Kashmir State where 400 participants were sampled. Based on the findings, 47.5% of the 400 respondents claimed that they became addicted to substances between 20 and 30 years of age and 14.5% of the 200 respondents experienced the physical consequences of substance use disorder as loss of health in the form of liver disorders, gastritis, accidental injuries and an increased risk for HIV infections due to intravenous drug use and involvement in risky behaviour in social contexts, such as sharing

needles with other drug users, known A intravenous drug use (Tracy & Wallace, 2016:150; Sidiq et al., 2016:32). The above-mentioned health consequences were also evident in Schulte and Hser's (2004:9) study that focused on evaluating the impact of substance use on health conditions throughout an individual's life span. A study that focused on the health consequences of alcohol and SUD generated similar findings (Henning, 2012:219-220).

Another factor that contributes to the effects of SUD on the individual are the barriers to accessing medical care, as was reported in a quantitative study that focused on perceived access and barriers to care among illicit drug users and hazardous drinkers (Matsuzaki, Vu, Gwadz, Delaney, Kuo, Trejo, Cunningham, Christopolus & Cunningham, 2018:1). These barriers include the costs involved with accessing quality medical services, difficulty accessing medical services, transport to healthcare facilities, especially if residing in remote areas and inadequate social support (Matsuzaki et al., 2018:5-6). Another factor that was reported was that users are sometimes treated poorly by healthcare practitioners (Matsuzaki et al., 2018:5). The use of illicit substances also adversely affects fertility and reproduction. To support this view, a study was conducted that found that women who smoked had fewer children than those that had ceased smoking or had never smoked (Oboni, Marques-Vida, Basterdot, Vollenweider & Waeber, 2016:1). For men, the findings were similar to those relevant to women (Oboni et al., 2016:1).

2.5.2 Psychological Impact

Jabeen et al. (2018:3) posit that the psychological effects of Substance use disorder stem from the premise that the user becomes addicted to drugs through frequent, excessive consumption that changes the brain. This claim is supported by Bettinardi-Angres and Angres (2010:31) who posit that psychosocial factors influence the development and manifestation of the psychological effects of substance use disorder. These changes occur due to changes in brain chemistry when the stimulation of the pleasure pathway in the neurological system and the psychological rewards reinforce the need for further drug use (Bettinardi-Angres & Angres, 2010:31-33; Shazzad et al., 2013: 84). This part of the brain is affected in a way that the reward pathway shifts its sensitivity to the substance, meaning that the brain begins to depend on outside chemicals for reward (Bettinardi-Angres & Angres, 2010:33). This dependency results

in subjective feelings where the user needs the drug to maintain a feeling of wellbeing thus causing psychological dependence (Shazzad et al., 2013:84). This manifests in the form of addictive behaviours related to pleasure seeking characterised by subjective experiences of the self (Sussman & Sussman, 2011:427). These subjective experiences relevant to young adults include feeling different; described as feeling uncomfortable, lonely, restless or incomplete (Sussman & Sussman, 2011:427). Another psychological consequence of SUD is the constant craving for the drug of choice. The psychological effect of this craving is that it fuels the person's belief that he or she cannot function or handle life without using substances (Jabeen et al., 2018:3). This belief can be linked to the emotional maturity of young adults and the general need for affirmation regarding their self-efficacy (Stanojlović & Cambra, 2017:182). The more advanced the emotional maturity, the higher the probability of having high self-efficacy that can in turn influence the outcomes of the psychological effects of cravings (Stanojlović & Cambra, 2017:182).

Another direct consequence of substance use is the prevalence of mood disorders such as depression, anxiety and bipolar disorder (American Psychiatric Association, 2013:486). The DSM-V specifies these as substance-induced, mood-related disorders with visible psychological criteria as symptoms (American Psychiatric Association, 2013:486). Another defining element relevant to the consequence of substance use disorder is loss of control. Sussman and Sussman (2011:4029) describe this consequence as difficulty in refraining from the addictive behaviour while consciously attempting to do so with little to no success, resulting in the addictive behaviour becoming increasingly more automatic.

2.5.3 Social Impact

There is a clear relationship between substance use disorder and crime in South Africa (Nyabadza & Coetzee, 2017:1). In the Western Cape, South Africa, the Department of Community Safety reported that more than a third (35%) of the crimes committed in the Western Cape were due to substance use disorder (Nyabadza & Coetzee, 2017:1). Jules-Macquet (2015:3) posits that substance abusers often engage in criminal activities to attain drugs. These criminal acts increase during the active addiction phase (Julies-Macquet, 2015:3). These criminal acts are drug-related offences connected to the use of drugs and include violent behaviour resulting from

the effects of drugs, theft, burglary, robbery and illegal drug dealing as defined by the law in South Africa (Cheteni, Mah & Yohane, 2018:7). Rhode, Lewinsohn, Seeley, Klein, Andrews and Small (2007:9) found that impaired academic and occupational functioning, specifically limited education, were consequences of substance use, of which resulted in a direct association with unemployment, particularly in adulthood. Limited education often results from school dropout during adolescence (Rhode et al., 2007:8). Spooner and Hetherington (2004:122-140) expressed similar views by highlighting that drug use and the effects on the individual's wider socio-economic status, specifically factors such as low education and occupational factors, result in unemployment or low-salaried occupations.

A literature review study that focused on IPV (Intimate Partner Violence) and drinking patterns found that male partners in various types of couple relationships commit acts of violence with the prevalence of male to female violence at 24% and female to male at 37%, which is an indication that violence is prevalent among substance users (Cox Jnr., Ketner & Blow, 2013:164). Taking a relationship to the next level implies marriage for young adults. Cox Jnr. et al. (2013:162) investigated how marriage affects substance use and found that marriage is a protective factor, as married couples reported lower alcohol and substance consumption combined with taking on more adult roles, although it is important to acknowledge that for some, substance use continues into adulthood (Cox Jnr. et al., 2013:162).

2.6 RISK AND PROTECTIVE FACTORS ASSOCIATED WITH SUD

Risk factors are categorised into three levels that place the individual at risk of use, recurrent use and relapse of SUD. The risk factors evident at all three levels include (a) risk of engagement, (b) constant recurrent engagement in substance use and (c) recurrent use after relapse whilst having engaged in intervention services that otherwise function to prevent relapse. The structure of the subsequent section includes categorising these risk factors as intrapersonal, interpersonal and environmental (Swanepoel et al., 2016). High-risk situations, events or circumstances can be defined as an individual's attempt to refrain from a particular behaviour when threatened that is directly influenced by the risk factor and these risk factors usually occur without warning (Menon & Kandasamy, 2018:474). The determinants of high-risk situations for individuals are through an analysis of previous lapses and by reports

of situations in which the client feels or felt “tempted and at risk” (Menon & Kandasamy, 2018:474). The risk factors that were identified rarely function in isolation and are usually interrelated. For example, one risk factor functions as a predisposing cue for the manifestation of another risk factor that places an individual at increased risk of relapse. Protective factors are characteristics within and around the individual that are associated with the reduced probability of drug use or transition in level of involvement in drug use (Frisher et al., 2007:3). These protective factors assist in improving the recovery potential of individuals and are instrumental in recovery when and where risk factors are prevalent.

2.6.1 Intrapersonal Risk and Protective Factors

Intrapersonal risk factors can be viewed as endogenous rather than exogenous with regard to the individual; the focus is on individual characteristics such as low self-efficacy, a negative emotional state and low motivation to name a few internal and cognitive processes (Rhodes et al., 2003:307). Three separate studies that were conducted (Menon & Kandasamy, 2018:474; Azmi, Hussin, Ishak & Fhiri, 2018:1; Razali, 2017:311) highlighted a common risk factor within individuals that contributes to use, recurrent use and relapse, namely self-efficacy. These three studies aimed to identify and examine the risk factors associated with drug use (Menon & Kandasamy, 2018:474; Azmi et al., 2018:1; Razali. 2017:311) and found that individuals with low self-efficacy were more inclined to relapse than those with high self-efficacy who had a high recovery potential and maintenance of sobriety over a longer period (Azmi et al., 2018: 3; Razali, 2017:311). Rahman, Rahaman, Hamadani, Mustafa and Shariful Islam (2016:3) conducted a study aimed at identifying the psychological and social factors associated with the relapse of substance use disorder among adult Bangladeshi men between 18 and 41 years of age and found that intrapersonal determinants serve as contributing factors for relapse. The respondents highlighted low self-efficacy, negative emotional state and lack of assertiveness as specific triggers (Rahman et al., 2016:3). This group contained mainly young adults, thus indicating the relevance of the focus on young adults in this study. A qualitative research study that was undertaken by Marangoni and Oliveira (2013:662) aimed to identify and discuss the triggers for harmful use of substances in women from three municipalities in the state of Paraná. The study produced similar findings within the

intrapersonal paradigm in that the factors that stood out were interpersonal bonds and negative emotional states (Marangoni & Oliveira, 2013:662).

Other concurrent factors that were evident and deemed risk factors included lack of motivation, especially in individuals recovering from SUD and lack of assertiveness in recovery (Menon & Kandasamy, 2018:475; Rahman et al., 2016:3). A quantitative study of a sample of recovering individuals for more than 6 months from the Northern, Southern, Central, and Eastern Zones found that the absence of coping skills was one of the main risk factors for relapse post-intervention (Razali, 2017:313). This risk factor was discussed in an article written by Menon & Kandasamy (2018:475), who explained that a failure to implement learnt coping strategies contributed to a high risk of relapse. Hunter-Reel, Crady and Hildebrandt (2009:5) mentioned in their study that craving is a risk factor that may be cue-driven, where the social network provides triggers for relapse either through engagement in substance use or the individual people with whom the individual previously used with in the past.

In South Africa, a study was conducted by Chetty (2011) that focused on the causes of relapse post-treatment for substance dependency within the South African Police Services (SAPS), specifically police officers. The sample included participants aged from 18 to 60 and 40.9% accounted for young adults between 18 and 35 (Chetty, 2011). The study employed a quantitative research approach utilising a self-administered questionnaire. The findings of the study identified the main causes for relapse as intrapersonal risk factors that included negative emotional states such as anger, frustration and anxiety (Chetty, 2011:53). The South African study's findings were consistent with the findings generated by Rahman et al. (2016:3), indicating a correlation and confirmation of these intrapersonal risk factors identified in Chetty's (2011) study as relapse determinants post-intervention within individuals. This transcends geographic and ethnic barriers, implying that the identified intrapersonal risk factors are universal. A quantitative research study that was conducted by Swanepoel (2016) explored risk factors for relapse among young black African male adults following in-patient treatment for substance use disorder in the Gauteng Province. The findings of the study were consistent with the findings from Razali (2017:313) and the consistent risk factors were identified as lack of motivation, lack of effective coping mechanisms and negative emotional states, which were also relevant

in the South African context (Swanepoel, 2016:426).One of the prominent risk factors associated with a high relapse rate was the stress experienced due to personal problems (Van Der Westhuizen, 2007:28). This stress may be due to a combination of factors external to the individual and over which they have no control (Mahlangu & Geyer, 2018:332; Swanepoel, 2016:426). Other identified intrapersonal risk factors that predisposed the individuals to relapse included reflection on the euphoric state induced by drug use, dealing with emotions by using drugs, loneliness and isolation, lack of self-efficacy, being easily influenced by others, craving drugs and/or alcohol and not attending aftercare support groups (Swanepoel, Geyer & Crafford, 2016:427).

Burkholder et al. (2007:32) identified other protective factors that are closely related to individual level protective factors and these include being employed, higher school grades and no history of school dropout or expulsion. Other protective factors included increased pressure to avoid substance use, higher perceived risk associated with risky behaviours and high religiosity (Burkholder et al., 2007:32). Similar factors were identified by Kazdouh, El-Ammari, Bouftini, El-Fakir and El Achhab (2018:4) in a study that utilised focus group discussions amongst adolescents, parents and teachers in Morocco. Their study revealed that the perceptions of the harmful effects of substances and belief therein served as protective factors. The above-mentioned factors were characterised by the authors as intrapersonal protective factors (Kazadouh et al., 2018:4; Burkholder et al., 2007:31). Referencing the protective factor of being employed identified by Burkholder et al. (2007), a peer review study by Walton and Hall (2016) found that employment served as a relapse prevention measure and further impacted treatment outcomes for those in recovery. A narrative inquiry that was conducted in Zimbabwe with 3 participants found that occupation served as a protective factor in relapse prevention, as it provided the participants with an opportunity for productivity, self-development and positive change in identity (Nhunzvi, Galvaan & Peters, 2019:19). These two studies indicate that employment and occupation are beneficial for recovery.

2.6.2 Interpersonal Risk and Protective Factors

Family dynamics and structure as risk factors for relapse have been prevalent in studies' findings over the years (Groenewald, 2018; Azmi et al., 2018; Marangoni & Oliveira, 2013; Rhodes et al., 2003). This implies that even over time this risk factor

has a significant role in increasing the probability for relapse in individuals recovering from SUD. Rhodes et al. (2003:313) identified family structure and quality of family relationships as risk factors, specifically, elements related but not limited to unsupportive aspects of the family such as conflict within the family system and lack of trust. A South African study identified lack of trust exhibited by family members as a risk factor for relapse amongst individuals because family members are naturally seen as enablers and a support structure for the individual and if the same family members lack trust in the individual, this may pose a risk (Zwane, 2019:49). Marangoni & Oliveira (2013:662) identified family conflict and inadequate family dynamics as interpersonal risk factors. Azmi et al. (2018:2) reviewed studies that focused on psychosocial factors that contribute to relapse and found that inadequate family support and family conflict were risk factors for relapse for individuals recovering from SUD (Azmi et al., 2018:4). The aforementioned studies that were conducted within ten years consistently identified family dynamics as risk factors for relapse.

Other interpersonal factors within the family system included drug dealing and drug use by spouses and relatives (Marangoni & Oliveira, 2013:662). In a study conducted by Rhodes et al. (2003:313-314), parental drug use was identified as a risk factor, as parents sometimes engage in substance use and this was intensified if the health and status of the relationship with the child who was engaging in substance use were strained. In South Africa, similar findings were generated in that substance use by parents and siblings was identified as a precipitating risk factor for relapse (Van Der Westhuizen, 2007:81). A study that was conducted in Port Elizabeth in the Eastern Cape also found that adolescents who are taken care of by parents who use substances were at risk of modelling the parents' behaviour (Felkers, 2019:63). A South African study that explored the relationship between a user and sibling non-user found that the siblings experienced a breakdown in their relationship, specifically about trust with the non-user feeling betrayed by the user sibling (Schultz & Alpaslan, 2016:100-102). This study delved deep into the dynamics between siblings and how these dynamics can become risk factors for the non-user. Schultz and Aplaslan's (2016) findings were cited in Felkers' (2019:68) study that explored the role of the parent in the aftercare of their adolescent children who participated in a treatment programme for substance use disorder and found that lack of parental supervision, lack of affection and parental neglect were also identified as risk factors (Kazdouh et

al., 2018:7). Mahlangu & Geyer (2018) and Mhangwa (2016) reported similar findings with regard to family dynamics in their respective studies that were conducted in South Africa. A significant factor that was highlighted in both studies was the lack of support following treatment due to the harm that was inflicted on significant others and the trail of destruction in family systems as a result of substance use disorder and these served as predisposing factors for relapse among young adults (Mahlangu & Geyer, 2018:333; Swanepoel et al., 2016:425). These trails of destruction were a result of individuals' past behaviours that included but were not limited to pilfering (Groenewald, 2018:6). This resulted in a lack of trust from the family, as the families were still distraught from the experience and this served as a risk factor for relapse in individuals with SUD (Groenewald, 2018:6). Similar findings to the aforementioned were found for a group of youths under the age of 18 in a study that was conducted in Port Elizabeth (Felkers, 2019:70).

The family component has been identified as a major protective factor, especially in well-functioning and supportive family systems (Burkholder et al., 2007:31). In deeming family as a protective factor, Kazadouh et al. (2018:8) postulated that specific dynamics needed to be in place, namely parental control with mutual trust, parental advice and family beliefs against risky behaviour. Being in a nuclear family served as a protective factor for future substance use (Ewing, Osilla, Pederson, Hunter, Milles & D'Amico, 2015:1). An exploratory study that evaluated the effects of potential risk and protective factors associated with family management relating to adolescent substance use in South Africa found that parental monitoring served as a protective factor, particularly in instances of an increase in parental knowledge and monitoring (Muchiri & dos Santos, 2018:7). Other protective factors that were identified within the same study included discipline and behavioural control through decision making by parents, setting of rules and limits, monitoring, defining behavioural control and emotional and interpersonal sharing, all of which served to protect and support adolescents' growth (Muchiri & dos Santos, 2018:7). While on the topic of parental supervision, a study in South Africa, specifically in Port Elizabeth that explored parents' experiences of monitoring their adolescents' compliance with diversion orders, identified specific monitoring methods that parents employed when their adolescents were diverted to alternative services by NICRO. These methods included asking the adolescent questions, phoning to check up on their whereabouts,

communicating with them, transporting them to their activities, limiting the time spent with their friends, setting boundaries of having the adolescents inform parents of their whereabouts, soliciting information from them about their activities and constant supervision (Abdulla & Goliath, 2015: 212). Both studies found that parental monitoring was a viable solution to ensure adherence to interventions and identified the monitoring of adolescents by parents as a protective factor (Muchiri & dos Santos, 2018:7; Abdulla & Goliath, 2015:212). Although the family has been explored extensively, another noted interpersonal factor relates to peers and how they are characterised as a risk factor.

Social isolation has been identified and associated with risk for relapse due to the rationale that isolation may generate feelings of loneliness and boredom that influence substance use outcomes (Tate, Brown, Unrod & Ramo, 2004:1719). A more recent study identified social isolation as being associated with a high risk of relapse (Leach & Kranzler, 2013:4). Peer influence was identified as another risk factor that significantly contributes to drug use and relapse amongst young adults (Frisher, Crome, Macleod, Bloor & Hickman, 2007:11). A literature review aimed at appraising the evidence relevant to risk, protection and resilience from studies on illicit drug use among young people found that associating with old friends who use illicit drugs, being friends with drug dealers and being offered drugs by these friends are risk factors for relapse (Frisher et al., 2007:11). It was also found that peer pressure from the old friends who still use and deal drugs was deemed a risk factor and had a high association with relapse (Azmi et al., 2018:3). Peer pressure is prevalent mainly in social events and this aspect functions as a cue for the manifestation of craving through peer and social networks (Hunter-Reel et al., 2009:5). Peer influence has to do with behaviour problems such as friends inviting the individual as a way of influencing the individual into using substances again (Azmi et al., 2018 3). Friends have a significant influence because the individuals spend more time with friends with substance use disorder as opposed to those in the protective family system and this is because friends are part of the social environment that can influence behaviour. Friends can be a source of rationalisation for deviant behaviours that are deemed socially acceptable within the group (Razali, 2017:314).

In the South African context, findings from Swanepoel et al. (2016:424) reveal that 66% of males recovering from SUD mentioned going back to the same friends or negative social group that still uses drugs and this is a risk factor. What makes it complex is that the same social group acts as a catalyst for peer pressure, as 71% of males reported peer pressure, wanting to blend in and wanting a sense of belonging as predisposing factors for relapse (Swanepoel et al., 2016:424). The absence of involvement with negative peer groups was deemed a protective factor. To support this statement on an international level, Burkholder et al. (2007:32) highlighted in their study no gang membership. This can be expanded by mentioning that having friends who are non-users and being close to them serves as a protective factor (Kazadouh et al., 2018:8). Similar correlating findings regarding peer influence were noted in South Africa from a qualitative research study that was conducted in Port Elizabeth that explored peer risk and protective factors in adolescents; both users and non-users (Burkholder et al., 2007). The rationale for citing this article was to compare and validate protective factors across the spectrum of substance use disorder. It was noted that participants who were non-drug users identified that associating with other non-drug users served as a protective factor against being influenced to use drugs and as was users detaching themselves from negative influences by connecting with prosocial outlets (Goliath & Pretorius, 2016:121-122).

Support group attendance has also been identified as a protective factor that is instrumental in recovery. A study that was conducted in Canada that focused on examining the results on post-treatment 12-step and other mutual help group attendance following inpatient substance use disorder treatment. (McPherson, Collins, Boyne, Kirkaldy & Waseem, 2017:5). The focus of the sub question wad exploring if there was any correlation effect between the frequency of 12-step and other mutual self-help group attendance and abstinence at six months post-inpatient addiction treatment (McPherson et al., 2017:1). The findings indicated that participants who attended 1-2 sessions a week reported a 66.7% abstinence rate and those who attended 3-5 times a week reported an abstinence rate of 77.6% (McPherson et al., 2017:1). Citing the study conducted by Goliath and Pretorius (2016), a user respondent identified being introduced to an adolescent drug support group by a former prosocial peer from her school (Goliath & Pretorius, 2016:122). The recommendation for implementation of an aftercare support group as an intervention

strategy in combating SUD can be motivated by the previous study conducted by McPherson et al. (2007), which reported abstinence percentages with regard to support group attendance. To further support this notion, Brown, Seraganian, Tremblay and Annis (2002:586) posit that aftercare support group attendance improves post-treatment recovery amongst individuals with SUD and reduces the probability of relapse. The foregoing discussion prompts further research into the role of support groups in preventing relapse amongst young adults. The NDMP (2013:30) identified in its drug master plan the need for the establishment of support groups to address the SUD problem at the community level.

Azmi et al. (2018:3) identified limited community support, the negative attitude the community has towards recovering substance users and alienating or ostracising substance users within the community as risk factors. A phenomenological study that was conducted in KwaZulu-Natal with 10 respondents that aimed to investigate the lived experiences of substance abusers in the South African context found that social influence within the social environment contributed to initial use, recurrent use and relapse among youths (Gopal & Collings, 2012:656). In another South African study, Mhangwa (2016:85) also identified limited community support as a risk factor and his illustration was in the form of community involvement that was not sufficiently evident in fighting SUD through the promotion of various community strategies because of the stigmatisation of users and the lack of resources within the community. Lack of trust from the broader community was prevalent and this was related to individuals who were involved in criminal behaviours (Groenewald, 2018:6-7). While in recovery, the lack of trust from the broader community also served as a risk factor for relapse, as those that were recovering feared being shunned by the community because of their perception of drugs and possible criminal activities in which they may have engaged (Zwane, 2019:49; Groenewald, 2018:6-7).

2.6.3 Environmental Risk Factors

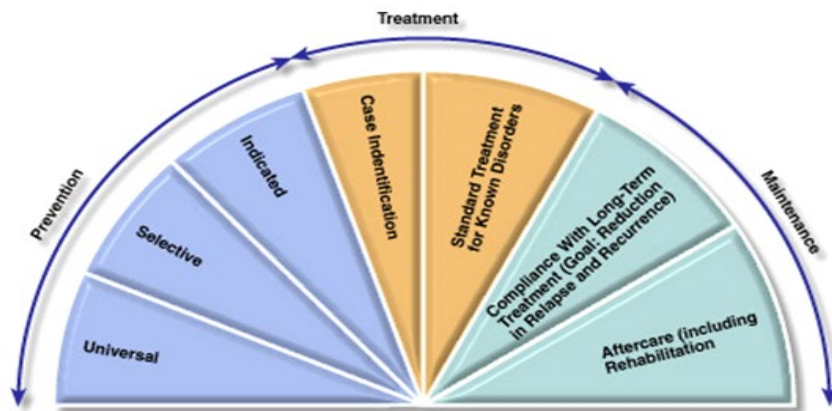
Environmental cues may function as a catalyst for eliciting physiological responses to trigger the body to use substances (Hunter-Reel et al., 2009:6). A study that was in the domain of environmental justice research investigated how and why environmental risks are distributed inequitably with regard to race and socioeconomic status. The study found that environmental risk factors such as access to substances,

neighbourhood concentrated disadvantage and disorder and environmental barriers to substance use disorder treatment were risk factors (Mennis, Stahler & Mason, 2016:3-6). The neighbourhood concentrated disadvantage and disorder refers to disadvantaged and impoverished communities that are characterised by low income, low educational attainment and high unemployment, all of which are environmental risk factors (Mennis et al., 2016:4). It was found that within disadvantaged communities where young people suffered exclusion from formal opportunities in terms of education and the job market, drugs and crime were viewed as means to alleviate poverty and generate income (Spooner & Hetherington, 2004:144). Badiani's (2013:588) study revealed that specific drugs were predominantly used in certain settings. Heroin was mainly used at home and cocaine away from the home. The study's focus was on exploring which settings were more associated with which type of substance, specifically heroin and cocaine and what predisposing circumstances needed to be in place for people to use those drugs in those specific settings (Badiani, 2013:588). The participants in the study claimed that the rewards that were gained from the two drugs determined where the specific drug was used (Badiani, 2013:589). The results of the experiment implied that the setting influences the drug use and preference rather than the other way around, where an individual makes a conscious decision to take a sedative drug in a place where one can slouch on the sofa and an activating drug in a place where one can socialise (Badiani, 2013:589). This can have an impact on aftercare for an individual if viewed from Badiani's (2013) perspective because the individual will always be exposed to the environmental settings in which the specific drug mentioned in the preceding sections was used and this will pose a constant environmental risk for relapse.

In South Africa, findings from a study that explored risk factors following treatment cited triggers such as the availability or access to drugs within the same environment, unemployment, places where the individual used drugs, poverty and continued drug dealing in the community posed risks for relapse (Swanepoel et al., 2016:423; Goliath & Pretorius, 2016:119). Mhangwa (2016:85) cited similar findings regarding environmental factors influencing recovery post-treatment. The foregoing statement implies that some of these environmental triggers are ever-present in communities where substance use disorder is prevalent.

2.7 CONTINUUM OF CARE FOR TREATMENT OF SUD

The treatment of SUD has expanded from initially prioritising the acute model of inpatient treatment of the chronic disease to including aftercare as part of the continuum of care in pursuing recovery management (Millet & Cort, 2013:3). Figure 2.1 depicts the proposed continuum of care and is briefly explained with the view to ascertaining where the current study fits in the broader continuum of care model.



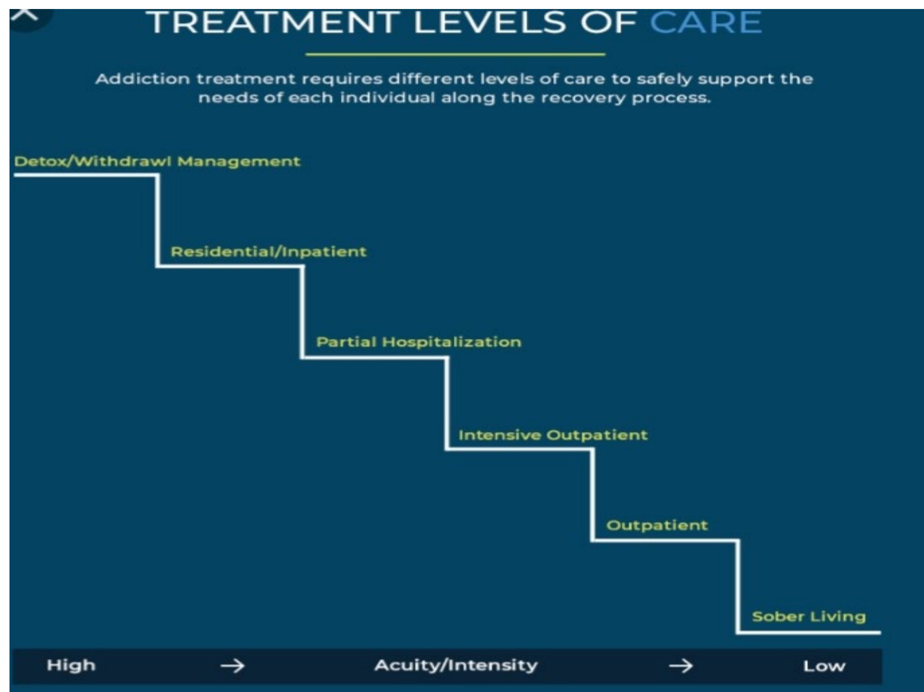
Source: Institute of Medicine (IOM) Prevention Classifications cited in McWhirter et al. (2013:289)

Figure 2.1: Continuum of care model

The continuum of care cited is extracted from the IOM prevention classification. The rationale for endorsement of the model was related to its suitability for planning interventions within the field of substance use disorder across the continuum (Springer & Phillips, 2013:3). It was noted that "this paradigm fits nicely with the growing empirical focus on risk factors as a way of focusing preventive, treatment and maintenance interventions for SUD and it provides a systematic conceptual framework for developing evidence-based knowledge on matching intervention to participants at progressive degrees of risk" (Springer & Phillips, 2013:4).

Prevention level can be described as services or interventions offered prior to the use of substances (Springer & Phillips, 2013:2). The treatment level on the protractor can be described as treatment interventions after being diagnosed with SUD and maintenance can be described as the evaluation of interventions and continuing care after treatment (Springer & Phillips, 2013:3). The first level on the continuum, i.e., prevention, is also known as primary prevention and early intervention and includes

interventions targeted at persons who are at low to medium risk of becoming (harmfully) involved in the use of substances. The model splits this population into three depending on the risk of exposure level. The wedge labelled "Universal" refers to interventions inclusive of the entire population addressing the prevention or delay of engagement in substance use (Springer & Phillips, 2013:6). Specific strategies include raising community awareness and general marches or community events. The second sublevel is selective, which narrows the population to specific groups at a higher risk of substance use. This may include individuals at risk directly or indirectly and individuals not at risk but exposed to risks known to be associated with SUD (Springer & Phillips, 2013:11). Specific strategies include psycho-education and short-term workshops. The third sublevel targets specific individuals who are at high risk and showing signs of use but these individuals do not meet the criteria for diagnosis of SUD (Springer & Phillips, 2013:17). Interventions at this level include early intervention preventative counselling and programmes specifically aimed at risk reduction with a focus on risk factors that may increase the chances of developing SUD (Springer & Phillips, 2013:17). The treatment level on the continuum of care, known as secondary intervention, includes case identification where individuals undergo screening and assessment for possible diagnosis of SUD by a health professional. The second sublevel is the standard treatment when interventions such as inpatient and/or intensive outpatient rehabilitation are administered. The maintenance level known as tertiary intervention focuses on long-term care where less intense outpatient services are administered focusing on aspects related to relapse prevention. The second sublevel is aftercare where interventions such as support groups and 12-step facilitation programmes are administered for long-term continuing care.



Source: https://images.app.goo.gl/PLbmhk4y4JYE5CTb8

Figure 2.2: Treatment levels of care

The foregoing continuum of care model depicted in Figure 2.2 that was utilised in this study focuses mainly on treatment. This model was extracted from an article written by Millet and Cort (2013) and was described as the first level on the continuum being detoxification and medical stabilisation, which incorporated medical intervention and detoxification. The second intervention incorporated intensive residential treatment described as traditional inpatient treatment. The next intervention is a step down from the more intensive intervention and incorporates intermediate residential care. Following this level is intensive outpatient service that includes outpatient group therapy sessions with a therapist. A level down from the previous intervention is standard outpatient services that are offered in group settings; less intense than the previous level of intervention. The final level is sober living, which includes Oxford recovery houses, which are programmes similar to halfway homes. Millet and Cort (2013) posit that we should move away from an acute model of care to more long-term recovery if we are to ensure individuals' long-term care and recovery. Similar views were expressed by Stein, Anderson and Bailey (2015:1), who highlighted that treatment without aftercare places individuals at high risk for relapse. In South Africa, similar views were expressed by several authors (Felkers, 2019; Mahlangu & Geyer, 2016; Van Der Westhuizen, 2013 that aftercare is required following treatment and if

aftercare programmes are not readily available, the risk of relapse increases. This is where the notion of incorporating aftercare, inter alia continuing care stems from, thus substantiating the approach of moving away from an acute model to a more long-term recovery model. The continuum of care model extracted from the IOM reflects the shift to a long-term recovery model that incorporates aftercare (Springer & Phillips, 2013). It is important to also note that individuals may enter the continuum of care at any level and can revolve back into a previous level, e.g., from the maintenance to the treatment level pending relapse (Millet & Cort, 2013).

2.8 FOCUS ON AFTERCARE AS PART OF RELAPSE PREVENTION

As previously mentioned, aftercare is recognised as an integral component of treatment for SUD within the continuum of care (Brown et al., 2002:586). Territories in the northern hemisphere mostly employ the concept of continuing care (Proctor, Wainwright & Herschman, 2017; McKay, 2009). The term continuing care can be described as a stage of treatment that follows intensive inpatient and/or outpatient and residential care (Mckay, 2009:3). As highlighted, the need for the development of aftercare programmes is in line with the view advanced by Millet and Cort (2013), who suggested a shift from an acute model of care to long-term recovery management. This builds on the notion that aftercare attendance improves post-treatment prognosis amongst individuals with SUD (Brown et al., 2002:586). Brown et al. (2004:447) confirm that participation in aftercare services was found to be effective in reducing drug use. A study was conducted with more than 136 participants comparing the characteristics of those who initiated aftercare with those that did not and the findings revealed that those individuals who initiated aftercare treatment were more likely to abstain from using drugs and alcohol (Frydrych, Greene, Blondell & Purdy, 2009:4).

As discussed in the foregoing sections, only limited research has been conducted into aftercare in South Africa. The Central Drug Authority (CDA) conducted a national rapid participatory assessment with various communities in South Africa and found that 40% of the respondents indicated that they were aware of support services and further indicated that to deal with the problem, the provision of access to aftercare services must be considered (NDMP, 2013:45). Two studies that were conducted in South Africa found that social workers rendering substance use disorder treatment and adolescent substance abusers in treatment agree that aftercare services are an

essential component in the treatment of substance use disorder (Mhangwa, 2016:113; Van Der Westhuizen et al., 2011:172). Young adults regard aftercare as an essential component of services to facilitate recovery and they linked this view to the need to achieve life-long recovery from SUD (Van Der Westhuizen et al., 2011:357). The participants in this study expressed their need for support groups that included their families in the aftercare service (Van Der Westhuizen, 2011:359). Maluleke (2013:90) posits that aftercare should be compulsory. This view is supported by the findings generated by Van Der Westhuizen et al., (2011:366) that aftercare should be made compulsory to improve treatment outcomes and relapse prevention. Maluleke (2013:90) and Van Der Westhuizen's (2011:336) views regarding compulsory aftercare attendance stem from the participants' articulation that there is a lack of post-treatment aftercare support, lack of adherence to referred aftercare support and most importantly, the need for aftercare services due to the high relapse potential following treatment. With regard to the lack of adherence and uptake in support group meetings, a study aimed at identifying community-level barriers to recovery from substance use disorder in rural residents found that these barriers included distance to meetings, number of meetings, recovery programme diversity, meeting diversity and sponsorship options and availability (Young, Grant & Tyler, 2015:4). One could wonder if these barriers are applicable and relevant in the Nelson Mandela Metropole for the claimed lack of adherence and uptake in support group meetings by recovering individuals. Several international studies (Sussman, 2010; Brown, O'Grady, Battjes, Eugene & Ferrell: 2004; Brown et al., 2002) confirm the need for aftercare, highlighting that aftercare is not only relevant internationally but also in South Africa and this stance led to the proposed focus on the aftercare continuum. The potential for relapse is higher among young adults who do not participate in aftercare programmes. The recovering young adults then fails to complete the whole treatment process, which adversely affects their ability to maintain sobriety and increases the potential for relapse during aftercare (Van Der Westhuizen et al., 2011:357). A study that explored the role of the parent in the aftercare of their adolescent children who participated in a treatment programme for substance use disorder in South Africa found that aftercare should not be seen as a treatment modality or maintenance intervention but a mere extension of a structured programme (Felkers, 2019:57). This view is further substantiated by explaining that therapeutic work has been undertaken and now

aftercare should build on the maintenance of what w2as imparted to the service user (Felkers, 2019:58).

2.9 GROUP WORK AS TREATMENT AND AFTERCARE METHOD

An intervention strategy that is proposed for strengthening family support and the maintenance and management of risk factors is a group work modality intervention approach. Social work practice distinguishes between community-initiated support groups and those initiated and facilitated by health services professionals. Group work practice is a strategy constantly employed to support individuals with SUD and significant others during the treatment phase and also in the aftercare. Support groups are seen as one of the strategies that offer social support because the group environment enhances the clients' willingness to examine their life situations and assists them to overcome substance use disorder (Forsyth, 2006:483). Support groups are formed by individuals who come together to address a specific need or problem that they all have in common and to offer social support to one another in these settings (Strobel, Adams & Rudd, 2015:9). There are various types of support groups, as reflected in Table 2.1 (Corey, Corey & Corey, 2013:11-16).

Table 2.1: Types of groups

	Types of groups			
	Task Group	**Counselling**	**Psycho-educational**	**Psychotherapy**
Purpose	Meets clients' and communities' needs.	Assists participants to cope with everyday problems	Prevents numerous educational challenges and psychological difficulties.	Addresses psychological problems and interpersonal everyday problems.
Focus	The use of group dynamics, principles and processes to enhance practice based experience	Interpersonal challenges and problem-resolution approaches that address thoughts, feelings and behaviour.	Increasing cognitive, affective and behavioural skills through a pre-planned and structured techniques	Previous circumstances affecting current conduct and connects past experiences to the present using assessments tools and diagnoses.

	Types of groups			
	Task Group	**Counselling**	**Psycho-educational**	**Psychotherapy**
Facilitation	Leaders and members' reciprocal interaction.	Leader-to-member interaction.	Leader-to-member interaction.	Leader-to-member interaction.

Source: Corey et al. (2013-:11-16)

The support group falls under the category of a task group and the rationale is based on the purpose of a task group as described in Table 2.1 (Corey et al., 2013: 11). Forsyth (2006:483) explains that support groups focus on a specific problem such as substance use disorder and members are encouraged to form personal relationships with one another, encourage the development of a strong sense of community and sharing within the group as well as emphasise mutuality of assistance. As mentioned, attendance of support groups has been categorised as a protective factor (McPherson et al., 2007:5).

2.10 SUPPORT GROUPS

Support groups are voluntary mutual aid groups whose members share a common problem and meet to exchange social support (Forsyth, 2006:483). There are mainly two types of support groups, namely non-professional, peer-based support groups and professionally run support groups (White & Dorman, 2001:1). In peer-based support groups, a further distinction is made, for example, 12-step groups and community-based peer support groups (White & Dorman, 2010:1; CSAT, 2008:1). An example of 12 step groups is AA (Alcoholics Anonymous), which is a treatment-based programme that places high regard on goals and activities (Montaltto, 2015:1). It is a self-help programme that aims to assist individuals in realizing that that they are powerless over the substance (Montalto, 2015:1). Twelve-step groups emphasise abstinence and have twelve core developmental "steps" that must be followed in recovering from dependence (Centre for Substance Abuse Treatment, 2008:1). By following the 12 core development steps, this will help them in coming to acceptance with their weakness, and eventually cessation of alcohol completely (Montaltoo, 2015:1). A study conducted by Stokes et al. (2018:2) posed the question, "how do people

recovering from a SUD experience and ***sustain*** their recovery?" This can be interpreted as relapse prevention and long-term sustained sobriety from SUD. The essence of the research question posed by Stokes (2018) was to determine how to sustain their recovery. Millet and Cort (2013) discuss sustainability in the form of long-term recovery support management. Sustainability mostly functions during the aftercare and implies preventing relapse. The study found that support group attendance played an important role in participants' journey to recovery in aftercare (Stokes et al., 2018:16).

A study that was undertaken by McPherson et al. (2007:5) on support group attendance identified positive outcomes from attendance, highlighting that frequent attendance of support group meetings increased recovery potential amongst individuals by up to 77.6%. This positive outcome coincides with Stokes et al.'s (2018) view on sustainability in recovery through frequent support group attendance. Melemis (2015:331) highlighted the five rules of recovery. One of the rules applicable to the proposed study was "asking for help" and according to Melemis (2015:331), joining a support group has been shown to significantly increase the chances of long-term recovery, relapse prevention and strengthening of family support. A study conducted by Harris, Baker, Kimball and Shumway (2007:223) that focused on achieving systems-based sustained recovery highlighted finding a network of social support. This was achieved through the establishment of a recovery community, the purpose of which is to create, implement and maintain peer-to-peer support services by offering strength-based services that emphasise social support from a community of peers in recovery over extended periods (Harris et al., 2007:225). To support the view of Harris et al. (2007) regarding the purpose of the recovery community, a study that focused on examining the experiences and perceived benefits of HIV-infected women in South Africa participating in support groups found that the key processes through which the support group was potentially beneficial were identification; modelling; acceptance and empowerment (Mundell, Visser, Makin, Forsyth, Sikkema, 2012:1). It was also found that participation in a support group required an understanding of the relationship between support group processes and potential benefits and that a bi-directional relationship exists between the two variables (Mundell et al., 2012:1). This was evident in the findings when the respondents mentioned after a 9-month follow-up that their lives had changed and 5 areas of change were identified (Mudell et al.,

2012:13). These areas included mental wellbeing, lifestyle change, disclosure of information and improved parenting and interpersonal relationships (Mundell et al., 2012:13-15).

Research articles on support groups outside the spectrum of substance use disorder were reviewed to seek similarities and differences within these groups in various settings. It was discovered that there are similarities in support groups and one such similarity across substance use disorder support groups, HIV support groups and mental health support groups was that they all aim to offer support and companionship to one another through the sharing of experiences and learning (Worrall et al., 2018:85; Bateganya et al., 2015:368 & Strobel et al., 2014:8). Another common aspect was that support groups played a role in addressing clients' psychosocial needs but the impact of support groups on key aftercare outcomes is yet to be fully determined (Bateganya et al., 2015:368). Although this gap was identified in a different field of health, it was applicable in the field of SUD in the South African context. Harris et al. (2007:225) held a similar view of support groups offering support and noted the similarities in characteristics across community-led support groups in various fields. Although the support group researched by Harris et al. (2007) was affiliated to an organisation namely a university, it was community-led in practice and incorporated students' needs and encouraged the members to take ownership of the support group to prevent relapse.

A significant feature of support groups is that the meetings provide a safe, private environment for members to express their struggles with SUD and experience peer support for behaviour change (Harris et al., 2007:228). Other distinct features of the support group are that members rely on their knowledge, skills, efforts and experiences to help one another to bring about change (Strobel et al., 2015:10; Bateganya, 2015:368). To support the need for research to be undertaken in understanding the role of community led support groups in South Africa, the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008 Section 13(f) makes provision for establishment of community-based interventions such as support groups in dealing with SUD problems within communities. This is done to achieve one of the NDMP eight key outcomes aligned to Section 13(f) in exploring the ability of how

people in South Africa have been dealing with the problems related SUD within communities.

In summary, aftercare attendance is associated with positive results and community-led support groups, as an alternative method of support, may achieve the desired results. The advantage is that it is peer centred and peers take ownership of the group. It is important to gain an understanding of how support groups offer support in the aftercare as data generated will be practice-based evidence and not an evidence-based practice. This is important within the field of substance recovery, as non-professionals need to explore strategies that work, how they work and how they can be improved to facilitate the sustained recovery of young adults

2.11 CHAPTER SUMMARY

This chapter presented a review and analysis of literature pertaining to research that has been conducted in the field of substance use disorder and recovery, which helped to illuminate the gap in the literature that this study aimed to address.

CHAPTER THREE

APPLICATION OF RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter presents a discussion of the research methodology that was employed during the research study. This chapter includes an in-depth discussion of the application of the research approach, paradigm, design, population and sample and sampling method, entry into the research site, data collection process, data analyses and the strategies that were employed to ensure trustworthiness as well as the ethical considerations that applied to this study. The study aimed to develop an in-depth understanding of how community-led support groups can facilitate relapse prevention in the aftercare of young adults with substance use disorders. In achieving the overall research aim, the following research objectives were formulated.

- To explore and describe the needs of young adults who are active in community-led support groups.
- To explore and describe how community-led support groups respond to the needs of young adults active in those groups.
- To determine what benefits community-led support groups offer to young adults in recovery.
- To explore and describe the role of community-led support groups in helping young adults deal with the cravings and triggers for relapse.
- To make recommendations that can improve the role of community-led support groups in facilitating relapse prevention.

3.2 APPLICATION OF THE RESEARCH APPROACH

The study employed a qualitative research approach that was aligned to the research aim to gain first-hand experience and understanding from the participants on how community-led support groups facilitate relapse prevention during aftercare and describe the role the support groups performed in their recovery. This research approach was appropriate as it facilitated gaining first-hand experience and a holistic understanding of the phenomenon under investigation (Delport & Fouche*,* 2005:74). The qualitative research approach achieved its purpose by gathering participant

accounts of meaning, experiences and stories through interviews guided by the framework of the research design that was employed. As a social worker, I am aware that the profession utilises research in an interpretive manner and relies on exploration, understanding and description of a problem to devise relevant social action within the context.

3.3 RESEARCH PARADIGM

The study adopted an interpretative paradigm as this is associated with a qualitative research approach. According to Chowdhury (2014:433), “interpretivism refers to the approaches which emphasise the meaningful nature of people’s character and participation in both social and cultural life”. This was important in implementing the interpretative paradigm because it facilitated eliciting participants’ understanding of the meaning behind human behaviour, social relationships, interactions and society in the context of their social and physical environments in which the support group functioned (Pulla & Carter, 2018:9). The application of the approach was achieved through the use of non-directed, semi-structured, open-ended questions to gain an in-depth, subjective understanding of people’s lives, keeping in mind the interpretivist view during the data collection phase.

Ontology can be defined as the “study of being”, or what it is possible to know about the world or the nature of existence and the structure of reality (Al-Saadi, 2014:1). My ontological stance was that there are multiple truths and that we socially construct our world view based on our understanding, interaction and interrelationships with phenomena and concepts with which we are directly and indirectly in contact. This includes social actors, cultural norms and social structures (Al-Saadi, 2014:1). I was also interested in how the participants made sense of the world and how they understood the behaviours of other people and interactions between other people and how they were influenced by these aspects (Pulla & Carter, 2018:10). I wished to explore the nature of the world and what we can know about it from the participants’ perspective and how they understand the interpretations that they have already made about their reality (Pulla & Carter, 2018; Al-Saadi, 2014:1).

According to Solomon, Elke and Juliet (2018:3), “Epistemology can be defined as the relationship between me and the reality or how this reality is captured or known”. It is rooted in the assumption of how knowledge came to be known and a way of looking at the world and making sense of it (Solomon et al., 2018:3). The epistemological view that assisted me was my prior engagement in a support group as a facilitator and this was one way of how my knowledge came to be known of support groups for recovering individuals. This view was further influenced through my academic engagement and qualification of Bachelor of Social Work (BSW) that included a module on substance abuse and at the master’s level through proposal development that entailed reading up on the topic to gain knowledge and insight. Other factors also influenced my epistemological views, such as my subjective beliefs, values, reasoning and understanding. As I was aware of such, I developed a clear research methodology that took an interpretivist approach that focused on the participants’ meanings and experiences rather than my own, thereby promoting objectivity and reducing subjectivity (Aliyu, Singhry, Adamu & Abubakar, 2015:5).

3.4 INTEGRATION OF EXPLORATORY-DESCRIPTIVE AND CONTEXTUAL RESEARCH DESIGN

The study employed an exploratory-descriptive and contextual research design as its model for operationalizing the research process. The selection of the integrated research design was guided by my review of the research question and objectives and exploring several research designs that would best assist in answering the research question. This guided the selection of the exploratory-descriptive and contextual research design to address the key research question.

3.4.1 Exploratory Design

Exploratory research is employed to explore and gain new insights into a phenomenon, particularly when there is limited understanding of that phenomenon (Swedberg, 2018:9). An exploratory research design in social science can be defined and constructed in various ways but its central function is to discover something new by working through the research topic and attempting to answer the research question (Swedberg, 2018:1). The research design coheres with the ontological stance of studying the nature of existence to arrive at new ideas pertaining to the studied phenomenon. Swedberg (2018:1) identified two functions of an exploratory study; the

one that applied to this particular study was to explore an existing topic to produce new ideas or hypotheses. In application, the study aimed to explore the role of community-led support groups in facilitating relapse prevention in the aftercare of young adults with a substance use disorder. This was achieved by aligning the ontological stance of exploration of knowledge with the function of the research design and this was operationalised by asking open-ended, semi-structured exploratory questions to gather relevant data.

3.4.2 Descriptive Design

The descriptive research design aims to describe a phenomenon and its characteristics (Nassaji, 2015:129). This descriptive design aimed to study phenomena in their natural state and answer the "how" question from the research participants' perspective (Lambert & Lambert, 2012:255). The descriptive design thus allowed me to provide a comprehensive summary of the events experienced by individuals or groups of individuals (Lambert & Lambert, 2012:255). I wished to describe the role the support group performs in offering support to young adults to prevent relapse during their aftercare. This could also be viewed as describing the "what" of the knowledge that was explored and acquired. This was achieved through asking open-ended, descriptive research questions and asking the probing "how" questions based on the participants' accounts of the phenomena.

3.4.3 Contextual Design

The cornerstone of the contextual research design was to collect data within the context of the participant (Wixon, Holtzblatt & Knox, 1990:332). The design facilitated the process of focusing on what they do, why they do it and learnt patterns of behaviour and discuss it within the context of social support in recovery (Wixon, Holtzblatt & Knox, 1990:332). This type of design maintains that any system embodies a way of working, implying that each system functions in a particular way in practice (Beyer & Holtzblatt, 1998:32). This view is supported by the point that the design facilitates the identification of what the system needs, how it functions, what the system does and how it is structured (Beyer & Holtzblatt, 1998:32). The participants had been attending support groups in person but during lockdown conditions had to begin utilising an online platform. The participants attend support group meetings where they offer support to one another by sharing their own experiences and being there for one

another. This was mainly achieved through face-to-face meetings but during lockdown conditions some support groups moved to an online platform as a medium of support and maintaining contact. When lockdown rules eased to levels 2 and then 1, support groups began transitioning back to face-to-face contact meetings while still complying with COVID-19 safety regulations during meetings. The online platform was not ceased for other support groups during this transitioning but was utilised in conjunction with the face-to-face meetings on days that there were no meetings.

3.5 SAMPLE AND SAMPLING PROCEDURE

A population can be described as a group of people that the study targets because they have experienced the phenomena under investigation and have the specific characteristics that are of interest to the study (Majid, 2018:3; Strydom & Venter, 2005:193). A sample is described as the smaller subset of individuals selected from a population with specific characteristics that are representative of the broader population (Strydom & Venter, 2005:193). The population from which the sample was drawn comprised members of community-led support groups in the Nelson Mandela Metro. Community-led support groups in this context referred to support groups that were established by members of the community were not affiliated to any organisation and not led by professionals in the field. The support group conveners were individuals from the community with no specific professional affiliation or operating as professionals within the support group. These support groups were situated in the Nelson Mandela Metro and comprised mostly members recovering from SUD. Organisation-based support groups were excluded from the sample because I was only interested in those that were community-led.

Non-probability, purposive sampling was employed to determine the individuals who had the characteristics most representative of the population for inclusion in the study (De Vos et al., 2007:328). Non-probability, purposive sampling was employed because not all members who were part of the support group had an equal chance or probability of being part of the sample as the inclusion criteria only permitted those individuals who fulfilled the criteria. The inclusion criteria were read to the members who were present at the time and it was at this point that the sampling process began. The inclusion criteria that were utilised in determining the sample are described hereunder.

- The participant had to be between the ages of 18 and 35 and in aftercare for at least six months post-formal treatment or natural sobriety from a substance use disorder.
- The participant had to have attended at least five support group meetings of a community-led support group. The matrix model proposes that a period of sobriety of six months post-formal treatment or natural abstinence would constitute the person being in the adjustment phase and therefore reduce the risk of a focus group interview serving as a trigger for cravings (Massah, Effatpanah & Shishehgar, 2017:197).
- The participant could be either male or female to eliminate gender exclusion.
- The participant had to be active in a community-led support group with periodic attendance and participation therein and could have joined at any stage since inception.

The sample comprised of males currently in recovery that had been attending support group meetings. The support groups that were sampled integrated Christianity, applied principles of religiosity in their daily meetings and did not adopt a theoretical framework in conferring support, as opposed to NA/AA that utilise the 12- step programme. The individuals sampled were all coloured and white males between 18 and 35 years of age. A total of seven support groups were approached, of which one became redundant and another had merged with NA although it was initially community-led. Of the five remaining support groups, two groups' members did not volunteer to be part of the study and members from the remaining three were therefore approached to participate in the study.

The non-probability sampling technique was combined with snowball sampling. The appropriateness of the inclusion and utilisation of this specific technique was due to the small population that was difficult to access because of the groups' closed nature, distance and scarcity of the population in geographical terms and with the view to expanding the sample size (Taherdoost, 2016:22). Snowball sampling was employed in two ways in his study, firstly to identify more participants within a support group to which the participant was affiliated. The participants who were already recruited served as the first point of reference in the implementation of the snowball technique for identifying additional potential participants who met the criteria. Consent was

sought and received to follow this approach. I asked the leaders if there were any other community-led support groups that they were aware of in the Nelson Mandela Metro (also referred to as the Bay). I was aware that there was some form of LDAC (Local Drug Action Committee) where the representatives of the respective resources convened meetings to discuss combating substance use disorder in the Bay. It is important to note that the LDAC was not active during the time of the study. This exercise proved fruitful as additional support groups were identified. The snowball technique was facilitated by telephone after approval was granted by the REC-H committee due to the Covid-19 regulations. At the end of the sampling process, the sample comprised nine participants from various support groups. The reason for the small sample was that there were not many support groups in Nelson Mandela Metro, several active support groups became redundant and the majority of the members chose to not participate in the study. The initial planned sample size was 15 members across the 7 seven community led support groups that were initially identified. Taking into consideration the ethical aspects of voluntary participation, this significantly limited the size of the sample. However, the sample size proved to be adequate for responding to the research question, as data saturation was reached.

3.6 ENTERING THE RESEARCH SITE AND THE RECRUITMENT PROCESS

Gaining entry into a research site or system needs to be done properly to respect the community or system with which I will be required to work in. This requires identifying the gatekeepers of the systems involved. Okumus, Altinay and Roper (2007:9) identified three types of access required to enter a research site, namely formal access, personal access and fostering individual rapport. I utilised the first two types in gaining entry into my research site. Before gaining entry into the research site, I compiled a research proposal that detailed the procedure for the research to be conducted and the process that would be followed. The study proposal went through the Departmental Research Committee, followed by the FPGC (Faculty Post-Graduate Research Committee) and the institutional REC-H (Research Ethics Committee - Human) to ensure that the study complied with the requirements set by the university. Approval was granted with the issued ethics reference H19-HEA- SDP-012. I compiled an email and attached Appendix 1, namely the letter to the gatekeeper providing an overview of the research project and the request to approach members of the support groups. I later contacted a stalwart that had served as a resource

connecter and had since retired, and he assisted me to navigate the various support groups of which he had knowledge and people I could contact for assistance with the study. The formal access request was utilised to devise an agreement between the support group leader and myself with terms such as time, place, what, when and how the prospective participants could be recruited and the empirical data could be collected (Okumus et al., 2007:9). I proceeded to contact the leaders of the support groups and sent them the gatekeepers' letter. The rationale for sending this document was that these leaders functioned as direct gatekeepers of their respective support groups. The second type of access, personal access, was used at a point when I visited the support group and the purpose was getting to know relevant individuals through a brief introduction so that the prospective participants could put a name to the face during the presentation of the information about the study's focus to recruit participants for inclusion in the study (Okumus et al., 2007:9). After having made contact with the leaders I visited the support group venue where I met with the members 10 minutes prior to the support group meeting to present the research project. I handed out the participant consent letter to the members so that they could read through it again in their own time after the meeting (Appendix 3). I scheduled a follow-up meeting with the members a week later to gather their feedback regarding whether or not they voluntarily chose to participate. I could not honour the meeting due to national lockdown due to the COVID-19 pandemic that was instituted in March 2020. This halted the recruitment and data generation process.

I requested permission from the REC-H committee to amend the recruitment and data collection method to utilise online-based technology to continue with the recruitment and data collection processes. The rationale for the change in methods stemmed from the COVID-19 pandemic during which face-to-face support group meetings were not permitted and had to be moved to an online platform (WhatsApp and Zoom meetings). The recruitment process initially entailed approaching potential participants at the end of face-to-face support group meetings, which became impossible during the lockdown. The new recruitment method that was proposed and approved entailed requesting the gatekeeper to post the invitation for people to participate in the study (refer to the amended Appendices 1 and 2) on the support group's WhatsApp virtual support group platform. The guidelines applicable to qualitative research at the time of lockdown due to COVID-19, compiled by Prof. Greeff, research ethics consultant

and mentor (05 May 2020), served as a guide on how to enrol participants during the COVID-19 pandemic. Support group members who had questions or who wished to participate in the study were given the opportunity to contact me directly. Alternatively, they could grant permission to the gatekeeper to notify me of their wish to enrol in the study. I then initiated contact, thus sparing the participant the financial cost of making the telephone call. The amendment was approved and I employed the snowball sampling technique to identify other support groups and gain online entry to the support groups to recruit prospective participants. This entailed me contacting the support group leader telephonically and explaining the research project. Thereafter, I emailed the relevant documentation to the support group leader who introduced me to the participants by sharing their contact details with me. I continued with the recruitment process by ensuring that the participants signed informed consent forms. The leader made contact with the participants to inform them of this study before sharing their contact details with me. By the time I contacted the participants they were expecting my call and had agreed to have their numbers shared. Appendix 3 was explained to them telephonically and sent to them online. During the telephone call, the prospective participants agreed to participate and a date for the interview was negotiated and scheduled.

3.7 DATA COLLECTION PROCESS

The initial primary data collection method that was approved was focus group interviews. Focus group interviews can be described as data collection tools that entail several participants meeting as a group to discuss a given research topic (Mack, 2005:51). Due to the impact of COVID-19 and the lockdown regulations that were instituted by the South African President and the National Corona Virus Command Council and subsequent regulations that came into effect, this choice had to be revised and I opted for an amendment of the data collection method from focus group interviews to online, one-on-one, semi-structured interviews (Preiser, Van Zyl & Dromowski, 2020:439). Individual interviews are appropriate for eliciting information pertaining to individual experiences and opinions regarding a phenomenon (Mack, 2005:30). Such an interview takes the form of a conversation in which I explored the topic to gain an understanding of the participant’s lived experiences relevant to the topic under investigation (Al-Balushi, 2018:728). This interviewing technique is conducted according to an interview guide that has open-ended questions that focus

on certain themes and may include suggested questions (Al-Balushi, 2018:728). The applicability of the method when following a qualitative approach can be substantiated because a qualitative inquiry seeks verbal accounts or descriptions in words through the use of open-ended questions in interviews (Elliot & Timulak, 2005:147). The available online methods were ordinary telephone calls, WhatsApp or Zoom, depending on the participant's preference and the platform that was accessible. The mentioned medium was also identified by Al-Balushi (2018:729) in his article as a type of online tool for conducting interviews. I offered to purchase data for each participant who needed such before the scheduled interviews. The participants indicated their preference to be interviewed telephonically and were asked to find a quiet place with no interruptions during the interview. The same semi-structured interview guide that would have been used for the focus group interviews was used in conjunction with the open-ended interview follow-up questions to stimulate exploration of the phenomena of interest. Probing techniques were employed to ensure in-depth exploration and explanations of key concepts that arose from the members' responses to the interview questions (Moerman, 2010:21). The guide structured the interview process into three parts. The first was the beginning phase, which dealt with the introduction and provided a brief overview of the study and the consent. The second phase, which was the middle phase, entailed the actual interview during which questions were asked. The ending phase entailed the reflection and debriefing part of the interview. The interviews were conducted by myself. I am a qualified Social Worker registered with the South African Council for Social Service Professions. I had a theoretical background in SUD stemming from undergraduate studies and practical experience from having been a facilitator of a support group for more than a year during which time I assisted members in the support group; these members were not part of the sample. I am a skilled and competent group facilitator from my training in the BSW theory and practicum. No relationships existed between the prospective participants and myself prior to this study and if there had been, no risk of coercion would have been posed because of the methods employed to enter the research site. The ethical principles of qualitative research were upheld. No field notes were made during the interviews but an audio recorder was utilised with the participants' knowledge and permission. Data saturation was reached when no additional issues could be identified in the data and there was a full understanding of the issues that were identified; no further insights or nuances were forthcoming (Hennink, Kaiser & Weber, 2019:3).

Homogeneity was ensured through the application of purposive sampling guided by the identified sample criteria.

After having conducted the first two interviews, the first of which served as a pilot study, I became aware of barriers with regard to language and the comprehension of English jargon, specifically that related to substance use disorder. I had to find strategies to implement in subsequent interviews to gather rich data from the participants. I then decided to share the interview questions prior to the interviews. The questions were reviewed, refined and restructured so that the participants could think about the questions and their responses before the interview. This action was aligned with the ethical principle of respect for persons as the participants were allowed to consider their responses (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). This course of action did not infringe on other ethical principles such as justice in that the first participants did not receive the interview questions and others did. The purpose of the pilot interview was to review and refine the research methodology to ensure a richness of data without infringing on any ethical principles (Strydom, 2005:206). Engagement with the participants was thus improved and the remainder of the interviews were successful. The potential drawback of this exercise was the possibility of having the participants share what they thought I wanted to hear. I addressed this potential problem by explaining that the study was about sharing their own experiences of being part of the support group.

I added a component for participants' reflection at the end of the interview. The guiding framework for the reflection was Kolbs' theory of experiential learning, which assists with reflecting on what has been learnt during the interview phase (Kolb et al., 1999:3). This formed part of the ending phase of the interview procedure. The rationale for this exercise was mainly to ascertain how the participants experienced the interview and to provide them with the opportunity to clarify any information that they shared if they felt they were not properly understood during the interview.

3.8 PILOT STUDY

A pilot study can be defined as a small-scale trial during which all planned aspects related to the main inquiry are tested to ensure that any problems are rectified before beginning the main inquiry (Strydom, 2005:206). A pilot study is implemented to

determine if the methodology, sampling, data collection method and analysis are adequate and appropriate (Strydom, 2005:206). After receiving approval from the ethics committee to change the data collection method, I conducted a pilot interview (Dikko, 2016). The feedback revealed that certain aspects of the wording of the interview questions had to be reviewed. The initial interview questions were derived from the research sub-questions mentioned under Section 1.5.2. After the pilot interview, new questions were formulated and used during the middle phase of the interview procedure. These questions are presented hereunder.

- Tell me about the support group you have been attending.
- What is the purpose of the support group?
- How often does the support group meet and what is the duration of the meetings (before lockdown)?
- Share with me your experiences of attending your support group meetings.
- Why have you chosen to attend support group meetings/what made you decide to attend the support group meetings?
- What needs were you hoping would be met by joining the support group (how were you hoping the group could help you)?
- Is there an instance when the support group was not helpful?
- How did the support group attend to your needs relating to triggers and cravings whilst in recovery?
- What recommendations (advice) do you have for how the support group can help young adults remain free from drugs?
- In your opinion, how long do you think a person should be part of a support group for him or her to continue staying clean?

During the pilot interview the responses to the questions allowed me to determine if the questions addressed the study’s objectives, the questions and follow-up questions reflected the exploratory and descriptive factors and evaluate whether or not the questions took contextual aspects into account. The pilot interview proved fruitful, as relevant research data was elicited during the subsequent interviews. The pilot study also helped in assessing my application of research interviewing skills and interview processes. As I am a social worker, the potential existed for overlapping the researcher and social worker roles and the pilot study allowed me to identify this

overlap and consciously separate the roles during the interview process. The research questions facilitated exploration of the topic from the participants' perspectives and the follow-up questions offered the opportunity for description. My knowledge and experience of substance recovery and support groups enabled me to elicit rich data from the participants during the interviews but it became apparent during the pilot interview that the participant did not always understand the questions and this was exacerbated by the language barrier, as the participant was predominantly Afrikaans and struggled to effectively express himself in English. I thus encouraged him to speak Afrikaans when struggling to express himself in English. I then reviewed the questions and paraphrased them to address the issue of language and comprehension of the research question for the subsequent interviews. With the assistance of the supervisors, the research questions were reviewed and refined to make them easier to understand. Other strategies included paraphrasing the question and utilising examples to describe the research question. Conducting telephonic interviews makes it difficult to pick up on non-verbal cues but the open-ended questions allowed for follow-up questions to be asked to gain in-depth understanding.

3.9 DATA ANALYSIS

Before the data analysis, a review of the data was undertaken to prepare it for further analysis, to describe the key features of the data, summarise the results and determine if the data generated from the semi structured interviews was consistent with the research objectives (Blischke, Karim & Murthy, 2011:159). The preliminary data analysis was achieved by listening to the interview recording, identifying the key terms that emerged from the interview and making a note of them. I then listened to the interviews in segments of five minutes to ensure that none of the key terms had been missed in the first step. This process was employed for all the interviews. These key terms were then linked to the research objectives by placing the key terms under five themes that were derived from the objectives of the study as a way of achieving the purpose of the preliminary analysis. This was achieved by compiling sub-themes based on the key terms that were recurrent across all the interviews and the sub-themes were also placed under the five themes that were derived from the research objectives.

In preparing for the data analysis, I listened to the recorded interviews after which I transcribed them verbatim. The purpose was to prepare for the data analysis process that would follow. Braun and Clarke (2006) proposed a method of data analysis, namely thematic analysis. This was based on the viewpoint that thematic analysis can be described as a process of identifying themes and patterns in qualitative data (Maguire & Delahunt, 2017:3355). This tool was appropriate because the aim was to discover and interpret a phenomenon (Alhojailan, 2012:40). Thematic analysis offers an opportunity to understand a phenomenon in depth (Alhojailan, 2012:40). The implementation process was divided into six phases as described hereunder.

1. **Familiarisation with the Data** - I read and re-read the transcripts to familiarise myself with the entire body of data (Maguire & Delahunt, 2017:3355). Whilst reading the transcripts I made note of several broad ideas that emerged.

2. **Generate Initial Codes** - this step entailed organising and reducing the data into smaller and more manageable chunks in a systematic way (McGuire & Delahunt, 2017:3355). In guiding the coding process, I was concerned with addressing the research question and analysed the data with this goal in mind (McGuire & Delahunt, 2017:3355). After reading the transcripts I proceeded to coding by assigning interpretive phrases and or labels to segments of the interview transcripts. McGuire & Delahunt (2017:3355) refer to this process as open coding as there were no pre-set codes but codes developed and were modified during the coding process whilst keeping the research question in mind. After the first round of coding, I did not return to the data for a week and then revisited the coded data to determine if the codes were consistent and reflected the essence of the interview and were interpretive and aligned with the research question. Once the coding process had been completed, I then began to categorise the coded data. Categorising is explained as the grouping of similar codes to generate categories so that data can be reduced into even more manageable chunks. This process involved organising, reorganising and grouping similar codes that had similar meanings under one heading and categories were thus established.

3. **Search for Themes** - As mentioned in the preceding section, the categories were then used to search for themes and sub-themes. McGuire and Delahunt

(2017:3356) define a theme as “a pattern that captures something significant or interesting about the data and/or research question”. In conceptualising the themes, I searched for patterns in the categories that emerged as a result of the codes. Similar categories were identified and grouped to form interpretive themes that were related to answering the overall research question. No initial or pre-set themes were identified in line with the process of open coding (McGuire & Delahunt, 2017:3355). The research objectives were utilised to guide the establishment of themes with the view to answering the research question. The identified and named themes were interpretive based on the greater data set and aligned with the study in question.

4. **Reviewing Themes** - This step entailed reviewing the themes that were initially generated, which was achieved by reviewing and refining the themes by going back to the raw dataset to ensure that the themes were consistent with the raw data (Xu & Zammit, 2020:6). This was achieved by reviewing how the categories were formed and any codes that were redundant yet relevant were placed in a category and renamed. This had an impact on the themes, which assisted in the renaming of the theme based on the altered categories. I sent the document containing the themes to my supervisors as a first draft for review. Another review process that was utilised was to include the external coder’s feedback. This was accomplished by arranging a session with the supervisors when I compared my themes to the external coder’s themes. The outcome was that the themes were similar and consistent with only slight changes and additions noted. This exercise prepared for the subsequent process of naming and defining the themes.

5. **Naming and Defining Themes** - after receiving feedback from the supervisors regarding the themes that were generated from the application of the earlier steps of the thematic analysis process, the themes were organised to avoid overlap or duplication (Xu & Zammit, 2020:7). I needed to make sure that each theme fitted into the broader context of the research project and answered the research question (Xu & Zammit, 2020:7). This process led to the tabulation and presentation of the themes, sub-themes and categories. The data was then ready for reporting the findings and these are presented in Chapter 4.

3.10 DATA VERIFICATION - ENSURING RIGOUR AND TRUSTWORTHINESS

Trustworthiness is an important concept in research, especially for qualitative researchers because validity and reliability cannot be ensured in the same way as positivists attend to naturalistic research projects (Shenton, 2004:63). Several authors, for example Silverman (2015), have devised a way that qualitative researchers can incorporate measures to ensure the trustworthiness of their research. Authors such as Guba have developed four criteria that should be considered to address the trustworthiness of a study (Shenton, 2004:64). These criteria are credibility, transferability, dependability and confirmability.

3.10.1 Credibility

Credibility involves ensuring that the study measures or tests what it is intended to measure or test (Shenton, 2004:64). I made several provisions to ensure that the study was credible and these included strategies such as those described hereunder.

- The adoption of well-established research methods, which entailed incorporating accepted operational measures to investigate the phenomena of interest (Shenton, 2004:64). The review of literature pertaining to research methodology and exploratory studies similar to mine (Goliath & Pretorius 2016) indicated that thematic analysis was the most appropriate method of analysis. The themes that were generated from the analysis responded to the purpose of the study and the key research question. Shenton (2004:64) posits that the decision to use a particular method of data analysis should be derived from previous successful, comparable research projects. The selection of the data collection tool, namely online, semi-structured interviews was guided by the review of exploratory studies in which the method was employed successfully (Al- Balushi, 2018:729). This type of tool offered the opportunity for participants to be interactive and respond immediately (Al-Balushi, 2018:729).

- Another strategy that was employed to ensure credibility was peer debriefing. Anney (2015:276) explains that peer debriefing offers researchers the opportunity to explore their growing insights and to expose themselves to reflective questions pertaining to the research project. This was achieved

through the support of research supervisors and their written feedback regarding aspects of the writing that required clarification.

- Another strategy, as noted by Shenton (2004:66), was to employ tactics to ensure that the participants were honest when sharing information and this was achieved by implementing the ethical principles of voluntary participation.

- The use of specific research interviewing skills (such as probing questions, clarification questions, paraphrasing and asking follow-up questions) were applied to ensure that rich data was generated (Shenton, 2004:67). This strategy promoted consistency across all the interviews based on the questions that were posed.

- Prolonged engagement in the research field ensured the credibility of the data that was collected. This was facilitated by utilising snowball sampling to identify additional participants. This process of prolonged engagement allowed for the building of trust with the participants and that resulted in them providing a deeper understanding of their support group experiences (Anney, 201:276).

3.10.2 Transferability

Transferability deals with the degree to which the findings can be transferred to other contexts, which can be interpreted as similar situations, populations and phenomena (Shenton, 2004:71). The strategies that were employed included those described hereunder.

- Providing thick descriptions of rich data including detailed descriptions of the methodology and context of the research and the step-by-step process of how the research methodology was applied (Anney, 2015:278). Providing this detailed information will assist other researchers to replicate this study under similar conditions in other settings. (Anney, 2015:278). To ensure transferability, I collected thick descriptive data that can be applied to other contexts (Anney, 2015:278).

- Another strategy that was employed was the application of purposive sampling in that individuals with characteristics relevant to the study were approached to participate. Purposive sampling entails sampling individuals who have the characteristics most representative of the population (De Vos et al., 2007:328). This was ensured by defining the sampling criteria and including only those who were particularly knowledgeable about the issues under investigation (Anney, 2015:278).

3.10.3 Dependability

Dependability refers to the stability of the findings over time (Anney, 2015:279). This entails evaluating and interpreting the findings and making recommendations to ensure that they are all aligned and inform the descriptive and contextual aspects of the data received from the participants (Anney, 2015: 279). There is a close association between credibility and dependability, implying that the demonstration of one contributes towards ensuring the other (Shenton, 2004:70). This implies that if the same study were to be repeated in the same context, with the same methods and with the same participants then similar findings would be generated, implying that the findings would be stable over time (Anney, 2015:278; Shenton, 2004:70). Strategies to ensure dependability include those described hereunder.

- Keeping an audit trail, which involved examining the research process and the results attained to validate the data, explaining all the research decisions and activities that led to data collection, recording and analysing to assist the auditor to follow the audit trail and cross-checking by supervisors (Anney, 2015:278). To ensure that the audit trail was complete, certain documents were required, including raw data, interviews, reflective journals and the consent forms used in the preliminary data analysis process (Anney, 2015:278).

- Peer examination, where I continuously discussed the research process, progress and findings with my supervisors during supervision sessions.

- Coding and recoding, where I coded the interviews and instituted a break before revisiting the interviews and recoding (Anney, 2015:278). The purpose of this exercise was to ascertain if the results were the same or different when compared (Anney, 2015:278).

- Another strategy was employing an independent coder to code the interviews and based on those results, I compared the themes and identified consistent themes to deepen dependability, I discussed other themes with the supervisors to reach a consensus (Anney, 2015:278). This practice is referred to as stepwise replication (Anney, 2015:278).

3.10.4 Confirmability

Confirmability is the degree to which the results of a research project can be confirmed or supported by other researchers in the relevant field (Anney, 2015:279). According to Anney (2015:279), this aspect is "concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are derived from the data and are of objectivity". Strategies that were used to ensure confirmability include those described hereunder.

- Keeping an audit trail, which involves examining the research process and accounting for all the decisions that were made regarding how the data was collected, recorded and analysed (Anney, 2015:278).
- Reflexive journal or reflecting on the data collection process after every interview (Anney, 2015:278). I reflected on the interviews using the 7c's and highlighted the "aha" moments. This tool was also used during the preliminary data analysis to plan for the data collection and identify any gaps to address. I reflected on the role of practitioner vs researcher. This was important due to the reason that I had both hats, and in this instance, I had to wear the researcher hat. It was important to note that my practitioner skills in probing had an influence in the structuring of interview questions and probing during participant feedback in the interview. To deal with this, it was important for me to always remember that the structure of questions should be from a researcher point of view, exploration, description and contextualization. In the pilot interview, the conflict between the roles emerged during the interview process in instances of probing. It was difficult at first to de-role myself from a practitioner role into a researcher role. Supervision and self-reflection assisted in resolving this internal conflict, and also by reminding myself to focus on the role of researcher. I was able to bracket the practitioner role in the subsequent interviews.

- Prolonged engagement in the research field was used in that I utilised snowball sampling to identify potential members to recruit to participate in the study. This was to ensure that the data would be consistent and objective. This assisted in gaining insight into the context of the study, which minimised any misleading information (Anney, 2015:246).

3.11 ETHICAL CONSIDERATIONS

Ethical considerations when interacting with research participants in any context are important. Sthalke (2018:1) posits that researchers themselves have ethical difficulties in the context of qualitative research studies and encounter ethical difficulties in fieldwork. It is important, however, to always uphold the ethical considerations pertaining to research and the participants therein. As a social worker registered with the South African Council for Social Service Professions, I was bound by the ethical guidelines applicable to working with clients that must be upheld at all times by the social service professional. The university's REC-H committee also imposes guidelines for ethical conduct, and I was bound to uphold the ethical standards that are mainly guided by the Belmont Report (1979) and the Department of Health's (2015) ethical guidelines for human research. The ethical standards discussed hereunder guided the research process.

3.11.1 Justice

This principle serves to protect people from bearing undue burdens resulting from the study (Wood, 2017:5). The principle aims to answer the question posed in the Belmont Report by The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research (1979) -"Who ought to receive the benefits of research and bear its burdens?" This principle is further linked to the selection of participants to ensure that people are not manipulated or exploited in any way (Wood, 2017:5-6). This principle was addressed through clear inclusion criteria that were presented to the population. The sample criteria were guided by the functions of the primary sampling technique of the study, mainly non-probability, purposive sampling to address the problem under investigation. In practice, this was achieved by reading Appendix 2, which included the sample criteria and explaining to the prospective participants the sample criteria and them deciding if they fit the criteria and would like to take part. This eliminated possible manipulation and facilitated justice. The sample

and general population may benefit from the study's findings. Although those who participated in the study could be seen as being burdened when sharing their experiences, in practice they had the opportunity to explain how the support group had benefitted them and their voices were heard. The study also facilitated a debriefing and reflection session that offered them the opportunity for personal reflection on their successes in remaining clean, which enabled them to realise how successful their recovery had been thus far. The research process covered the five formulations that were posed by the Belmont Report as described hereunder.

- **Equal share** - reflecting on the research approach, paradigm and design and data generation process offered the participants an equal share or opportunity to describe their experiences in their own words and be heard and considered. One of the participants was a spiritual leader in a support group that practiced Christian principles and I was interested to realise that this person could assume the role of spiritual leader and also be a regular member of the support group who required the support of the other members. This aspect of group dynamics and the roles of the members in the group were thus highlighted (Forsyth, 2006).

- **Individual needs** - individual needs in the context of the study were satisfied by the participants sharing their experiences and constructing their social world as they have seen and lived it. This process was facilitated when the participants were debriefed and reflected on their experience of the interview. This process was in place to determine if the participants required further interventions based on their individual needs. Another way in which individual needs were satisfied was by having the participants speak in their mother tongue during the interview. I realised that each participant had his needs and it was important for me to embrace those needs. The research taught me how the needs of those in recovery are addressed through social support.

- **Individual effort** - this aspect was facilitated through having the participants speak freely during the interview when answering the open-ended questions that were posed. This aspect offered the opportunity for members to add their own effort in their own capacity and not creating a certain level of expectation for the participants to fulfil.

- **Societal contribution** - The participants' accounts of their experiences may contribute to understanding how the support group has helped them. The recommendations advanced by the participants may assist other support groups to improve their service delivery in the medium to long term through the application of the various recommendations. While we know that the population is open, meaning those who are considering recovery and joining support groups for achieving sobriety have the potential to benefit, the experiences of the sample may potentially motivate them to pursue a support group as their medium of support.

- Individual merit - merit in the context of the study refers to the sample criteria that the participants had to meet based on their conduct and function before the deliberation of the research project. Their achievements and status related to the sample criteria, which gave merit to their participation in the study.

In further promoting justice, the findings and recommendations from the study will benefit the members involved in community-led support groups rather than other communities unrelated to substance recovery support groups. The community-led support groups will have access to the anonymised feedback thus promoting justice in utilising information that was collected from the community-led support groups. The participants were not requited for participating and this prevented undue influence.

3.11.2 Respect for persons

This principle is divided into two separate moral requirements. The first is that individuals be treated as autonomous agents to promote mutual respect and the second is that those who have reduced autonomy must be protected (Wood, 2017:4; The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). Respect for the participants was ensured during the research process firstly by having the members decide whether or not to participate in the study and secondly by the sharing of interview questions before the actual interview, thus promoting freedom of judgement and self-determination on what to share and how to share it. This was firstly achieved during the recruitment process when I read and explained the research project in detail and provided a copy of the participant letter to read in their own time. Prospective participants would have been

given a week cooling-off period before following up on their decision to participate in the study but this was not possible because of the COVID-19 pandemic and the lockdown regulations that were implemented. The alternative procedure was to utilise online technology as was approved by the REC-H committee and I telephoned the participants that were interested and explained the project in detail and a copy of Appendix 2 was sent via WhatsApp and email for them to read. Upon agreement, I had the participant choose a day and time for the interview, thus showing respect for autonomy. Before the interview, I read Appendix 2 and reminded the participant about the information contained in Appendices 2 and 3, depicting the aspect of freedom of judgement and reiterated that they could withdraw from the interview despite initially agreeing to participate. Participants with reduced autonomy were protected by the clear exclusion and inclusion criteria. One of the sample criteria was that a participant had to have been in recovery for at least six months as it is understood that relapse is probable (Hendershot et al., 2011:3). It was important for me to be aware of the rapid cycle of treatment, aftercare and relapse and to protect vulnerable participants. This was achieved by stipulating that the participant had to have been in recovery for six months and measures were in place should any of the participants require immediate intervention.

3.11.3 Beneficence

The principle of beneficence in the research process was addressed by listing the benefits and the risks related to the study during the recruitment stage and the participants signing the informed consent. Informing the participants of the risks and benefits of the study and their participation in the study served as a risk prevention strategy to minimise and/or prevent any potential harm. The data collection method was changed due to the COVID-19 pandemic lockdown regulations that were imposed. The risks of using online platforms for data collection could have caused the participants the discomfort of having to find a quiet place for the interview and this was addressed by me having the participant schedule a day and time for the interview so that he could prepare a quiet place for the interview. The second risk that the study could have posed was the reminder or transference of feelings during the data collection and this was addressed by including a reflection and debriefing session after the interview to have the participant speak about his experience of the interview. During this debriefing, I would have picked up if any particular participant needed

further intervention. No interventions were required after the interviews were completed. Benefits were encouraged through the sharing of their experiences and having their voices heard. The participants mentioned helping others in need and their view was that information they shared could help someone else in the future and that helping others was part of their mandate and motivation for change. Another benefit was reflecting on their experiences of the interview process. The participants became aware of their achievements in gaining sobriety. The experiential learning cycle offers the benefit of cementing experiences and prompting thinking and action (Kolb et al., 1999:3). The findings of the research were shared with the support group conveners through a compilation of an anonymised feedback report in the hope that those who participated would benefit from the findings.

3.11.4 Informed consent

Informed consent was addressed by ensuring that all information relating to the inquiry including the goals, purpose and procedures to be followed during the inquiry; the advantages and disadvantages related to the inquiry and the potential dangers to which the participants could be exposed were explained so that they could make a voluntary and informed decision to either agree or decline to participate in the research (De Vos et al., 2007:59). Promoting informed consent was guided by three components cited in the Belmont Report, namely information, comprehension and voluntariness (NCPH The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). Informed consent was ensured by reading the consent form, explaining the study to the participants and providing them with a copy of Appendix 2 and later Appendix 3 so that after perusal the participants made an informed decision and consented verbally and in writing. During the lockdown period, I sent Appendices 2 and 3 to the participants and read them to them during the telephonic recruitment stage. I received consent and then scheduled an interview date where the consent was read again before the interview. The concept of informed consent was further promoted and guided through the practical application of the three components highlighted in the Belmont Report, namely information, comprehension and voluntariness (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). Information was addressed by having all the important information compiled in Appendices 2 and 3 that was read and given to the prospective participants during the recruitment stage. Comprehension was

addressed by using words that the community or population easily understood. In determining that they understood fully while reading Appendix 2 I explained the content further and asked if they had any questions. The participants were informed that participation in the study was voluntary and that they could withdraw from the study at any time without any percussions. Voluntariness was addressed as explained.

3.11.5 Confidentiality, Privacy and Anonymity

During the recruitment stage, the participants were told how the information they shared would be used and that the interviews would be audio-recorded and transcribed, the data would be coded, themes would emerge and that the report would be based on the themes that were found to be common to all the interviews. I explained that the transcripts would be anonymised to protect the identity of the participants and that the research supervisors would have access to those transcripts. This was to protect the participants' identity, confidentiality, privacy and anonymity (The National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1979). They were informed that written information in the form of a dissertation would be used for examination purposes and would perhaps be disseminated on various platforms that included anonymised feedback to the support groups, presentation at seminars and an article write-up. The participants understood and agreed to such dissemination. Anonymity was maintained by explaining to the participants that they should refrain from using people's names or referring to the name of their support group. During the interview process, I numbered the participants and during the interview addressed them as "sir", thus demonstrating respect and also maintaining participant anonymity. During the process of transcription, I excluded the names and only wrote the first letter followed by stars. Data was to be stored for a maximum of 5 years for verification on a password-protected laptop and cloud and the interviews were erased from recording devices. Access to the cloud was limited to only myself and my supervisors and agreed upon protocols were in place for gaining access to the information.

3.12 DISSEMINATION OF RESULTS

The research project generated positive results for the stakeholders. I submitted an electronic copy to the Nelson Mandela University Library, an anonymised feedback report was distributed to the support groups that participated in the study, I submitted

an abstract to the SANCA Addiction Conference 2021 for consideration to present the findings to the wider academic community and other individuals that would take part in the conference that were directly and indirectly affected by substance use disorder and exploring practice-based strategies for recovery and a journal article was written for the academic community.

3.13 CHAPTER SUMMARY

This chapter reported how the research methodology was applied and included explanations of the research methodology, ethical principles and aspects of trustworthiness. All research protocols were adhered to during the data collection phase and ethical principles were upheld to protect the participants from any potential unethical practice or harm resulting from the research process. The results of the application are reported in the ensuing chapter.

CHAPTER FOUR

DISCUSSION OF FINDINGS AND LITERATURE CONTROL

4.1 INTRODUCTION

The preceding chapter described the methodology that was followed in the research process to achieve the aims and objectives of the study. As mentioned previously, the study aimed to develop an in-depth understanding of how community-led support groups can facilitate relapse prevention in the aftercare of young adults with substance use disorders. This chapter reports on the findings in line with the research objectives that were documented under 3.1 of the research methodology chapter.

As documented in the previous chapter, thematic analysis was applied to the data. Thematic analysis can be described as a process of identifying patterns or themes within large qualitative datasets that are important in addressing the research question (Maguire & Delahunt, 2017:3355). It is also employed to analyse classifications and generate themes in relation to the data that was generated (Alhojailan, 2012:40). This type of data analysis process was appropriate, as this study sought to explore a phenomenon using interpretations of the participants' experiences as narrated by them (Alhojailan, 2012:40). This chapter presents a discussion of the demographic profile of the support groups and data analysis process and presents the findings and the conclusions that were drawn.

4.2 DEMOGRAPHIC PROFILE OF SUPPORT GROUPS AND PARTICIPANTS

A total of nine volunteers recruited from three community-led support groups participated in the study. The support groups all integrated faith in their support and had a similar vision to provide care and support to prevent members from resuming substance use. The participants were all males from 18 to 35 years of age and had been in recovery for a minimum of six months with some being in recovery for several years while remaining active members of the support group. Brady and Randall (1999:241) posit that substance use disorder is more prevalent among males than females and at one point was considered to be a male-specific problem. The study revealed that more males than females engaged in harmful substance use and the gap widened when the dependence factor was included (Brady & Randall, 1999:248).

A more recent study agreed with the view that men have a higher rate of substance use (Tuchman, 2010:127). Both studies argued that this is because women are more likely to encounter barriers in accessing substance-related treatment than are men (Brady & Randall, 1999; Tuchman, 2010:127). Interestingly, my study also revealed that women encounter difficulties in accessing treatment and intervention for substance use and no women took part in the study. Approximately 20 prospective participants were approached during the recruitment stage but only 9 chose to participate. Of the 20 only 4 were females and of those 4 one did not fit the criteria because she had not been in recovery for longer than 6 months during the time of recruitment. How this data correlates to my study is based on the notion of low numbers of females in substance-related intervention and this is due to barriers and also the generally low numbers of females in addiction than males. A study that explored the effects of 12-step, self-help group attendance and participation in drug use outcomes among cocaine-dependent patients found that of the 487 participants, 76.8% were males, thereby reinforcing the claim that statistically more males than females join support groups (Weiss, Griffin, Gallop, Najavits, Frank, Crits-Christoph et al., 2004:179).

4.3 DATA ANALYSIS

Thematic analysis was employed to generate the findings. Thematic analysis can be described as a process of identifying themes and patterns in qualitative data (Maguire & Delahunt, 2017:3355). The six phases of thematic analysis are phase 1 - familiarising yourself with the data; phase 2 - generating initial codes; phase 3 - searching for themes; phase 4 - reviewing the themes; phase 5 - defining and naming the themes and finally phase 6 - writing a report. Chapter 4 presents this study's findings in alignment with Phase 6 with literature control. The independent coder followed the same process after which the two sets of themes, presented in tables, were discussed and compared and a consensus was reached regarding the themes, sub-themes and categories that are presented in the ensuing section. A total of five themes, twenty sub-themes and twelve categories were identified.

4.4 PRESENTATION OF FINDINGS

Table 4.1: Presentation of findings

Themes	Sub-themes	Categories
1. The needs of young adults with SUD who are active in community-led support groups	1.1 Need assistance with longstanding addiction recovery 1.2 Need assistance to identify and manage the risk factors for relapse	1.2.1 Dealing with perceived rejection (of self by others) 1.2.2 Dealing with low motivation for change 1.2.3 Negative thoughts and attitude 1.2.4 Suppressing (bottling up) emotions
2. How community-led support groups respond to the needs of young adults that are active in support groups	2.1 Religious faith as a key component of support group 2.2 Connecting through online media during lockdown when face-to-face contact was not possible 2.3 Providing individual and group support 2.4 Gaining coping skills and guidance	2.3.1 Group support as a form of intervention 2.3.2 Intervention in the form of one-on-one support

Themes	Sub-themes	Categories
3 Benefits of community-led support groups to young adults in recovery	3.1 A place for intrapersonal growth 3.2 Reciprocal learning from experiences 3.3 Social support 3.4 Safe platform to share and learn from one another's life stories 3.5 Social support group provides a safe environment for fostering acceptance and care 3.6 The support group facilitates the restoration of family relationships and thus assists with relapse prevention	3.5.1 Non-judgemental support is provided 3.5.2 Can learn to forgive the self, which enhances understanding of others
4 How community-led support groups assist young adults address risk factors of relapse	4.1 Assist in the identification of triggers 4.2 Implement behavioural strategies in response to the triggers 4.3 Religiosity as an intervention to combat triggers	4.2.1 Avoid situations that could tempt relapse 4.2.2 Find a constructive alternative outlet 4.2.3 Remain busy for the day

Themes	Sub-themes	Categories
5 Recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention	5.1 Motivate for consistent attendance 5.2. Long-term attendance and support needed for long-term recovery 5.3 Support group to have structure 5.4 Filling up time through keeping busy 5.5 Homogeneity in social network (stay connected to positive people who have overcome addiction) 5.6 Facilitating attending group meetings by creating groups that are physically accessible	

4.5 DISCUSSION OF THEMES

Five main themes were identified during the study that were aligned to the objectives and categorised into overarching themes. Each theme and its related sub-themes and categories that were identified from the data analysis are discussed with literature control and the study's integrated theoretical framework, namely social support and social cognitive theories, are applied to understand the findings. Participant quotes are reflected verbatim under each sub-theme and category.

4.5.1 The needs of young adults with SUD who are active in community-led support groups

Recovery is a transformative yet daunting period for any person who voluntarily ceases the use of substances. These individuals recognised the need to change their lives by taking action, which entailed participation in community and/or agency-led support groups to facilitate recovery. The findings indicated that participants in the current study joined support groups to attain social support and improve their recovery potential by preventing relapse. The participants also expressed certain needs that they hoped would be met by the support group. These needs were related to

assistance with recovering from substance use disorder, as this is something they felt they could not do alone. Their needs included identifying and managing situations and experiences that would otherwise place them at risk and counteract their addiction recovery. The participants' particular needs are discussed as sub-themes under this theme.

4.5.1.1 Require assistance with longstanding addiction recovery

The participants mostly noted that they had a problem with addiction and as such required assistance with overcoming the addiction itself. Most of the participants identified that their rationale for attending a support group was that they needed assistance whilst in recovery, with the primary need for social support as a tool for assistance in addiction recovery. Young et al. (2015:7) identified the presence of social support as positively related to recovery and the absence of social support was associated with relapse. This view was echoed by Chen (2006:14). A study conducted by Mahlangu and Geyer (2016:339) with nyaope users reinforced the need for emotional support from significant others. Three participants in the current study reflected on their needs as described hereunder.

Participant 4: "Because I found it almost impossible to stay sober on my own without really good guidance and it's not the easiest thing to deal with emotions as you start sobering up in life you know it's a very big change and I needed a support group of people who have been there to be able to point me in the right direction on how to keep sane in an insane world."

Participant 1: "Ek het addiction gehet en dan kan ek van my addiction het my gehelp maar wat my gestuur het was die woord and I was surrounded with positive people" (I had an addiction and then I got help with my addiction. But what helped me was the word).

Participant 6: "I think my reason for coming to a support group like I am now was to break the cycle so that I can be someone better in society".

The participants' reflections indicate that they felt that they could not address the need alone and thus required the assistance of the support group. Based on the findings, most of the participants expressed that they needed a social network of experienced

recovering individuals and the right social support that would assist them because such people would understand what they were going through. This implies that the road to recovery is difficult and one cannot expect to walk this road alone. Those in recovery need to walk this road with other people that support and guide them in their journey to recovery. Chen (2005:14) posits that high levels of perceived social support contribute positively to personal change and addressing problems related to addiction. Song et al. (2011:9) assert that the social support network properties can be objective or subjective and differ in strength, relational content and structural attributes. The latter refers to the size, characteristics and nature of the network, all playing a role in conferring effective social support on individuals in recovery (Song et al., 2011:9). The value of social support, especially from people with lived experiences of recovering from addiction, resonates with the view expressed by Bandura (2001:14). This seminal author on social learning theory emphasised that people do not live alone and as such, much of what they seek may be attainable through socially interdependent effort (Bandura, 2001:14).

4.5.1.2 Need assistance with identified intrapersonal factors that may impact the level of social support conferred

Several factors inhibit the conferring of reciprocal social support, which is particularly important as these translate into needs that affect the level of support that can be offered to an individual. It was noted from the analysis that the findings closely mirrored components of cognitive behaviour theory (CBT). The relevant categories found in this order were negative thoughts and bottled-up emotions. The CBT model posits that negative thoughts influence negative emotions and negative emotions influence behaviour (Larimer, Palmer & Marlatt, 1999:153). Therefore, there is a need to deal with these components with the view to changing the narrative about the behaviour because they perform a role in recovery and can potentially improve the level of social support that is offered. Other findings from my study include participants' perceived rejection and their low levels of motivation that impacted their level of social support.

Gaining social support, as mentioned in the foregoing sub-theme, is associated with positive outcomes and the perception of limited social support may place an individual at risk for relapse. As mentioned previously, Taylor (2011:192) posits that social support can be described as the experience of being cared for and loved by others in

different ways as part of a mutually supportive social network. Certain contributing factors impact the perceived low level of social support, which include the underlying intrapersonal needs that were identified (Chen, 2005:14; Rhodes et al., 2003:307). The level of perceived social support is also dependent on the individual's subjective perception of his or her relationships with others, namely social networks that may positively or negatively affect the intrapersonal needs (Chen, 2005:14). This subjective perception of the relationships within his or her social network may have either a positive or negative impact on one's intrapersonal needs (Chen, 2005:14). A component that was noted as influencing the level of social support was the perception relating to honesty about requiring assistance, which was mentioned by one of the participants. Honesty also plays a role in the level of social support that is conferred. In support of this view, one of the participants had this to say:

Participant 1: "Why because if you are honest with yourself it makes it easy for the other person to help you that's the main thing I can tell you. So if you come with the intention that you want help and these people are going to help you".

The aforementioned intrapersonal factor relates to the sub-theme in a way that if a person is honest about the challenges he is facing and needs help, he is more likely to get help. This statement can be interpreted from a transtheoretical model perspective in that when an individual becomes aware of the problem and is thinking about overcoming it but has not committed, he is thought of as a contemplator (Krebs, Norcross, Nicholson & Prochaska, 2018:2). This is relevant because when a person is honest about his challenges, he is aware and acknowledges the presence of a problem but has not made any commitment to change. The quote refers to the fact that when an individual is a contemplator, it makes it easier for that person to potentially receive help from others. The next stage of change is preparation when an individual indicates the intention to make the change (Krebs et al., 2018:3). This intention stems from the honest acknowledgement of the presence of the problem. The quote refers to intention, which fits the description of this change. Krebs et al. (2018:3) also mention that the individual takes baby steps to change and these steps can be interpreted as attending support group meetings in the initial stage. By attending a support group, the person is acknowledging the presence of the SUD. On the contrary, if the person is not honest about issues, this will impact the level of

support and if the individual does not fully acknowledge the intrapersonal factors identified, this may have detrimental effects on his recovery potential. This person may then be referred to as a pre-contemplator, as he indicates no intention to make any changes, thus relating to not acknowledging the presence of a problem (Krebs et al., 2018:2). Looking at it from a social support perspective and integrating it with the transtheoretical model perspective, low-level social support is related to suspicion of the social environment, which is associated with the degree of trust and openness of the individual toward the support group and a lack of confidence in receiving assistance from the other members (Chen, 2005:14). This viewpoint acknowledges the presence of an intervention strategy to address the problem. A contemplator will acknowledge the presence of assistance but their confidence in the strategy can place them at this stage for a long time before moving on to the preparation stage, which would be characterised by demonstrating intention to fully participate in the support group meetings (Krebs et al., 2018:2). When in the contemplation stage, individuals tend to perceive support that is considerably low (Krebs et al., 2018:2; Chen, 2005:14). This perception is prevalent at various stages in members' support group attendance and, according to the participants, is a consistent need. Reflecting on the various stages of the support group, it is important to note that low levels of trust are normal during the forming and norming stages of the support group life. This implies that as the group matures over time, the level of trust and the nature of the relationship deepens, thus positively affecting the level of support. With time and the group maturing, the individual concurrently moves through the stages of change into taking action and fully participating. Having identified these intrapersonal factors or issues, Dennis and Scott (2007:50) mention that there are enhanced outcomes when individuals join support groups that focus on their particular issues or needs. These specific intrapersonal factors are discussed as categories of this sub-theme. While these interpersonal factors are coined as needs, the term "risk factor" is used interchangeably to refer to these factors.

4.5.1.2.1 Dealing with perceived rejection (of self by others)

The participants referred to feeling rejected, particularly by their communities and previous social networks. This perception of rejection is rooted in the shame and stigma related to substance use disorder. This view was supported by McGaffin, Lyons & Deane (2013:2) who mentioned that individuals who use substances are stigmatised

and feel shame and guilt because of their substance use. There is a body of literature implying that the aforementioned stigmatisation is prevalent and inherently and adversely affects users and ex-users because the stigmatisation regarding the substances is associated with the individuals who use them. Users often stigmatise themselves based on the stigma bestowed on the substances they use. A few of the participants expressed that their families at one point viewed them as outsiders and those perceived rejections became projected onto other social networks. This perceived rejection was attributed to their past experiences of being stigmatised and rejected by family and society because of their association with substance use. Members noted such perceived rejection from the other support group members and several participants expressed that due to the perceived rejection, members tended to be reserved in their participation in the support group meetings. The perception of rejection was evident in some of the participants who reported that they thought that members of their support group would reject them the same as their family network and community members had rejected them because of their past life of drug use. This thought could be the reason for members initially being reserved in support group meetings. One of the participants had this to say:

Participant 3. "In that time, that person is going to get a spirit of rejection and be like why is this guy always like that you understand what I'm saying?"

Some of the participants expressed the need for the members to be part of a social network where they are not judged, not stigmatised, accepted and not rejected because of society's labelling or stigmatisation of them. This need is for an accepting social network. As mentioned earlier, although identified in a negative light, it is a need for acceptance without judgement and if this need cannot be met it may pose a risk for relapse. To support this interpretation, a participant mentioned the following:

Participant 6: "How they've been accepting me is that they don't judge me for what I have done. They actual[ly] look for what I have done; they looking at me now and how far [I've come] and accepting me for the way that I am".

The perceived rejection and its manifestation could be explained by Lee and Boeri (2018:15) who posit that although people attempt to improve their lives after ceasing their use of drugs, society still stigmatises them and this is perceived as a rejection of

self by others and is known as stigma-related rejection. This rejection is solidified by labels such as "*addict" and "former drug user*" assigned by society and other social networks to users (Lee & Boeri, 2018:15). Another effect of stigma is the use of stigmatising language (https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction). The article mentions solutions to reduce stigmatisation and this includes the use of non-stigmatising language when engaging with a person with SUD and using the first-person language (https://www.drugabuse.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction). Although the participants in this study did not mention any labels, rejection has been correlated with the labelling of individuals (Lee & Boeri, 2018:15). Explaining this component from a theoretical perspective, Bandura (2001:6) mentioned that we learn new patterns and behaviours from our social environment (social support network) and that these learnings are guided by human agency, which can be described as actions performed deliberately or intentionally (Bandura, 2001:6). A relevant human agency is intentionality when acts are deliberate and this depicts acts or courses of actions to be performed in the future (Bandura, 2001:6). This concept was applicable in that members in the social network (support group) intentionally exhibit and model non-stigmatising and accepting behaviour towards others and the level of empathy demonstrated stems from possibly understanding how complex and difficult sustained recovery can be.

4.5.1.2.2 Dealing with low motivation for change

The participants noted that some members in their support group were only motivated to change for the sake of family members, thus lacking the required internal motivation for change. Their rationale for the change was predominantly external motivation, which is closely correlated with coercion to change (Groshkova, 2010:496). The participants were fully aware of the danger of being involved with substance use but were still attracted to the behaviour with little to no motivation to pursue change or treatment themselves but rather to satisfy external parties coercing them to change (Junior & Calheiros, 2017:81). This can be interpreted from a transtheoretical model of change perspective where individuals that are pre-contemplators are under-aware of the problem and indicate no intention to change (Krebs et al., 2018:2). They often attend change-related interventions because they are pressured by others and this

correlates with threats of sanctions being put in place if no effort is made to change (Krebs et al., 2018:2). Other participants touched on the aspect of willpower associated with motivation. One of the participants mentioned the following:

Participant 3: "The main thing is it depends on yourself also you have your own will also, but sometimes as I can say lots of children they [are] there for the sake of their parents but their will is not in that".

One of the participants indicated that if a person wants to change, "*it depends on yourself*", implying that an individual needs to have an internal motivation to improve their recovery potential. Another aspect related to motivation to change that was reported by the participants was being honest with oneself regarding the change. Honesty is another predictor of high or low motivation levels depending on their honesty to themselves about their internal motivation. Internal motivation is understood as the need to change that arises from inside through honest acknowledgement of the negative physical and psychosocial consequences of substance use (Groshkova, 2010:496). The aspect of honesty was noted in the previous theme regarding the impact on the level of social support and also the correlation with acknowledgement of the presence of the problem. The participants also indicated the correlation of willpower with motivation for change. Motivation is a critical component in seeking and adhering to treatment approaches that will foster change (DiClemente, Bellino & Neavins, 1999:87). The participants identified that if a person does not have the willpower to change, this may pose a risk to initiating and maintaining recovery. The correlation can be explained in the sense that self-control in resisting short-term temptations enables the achievement of the long-term goal of recovery (Baumeister & Tierney, 2012). Continuously resisting the urge and successfully fighting it off motivates them to remain clean. Therefore, the absence of or diminished willpower may demotivate a person to continue to resist substance use, causing them to lose self-control and feel demoralised in their inability to make the change (Baumeister & Tierney, 2012:1; Prochaska & Velicer, 1997:39). Miller, Walton, Dweck, Job, Trzesniewski and McClure (2012:2) found that unlimited willpower played a role in sustained learning and that willpower can affect a person's ability to identify and draw on cognitive resources related to one's ability to sustain learning over time. Applying this finding to my study's findings would imply that willpower plays a

significant role in sustaining sobriety. The concept of willpower facilitates the process of drawing on the cognitive processes that are required to influence the level of motivation and sustained participation in recovery (Miller et al., 2012:2). The focus has thus far been on cognitive components and nothing has been said about the physical dependence and the biological challenges associated with addiction. The relevant biological factors exert pressure on the person with substance use disorder to the point where they have to seek assistance. In seeking assistance, they attribute their need for change and motivation to cognitive components, whereas they require allopathic care to foster motivation for change. The participants also noted that support group members need to be kept constantly motivated. Assigning tasks and responsibilities and short learning courses is a way of dealing with low motivation and serves as a key factor for them to continue participating in treatment recovery (Junior & Calheiros, 2017:79). One of the participants said:

Participant 2: "Give him something like (it's like) you know man it's [something] like operate[ing] email, paperwork or something like you know give him homework or something to do. You know something to think about, go home today and I want you maybe a[on] Wednesday I want every part. Must give him [me] an answer and something that you ask them you know at [with] your question there and you want the answer on the next Wednesday. Now he's excited because you keep him motivated and you keep motivating him now he's excited because you know maybe he didn't know the answer (you know) and he cannot wait to be there the time to give you an answer".

Razali (2017:313) found that one of the reasons related to relapse was individuals not being prepared to change or lacking the motivation to change. Although other authors have also written about low motivation as a factor, a different interpretation is advanced by the transtheoretical model. Prochaska and Diclemente (1983:391) posit that individuals who are in the stage of pre-contemplation are not yet ready for change (Prochaska & Velicer, 1997:39). The contributing factor could be that they are unaware of the effects and consequences of their behaviour or that they have attempted to change without success, and this led to them becoming demoralised with diminished motivation for change (Proschaska & Velicer, 1997:39). The theory purports that motivation is a predictor of effective participation in treatment recovery, which implies

that longstanding support group members need to be kept motivated for them to continue participating in recovery. Constant motivation is a need for each person in the social network, as recovery is a long-term project and motivation levels can fluctuate during recovery. Consistent with the current study's findings, other researchers (Junior & Calheiros, 2017; Razali, 2017; Rahman et al., 2016) also reported on low motivation as a risk factor. Bandura (2001:6) identified self-reactiveness as a particular aspect of human agency for learning behaviour from others and explained self-reactiveness as an individuals' ability to construct and regulate appropriate behaviours. A vehicle for operation can be collective agency where there is a shared belief in collective power to produce desired results and this desired outcome is supplemented with social support (Bandura, 2001:14).

4.5.1.2.3 Dealing with negative thoughts and attitudes

Several participants reported negative thoughts as a risk factor that is constantly present and noted that if negative thoughts creep in then the risk for relapse increases. One of the participants explained that negativity brings one down and results in one becoming cold and this can lead to negative behaviour. One of the participants expanded on this notion of negative thoughts by saying that:

Participant 8: "So once you start with your negative thoughts, and you bring yourself down, then it's not going to work out as what it should be".

Negative thoughts as a risk factor can be explained from the perspective of the cognitive behaviour theory that was mentioned in sub-theme 4.5.1.2 (Filges & Jorgenson, 2018:364). The participant's words imply that once an individual begins to experience negative thoughts he places himself at risk for a possible relapse. This view was also found in a study that highlighted negative thoughts as a relapse factor (Azmi et al., 2018:3). A need was thus identified for people in recovery to recognise negative thoughts and replace these with positive thoughts. By changing negative thought patterns and being in a positive environment, the behaviour can be changed to be more positive (Filges & Jorgenson, 2018:364). Several of the participants felt that they need to be around positive people, as this assists them to ignore their negative thoughts and maintain positivity. Explaining this need from the theoretical perspective of social support and social cognitive theory, the need is for members to

be around positive people who can teach fellow members new patterns of behaviour of identifying negative thoughts, replacing them and exhibiting the behaviours of a positive person in a social network. This can be achieved by exhibiting the human agency of positive intentionality (Bandura, 2001:6), which implies that an individual performs deliberate acts that exhibit positive behaviour related to positive affirmations in a social network where there is close and caring social support (Broocke et al., 2014:1).

4.5.1.2.4 Suppressing (bottling up) emotions

Most of the participants mentioned that bottling up their emotions affected them to a point of substance use disorder. Individuals tend to bottle up emotions and these negative emotions drive them to use drugs as a way of numbing their feelings. This is a contributing factor to the onset of the harmful use of substances. One of the participants shared that when recovering from substance use disorder, a person experiences numerous emotions. As a person sobers, they experience an array of emotions that are triggered by the social environment and social networks. These become difficult to address alone whilst in recovery. It is necessary to learn how to deal with one's emotions effectively, as expressed hereunder.

Participant 8: "What we tend to do is to start bottling up inside ok and cause us to be very emotional we start to keep bottling inside, it's better to speak to someone else, it's better to speak to someone that uhmm allows you to release what's inside and release that emotion that you kept bottled up inside".

Building on the CBT principle that emotions stem from thoughts, it is evident from the quote that to prevent the negative behaviour some participants resorted to suppressing their emotions. Individuals in addiction struggle to deal with their emotions (Bain, 2004:153). This could be why they coped with their emotions by using substances, which resulted in their diminished ability to effectively address and express the emotions that they experienced. It has been reported that numerous individuals are at increased risk of relapse due to experiencing negative emotions (Rahman et al., 2016:3). It was identified in a study of the relapse process that bottling up emotions could set people up for a possible relapse (Melemis, 2015:326). Common negative emotions that are bottled up included a low mood or sadness, frustration,

anger, anxiety and resentment (Rahman et al., 2016:3). These are some of the predominant emotions that people in addiction experience and suppress. One of the participants mentioned that he experienced feelings of depression and anger that were detrimental to him in the sense that he experienced a diminished ability to confront these emotions because of having opted for drug use as an alternative coping mechanism. The participants expressed their need to have someone to assist them to address their suppressed emotions. One of the participants had this to say:

Participant 4: "Right now just to have that someone to speak to when times are tough. All right like for example when you lose your job or something yhooo, the emotions that come along with those kind of things is not easy to deal with as an addict because our first escape is always run towards drugs".

Participant 4's statement highlights the need to have someone to speak to when difficult challenges come about to prevent the bottling up of emotions so that these emotions do not pose risks. The participants in a study conducted by Swanepoel et al. (2015:426) reported using drugs as a way of resolving emotions, thus highlighting the need to have social support and someone to speak to as a critical preventative measure against drug use. Having this preventative measure in place will assist in dealing with the emotions so that they do not pose risks. The support group offers the value of speaking to people in a social network and deriving the required social support as a way of mediating challenges (Taylor, 2011:192).

4.5.2 How community-led support groups respond to the needs of young adults active in support groups

The participants identified their needs in relation to their recovery in the aftercare process, as was discussed in the first theme. The first theme's findings and discussions echo the importance of support groups in responding to the needs of individuals in recovery as a means of preventing relapse and improving the recovery potential of all individuals who are part of the support group. This need coheres with the sentiment expressed by Van Der Westhuizen (2013) that the goal of aftercare is to prevent relapse and one way to achieve this is by support groups responding to their members' needs. The overall findings of how the support groups respond to their members' needs is through integrating faith (Christianity) in the meetings, the availability of group and individual support within the social network and offering

guidance regarding coping skills. These findings are unpacked and discussed in the ensuing section.

4.5.2.1 Religious faith as a key component of support groups

Most of the participants reported that Christianity had assisted them in their recovery and remaining sober. The participants also reported that the support group played a role in building their faith and their relationship with God. Most of the support groups included in this study had integrated religiosity in their approach to intervention and support for members. This has yielded positive results, as most of the participants reported a change in themselves after having an encounter and continuous engagement with their religious faith. Chen (2005:14) found that spirituality was vital for a successful recovery from addiction. Most of the participants expressed that in their support group they read the bible and prayed. One of the participants expressed that their mentor utilises bible scriptures in dealing with various problems. The participant expressed this during the interview:

Participant 4: "So the support group meetings I go to are Christian meetings that is held at my church and what happens was that most important part of my recovery has been my relationship with God and we understand him. A lot of our support group meeting start off with the people saying what's going on with them at the moment then the pastor will reply with a Bible verse and from the Bible and his own experiences with dealing with people with addiction and we go through and we actually find that the way pastor is doing it is building my spiritual life to take care of the addiction problem."

Based on the findings, it was evident that Christianity plays a significant role in a person's recovery and having a relationship with God is paramount. The support group offering this opportunity and having this component integrated into their practice has had a significant impact on participants' recovery. It was also noted that faith influenced perceived rejection, as faith fights against the spirit of rejection. It has been hypothesised by the faith-based community and academia that the negative things we experience in life are a result of evil spirits. An example explaining the preceding statement is when an individual commits adultery and it is referred to as the spirit of lust. In this particular case, the rejection, whether perceived or real in the case of the

religious community, is referred to as the spirit of rejection. It has also been reported that high levels of faith-based immersion have been linked to a decreased risk of substance use and spirituality performs an important role in recovery (Lund, 2017:352). Most of the participants expressed how they build one another's faith in support group meetings and the consensus is summarised in one of the participant's opinions when he said that:

Participant 3: "When we were together in the group, we were like sitting in the word and open up [the] word to strengthen our spirit[ual] energy. The support is very, very good as because you know why? Because [of the] lots of prayer."

Participant 9: 'I pray to God, I speak to God. He answers me in different ways and it shows you [a lot] the support group help me with that."

Engaging in religious activities such as reading the bible and praying significantly strengthened their faith. These activities were mostly practiced in a group setting in which social support was reciprocally exchanged amongst the participants. All the participants mentioned that faith had expanded their views and understanding. The consensus expressed by the participants regarding faith was that it gave meaning to life. This was a particularly interesting view in that they all expressed that faith and having a relationship with God assisted them in remaining sober. Chen (2005:2) mentioned that a spiritual dimension was associated with the meaning of life. This is defined as having a sense of coherence and purpose in one's existence (Chen, 2005:2). Having meaning in life is important, especially when it is associated with spirituality. Whilst religion and spirituality are different, these two concepts are interrelated and drive key faith-based interventions. It is important to note that the participants spoke of these concepts interchangeably, which implies that they did not distinguish between the two. Religion can be described as beliefs and practices that are initiated and united into one single moral community referred to as a church (Van Niekerk, 2018:3). Examples reported by the participants included attending church services, engaging in praise and worship, reading the bible as a group and focusing on the word. Spirituality can be described as having a relationship with God through Jesus Christ through the indwelling of the Spirit within the context of a community of believers (Van Niekerk, 2018:8). It means believing that there is a higher being that transcends the self and that we are all connected to the higher being (Spencer,

2012:2). Several of the participants reported having a relationship with God and praying to God.

4.5.2.2 Connecting through online media during lockdown when face-to-face contact was not possible

Most of the participants noted that some form of an online medium was employed to support them in their recovery. This medium was utilised in various ways and for different purposes. The three most common ways that this online medium was used was through WhatsApp texting among peers regarding challenges and sharing motivational texts, as a way to maintain contact with the convener of the support group and with other members of the support group, especially when they could not meet at support group meetings. The second medium was cell phone calls with support group members phoning and texting one another to maintain contact, especially those who did not have smartphones.

Participant 4: "When you on this road like in lockdown specially we can't get the face-to-face anymore which is difficult but if you got communication we can Skype one another and stuff it's been really good".

Online media were utilised sparingly before COVID-19 and lockdown regulations but when face-to-face meetings were no longer allowed, they were relied upon when responding to the needs of members in addiction recovery and offering support to them. It was found that the support groups still convened online meetings as far as possible through these media during the lockdown.

Participant 4: "I still attend my support meetings every week when they are available. Lockdown has been a bit more difficult, but we have our meetings now on Whatsapp with WhatsApp calls and stuff like that and it's been, it works because everybody is just a call away literally call away and now also WhatsApp message away".

The foregoing quote ties in with the earlier findings that some of the participants who had smartphones utilised WhatsApp for communication and support. The foregoing discussion implied that remaining in contact via online media prevented the risk of exposure to COVID-19 and saved on the cost of transport. This type of support was available 24/7, whereas face-to-face meetings were not (White & Dorman, 2001:694).

This medium was instrumental in assisting members with their need for support in addressing longstanding addiction recovery and offered the opportunity for indirect assistance to manage the risk factors for relapse. Bergman and Kelly (2020:2) posit that online recovery services that facilitate peer-to-peer connections may help to prevent SUD relapse. In practice, this strategy enabled adherence to lockdown regulations and could enhance members' coping skills through gaining new information and vicarious learning and enhance recovery potential and self-efficacy through access to online peer support (Bergman & Kelly, 2020:2). The social cognitive theory posits that we learn new ways of coping from one another through observation and cognitive processes such as intentionality, which in this case was instrumental in the learning process in the social environment (Bandura, 1989). This process of learning new behaviours of coping is guided and facilitated by the principles of social support, where the experience of being cared for and loved by others as part of a mutually supportive social network was instrumental (Taylor, 2011:192). The process was that members made contact online as a social network and exchanged intentional behaviour that exhibited emotional and informational support through social learning (Taylor, 2011; Bandura, 1989).

4.5.2.3 Providing individual and group-based support

All the participants reported that they received support from their peers and mentors in the support group. Being part of a social network and receiving social support has seen notable benefits from the implementation of both the one-on-one and group support that are discussed in detail hereunder. To support and show the relevance of these two intervention strategies, participants had this to say:

Participant 5: "Uhh my experiences of attending or being at the support group is the fact that you know, my experiences are most definitely the fact that talking about your problem and sharing with people that care, that are willing to support you, that are willing to help you is very good in order for you to overcome."

Participant 6: "Basically the support group gave me just somebody to listen. You want somebody to listen and have [the] perfect experience to understand what you going through and after that you can work through it and you will live longer."

The first quote indicates that the support group offered support and intervention in a group format with members engaging with one another through sharing their problems and offering support to one another. The findings indicated that intervention on a one-on-one basis was also practiced. The findings indicated that the two methods assisted members to address their respective support needs. The two methods are expanded upon as categories hereunder. The rationale for an in-depth discussion is to show how support groups intervene in a group format and on a one-on-one basis. Although support groups are referred to as interventions, the strategies that are employed differ in their application and must therefore be discussed separately and in-depth.

4.5.2.3.1 Group support as a form of intervention

Most of the participants opined that the support group offered group-based support where they were given a platform to share their problems and issues and to work around them. Some of the participants expressed that they spoke about general topics or things that were bothering them. These general topics included but were not limited to emotions and trigger management. The intervention component of religious faith, as mentioned in the preceding sub-theme, was presented through the medium of group-based support, where religious faith-related practices were implemented in response to members' needs. The central aspect was having the platform to share problems and have access to people who could offer a helping hand in dealing with any issues that the member was experiencing. Most of the participants expressed that the support group assisted them by members listening to their issues and them learning new skills from one another on how to deal with these issues. The support group offered social, emotional, informational and structural support in a safe environment. Structural support refers to patterns of interrelationships within a social network and how interaction is channelled within the social network (Tuliao, 2008:86). The participants had this to say:

Participant 8: "…and the nice thing is the support group is that [it] is people who love you, we give attention to the people with the same problem and then maybe too[we] learn from their experiences and maybe you didn't know about something and something maybe start doing this that's the thing."

Participant 7: "I've been through a lot and talking to them it's [has] help me to deal with a lot of things I've dealt with emotions and yeah just general things that I subconsciously beat myself up I beat myself up about it and this so speaking to them just helped me realise that there is a way to go during the choices I've made and all that so that's the job that they do for me."

Participant 5: "And I was hoping that the support group was going to help me towards change more than anything."

The foregoing statements imply that group-based support intervention assisted by paying attention to the members' needs and problems and offering support and advice. The benefit of this response was learning from one another's experiences and prompting the individual to change his actions and decisions. The focus of the support group was to facilitate change in individuals in recovery. This implies that the purpose of the implementation of this strategy was to bring about change. Mutual aid support groups assist individuals to take responsibility for their drug-related actions (CSAT, 2008:1). Peer support can be explained as the process of giving and receiving non-professional support and assistance from individuals with similar problems and challenges by sharing knowledge, experiences and coping strategies and offering an understanding of addiction and recovery (Tracy & Wallace, 2016:144). The essence of support is sharing knowledge and experience to benefit other active participants. Mogro-Wilson, Letendre, Toi and Bryan (2015:135) found that utilising mutual aid support groups significantly reduced favourable attitudes toward drug use and decreased the consumption of drugs as individuals changed their attitudes and learnt coping skills. We learn new patterns of behaviour through observation and modelling and drawing from the rules embodied or the learnings involved in the modelled behaviour (Bandura, 1979:3). The cognitive component of intentionality was instrumental in facilitating the learning of modelled behaviours (Bandura, 2001:6). This occurs when deliberate acts of conferring support are performed, the learnings from the modelled behaviour are extracted by other members and the self-efficacy principle kicks in and the belief in one's ability to emulate the learnt behaviour (Bandura, 2001:6;60). All this occurs through the implementation of collective agency, where people achieve desired results through interdependent effort (Bandura, 2001:13). The component of collective agency can be explained from a social support perspective as

learnt behaviour being a form of social support in that exhibited behaviours are aimed at giving and receiving social, emotional, informational and structural support (Taylor, 2011:192; Bandura, 2001:13). These characteristics of social networks play a role in the conferring of support, as these include compositional attributes such as struggling with SUD and recovery (Song et al., 2019:9).

4.5.2.3.2 Intervention in the form of one-on-one support

Most of the participants expressed that while they were in a support group, they had access to one-on-one support. This was evident when most of the participants mentioned that the support group offered someone to speak to, especially when times were tough. The one-on-one assistance was from the mentors or leaders of the support groups and sometimes from peers. The peer support was more by means of online media. As part of a social support group, individuals can build a relationship with all the members and the leader until an individual identifies someone to confide in inside and outside the group. A common practice in support groups is that members and leaders avail themselves as a ‘sponsor’ to a particular individual to deliberate on issues that the individual might be going through. Most of the participants mentioned having such a person with whom they could speak and one of the participants shared the view expressed hereunder.

Participant 4: “To have that someone to speak to when times are tough like for example when you lose your job or something, the emotions that come along with those kind of things is not easy to deal with as an addict because our first escape is always run[ning] towards drugs. I find myself running towards my pastor who is my mentor in the support group and ja, I can't even begin to explain the amount of help I get from him it's incredible it's been a life-changing experience for lack of a better word.”

The support groups that utilise the 12-step principles also incorporate sponsors. A study conducted by Crape, Latkin, Laris and Knowlton (2002:297) confirmed that receiving direction and support from a sponsor was associated with sustained abstinence. Some of the participants expressed that they value helping others because they reap reciprocal benefits and both parties are empowered in the process.

One of the participants shared the statement hereunder in relation to providing individual support.

Participant 3: "You have that one person interests you then you work him from inside the group and out of the group."

Participant 3: "You can go to people to empower yourself or encourage others while you encourage other people you can get empowered within yourself by encouraging other people."

It was clear that helping others and assuming the role of a sponsor empowers one and improves one's recovery potential. The participants in the current study were sponsors that had been in the support group for a long time. Crape et al. (2002:297) found that sponsors are valued and that maintaining this role could motivate them to maintain sobriety. This process, identified as intentionality in a group format, also applies to a one-on-one format where verbal modelling and learnt behaviour occur intentionally (Bandura, 2001:6). Social support can take various forms and in this instance, it was one-on-one (Taylor, 2011:192). It was noted that informational support occurs when one individual helps another to gain an understanding and knowledge of a problem and offers advice about how to cope with the problem (Taylor, 2011:192).

4.5.2.3.3 Gaining coping skills and guidance

Several of the participants mentioned gaining coping skills to address problems and maintain sobriety. They also mentioned that they were guided by other support group members, mainly the older members in the support group who have more experience of addiction and recovery. This guidance was in the form of informational support about what to do and how to do it when making behavioural changes. The guidance is usually related to whatever the individual might be going through and is viewed as social support. One of the participants expressed the view presented hereunder regarding guidance and advice and how it is conferred.

Participant 8: "Ok we come together as the guys to have that brotherly connection to confide in one another and also to advise one another."

Participant 4: "It makes you feel calm they guiding me with how to deal with whatever I'm struggling with."

These coping skills were gained through online, individual and group support by reflecting on the members' own experiences and knowledge of addiction and recovery. Transferring coping skills and guidance is a response to members' needs. Moos (2008:391) added that individuals who are involved in support groups are more likely to rely on coping skills directed at controlling addiction. Donovan, Ingalsbe, Bebow and Daley (2013:6) posit that support groups offer behaviour change processes and role models for how to work toward abstinence through the development of more effective coping skills. Several of the participants admitted that they needed to learn to control their emotions in recovery. This could be viewed as one of the roles the support group plays in working towards decreasing risk factors by offering a platform where individuals can gain coping skills and guidance as a way of preventing relapse. Moos (2008:391) found that individuals who participated in support groups relied more on approaches to coping and less on avoidance strategies. It is important to note that there are two types of coping mechanisms and although different, the participants did not appear to see a distinction, which could mean that they have experience of both. These are referred to as problem-focused and emotion-focused coping. Problem-based coping can be defined as active efforts or actions aimed at managing stressful situations (Schoenmaker, van Tilburg & Fokkema, 2015:154). Emotion-based coping can be described as regulative efforts aimed at minimising the emotional consequences of stressful events (Schoenmaker et al., 2015:154). Both of these were evident in this study's findings. Based on the current findings, these strategies included having someone to talk to and also having a support group to communicate with when experiencing emotions. These are efforts to minimise the consequences of bottled-up emotions. Problem-focused coping includes eliminating friends that harm one's wellbeing. As noted by the social cognitive theory, people learn from one another by observing behaviour. The vehicle for learning new patterns of behaviour is through the observation of abstract and verbal modelling (Bandura, 1989). In the current study, verbal modelling and observation were applied to gain coping skills that would assist in addressing problems experienced by the members. The human agency (the cognitive component) responsible for the operationalisation of modelled behaviour relating to the learning of coping skills was forethought (Bandura, 2001:7), which can

be understood as the process of anticipating prospective actions, setting goals for themselves and planning a favourable course of action that is likely to produce desired outcomes and avoid detrimental outcomes (Bandura, 1989:39). They thus learn new coping skills to address future challenges that may arise and plan further courses of action (Bandura, 1989:39).

4.5.3 Benefits of community-led support groups to young adults in recovery

Responding to the needs of support group members has various reciprocal benefits for individuals who are actively providing and receiving social support. The overall findings are based on strategies that are employed by support groups, as noted in Theme 4.5.2 in responding to the needs that were identified in Theme 4.5.1. The sub-themes that illuminate the specific benefits include the support group being a place for intrapersonal growth, reciprocal learning from experiences, social support, a safe platform to share and learn from one another's life stories, the support group as a safe environment in fostering acceptance and care, non-judgmental support and members learning to forgive themselves, which increases their understanding of others. The support group also facilitates the restoration of family relationships and thus promotes relapse prevention. All of the above-mentioned findings are discussed in detail in the ensuing sections.

4.5.3.1 Place for intrapersonal growth

This sub-theme deals with the intrapersonal growth reported by all the participants, especially as it relates to the spiritual growth that was gained from incorporating faith into the support group meetings. This was a particularly important benefit because the support group offered the opportunity for spiritual growth and development in its practice. Some of the participants attested to changes in their lives due to the personal growth experienced from participation in the support group and others experienced a change in their mindset, with more positive than negative thoughts occurring. This is an internal change and implies that the support group intervention yielded positive results towards cognitive change. The participants' narratives suggest that the support group offered them an opportunity for reflection on their lives and challenging the areas that required change, as expressed by Participant 6 hereunder.

Participant 6: "At the moment it's given me a platform to sit back evaluate the areas that went wrong in my life and is giving me the platform to rebuild and restructure my life so that I don't have to experience those problems again."

Another participant who reported that the support group prompted character development, expressed himself as follows:

Participant 5: "You have to meet God's other son I mean other sons of God you know that have been through what you have been through where they communicated and shared and you know developed character and showed positivity, reflection and everything. It is also important that the group should dissect into avenues that will guide you towards or rather each one guide you towards their purpose."

The findings link to the support group offering a platform to rebuild and restructure members' lives, which is a benefit of participating in a support group. Moos (2008:389) posits that support groups encourage personal growth in the areas of responsibility, self-discovery and spirituality. These reported personal growth areas highlight the inclusivity of faith. These reported benefits are consistent with the findings of the current study. Tracy and Wallace (2016:145) posit that peer-led support groups are facilitated by people who are also in recovery and the benefits for them are increased self-esteem, confidence and positive feelings of accomplishment that contribute to personal growth. Participants in a study undertaken by Boycee (2015:101) confirmed that the support group was a space where one could communicate and learn from other members and this contributed to increased self-awareness and personal insights. The various social support strategies facilitated personal growth among the support group members. Personal growth was also facilitated by self-reflection, which is when one reflects on oneself and the adequacy of one's thoughts and actions (Bandura, 1989:58). This process was facilitated the through reflecting on actioned behaviours that was learnt during the process of conferring social support to each other and further applying intentionality related behaviours on members to draw learnings from this actioned behaviour (Bandura, 2002).

4.5.3.2 Social Support

The participants' need for social support in their recovery from addiction was discussed in Theme 1 when it was discussed how the level of social support could influence addressing the participants' needs. Social support can be described as being aided, cared for and loved within a mutually supportive social network (Chan et al., 2020:1; Taylor, 2011:192). The current discussion focuses on social support and its benefits in response to the participants' needs. The findings indicated that high levels of social support contributed positively to change and addressed problems related to addiction. All the participants shared in their own words how they have been cared for, accepted and loved by their peers in the support group. Another description of social support is perceived support emerging from members giving and receiving emotional, informational and practical assistance within a social network (Chan, Chen, IP & Hall, 2020:1; Nurullah, 2012:173). These were the benefits that the participants gained from being part of a support group. The participants also expressed how they are around like-minded people who are willing to listen to their problems. Their common experiences with regard to addiction and recovery made supporting one another easy. As mentioned earlier, the various types of support were identified as social, emotional, informational and structural. Reflecting on the benefits of mutual support, the participants shared the views presented hereunder.

Participant 7: "It's nice to have people that can relate to you and then can be there for you just emotionally and whether you need anything they also there for you then it feels good I mean it helped me a lot."

Participant 1: "So I cannot explain this thing but to me it's a good thing for me because really it's starting to change my life every day and [I] learn new things by the support group and with people's lives it's benefiting for me in being here and helping. The support from other people is very good."

Emotional support was in the form of supporting the individual emotionally and offering a platform for him to share his emotions. This ties in with the need to have an outlet for expressing emotions and not using drugs as a means to suppress emotions. Informational support can be in the form of sharing information related to drugs and recovery, specifically ways of preventing relapse. The findings indicated that the

participants learnt about danger points or triggers and how to deal with them. The provision of social support was evident in the support groups providing members with a platform to share their problems and the members focused on addressing their problems. This was facilitated by having members learn how they interact within a social network and how they should support and communicate with one another. Their realisation of having support was based on the positive social ties built with like-minded people who were willing to offer various types of support. Chen (2005:14) mentioned that those perceiving high levels of social support depict behaviours of being more supportive than do those with low levels of support. The mode of agency that was applicable was collective agency, as referenced in Bandura's social cognitive theory (Bandura, 2001:13). This was supplemented by the human agency of intentionality, where one constructs and shapes courses of actions and regulates one's behaviour (Bandura, 2001:7). The implementation of such is guided by social support principles that align with collective agency, where efforts and actions are interdependent in conferring social support (Taylor, 2011:192; Bandura, 2001:13).

4.5.3.3 Safe platform to share life stories and learn from one another's experiences

All the participants noted that the support group offered a platform where they could share their life stories pertaining to addiction. The support group was a safe environment where the members were accepted and not judged for their past life. All the members had a story to tell and felt at ease to tell this story in a safe space. This sharing also offered the opportunity to open up about the needs they had in recovery, as was suggested in the first theme. Not only stories were shared but also testimonies and learning from one another's experiences, as noted by all the participants.

Participant 4: "It definitely becomes easier because with new people that are coming in and you get to share your experiences and stories with them and then with the people that have been there longer you get to share your experiences with them and they share their experiences and you get to learn a lot man you can learn things you didn't even realise that even if you were sober for five years and in you and you can come in looking for help and he can teach you something that will just blow your mind you know so it's awesome."

Participant 5: "To feel supported and to also to be willing to do my best to change for the better and also, my experiences are that the support group usually filled with different people from different nations and it comes to enlighten and I'm learning love, I am learning to communicate."

The essence of this sub-theme was reciprocal learning and how this was achieved through observing behaviours modelled by other members in a collective agency (Bandura, 2001:13). The process of sharing experiences was the verbal modelling of informational and emotional support. The guiding cognitive processes included all the cognitive components of the social cognitive theory that promote learning (Bandura, 2001).

4.5.3.4 Social support group - a safe environment for fostering acceptance and care

Several of the participants reported that their needs for acceptance and care were satisfied by their social support group network. The participants reported that acceptance and care were exhibited by not labelling, showing kindness, listening and assisting with problems, which encouraged them to work on forgiving themselves. One of the participants had this to say:

Participant 5: "…giving me support like a family… they don't judge me for what I have done. …they looking at me now and accepting me for the way that I am growing and they give me that room to be able to grow to a new person."

This finding indicates that the support group as a social network exhibited acceptance, mirroring the humanistic characteristics of a family system by accepting and not judging. Creating a safe environment was of the utmost importance for the support group, as individuals heal and grow in a safe and positive environment. Further deliberation of this sub-theme is in the form of categories, namely non-judgemental support and forgiveness of oneself to understand others.

4.5.3.5 Non-judgmental support received

Some of the participants expressed that they received non-judgemental support and were accepted for who they are, despite having shared their past experiences with group members. This enabled individuals in the support group to work towards forgiving themselves, which in turn helped them to understand others' experiences.

Participant 6: "How they've been accepting me is that they don't judge me for what I have done they actual (-ly) look for what I am doing they looking at me now and how far and accepting me for the way and the way that I am growing."

The foregoing statement reiterates the non-judgemental support through the explicit action of accepting the person. This was all possible because they were able to forgive themselves to understand others' experiences and subsequently accept them without bias. This acceptance was critical to each individual's recovery and this links to the sub-theme 4.5.1.2.3 that was identified as members needing a non-judgemental, non-stigmatising environment where they would not experience any form of perceived rejection. The actions that were exhibited were deliberate and supplemented by the self-reactiveness of actions that constructed and shaped their courses of action and included offering non-judgemental support (Bandura, 2001:10). The appropriate actions cited were aligned to the principle of social support of caring for others without judgement.

4.5.3.4.2 Learn to forgive the self to forgive others

Some of the participants expressed they were able to forgive themselves to then attempt to forgive others. They mentioned that they needed to forgive others because it was a part of trying to fully forgive themselves. Perceived self-rejection played an inhibiting role in forgiving the self. As mentioned earlier, rejection was associated with feelings of shame and guilt and learning to forgive oneself was important in removing those feelings (McGaffin et al., 2013:2). The participants felt guilty about their past actions and felt that carrying the burden of guilt with them was a way of punishing themselves and they sometimes felt unworthy of forgiveness. This guilt was fuelled by the perceived stigma of substance use. Self-forgiveness diminished the guilt, which resulted in the establishment of a shame-free identity (Guetta, 2013:450).

Participant 9: "Forgiveness okay they told me, and as I've said[have] experienced [is] that if you don't learn to forgive yourself then you won't be able to forgive others you understand? So in my life as in the past, I've gone through a lot of stuff you understand so that stuff hurt me emotionally, physically and bottling that stuff up and expressing it to other people helped me a lot yes."

Self-forgiveness facilitated the process of forgiving others. In my opinion, they needed to forgive themselves for the decisions they had made in the past and the destructive actions that harmed them and others emotionally and physically. Pursuing self-forgiveness contributes positively to recovery by reducing anger, depression and anxiety and their vulnerability with regard to drug use (Guetta, 2013:451). Guetta (2013:451) noted that those who have undergone self-forgiveness reported positive gains with regard to abstinence, recovery potential and the reduction of exposure to intrapersonal factors that could place them at risk.

It was important to the participants to ask for forgiveness from the people whom they had wronged in the past. The support group enabled the participants to realise that they needed to forgive themselves for what has occurred in the past. Once they had forgiven themselves and others, they began to experience the benefits of seeking forgiveness from others, which included emotional healing, repairing broken relationships and repairing broken trust. Religion served as a catalyst for forgiving themselves. Part of self-forgiveness included "accepting who I am" and several of the participants referred to their spirituality as the catalyst for self-forgiveness. The support group intervention strategies facilitated the members sharing their hurt in an accepting environment and learning was instrumental in this. Bandura (2001:6) explains that we learn from observation and the participants learnt from observing the behaviour exhibited by other members on how to promote self-forgiveness.

4.5.3.5 The support group facilitated the restoration of family relationships and thus helped with relapse prevention

Repairing and rebuilding relationships is important in recovery because it has to do with growing a social network of support that is instrumental in recovery. Several of the participants expressed that the support group facilitated the repair and restoration of their family relationships by teaching them how to communicate, rebuild their lost bonds and love their family members. The support group as a social network mirrored

the aspect of building, communicating and loving people within the unit. Another way the support group was instrumental in the restoration of the family was by encouraging the individual with SUD to change. This resulted in the individual growing his support structure by including his family and the dysfunctionality that was once in the family no longer served as a trigger for relapse. This change in the individual had a positive effect on the family, as a change in a subsystem brings about a change in the whole system (Poole, 2014; Lander, Howsare & Byrne, 2013:4).

Participant 5: "It has helped me positively because at least now I am more of a man in the house than I have ever been at home. I have a good relationship with my mother, a good relationship with my sister, a good relationship with my daughter, I have a good relationship with my nieces you know I spend lots of time at home instead of being in the streets.''

The foregoing statement aligns with how the participant expressed that the support group meetings and interventions had helped him positively in that he was able to have a relationship with his family system and spend more time with them. It has been found that restoration, reunification and newly established social relationships with family and support groups are paramount to recovery and offering ongoing support (Stokes et al., 2018:7). These are the benefits that the support groups offer to members who are active participants. This ties in with Participant 5's ability to forgive himself and gain an understanding of his family members and ask for their forgiveness. This aspect of recovery was important to all the participants. Focal to support group intervention is repairing and restoring the members' former relationships. The consensus was that most of the participants had received such benefit from being part of the support group despite only one of them explicitly stating such. The participants learnt from the modelled behaviours related to the relationships they had formed with other members of their support group. This could be based on how they accepted one another and showed love, care and support (Bandura, 2001). These modelled behaviours were mostly guided by the principles of intentionality and self-reactiveness in exercising or modelling these behaviours (Bandura, 2001).

4.5.4 How community-led support groups assist young adults address risk factors of relapse

The term ‘relapse’ has been challenged and was used in the earlier themes. Academics have begun to acknowledge the existence and relevance of the term ‘setback’. The rationale is based on people making subtle mistakes early in their recovery. Individuals regress to negative behaviour for numerous reasons and this should not be mistaken for relapse. It is therefore important to acknowledge this term but, in this study, the term ‘relapse’ was utilised. The primary aim of recovery is preventing relapse during aftercare. Most of the participants mentioned how the support group had performed a role in the identification and management of triggers. Relapse prevention can be seen as a behavioural approach with the outcomes of identifying and addressing high-risk situations that could increase the likelihood of relapse and assist individuals to maintain sobriety (Menon & Kandasamy, 2018: 473). Triggers experienced by individuals in recovery contribute to probable or increased risk of relapse. In this study, the term ‘risk factors’ was used interchangeably with ‘triggers. Knowing how to deal with triggers is important in recovery to decrease the risk of succumbing to cravings that may lead to relapse. Relapse prevention has two specific aims, which are preventing an initial lapse, maintaining sobriety and managing a lapse if it occurs (Menon & Kandasamy, 2018:473). These specific aims were evident in the study’s findings, but the first aim was more applicable to this theme. Achieving this aim entails finding ways of managing triggers and employing intervention strategies for trigger management. The support group is one of the vehicles employed for dealing with triggers. The findings pertaining to the support group’s assistance in dealing with triggers included: assisting to identify triggers; implementing behavioural strategies in response to the triggers; religiosity as an intervention to combat triggers; avoiding situations that could tempt relapse; finding a constructive alternative outlet and remaining busy. The identified sub-themes were viewed as viable strategies to address triggers. These concepts mirror protective factors. These findings are discussed as sub-themes and categories in the ensuing paragraphs.

4.5.4.1 Assists in the identification of triggers

Several of the participants opined that the most important facet of recovery is identifying one's triggers. One of the participants referred to triggers as danger points. High-risk situations, or triggers, are circumstances or situations that threaten or make a person in recovery vulnerable to not maintaining abstinence (Hendershot et al., 2011:2). The participants expressed that the support group was instrumental in teaching them how to recognise these triggers and high-risk situations. Some of the triggers that the support group assisted the participants to identify were environmental risk factors, for example, places the participants would frequent when using. Interpersonal factors were identified as friends that still used or that were unsupportive and a lack of recreational activities. Intrapersonal factors include a lack of motivation, negative emotions and perceived rejection. Although there is a wide array of triggers, those that the participants identified were mentioned in the earlier literature review chapter (Swanepoel et al., 2016:422). The participants' statements regarding triggers are included hereunder.

Participant 6: "I believe, the only way you can start to handle triggers is by the support group, by being aware to what your triggers are and by giving you the tools to overcome those triggers."

Participant 7: "Well, we learn to identify triggers, suss [assess] out a situation, identify your triggers and you avoid them not only can you avoid them but a lot of times…''

These findings align with the view that support groups serve as an intervention strategy for the identification of triggers. Trigger identification can be categorised as informational support. The assistance provided in the identification of triggers leads to the identification of specific intervention strategies to combat those triggers. Explaining this from a theoretical perspective, individuals conferred informational support through self-reflection (Bandura, 2001:10). The applicability of this can be explained in the sense that one reflects upon oneself and the adequacy of one's thoughts and actions and these reflections on past experiences and the determinants of relapse can then be identified in a collective agency as triggers (Bandura, 2001:10).

4.5.4.2 Implement behavioural strategies in response to triggers

Recognising triggers or risk factors is the first step in trigger management. After identifying one's triggers one must devise behavioural strategies to implement to prevent and manage those triggers. As noted earlier, relapse prevention is a behavioural approach to prevent lapses and encourage abstinence through responding to triggers or high-risk situations (Menon & Kandasamy, 2018:473). Strategies for response are trigger-specific and as such, a wide array of behavioural strategies are employed. The findings regarding these strategies are discussed hereunder as categories. To depict the importance of being equipped with strategies for handling triggers, one of the participant shared this:

Participant 6: "So if you get equipped by the support group on all these things on what these triggers are and how to handle them, what you should do like this and like this then you become suddenly active."

The findings confirm that support groups play a vital role in trigger management and response. This is particularly important, as support group functions and social support particularly address risk factors to prevent relapse. These findings are unpacked in the categories discussed hereunder as well as selected strategies with which the participants were equipped through their participation in the support group. As mentioned previously, this is informational support and utilising information that was gained through self-reflection and applying forethought in response to this information as a way of planning and anticipating the likely future consequences of prospective actions and identifying courses of action that will likely produce desirable outcomes is necessary (CSAT, 2008:1; Bandura, 2001:7). This aspect is unpacked further as a category. It is important to note that these behavioural strategies include protective factors, as mentioned earlier in the literature review chapter. Protective factors are characteristics within and around the individual that are associated with the reduced probability of drug use or transition in level of involvement in drug use (Frisher et al., 2007:3).

4.5.4.2.1 Avoid situations that could tempt relapse

Several of the participants expressed that they deal with triggers by avoiding situations that may place them at risk of relapse. Some of the participants mentioned avoiding friends with whom they used to associate as users. The rationale, as stated by one of the participants, was that if you want to overcome an addiction you must make the necessary changes, one of which was avoiding high-risk situations. One of the participants mentioned a change in environment and described that he would not have been able to make the required changes if he remained in the same environment as when he was a user.

Participant 1: "…and it was my crowd that I changed the friends that I used to have so that I can come out of the place I was [in] so[because] I was no longer the same man, I could not stay in the same environment."

The aforementioned situations are referred to as environmental and interpersonal risk factors and avoiding these high-risk situations can contribute significantly to the reduced risk for relapse. This is based on the notion that minimised exposure to triggers can be achieved by avoiding those triggers. All this information was shared in a support group setting. Goliath and Pretorius (2016:123) found that avoiding places where substances were used and travelling a different route contributed to the maintenance of sobriety. Altering one's social network by avoiding old friends and associating with non-drug users served as a protective factor against being influenced to engage in drug use (Goliath & Pretorius, 2016:121-122). This view was supported by Burkholder et al. (2007:32), who found that the absence of gang membership was a protective factor. The human agency of intentionality was applicable in this section. Intentionality refers to intentional acts related to avoidance and changing an adverse social network (bad friends) into a positive social network that best fits the characteristics related to strength, interpersonal matters and size of the network and attributes that include characteristics of members within their network (Song et al., 2011:9; Bandura, 2001:6).

4.5.4.2.2 Find a constructive alternative outlet

Part of recovery is finding strategies to respond to triggers. As mentioned previously, there are numerous strategies. Finding a constructive alternative outlet has proved to be an effective approach to trigger management. The participants asserted that support group attendance offered an alternative outlet for trigger management because of the social, emotional, informational and structural support that the support group offers them. Several of the participants expressed that they did not experience any cravings whilst attending support group sessions. This was particularly interesting, as it tied in with one of the participants' assertions that the availability of a support group is important in preventing relapse. This also tied in with Theme 4.5.2 on how the support group responds to needs. The approaches cited in Theme 4.5.2 were also used as responses to triggers or risk factors. Some of the participants mentioned one such approach as talking to someone who understands what you are going through, referring to a sponsor or mentor. These strategies reflect interpersonal protective factors.

Participant 6: "Well the first sign is that we will sit him down and start seeing what [if] something is coming up he needs a bit of help he needs to get someone to talk that's the best thing, that's the best thing. That's why talking to someone who is understanding who has also been through the same thing that is the first one. The second one would be we try to build him if you start feeling down and you want to go back and you feeling you like you want to pop, go find something to do that will take your mind off it those could be the… things you could do to stop feeling those triggers from coming up in your life."

If individuals experience challenges and negative emotions, they require effective coping mechanisms to deal with the problem and these include speaking to someone who understands. When one perceives that a relapse is imminent, one should focus on constructive behaviour rather than thinking about the craving to use and ultimately place yourself at risk. This is a distraction tactic and finding a distraction is viewed as a trigger management strategy. Therefore, supporting an individual through a specific situation assists in lowering the risk of relapse and improving the potential for recovery (Crape et al., 2002:37). The findings revealed that those who attended mutual support groups recorded an abstinence level of between 66% and 77% depending on the

frequency of their attendance (McPherson et al., 2017:1). Brown et al. (2002:586) posit that aftercare support group attendance improves recovery potential and lessens the probability of relapse. This is commensurate with what was found in category 4.5.4.2.1, where the participants mentioned avoiding previous friends and making new friends to create a positive social network such as that found in support groups.

4.5.4.2.3 Keep busy for the day

Most of the participants expressed that keeping busy was important in recovery. One of the participants shared that keeping busy includes engaging in positive activities with friends. The rationale was that whilst in addiction a person missed out on numerous experiences and when in recovery realised that there are better things in life than drugs. Several of the participants noted that keeping busy with small jobs, gardening and housework helped them to implement the trigger management approach. Performing such tasks also indicated to others their seriousness about trying to change their ways.

Participant 7: "So not to put myself in a situation where I'll be tempted to relapse, so just stay away from all the temptations, rather go to a friend that you know has got the best interests for you and go do something for the day."

The findings revealed that keeping busy was instrumental as a behavioural approach to dealing with triggers and that performing positive activities with a positive social network assisted in boosting confidence in recovery and potentially prevented relapse. This category complemented the category of avoiding high-risk situations. Filling time and remaining busy was important because in their past life they spent most of their time finding ways to obtain money to purchase and use drugs.

Rhodes et al. (2003:317) posit that social activity is a protective factor against relapse and that some drug prevention interventions promote diversions. Active participation in positive, non-drug associative social activities was recommended and supported (Rhodes et al., 2003:317). Keeping busy entails planning for the day about how to keep busy as a way of avoiding exposure to triggers. The relevant agency is forethought and planning to achieve the desired outcome of avoiding triggers (Bandura, 2001:6). Instrumental in the planning was the informational support received from the support group members through their exhibiting of verbal modelling and

observing such in relation to the topic (Sari et al., 2018:68; Nabavi, 2012; CSAT, 2008:1; Bandura, 1989, 2001:6).

4.5.4.3 Religiosity as an intervention to combat triggers

Although faith and religion are discussed in detail in sub-theme 4.5.2.1 as a response strategy, it is important to note that in this sub-theme, the focus was on how faith and religiosity assisted in trigger management specifically. The motivation for discussing this component as a sub-theme was that it expanded Theme 2.1. Most of the participants asserted that the religiosity incorporated into the support group meetings assisted them in combating triggers, as their spirituality and faith were strengthened and they gained a sense of purpose. One of the participants mentioned that the support group assisted its members to establish a relationship with God and ask Him to take away the addiction. The findings revealed that most of the participants perceived their religious beliefs as a protective factor in overcoming addiction and that they were unable to overcome SUD without faith and believing that a higher power would assist them to resist the temptation to revert to drug use.

Participant 9: "They taught me that if a danger point comes towards you and then you must just not let it go out of your mind you must just know that there is God that you can rely on in the support group honestly".

The quote hereunder by Participant 4 describes how religiosity is incorporated into support group meetings. *Participant 4: "So the support group meetings I go to are Christian meetings that is held at my church and what happens was that most important part of my recovery has been my relationship with God and we understand him, so a lot of our support group meeting start off with the people saying what's going on with them at the moment then the pastor will reply with a Bible verse and from the Bible and his own experiences with dealing with people with addiction."*

The findings indicate that building spirituality and faith assist in recovery through prayer and reading passages from the bible that address the problems being experienced by the support group members. Religiosity has been identified as a protective factor in preventing relapse (Burkholder et al., 2007:32). Spirituality is vital for successful addiction recovery (Atkins & Hawden, 2007:9; Chen, 2005:14). The operationalisation process of responding to triggers corroborates sub-theme 4.5.2.2,

which highlighted that faith was a key component of support groups. This incorporated trigger management and how faith played a role as an effective intervention approach in response to the needs and triggers of young adults in aftercare. Verbal modelling was utilised as a medium and this was evident when members in the social network gathered and applied human agency to depict patterns of behaviour related to verbal modelling and the sponsor reciprocally utilised the same cognitive processes in depicting informational support patterns of behaviour and the members observed the behaviour within the social environment (Bandura, 1989; 2001).

4.5.5 Recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention

All the participants asserted that their support groups' intervention in their lives had been helpful. Every intervention must be evaluated by means of feedback and recommendations made on how to improve the approach if necessary. These recommendations are important for the growth of the support groups as they need to remain relevant because the dynamics of substance use disorder are ever-changing. This aligns with what one of the participants shared about support groups developing character, which implies that they grow and change. This view gave rise to the research sub-question that asked what recommendations (advice) participants had for the support group to help young adults remain drug-free. This question presented a platform for the participants to share their views and recommendations about how their respective support groups could improve their interventions to assist members and fulfil their main goal of relapse prevention. The recommendations that were advanced by the participants were to motivate for consistent attendance, as long-term attendance and support are required for long-term recovery; the support group should have structure; the support group should offer activities that will keep the members busy; the support group should offer homogeneity in the social network (stay connected to positive people who have overcome addiction) and the support group should facilitate attendance by creating support groups that are easily accessible. These recommendations are discussed as sub-themes in the ensuing sections.

4.5.5.1 Motivate for consistent attendance

Some of the participants affirmed that consistent attendance of support group meetings was important and that members must be encouraged to attend support group sessions as frequently as possible if they wish to cope with their addiction. One of the participants shared that if a person wishes to change, he needs to attend the support group every second or third day. This was in line with the recommendation for consistent attendance. Another of the participants shared that one needs to attend a support group for at least three months and thereafter continue attending or join another support group, indicating that attendance must be ongoing and consistent. The rationale for the recommendation for consistent attendance can be summarised in one of the participant's words when he said that addiction is a lifetime battle and that one needs support because one cannot do it alone. To support the recommendation for consistent attendance, one of the participants had this to say:

Participant 4: "Well my personal experience I don't believe you should stop going to a support group I believe you need to attend one support group a week at least one and I don't think one is enough I think there were two minimum per week and then in the beginning I did 7 days because really, it's an important foundation of where you going and what you're supposed to be doing with your life you know."

Participant 4 asserted that with consistent attendance he was able to build a good foundation for his recovery. Several of the participants emphasised that it is important to attend meetings regularly and to not take a break because addiction recovery is a lifetime battle. Proctor and Herschman (2014:5) found that people who attended one or more support group meetings had better outcomes in terms of recovery than those who attended fewer meetings. It was also found that those who attended only one meeting a month had lower abstinence rates than those who attended more meetings (Proctor & Herschman, 2014:6). Henson et al. (2008:264) conducted a study in which one of the participants expressed that they attended meetings almost every day for the first five years. McPherson's (2017:5) study revealed similar findings that consistent attendance of support group meetings produces favourable outcomes in terms of abstinence. The foregoing discussion indicates the importance of consistent support group attendance in enabling favourable outcomes. Other reasons and motivation for consistent attendance are the benefits mentioned in the findings of

Theme 3 and how these are instrumental in preventing relapse. Support groups were also noted as a trigger management strategy as was revealed in Theme 4 and consistent attendance of meetings directly assisted in the consistent management of triggers and the consequent prevention of relapse.

4.5.5.2 Long-term attendance and support required for long-term recovery

Although there are similarities with the foregoing sub-theme, they differ in practice. They are different in the sense that this sub-theme refers to the period of attendance in a support group rather than the frequency of attendance. The rationale for including this sub-theme links to the influence the period or duration of support group attendance has on recovery potential. These sub-themes are similar and interwoven but, based on the findings, differ in focus and purpose. The focus of this sub-theme directly responds to the interview question of how long participants thought a person should be part of a support group for him or her to remain clean. The consensus was that long-term attendance is necessary for a person to remain clean and one cannot cease to attend support group meetings because addiction is a lifetime battle. No limit can be placed on the period of support that is required and one of the participants felt that support group attendance needs to be ongoing and should have continuity, implying that long-term attendance is recommended.

Participant 8: "Yhoo it's a lifetime battle, it's a lifetime battle because we can never be prepared for what's in life and when something hit us, or something bad happens we need to avoid that something bad from consuming your life. We need to speak to someone, we need advice we need someone to support us through that phase to prevent us from falling again. That's why the timing for the support group or the life span in a support group it's unlimited, you need unlimited time because we always ignore always as long as we in recovery we will be recovering for a very long time, and any support group bringing support should always be there."

Participant 4: "I think people need to be there as long as actually as long as physically possible I don't think it's a one-year thing, I don't think it's a two-year thing it takes a lot more time to prepare the mind and the body."

The findings revealed that support is required for as long as members are in recovery because of the unpredictability of recovery and the ever-present risk for relapse. What the participant could have been referring to when he mentioned addiction as a lifetime battle were the challenges of life and the high-risk triggers that a person may encounter in the future. It is important to acknowledge these and support groups respond to these aspects through their social support strategies that were identified in Theme 4.5.2 and sub-theme 4.5.4.2.1 regarding high-risk situations. Referencing the first quote, the same participant affirmed that a support group is required to prevent relapse. One of the participants claimed that he had been an addict for 25 years and that he could not expect one year of support to enable him to overcome his addiction. This implies that long-term support is necessary and there is no quick fix to get through addiction recovery. In support of this view, Proctor and Herschman (2014:6) postulated that consistent attendance of support group meetings had favourable outcomes, as previously stated but how does consistency of support group meeting attendance influence prolonged recovery? It was found that those who attended support group meetings frequently over 24 months maintained sobriety during that time whereas those who attended occasionally and those who did not attend at all were not as successful (Proctor & Herschman, 2014:6). The rationale for this statement is that friends and families are not equipped to handle the challenges that a person in recovery poses; support groups are equipped, experienced and able to identify and assist with the challenges encountered by those in aftercare. The second quote confirms that short-term support group attendance is not a quick fix for recovery management, as the mind and body need time to adjust to the absence of the drugs. This sub-theme builds on and ties in with the previous sub-theme in which it was stated that consistency is required over an extended period to facilitate long-term recovery. These two themes go hand-in-hand because consistent attendance is recommended for an extended period. One cannot function effectively without the other and as such these two aspects were noted as separate sub-themes.

4.5.5.3 Support groups provide structure

Although not all the participants expressed this in these words, this sub-theme was important to note, as it provided insight into the recommendations that were advanced for improving support groups' services. It was noted from the analysis of the data that individuals in recovery require structure in their lives and while they have support or

structure they must constantly improve the quality of their lives. There is no limit to the structure one should have. One of the participants expressed that a person must have structure in the form of social support and another shared that people who are used to never having structure in their lives benefit from the support group that offers structured support and activities. The structure referred to is the process of being supported to prevent reverting to substance use disorder. One of the participants explained that having a structure is like planning for the future and the support group offers structure in the form of support in that one feels accepted, part of a family and also receives social support.

Participant 6: "…also to give them that... structure, that love like a feeling of being part of a family of a support group."

This supports the view that support groups need to offer structured support to assist members with the problems they experience. One of the participants expressed that he did not have a purpose in life whilst under addiction and felt he needed to break through his addiction cycle by seeking assistance from a support group. Having structure can be viewed as setting personal goals to seek support and taking the support group seriously will prevent a person from falling and ultimately break the cycle. The recommendation was to strengthen the structured social support that was provided for members of the support group. The rationale for this is that the function of social support is to support thriving through adversity, serve as a buffer between the individual and negative stressors and assist that person to emerge from the stressful situation and flourish and grow despite their circumstances (Feeney & Collins, 2014:4). This can be achieved by intensifying all types of support that were identified from the findings. Feeney and Collins (2014:1) posit that being socially integrated within a close network of meaningful relationships has beneficial outcomes with regard to mortality, which implies that the individual's quality of life improves. The strength of the social ties, the quality of support and the willingness to provide support are more important in recovery than the number of ties that a person has in a network (Nurullah, 2012:173).

4.5.5.4 Filling time by remaining busy

It is important to note that this sub-theme was recognised as a strategy to respond to triggers but leans towards how the support group can be instrumental in occupying a person's time. Another rationale for this sub-theme was based on the information that was received when interview questions related to recommendations were posed to the participants. A way of keeping busy is by support groups assigning members homework and tasks. One of the participants suggested offering members skills development training and workshops to make them employable. A few of the participants suggested providing casual employment such as gardening and cleaning to keep them busy and motivate them to make a meaningful contribution to society. It was also noted that filling their time by taking them to church on Saturdays or Sundays was helpful and built their spirituality. Lastly, it was found that involving the members in sports could occupy their time. Based on the findings mentioned, the consensus was that having practical tasks to fill their time and keep them busy assisted their recovery. Relevant quotes by the participants follow.

Participant 1: "What I suggest to you maybe if we can get some stuff like soccer people to play soccer or something like that to keep them busy as well after that or get a workshop where we can put people in something that they can learn and that they are good at because why every one of them every have a skill so we can upgrade them in that area."

Participant 3: "Maybe you have a house …here I have a garden, something like that then he come work there for me maybe after 3 months you have trust in him then you see you work from that point [and ask], is there really change in this guy is he really able to change."

Participant 7: "To be busy with positive things I mean this even if it's gardening you know go out for the day get things because I mean whoever has been on an addiction has missed out on most of their lives already and but just taking an addiction meltdown and… just taking him out of that environment and taking him where they actually are seeing that they are better things in life."

The findings indicated that filling one's day is an important strategy for recovery management. The strategies highlighted by participants indicated that filling their time with various activities was an effective strategy and as such could be advanced as a formal recommendation. This sub-theme ties in with Category 4.3.2 of keeping busy for the day. The inclusion of this recommendation emphasised how it prevented members' exposure to high-risk situations, which was noted as an effective intervention strategy to reduce exposure to high-risk situations. Rhodes et al. (2003:317) found that social activity served as a protective factor for individuals. The recommendation is that the support group and the members thereof develop strategies to occupy their time meaningfully. The support group can assign its members homework and tasks, can link members to skills development programmes and involve them in positive relationship-building tasks such as going out with positive friends, this could be to the beach or any fun activities that are not associated with substances (Rhodes et al., 2003:317).

4.5.5.5 Homogeneity in the Social Network (remain connected to positive people who have overcome addiction)

All the participants echoed the view that when in recovery one must surround oneself with like-minded positive people as a way of distancing oneself from the environment or social network associated with the substance use lifestyle. This theme was also evident in sub-theme 4.5.4.2.1 that mentioned being around positive people. Based on the findings, this sub-theme confirmed and built on the notion that such an intervention strategy was effective. There is a saying that "if it works, do more of it". One of the participants expressed that if he had stayed in the same environment or network, he would not have changed and would still be using drugs. All the participants agreed that you cannot be around people who are using drugs when you are no longer using drugs. It was noted that during recovery you need to be around people who are recovering from substance use disorder rather than alcohol addiction because the experiences of people recovering from alcoholism are different from those recovering from substance use disorder. Being among peers who are also in recovery indicates homogeneity of experiences and the social network is more able to offer effective support.

Participant 1: "I have changed the friends that I used to have so that I can come out of the place I was in. I was no longer the same man, I could not stay in the same environment. I was now surrounding [myself] with positive people."

Participant 1: " What I need is to be with positive people, people that don't judge you, people that want to help you. You see sir, that's what I can tell you and also be around people who are strong that have also came out of drugs that want to help me that's how I changed."

The findings revealed that on an individual level, several of the participants shared that it is easier to help someone who has a similar problem to one's own. One of the participants used the analogy of prison and that he cannot describe to someone what it is like to be in jail because he has never been in jail. This participant asserted that you cannot send a person with an alcohol problem to a person with a drug problem as there is no similarity in experiences and the ways of coping are different. The characteristics of homogeneity, as noted from the data, are age, gender, primary drug and experiences related to the current problem. Matching these characteristics will assist the individuals to access meaningful support. One of the participants had this to share:

Participant 2: "That person must be like me, I was using a lot of drugs. When I go to that person I will know how to deal with a person like that. You cannot send somebody that is using alcohol that is a danger. You will not understand, you know because he didn't go through the same problem as he has a drinking problem you know, you send a person who went through the same thing."

This finding highlights the recommendation that being around positive people who are recovering from addiction and like-minded people with similar experiences and problems may contribute effectively to the level of social support. The notion of being around people in recovery contributes positively in terms of peer support. A recommendation pertaining to the change in a social network to a network of recovering individuals assists in preventing relapse. A participant shared that he had to change his friends and after a while gained new friends who became supporters that helped shift his focus to recovery (Henson et al., 2008:269). This new network comprised support group members (Henson et al., 2008:269). Goliath and Pretorius

(2016:121) found that association with non-drug-using peers assisted recovering users to avoid substance use. Sub-theme 4.2.1 emphasised the importance of avoiding high-risk situations that could tempt relapse and changing one's social network as strategies that were effective for those in recovery. With regard to homogenous social networks, in the field of aftercare, specifically support groups, one can access NA (Narcotics Anonymous) and AA (Alcoholics Anonymous). Offering the services of different 12-step groups focusing on different substances implies that their experiences of addiction are different and that the intervention strategies for addressing drug and alcohol users also differ. This implies that the various methods of social support would not be as effective in heterogeneous support groups as in homogenous support groups. The second quote covers the recommendation on an individual level in that a person who has gone through the same problems can better assist the person in need rather than someone who has a different substance addiction. Homogeneity also refers to age and the recommendation was for people in the same age group to support one another. This has to do with them being able to relate to one another as peers in all aspects. Homogeneity impacts the support positively, as the support to be conferred will be more readily accepted.

4.5.5.6 Facilitating attendance by creating support groups that are easily accessed

One of the participants expressed that there should be more support groups that are easily accessible and remarked that there are only a limited number of support groups available for women. In general, there are insufficient support groups in communities and the recommendation is that more support groups be formed. The next recommendation, which was advanced by the same participant, was for the various support groups to interact with one another to promote recovery. In support of the recommendation, one of the participants said:

Participant 8: "…think they need to have more support groups in more locations. There are not many support groups out there especially for females who seek help. There is no help for them. They have to go up the mountain into the sea. I know a lot of people, and for them to find help, it's a mission for them to find help. What is needed is to set up more in more locations where you can have more support groups."

The recommendation to establish more support groups that are physically accessible in various locations was emphasised and also that they include women. The participants recruited for inclusion in this study were all males and although some of the support groups had female members, their numbers were low and despite there being large numbers of females who require support, and there are no exclusively female support groups. Although the support groups that are present do accept female members, they find it difficult to attend these groups because of accessibility and availability. Mhangwa (2016:100) found that women struggle to get to aftercare programmes for various reasons that include transport because the distance to travel to the support group meetings is excessive considering the low numbers of support groups in the Nelson Mandela Bay Metro. Young et al. (2015:7) found that transport and distance were barriers to support group attendance. A less prevalent reason noted in a study undertaken by Mhangwa (2016:101) was that parental responsibilities in the evenings contribute to the low attendance of support group meetings by women.

4.6 CHAPTER SUMMARY

This chapter reported and discussed the findings under five themes. It was noted that individuals in recovery had needs that the support group could respond to through various means and strategies at their disposal. In responding to those needs, the individuals gained the benefits of participating in a support group. One of the ways in which the support group facilitated relapse prevention was by finding ways of dealing with the cravings and triggers of relapse. Recommendations were advanced about how support groups can improve their effectiveness in preventing relapse during recovery. The findings and discussion thus informed the role of support groups in facilitating relapse prevention in the aftercare of young adults with a substance use disorder.

The final chapter presents the summary, conclusion and recommendations that arose from the research project, as well as the value and limitations of the study and recommendations for future research.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The preceding chapter presented a discussion of the findings with literature control to answer the research question. This chapter presents a summary of the findings, the conclusions that were drawn and recommendations in relative to the goal, the reviewed literature, the methodology and the findings that were generated. The overall goal of the study was to develop an in-depth understanding of how community-led support groups facilitate relapse prevention in the aftercare of young adults with substance use disorder. Objectives were formulated as a guide to attain the goal. This chapter also addresses the limitations of the study and recommendations for future research.

5.2 SUMMARY AND CONCLUSION

The themes that emanated from the data analysis and discussion of the findings were aligned to the objectives of the study and enabled the achievement of the goal. The findings indicated that support groups play a role in the prevention of relapse through the provision of social support for their members. The types of support that emanated from the findings included emotional, social, structural and informational support. It was further noted that the participants had specific needs that included assistance with longstanding addiction recovery and identified intrapersonal factors that could influence the level of social support received. These identified intrapersonal factors included perceived rejection, negative emotions, dealing with low motivation and negative thoughts and attitudes.

The support groups extended support by responding to the members' specific needs through strategies that included group support, individual support and faith or religiosity as a key component. As noted, being part of a support group had benefits that impacted the members positively. In the support group intervention delivery, the focus was on trigger management strategies to prevent relapse. Recommendations were made to improve the role support groups perform in offering support to prevent relapse and enhance the participants' quality of life and relationships. For the support

to improve, they would need to motivate for consistent and long-term attendance of support group meetings. This is based on the view that addiction is a lifetime battle and that a person needs support for as long as he/she is in recovery. Another recommendation would be to improve the level of social support (structure) they offer to individuals. This is to improve the level of social support being conferred. Support groups must also implement strategies to occupy an individual's time with various tasks and activities, at the very least link them to resources that will keep them busy. Advocating for homogeneity will assist in improving the social support given and received by the members and lastly, establish several support groups to increase the consistency and long-term attendance of members.

5.3 SUMMARY AND CONCLUSIONS DRAWN FROM THE RESEARCH FINDINGS

Five themes that were aligned to the research objectives emerged from the findings: the needs of young adults with SUD who are active in community-led support groups; the way in which community-led support groups respond to the needs of young adults that are active in support groups; the benefits of community-led support groups to young adults in recovery; how community-led support groups help young adults to deal with the cravings and triggers for relapse and recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention. These themes were supported by sub-themes and categories that are summarised in the ensuing sections in which conclusions are also drawn.

5.3.1 The needs of young adults with SUD who are active in community-led support groups

It was noted that the participants attended the support groups with the expectation to enhance their recovery from a substance use disorder. This entailed identifying and managing potential intrapersonal risk factors that could trigger a relapse. This theme illuminated the participants' specific needs in this regard, which are summarised in the sub-themes and categories discussed hereunder.

5.3.1.1 Requiring assistance with longstanding addiction

The attraction of the support group was specifically linked to receiving social support from persons who had the experience of the journey of recovery from addiction. The support group appeared to provide an essential social network that was a vital component of recovery from addiction.

5.3.1.2 Require assistance with intrapersonal factors that may impact the level of support required

The study's findings indicated that the participants presented with intrapersonal factors that determined the level of support they required. These included dealing with negative thoughts and bottled-up emotions, a lack of motivation and perceived rejection. The participants required assistance to manage these risk factors for substance use.

5.3.1.2.1 Dealing with perceived rejection (of self by others)

It was noted from the study that the participants required assistance in dealing with their perceived rejection. The support group was shown to be a safe, non-judgemental space to address the stigmatisation that would routinely result in rejection.

5.3.1.2.2 Dealing with low motivation for change

The findings indicated that the participants presented with variations in their level of motivation for change. Those who had low motivation for change were driven by the external rewards of appeasing family members by attending the support group. The participants who presented with high levels of motivation were intrinsically motivated and presented with strong willpower and commitment to their recovery.

5.3.1.2.3 Dealing with negative thoughts and attitude

Several of the participants noted negative thoughts as a risk factor, as these directly influence their actions and behaviours. The need was to change negative thoughts to positive by surrounding themselves with a positive social network in a positive environment.

5.3.1.2.4 Suppressing (bottling up) emotions

It was found that bottling up emotions led to the recurrent use of substances because substance use enabled them to suppress or ignore their emotions, which led to a diminished ability to address their emotions. Being able to cope with emotions is important and having someone to speak to is a critical preventative measure against relapse. The social support group provided the required support.

5.3.2 How community-led support groups respond to the needs of young adults that are active in support groups

Having identified what the participants required, the support groups devised several strategies to respond to their needs. The rationale for support groups responding to these needs was to improve the recovery potential of all individuals who were part of the support group to prevent relapse during aftercare. This theme and its sub-themes aimed to answer the research question by providing practice-based response strategies, some of which are discussed hereunder.

5.3.2.1 Religious faith as a key component of support groups

This sub-theme highlighted that religious faith played a positive role in an individual’s recovery by giving meaning to the person’s life and building their faith and their relationship with God by engaging in religious activities. The support groups were instrumental in building the participants’ faith by incorporating religion into their interventions.

5.3.2.2 Connecting through online mediums during lockdown when f2f contact was not possible

Based on the findings, most of the participants noted that they had utilised an online medium to assist them in recovery. The conclusion can thus be drawn that the online medium brought about benefits in responding to needs and conferring support, particularly during the COVID-19 pandemic when lockdown regulations restricted face-to-face and group contact. Utilising online media meant that the participants did not have to wait for a meeting to connect with peers but could effectively access assistance and support at any time.

5.3.2.3 Providing individual and group support

The participants reported receiving social support from their peers and the support group conveners, better known as mentors. The support group employed two intervention methods as vehicles for providing support; group and one-on-one support. The two methods are discussed and summarised hereunder. The rationale for the separate discussions was to indicate that the support groups intervened in both methods.

5.3.2.3.1 Group support as a form of intervention

The group-based intervention was shown to be a viable approach to providing the various types of support required. It was concluded that group-based intervention focused on the members sharing their problems and experiences and working through them with others. The support group offered social, emotional, informational and structural support with a focus on learning from one another's experiences.

5.3.2.3.2 Intervention in the form of one-on-one support

The support group offered the opportunity for individuals to have someone to speak to, especially in times of difficulty. This intervention could be in the form of a sponsor or peer-to-peer support. Both forms had reciprocal benefits in relation to their recovery and satisfying their needs. In conclusion, this approach proved fruitful and the participants utilised the services that were on offer.

5.3.2.4 Gaining coping skills and guidance

The participants revealed that they had learnt coping skills to address the challenges they encountered in their quest for recovery. They were also offered guidance, mainly by the older members in the support group who had more experience in addiction recovery. This guidance applied to what to do, how to do it and what not to do in bringing about behaviour change. These coping skills and guidance were gained through online media, individual and group-based support in response to the participants' needs.

5.3.3 Benefits of community-led support groups to young adults in recovery

Actively participating in a community-led support group had several benefits for the participants in relation to social support in their recovery. These benefits included intrapersonal and interpersonal growth that resulted from the support group interventions.

5.3.3.1 Place for intrapersonal growth

The participants reported that their lives had changed for the better after joining a support group and they had experienced cognitive and spiritual growth as a result of the reciprocal social support offered by the support group.

5.3.3.2 Social Support

The findings highlighted social support as a positive factor and that a high level of social support contributed significantly to the participants' recovery. Social support can be described as the provision of reciprocal assistance, care and love for one another within a mutually supportive social network. The various types of support were instrumental in the attainment of high levels of social support.

5.3.3.3 Safe space to share life stories and learn from one another's experiences

The findings revealed that the support group offered the opportunity for individuals to share their experiences and feelings in support group meetings, prompting active participation and positive communication amongst themselves. Further benefits included the support group meetings being a platform for people to share similar problems and experiences to learn from one another about how to cope with their individual and collective challenges in recovery.

5.3.3.4 Social support group a safe environment for fostering acceptance and care

The participants shared that they required a social network in which they were accepted, not judged, not labelled and not stigmatised but rather shown kindness, attention and assistance to overcome their challenges. It was interesting to note that the acceptance the participants found so important mirrored the humanistic characteristics of a family system.

5.3.3.4.1 Non-judgmental support received

Acceptance and care were achieved through offering non-judgemental support. Receiving such support was important for the participants and their recovery because in the past they were judged, rejected and labelled by their families and communities. The support group accepted them for who they were, which brought about a sense of belonging that enabled them to work towards forgiving themselves and understanding others' circumstances, experiences and decisions with regard to recovery.

5.3.3.4.2 Learnt to forgive themselves, which increased their understanding of others

The findings revealed that the participants were able to forgive themselves and others. The support group played a role in facilitating the realisation that they needed to forgive themselves for what had happened to them and the harm they had caused others and themselves. The catalyst for forgiveness was the role played by religiosity. Part of forgiving oneself included accepting oneself, which led to a shame-free identity. A way to forgive oneself was by acknowledging the reason for not being forgiven and the support groups' role was to offer a platform where they could share these thoughts in an accepting environment. Forgiving oneself was therefore important and necessary to move forward, heal and forgive others. This forgiveness of self and others led to diminished guilt and ultimately reduced vulnerability to relapse.

5.3.3.5 The support group facilitated the restoration of family relationships and thus facilitated relapse prevention

The findings revealed that the support group assisted the participants to repair and rebuild relationships with their family because in their striving to change they learnt how to communicate effectively, rebuild broken bonds through seeking forgiveness and learning how to love their family members again. This became possible because the support group, as a social network, mirrored aspects of relationship building, communicating and loving members in the unit.

5.3.4 How community-led support groups help young adults to deal with the cravings and triggers for relapse

The participants noted that the support groups were instrumental in the identification of triggers to prevent relapse. The support groups also assisted in the management of triggers by providing behavioural strategies to deal with these triggers, also referred to as risk factors. The various strategies are summarised and conclusions are drawn in the ensuing section.

5.3.4.1 Assist in the identification of triggers

It was revealed that support groups played a vital role in teaching members how to identify their triggers. Clear identification of triggers enabled the effective identification of response strategies to address the triggers at every level. The common triggers included environmental, interpersonal and intrapersonal risk factors.

5.3.4.2 Implement behavioural strategies in response to the triggers

The findings coincided with the view that behavioural strategies need to be implemented to address the identified triggers to prevent relapse. Some of the behavioural strategies mirrored protective factors and were trigger specific. Behaviour response strategies are summarised hereunder as categories.

5.3.4.2.1 Avoid situations that could tempt relapse

The findings revealed that avoiding high-risk situations was an effective way to respond to triggers. The result of this approach was reduced exposure to risk factors to prevent relapse. A wide array of avoidance strategies were noted, all of which were successful in reducing exposure to risk factors.

5.3.4.2.2 Find a constructive alternative outlet

The participants revealed that attending support group meetings and having someone to speak to within the support group assisted with trigger management because of the social, emotional, informational and structural support that the support group offered to them. This resulted in members not giving in to cravings while actively participating in the support group. Applying these protective factors served as a constructive outlet

for trigger management and generated positive outcomes by lowering the risk of potential relapse and managing cravings.

5.3.4.2.3 ***Keep busy***

The findings revealed that keeping busy by actively engaging in positive tasks and activities served as a trigger management strategy. This trigger management was referred to as a distraction; occupying your time and focusing on tasks. The participants' past lives did not have structure, which exacerbated the problem of drug use and remaining busy thus served as a strategy for establishing and maintaining structure.

5.3.4.3 Religiosity as an intervention to combat triggers

Although religiosity and spirituality were summarised earlier, this sub-theme focused on how faith and religiosity assisted with trigger management specifically. The findings revealed that faith and religiosity were instrumental in combating SUD. This was achieved by support groups basing their strategies on spirituality, which gave the members a purpose in life. The support group facilitated the building of members' relationship with God and prayed with members for God to take care of their addiction. The participants expressed the belief that they were not able to manage recovery without God, who helped them in difficult times.

5.3.5 Recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention

The participants advanced recommendations based on their first-hand experience on how support groups can assist in preventing relapse amongst their members. One of the participants asserted that support groups develop members' character and promote personal growth. It is important to note that times are changing and support groups deal with people who are constantly changing, as are the dynamics of substance use disorder. Based on this view, the recommendations must be explored so that the support groups can align their interventions to enhance their effectiveness. The recommendations are summarised hereunder as sub-themes.

5.3.5.1 Motivate for consistent attendance

The findings indicated that consistent attendance is necessary and that members need to be encouraged to attend support group meetings as frequently as possible because addiction is a lifetime battle. Consistency can be viewed as not missing support group meetings and being consistently available on the days the support group meetings take place. In conclusion, consistent attendance is recommended as a mandatory practice and the members should attend at least once a week.

5.3.5.2 Long-term attendance and support required for long-term recovery

It is important to note that while there are similarities with the foregoing sub-theme, they differ in application, as this sub-theme refers to the period of attendance rather than the frequency and consistency of attendance. The findings revealed that long-term attendance was recommended because addiction is a lifetime battle and the consensus was that support is required for as long as one is in recovery. This implies that individuals in recovery always encounter challenges and the members were at constant risk of experiencing triggers. The two identified sub-themes, as mentioned, are intertwined and regular and long-term attendance is recommended for relapse prevention.

5.3.5.3 The support group as a structure

The findings revealed that individuals in recovery need structure in their lives to prevent relapse. One of the participants asserted that living a structured life was like planning for the future. Structure was also identified as having a formalised support network where one can feel a sense of belonging and receive social support.

5.3.5.4 Filling time by keeping busy

This sub-theme was presented in 5.3.4.2.3 as a response strategy but the support group can be instrumental in occupying members' time. The support group could assign tasks and activities to keep people busy. Filling up time prevents exposure to trigger factors and can thus be viewed as a trigger management strategy of avoidance.

5.3.5.5 Homogeneity in the Social Network (remain connected to positive people who have overcome addiction)

The findings revealed the importance of being surrounded by positive, like-minded people when in recovery. A recommendation was that members must be in a support group that, as far as possible, is homogenous to foster positive recovery and to assist people with similar lived experiences. A second recommendation was to have a support structure that is homogenous in terms of age group and the substance used.

5.3.5.6 Facilitating attendance of meetings by creating support groups that are easily accessible.

The recommendation was for the establishment of more support groups in the Nelson Mandela Metro, dispersed across various geographical areas and that these support groups collaborate and interact with one another to improve members' recovery potential, learn from one another and expand the recovery social network.

5.4 SUMMARY OF METHODOLOGY AND RESEARCH DESIGN

The research methodology that was utilised, the trustworthiness of the findings and the ethical considerations are summarised in the ensuing sections.

5.4.1 Summary of research methodology

The research problem required exploration and understanding, which required the application of a qualitative research approach and in-depth exploration of the role that support groups perform in facilitating relapse prevention in the aftercare of young adults with substance use disorder. The guiding paradigm was interpretive, as it is rooted in the qualitative approach. To supplement the identified approach, an exploratory, descriptive and contextual research design was employed to generate data with the view to understanding the phenomena under investigation and answering the research question. A non-probability, purposive sampling technique was employed to select the sample. This technique was supplemented by the snowball sampling technique to expand the sample. Permission to enter the research site was sought from the gatekeepers of the support groups. The initial method of data collection entailed the use of focus group interviews but due to COVID-19 and lockdown regulations, the data collection tool was changed to one-on-one online, semi-structured interviews. A pilot study was undertaken to test the applicability of the

research methodology. Data was collected until the point of saturation was attained and thematic analysis was employed to analyse and interpret the data that was gathered. In conclusion, the research methodology that was employed achieved the purpose of the study and answered the research questions that arose from the problem statement.

5.4.2 Data verification - Trustworthiness

Specific strategies were employed to enhance the four criteria of trustworthiness of the data and the research process. Credibility was ensured using well-established research methods, peer debriefing and honesty from the participants and interactive questioning. Transferability was ensured through the application of thick descriptions of the research methodology process and purposive sampling with clear inclusion and exclusion criteria. Dependability was achieved by maintaining an audit trail. Peer review and examination were employed. An independent coder analysed the data, and this enabled a comparative and deeper data analysis process to verify the findings. Coding and recoding were employed to ensure consistency. Confirmability was ensured through prolonged engagement in the research field as well as maintaining an audit trail and reflective journaling of the research process. The reflexive journal was also used in reflecting on the role of researcher vs practitioner, and this internal conflict was resolved through supervision and constant reminder of assuming researcher role. In conclusion, trustworthiness was ensured using a variety of strategies.

5.4.3 Ethical Considerations

The ethical principles that applied to the study included justice, respect for persons, beneficence, informed consent, confidentiality, privacy and anonymity. The ethical principle of justice was upheld by indicating clear inclusion and exclusion criteria, by the participants having their voices heard and sharing their experiences. The five formulations that were recommended in the Belmont Report (1979) were adhered to and the ethical principle of respect for persons was ensured by the participants acting freely and knowing that they could voluntarily withdraw from the study at any time without retribution. Beneficence was ensured by listing the risks and benefits of participating in the study during the recruitment stage. Strategies employed to reduce the risks included reflection and debriefing. The benefits for participation included the

sharing of their experiences and have their voices heard. Informed consent was ensured with the implementation of three components, namely providing information, ensuring comprehension and volunteering to take part. The potential participants were provided with all the relevant information regarding the study and comprehension thereof was ensured by using vocabulary that was easily understood and explain the information contained in Appendices 2 and 3. Voluntariness was achieved by informing the participants of their right to withdraw from the study at any time without any sanctions. Confidentiality and anonymity were ensured to protect the participants' confidential information by refraining from using names during the interview and the omission of names and any identifying details during the transcription of the data. The method of storage was a password-protected Nelson Mandela University's OneDrive or cloud with only myself and the supervisors having access to the information. In conclusion, all identified ethical principles were upheld throughout the research project thereby ensuring that the project was ethically sound and proper and that the participants were protected in the process.

5.5 VALUE AND LIMITATIONS OF THE STUDY

Each research project has value and limitations. The study added value for academics, support group leaders and young adults in recovery. The value for academics was that it facilitated an understanding of the use of online interviews as a method of data collection. This method has the potential to expand a sample as it is not restricted by geographic or mobility-related constraints. This research project also presented challenges, as discussed hereunder.

- The most significant limitation was the small population of community-led support groups in the Nelson Mandela Bay Metro. This could be attributed to the merging of several community-led support groups with an organisational support group and, in line with the sampling criteria, such members were excluded.
- The second limitation was that several members of the identified support groups did not fit the inclusion criteria as they had been sober for fewer than 6 months.

- The effects of the COVID-19 pandemic had a considerable impact on support group attendance, which led to a smaller number of members.

- Technology also played a role in that a small number of the participants did not have cell phones that they could use for the interviews. The background noise also served as a limitation as several of the participants could not find a quiet place for their interview.

- Literature pertaining to online interviews was limited, which required cross-referencing similar uses of online interviews in different contexts to substantiate their use for data collection.

5.6 RECOMMENDATIONS FOR PRACTICE

Based on the findings of the study, the following recommendations were generated for implementation.

- Support group members can be taught the skill of reflection to reflect on the value and benefits they derive from being in the group. This can be performed as an exercise at the end of each session.

- Support group members should be encouraged to articulate what they require from one another and the group as a whole.

- The leaders of the support groups should encourage consistent, long-term attendance from the members.

- The leaders of the support groups should focus on building and utilising the various social support categories.

- The Department of Social Development should invest more resources in the establishment and maintenance of more community-led support groups.

- The members should be made aware of strategies that they can utilise to prevent a relapse.

- Individuals to attend support group meetings in line with the principles stipulated under sec 33(1) of the Prevention and Treatment of Substance

Abuse Act 70 of 2008. Based on the above, it is recommended that the policy include support group attendance as a court mandated aftercare service. The implication on policy would mean revising chapter 7 of the Prevention and Treatment of Substance Abuse Act 70 of 2008 by including involuntary attendance of support groups in the aftercare.

5.7 FUTURE RESEARCH

- Future studies can employ participatory action learning and action research to motivate for the establishment of additional community-led support groups.
- Future research can explore the resilience-based factors required for consistent and long-term attendance in support groups.
- A study can be undertaken of the practice model that will include support groups as a diversion program in the criminal justice system for individuals whose transgression was heavily influenced by substance use and who will require assistance and support when returning to their environment.
- Future research can explore the inclusion of support group attendance as part of the involuntary, court-mandated service for individuals within and outside the criminal justice system.
- Action research can investigate how the Department of Social Development and the Local Drug Action Committee can be involved in mobilising resources for the establishment and sustainability of support groups in the Nelson Mandela Bay Metro.
- Exploratory research can be conducted to ascertain how families who have a young adult in recovery and attending a support group can be offered support and care.
- A descriptive, exploratory study can be conducted to ascertain how support groups can establish relationship rebuilding programmes for young adults and their families that are affected by their substance use disorder.

- An exploratory, descriptive study exploring the importance of discipline in an intervention as opposed to motivation in facilitating treatment adherence and recovery can be undertaken.

5.8 CHAPTER SUMMARY

This chapter summarised the findings regarding the role that community-led support groups fulfil in facilitating relapse prevention in the aftercare of young adults with substance use disorder. The role that support groups perform in their members' recovery was highlighted and conclusions were drawn from the various themes that emerged from the study's findings. It came to light that support groups were instrumental in the participants' recovery and the support they offered assisted the young adults to maintain sobriety and manage their triggers for relapse. The participants' recommendations on how the support groups can improve their delivery of intervention services to facilitate recovery in aftercare were summarised. This informed the recommendations that were advanced for implementation. The research methodology applied in this study was summarised and the limitations of the study were indicated followed by recommendations for future research.

REFERENCES

Abdulla, Z. and Goliath, V., 2015. Parents' experiences of monitoring their adolescents' compliance with diversion orders. *Social Work*, *51*(2), pp.204-220.

Adom, D., Hussein, E.K. and Agyem, J.A., 2018. Theoretical and conceptual framework: Mandatory ingredients of a quality research. *International journal of scientific research*, *7*(1), pp.438-441.

Al-Balushi,K., 2018. The Use of Online semi-structured interviews in interpretive research. *International Journal of Science and Research*, *7*(4), pp.726-732.

Alhojailan, M.I., 2012. Thematic analysis: A critical review of its process and evaluation. *West East Journal of Social Sciences*, *1*(1), pp.39-47.

Aliyu, A.A., Singhry, I.M., Adamu, H., and AbuBakar, M.A.M., 2015, December. Ontology, epistemology and axiology in quantitative and qualitative research: Elucidation of the research philophical misconception. In *Proceedings of the Academic Conference: Mediterranean Publications & Research International on New Direction and Uncommon, 2*(1).

Al-Saadi, H., 2014. Demystifying Ontology and Epistemology in research methods. *Research gate*, *1*(1), pp.1-10.

American Psychiatric Association, 2013. *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Anney, V.N., 2015. Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies 5*(2): 272-281

Atkins Jr, R.G. and Hawdon, J.E., 2007. Religiosity and participation in mutual-aid support groups for addiction. *Journal of substance abuse treatment*, *33*(3), pp.321-331.

Azmi, A.A., Hussin, H., Ishak, S.I.D. and Daud, N.S., 2018. Drug addicts: Psychosocial factor contributing to relapse. In *MATEC Web of Conferences* (Vol. 150, p. 05097). EDP Sciences.

Badiani, A., 2013. Substance-specific environmental influences on drug use and drug preference in animals and humans. *Current opinion in neurobiology*, *23*(4), pp.588-596.

Bain, K.A., 2005. *Chased by the dragon: the experience of relapse in cocaine and heroin users* (Doctoral dissertation, University of Pretoria).

Bandura, A., 1979. The social learning perspective: Mechanisms of aggression.

Bandura, A., 1989. Human agency in social cognitive theory. *American psychologist*, *44*(9), p.1175.

Bandura, A., 2001. Social cognitive theory: An agentic perspective. *Annual review of psychology*, *52*(1), pp.1-26.

Bateganya, M., Amanyeiwe, U., Roxo, U. and Dong, M., 2015. The impact of support groups for people living with HIV on clinical outcomes: a systematic review of the literature. Journal of acquired immune deficiency syndromes (1999), 68(0 3), p.S368.

Baumeister, R.F. and Tierney, J.M., 2012. *Willpower: Rediscovering the greatest human strength*. Penguin.

Bergman, B.G. and Kelly, J.F., 2020. Online digital recovery support services: An overview of the science and their potential to help individuals with substance use disorder during COVID-19 and beyond. *Journal of substance abuse treatment*, p.1-2.

Bettinardi-Angres, K. and Angres, D.H., 2010. Understanding the disease of addiction. *Journal of Nursing Regulation*, *1*(2), pp.31-37.

Beyer, H. and Holtzblatt, K., 1998. Contextual inquiry. Defining Customer-Centered Systems, 31.

Blischke, W.R., Karim, M.R. and Murthy, D.P., 2011. Preliminary data analysis. In *Warranty data collection and analysis* (pp. 159-189). Springer, London.

Brady, K.T. and Randall, C.L., 1999. Gender differences in substance use disorders. *Psychiatric Clinics of North America*, *22*(2), pp.241-252.

Brown, B.S., O'Grady, K., Battjes, R.J. and Farrell, E.V., 2004. Factors associated with treatment outcomes in an aftercare population. *American Journal on Addictions*, *13*(5), pp.447-460.

Brown, T.G., Seraganian, P., Tremblay, J. and Annis, H., 2002. Matching substance abuse aftercare treatments to client characteristics. *Addictive Behaviors*, *27*(4), pp.585-604.

Burkholder, G.J., Schensul, J.J. and Pino, R., 2007. Risk and protective factors for drug use among polydrug-using urban youth and young adults. *Journal of Social, Behavioral, and Health Sciences*, *1*(1), p.2.

Burnhams,N.H., Erasmus,J., Parry,C., Bhana,A., Pretorius,S., Wiemann, R., & Kitshoff, D., 2018. South African Epidemiology Network on Drug Use: Monitoring Alcohol, Tobacco and Other Drug Use Trends in South Africa. Alcohol and Drug Research Unit, MRC, Cape Town.

Center for Substance Abuse Treatment. 2005. Substance Abuse Treatment: *Group Therapy*. Series. No. 41. Rockville. Substance Abuse and Mental Health Services Administration

Center for Substance Abuse Treatment.2008. An Introduction to Mutual Support Groups for Alcohol and Drug Abuse. Substance Abuse in Brief Fact Sheet, 5(1). Rockville, MD: Substance Abuse and Mental Health Services Administration.

Chan, E.W., Chen, W., Ip, I.C. and Hall, B.J., 2020. Effects of social support and depression on problematic drinking among trauma-exposed Chinese adults: A population-based study. *Heliyon*, *6*(2), p.e03405.

Chen, G., 2006. Social support, spiritual program, and addiction recovery. *International Journal of Offender Therapy and Comparative Criminology*, *50*(3), pp.306-323.

Cheteni, P., Mah, G. and Yohane, Y.K., 2018. Drug-related crime and poverty in South Africa. *Cogent Economics & Finance*, *6*(1), p.1534528.

Chetty, M. and Taut, F., 2011. Causes of relapse post treatment for substance abuse dependency within the South African police services (Doctoral dissertation, Faculty of Humanities, University of Pretoria,)

Chowdhury, M.F., 2014. Interpretivism in aiding our understanding of the contemporary social world. *Open Journal of Philosophy*, *2014*.

Corey, M.S., Corey, G. and Corey, C., 2013. *Groups: Process and practice*. Cengage Learning.

Cox Jr, R.B., Ketner, J.S. and Blow, A.J., 2013. Working with couples and substance abuse: Recommendations for clinical practice. *The American Journal of Family Therapy*, *41*(2), pp.160-172.

Crape, B.L., Latkin, C.A., Laris, A.S. and Knowlton, A.R., 2002. The effects of sponsorship in 12-step treatment of injection drug users. *Drug and Alcohol Dependence*, *65*(3), pp.291-301.

De Lannoy, A., Swatrz, S., Lake, L., Smith, C., 2015. Child Gauge, Cape Town, Children's Institute, University of Cape Town.

De Vos, A.S., Strydom, H., Fouche, C.B. and Delport, C.S.L., 2007. Research at Grass Roots. 3rd Impression.

Del Mar Capella, M. and Adan, A., 2017. The age of onset of substance use is related to the coping strategies to deal with treatment in men with substance use disorder. *PeerJ*, *5*, p.e3660.

Delport, C.S.L. and Fouché, C.B., 2005. The qualitative research report. Research at grass roots. A primer for the caring professions. Pretoria: Van Schaik, pp.350-354.

Dennis, M. and Scott, C.K., 2007. Managing addiction as a chronic condition. *Addiction Science & Clinical Practice*, *4*(1), p.45.

DiClemente, C.C., Bellino, L.E. and Neavins, T.M., 1999. Motivation for change and alcoholism treatment. *Alcohol Research & Health*, *23*(2), p.86.

Dikko, M., 2016. Establishing Construct Validity and Reliability: Pilot Testing of a Qualitative Interview for Research in Takaful (Islamic Insurance). *Qualitative Report*, *21*(3).

Donovan, D.M., Ingalsbe, M.H., Benbow, J. and Daley, D.C., 2013. 12-step interventions and mutual support programmes for substance use disorders: An overview. *Social work in public health*, *28*(3-4), pp.313-332.

El Kazdouh, H., El-Ammari, A., Bouftini, S., El Fakir, S. and El Achhab, Y., 2018. Adolescents, parents and teachers' perceptions of risk and protective factors of substance use in Moroccan adolescents: a qualitative study. *Substance abuse treatment, prevention, and policy*, *13*(1), pp.1-12.

Elliott, R. and Timulak, L., 2005. Descriptive and interpretive approaches to qualitative research. *A handbook of research methods for clinical and health psychology*, *1*(7), pp.147-159.

Ettang, D.O., 2017. 'Desperados, druggies and delinquents': devising a community based security regime to combat drug related crime. *Africa Development*, *42*(3), pp.157-176.

Ewing, B.A., Osilla, K.C., Pedersen, E.R., Hunter, S.B., Miles, J.N. and D'Amico, E.J., 2015. Longitudinal family effects on substance use among an at-risk adolescent sample. *Addictive Behaviors*, *41*, pp.185-191.

Feeney, B.C. and Collins, N.L., 2014. A theoretical perspective on the importance of social connections for thriving.

Felkers, K., 2019. Exploring the role of the parent in the aftercare of their adolescent children who participated in a treatment programme for substance abuse.

Filges, T. and Jorgensen, A.M.K., 2018. Cognitive–Behavioral Therapies for young people in outpatient treatment for nonopioid drug use. *Research on Social Work Practice*, *28*(3), pp.363-385.

Fisher, M., 2016. The social care institute for excellence and evidence-based policy and practice, The British Journal of Social Work, 46(2), pp.498-513.

Fleury, J., Keller, C. and Perez, A., 2009. Social support theoretical perspective. *Geriatric Nursing (New York, NY)*, *30*(2 0), p.11.

Forsyth, D.R., 2006. *Group dynamics.* (6th Ed.). Belmont, CA: Wadsworth Cengage Learning

Frisher, M., Crome, I., Macleod, J., Bloor, R. and Hickman, M., 2007. Predictive factors for illicit drug use among young people. *Probation J*, *54*(3), p.2017.

Frisher, M., Crome, I., Macleod, J., Bloor, R. and Hickman, M., 2007. Predictive factors for illicit drug use among young people. Probation J, 54(3), p.2017.

Frydrych, L.M., Greene, B.J., Blondell, R.D. and Purdy, C.H., 2009. Self-help program components and linkage to aftercare following inpatient detoxification. *Journal of Addictive Diseases*, *28*(1), pp.21-27.

Goliath, V. and Pretorius, B., 2016. Peer risk and protective factors in adolescence: Implications for drug use prevention. *Social work*, *52*(1), pp.113-129.

Gopal, N.D. and Collings, S.J., 2012. Psychosocial Influences on Substance Abuse in a Sample of South African Youth: A Qualitative Analysis. *Journal of Psychology in Africa*, *22*(4), pp.655-658.

Groenewald, C., 2018. ‘It was riotous behaviour!’: Mothers’ experiences of adolescents’ conduct while abusing drugs. *International journal of mental health nursing*, *27*(5), pp.1564-1573.

Groshkova, T., 2010. Motivation in substance misuse treatment. *Addiction Research & Theory*, *18*(5), pp.494-510.

Guba, E.G. and Lincoln, Y.S., 1981. *Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches*. Jossey-Bass.

Guetta, K., 2013. Self-Forgiveness in the Recovery of Israeli Drug-Addicted Mothers: A Qualitative Exploration, p43(4)

Harris, K.S., Baker, A.K., Kimball, T.G. and Shumway, S.T., 2008. Achieving systems-based sustained recovery: A comprehensive model for collegiate recovery communities. *Journal of Groups in Addiction & Recovery*, *2*(2-4), pp.220-237.

Hart, C., 2018. Doing a literature review: Releasing the research imagination.

Hendershot, C.S., Witkiewitz, K., George, W.H. and Marlatt, G.A., 2011. Relapse prevention for addictive behaviors. *Substance abuse treatment, prevention, and policy*, *6*(1), pp.1-17.

Henning, K., 2012. Criminalizing normal adolescent behavior in communities of color: The role of prosecutors in juvenile justice reform. *Cornell L. Rev.*, *98*, p.383.

Hennink, M.M., Kaiser, B.N. and Weber, M.B., 2019. What influences saturation? Estimating sample sizes in focus group research. *Qualitative health research*, *29*(10), pp.1483-1496.

Hunter-Reel, D., McCrady, B. and Hildebrandt, T., 2009. Emphasizing interpersonal factors: An extension of the Witkiewitz and Marlatt relapse model. *Addiction*, *104*(8), pp.1281-1290.

Jabeen, I., Venkataswamy, M., Sadaf, J., Reddy, M.N., Mallika, A.N. and Sushmitha, M., 2018. Drug abuse, addiction, its causes and treatment. Research Journal of Pharmaceutical Dosage Forms and Technology, 10(4), pp.259-265.

Jules-Macquet, R., 2015. Exploring female offender profiles and social Reintegration service delivery. *South Africa: National institute for crime prevention and the reintegration of offenders.* [Online] Available from: http://press.nicro.org.za/images/PDF/Exploring-Female-Offender-Trends-and-Dynamics.pdf. (Accessed:14th January 2019).

Junior, I.J.F. and Calheiros, P.R.V., 2017. Motivação para mudança em usuários de drogas e justiça: revisão de literatura. *Psicologia: Teoria e Prática*, *19*(2), pp.60-72.

Kabisa, E., Biracyaza, E., Habagusenga, J.D.A. and Umubyeyi, A., 2021. Determinants and prevalence of relapse among patients with substance use disorders: case of Icyizere Psychotherapeutic Centre. *Substance Abuse Treatment, Prevention, and Policy*, *16*(1), pp.1-12.

Kolb, D.A., Boyatzis, R.E. and Mainemelis, C., 1999. Experiential learning: Previous research and new directions. *2000). Perspectives on cognition, learning and thinking styles. NJ: Lawrence Erlbaum*.

Krebs, P., Norcross, J.C., Nicholson, J.M. and Prochaska, J.O., 2018. Stages of change and psychotherapy outcomes: A review and meta-analysis. *Journal of Clinical Psychology*, *74*(11), pp.1964-1979.

Lambert, V.A. and Lambert, C.E., 2012. Qualitative descriptive research: An acceptable design. *Pacific Rim International Journal of Nursing Research*, *16*(4), pp.255-256.

Lander, L., Howsare, J. and Byrne, M., 2013. The impact of substance use disorders on families and children: from theory to practice. *Social work in public health*, *28*(3-4), pp.194-205.

Larimer ME, Palmer RS, Marlatt GA.1999. Relapse prevention. An overview of Marlatt's cognitive-behavioral model. Alcohol Res Health. 23(2):151-60

Leach, D. and Kranzler, H.R., 2013. An interpersonal model of addiction relapse. *Addictive disorders & their treatment*, *12*(4), p.183.

Lee, N. and Boeri, M., 2017. Managing stigma: women drug users and recovery services. *Fusio: the Bentley undergraduate research journal*, *1*(2), p.65.

Lund, P., 2017. Christian faith and recovery from substance abuse, guilt, and shame. *Journal of Religion & Spirituality in Social Work: Social Thought*, *36*(3), pp.346-366.

Luszczynska, A. and Schwarzer, R., 2015. Social cognitive theory. *Fac Health Sci Publ*, pp.225-51.

Mack, N., 2005. *Qualitative research methods: A data collector's field guide*. North Carolina : FLI USAID

Maguire, M. and Delahunt, B., 2017. Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Higher Education*, *9*(3).

Mahlangu, S, and Geyer, S., 2016. The aftercare needs of nyaope users and their significant others: implications for aftercare and reintegration. *Social Work/Maatskaplike Werk*. 54(3), pp.327-345

Mahlangu, S. and Geyer, S., 2018. The aftercare needs of Nyaope users: implications for aftercare and reintegration services. Social Work, 54(3), pp.327-345

Majid, U., 2018. Research fundamentals: Study design, population, and sample size. *Undergraduate research in natural and clinical science and technology journal*, *2*, pp.1-7.

Marangoni, S.R. and Oliveira, M.L.F.D., 2013. Triggering factors for drug abuse in women. *Texto Contexto Enferm*, *22*(3), pp.662-70.

Massah, O., Effatpanah, M. and Shishehgar, S., 2017. Matrix model for methamphetamine dependence among Iranian female methadone patients: The first report from the most populated Persian Gulf country. *Iranian Rehabilitation Journal*, *15*(3), pp.193-198.

Matsuzaki, M., Vu, Q.M., Gwadz, M., Delaney, J.A., Kuo, I., Trejo, M.E.P., Cunningham, W.E., Cunningham, C.O. and Christopoulos, K., 2018. Perceived access and barriers to care among illicit drug users and hazardous drinkers: findings from the Seek, Test, Treat, and Retain data harmonization initiative (STTR). *BMC public health*, *18*(1), pp.1-11.

McGaffin, B.J., Lyons, G.C. and Deane, F.P., 2013. Self-forgiveness, shame, and guilt in recovery from drug and alcohol problems. Substance abuse, 34(4), pp.396-404.

McGaffin, B.J., Lyons, G.C. and Deane, F.P., 2013. Self-forgiveness, shame, and guilt in recovery from drug and alcohol problems. Substance abuse, 34(4), pp.396-404.

McPherson, C., Collins, E., Boyne, H., Kirkaldy, E. and Waseem, R., 2017. Self-reported chronic pain as a predictor of relapse post residential addiction treatment: a 6-month follow-up pilot study. *International Journal of Mental Health and Addiction*, *15*(5), pp.1069-1079.

Meiring, L., Visser, M. and Themistocleous, N., 2017. A student-facilitated community-based support group initiative for Mental Health Care users in a Primary Health Care setting. *health sa gesondheid*, *22*, pp.307-315.

Melemis, S.M., 2015. Focus: addiction: relapse prevention and the five rules of recovery. *The Yale journal of biology and medicine*, *88*(3), p.325.

Mennis, J., Stahler, G.J. and Mason, M.J., 2016. Risky substance use environments and addiction: a new frontier for environmental justice research. *International journal of environmental research and public health*, *13*(6), p.607.

Menon, J. and Kandasamy, A., 2018. Relapse prevention. *Indian journal of psychiatry*, *60*(Suppl 4), p.S473.

Merline, A.C., O'Malley, P.M., Schulenberg, J.E., Bachman, J.G. and Johnston, L.D., 2004. Substance use among adults 35 years of age: prevalence, adulthood predictors, and impact of adolescent substance use. *American Journal of Public Health*, *94*(1), pp.96-102.

Mhangwa, T.H., 2016. Perceptions concerning the effectiveness of aftercare programmes for female recovering drug users (Doctoral dissertation).

Miller, E.M., Walton, G.M., Dweck, C.S., Job, V., Trzesniewski, K.H. and McClure, S.M., 2012. Theories of willpower affect sustained learning. *PloS one*, *7*(6), p.e38680.

Millette, S. and Cort, B., 2013. Treatment for substance use disorders–The continuum of care. *National Partnership on Alcohol Misuse and Crime*.

Moerman, G.A., 2010. Probing behaviour in open interviews: *A field experiment on the effects of probing tactics on the quality and content of the received information*. Amsterdam. Vrije Universiteit

Montalto, M., 2015. Alcoholics Anonymous: One Treatment Program to Rule Them All?. *Journal of Alcoholism & Drug Dependence*.

Mogro-Wilson, C., Letendre, J., Toi, H. and Bryan, J., 2015. Utilizing mutual aid in reducing adolescent substance use and developing group engagement. *Research on social work practice*, *25*(1), pp.129-138.

Moos, R.H., 2008. Active ingredients of substance use-focused self-help groups. *Addiction*, *103*(3), pp.387-396.

Muchiri, B.W. and Dos Santos, M.M., 2018. Family management risk and protective factors for adolescent substance use in South Africa. *Substance abuse treatment, prevention, and policy*, *13*(1), pp.1-10.

Mundell, J.P., Visser, M.J., Makin, J.D., Forsyth, B.W. and Sikkema, K.J., 2012. Support group processes: Perspectives from HIV-infected women in South Africa. *Qualitative research in psychology*, *9*(2), pp.173-187.

Nabavi, R.T., 2012. Bandura's social learning theory & social cognitive learning theory. *Theory of Developmental Psychology*, pp.1-24.

Nassaji, H., 2015. Qualitative and descriptive research: Data type versus data analysis.

National institute on drug abuse (NIDA). 2003. Preventing drug use among children and adolescents: a research-based guide. Maryland: US Department of Health and Human Services.

National institute on drug abuse (NIDA). 2003. Preventing drug use among children and adolescents: a research based guide, Maryland: US Department of Health and Human Services.

National institute on drug abuse (NIDA). 2018. *Principles of Drug Addiction Treatment: A Research-Based Guide.* (3rd Ed.). Maryland: US Department of Health and Human Services.

Nhunzvi, C., Galvaan, R. and Peters, L., 2019. Recovery from substance abuse among Zimbabwean men: an occupational transition. *OTJR: occupation, participation and health*, *39*(1), pp.14-22.

Nurullah, A.S., 2012. Received and provided social support: A review of current evidence and future directions. *American Journal of Health Studies*, *27*(3), pp.173-188.

Nyabadza, F. and Coetzee, L., 2017. A systems dynamic model for drug abuse and drug-related crime in the Western Cape province of South Africa. *Computational and mathematical methods in medicine*, *2017*.

Oboni, J.B., Marques-Vidal, P., Bastardot, F., Vollenweider, P. and Waeber, G., 2016. Impact of smoking on fertility and age of menopause: a population-based assessment. *BMJ open*, *6*(11).

Obot, I.S., 2013. *Prevention and treatment of drug dependence in West Africa*. Center on International Cooperation.

Okumus, F., Altinay, L. and Roper, A., 2007. Gaining access for research: Reflections from experience. *Annals of Tourism Research*, *34*(1), pp.7-26.

Poole, M.S., 2014. Systems theory. *The SAGE handbook of organizational communication: Advances in theory, research, and methods*, pp.49-74.

Popovici, I., French, M.T. and McKay, J.R., 2008. Economic evaluation of continuing care interventions in the treatment of substance abuse: recommendations for future research. *Evaluation Review*, *32*(6), pp.547-568.

Popovici, I., French, M.T. and McKay, J.R., 2008. Economic evaluation of continuing care interventions in the treatment of substance abuse: recommendations for future research. *Evaluation Review*, *32*(6), pp.547-568.

Poudel, A. and Gautam, S., 2017. Age of onset of substance use and psychosocial problems among individuals with substance use disorders. *BMC psychiatry*, *17*(1), pp.1-7.

Preiser, W., Van Zyl, G. and Dramowski, A., 2020. COVID-19: getting ahead of the epidemic curve by early implementation of social distancing. *SAMJ: South African Medical Journal*, *110*(4), pp.0-0.

Prochaska, J.O. and DiClemente, C.C., 1983. Stages and processes of self-change of smoking: toward an integrative model of change. Journal of consulting and clinical psychology, 51(3), p.390.

Prochaska, J.O. and Velicer, W.F., 1997. The transtheoretical model of health behavior change. American journal of health promotion, 12(1), pp.38-48.

Proctor, S.L. and Herschman, P.L., 2014. The continuing care model of substance use treatment: What works, and when is “enough,”“enough?”. *Psychiatry Journal*, *2014*.

Proctor, S.L., Wainwright, J.L. and Herschman, P.L., 2017. Patient adherence to multi-component continuing care discharge plans. *Journal of substance abuse treatment*, *80*, pp.52-58.

Pulla, V. and Carter, E., 2018. Employing interpretivism in social work research. *International Journal of Social Work and Human Services Practice*, *6*(1), pp.9-14.

Rahman, M.M., Rahaman, M.M., Hamadani, J.D., Mustafa, K. and Shariful Islam, S.M., 2016. Psycho-social factors associated with relapse to drug addiction in Bangladesh. *Journal of Substance Use*, *21*(6), pp.627-630.

Ramdhani, A., Ramdhani, M.A. and Amin, A.S., 2014. Writing a Literature Review Research Paper: A step-by-step approach. *International Journal of Basic and Applied Science*, *3*(1), pp.47-56.

Ramlagan, S., Peltzer, K. and Matseke, G., 2010. Epidemiology of drug abuse treatment in South Africa. *South African journal of psychiatry*, *16*(2), pp.40-48.

Razali, A., 2017. Personal and interpersonal factors with the inclination to relapse. Masyarakat, Kebudayaan dan Politik, 30(3), pp.310-321

Rhode, P., Lewinsohn, P.M., Seeley, J.R., Klein, D.N., Andrews, J.A. and Small, J.W., 2007. Psychosocial functioning of adults who experienced substance use disorders as adolescents. *Psychology of Addictive Behaviors*, *21*(2), p.155.

Sari, A.P.S.P., Wahyuni, C.U. and Wibowo, A., 2018. Social support and substance abuse relapse. *Health Notions*, *2*(1), pp.65-69.

Satel, S. and Lilienfeld, S.O., 2014. Addiction and the brain-disease fallacy. *Frontiers in psychiatry*, *4*, p.141.

Schoenmakers, E.C., van Tilburg, T.G. and Fokkema, T., 2015. Problem-focused and emotion-focused coping options and loneliness: how are they related?. *European Journal of Ageing*, *12*(2), pp.153-161.

Schulte, M.T. and Hser, Y.I., 2014. Substance use and associated health conditions throughout the lifespan. 3XEOLF KHDOWK UHYLHZV (2).

Schultz, P. and Alpaslan, A.H.N., 2016. Our brothers' keepers: Siblings abusing chemical substances living with non-using siblings. Social Work, 52(1), pp.90-112.

Shazzad, M.N., Abdal, S.J., Majumder, M.S.M., Ali, S.M.M. and Ahmed, S., 2013. Drug addiction in Bangladesh and its effect. *Medicine today*, *25*(2), pp.84-89.

Shenton, A.K., 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for information*, *22*(2), pp.63-75.

Sidiq, T., Bhat, B.A., Nusrat, F.A.W. and Ahmad, F.J., 2016. Drug Addiction Causes and Awareness among people of Pulwama District of Jammu and Kashmir State. *Biomed. Res*, *1*, pp.30-33.

Silverman, D., 2015. *Interpreting qualitative data*. Sage.

Singh, J. and Gupta, P.K., 2017. Drug addiction: Current trends and management. *The International Journal of Indian Psychology*, *5*(1), pp.186-201.

Song, L., Son, J. and Lin, N., 2011. Social support. *The SAGE handbook of social network analysis*, *9*, pp.116-128.

South Africa, 2008. Prevention of and Treatment of Substance Abuse Act No 70 of 2008: Gazette No 32150 Cape Town.

South Africa. 1966. Medicines and Related Substances Amendment Act, 1966 (Act 101 of 1966). National Department of Health. [Online] Available:

South Africa. 1992. Drugs and Drug Trafficking Act, 1992 (No. 140 of 1992). National Department of Justice and Constitutional Development. [Online] Available: https://www.justice.gov.za/legislation/acts/1992-140.pdf.

South Africa. 1996. The National Youth Commission's (Act 19 of 1996). National Youth Commission. [Online] Available: http://www.gov.za

South Africa. 2005. Children’s Act (No 38 of 2005). National Department of Social Development. [Online] Available: http:// www.sagov.dsd.gov.za.

South Africa. 2008. Prevention of and Treatment for Substance Abuse Act (No 70 of 2008). National Department of Social Development. [Online] Available: http:// www.sagov.dsd.gov.za.

South Africa. 2012. Department of Social Development. National Drug Master Plan (NDMP) 2012-2016. RP05/2007. Pretoria: Government Printers.

South Africa. Department of Health. 2015. Ethics in Health Research Principles, Processes and Structures. Pretoria. Government Printers

South Africa. Department of Social Development. 2013. National Drug Master Plan (NDMP) 2013-2017, RP05/2007. Pretoria. Government Printers.

Spencer, M., 2012. What is spirituality? A personal exploration. *Retrieved March*, *16*, p.2020.

Spooner, C. and Hetherington, K., 2004. *Social Determinants of Drug Use. National Drug and Alcohol Research Centre. University of New South Wales* (No. 228). Technical report.

Springer, J.F., & Phillips, J., 2007. The Institute of medicine framework and its implication for the advancement of prevention policy, programmes and practice, Centre for applied research solutions.

Stahlke, S., 2018. Expanding on notions of ethical risks to qualitative researchers. International Journal of Qualitative Methods, 17(1),

Stahlke, S., 2018. Expanding on notions of ethical risks to qualitative researchers. *International Journal of Qualitative Methods*, *17*(1), p.1609406918787309.

Stanojlović, M. and Cambra, U.C., 2017. Self-Affirmation Effect on Risk Perception and the Moderating Role of Self-Efficacy in Anti-Alcohol Messages. *European Journal of Social Science Education and Research*, *4*(4), pp.178-186.

Stein, M.D., Anderson, B.J. and Bailey, G.L., 2015. Preferences for aftercare among persons seeking short-term opioid detoxification. *Journal of substance abuse treatment*, *59*, pp.99-103.

Stevens, E., Jason, L.A., Ram, D. and Light, J., 2015. Investigating social support and network relationships in substance use disorder recovery. *Substance abuse*, *36*(4), pp.396-399.

Stokes, M., Schultz, P. and Alpaslan, A., 2018. Narrating the journey of sustained recovery from substance use disorder. Substance abuse treatment, prevention, and policy, 13(1), pp.1-12.

Stokes, M., Schultz, P. and Alpaslan, A., 2018. Narrating the journey of sustained recovery from substance use disorder. *Substance abuse treatment, prevention, and policy*, *13*(1), pp.1-12.

Stone, A.L., Becker, L.G., Huber, A.M. and Catalano, R.F., 2012. Review of risk and protective factors of substance use and problem use in emerging adulthood. *Addictive behaviors*, *37*(7), pp.747-775.

Strobel, N., Adams, M.C. and Rudd, C., 2014. The role of support groups and ConnectGroups in ameliorating psychological distress.

Strydom, H. and Venter, L., 2005. Sampling and sampling methods. De Vos, AS, Strydom, H., Fouché, CB & Delport, CSL, pp.192-203.[7]

Sussman, S. and Sussman, A.N., 2011. Considering the definition of addiction. *International journal of environmental research and public health*, *8*(10), pp.4025-4038.

Sussman, S., 2010. A review of Alcoholics Anonymous/Narcotics Anonymous programs for teens. *Evaluation & the health professions*, *33*(1), pp.26-55.

Swanepoel, I., Geyer, S. and Crafford, G., 2016. Risk factors for relapse among young African adults following in-patient treatment for drug abuse in the Gauteng Province. *Social Work*, *52*(3), pp.414-438.

Swedberg, R., 2018. On the uses of exploratory research and exploratory. *Producing Knowledge. Forthcoming*.

Taherdoost, H., 2016. Sampling methods in research methodology; how to choose a sampling technique for research. *How to Choose a Sampling Technique for Research* (April 10, 2016).

Tate, S.R., Brown, S.A., Unrod, M. and Ramo, D.E., 2004. Context of relapse for substance-dependent adults with and without comorbid psychiatric disorders. *Addictive Behaviors*, *29*(9), pp.1707-1724.

Taylor, S. E., 2011. Social support: A review. *I*n H. S. Friedman (Ed.), *the handbook of health psychology* (pp. 189–214). New York, NY: Oxford University Press.

The Canadian Institute of Health Information. 2012. The role of Social Support in reducing psychological distress. Health Canada.

The National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. 1979. The Belmont Report: *Ethical Principles and Guidelines for the Protection of Human Subjects of Research.* Washington D.C. Department of Health, Education and Welfare

Tracy, K. and Wallace, S.P., 2016. Benefits of peer support groups in the treatment of addiction. *Substance abuse and rehabilitation*, *7*, p.143.

Tuchman, E., 2010. Women and addiction: the importance of gender issues in substance abuse research. *Journal of addictive diseases*, *29*(2), pp.127-138.

Tuliao, A.P., 2008. Structural and functional social support and drug-abuse recovery. *Loyola Schools Review*, *7*, pp.83-103.

Uchino, B.N., 2006. Social support and health: a review of physiological processes potentially underlying links to disease outcomes. *Journal of behavioral medicine*, *29*(4), pp.377-387.

Uchino, B.N., 2009. Understanding the links between social support and physical health: A life-span perspective with emphasis on the separability of perceived and received support. *Perspectives on psychological science*, *4*(3), pp.236-255.

van der Westhuizen, M., Alpaslan, A. and de Jager, M., 2011. Preventing relapses amongst chemically addicted adolescents: exploring the state of current services. *Social Work/Maatskaplike Werk*, *47*(3).

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

Van der Westhuizen, M.A., 2007. Exploring the experiences of chemically addicted adolescents regarding relapsing after treatment (Doctoral dissertation, University of South Africa).

Van Niekerk, B., 2018. Religion and spirituality: What are the fundamental differences?. *HTS Theological Studies*, *74*, pp.1-11.

Walton, M.T. and Hall, M.T., 2016. The effects of employment interventions on addiction treatment outcomes: a review of the literature. *Journal of Social Work Practice in the Addictions*, *16*(4), pp.358-384.

Weiss, R.D., Griffin, M.L., Gallop, R.J., Najavits, L.M., Frank, A., Crits-Christoph, P., Thase, M.E., Blaine, J., Gastfriend, D.R., Daley, D. and Luborsky, L., 2005. The effect of 12-step self-help group attendance and participation on drug use outcomes among cocaine-dependent patients. *Drug and Alcohol Dependence*, *77*(2), pp.177-184.

White, M. and Dorman, S.M., 2001. Receiving social support online: implications for health education. Health education research, 16(6), pp.693-707.

White, M. and Dorman, S.M., 2001. Receiving social support online: implications for health education. *Health education research*, *16*(6), pp.693-707.

Wixon, D., Holtzblatt, K. and Knox, S., 1990, March. Contextual design: an emergent view of system design. In *Proceedings of the SIGCHI Conference on Human Factors in Computing Systems* (pp. 329-336).

Wood, L., 2017. The ethical implications of community-based research: A call to rethink current review board requirements. *International Journal of Qualitative Methods*, *16*(1), p.1609406917748276.

Worrall, H., Schweizer, R., Marks, E., Yuan, L., Lloyd, C. and Ramjan, R., 2018. The effectiveness of support groups: a literature review. Mental Health and Social Inclusion.

Xu, W. and Zammit, K., 2020. Applying thematic analysis to education: A hybrid approach to interpreting data in practitioner research. International Journal of Qualitative Methods, 19, p.1609406920918810.

Yang, C., Xia, M., Han, M. and Liang, Y., 2018. Social support and resilience as mediators between stress and life satisfaction among people with substance use disorder in China. *Frontiers in psychiatry*, *9*, p.436.

Young, L.B., Grant, K.M. and Tyler, K.A., 2015. Community-level barriers to recovery for substance-dependent rural residents. *Journal of Social Work Practice in the Addictions*, *15*(3), pp.307-326.

Zwane, D., Violence and crime in public schools: the case of three schools in eTwatwa, Daveyton (Doctoral dissertation).

APPENDIX 1: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH THE SUPPORT GROUP

Faculty of Health Sciences
Nelson Mandela University
Tel: +27 (0)41 504-2235 Fax: +27 (0)41-504-9085
E-mail: Luvuyo Teko s214096513@mandela.ac.za

Ref: H19-HEA-SDP-012

REQUEST FOR PERMISSION TO CONDUCT RESEARCH with THE SUPPORT GROUP

Title: The role of community-led support groups in facilitating relapse prevention to young adults with substance use disorder.

To the leader of the group

My name is Luvuyo Teko, and I am currently studying towards a Master in Social Work degree (Research) at the Nelson Mandela University in Port Elizabeth. The research I intend conducting will seek to explore how community-led support groups to facilitate relapse prevention in the aftercare to young adults with substance use disorder. The study will look at community-led support groups as an intervention strategy and its effectiveness in facilitating recovery. The goal of the study will be to develop an in-depth understanding of how community-led support groups can facilitate relapse prevention in the aftercare to young adults with substance use disorders. For this research study to be conducted I need to recruit participants who meet the following inclusion criteria:

- All individuals over the age of 18,
- Recovering from substance use disorder,
- Active in a community-led support group,
- Have joined at any stage since inception.
- Have attended a minimum of 5 sessions
- The individual would have to be in recovery for 6 months or more

This project will be conducted under the supervision of Prof V. Goliath and Dr Z. Abdulla and will culminate into a full research project. The nature of the project will be exploratory where the study will seek to gain the members understanding and experiences of being part of a community-led support group.

Data collection will be in the form of **online one on one semi structured interviews**. Participants will be recruited from other support groups in the metro to realize the study population. The PI will accommodate everyone that shows willingness to participate provided that they meet the inclusion criteria.

I hereby seek your consent to approach the individuals who are part of your support group to seek consent from them to participate in the **online one on one semi structured interviews.** I will attach a copy of the research proposal which includes copies of the research methodology and consent forms to be signed for voluntary participation.

Upon completion of the study, I undertake to provide the leader of the community-led support group convener with an anonymised summarized feedback. If you require any further information, please do not hesitate to contact me on 0605073263. Thank you for your time and consideration in this matter.

Yours sincerely,

Name of leader

Of support group	Signature of leader	Date
………………………	………………………..	....

Name of Researcher	Signature of leader	Date
………………………	………………………..	....

APPENDIX 2: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH THE SUPPORT GROUP

Faculty of Health Sciences
Nelson Mandela University
Tel: +27 (0)41 504-2235 Fax: +27 (0)41-504-9085
E-mail: Luvuyo Teko s214096513@mandela.ac.za

Ref: H19-HEA-SDP-012

REQUEST FOR PERMISSION TO CONDUCT RESEARCH with THE SUPPORT GROUP

Title: The role of community-led support groups in facilitating relapse prevention to young adults with substance use disorder.

To the leader of the group

My name is Luvuyo Teko, and I am currently studying towards a Master in Social Work degree (Research) at the Nelson Mandela University in Port Elizabeth. The research I intend conducting will seek to explore how community-led support groups to facilitate relapse prevention in the aftercare to young adults with substance use disorder. The study will look at community-led support groups as an intervention strategy and its effectiveness in facilitating recovery. The goal of the study will be to develop an in-depth understanding of how community-led support groups can facilitate relapse prevention in the aftercare to young adults with substance use disorders. For this research study to be conducted I need to recruit participants who meet the following inclusion criteria:

- All individuals over the age of 18,
- Recovering from substance use disorder,
- Active in a community-led support group,
- Have joined at any stage since inception.
- Have attended a minimum of 5 sessions
- The individual would have to be in recovery for 6 months or more

This project will be conducted under the supervision of Prof V. Goliath and Dr Z. Abdulla and will culminate into a full research project. The nature of the project will be exploratory where the study will seek to gain the members' understanding and experiences of being part of a community-led support group. Participants will be recruited from a range of community initiated support groups in the metro to obtain a comprehensive view of the value of support groups. The PI will accommodate everyone that shows willingness to participate provided that they meet the inclusion criteria.

My understanding is that you are continuing with the support group via an online meeting platform. I therefore seek your assistance in informing members of your support group about the research and seeking their permission to share their names and contact numbers of the ones wishing to be enrolled in the study. Alternatively, you can share my number with them if they wish to make direct contact. I will explain the detailed process of registering the research participant's informed consent, to them, prior to the commencement of the study.

Data collection will be in the form of **online (telephonic/Zoom or skype) one on one semi structured interviews, with approximate duration of 30-60 minutes**. I will place the call to the research participant, and in the event of Zoom calls, I will provide the participant with 600MB of pre-paid data thirty minutes prior to commencement of the interview.

Upon completion of the study, I undertake to provide the leader of the community-led support group convener with a research feedback report (omitting all personal information of the research participants). If you require any further information, please do not hesitate to contact me on 0605073263. Thank you for your time and consideration in this matter.

Yours sincerely

……………………… ……………………….. ....

Luvuyo Teko (Researcher) Signature Date

……………………… ……………………….. ....

Veonna Goliath (Research supervisor) Veonna.goliath@mandela.ac.za

APPENDIX 3: INFORMATION AND INFORMED CONSENT FOR PARTICIPATION IN THE STUDY

INFORMATION AND INFORMED CONSENT FOR PARTICIPATION IN THE STUDY

Title: The role of community-led support groups in facilitating relapse prevention amongst young adults with substance use disorder.

Dear Support group member

You are receiving this letter because you showed an interest to participate in a research study undertaken for my Master's Degree in Social Work (Research), aimed at understanding how support groups can help to prevent relapses for young adults in recovery from a substance use disorder. The study was approved by the Universities research ethics committee and the reference number is **REC-H19 HEA SDP 012**

Explanation of the Study

The study will be an exploratory-descriptive contextual study, meaning that I am interested to find out what works for YOU, in your specific support group and your community. The goal of the study will be to arrive at learnings of how support groups can improve what they do and how they function in order to enhance the benefits for young adults trying not to relapse to drug use. I am requesting at least 30 minutes to an hour of your time to conduct a telephonic or Skype or Zoom call with you (whatever is possible for you).

Risks or Discomforts of Participating in the Study (Can anything bad happen to me?)

The only risk or discomfort relate to you needing to secure a private space where we can have a telephonic conversation without any possible interruptions. I will also need to record the conversation to ensure that I do not omit anything that you share with me when I do the research write up. We both may then be inconvenienced by needing to "find" the right volume to be audible enough for the audio recording of the telephonic interview.

There are no further foreseeable risks involved in participating in the study. Should you get hurt by any unforeseen risk, you will be referred immediately for further intervention at the University Psychology Clinic situated at the Missionvale Campus of the Nelson Mandela University, which are rendering a telephonic counselling service during the lockdown period.

Benefits of Participating in the Study (Can anything good happen to me?)

The benefits of partaking in the study will entail having your voice heard in terms of your experiences in being part of the support group, gain insights on the functions of your support group and learning new strategies in preventing relapse from other young adults.

Confidentiality (Will anyone know I am in the study?)

Confidentiality will be maintained at the highest standards, no identifying particulars will be mentioned when information will be collected and written down during data collection, and secondly, no identifying particulars will be evident in the academic write up on the findings. Recognition and acknowledgement in participation in the research project will be negotiated and discussed in detail with you. I will ensure exclusion of identifying details to protect your identity and privacy.

Criteria for participation (The boxes I need to tick based on self-report)

- Must be over the age of 18,
- Recovering from substance use disorder,
- Active in a community-led support group,
- Have joined at any stage since inception
- Have attended a minimum of 5 sessions
- Have been drug free for at least 6 months

Compensation for Participation (Do I get paid for participating?)

You will not be compensated for participating in the study. The interviews will be conducted via ordinary telephone calls, WhatsApp or Zoom depending on the platform the participant is comfortable with. I will purchase 600 MB data for each participant and send a copy of the receipt for the data purchased 30 minutes before the scheduled interviews. Alternatively, should the participant opt for the method of telephonic interview, I will call the participant, thus eliminating any potential costs from the

participant's side. These measures are in place to ensure that the prospective participant do not suffer financially as a result of participation in the study.

Contact Information (Who can I talk to about the study?)

The Department of Social Development Professions and request for the supervisor Prof. Goliath or Dr. Abdulla. (email contact details Veonna.goliath@mandela.ac.za)

Voluntary Participation (What if I do not want to do this?)

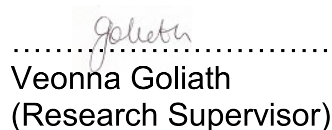
I will not in any way coerce you into participating in the study. Participation is voluntary, you have the decision whether or not to participate and it will in no way affect your present or future lifestyle. No pressure will be exerted on you to consent to participate and understand that you may withdraw at any stage without penalisation. Since I cannot deliver the consent form to you in person, I propose that we follow the following procedure:

- That you read through the informed consent form and sign it if you agree to participate in the study
- That you get a trusted family member/significant other co-sign the form as a witness
- That you then send me a picture of the signed consent form (clearly showing the two signatures) to my whats app nr 060 507 3263
- I will then co-sign in my section as the researcher, together with the signature of a witness
- In addition to the above, you can also send me a voice note on the above number to confirm your willingness to proceed with the research interview
- I will then consult with you about a suitable date and time for the interview.

Please do not hesitate to contact me if you have any questions

Kind Regards

…………………………..
Luvuyo Teko
(Researcher)



…………………………..
Veonna Goliath
(Research Supervisor)

NELSON MANDELA UNIVERSITY

INFORMED CONSENT FORM

Name and Student Number of Researcher
Luvuyo Teko, student number s214096513
Ethics Reference number
H19 HEA SDP 012
Title of study
The role of community-led support groups in facilitating relapse prevention amongst young adults with substance use disorder.

Please read and complete this consent form carefully. If you are willing to participate in this study, circle the appropriate responses and sign and date the declaration at the end. Get a witness to co-sign with you. Either email the completed and signed form to me or send a picture via whats app to me on the numbers listed below. If you do not understand and would like more information, please ask me by contacting him on 0605073263 or email questions to s214096513@mandela.ac.za.

- I have had the research proposal explained to me in written form by the researcher. **YES / NO**
- I understand that the research will involve having one telephonic (or Skype or Zoom) interview of between 30-60min long; and that I need to secure a quiet place where we can have an uninterrupted telephonic interview **YES / NO**
- I understand that I may withdraw from this study at any time without having to explain. This will not affect me in any way **YES / NO**

- I understand that all information about me will be treated in strict confidence and that I will not be named in any written work arising from this study. **YES / NO**
- I understand that the interview will be audio-recorded and that any audiotape material of me will be used solely for research purposes and will be stored for 5 years and after the period destroyed. **YES / NO** **YES / NO**
- I understand that the researcher will be discussing the progress of the research project with Dr V. Goliath and Dr Z. Abdulla at the Nelson Mandela University
- I understand the contents that was written on the letter and I do not have any objections or misunderstandings **YES / NO**
- I understand that any confidential identifiable information such as name and number will be treated with strict confidence and will be stored in a password protected file and laptop.

I freely give my consent to participate in this research study and have received a copy of this form for my information.

Name of Participant…………………………… Signature: ………………………….

Number of participant………………………….

Name of witness:…………………………………Signature: ………………………..

Date: ……………………………………………………………………

Signature of researcher…………………………Signature …………………………..

Name of witness: ………………………………Signature: …………………………..

Date: ………………….

APPENDIX 4: INTERVIEW SCHEDULE

List of interview Questions

- Tell me about the support group you have been attending
- What is the reason or purpose of the support group
- How often does the support group meet and how long are the meetings(before lockdown)
- Share with me your experiences of attending your support group
- Why have you chosen to attend the support group meetings/ what made you decide on attending the support group meetings
- What needs were you hoping would be met from attending the support group (how were you hoping the group could help you)
- Is there a time that you can say maybe that the support group has not been helpful?
- How did the support group attend to the needs relating triggers and cravings whilst in recovery?
- What recommendations(advice) do you have for how the support group can help young adults stay free from drugs
- In your opinion how long do you think a person should be part of a support group for him or her to continue staying clean?

APPENDIX 5: TRANSCRIPT

Participant 5

INTERVIEWER: “So, we can start as I said I just read to you the consent form which you agreed too. So now we will start off with the questions, the questions that I sent to you prior to, to the interview. Tell me more, give me an overview of the group you have been attending, what is the reason or purpose of the support group and how often does the support group meet and how long are the meetings?”

PARTICIPANT 5: “I am not exactly sure how to put it, the purpose of the uhm…. support group is, but one thing I know is that the reason why I want to be part of the support group is because I want to be able to have a purposeful life”.

INTERVIEWER: Uhm hmm…

PARTICIPANT 5: “That uhm…as a man of God learning the ways of God and getting out of the temptation of living in this drug filled world [a moment of silence] I hope you understand it’’.

INTERVIEWER: “No, Yes I do understand and so in you having the reason, the reason you have stated now, how has the support group been uhm…helping in that purpose, in your purpose of why you want to attend, why you attending a support group?”

PARTICIPANT 5: …….“I think that a support group can help me in realizing that there is another world out there, that does not part take of these destructive things that I have been surrounding myself around [a moment of silence] and it kind of introduces me to a whole another perspective of looking at things and also, being able to have a brotherhood. People that are willing to help me and to support me as far as change is concerned”.

INTERVIEWER: “Uhm hmm... Uhm hmm…That is true you know “touched” on something interesting you know, you mentioned brotherhood so in a word brotherhood would you say that it comes with support?”

PARTICIPANT 5: ……..“Support?”

INTERVIEWER: “Yes”

PARTICIPANT 5: “Yes”

INTERVIEWER: “And how have they been showing support to you?

PARTICIPANT 5: “Uhm…They have been encouraging me to keep coming to the support group, they have been encouraging me to keep doing what I am doing. They have been encouraging me to pray to…..spend more time with God you know and showing me at the same time and / or rather telling me or rather giving me their own testimonies about what they did in the past and how they got to be the men that they are already are that come and inspire me to be a man that is like them”.

INTERVIEWER: “Uhm hmm…Uhm hmm…yes and how has their testimonies helped you or how their testimonies has been assisting you?”

PARTICIPANT 5: “It has helped me positively because at least now I am more of a man in the house than I have ever been at home uhm… I have a good relationship with my mother, a good relationship with my sister, a good relationship with my daughter, I have a good relationship with my nieces you know I spend lots of time at home instead of being in the streets. Looking forward to seeing the brotherhood again when the next support group is, at hand so that I can be able to learn more of how to live this purpose filled life”.

INTERVIEWER: “Hmm…”

PARTICIPANT 5: “So that’s how it helps me”.

INTERVIEWER: “Wow, that is interesting thank you for sharing that you know... it goes to show that getting support in the form of brotherhood also, has been assisting you in that regard”.

PARTICIPANT 5: “Yes, it has”.

INTERVIEWER: “Hmm… thank you for that so tell me...so share with me your experiences of attending the support group, so share with me your experiences of the support group meetings?”

PARTICIPANT 5: …….Uhm…my experiences of attending or being at the support group is the fact that you know, my experiences are most definitely the fact that talking

about your problem and sharing with people that care that are willing to support you, that are willing to help you is very good in order for you to overcome uhm…uhm…uhm… mental challenges like depression because, as of me I am a schizophrenic patient and as a schizophrenic patient, I do have a sense of depression which kind of causes the aggressiveness of the schizophrenia.

Now what the group does it or rather my experiences in the group is that I actually learnt to communicate about your problem then to bottle it up. Because, bottling things up I think is one of the reasons why I got to the point where I became depressed to the point that I became uhm…uhm… diagnosed as schizophrenic more than anything else and so communicating and sharing is important.

Talking about my problems is of utmost importance because, I get to see different views and opinions from people that strengthens me. To feel supported and to also to be willing to do my best to change for the better and also, it… my experiences are that the support group usually filled with different people from different nations and it comes to enlighten that [silence…] it is after all or rather South Africa is becoming after all nations and countries still love one another and I'm learning love, I am learning communication, I'm learning a lot, I am experiencing a lot of things, I am seriously love communication you know uhm…uhm…uhm…dedication uh… support you know brotherly love and a lot of sharing I guess".

INTERVIEWER: "Hmm…Wow, that is very insightful, that is very insightful thank you for that you know so, the support group has been offering uhm…these aspects that you have mentioned now so would you say uhm…what are the what are needs you were hoping would be met from attending the support group?

So when I mentioned needs you know, when you attend a support group or you are attending a support group obviously there is reasons behind it and there is somethings that you need in order for you, for your recovery to be certain but now there are certain needs that cannot be met maybe individually but rather maybe in a group setting so what were those needs that you initially had that the group had offered to you?"

PARTICIPANT 5: "Uhm…My needs or rather I how cope that a support that the support group [mumbles…]"

INTERVIEWER: “Like the support group, like you know uhm… there are certain needs we have certain needs in recovery, right? That we need for in order for our recovery to to… to be good you know so, some of these needs cannot be met uhm…maybe individually maybe on one on one basis but could be met in a group setting so, what were these needs that you had that the support group could help you with or could offer?”

PARTICIPANT 5: “Oh Okay, I was hoping that the support group or rather I was hoping that the support group would meet [mumbles] I was hoping as a support group would meet the fact that uhm…[mumbles…how can I put it] I was hoping that the support group would help me to come out of the closet [noise in the background] with my issue of being a….drug addict and a….. verbally abusive and angry [noise in the background] man of God yeah not necessarily an angry man you know”.

INTERVIEWER: “Hmm…”

PARTICIPANT 5: “And I was hoping that the support group was going to help me towards change more than anything”.

INTERVIEWER: “Yes”

PARTICIPANT 5: “I was hoping that the support group would help me change and I was hoping that it would, it would, it would give me the kind of support that I wasn’t getting from my peers and family because they had because, they have been so disappointed in me for such a long time and we couldn’t necessarily sit and discuss anything without them being judgmental about whatever I did in the past so I was hoping that ... meet new people with different experiences who are willing to listen to my situation or to my problem and you know guide me and advise me in ways that might help change and to become a better man and, and…to become a man of God and to be acceptable in society so that even as I take my treatment of schizophrenia ... I may know for a fact that as much as the treatment is helping me to or rather is helping me mentally I have also, now have [mumbles] I have also now getting help and support from this or rather a support group which is any help with a support group.”

INTERVIEWER: “Yes, yes definitely hmm…thank you for that insight you know, so you mentioned that one of the needs[noise in background] out of the many that you

have mentioned was that uhm… was support and which you've gained that support by being part of the support group".

PARTICIPANT 5: "Yes"

INTERVIEWER: "Yes you know, thank you, thank you for that insight and would you say that there was ever a time that the support group was not helpful for you?"

PARTICIPANT 5: No there wasn't"

INTERVIEWER: "Hmm..."

PARTICIPANT 5: "There wasn't because, the thing is the support group was just a professional support group that is there to teach me how to become a good person but you know the fact that it is also, a brotherhood it teaches me how to love or rather how to be loved by a brotherhood and receive love from a brotherhood".

INTERVIEWER: Hmm…

PARTICIPANT 5: "So it teaches me and also helps me to develop character ... I'm done".

INTERVIEWER: "Oh yes, so it helps you develop character and how has the brotherhood or support group helped you in developing this positive character that you've gained this far?"

PARTICIPANT 5: "Love, loving their neighbor like they love themselves kind of that is what get from the brotherhood, I receive lots of love and I am wanting to get love as well so it is giving me character in that sense because, the aggressiveness, the anger, drug able all of that has caused me to be a cold person, a cold hearted person an aggressive person, an angry person, a person who is just really destruct full person through this anarchy but, the brotherhood showed through love is building character this is now instead of me being so negative it was kind of helping me to be just positive and to become to become more laid back and to become more that to realize that it's okay to be who I am but, there is another way of looking at things you know through love [mumbles] lots of other ways of experiencing life and being accepted in the community, in society, to my family most importantly. So, I am loving the brotherhood

by being loved in the brotherhood I have learnt character and I am able to love, I am able to show my family love. I am able to show any other person love and I have been able to show my enemies love. Though the support group actually helped me to come out like being surrounded by people who are not my enemies, people who are family you know not just family as in according to my bloodline as according to the blood of the lamb and Christ".

INTERVIEWER: "Hmm…Yes thank you for that, thank you that's very quite true thank you for that insight you know it's showing me it's painting a picture of how the support group has brought about constant change in you every time you know it has brought about positive change in your life".

PARTICIPANT 5: "Yes sir"

INTERVIEWER: "So the support group has definitely been uhm…assisting you in that regard bringing about…"

PARTICIPANT 5: "It has definitely been worthwhile"

INTERVIEWER: "Hmm…so tha… thank you for that, so now just getting to our last two questions from our side just obviously on your reflection and experiences".

PARTICIPANT 5: "Okay"

INTERVIEWER: "So what recommendations or advice would you, would you have for how a support group can help another person to stay free from drugs?"

PARTICIPANT 5: "[Silence…] Uhm… uhm…

INTERVIEWER: "Or let me ask it this way,

PARTICIPANT 5: "You know as…

INTERVIEWER: "Okay, you can give it a try".

PARTICIPANT 5: "Okay, as someone who has been motivated and ambitious ... uhm… ... the support group, one of the reasons why I wanted for them to the support group was in order to help myself and in order to help others who I see are already part of God's people but just like myself have been lost. They like a lost flock basically,

now as someone who has that kind of ambition to help myself and also, to help others ... I would, I would be willing to give information to someone about the support group merely because I would love him to receive the same kind of help I have received and I think or rather I believe brotherly love”.

INTERVIEWER: “Hmm...”

PARTICIPANT 5: “Brotherly love is a ... uh…..an important need to people like myself or to addicts like myself ... so as soon as I could be able to, as soon as I can be able, as soon as the support group can be able to armor me, armor, I am armor me with all that I need and deserve in order to change it is of my intentions to [mumbles] for that matter , that the rest of the brotherhood that I love and have loved me but that is just caught up in the wrong time set up that is still living my past life. I would I have the intentions of ... sharing about, I mean sharing to them about the support group and showing them how much or rather getting them insight of how I have changed and it has obviously been, it will be obvious because that is a lot of change in me so, [silence] in other words I would encourage them that if they want to get to the point where I am at they should realize that there is a true God out there and this God has restored to me the miracle, the lack, the blessing and the fortune to be around people of noble character who have love and who are a brotherhood just like myself who have been in situations that we have been through and they are willing to help people like us become like who I am today.

INTERVIEWER: “Hmm…”

PARTICIPANT 5: “I…. don’t know If that answers the question”.

INTERVIEWER: “That was perfect, thank you for that reflection you that and it is always reflecting from your experience and how you view things you know and which is quite positive, you’ve given me quite an interesting insight you know as to the recommendation you know and how a support group can help someone else you know and how helping someone else has also, been helping you in that regard. You know it has given me a good insight thank you for that and then coming over to our last question before we close off. In your opinion how long do you think a person should be part of a support group for him or her to continue staying clean or to continue in his positive uhm…uhm…recovery journey a drug free journey?”

PARTICIPANT 5: "Hmm…... okay sir, a support group to me is like an ongoing experience like it's it doesn't end, but it just you know dissects into this different avenues of networking of building you of becoming responsible you know uhm…uhm…uhm…a support group can mean I feel should be an ongoing process it should have lack of business continuity".

INTERVIEWER: "Yes"

PARTICIPANT 5: "You know but, as it continues and as it develops characters ... you know it ... you begin to find purpose you know as it develops character ya and to begin ... to share and love then you, you you begin to inherit character then you know you seem to find purpose and this is where the support group is leading me but it's not just because of talking in front of a crowd for you to start performing but rather is going to show you the crowd, introduce you and then pull you back just to equip you okay you have to do in this in this direction you know guide you, you know sometimes it happens that a person is guided all the way to the stage and then on the stage it's stage fright and because of that stage fright and factor of this was a depressed person, this was an addict, this you know automatically ... it gives or rather leaves room for a moment for that person to reject what that person has been done to help him get to this stage or yeah to help him get to this stage and now you find that the person tends to tell themselves no I don't see the point of that. You know protect themselves try and console himself for leaving the crowd you know and that usually deters fears and the fear that is planted by the devil in us as addicts you know".

INTERVIEWER: "Hmm…"

PARTICIPANT 5: "So, it's important that once, the person gets to the stage, introduce them being introduced to an audience it is also important that it, should the support group continue to nurture that person into a character of leadership you know of… you know overcoming fear you know, overcoming this that's why I say support group is something that is suppose to be on going because it's like, it's like uh…uh…uh… starting a relationship with God and by starting a relationship with God you have to meet the brotherhood, you have to meet God's other son I mean other son's of God you know that have been through what you have been through wanted, communicated and shared and you know developed character and show positivity, reflection and

everything it is also important that the group should dissect into avenues that will guide you towards or rather each one guide you towards their purpose and still maintain a relationship as brothers even beyond the formality of sitting down and you know yeah and sharing all of that [mumbles] it is important for the support of the group to have continuity".

INTERVIEWER: "Hmm…wow thank you for that insight you know, what you've mentioned based on your feedback is actually quite true and having continuity also helps in building character so it goes about character development quite a few times so in character would take time so, in taking time you need to be part of a support group for over a long, long period of time".

PARTICIPANT 5: "Yes"

INTERVIEWER: "So, thank you for that insight you know and you have thought me something new you know and you know that's very insightful so, we've just come now uhm…to the end of our interview. So, just a short reflection from your side how was the experience for you of the interview?"

Figure 1 Continuum of Care

Figure 1

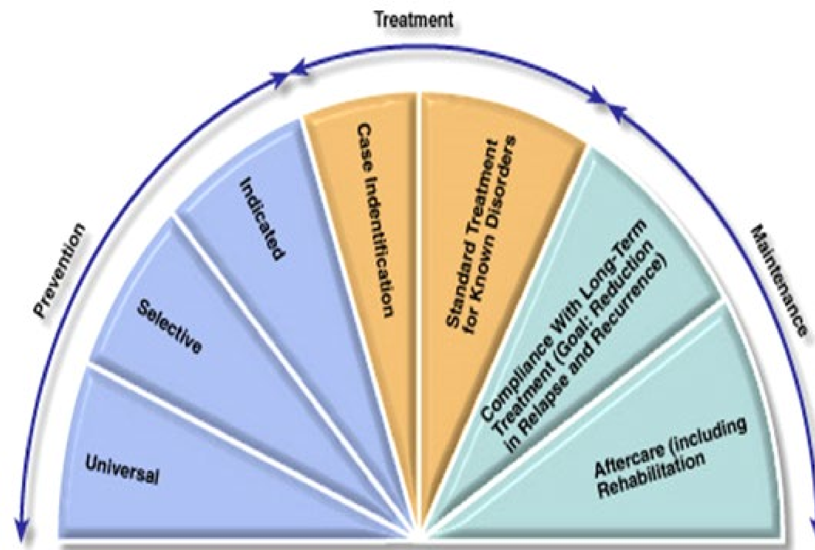


FIGURE 2.1: Continuum of care model

[Source: Institute of Medicine (IOM) Prevention Classifications cited in McWhirter *et al.* (2013:289)]

Figure 2- Treatment Levels

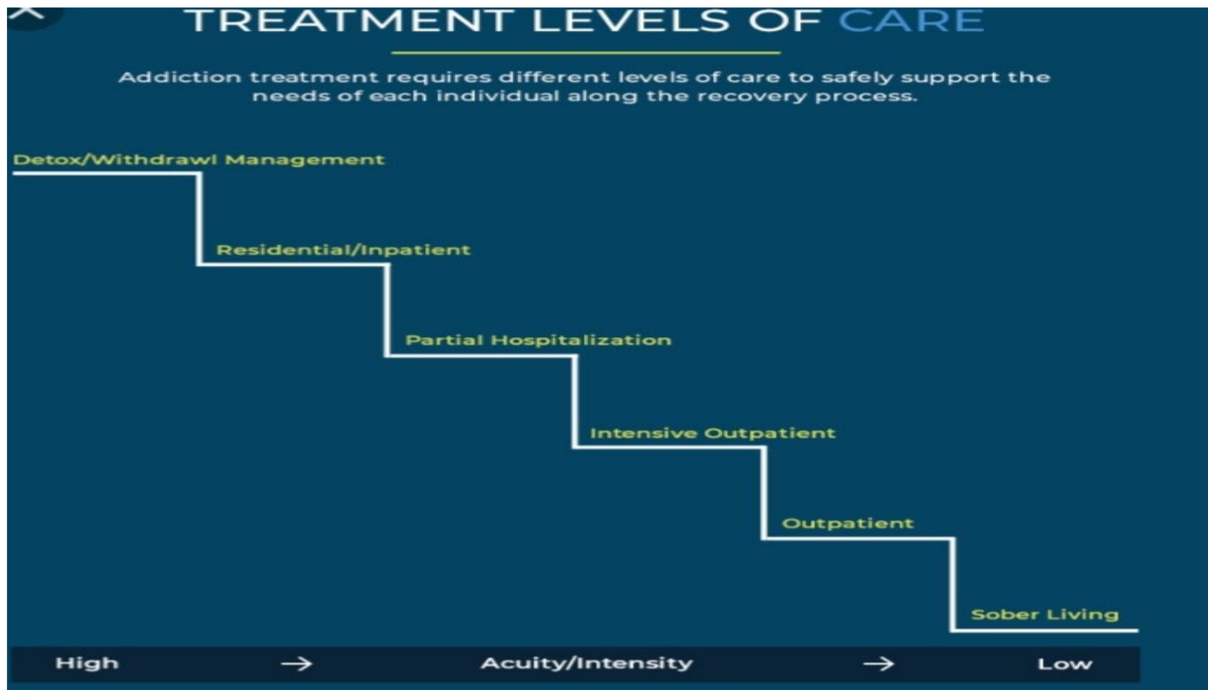


Figure 3- Typology of groups

Table 2.1: Types of groups (Corey et al., 2010:11-16)

	Types of groups			
	Task Group	**Counselling**	**Psycho educational**	**Psychotherapy**
Purpose	meeting clients' needs, meeting community needs	helps participants resolve difficult, problems of living.	prevent an array of educational deficits and psychological problems	psychological problems and interpersonal problems of living
Focus	application of group dynamics principles and processes to improve practice	interpersonal process and problem-solving strategies that stress thoughts, feelings, and behaviour	Developing cognitive, affective, and behavioural skills through a structured set of procedures	antecedents to current behaviour and connects historical material to the present using assessments and diagnosis
Facilitation	Leader and member reciprocation interaction	Leader to member interaction	Leader to member interaction	Leader to member interaction

Figure 4- Themes, sub themes and categories

Themes	Subthemes	Categories
1. The needs of young adults with SUD who are active in community-led support groups	1.1 Need assistance with longstanding addiction recovery 1.2 Need assistance to identify and manage the risk factors for relapse	1.2.1 dealing with perceived rejection (of self and by others) 1.2.2 dealing with low motivation for change 1.2.3 negative thoughts and attitude 1.2.4 Suppressing (bottling up) emotions
2. The way in which community-led support groups respond to the needs of young adults active in support groups	2.1. Religious faith as key component of support group 2.2 Connecting through online mediums during lockdown when f2f contact was not possible 2.3 Providing individual and group based support 2.5 Gaining coping skills and guidance	2.3.1 Group support as a form of intervention. 2.3.2 Intervention in a form of one-on-one support

Themes	Subthemes	Categories
4 Benefits of community-led support groups to young adults in recovery	4.1 Place for intrapersonal growth 4.2 Reciprocal learning from experiences 4.3 Social Support 4.4 Safe platform to share and learn from one another 's life stories 4.5 Social support group a Safe environment in fostering acceptance and care 4.6 The support group facilitated the restoration of family relationships and thus helped with relapse prevention	3.5.1 Non-judgmental support received 3.5.2 Learnt to forgive the self which increased understanding of others
5 How community-led support groups help young adults deal with the cravings and triggers of relapse	5.1 Assist in identification of triggers 5.2 Implement behavioural strategies in response to the triggers 5.3 Religiosity as an intervention to combating triggers	5.2.1 Avoid situations that could tempt relapse 5.2.2 Find a constructive alternative outlet 5.2.3 Keep busy for the day

Themes	Subthemes	Categories
6 Recommendations that can be made to improve the role of community-led support groups in facilitating relapse prevention	6.1 Motivate consistent attendance 6.2. Long term attendance and support needed for long term recover 6.3 Support group to have structure 6.4 Filling up time through keeping busy 6.5 Homogeneity in Social Network (Stay connected to positive people who have overcome addiction) 6.6 Facilitating attending groups by creating groups that are physically accessible.	

APPENDIX 6: ETHICS APPROVAL

PO Box 77000, Nelson Mandela University, Port Elizabeth, 6031, South Africa mandela.ac.za

Chairperson: Research Ethics Committee (Human)
Tel: +27 (0)41 504 2347
Sharlene.Govender@mandela.ac.za

Ref: [H19-HEA-SDP-012 / Approval]

27 February 2021

Prof V Goliath
Faculty: Health Sciences

Dear Prof Goliath

THE ROLE OF COMMUNITY LED SUPPORT GROUPS IN FACILITATING RELAPSE PREVENTION TO YOUNG ADULTS WITH A SUBSTANCE USE DISORDER

PRP: Prof V Goliath
PI: Mr L Teko

Your above-entitled annual progress report (APR) was reviewed by REC-H for approval. We take pleasure in informing you that the Research Ethics Committee (Human) has approved your report. Please note the following as you continue your study to its completion:

1. In the event of a requirement to extend the period of data collection (i.e. for a period in excess of 1 calendar year from date of original approval of study), completion of an extension request is required (form RECH-005 available on Research Ethics Committee (Human) portal)
2. In the event of any changes made to the study (excluding extension of the study), completion of an amendments form is required (form RECH-006).
3. Immediate submission (and possible discontinuation of the study in the case of serious events) of the relevant report to RECH (form RECH-007) in the event of any unanticipated problems, serious incidents or adverse events observed during the course of the study.
4. Immediate submission of a Study Termination Report to RECH (form RECH-008) upon expected or unexpected closure/termination of study.
5. Immediate submission of a Study Exception Report of RECH (form RECH-009) in the event of any study deviations, violations and/or exceptions.
6. Acknowledgement that the study could be subjected to passive and/or active monitoring without prior notice at the discretion of Research Ethics Committee (Human).

Please inform the REC-H, via your faculty representative, if any changes (particularly in the methodology) occur during this time (forms as above). An annual affirmation to the effect that the protocols in use are still those for which approval was granted, will be required from you.

Please quote the ethics clearance reference number in all correspondence and enquiries related to the study. For speedy processing of email queries (to be directed to Imtiaz.Khan@mandela.ac.za), it is recommended that the ethics clearance reference number together with an indication of the query appear in the subject line of the email.

We wish you well with the continuation of your study.

Yours sincerely

Dr S Govender
Chairperson: Research Ethics Committee (Human)

Cc: The Office of Research Development
Faculty Officer: Health Sciences

APPENDIX 7: PROOFREADING CERTIFICATE

Proofreading Certificate

It is hereby certified that this dissertation has been proofread and edited for spelling, grammar and punctuation by a professional English language editor from www.OneStopSolution.co.za

Client

Luvuyo Teko

The role of community-led support groups in facilitating relapse prevention in young adults with a substance use disorder

Submitted in fulfilment of the requirements for the degree of
Master of Social Work (Research)
in the Faculty of Health Sciences at Nelson Mandela University

Editor

Michele van Niekerk .... Name

.... Signature

24 June 2021

Date

I cannot guarantee that the changes that I have suggested have been implemented nor do I take responsibility for any other changes or additions that may have been made subsequently. The track changes of the language editing will be available for inspection upon enquiry, for a period of one year.

Contact

One Stop Solution
18 Woltemade str
Kabega Park
Port Elizabeth
6045

Redène Wynand
076 481 8341 / 060 520 1047
www.onestopsolution.co.za