THE UTILISATION OF THE CONTINUUM OF CARE FOR TREATMENT OF PERSONS WITH A SUBSTANCE USE DISORDER: SERVICE PROVIDERS' AND SERVICE USERS' EXPERIENCES AND PERCEPTIONS

by

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ABSTRACT

In South Africa, substance use, abuse and dependency is twice the world norm. To address this trend, the continuum of care guides legislative prescriptions for the treatment of a substance use disorder. This study aimed to address the lack of a description of the utilisation thereof in literature and recent research findings. A qualitative approach was followed and purposive sampling was employed to collect data from both service providers and users of services. Tesch's framework for qualitative data analysis (Creswell, 2014:218) was used to identify themes, sub-themes and categories, while the data was compared with existing literature on the identified themes. The trustworthiness of the findings was enhanced by the verification of the data through aspects of credibility/authenticity, transformability, dependability and conformability (Schurink, Fouché and de Vos, 2011:397). Informed consent, confidentiality , non-compensation, debriefing of participants, and the management of information were considered to ensure ethical practice.

Key words: Chemical substance, continuum of care, service provider, service user, substance use disorder, and utilisation.

DECLARATION

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I declare that the above dissertation is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

17 January 2019

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Signature Date

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
APA	American Psychiatric Association
CAD	Christelike Afhanklikheidsdiens/ Christian Action for Dependence
CNS	Central nervous system
NA	Narcotics Anonymous
NDMP	National Drug Master Plan
SACENDU	South African Community Epidemiology Network on Drug Use
SACSSP	South African Council for Social Service Professions
SANCA	South African National Council on Alcohol and Drug Addiction
SAPS	South African Police Service
SUD	Substance Use Disorder
TPA	Transfer Payment Agreement
UN	United Nations
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTION

Substance use, abuse, and dependence are worldwide phenomena, and in the South African context it is a serious socio-economic issue. Alarmingly, Tshitangano and Tosin (2016:234) report that substance use in South Africa is estimated to be double the international norm. On a social level, this phenomenon has far reaching consequences, as substance abuse and dependence are both contributing factors to and a result of other social issues, such as poverty, crime and domestic violence (Department of Social Development, 2012:83). For example, the World Health Organization (WHO, 2014:5) postulates that 44% of interpersonal violence incidents in South Africa are related to substance abuse, while crime statistics of the South African Police Service (SAPS) show that 60% of crime incidents known to the police are linked to substance abuse (Tshitangano and Tosin, 2016:234). In line with these statistics, the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (2008:14-16) acknowledges the seriousness of the situation, stating: “Substance abuse in South Africa has increased rapidly and demands a comprehensive national response”.

In spite of the concern raised in the above-mentioned Act, South African research statistics show a constant and alarming increase in substance use, abuse and dependence, as well as substance-related problems. Of particular concern is the upward trend in substance use among the nation’s youth (Tshitangano and Tosin, 2016:234; Plüddemann, Dada, Parry, Bhana, Bachoo, Perreira, Nel, Mncwabe, Gerber and Freytag, 2010:6). In the Western Cape, the highest reported substance abuse cases of the South African National Council on Alcoholism (SANCA) during the period 2016 to 2017 have been for the age group between 14 and 17 years, while a rising number of reports were received for the age group between nine to 13 years (SANCA, 2017:24). In addition, specific challenges in rural areas have been reported (Department of Social

Development, 2012:3). Based on this description of the ongoing social issue of substance abuse and dependency in the South African context, this research study seeks to contribute to a knowledge base to inform a comprehensive response to address a substance use disorder (SUD).

The key concepts pertaining to the focus of this research will be clarified next as a backdrop to the ensuing discussions.

1.1.1 Clarification of key concepts

This research study focused on "The utilisation of the continuum of care for treatment of a substance use disorder." Thus, the following important key concepts used within this study are defined below: Chemical substance, continuum of care, service provider, service user, substance use disorder, and utilisation. This section will introduce these concepts, while a broader description will be provided as part of the literature review that follows.

Chemical substance: A SUD is caused by a substance that affects the central nervous system (CNS), producing physical and/or psychological changes in the body (Fox, Oliver and Ellis, 2013:2). Williams and McElhiney (2011:9) provide a similar definition, but go even further to describe a chemical substance as a mind-altering substance that may lead to physical and psychological dependency, determined by genetic, physiological, biochemical, and emotional vulnerability. Substances that may lead to dependency can be classified as CNS stimulants, depressants and cannabinoids (Fisher and Harrison, 2013:28-29). Based on the above descriptions of a chemical substance, the researcher views this term as the description of a substance that affects the CNS, and therefore, the social, emotional, physical and cognitive functioning of the user. In the present study, the use of a chemical substance often leads to the abuse thereof, and results in a SUD that requires treatment.

Continuum of care: Puddy and Wilkins (2011:67) describe the 'continuum of care' as a framework for the treatment of a SUD. The authors assert that a continuum refers to an integrated system of care options. These options ensure that a variety of options are available and that services are appropriate to the individual's needs. Treatment, according to the continuum of care, is long-term in nature and it guides and tracks a person over time. Garthwait (2012:14) also refers to the continuum of care as a "spectrum of services", and adds that such services should be integrated in such a way that all the recovery needs can be met throughout the recovery process, while duplication of services are minimised. In this study, the continuum of care relates to the focus areas for the treatment of chemical substance abuse and dependency, and includes prevention, early intervention, treatment, and continuing care and recovery support (Department of Social Development, 2013b:27-29; South Africa, 2008). The researcher chose the continuum of care as the theoretical framework that informed the investigation in this present research study. He was interested in understanding how this framework for the treatment of a SUD is being utilised and if it provides service users with a variety of care options depending on their needs, over a long-term period, possibly throughout the whole recovery process. This choice was further informed by the fact that the continuum of care is the prescribed treatment framework in legislative and policy documents (Department of Social Development, 2013b:27-29; South Africa, 2008).

Service provider: In this study, a service provider is a social worker that is registered with the South African Council for Social Service Professions (SACSSP), has been working in the SUD field for at least two years, and is currently employed by a SUD treatment centre or community-based organisation. Social work, for the purpose of this study, relates to the global definition of social work as a practice-based profession that is aimed at social change, personal development and the empowerment of people. It makes use of indigenous knowledge to engage with people and assist them to address real life challenges, as well as enhance well-being (International Association of Schools of Social Work, 2014). Service providers, therefore, provide a service for the treatment of a SUD through an empowering process that seeks to create change that will increase well-being. This research study seeks to contribute by providing service providers with indigenous

knowledge related to the utilisation of the continuum of care within the South African context.

Service user: A service user means a person who is abusing or dependent on a chemical substance(s) and who, following assessment, receives services in a treatment centre, halfway house or community-based service (South Africa, 2008). In this study, a service user refers to a person who is older than 18 years of age, is dependent on a chemical substance(s), and is receiving treatment for a SUD from a service provider(s).

Substance use disorder: Substance abuse refers to the frequent use of a substance(s) over an extended period of time. In this study, the focus is on the abuse of chemical (i.e. mind-altering) substances. The abuse causes harm on the social, occupational, psychological and physical levels of functioning. Abuse is specifically characterised by the fact that the abuse continues despite its harmful consequences (Sue, Sue and Sue, 2010:234; *Nutt, King, Saulsbury and Blakemore, 2007:1048*). Substance abuse may lead to a physical or emotional dependency, which refers to the "repeated use of a psychoactive substance or substances, to the extent that the user is periodically or chronically intoxicated, shows a compulsion to take the preferred substance(s), has great difficulty in voluntarily ceasing or modifying substance use, and exhibits determination to obtain psychoactive substances by almost any means" (United Nations (UN), 2016:62). This then leads to a SUD, which involves an increased tolerance to the substance of choice and the development of psychological or physical withdrawal symptoms after abrupt cessation or reduced intake of a substance (Fisher and Harrison, 2013:28-29). The participants in this study will be in the process of receiving treatment for a SUD, meaning that their functioning has been impaired and that they have difficulty to cease abusing substances due to increased tolerance and withdrawal symptoms.

Utilisation: The term 'utilisation,' for the purpose of this study, is linked to the terms 'service provider' and 'service user'. On the one hand, it refers to how the service provider makes use of the continuum of care to guide the structure and nature of services, while it also refers to the way in which service users access services within the framework of the

continuum of care on the other hand. In support of this viewpoint, according to the WHO (2006:22), utilisation refers to how services are made available *and* how such services are being used by the persons who can benefit from them. Hansen (2013:10) asserts that, on the one hand, when a service provider utilises a specific framework for services, it does not necessarily mean that it will be utilised effectively by the users of the services. On the other hand, the utilisation of a service by service users does not necessarily mean that the nature of services are in line with a prescribed framework. This author therefore highlights the need to explore the utilisation of services from the perspectives of both the provider and the user.

It should be noted that the definitions and descriptions given above were used to furnish the framework from which the research study was conducted. It is, however, noted that these descriptions should be viewed as tentative due to the evolving nature of qualitative research (cf. Creswell, 2014:75).

In order to introduce the research problem that informed this research study, the term ‘chemical substance’ will be further unpacked in the next sub-section. The prevalence of a SUD will then be presented, followed by a discussion of the terms ‘abuse,’ ‘addiction,’ ‘dependency’ and ‘substance use disorder’. A description of the impact of substance use and abuse will introduce a discussion of policies and legislation related to the treatment of a SUD. Thereafter, recent research studies focusing on a SUD and the treatment thereof in the South African context will be explored in order to highlight the need for further research on the identified problem that led to this study.

1.1.2 Background to the research study: A literature review

For the purpose of this research study, the term ‘a substance use disorder’ will focus on dependence on chemical substances. A chemical substance refers to a mind-altering substance that may lead to physical and psychological dependency. Substances that may lead to dependency can be classified as CNS stimulants, depressants and cannabinoids

(Fisher and Harrison, 2013:28-29). All of these substances are characterised by the fact that regular use leads to higher tolerance levels and withdrawal symptoms.

Examples of stimulants include amphetamine, methamphetamine, Ritalin and cocaine. These substances increase energy levels, feelings of pleasure, and heighten alertness. These experiences are linked to feelings of euphoria, which are false and short-lived (Myers, 2010a:8). Side effects include both psychological and physical symptoms, such as blurred vision, blood pressure changes, insomnia, a loss of appetite, Tourette's syndrome (i.e. involuntary tics and twitching), depression, aggression and violent behaviour (Myers, 2010a:10; Popescu, Popescu, Lupu, Panus, Neagu-Sadoveanu and Buda, 2010: 231-236).

Depressants, which are also referred to as sedatives and tranquilisers, include sleeping pills, painkillers, and alcohol. They cause drowsiness, confusion, incoordination, tremors, slurred speech and depressed pulse rate, to mention just a few side effects. The side effects also include both psychological and physical symptoms, such as chronic fatigue, changes in eyesight, restlessness, anxiety and depression (UN, 2016:39-45; Popescu et al., 2010: 231-236).

Cannabinoids include cannabis and synthetic cannabinoids. It affects attention, working memory and concentration, the ability to make decisions and/or impulsivity, reaction time, and risk-taking. Long-term abuse of cannabinoids may lead to the so-called 'A-motivational syndrome' (Madras, 2015:9).

Considering the classification of substances and the specific effects thereof, it was noted that in the Western Cape, where this study was conducted, Methamphetamine (stimulant), alcohol and heroin (depressants) and cannabis (cannabinoid) were identified as the most common substances of abuse, comprising 93% of all admissions in treatment centres (Dada, Erasmus, Harker Burnhams, Parry, Bhana, Timol, Fourie, Kitshoff, Nel and Weimann, 2015:3-4). Furthermore, alcohol dependence is particularly rife amongst farm workers in the said province, and is most notably attributed to the 'dop system,'

where workers were paid a small amount of money supplemented by a food parcel and cheap wine ('dop' is the Afrikaans term for wine) (McLoughlin, Little, Mazok, Parry and London, 2013:8799; Falletisch, 2008:61-62). Although this system is no longer practiced, the abuse of alcohol remains a significant social problem in the region (Lindoor, 2011:2). Furthermore, 60% of substance dependent persons and their families in rural areas indicated that they are unaware of support systems that are available and accessible to them (Department of Social Development, 2012:15). Further barriers to the prevention and treatment of a SUD in rural areas have been reported as the lack of or limited options for treatment, inability to pay for treatment due to poverty, and a lack of transport and accessibility to service providers (Pullen and Oser, 2014:892).

When looking at the prevalence of a SUD, the high relapse rate following treatment must also be considered. Gomba (2013) refers to the Gauteng Health Minister Aaron Motsoaledi, who acknowledges that interventions for substance abuse and dependence are often ineffective, with a relapse rate as high as 80%. This author compared this description with a study in the United States of America, which showed a 90% relapse rate. Van der Westhuizen (2010:417-418) recommends that one way to address the high relapse rate is to present detoxification, treatment (in- or outpatient), aftercare and reintegration as an integrated service.

The progression of substance abuse follows the process of experimentation (i.e. using the substance only once) to regular use, where a person uses the substance when it is available. Substance use, at this stage, does not have a significant influence on the person's day-to-day functioning. The frequent use of substances over a period of time is viewed as substance abuse.

Substance abuse is characterised by dysfunctional behaviours that create physical, emotional and social problems for the individual, as well as financial and employment difficulties. An important aspect is that substance abuse continues, despite these negative consequences (Sue et al., 2010:234). Confirming this description, the American Psychiatric Association (APA, 2013:483) describes a SUD in terms of a variety of

cognitive, behavioural and physiological symptoms that are characterised by the continued use of a substance, despite significant substance-related problems. A further important characteristic of a SUD is “an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders”. This characteristic demonstrates the long-term effect of substance abuse that needs to be considered when seeking to provide effective treatment. A vulnerable brain can experience intense cravings for the substance when exposed to substance-related stimuli, increasing the risk for multiple relapses. The APA (2013:483), therefore, emphasises the need for a long-term approach to treatment.

Substance abuse may result in addiction, which is associated with a higher tolerance level (i.e. more of the substance is needed to experience the desired effect) and withdrawal symptoms when the person attempts to stop using the substance. Painful and uncomfortable withdrawal symptoms and exposure to substances or substance-related stimuli can trigger a relapse, impacting negatively not only on the substance dependent person, but also on his/her family and community (cf. APA, 2013:483). Puddy and Wilkens (2011:41) also refer to the above-mentioned characteristics of addiction and argue for the inclusion of multiple components in a comprehensive treatment plan.

The United Nations Office on Drugs and Crime (UNODC) (UN, 2016:62) advises that the term ‘addiction’ be replaced with ‘substance dependence’. This term includes both descriptions of abuse and addiction provided above. The UNODC describes dependence on a substance(s) as the continued use of a psychoactive substance(s) where the person exhibits signs of intoxication (periodically or chronically), experiences a compulsion to take the preferred substance(s), lacks control to cease or modify substance use voluntarily, and is determined to obtain the preferred substance(s) by any means regardless of the consequences (UN, 2016:62).

A SUD is mostly determined by genetic, physiological, biochemical, and emotional vulnerability (Williams and McElhiney, 2011:9). Haase (2010:81-93) identifies a number of high risk factors that may contribute to a SUD at several levels, namely:

- *Micro level*: Lack of self-esteem, inability to deal with stress, trauma, general feeling of hopelessness due to poverty, violence and unemployment
- *Mezzo level*: Loneliness, lack of support systems, significant others abusing substances, domestic violence
- *Macro level*: Poverty, unemployment, availability and affordability of substances

In line with the discussion on the classification of substances and the characteristics of a SUD, a distinction is made between psychological and physical dependency. 'Psychological dependence' refers to the impaired control over substance abuse, while 'physical dependence' involves the development of tolerance to the substance(s) and withdrawal symptoms when the use of the substance is ceased; indicating physiological dependence. This is a result of changes within the body to adapt to the continued presence of a substance(s) (UN, 2016:64).

The effects of a SUD, as described in the above analysis, are articulated next in terms of the physical, psychological, cognitive and social impact.

- *The physical impact*: The physical impact includes malnutrition, heart disease, neurological disorders, liver disease and physical weakness. This causes the person to underperform in his/her daily tasks.
- *The psychological impact*: Psychological withdrawal symptoms include anxiety, stress and depression. Personality and behavioural changes are also observed, for example aggressiveness and compulsiveness. These changes, in turn, have a negative effect on relationships.
- *The cognitive impact*: The long-term cognitive impact of substance abuse includes cognitive problems such as the inability to achieve full occupational/educational performance due functional impairment, as well as memory and concentration problems. This often results in dismissal from one's workplace, which negatively affects the financial situation of the family.
- *The social impact*: On a social level, substance dependence causes isolation from close relationships with family and friends, and greater association with substance-using/abusing persons. Changes in behaviour and the substance dependent person's

nonconformity to family rules and expectations, in turn, contribute to family conflict and violence (WHO, 2014:4; Bezuidenhout, 2008:138-140; Nevid, Rathus and Greene, 2006:299-230).

In summary, the initial voluntary use of a substance(s) over a period of time changes a person's brain chemistry, resulting in a total loss of control of substance intake. This then leads to substance abuse, which impairs the ability to make sound decisions and to voluntarily cease the use of the substance(s), due to an intense impulse to take the substance(s) and withdrawal symptoms. This long-term influence then impacts on how treatment of a SUD should be approached (Puddy and Wilkins, 2011:41; cf. Van der Westhuizen, 2010:417-418).

Over the years, the South African government has attempted to address this social issue through the development of policies and legislation. Already in 1994, the Liquor Act (South Africa, 1994) came into effect with the aim to "prevent detrimental societal, social and health effects caused by alcoholic substances by controlling the consumption of alcohol". The National Liquor Policy of 1997 was revised in 2015, due to the continued impact of alcohol abuse that has led to the ongoing "social breakdown, family violence, alcohol related diseases, crime and accidents in poor communities" (Department of Trade and Industry, 2015:4). In 2009, the Prevention of and Treatment for Substance Abuse Act, 2008, came into effect. According to this Act, available resources should be focused on combatting substance abuse through both the development *and* coordination of interventions that are aimed at three outcomes, namely: demand reduction, harm reduction and supply reduction. This study focused on *harm reduction*. This entails treatment and support services to substance dependent persons and their families, as well as addressing the social, psychological and health impact of substance abuse through a holistic approach. The Prevention of and Treatment for Substance Abuse Act (South Africa, 2008) furthermore makes provision for the adaptation of a National Drug Master Plan (NDMP).

The NDMP for 2006 – 2011 placed an emphasis on finding solutions "…from the bottom up rather than from the top down" and the utilisation of evidence-based solutions, meaning that research findings should be acknowledged. It was also noted that there should be a shift from "…supply reduction to primary prevention in an integrated strategy". The NDMP for 2013 to 2017 (Department of Social Development, 2013a:3) supports the Prevention of and Treatment for Substance Abuse Act (South Africa, 2008:14-16) and refers to the "…harmful use of alcohol and drugs". The need to address the socio-economic impact of this ongoing phenomenon is highlighted. The NDMP for 2013 to 2017 serves as the blueprint for addressing substance abuse and dependency and its associated socio-economic consequences on South African society, and is described as "a national strategy that guides the operational plans of all government departments and other entities involved in the reduction of demand for, supply of and harm associated with the use and abuse of, and dependence on, dependence-forming substances" (Department of Social Development, 2013a:18). Furthermore, in response to the ongoing problem of SUDs, the NDMP for 2013 to 2017 (Department of Social Development, 2013a:3-5) identified specific preferred outcomes for initiatives aimed at addressing this socio-economic issue. Preferred outcomes that are specifically relevant to the focus of this research study are: the minimising and addressing of the bio-psycho-social and economic impact of substance abuse and dependency, addressing substance-abuse-related problems, such as domestic violence, and the development and utilisation of multi-disciplinary and integrated treatment services for a SUD.

In an effort to obtain information regarding current treatment interventions of a SUD, the topics and findings of recent research studies were explored. In terms of the mentioned situation in rural areas, Mudavanhy and Schenck (2014:389) investigated substance abuse among youth in a rural area, while Marinus (2014) explored the experiences of children of farm workers who are dependent on substances. These studies identified the need for access to services and long-term interventions to ensure the holistic treatment of substance dependent youth or the children of substance dependent persons in rural areas. In line with the latter study, Schultz and Alpaslan (2016:110) investigated the need for services and support to siblings of substance dependent youth. Setlalentoa, Ryke and

Strydom (2014:365) looked at the impact of binge drinking on social support networks, also focusing on services to significant others of substance dependent persons. In addition, studies by Mogorosi (2009:512) and Smook, Ubbink, Ryke and Strydom (2014:80) focused on substance abuse and dependency in the workplace and explored some solutions aimed at the development of Employee Assistance Programmes. Mokwena (2016:140) focused on nyaope as a substance, and the experiences of nyaope users. The findings of the mentioned study pointed to the need for accessibility to treatment, and more specifically, the need for long-term support within the community. In line with this identified need, Van der Westhuizen (2007; 2010) focused on relapse after treatment among chemically dependent adolescents and also on aftercare needs in an effort to address factors contributing to relapse. The need for long-term social work involvement came to the fore in these studies. Similarly, Matsimbi (2012) explored the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family systems. In terms of treatment, Strebel, Schefer, Stacey and Shabalala (2013:50), as well as Setlalentoa, Ryke and Strydom (2015:98) evaluated intervention strategies implemented in specific provinces. It was noted that these intervention strategies were focused on specific services, such as prevention, treatment or aftercare, and not the integration thereof. Addressing the diverse cultural context of the South African society, Goliath (2014) focused on practice guidelines for culturally sensitive substance abuse prevention interventions. The mentioned studies covered a range of focus areas. However, an investigation and description of how the continuum of care, prescribed by the Department of Social Development (2013b:27-29) and the Prevention of and Treatment for Substance Abuse Act (South Africa, 2008) are implemented in practice and how providers and consumers view this continuum were not found in recent literature pertaining to the South African context. This, in turn, informed the identification of the research problem that provided the focus of this study.

1.1.3 Problem statement

The formulation of a research problem is based on a review of current and relevant research and literature that leads to the identification of a gap in current knowledge and

understanding of a specific topic. The need to investigate this gap through a scientific process is then identified (Dissanayake, 2013:3; Boudah, 2011:22; Yegidis and Weinbach, 2009:47). A review of the literature provided the researcher with the specific focus of this study, based on an identified gap in the literature. The research problem for this study was then formulated as follows:

> Problems associated with a SUD include physical, psychological, social and cognitive functioning. All of these aspects should be addressed through a comprehensive framework for treatment. In line with this viewpoint, recent research studies, as well as South African legislation and policies highlight the need to render a comprehensive and integrated service to persons who are dependent on chemical substances. Clear guidelines regarding how such a service should be rendered are provided in the framework for an integrated continuum of care. Despite these guidelines, substance use and abuse remains rife and relapse rates after treatment are alarmingly high, pointing to ineffective treatment of a SUD. Recent research studies regarding substance use and abuse and the treatment thereof confirm that the specific treatment and aftercare needs of dependent persons are not effectively included in service delivery, which leads to the question of whether the continuum of care is being implemented or not. However, there is a lack of information on how service providers and users view the continuum of care and the utilisation thereof, particularly in the South African context. Therefore, the need to explore how this continuum of care is utilised from the perspectives of both providers and users of services was identified.

The research problem is complemented by the researcher's rationale for conducting the study.

1.1.4 Rationale for the study

Based on his practical experience as a social worker, as well as on the above analysis, the researcher is aware that there is a need to explore how the continuum of care is

utilised from the perspective of both providers and users of services so as to be able to make recommendations regarding the development of a comprehensive and integrated service. Moreover, as highlighted by the Department of Social Development (2013a:3), solutions should be based on research findings. Hence, the researcher hoped to obtain data that will contribute to the contextualised understanding of the needs and perspectives of service providers and users of services, as well as praxis through making research-based recommendations. It is also envisaged that the findings of this study will provide a rich and valuable knowledge base for those working in the field.

The theoretical framework chosen for this research study and how it supports the treatment of a SUD by addressing the socio-economic harm caused by dependency will be discussed next.

1.1.5 Theoretical framework

The treatment of a SUD needs to be comprehensive, as different chemical substances affect the user/abuser of the substance differently (cf. Fisher and Harrison, 2013:28-29). In addition, the social, emotional, cognitive, physical and spiritual impact of chemical substances requires that all of these aspects be included in the content of treatment services (cf. WHO, 2014:4; Bezuidenhout, 2008:138-140; Nevid et al., 2006:299-230). Considering the progression from substance use to substance abuse and then to substance dependency, it is also clear that different care options must be offered. The continuum of care, which will be described as the theoretical framework that guided this present study, is a comprehensive and integrated framework of service delivery that addresses the above-mentioned components (cf. Puddy and Wilkins, 2011:67).

The treatment of a SUD is described by Walitzer, Dermen and Barrick (2009:392) as a behaviour modification therapy for those who use substances to the detriment of themselves and others. Behaviour modification, in the context of the treatment of a SUD, requires that the specific needs of the person with such a disorder must direct the nature of services. The authors, therefore, accentuate the need to address different treatment

needs and explain that treatment may vary between low level professional inputs to a high level input. Also focusing on these levels of input, the UN (2003:8) refers to the following focus areas for the treatment of a SUD, which should all be included in service delivery programmes:

- Early detection and outreach that involves a multi-disciplinary assessment.
- Treatment that includes in-patient, out-patient, and/or self-help programmes, consisting of –
    - Brief, preventative interventions, or
    - Short- and/or long-term treatment that includes individual, group and family therapy.
- Aftercare and reintegration into the family and community.

The theoretical framework that supports this study is related to the focus areas for treatment described above. This description relates to the **continuum of care**, which can be described as an integrated system of care options, consisting of a comprehensive variety of services related to specific needs with the aim of guiding a person towards recovery from a SUD (Puddy and Wilkins, 2011:67). In terms of the utilisation of the continuum of care, the Department of Social Development (2013b:27-29) prescribes that the following continuum of care be provided to client systems:

1) Prevention with the focus on "…preventing development needs from developing into social challenges or risks".
2) Early intervention aimed at "…limiting the impact of the risk and preventing the development/progression of social problems".
3) Statutory/residential/alternative care, which entails "…protection services that endeavour to safeguard the well-being of service beneficiaries". It could also require no statutory intervention, with a focus on rehabilitative and continued care services.
4) Reunification and aftercare, which "…enable service beneficiaries to regain self-reliance and optimal social functioning in the least restrictive environment possible".

Specifically focusing on a SUD as a social issue to be addressed, the Prevention of and Treatment for Substance Abuse Act 70 of 2008 (South Africa, 2008) also bases its

description of treatment on the continuum of care and makes provision to provide prevention, early intervention, treatment, aftercare and reintegration services for those abusing substances *and* those affected, such as children, youth, families and communities.

According to the mentioned Act, the participation of service users and persons affected by substance abuse in decision-making processes regarding their needs and requirements should be promoted (South Africa, 2008). This principle places the emphasis on the need to develop an understanding of the experiences of all persons who are affected by a SUD. However, recent descriptions of services to substance dependent persons and their families reveals a fragmented form of service delivery, meaning that the various care options are delivered by different service providers where contact between the service providers are not always favourable (*cf*. Mokwena, 2016; Setlalentoa et al., 2015:98; Strebel et al., 2013; Van der Westhuizen, 2010). This present study explored how the different treatment components described by the continuum of care are being utilised from the perspectives of both the service providers and service users.

The research problem and rationale for the research informed the formulation of research questions, the primary goal, and the objectives of the study.

1.2 RESEARCH QUESTIONS, GOAL AND OBJECTIVES

The above introductory literature review of this research study informed the research problem. The research questions, goal and objectives flowed from the identified research problem to ensure that a “golden thread” links all the aspects of the research study together (Fabricius, Roux, Barendse and Currie, 2014:6).

1.2.1 Research questions

Research questions are determined by an identification of a specific aspect in a field of study that must be explored further in order to develop a better understanding (Farrugia, Petriso, Farrokhyar, and Bhandari, 2009:278). In the present study, the implementation of the continuum of care for treatment of a SUD was identified as the aspect that needed to be explored. Furthermore, the research questions for this study placed the focus on the experiences and perceptions of specific persons in the field of interest (i.e. a SUD). Agee (2009:440, 443) recommends that research questions should be researchable, answerable and ethically responsible. This then guided the researcher to formulate the following research questions:

1) What are the experiences and perceptions of the service providers regarding the utilisation of the continuum of care for treatment of a SUD?
2) What are the experiences and perceptions of the users of services regarding the utilisation of the continuum of care for treatment of a SUD?

1.2.2 Research goal

The terms ‘goal’, ‘purpose’, ‘aim’ and ‘objective’ are often used synonymously (De Vos, Strydom, Fouche and Delport, 2011:94). Thomas and Hodges (2010:38), however, distinguish between the research goal and objectives in that the research goal can be seen as the preferred end result of the research study, while the objectives provide clear steps on how to reach the goal. In order to be able to answer the identified research questions, the following research goal was formulated:

- To develop an understanding of the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD.

1.2.3 Research objectives

The formulation of the objectives of this study followed on from the research goal. Farrugia et al., (2009:280) explain that the objectives of a research study is important to develop a protocol for the way in which the research study will be conducted. This protocol includes the sampling, methods of data collection and analysis, and ethical practice. It therefore provides a detailed description of the steps that will be followed to attain the

goal of the study, and forms the foundation for the choice of research methodology that will be discussed in the next section (Thomas and Hodges, 2010:38). The following research objectives were formulated for this study:

- To obtain two samples: One comprised of service providers for the treatment of a SUD and the other of service users.
- To conduct semi-structured interviews aided by open-ended questions contained in an interview guide with the participants.
- To explore the respective experiences and perceptions of service providers and service users regarding the utilisation of the continuum of care for the treatment of persons with a SUD.
- To sift, sort and analyse the data obtained according to the eight steps of qualitative data analysis constructed by Tesch (in Creswell, 2014:218).
- To describe the respective findings regarding the experiences and perceptions of service providers and service users concerning the utilisation of the continuum of care for the treatment of persons with a SUD.
- To interpret the data and conduct a literature control in order to verify the data.
- To draw conclusions about the experiences and perceptions of service providers and service users regarding the utilisation of the continuum of care for the treatment of persons with a SUD, and to make recommendations for future practice.

In a further attempt to ensure that a golden thread runs through this research study, the research questions, goal and objectives informed the choice of research method.

1.3 RESEARCH METHODOLOGY

Research methodology refers to the procedures, methods and techniques used to obtain data from samples, and to analyse and interpret the findings in a scientifically sound manner (Pandey and Pandey, 2015:8; Kumar, 2011:25-26). The research methodology that was chosen to assist the researcher to address the research problem, answer the research questions, and attain the research goals and objectives will be provided in this section. The application of the chosen methodology will be described in the next chapter.

In order to obtain the research goals of this study, a **qualitative research approach** was chosen. The main reason for this choice was that qualitative research provides a framework from which a better understanding of complex situations from the participants' point of view can be obtained (Leedy and Ormrod, 2013:94-97). In this regard, Merriam (2009:13) explains that the qualitative researcher aims to develop insight and knowledge based on the meaning people attach to their real-life experiences. In further support of this approach, Bickman and Rog (2009:3-43) assert that the qualitative approach contributes to finding solutions to problems, as it is based on the felt issues of insiders to the situation. Reflecting on the above description of a qualitative research approach, this approach was viewed as appropriate for the present study as it explored the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD with the specific goal of making research-based recommendations for future practice. To this end, a combination of the following qualitative research designs were chosen to guide the decisions related to the sampling, data collection and data analysis methods:

The **collective instrumental case study research design** focuses on the study of a case that could include a person, group, occupation, etc. Cohen, Manion and Morrison (2011:255-256) explain that this design is particularly appropriate when a researcher seeks to explore organisational, institutional and individual points of view, amongst others. The collective instrumental case study design, therefore, provides the researcher with boundaries within which a phenomenon can be explored in terms of the different roles and functions people play within a specific context of the field of study. Furthermore, these authors emphasise that this research design acknowledges the contribution that individuals and groups within a specific setting can make towards understanding a phenomenon. Therefore, for the present study, this design was chosen to assist the researcher to investigate the utilisation of the continuum of care for the treatment of a SUD with the aim of developing an in-depth understanding of the subject and to pursue new knowledge. The collective nature of this research study was based on the inclusion

of multi-faceted perceptions and experiences of both service providers (i.e. organisational/institutional) and service users (i.e. individuals) (Grandy, 2010:474-475).

The **contextual research design** was chosen to assist the researcher with exploring and describing the research problem and questions within the context in which the participants functioned. Roller (2015:27) explains that this research design supports researchers to develop an understanding of "humanity" and the way people experience, feel, think and act within a specific context. This design was chosen to support the researcher's effort to develop and maintain a specific focus on the context in which the research problem occurred in order to obtain a better understanding of the research problem from the viewpoints of the people who function within this context, and thereby contribute to understanding the human component of the research topic (Babbie and Mouton, 2009:272).

The **explorative research design** is aimed at identifying specific characteristics, problems and interrelated components of lived experiences. This design requires a flexible and less structured research approach (Babbie and Mouton, 2009:271). In order to encourage participants to share their experiences, the meanings they attach to these experiences and their perceptions of specific aspects thereof, the explorative research design was chosen to help the researcher to obtain information that added to the understanding of the utilisation of the continuum of care in the treatment of SUD.

In order to ensure that the experiences and perceptions of the participants were well described to obtain a deeper understanding of the research topic, the **descriptive research design** was chosen to be used together with the explorative research design (Babbie and Mouton, 2009:272). This design was viewed as being particularly appropriate because it focused on identifying the characteristics of the utilisation of the continuum of care from the perspectives of the people involved, and to interpreting the data obtained through the exploration of the research topic.

The research questions, the collective instrumental case study, and the contextual and explorative research designs informed the decision the researcher made about the population and sampling method for this study. The choices regarding the population and sampling for this research were also informed by Nicholls' (2009:638-640) opinion that the population and the sampling method in qualitative research studies should show a concern for how the participants view their world in terms of the research topic, and that their expressions in terms of language should be of key interest. Therefore, the researcher wanted to ensure that the sample would be drawn from a population that would include those persons who are representative of the focus of this study. As this study included two research goals, each focusing on a specific group, two **population** groups were identified, namely:

- *Service providers*: Social workers in the Western Cape who work for treatment centres and organisations that render services to persons who are affected by a SUD.
- *Users of services*: Persons who have been receiving services to treat a SUD in the Western Cape.

In order to obtain samples from the two population groups, the **non-probability sampling method**, together with the purposive sampling technique were chosen, as the researcher needed to purposefully select participants that were best equipped to answer the research questions (Creswell, 2009:125). It was noted that the non-probability sampling method was relevant due to the fact that random selection of participants (i.e. probability sampling) could result in a lack of access to experts in the field of study (Nicholls, 2009:640). In support of the reason behind the choice for the method and technique of sampling, Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood (2015:533-544) assert that the **purposive sampling technique** assists qualitative researchers to identify and select possible participants that will be able to provide information-rich inputs through a non-random selection process. In qualitative research, the **sample size** is often not determined prior to the data collection, so as to ensure that data is collected until no new information is obtained. It was therefore decided that the researcher would continue with data collection until data saturation was detected to further contribute to the effort to obtain information-rich data (Guetterman, 2015:18).

Interviewing was chosen as the method of **data collection**. Interviews take the researcher, as the research tool, to the natural setting where experiences and perceptions can be reported (Mikėnė, Gaižauskaitė and Valavičienė, 2013:50-51). This method links well with the collective instrumental case study research design, as the utilisation of the continuum of care could be explored through the eyes and expressed views of the people who provide services and who receive services for the treatment of a SUD (Cohen et al., 2011:256). To obtain data from the service providers, the *face-to-face interviewing method* of data collection was chosen. Through this method participants could be provided with a private and confidential milieu within which they could reflect on current practices and share their experiences and perceptions in a semi-structured manner (Creswell, 2014:240). *Focus groups* were chosen as the method of data collection for the service users. This choice was supported by Onwuegbuzie, Dickinson, Leech and Zoran (2009:2), who assert that qualitative research benefits from focus group interviews when people in a similar context are provided with a platform to discuss and explore perceptions, ideas, opinions and thoughts based on shared and individual experiences.

In order to analyse and interpret the qualitative data, the researcher chose Tesch's (1990) eight steps for **qualitative data analysis**, described by Creswell (2009:186) as a scientific framework from which he could identify themes, sub-themes and categories. It was decided that both the researcher and an independent coder would use this framework to analyse the data obtained from both participating groups in order to enhance consistency.

The scientific value of qualitative research is often questioned, as it portrays the subjective interpretations of people. Carcary (2009:12), however, argues that "people cannot be understood outside of the context of their ongoing relationships with other people or separate from their interconnectedness with the world". This author therefore advises that qualitative researchers should focus on issues such as credibility, dependability and transferability to enhance the trustworthiness of their research findings. For this reason, the researcher chose Schurink, Fouché and de Vos' (2011:397) description of **data verification** for qualitative research to ensure the validity of the

research findings. According to this description, the researcher included the following aspects in the verification of the qualitative data: credibility/authenticity, transformability, dependability and conformability.

In the present study, the following **ethical considerations** were taken into account to safeguard all participants and the data collection process: informed consent, confidentiality, debriefing of participants and compensation, as described by Bless, Higson-Smith and Sithole (2013:143); Strydom (2011:126), Kumar (2011:212) and Denscombe (2010:67).

The chosen methodology that was presented above will be discussed in depth in the next chapter. The implementation of the methods and techniques will be described and compared to theoretical descriptions.

1.4 CONCLUSION AND LAYOUT OF RESEARCH DOCUMENT

This introductory chapter provided a background to the study, a description of key concepts, and a discussion of existing information pertaining to the research topic. Included in this chapter was the theoretical framework and research problem from which the study was conducted. The research questions, goal and objectives were also presented, as well as a summary of the chosen research methodology, which addressed the research problem and questions.

Chapter 2 is dedicated to an in-depth description of the research methodology and the implementation thereof. The limitations experienced during the research process will also be described. Chapters 3 and 4 will present the findings together with a literature control.

Chapter 5 will present conclusions drawn from the findings, recommendations and suggestions for future social work practice.

CHAPTER 2
APPLICATION OF THE RESEARCH METHODOLOGY

2.1 INTRODUCTION

The focus of this research study is on the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD. This focus is based on the research problem that emanated from the background description, which was presented in Chapter 1 together with the chosen research methodology to address the research problem. In line with this focus and in order to address the research problem, the following research questions directed the data collection and analysis processes:

- What are the experiences and perceptions of the service providers regarding the utilisation of the continuum of care for treatment of a SUD?
- What are the experiences and perceptions of the users of services regarding the utilisation of the continuum of care for treatment of a SUD?

The research questions in turn informed the goal of this study, which is to develop an understanding of the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD.

In order to ensure the validity of the qualitative data in terms of applicability and consistency, an in-depth description of the application of the research methodology is needed (cf. Schurink et al., 2011:419). This chapter will provide a thick description of the implementation of the research methodology, which will be verified by literature.

2.2 RESEARCH METHODOLOGY

Nicholls (2009:587) refers to research methodology as "…the way the research study was conducted." It is a collective term that includes the specific methods, approaches, procedures and techniques that guide the research process (Kumar, 2011:25, 30). More

specifically, it concerns the procedures for collecting and analysing data to address a particular problem. It considers the logic behind using the selected methods and techniques, and offers justification for the research strategy, data collection methods, and techniques for data analysis (Leedy and Ormrod, 2013:12; Cohen et al., 2011:44-45). It is therefore the framework within which a study is conducted. Nevertheless, there must be a clear link between the research goal(s), the research methodology, and the research methods of a research study (Kumar, 2011:25, 30).

In order to obtain data to explore and describe the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD (cf. Denzin and Lincoln, 2011:8), this section provides a description of the research approach, designs, methods and techniques chosen for this study in terms of how it links with the research goal, the theoretical descriptions and the implementation thereof in this present study.

2.2.1 Research approach

The research approach for this study was based on the research problem and the nature of information needed to answer the research questions (Pandey and Pandey, 2015:11). The researcher contrasted the qualitative and quantitative research approaches in order to identify which approach would be suitable for this research study. On the one hand, in quantitative research researchers obtain data by using instruments that produce numerical descriptions to describe the data obtained (Remler and Van Ryzin, 2011:57-58). On the other hand, the qualitative research approach helps researchers to gather data focusing on the real life experiences of people. It makes use of language, illustrates what insiders of a situation experience, as well as how they perceive the situation under investigation (Creswell, 2014:44; Leedy and Ormrod, 2013:94-97). In this study, the research goal pointed to a qualitative approach, as the experiences and perceptions of the people in the context (i.e. service providers and users of services) would be explored and described in order to gain better insight into the utilisation of the continuum of care and to provide a framework for the conclusions and recommendations. The

implementation of the qualitative research approach was related to the characteristics of the said approach, as described by Creswell (2014:45-46):

- Qualitative research involves fieldwork. In this research study, the researcher collected data in the real life contexts where treatment of SUDs occurs. Data was collected from treatment centres and organisations that render services to persons who are affected by a SUD, as well as from users of such services.
- On the one hand, the researcher collected the data and was therefore the key instrument in the process of data collection, and on the other hand, the participants were active participants in the research process (cf. Cohen et al., 2011:255-256).
- In this study, the researcher gathered data from multiple sources (i.e. service providers and users) using multiple methods of data collection (i.e. individual and focus group interviews). Triangulation of data sources and methods of data collection contributed to the consistency of the findings (cf. Cohen et al., 2011:141).
- The data were analysed through an inductive process where themes, sub-themes and categories were built from the bottom up.
- Qualitative research is interpretive and this research study interpreted the meanings that service providers and users of services attach to their experiences and perceptions regarding the utilisation of the continuum of care for treatment of a SUD and their suggestions for social work praxis.
- Qualitative research is holistic in nature. In this study, multiple perspectives were explored in an effort to develop an understanding of the research problem based on different components related to the utilisation of the continuum of care as identified by the participating service providers and users.

2.2.2 Research designs

A research design refers to the plan or strategy that will be used to solve the research problem and answer the research questions (Creswell, 2014:49; Leedy and Ormrod, 2013:85). Kumar (2011:41) notes that the research design focuses on how the study will be conducted, as well as the logistical arrangements, sampling methods and techniques, and the methods and techniques of data collection and analysis that will be best suited to answering the research questions.

In order to determine which qualitative research designs should be used to address the research problem and answer the research questions adequately, the researcher focused on the research goal, which pointed to the exploration and description of the phenomenon of a SUD, specifically in a treatment context. The collective instrumental case study, and contextual, exploratory, and descriptive research designs, which are associated with a qualitative research approach, were identified as designs that could assist the researcher to identify the methods and techniques best suited to address the research problem. The implementation and relevance of these designs for this study will be discussed next:

- The *collective instrumental case study research design* focuses on an investigation of a specific field of interest with the aim of building knowledge and understanding. Data is collected from a specific case that could include a person, group, occupation, etc. (Grandy, 2010:474-475). Crowe, Creswell, Robertson, Huby, Avery and Sheikh (2011:2-3) recognise this type of case study as particularly relevant when the researcher seeks to generate a comprehensive understanding of a social issue in its real-life context, while Grandy (2010:475) asserts that the collective instrumental case study is particularly valuable when the nature of a service is being explored. In this research study, the implementation of the instrumental nature of the case study was seated in the fact that the focus of the research was on exploring the utilisation of the continuum of care for the treatment of a SUD, while the case study was the instrument through which understanding was generated. The collective nature of this research study was based on the inclusion of multi-faceted perceptions and experiences (Grandy, 2010:474-475). The case study explored experiences and perceptions of service providers to persons with a SUD, as well as of the users of these services. This research design directed the sampling method and technique of this study, as well as the methods of data collection and analysis.
- The *contextual research design* assisted the researcher to explore and describe the research problem within the natural context in which the participants function (Babbie and Mouton, 2009:272). In this research study, the researcher specifically focused on the context of treatment services to substance-dependent persons. This design was chosen to assist the researcher with choices related to the population and sampling

method and techniques. It also provided boundaries from which to interpret the findings.

- The *exploratory research design* is used to support qualitative research when the researcher wants to develop a better understanding of the research topic, so as to contribute to the knowledge base of a field or discipline (in this case, the social work discipline) (Babbie and Mouton, 2009:271). This study's goal was to explore the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD. The explorative nature of the research goal implied that this design would be relevant to assist the researcher to obtain data that would contribute to finding answers to the research questions. It was used to guide the decisions regarding the population, sampling, and data collection in terms of the construction of an interview guide.
- According to Babbie and Mouton (2009:272), the *descriptive research design* assists the researcher to develop a thorough overview of the participants' viewpoints of the research topic. In this study, the descriptive research design was used to compliment the explorative research design. The data obtained from the exploration of the research questions were described in order to provide information that contributed to the social work knowledge base and praxis. The use of this design informed the researcher's choices regarding the methods of data collection, data analysis, and data verification in terms of a literature control and the use of the theoretical framework to interpret the findings.

The utilisation of the research designs will be discussed in the subsequent sections.

2.2.3 Sampling, and sample size

2.2.3.1 Sample

A population refers to all the subjects (e.g. people or items) that are able to provide answers to the research questions of a particular research study. More formally, a population is "the theoretically specified aggregation of study elements" (Rubin and Babbie, 2010:135; Denscombe, 2008:141). In determining the population of this study in

terms of people related to the research topic and those best suited to answer the research questions, the instrumental collective case study, as well as explorative and contextual research designs, assisted with the identification of the two populations, namely:

- *Service providers*: Social workers in the Western Cape who work for treatment centres and organisations that render services to persons who are affected by a SUD.
- *Users of services*: Persons who have been receiving services to treat a SUD in the Western Cape.

2.2.3.2 Sampling

Moriarty (2011:7) refers to qualitative sampling as "iterative," depending on how the qualitative research study unfolds. In this qualitative research study, the non-probability sampling method was deemed appropriate, as it ensured that all the persons in the two identified populations had an equal chance (probability) of being selected to take part in the study (Bless et al., 2013:103-105). In addition, the purposive sampling technique was employed to support the non-probability sampling method. Through this sampling technique, the researcher purposefully invited persons from the sample to take part in the study, based on his judgement that they would be able to answer the research questions. The following criteria for inclusion were used to support the researcher in this regard:

Inclusion criteria for the sampling of service providers:

- Social workers,
- Working in the Western Cape,
- Have been working in the SUD field for a minimum of two years, and are
- Currently employed by a SUD treatment facility.

Inclusion criteria for the sampling of users of services:

- Adults (i.e. persons older than 18 years), who are
- Dependent on chemical substances, and who
- Are receiving treatment for a SUD from
- A treatment facility.

Firstly, the researcher approached the University of South Africa's Department of Social Work's Research and Ethics Committee (See Addendum H) to obtain permission to conduct the study. Once the proposal was approved, contact was made with service providers in the Western Cape (See Annexure A) in order to obtain permission to carry out the research at their treatment facilities. The service providers were provided with information on the goal of the study, the population and sampling criteria, ethical considerations, and the format in which data would be collected. They were invited to participate and to identify 1) social workers who could participate, and 2) users of services that were able to answer the research questions. The service providers, therefore, acted as gatekeepers. Reeves (2010:315-316) explains that qualitative research "seeks to describe a human community or culture, built up of the subjective meanings and perspectives of those people participating in the culture". In this study, the researcher aimed to describe the utilisation of the continuum of care, as experienced and perceived by social workers and service users. The service providers were key in obtaining access within to the natural setting. Through a clear and open description of the research goal and the recognition of the possible benefits of this study (for service providers as well as for users of those services), the service providers became partners in the research process.

2.2.3.3 Sample size

For the purpose of this study, the sample size was determined by data saturation. This means that data were collected until it became repetitive and no more new information was provided by the participants (Kumar, 2011:213). Data saturation was observed after four interviews with social workers and after two focus groups with service users. The researcher continued with two more interviews and one more focus group after data saturation was observed to ensure that no new information came to the fore. A total of six social workers and 10 service users participated in this study.

2.2.4. Methods of data collection

Methods of data collection are chosen to support the qualitative researcher to collect relevant, rich and adequate data that will provide answers to the research question(s).

These methods include the way in which the researcher prepares for the process in terms of collecting the data and recording the data (Sutton and Austin, 2015:229). Data collection in the present study will be described in terms of the preparation for data collection, the chosen methods of data collection, the interview guide, method of data recording, as well as the pilot test.

2.2.4.1 Preparation for data collection

Once the service providers supported the researcher with access to possible participants, he made contact with the identified social workers and users of services, gave them with the mentioned information regarding the study (Annexure B), and invited them to participate in the study. Potential participants were provided an opportunity to ask questions to clarify any points of confusion. Once they agreed to participate, they were requested to sign an informed consent form (Annexure C). The researcher then arranged to conduct the interviews at mutually convenient times and venues.

2.2.4.2 Methods of data collection

Observations, interviews, documents, and audio-visual materials are typical qualitative data collection procedures (Creswell, 2014:211). Merriam (2009:88-89) proposes that qualitative researchers make use of interviews as the method of data collection when attempting to develop an understanding of the perspective and experiences of people who are closely associated with the research topic. In line with this viewpoint, the instrumental collective case study, exploratory, and descriptive research designs point to the need to collect the data by means of interviews with service providers and users of services.

Interviews can be structured, semi-structured or unstructured (Remler and Van Ryzin, 2011:63). On the one hand, structured interviews provide little scope for added information to be collected, as the participants are requested to answer direct, often closed-ended questions. On the other hand, unstructured interviews provide participants with ample opportunity to provide any information that they deem relevant or necessary. While the former poses the danger of limiting the depth of the data, the latter poses the

danger of losing the focus of the research study. Semi-structured interviews offer a middle way, where questions are open-ended, but focused on the research topic. Participants can answer questions freely, while the researcher can use specific interviewing techniques to encourage participants to explore the question fully (Kumar, 2011:116). The researcher therefore chose semi-structured interviews as the method for data collection.

Apart from making a choice between the types of interviews, the researcher also considered the option of conducting the interviews individually or in focus groups. Guest, Namey, Taylor, Eley and McKenna (2017) found that focus groups often encourage participants to share personal experiences, while stimulating thoughts. This then contributes to rich data. Individual interviews provide participants with a safe environment and are especially useful when the researcher does not want the participants to feel threatened or judged. It was noted that the social work participants might feel that the quality of their services are being judged or compared when providing answers in a focus group. Thus, the researcher opted to make use of individual interviews with the social work participants to provide them with a safe and non-judgmental environment where they could reflect on services and freely share their perceptions and experiences (Monette, Sullivan and DeJong, 2010:186). It was acknowledged that the users of services would not be knowledgeable about the theoretical framework for the study, and would therefore mostly contribute through their rich descriptions of how they perceive and experience the nature of the services. For this reason, the researcher opted for focus group interviews with the users of services, to provide them with an interactive platform to explore their perceptions and experiences.

Bulpitt and Martin (2010:7-8) propose that the qualitative researcher collect data during semi-structured interviews through a reflexive approach, utilising the following interview techniques: Reflecting, asking open-ended questions, being non-directive, and giving participants sufficient time to answer. These techniques were used during the semi-structured interviews with both samples.

2.2.4.3 Interview guide

Semi-structured individual interviews with the social worker participants were conducted using the questions indicated in the interview guide provided in Table 1 below:

Table 1: Interview guide for social worker participants

Biographical information	▪ Gender ▪ Age ▪ Social work qualification ▪ Years of experience working as a social worker ▪ Years of experience working with persons who are affected by a SUD ▪ The municipal boundaries where the organisations that the social workers are working for is located
Research interview questions	▪ What is your understanding of the concept 'continuum of care' for the treatment of a SUD? ▪ Can you describe to me the nature of the services you render to persons who are affected by a SUD? o Methods and techniques that are being used o Resources and networks utilised ▪ How do you think your current services relate to or support the utilisation of the continuum of care? ▪ What are some of the enabling factors and conditions that you have experienced when applying the continuum of care in the treatment of a SUD? ▪ What are some of the challenges you have experienced when applying the continuum of care in the treatment of a SUD? ▪ From your point of view, in what way can social workers be assisted to improve the utilisation of the continuum of care in the treatment of a SUD?

Table 2 below illustrates the interview guide for the semi-structured focus group interviews with the service user participants:

Table 2: Interview guide for service user participants

Biographical information	▪ Gender ▪ Age ▪ Substance of choice ▪ Treatment opportunity (how many times) ▪ Nature of treatment (level of care according to continuum of care)

Research interview questions	▪ Tell me about your efforts to address substance dependency so far. ▪ Tell me about the type of social services that you have received previously to address your substance dependency. In probing further, the following questions could be considered: ▪ Tell me about experiences where you were exposed to preventative services before your dependency started (Continuum of care: Prevention). ▪ Tell me about the nature of the first services you received? (Continuum of care: Early intervention). ▪ What in- and/or out-patient services did you receive? (Continuum of care: Residential/statutory/alternative care). ▪ What services in terms of aftercare and reunite with your family have you received? (Continuum of care: Aftercare and reintegration) ▪ What do you think is the role of social workers when people are supported/receive treatment for substance dependency? ▪ What are the aspects that you find valuable in your recovery process? ▪ What other aspects do you think should be included to assist you on your road to recovery?

2.2.4.4 Data recording

Qualitative data is documented by means of audio recordings and field notes (Creswell, 2014:214; Merriam, 2009:85, 109-110). In order to document the qualitative data collected in this present study, the researcher made use of audio recordings and field notes. The former provided him with the verbatim responses, while the latter recorded the non-verbal data (such as facial expressions). The recordings were transcribed directly after the interviews and the field notes were added to the transcripts. The transcripts were then used to analyse the data. Both the informed consent forms and the transcripts were stored in a safe place, accessible only to the researcher, his supervisor, and the independent coder. This ensured the privacy and confidentiality of the participants.

2.2.4.5 Pilot testing

Pilot testing determines the feasibility of the research methods and techniques planned for the larger study by means of conducting interviews prior to the formal collection of data. Through these interviews, the researcher can determine whether the participants are able to answer the research questions and whether the questions lead to a better understanding of the research topic. It also tests the relevance and effectiveness of the

interviewing techniques, and enables the researcher to check whether the research goal can be attained through the chosen methodology (Fouche and Delport, 2011:73; Grinnell and Unrau, 2008:336). The researcher therefore made use of pilot testing to ensure that the questions described under the heading 'Data collection' would assist him to describe the perceptions and experiences of the utilisation of the continuum of care for the treatment of a SUD. The pilot testing in this study entailed two individual interviews with social work participants and one focus group with users of the services. The data was recorded and analysed and the findings were discussed with the researcher's supervisor. It was however determined that the data collection methods did assist the researcher to find answers to the research questions and therefore no changes were made.

Once the data collection was finalised (i.e. when data saturation was determined) and the transcripts completed, the researcher commenced with the analysis of the data.

2.2.5 Method of data analysis

According to Creswell (2009:183), the analysis of qualitative data is a process that begins once the data are obtained and transcribed. This process starts when the data is transcribed, followed by a scientific method to identify themes, sub-themes and categories that depict the main ideas shared by the participants. This is followed by the interpretation of the data. Employing this framework helped the researcher bring "order, structure and meaning to the quantity of the collected data" (Schurink et al., 2011:397). The researcher used Tesch's (1990) eight steps to analyse both sets of data. These steps provided a suitable framework to analyse the data in a structured and systematic manner. The themes, sub-themes and categories that emanated from the data analysis process were in turn compared with the literature (Creswell, 2014:218). The steps of data analysis that were followed are as follows:

- The researcher read through all the transcripts to form an overall picture. Ideas that emerged were jotted down.
- Then, the researcher selected one of the transcripts to read through in detail. Here, the researcher asked: "What is this about?" Thoughts were plotted in the margin next to the specific text in the transcript.

- The remaining transcripts were handled in the same way. Next, a list was made of all the topics indicated in the margin. Similar topics were grouped together into columns, which consisted of main themes and sub-themes.
- The list of themes and sub-themes were returned to the transcripts. Codes were given to the topics and sub-topics were added along the appropriate segments in the text. At this stage, the researcher continued to search for new/hidden topics or codes.
- The most descriptive wording was selected for the topics and these were converted into categories. Similar categories were listed under the relevant sub-themes and similar sub-themes were placed under the main themes.
- A final decision was made regarding which themes, sub-themes and categories to include.
- Corresponding data were placed under each theme, sub-theme and category.
- The themes, sub-themes and categories were then discussed and described, as well as compared to existing literature.

In order to ensure the scientific value of the findings of this study, the researcher verified the data. This is described next.

2.3 METHOD OF DATA VERIFICATION

Kumar (2011:149) explains that data verification in qualitative research focuses on the trustworthiness of the findings or results of a research study. It is also based on the consistency of the research methods used and provides an accurate representation of the population being studied (Thomas and Magivy, 2011:151). Trochim and Donnelly (2007:149) explains the difference between data validity and reliability in quantitative research and data verification in qualitative research in terms of the following four criteria:

- Internal validity in quantitative research relates to credibility in qualitative research.
- External validity in quantitative research relates to transferability in qualitative research.
- Reliability in quantitative research relates to dependability in qualitative research.
- Objectivity in quantitative research relates to conformability in qualitative research.

Guba's model for the verification of qualitative data (in Krefting, 1991:214-222) was designed as a framework to address the above criteria for qualitative research. It ensures the validity of a qualitative research study and is viewed as a classic framework. More recently Schurink et al. (2011:429) adapted this model. This adaptation guided the researcher to verify the data obtained in this research study, as follows:

- *Credibility*: According to Trochim and Donnelly (2007:149), credibility focuses on ensuring that the research findings "are credible or believable from the perspective of the participants". The researcher must therefore ensure that what the participants shared matches how the data is described in terms of the identified themes, sub-themes and categories. In this study, credibility was ensured by means of the interview guide and interviewing techniques, as well as methods of data recording and analysis. The independent coder further ensured that the participants' contributions were not contaminated by the perceptions/interpretations of the researcher, and that the findings were a true reflection of the data obtained. Additionally, triangulation of data sources and methods of data collection strengthened credibility, as different voices in different contexts were documented and analysed.
- *Transferability*: This criterion focuses on whether the findings of the research study can be transferred to other applicable studies. Schurink et al., (2011:420) and Kumar (2011:150) explain that this is a 'problematic' aspect in qualitative research studies. The researcher provided a thick description of the methodology that was utilised in an effort to enhance the transformability of this study. It should also be noted that the contextual research design and the criteria for inclusion into the sample should guide how the findings of the study are interpreted and compared to other contexts.
- *Dependability*: The dependability of a qualitative research study is based on a logical and well-documented research process. It means that the research process and applied methodology must be clearly and thoroughly documented so that it can be replicated with the expectation of obtaining the same or similar findings. The researcher ensured that the methods and techniques that were employed in this study were described in detail and supplemented with a literature control once the data were analysed.

- *Conformability*: This criterion refers to the neutrality of the findings. Conformability requires evidence of how the findings were reached and interpreted. In this study, the researcher made use of transcripts and field notes to document the findings, the scientific process of Tesch's eight steps for data analysis was followed by both the researcher and an independent coder, and the findings were complemented with a literature control to ensure conformability.

In addition, the researcher also made use of reflexivity as a method to verify the qualitative data in this study. It meant that he reflected –

- *On the research process*: Each step was reflected on to draw a link between the methodology and the way in which it influenced goal attainment.
- *On the interpretation of the findings*: This is also known as self-reflection. The researcher had to continuously reflect on his own experiences with the awareness that his own perception could influence the interpretation of the findings. In this study, the researcher made use of the above criteria for credibility and conformability as part of self-reflection and to ensure that the data obtained from the participants influenced the interpretation of the findings (Roller and Lavrakas, 2015:398).

Apart from verifying the qualitative data of this research study, the researcher also implemented ethical practice, which will be discussed next.

2.4 ETHICAL CONSIDERATIONS

Ethical practice in social research "refers to the system of moral principles by which individuals can judge their actions as right or wrong, good or bad" (Denscombe, 2010:59). Houston (2016:4) identifies the following key elements to be considered for ethical practice for research in the social sciences:

- *Obtaining ethical clearance*: In this study, the researcher requested ethical clearance from the University of South Africa (UNISA) through a research proposal that first had to be accepted by the Department of Social Work's Research and Ethics Committee before he could commence with the research.

- *Ensuring the validity of the findings*. The method of data verification described earlier in this chapter addressed this aspect.
- *Privacy, confidentiality, and informed consent*: The implementation of these aspects will be discussed below.

2.4.1 Informed consent

Informed consent means that "the person involved should have legal capacity to give consent, should be situated as to be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, duress, over-reaching or any other ulterior form of constraint or coercion" (Denscombe, 2010:67). Houston (2016:4) emphasises the importance of the ability of participants to understand what their consent entails. In this research study, voluntary participation was guided by invitations to participate and by providing potential participants with the relevant information to be able to make an informed decision (see Annexure A [request for permission by organisations], B [invitation to participate], and C [informed consent form]). The organisations who were requested to permit the research to be conducted among staff and users of services, as well as the potential participants were first introduced to the study by means of an invitation letter, followed by interviews where they could ask additional questions before they were requested to sign an informed consent form. Participants were also made aware that they could withdraw from the research study at any given time without repercussions.

2.4.2 Confidentiality, anonymity and privacy

Confidentiality is of paramount importance in a qualitative research study. In terms of maintaining confidentiality, reasonable precautions should be taken to avoid the disclosure of personal identities and sensitive information to third parties (Denscombe, 2010:75). In this study, confidentiality, anonymity and privacy was dealt with simultaneously. During the invitation interviews, participants were informed that their personal information would only be known to the researcher and his supervisor, that their contributions would be transcribed with code-names attached to the transcripts so that their identities would remain unknown, and that all the recordings and transcripts would

be stored in a safe place. This required a **management of information system** aimed at ensuring confidentiality and privacy. Furthermore, the findings were presented as a collective story to prevent identification of individual contributions. The participants' personal information and contributions were dealt with in such a way that their identities were protected. Confidentiality was also ensured through a confidentiality agreement between the participants in the focus groups (see Annexure D).

2.4.3 Compensation

Compensation for participating in a research study poses the threat that the decision to participate is only based on monetary compensation. If the willingness to share and contribute is externally motivated, it can have a negative effect on the credibility of the data (Strydom, 2011:121). This aspect also has to do with ensuring that participation is voluntary. In this study, no compensation was offered to ensure that participants truly wanted to participate and contribute to the research goal.

2.4.4 Debriefing of participants

When discussing sensitive issues in qualitative research studies (in the case of this study, for example, users of services reflecting on their SUD, or service providers feeling emotional about the outcome of services), participants may become emotionally influenced by the discussions. Therefore, debriefing sessions must be made available so that participants have the opportunity to reflect on their experience (Strydom, 2011:122). The researcher made an arrangement with a social worker to be available for support and debriefing, just in case an interview causes any form of distress, or should a participant request such support. To make sure that any form of harm is dealt with in an ethical manner, an arrangement was made with a social worker registered with the SACSSP in accordance with Act 110 of 1978 (South Africa, 1978) to be available to provide debriefing services (see Annexure E), should the need arise. Participants were informed about this option during the invitation interviews and again reminded at the end of the interviews. However, none of the participants requested this service.

Please also see Annexure G: Risk assessment tool.

2.5 LIMITATIONS

The findings that will be presented in the next chapters must be viewed together with the limitations experienced. Firstly, the study was conducted in the Western Cape Province. The findings are therefore contextual in nature.

Secondly, only male service user participants participated, which resulted in findings that only reflect the experiences and perceptions of one gender. Similarly, all the participants were older than 18 years of age, and therefore the voices of children and youth are not reflected in this study. The decision to only include adult participants was based on ethical challenges related to minor participants.

Lastly, it must be noted that the researcher was challenged to arrange the focus group sessions at outpatient treatment organisations. This resulted in small group sizes, and also contributed to the lack of the female voice in this study.

2.6 CONCLUSION

This chapter provided an in-depth discussion of the application of the research methodology that was chosen for this study. The reasons behind these choices were described in Chapter 1. The implementation of the chosen methodology, as discussed in this chapter, was based on theoretical descriptions of the relevance of the chosen approach, designs, methods and techniques, and characteristics thereof.

The next two chapters will present the research findings. Chapter 3 will focus on the data obtained from the social worker participants.

CHAPTER 3

RESEARCH FINDINGS: THE EXPERIENCES AND PERCEPTIONS OF SOCIAL WORKERS

3.1 INTRODUCTION

This chapter is dedicated to the research objective to explore the experiences and perceptions of service providers regarding the utilisation of the continuum of care for the treatment of persons with a SUD. In this study the term 'service providers' refers to social workers who work in the substance abuse field. The previous chapter presented the methods of sampling, data collection, and data analysis that were used to explore and describe their experiences and perceptions. A description of the biographic profile of the participating social workers will introduce this chapter. This will be followed by an in-depth discussion of the findings, which will be described in terms of themes, sub-themes and categories. The findings will be compared with existing literature.

3.2 BIOGRAPHIC INFORMATION OF THE PARTICIPATING SOCIAL WORKERS

The biographic profile of the social work participants is presented to contextualise the research findings. The participants were identified and recruited by means of the non-probability sampling method and the purposive sampling technique. Etikan, Musa and Alkassim (2016:2) note that purposive sampling is valuable in qualitative research where "… the data is meant to contribute to a better understanding of a theoretical framework". In this study, the researcher wanted to explore services to people affected by a SUD from the framework of the continuum of care, as prescribed by legislation and policy documents (cf. Department of Social Development, 2013b:27-29; South Africa, 2008). The mentioned sampling technique assisted the researcher to gain access to people who have the needed knowledge and experience to answer the research questions (see Chapter 1).

Six social workers participated in this study. Data saturation was detected after four interviews, after which two more interviews were conducted to ensure that no new information came to the fore. The biographical information of the social workers is presented in Table 3 below, where after this information will be discussed and compared with existing information on this population.

Table 3: Biographical description of service provider participants

Gender	**Age**	**Social Work qualification**	**Years of experience working as a social worker**	**Years of experience working with persons who are affected by a substance use disorder**	**The municipal boundaries where the organisations that the social workers are working for are located**
Female	50	BSW	26	25	Elsies River
Female	57	BSW	37	12	Stellenbosch
Male	54	BSW	25	18	Stellenbosch
Female	36	BSW	6	6	Tygerberg
Female	44	BSW	8	6	Athlone
Female	34	BSW	11	10	Tygerberg

Five female and one male social workers participated in this study. This is in line with both international and national reported trends that social work is a female dominated profession. For example, Myers (2010b:39) reports that social work in Ireland is “mainly a woman’s profession”. In South Africa, Khunou, Pillay and Nethononda (2012:21) describe social work as a profession that is dominated by females. According to the latter authors, between 10 and 13% of students in social work at South African universities are male.

The ages of the participating social workers ranged from 34 to 50 years. They represent the early and middle adulthood life stages. Feldman (2017:290) mentions that early adulthood has to do with the exploration of a personal identity, which includes a work identity. Reflective thinking about life experiences result in realistic expectations and the ability to learn from experiences. This, then, leads to generativity, which means that the person in middle adulthood is able to look beyond him/herself, and to contribute to the

community. This viewpoint is supported by Malone, Liu, Vaillant, Rentz and Waldinger (2016:497-499), who assert that middle adulthood reflects the ability to consolidate lessons learned through life experiences, and to use this to guide and support others. In this study, the participants were in a life stage where they were able to reflect on what they have learned about the utilisation of the continuum of care for treatment of a SUD and to make suggestions for future social work practice. In terms of life experiences in the substance abuse treatment field, the participating social workers had between six and twenty five years of experience.

The experiences and viewpoints of the participating social workers regarding the research topic will be presented in the next section.

3.3 THE EXPERIENCES AND PERCEPTIONS OF THE SERVICE PROVIDERS REGARDING THE UTILISATION OF THE CONTINUUM OF CARE FOR TREATMENT OF A SUBSTANCE USE DISORDER

The data that informed the findings that will be described in this section was obtained through semi-structured individual interviews. The researcher audio recorded the interviews and made field notes to include the non-verbal data. During the interviews, the non-verbal cues were also valuable to probe and encourage participants to expand on their descriptions (Irvine, Drew and Sainsbury, 2013:91). The audio tapes and field notes were transcribed and analysed by means of Tesch's (1990) eight steps for qualitative data analysis (Creswell, 2014:218). The themes, sub-themes and categories that emanated from the data analysis process were in turn compared with the literature, which served as a literature control that enhanced the conformability of the data (cf. Schurink et al., 2011:429). Table 4 below summarises the themes, sub-themes and categories of the findings that describe the participating social workers' descriptions of the utilisation of the continuum of care for treatment of a substance use disorder.

Table 4: Service providers: themes, sub-themes and categories

Themes	Sub-themes	Categories
Theme 1: A description of the concept 'continuum of care' for treatment of a substance use disorder	Sub-theme 1.1: Descriptions of the different stages of care	Category 1.1.1: Prevention and early intervention
		Category 1.1.2: Treatment
		Category 1.1.3: Aftercare
Theme 2: The nature of the service rendered to persons who are affected by a substance use disorder	Sub-theme 2.1: A description of service users	
	Sub-theme 2.2: Levels of care	
	Sub-theme 2.3: Content of service programme	Category 2.3.1: Services to persons with a substance use disorder
		Category 2.3.2: Services to families of persons with a substance use disorder
	Sub-theme 2.4: Approaches, methods and techniques that are being used	Category 2.4.1: Assessments
		Category 2.4.2: Social work approaches and methods
		Category 2.4.3: Techniques used
	Sub-theme 2.5: Role players to ensure holistic treatment	Category 2.5.1: Formal role players
		Category 2.5.2: Informal role players
	Sub-theme 2.6: Perceptions and experiences of how current services relate to or support the utilisation of the continuum of care	Category 2.6.1: Accessibility
		Category 2.6.2: More than one level of care and in line with legislation and based on trends in community
		Category 2.6.3: Links with other service providers
Theme 3: Enabling factors and conditions experienced when implementing the continuum of care for treatment of a substance use disorder	Sub-theme 3.1: Community-based services	
	Theme 3.2: Resources to support services	Category 3.2.1: Community-based resources
		Category 3.2.2: Linking service users with different service providers and support systems
		Category 3.2.3: Resources to build on expertise

		Category 3.2.4: Networks
	Sub-theme 3.3: Trained and experienced staff	Category 3.3.1: Supervision and mutual support
Theme 4: Challenges experienced when implementing the continuum of care for treatment of a substance use disorder	Sub-theme 4.1: Funding	Category 4.1.1: Funder requirements
		Category 4.1.2: Fundraising efforts
	Sub-them 4.2: Manpower	
	Sub-theme 4.3: Service users' level of motivation to complete the process	Category 4.3.1: Family members' being unsupportive
		Category 4.3.2: Challenges experienced by service users
	Sub-theme 4.4: Dual diagnosis	
Theme 5: A description of how social workers can be assisted in improving the utilisation of the continuum of care for treatment of a substance use disorder	Sub-theme 5.1: Training	Category 5.1.1: Supervision
	Sub-theme 5.2: Networking	Category 5.2.1: Collaboration as an important aspect
	Sub-theme 5.3: Planning according to the continuum of care	Category 5.3.1: Needs-based approach
		Category 5.3.2: Coordinating services by more than one organisation
	Sub-theme 5.4: Funding aimed at supporting the implementation of the continuum of care	Category 5.4.1: Resources
		Category 5.3.3: Addressing aftercare

The findings will be discussed in terms of verbatim responses and existing literature on the topic.

Theme 1: A description of the concept 'continuum of care' for treatment of a substance use disorder

The participating social workers referred to the continuum of care in terms of a treatment plan that includes a range of services over a period of time. They emphasised that the treatment plan should be individualised, and that it must be developed *with* the service

user. The utterances below describe their viewpoints of the continuum of care as a treatment plan.

> "*It has to do with a treatment plan for a person with a substance use disorder*."
>
> "*It will start off with a brief assessment; gathering some background with regards to what is the problem and then working out a plan together with the client*."
>
> "*It is based on an individual treatment plan*."

Chittleburgh (2010:4) uses the term 'through-care' as a description of the continuum of care in social work. This means that a treatment plan involves long-lasting relationships with social workers that are needed to assist the client-system through the whole process of intervention. In line with this viewpoint, and focusing on the treatment of persons affected by a SUD, Van der Westhuizen (2010:14) refers to treatment as an integration of detoxification, treatment programmes and aftercare. The through-care will then refer to a treatment plan that consist of all three mentioned components. Puddy and Wilkins (2011:67) agree with this viewpoint and assert that the continuum of care in the treatment of a SUD is a framework that integrates all the different options that could be included, depending on the individual needs of the service user. Similarly, the participants in this study referred to catering for individual needs and different options when describing their understanding of the continuum of care:

> "*Whatever the client presents us with is what we will be treating*."
>
> "*I think that will be our basket of services we offer to our clients and all the resources that we obviously offer*."

The long-term nature of the continuum of care was highlighted as follows:

> "*It is not like you start in the rehabilitation centre and then finish with the process. Also after the person leave the rehabilitation centre, then they must continue in an aftercare service*."

"*My understanding is that the continuum of care starts when the client enters the organisation or is being referred. When you start the process with the client, filling the whole process in terms of the intake process and assisting the client into intervention or referring, and when the client has completed maybe an inpatient programme. And even after completion of the treatment programme; then the client comes back into an aftercare programme. And then you link the client with support structures within the community or with stakeholders.*"

The participants distinguished between the different stages of the continuum of care, which will be presented in the sub-theme below.

Sub-theme 1.1: Descriptions of the different stages of care

Chandrika (2015:57-58) notes that the continuum of care supports social workers to mobilise a wide range of services to restore, maintain and enhance well-being. In line with this description, South African legislation and policy documents distinguish between the following stages in the continuum of care for treatment of a SUD: prevention, early intervention, treatment, continuing care, and recovery support (Department of Social Development, 2013b:27-29; South Africa, 2008). The participants in this study particularly focused on prevention and early intervention, treatment and aftercare as components of the continuum of care.

"*Early prevention, treatment and aftercare that is the continuum of care for me*."

"*We have the early intervention and we have treatment. Then aftercare; so once the person is done with our services, we can link the person to a support group or AA* (Alcoholics Anonymous) *or NA* (Narcotics Anonymous)."

The statements that follow highlight that all the stages are viewed as important components of service delivery:

"*None is more important than the other*."

"*With each intervention it gives us a window of opportunity in terms of where the client is and needs*."

The categories below will describe the participants' perceptions and experiences related to each stage of the continuum of care.

Category 1.1.1: Prevention and early intervention

Some participants referred to prevention and early intervention as one stage, as illustrated by the following statement: "*Okay, so the early intervention is where we go and give information about drug addiction and some information of what is the bad habits of taking drugs and that sort of things. And where there is a high risk we will also give information as a form of early intervention*". Other participants distinguished between prevention and early intervention. The described prevention as informative in nature: "*So it is brief psycho-education and information sharing*". In terms of early intervention, they focused mainly on school children who are being referred for services or youth at risk. These services focus on drug tests and education, and include the family and communities:

"We do a drug test on that person (when a school refers a child for drug testing). *Then we do an education with regards to substances, the effect on the brain… just to inform the parents also, because sometimes the parents… they are uninformed and have no background with regards to substances*."

"*Especially if it is a minor, the family member must accompany them to services."*

"*We have an early intervention programme where we focus on young people that are at risk; that are experimenting with substances. We take them through the whole process. We make use of brief interventions*."

"*We also do awareness in terms of the broad community where we reach out to schools, to families and we use different platforms to communicate that information*."

In line with the distinction between prevention and early intervention described above, the Department of Social Development (2013b:27-29) describes prevention as services that acknowledge development needs, and that are focused on preventing needs to develop into risks. In other words, needs are being addressed before the person/group becomes at risk of using and abusing substances. Early intervention takes place when the person/group has already moved into a high-risk category, and is focused on limiting the impact of the risk. Thus, services are aimed at addressing the high-risk so as to prevent a SUD to develop.

Category 1.1.2: Treatment

The social work participants referred to treatment as an option between in- and outpatient programmes (cf. Van der Westhuizen's, 2010:7-8): "*Intervention is when a social worker comes in and have a discussion and that is in terms of treatment options. There is outpatient and inpatient treatment*". A participant also linked the term 'treatment' to the individual needs of the service user as follows: "*With treatment you focus on areas of concern*".

The Department of Social Development (2013b:27-29) refers to the treatment stage in terms of three options, namely statutory treatment, residential programmes and alternative community-based programmes, which are aimed at addressing the SUD. In addition, Van der Westhuizen (2010:8) emphasises that the length of treatment is an important aspect to consider. This, then, means that the integration of treatment and aftercare is an essential component to ensure effective treatment outcomes.

Category 1.1.3: Aftercare

A participant in this study differentiated between aftercare and treatment services as follows: "*Aftercare is a bit different. So now you move from triggers and cravings to stages of recovery. It is more to help the client to rebuild their lives again and that is the difference between treatment intervention and aftercare*". Other participants also drew a link between aftercare and treatment (cf. Van der Westhuizen, 2010:14) as follows:

> "*We do relapse prevention, which is part of the treatment*."
>
> "*It* (aftercare) *goes with the treatment options, it is part of how the treatment should go*."
>
> "*Now, so after the client has completed our programme, they must also complete the aftercare programme, because it is all about building resilience*."

A participant noted that aftercare is also based on the individual's needs: "*The whole process* (of aftercare) *starts where we re-access where the client is and what we need to focus on*". Martin (2008:3) supports this viewpoint and notes that the continuum of care is a framework, but that it cannot be a set-in-stone structure for services. Each service user will have unique needs, and this framework should provide a variety of options so that the individual needs can be accommodated (cf. Puddy and Wilkins, 2011:67).

In this study, the participants emphasised that aftercare is vital to ensure positive treatment outcomes. They noted:

> "*Aftercare is vital, because you need to cope with the life after getting treatment*."
>
> "*I think aftercare is essential, because most people when they are done with the treatment they feel like 'I am cured'. But they are not. I think what aftercare offers them in a sense is not to forget to live your life and not be over confident in making certain decisions, because this is always going to be a struggle of yours*."

The importance of aftercare was related to a relapse risk, as highlighted by the following utterances:

> "*When you send the person back to the community and there is no aftercare services in that particular community, that is actually the one factor in relapsing we see*."
>
> "*I think aftercare is very important and that is why a lot of clients relapse*."
>
> "*Many clients, when half way through the programme, they become confident and then they feel good and want to start working. Sometimes family members put pressure on them to say, listen you need to start working. We cannot afford to have you at home, you need to help contribute to the household and then clients drop out and that is why our aftercare numbers are affected because they think that after four or five sessions they are okay.*"

A participant reported that successful outcomes are linked to the fact that service users and their families are motivated from the start to include aftercare in the treatment plan. "*But we have seen some change, because we have been motivating them from the start of aftercare. Especially in family sessions*". Aftercare also includes reunification or reintegration with families and communities. The Western Cape Department of Social Development (2010:2-3) asserts that service users should be linked with resources and services in the community so as to strengthen their coping mechanisms and to adapt to the family and community environment. This description is further supported by the National Department of Social Development's Framework for Social Welfare Services (Department of Social Development, 2013b:27-29), which emphasises that aftercare and reunification should enable service users to regain self-reliance and optimal social functioning after formal treatment was completed.

The statements above are in line with South African research findings related to aftercare, which point to a link between relapse potential and the availability, accessibility and

utilisation of aftercare services. Swanepoel, Geyer and Crafford (2016:431) found that a lack of access to and availability of aftercare contributes to relapses and recommend that aftercare should be seen as key to relapse prevention. Similarly, Elias (2016:13) notes that the utilisation of aftercare options results in better treatment options. The participants in this study also referred to relapse prevention and building resilience, as key components of aftercare, as portrayed in the next statements:

> "*When a client is referred to a rehabilitation centre or a rehabilitation centre refers back to us, we will put that client in the aftercare process where we will focus on relapse prevention and resilience in terms of staying sober*."
>
> "*We focus on why people relapse and the signs of a relapse and when to know you are relapsing. It is education on what is relapse and also they help them look at other aspects of life and focus on their goals*."
>
> "*Aftercare will support those areas in terms of maintaining the sobriety.*"

The participating social workers continued to accentuate the long-term nature of aftercare through the following utterances:

> "*That* (aftercare) *can be long-term or brief, but most of the time, as we do know the nature of substance dependency, it is long-term*."
>
> "*Aftercare is once a person has attained some changes. You then monitor that client either weekly, monthly or yearly which can be long-term, depending on what the client needs*."

The length of the aftercare stage is also accentuated in the literature. Van der Westhuizen (2010:8) refers to an aftercare period of between 12 and 24 months, while Martin (2008:3) assert that persons with a SUD "will require between one to five years to find some sort of homeostasis (balance) between body, mind, and spirit". The latter author advise that the continuum of care, starting with the treatment stage, should not be shorter than 12 months.

With the above description of the participants' understanding of the continuum of care as a backdrop, the participants continued to describe the nature of current services.

Theme 2: The nature of the service rendered to persons who are affected by a substance use disorder

When describing the nature of services rendered by their organisations, the participants focused on the service users, the levels of care provided, the content of service programmes, as well as the social work methods and techniques they use. They also discussed formal and informal role players that assist them to deliver a holistic service, and reported on their viewpoints regarding how their services relate to the implementation on the continuum of care. The sub-themes and categories below will expand on these topics.

Sub-theme 2.1: A description of service users

The participating social workers referred to age and gender as descriptors of service users. Two of the three organisations that participated in this study rendered services to both male and female persons affected by SUDs, while one organisation only rendered services to males. The latter organisation, however, included both youth and adult service users. A participant reported: "*We take in men and boys, but we do not take females*". The participants continued to distinguish between youth and adults, and explained that services are client-centred. Services to different age groups therefore differ in terms of development needs.

> "*Currently we render services to youth from the age of 12 to 35; we also render services to adults*."

> "*We have specific services for youth that is based on where they are at; it's client-centred*."

The South African Community Epidemiology Network on Drug Use (SACENDU, 2018:2) reported that 20 to 34% of service users in the first half of 2017 were younger than 20 years. Winters, Botzet and Fahnhorst (2011:419) reflected on services to youth, and advice that the development stage of this group requires an assessment of development milestones achieved, as well as delays that might impact on the youth's ability to engage with services. Such services should also focus strongly on parenting issues, as well as educational needs.

Sub-theme 2.2: Levels of care

A distinction was made between inpatient and outpatient care. These forms of care were related to the continuum of care. Inpatient services, according to the participants, focus on the third stage of the continuum of care, namely treatment that could be statutory, residential or community-based. In this study the participants also noted that treatment focuses on the SUD and prepares service users for the aftercare stage.

> "*We are an inpatient programme; that is where our focus is at the moment*."
>
> "*We do the treatment in a rehabilitation centre*."
>
> "*We also do relapse prevention as part of the programme*."

The participants identified outpatient services as addressing all four stages of the continuum of care, namely prevention, early intervention, community-based treatment and aftercare (cf. Department of Social Development, 2013b:27-29). The following statements represent these descriptions:

> "*We render awareness programmes so we can create a level of education with regards to the negative impact of substance use with children in primary schools and even in high schools*."
>
> "*We do out-patient treatment where we work with the client and, if possible, with the family. Often we do this while they are waiting to go to an inpatient programme*."

"*We also render aftercare services after our clients leave the treatment centres*."

Supporting the description of a combination of services above, Martin (2008:2) notes that treatment within the continuum of care depends on the individual needs of service users. This author postulates that, depending on the intensity of the dependency, each stage may require a specific time needed for the individual to move into recovery. This may result in a combination of in- and outpatient treatments. Similarly, Proctor and Herschman (2014:3) explain that "the treatment of SUDs involves varying levels of care". These authors assert that some service users respond well to brief interventions or less formal outpatient programmes, while others need intensive support, which requires inpatient treatment. This is often dependent of the nature of the substances, as well as on the progression of the substance abuse.

Sub-theme 2.3: Content of service programme

The service programmes described by the participants focused on services to the persons with a SUD, as well as services to the families.

Category 2.3.1: Services to persons with a substance use disorder

Services by the service providers in this study focused on education and life skills.

"*We focus on education; on what substance disorder is and what effect it has on the brain; why it is called a disease*."

"*We also have addiction lectures and we also have a medical people that speak to the person about how the drugs affects them and their mind*."

"*Addiction lectures where we speak about how drugs not only affect them, but their family also and the communities*."

"*Coping and management skills to deal with this disease*."

"*I give them a boost in life skills, especially self-confidence, because a lot of them have lost that. So to give them like proper skills, because they have lost all that stuff*."

"*We also have lectures about life skills development*."

Drug testing as part of outpatient programmes was noted as a service aimed at identifying whether the person is motivated and to monitor if the service is effective or not. It was also reported that drug testing is often something that the family or employers request:

"*We also may refer to a drug test if it is necessary*."

"*So our programme also includes drug testing. It monitors whether the person is actually off the drugs and then we can see if they are struggling and still in denial, or if they are motivated and benefiting from the services*."

"It also got to do with drug testing to be aware if the person is using or not. *The families or employer might want this, but it is also a sense of achievement for the client when he or she is testing negative*."

The latter statement points to service users moving into recovery, and an acknowledgement that becoming and remaining sober is a process. This is supported by Martin (2008:2-3), who distinguishes between stages in treatment as primary treatment, followed by extended care treatment. The person moves into a transitional sober living stage until he/she is able to maintain sober living.

Category 2.3.2: Services to families of persons with a substance use disorder

McDonagh and Reddy (2015:6) assert that including families of persons with a SUD is crucial, but challenging. In line with this sentiment, the importance of including the family in services were noted by the participants in this study.

"*Engaging the client also includes building a relationship with his family and people that are of interest to the client*."

"*Then we look at the family support when you attend to your client. You cannot just look at a person individually, because he or she belongs to a family somewhere*."

"*We also offer services to family members. A lot of family members need information since they do not know the process* (referring to recovery process)."

Family involvement is acknowledged as a key indicator of successful outcomes for the treatment of SUDs (Copello, Templeton and Powell, 2010:65). McDonagh and Reddy (2015:18) go further to argue that families could have contributed to the SUD on the one hand, and could be seriously affected by the SUD on the other hand. Including them in services supports the whole family to move into recovery, which then leads to the family becoming an important resource and social support for the ongoing treatment of the SUD. Similarly, the participants reported that they focus on information to deal with the SUD on the one hand, and also on supporting the family to deal with the harm they suffered as a family on the other hand:

"*Each first Friday of the month we have a family programme where we give information about addiction, they share their feelings as well, we have discussions afterwards*."

"*We also educate the family members on that* (addiction and recovery) *as well as giving them the coping skills for both the person and the family*."

"*We also focus on a family session. So part of that is also to get family members to be part of the programme to see progress at home.*

Chandrika (2015:57-58) follows this train of thought and mentions that strengthening the family's ability to deal with the SUD effectively contributes to social development of communities.

Sub-theme 2.4 Approaches, methods and techniques that are being used

Assessments were identified as an important part of service delivery. This aspect was therefore included in the discussion of this sub-theme.

Category 2.4.1: Assessments

When asked about the methods and techniques they use in their services, the participating social workers reported that the first task is to do an assessment, which results in a psychosocial report.

> "*Okay, I am going to refer to our intake process when the client enters our care. We start taking the details of the client; that is personal details. We also do a screening to determine whether the client is active in terms of use*."

> "*We have a comprehensive psychosocial report that we complete to assess the background; whether there are any predispose factors. You know, in terms of the client's addiction*."

The participants reported that assessments are used to determine if their services are relevant to the person's needs, to develop an individual plan, and to make referrals to other service providers when needed.

> "*When a guy first comes here we do the assessment interview, then we will discuss if he is fit for the programme. Then we do the medical assessment and then he will be admitted to our programme*."

> "*We make use of tools like eco-maps and any other tools that can help us to gather the necessary information. Then we draw up a comprehensive development plan so that we can gear the client towards taking ownership of his or her own rehabilitation*."

> "*Then we structure the treatment plan with the client after the assessment. Then we would deliver or promote services to the client to meet the needs of the client.*"

"*We do screening and assessment to see if the client is suitable for us. Then we also refer if necessary; like should it be in- or outpatient treatment*."

Category 2.4.2: Social work approaches and methods

Approaches to services by the participating service providers were identified as client-centred, motivational, and cognitive-behavioural approaches. The participants described these approaches as follows:

"*We are more client-centred at the moment.*"

"*We use a motivational approach, which includes cognitive-behaviour therapy and addiction therapy*."

"*Cognitive-behaviour therapy; that is for me the most important*. *We are focusing information to understand the addiction, the attitude, and how you need to change behaviour to live a sober life*."

The cognitive-behavioural approach is seen as a valuable approach to treatment of SUDs to ensure that service users develop a new way of thinking and doing. Through cognitive restructuring a new understanding of the dependency and related behaviours is developed. This then forms the foundation to learn new assertiveness and coping skills that lead to effective change (Proctor and Herschman, 2014:8). Carroll (1998:41-88) developed a therapeutic structure for the treatment of SUDs from this approach. Similar to the descriptions by the participants in this present study, this author combines the cognitive-behavioural approach with a client-centred and motivational approach. The focus of cognitive-behavioural services is on the identification of individual needs (assessments) and personal goal setting, development of a personal motivation for moving into recovery, developing coping skills to deal with cravings, and the development of life skills such as assertiveness, decision-making and problem-solving skills. Van der Westhuizen (2010:342) also found that these life skills are needed to prevent relapses.

The participants reported that they mainly make use of case and group work methods during their services, as described by the following statements. "*We use the different methods like case work and group work intervention*". Case work, according to the participants, focuses on therapeutic work that addresses individual needs. Group work is aimed at social support and the development of life skills.

> "*We have individual social services like therapeutic intervention*."
>
> "*Individual sessions will primarily focus on what is relevant to the client*".
>
> "*So the individual sessions will be targeted on topics or needs that is a unique need of the client, whereas with groups it is more open and there is that exposure that they are not alone in whatever they are going through*."
>
> "*That is group work, individual sessions and we have lots of climate meetings because what are the frustrations among each other* (patients in a treatment centre). *Every Monday morning I am doing that because there are tensions amongst each other: 'why are you looking at me like that?' So, whatever is needed we will try and sort it out*."
>
> "*So in a group they learn through engaging with each other and learning from each other. The common goal is reaching sobriety, but t it is a lot of interaction. They learn through role plays and how it relates to their family dynamics and work.*"
>
> "*In groups we focus on life skills focusing on aggression and how to manage your stress and emotions*."

Category 2.4.3: Techniques used

The participants identified motivational interviewing, the 12-Steps programme of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), and harm reduction as specific techniques used during service delivery. The use of motivational interviewing was explained as follows:

> "*You have to basically have great way of motivating the client well*."

"*The clients' level of motivation… remember we do not always get clients that want to be in treatment. So we sometimes get pre-contemplating clients. But then motivational interviews help us to be able to help those clients to move from pre-contemplation to contemplation or to become more motivated*."

"*We also use tools such as motivational interviewing, because for example if a learner from school taps into the programme and she was coerced, then there is no option but she has to come* (for early intervention services)*. That person only presents what we call a pre-contemplative state; meaning they do not really want to be here, but they also understand that there is a need for it because they need to go back to school. So then motivational interviewing honours the clients' motivation for change rather than the person being sent here because of a school or family. So the person now understands the nature and the harm of the substance concerned.*"

Motivational interviewing is based on the cognitive-behavioural approach and provides service users with information and guidance to develop internal motivation to change behaviour (Latchford, 2010:6-9). Similarly, the participants linked the 12-Steps programme to the cognitive-behavioural approach in that it focuses on a new way of thinking and skills to deal with the effects of the dependency.

"*We work from the 12-Steps programme, which is good to help our clients to address the harm their addiction caused. It also helps to accept that the addiction is real*."

"*The 12-Steps is a useful tool to help them* (service users) *to understand the addiction and to learn how to become sober*."

Proctor and Herschman (2014:12) assert that harm reduction, such as the use of Methadone to address withdrawal symptoms, could be valuable during the early stages

of treatment. Harm reduction as a technique to assist service users were described by the participants as follows:

> "*We also do harm reduction, because in the past we said the heroin patients, that is a risk factor of overdose, but we have come to realise that some of the guys need a little bit of help with methadone*."

> "*At the moment I think we have two patients that are on harm reduction and the other three sitting out. They say" 'I want to do it my way, I do not want any medications. I want to feel clean from anything.' And that is their choice. We give them the options but if they do not` want, that is alright with us*."

Sub-theme 2.5: Role players to ensure holistic treatment

The participating social workers identified formal and informal role players that are included in services to address the different needs of service users holistically.

Category 2.5.1: Formal role players

The UN views a multi-disciplinary team as one of the principles of treatment of SUDs (UN, 2008:8). In this study, the participants noted that a multi-disciplinary team is needed to render a holistic service. The statements below attest to their viewpoints:

> "*You cannot just have social work services and psychologist; maybe the person needs spiritual or medical assistance*."

> *"It is a holistic approach. The role players are the social workers, psychologists, pastors and psychiatrist; a person that focus on psychiatric problems or mental problems*."

> "*It's obviously social workers. Then it would be health care practitioners which would include doctors, medical nurses, psychiatrists and phycologists*."

> "*We work together, the social workers, medical staff and pastor*."

"*We* (multi-disciplinary team) *will discuss difficult cases. Say for instance we have cases that we struggle with, we present them and then us as a multi-disciplinary; the social workers, the nurse and the psychiatrist; will sit together and discuss the plan and what are some of the interventions we can use in the cases*."

"*Working in a group that is a multidisciplinary team, that is helping us. We submit reports at four in the afternoon and we come in together and report on that particular client. Then we can see how we can further assist that particular client*."

"*We have a reporting structure in the morning and also in the afternoon so if there is any problem identified by a particular person, we can give attention to that particular problem of that particular client*."

"*If we did not have the multi-disciplinary team that would be a challenge. For instance, if you have a bipolar patient showing up with substance use and that is a dual diagnosis. So if the particular client shows up and we are only within our scope of practice, we can now link with the psychiatric scope*."

The participants further emphasised that the individual plan includes different role players, as illustrated by the statements below:

"*If I finish a plan, then this is my development care plan for the particular client. Then we know, okay we are going to do this with a particular person; there is pastoral care, the nursing must do that and that person must do that."*

"We plan services through our individual treatment programme. So we sit down with the client and we look at life areas or we look at what is currently going on with the client, like what is specifically needed and then we coordinate the service that we are going to render to them according to that. So if a client comes in here with dual diagnosis, obviously we have our medical staff."

The statements above point to a multi-disciplinary team within the organisation. Other statements show that referrals might be needed to ensure that service users receive holistic care:

> "*We have a resource directory that we utilise to refer clients whether to rehabilitations centres, whether to outpatient structures within City of Cape Town, within government structures and even private institutions*."

> "*Remember, in this field of work we need to work in a multi-disciplinary way, which means that sometimes we need to work with other organisations like a hospital if there is any dual diagnosis*."

> "*And also then we have got a person presented with a psychiatrist history, then there would be a referral to a psychiatrist*."

> "*And sometimes we also refer to a hospital, especially if it is a suicidal client. We send them for a 72 hour observation*."

> "*Sometimes we need to do referrals to child youth care centres or we need to complete a form of removals if or to report whether there is like a neglect or abuse. And for that reason we cannot work alone and it is definite that we need to network with organisations also*."

Category 2.5.2: Informal role players

As also discussed in Category 2.3.2 above, the family was identified as a role player that could provide the client with valuable support (cf. McDonagh and Reddy, 2015:18).

> "*It is also with the client in the circle that can be family members, spouse, parents, and siblings*".

> "*Role players will obviously also be the clients and the family*. *The family is really important to serve as support for our clients*."

The UNODC refers to informal community-based support as empowering in nature, and not that a wide range of individual needs can be met through the inclusion of role players in the community (UN, 2014:2). The social workers who participated in this study referred to support groups, churches, employers and schools as role players that are included in services to provide service users with community-based support.

> "*And then other role players would obviously be in your support groups*."
>
> "*Churches play a role as well, and I think they can make a huge difference in the continuum of care and also that they will support and maintain the sobriety*."
>
> "*The other role players are schools, because a lot of our clients come from schools where they are tested positive.*"
>
> "*And sometimes even the employer. A lot of the referrals we receive come from the work place and clients are maybe tested positive at work and then they are referred by employers*."

Sub-theme 2.6: Perceptions and experiences of how current services relate to or support the utilisation of the continuum of care

The participants reported that their services relate to the continuum of care as it ensures accessibility of services, provides more than one level of care and links service users with different service providers. Their descriptions align with the Department of Social Development's Framework for Social Welfare services in that it is aimed at the individual needs of service users, and supports accessibility of services (Department of Social Development, 2013b:29).

Category 2.6.1: Accessibility

Accessibility was noted to be enhanced through community-based services that are aimed at addressing the specific needs within the community.

"*We are a community-based organisation, which means we are accessible to our clients and in terms of the need of the community*."

"*We work in the community, so they can reach us and we can be available*."

Category 2.6.2: More than one level of care and in line with legislation and based on trends in community

The descriptions below highlight the fact that the continuum of care is not seen as a hierarchy, and that it rather lists different options to be used depending on the needs of the service users (cf. Department of Social Development. 2013b:29).

"*I think the type of services that we render like the intervention, the aftercare and the awareness. I think it is on par and even in terms of the Substance Abuse Act and the focus of government*.

'*Although we are not funded for prevention, we do that because in terms of substance abuse we have noticed that the users are becoming younger*."

"*We focus on what the clients need. A trend that we are seeing currently is that primary school children are starting to use and they are starting to combine substances. So we do prevention and early intervention, but we need to focus on the treatment too. And obviously aftercare is always needed*."

Category 2.6.3: Links with other service providers

As also noted in Category 2.4.1, the participants reported that they link service users with other service providers when needed. This, then, insures that the service users have access to the different care options (cf. Department of Social Development. 2013b:29).

"*I think our services supports the continuum of care to the extent that we do the necessary referrals in terms of catering for the clients' needs and what they exactly need*."

"*We also do referrals. Let's say a client want to go to an inpatient rehabilitation centre, they will start off with coming first into our programme, attend a few sessions and then the social worker will do a referral*."

"*And if the assessment has been made* (referring to a service not rendered by the participating organisation), *then we might not be able to do anything* (referring to the services of the organisation), *but the client will be referred to the relevant organisation that can offer a service in that regard*."

"*When we finish our services here* (inpatient treatment), *we contact other organisations or contact some aftercare programme that is out there in the community*."

A participant reported that these links prevent the duplication of services: "*Without working with other organisations, the whole time there will be duplication from organisation to organisation*". While reflecting on the nature of the services rendered by their organisations, the participants identified enabling factors and conditions that support the implementation of the continuum of care. The next theme will focus on this aspect.

Theme 3: Enabling factors and conditions experienced when implementing the continuum of care for treatment of a substance use disorder

This theme expands on the previous descriptions of the participants' perceptions of the term 'continuum of care' and the nature of services provided by their organisations. The participants identified community-based services, resources to support the individual needs of service users, and staff's expertise as enabling factors and conditions that support their efforts to implement the continuum of care.

Sub-theme 3.1: Community-based services

The participants in this study emphasised the value of community-based services in terms accessibility, the use of resources in the context of the service user, and the importance to address the specific needs experienced within a community (cf. South Africa, 2008; UN, 2008:5-6).

> "*We are a registered community-based organisation. I think also the fact that we focus on a specific client system where we have access to the clients is also an added factor*."
>
> "*We work mostly with school learners and it is easy to access them, because we go and see them at their schools*."
>
> "…*and even in terms of the Substance Abuse Act and the focus of government I think we are meeting that criteria and even the need in the community*."
>
> "…*we have that kind of* (community-based) *resources at our disposal*."

The latter statement refers to resources as important to be able to implement the continuum of care. This will be discussed in the next sub-theme.

Sub-theme 3.2: Resources to support services

The categories below will depict the participants' descriptions of community-based resources, linking service users with resources, resources that assist them to build on their expertise, and networks as enabling factors to implement the continuum of care.

Category 3.2.1: Community-based resources

The social worker participants referred to support groups, community structures and informal support, as well as governmental initiatives as valuable community-based resources. Referrals to community-based support groups were described as followed:

"*We try to link them with support groups, which are very limited in our area, but we have a few*."

"*There are support groups that clients can use as extra support*.

"*With the AA and NA the client can also be supported*."

Support groups stem from a self-help tradition, typical of the SUD treatment field (United States Department of Health and Human Services, 2015:20). Toseland and Rivas (2014:21) state that such groups help group members to cope with stressful events, and develop or build on existing coping abilities. It is viewed as a resource that aims to contribute to the long-term recovery goal of a change in lifestyle. In support groups, persons who want to gain and/or maintain sobriety support one another through discussing current challenges and successes. Members provide one another with encouragements and advice through "…unconditional acceptance, inward reflection, open and honest interpersonal interaction, and commitment to change" (United States Department of Health and Human Services, 2015:20-21).

Community structures were described as a form of informal support that focuses on social and economic well-being.

"*And there is community involvement. So we try to link them with that; with the churches in the community and just building a support network around the person*."

"*I think I must also mention that if it is an adult, we try to link them with job opportunities*."

Community structures become valuable resources that complement the continuum of care by means of an integration of social services with community health, focusing on the emotional, social and financial well-being of a person in his/her context (UN, 2014:2). It can also include community-based initiatives of the government. In this study,

employment opportunities provided by governmental initiatives, financial support to the organisation in order to deliver community-based services, and access to health care were described as governmental initiatives that serve as resources.

> "*Okay, in terms of referring our clients, we work closely with political parties like councillors in the community in terms of the EPWOS programme* (Expanded Public Works Programme). *We refer to them and also government structures in terms of securing employment, universities in terms of internship and job readiness training*."
>
> "*Okay, we are subsidised by the Department of Social Development and mainly their money is the main source of income at the moment, and that is not a healthy situation for me*."
>
> "*We use local hospitals. We refer them a lot there*."

According to the descriptions above, government plays an important role to ensure community-based services. The Framework for Social Welfare Services (Department of Social Development. 2013b:29) supports the notion of community-based services to provide treatment for a SUD, while the UN (2008:5) lists the following advantages. Community-based services address challenges in the context of the person, it responds to the individual needs of service users, and it actively involves government and community organisations, community members and service users to create opportunities for change. Linking service users to different community-based resources is therefore essential to ensure the effective implementation of the continuum of care. The above descriptions are also in line with the NDMP for 2013 to 2017 (Department of Social Development, 2013a:3-5) that highlights the need to minimise and address the bio-psycho-social and economic impact of substance abuse and dependency, to address substance-abuse-related problems (e.g. domestic violence), and to develop and utilise multi-disciplinary and integrated treatment services for a SUD.

Category 3.2.2: Linking service users with different service providers and support systems

Elaborating on the discussions in Category 2.5.1 regarding formal role players and Category 2.6.3 regarding links with other service providers, the participants explained how these aspects support them to implement the continuum of care. Firstly, they explained how community-based support contributes to aftercare and reintegration services (cf. Western Cape Department of Social Development, 2010:2-3).

> "*So we try to link them to where in the community they can get support, like medical services at the clinics, or where they can go for skills development*."

> "*We have homeless shelters here as most of our clients end up on the streets and the shelters are willing to work with us if you phone they assist. They are willing to help the client in terms of that*."

Secondly, the value of support groups that were discussed in Category 3.2.1 (cf. United States Department of Health and Human Services, 2015:20-21) were also noted as a factor that supports efforts to implement the continuum of care. The participants explained how they expose and link service users to such groups.

> "*On every third Wednesday afternoon CAD* (Christian Action for Dependence) *comes to share their experience and to invite the patients to their groups*."

> "*The other thing that I think is good at the centre is that on a Monday night the AA group, the aftercare group come to the centre so they get used to that how is it done when they go out*."

> "*On every second Saturday the NA group come so that they know what the difference between the AA and NA*."

Thirdly, links to spiritual support were identified. Chen (2006:306) found a link between a spiritual component in support groups and success in recovery from a SUD. In line with

this finding, Lessa and Scanlon (2006:199) refer to a spiritual dimension of recovery that lead to prevention of relapses in terms of developing a sense of purpose and a related purposeful lifestyle. Similarly, Van der Westhuizen's study (2010:151) identified a need for spiritual support as part of aftercare. In this study, the participants reported that they link service users with spiritual support systems to address the spiritual needs of service users.

> "*We have spiritual caring people coming during the week for spiritual caring*."

> "*Churches come in during the week and there is also a spiritual person coming on Monday*."

Fourthly, the participants stated that they value the need to build cooperative relationships with other service providers and systems to ensure a holistic service. In this regard they reported that they plan to invite role players to open days where an awareness of different focus of services can be ensured to further such cooperative work.

> "*We are planning for an open day on the 16th of September to just inform social workers outside about the services rendered here*."

> "*We want to have an open day just to clarify to the social workers* (who render early intervention and aftercare services) *that, listen give the stuff to the patients so they can also be prepared* (for the treatment programme)."

> "*We try to do it in a holistic way. So we need to cooperate with other service providers*."

In addition to supporting the needs of service users, resources were also noted as valuable to assist social workers to gain knowledge and skills.

Category 3.2.3: Resources to build on expertise

Slabbert (2015:551) views the treatment of a SUD by social workers as a specialised field. The author asserts that social workers need knowledge of substance dependency and recovery processes, as well as an understanding of the complexity of a SUD. In this study, the participants supported this viewpoint and explained how they make use of resources to build on their knowledge and insight.

> "*What we do is we connect our staff to places where they get updated in terms of what is happening in the substance abuse field. We usually enrol them at UWC* (University of the Western Cape), *which has an undergraduate programme for social workers. It is quite a comprehensive one and I think it is quite relevant in the substance abuse field*."

> "*Every month we go to Stikland hospital, there is an academic meeting about a research topic*."

Resources that support the development of expertise also relate to networks that serve as a resource, as described in the next category.

Category 3.2.4: Networks

Networks that serve as valuable resources to deliver services were identified in terms of obtaining information and to do referrals. The participants spoke about networks where information assists them to build on their knowledge and understanding of a SUD.

> "*We are part of a substance network within Western Cape. I am also part of the provincial substance network where we usually share trends of what is happening. We update one another in terms of new policies and legislation*."

> "*Okay, so we belong to the Bellville network. So every two months we come together and there is a topic; social work related*."

> "*There is a network in Tygerberg, every month we are going there for a lecture*."

"*In Stellenbosch there is a network of social services where we can refer people to other services*."

In terms of addressing the specific needs of a service user, the participants described networks that help them to do referrals. These networks support the description of role players to ensure holistic care in Sub-theme 2.5 within the continuum of care (cf. UN, 2008:8).

"*If there is a network of organisations then it is better, because if one service is finished the others can continue with other services*."

"*We are part of this network of NGOs* (Non-Government Organisations); *they refer to us and we refer to them. There is also rehabilitation centres*."

Elaborating on the utilisation of resources and networks to develop professionally, the participants described how trained and experienced staff contributes to the effective implementation of the continuum of care.

Sub-theme 3.3: Trained and experienced staff

Category 3.2.3 focused on the importance of making use of resources to build on expertise. The participants reported further that specialised training, experience and on-going professional development contribute to more effective services that address the complexities of a SUD (cf. Slabbert, 2015:551).

"*The staff have received training in the substance abuse sector*."

"*I think my experience in the field is adding value in assisting the client*."

"*I think we are all well qualified and the other thing is that we go to all these personal development meetings*."

Supervision to encouraged training and building experience will be expanded on in the category below.

Category 3.3.1: Supervision and mutual support

Hughes (2010:59-62) explains the focus of supervision in social work as building on knowledge and skills to ensure effective and quality services on the one hand. On the other hand, supervision is also a valuable platform for mutual support between social workers to provide an opportunity to reflect on practice and to search for creative solutions to address the unique needs of service users. Ncube and Noyoo (2017:5) go further and postulate that supervision requires more than a mere exchange of knowledge and theory, and that it must place the focus on the application of knowledge and skills to address the unique needs of client systems. The participants in this study acknowledged the importance of supervision, and described the value thereof as a contributing factor to effective service delivery. However, they noted that it is not always provided, and that it depends on the reported needs of social workers,

> "*We have a great team and also I have multi-disciplinary team. What I like is I can sit with my colleagues and I can balance ideas with them like if this is going to work or not*."
>
> "*We make it possible, because of the support we get from our fellow colleagues and also our resources and our networking relationships are good that we can go and ask for help if we struggle*."
>
> "*Also supervision is really important, but there can also be a lack of that depending on the demand the staff needs in terms of supervision*".

While the discussions in this theme highlights those factors that contribute to the effective implementation of the continuum of care, the participants also identified challenges that they experience. The next theme will present their viewpoints in this regard.

Theme 4: Challenges experienced when implementing the continuum of care for treatment of a substance use disorder

A lack of resources, which impacts negatively on social work services in South Africa, is continuously reported in local studies (Dlamini and Sewpaul, 2010:469; Alpaslan and Schenck, 2012:367-386). Dlamini and Sewpaul (2010:469) report that findings from a South African research study highlight "…intense dissatisfaction with the poor salaries, resources and working conditions, high caseloads and competing demands". In this study, the participants identified funding and manpower as two challenges that they experience in their efforts to implement the continuum of care. The two sub-themes below will present their viewpoints in this regard.

Sub-theme 4.1: Funding

The participants explained that a lack of funding hampers the effectiveness of services and their ability to address the individual needs of service users.

> "*The main challenge is of course lack of funding. We do not have sufficient funds to do everything that we need to do*."

> "*We try to work with the needs of the clients. Then that means we need to deliver services for which we do not get funds*."

Funder requirements and unsuccessful fundraising efforts were described, as presented in the categories below.

Category 4.1.2: Funder requirements

The Policy on the Funding of Non-Government Organisations for the Provision of Social Welfare and Community Development Services (Department of Social Development, 2015:3-4) refers to appropriate prioritisation and efficiency, and cost-effectiveness as core principles for the funding of social services. This entails that funds will be prioritised based

on community needs, while making use of resources where possible. However, the participants found that the requirements for funding influenced their ability to attend to individual needs when implementing the continuum of care. The following statements represent their viewpoints.

> "*As an organisation, we are supported and funded by the Department of Social Development and we are required to follow relevant TPAs* (Transfer Payment Agreements)*. So many times there is a huge influx of clients and we tend to focus more on reaching the numbers, and sometimes our approach is more a quantitative than qualitative one. We do not really get to spend that much time with a client; getting to know the client and actually render your best service, because of the numbers that you have to produce at the end of the day.*"
>
> "*TPAs have a huge impact; a negative like more than a positive impact when it comes to retaining clients in the programme.*"
>
> "*TPAs sometimes have an impact on our quality of work when it comes to care and continuum of care and you being in a position to track your client exactly.*"
>
> *"So in our meeting with that particular client, given the timeframe that we have, I am not sure how we can change anything. At the end of the day we want to really say that we are successful in bringing about change and it needs to be long-term whereas many times we tend to work for these targets, which is not consistent in terms of continuum of care*."

Category 4.1.2: Fundraising efforts

Efforts to find alternative funding opportunities were reported to be unsuccessful.

> "*We have tried fundraising, but you make R2000 or R5000 and that is weeks that we invest in that*."
>
> "*We had a group that sang in Kraaifontein and the profit was only R10. That is not worthwhile*."

Sub-them 4.2: Manpower

Similar to findings in other research studies and discussions in literature, a lack of manpower were identified as a challenge when attempting to provide effective long-term services (cf. Dlamini and Sewpaul, 2010:469; Chittleburgh, 2010:4).

> "*There is a need in our area and people need our help, but the organisation has only two social workers. So we cannot do our work efficiently*."

> "*Oh yes, the other challenge is staff turnover. When you have a new social worker or social auxiliary worker, it takes time to train them and for them to understand the continuum of care*."

According to White and Garner (2011:4) staff turnover within SUD treatment organisations may be based on two reasons. Firstly it can be due to better professional and financial opportunities in other social work fields, and secondly it could be due to dissatisfaction with working conditions and emotional distress within the SUD field. These authors alert to the fact that staff turnover can have a negative effect on service users. Within the continuum of care, it also means that service users will have to build new relationships with social workers, which could affect the recovery process negatively.

The above challenges could be seen as organisational challenges. The next two sub-themes will describe challenges related to service users.

Sub-theme 4.3: Service users' level of motivation to complete the process

The participants reported that they experience a challenge to motivate service users to commit to the complete recovery process through the following statements:

> "*The other challenge that we face is when our clients drop out of school. As you know, most of our clients are learners. So when they drop out of school it is difficult to access them, because we always see our clients in their school premises*. *The*

problem is that they are not motivated to come for help; they only saw the social worker because the school expected it."

"*My biggest concern is we can have patients in the treatment centre, but when they go out and the aftercare is not there, that is sometimes for me is the worst. NA is there, AA is there, SANCA is there. All the aftercare service groups are there, but the patients do not like to go to the groups, and that is when they relapse because they do not have guidance. They do not have the support and they do not understand why they relapse*."

These descriptions are in line with Groshkova's (2010:494) viewpoint that the internal motivation to enter treatment and to sustain recovery has a significant influence on the outcome of treatment options. The author also acknowledges this aspect as a challenge for practitioners and emphasises that a cognitive-behavioural approach could guide reluctant service users to become motivated to change.

The role of family support to encourage motivation to change, as well as specific challenges experienced by the person with a SUD were also noted as factors that could support services, or that could pose a challenge.

Category 4.3.1: Family members being unsupportive

The participants focused specifically on family of adolescents with a SUD. They reported that a lack of insight and understanding prevent parents from supporting the services. On the contrary, this becomes a challenge to deliver services.

"*Family members not being as supportive as they should be… I can only do as much services as I can, but the client needs a lot of family support and it makes a lot of difference in a client's life*."

"*We sometimes also struggle with parents, as they are not always involved and supportive*."

"*Some of the challenges we are getting are that our clients are becoming younger. Without the parents' support it is very challenging because we are working from our side, but then the school kicks that learner out of the school and say there is no progress*."

"*Parents do not know how to handle a situation where a person has been using drugs, and it is because of them not being educated and informed about substance abuse.*"

"*And also parents are in denial. They would come and say the client is not really addicted when we as social workers know that this client is definitely addicted, because we have done the assessment."*

"I think parents play a big role, because if a parent does not have insight and understanding of the problem they can just make the person continue using."

The mentioned challenge to involve families in the treatment process is supported by McDonagh and Reddy (2015:6), who postulate that, although family involvement is crucial for successful outcomes, it remains a difficult aspect in treatment of a SUD. These authors further accentuate the need to support the families to recover from the impact of the SUD on the family members, as well as to empower families to become a support system during the treatment process. Wand (2013:22-23) explored the benefits of family involvement in the treatment of a SUD. Working from a systems approach, the author asserts that the SUD will affect the family members individually, and the family as a whole. In an effort to motivate the person with the SUD to move towards recovery, the family's level of motivation to support the recovery process will therefore impact on the person with the SUD. This author further distinguishes between family therapy and family-involved therapy. The latter is aimed at educating family members about how the family relationships impact on the substance abuse and the recovery process. Through focusing on the relationships, family members are educated to become agents of change that guide the person with the SUD towards internal motivation to change.

Category 4.3.2: Challenges experienced by service users

The social worker participants explained that challenges experienced by the service users also impact on their efforts to implement the continuum of care. They noted a lack of transport and support of employers as key challenges.

> "*The other challenge is that, because we are one office that serves a really big area, it is a lot harder for clients to pitch up to us*."
>
> "*Clients, especially when it rains and its winter… they struggle to get here*."
>
> "*Another challenge is people who come from far must have transport money to come here and attend sessions*."
>
> "*Some cannot travel daily from work, because of time so they have to take unpaid holidays or leave*."

Another challenge was noted as the fact that services should adopt to the development needs of children/youth with a SUD, as portrayed by the following statement: "*The challenge is our clients are becoming younger and younger and we now need to look at our programme to be able to work with our clients that are 10 or 11 years old*". Rathore, Joshi and Pareek (2017:178) assert that SUDs among children is becoming a global problem. The above statement by the participant in this present study reflects the statistical indication that service users are becoming younger (SACENDU, 2018:2). Brotnow and Sinha (2014:70) assert that children and adolescents with a high risk to SUD should receive services that address personal and contextual risk factors in relation to their development stage; those aspects that make them particularly vulnerable should be identified and be the focus of services (cf. Winters et al., 2011:419). The authors continue to advise that services to children/youth should include family-focused therapy, school-based interventions and the incorporation of community resources that can address the vulnerabilities.

Sub-theme 4.4: Dual diagnosis

The United States of America's National Institute on Drug Abuse (NIDA, 2010:10) defines a dual diagnosis as "…the comorbidity of a drug use disorder and another mental illness". According to this institute (NIDA, 2010:2) there is a high prevalence of this comorbidity. However, barriers to address a dual diagnosis effectively include the fact that different professional services address a specific aspect of the diagnosis. For instance, social workers will focus on the SUD, while physicians will focus on the mental disorder. A lack of coordinated services impacts negatively on treatment. Additionally, traditional treatment of a SUD tend to be negative towards any use of medication, while these medications are needed to treat the mental disorder effectively. The descriptions below by the participating social workers correlate with the mentioned barriers.

> "*Another challenge is dual diagnoses, because it put a lot of strain on us. We need to refer the client, and it has a financial implication as well as that now the client goes through two treatment processes*."

> "*When a guy is diagnosed with depression or schizophrenia and they are here, and they do not really cope within the centre*. *And our services focus on the addiction side*… "

The final theme will present the suggestions regarding how social workers could be assisted to implement the continuum of care effectively.

Theme 5: A description of how social workers can be assisted in improving the utilisation of the continuum of care for treatment of a substance use disorder

The suggestions for practice provided by the participating social workers are in line with the discussions in the previous themes. The participants reported that training in the SUD field, networking and collaboration between role players, planning of services according to the continuum of care, and funding that would support the implementation of the continuum of care should receive attention.

Sub-theme 5.1: Training

As illustrated by the following comment, the participants suggested that ongoing training is essential to ensure that current issues and trends in the SUD field is understood (cf. Slabbert, 2015:551): "*Sometimes when social workers are in the field for so many years they tend to think that they know so much, but I think it is very important for us to get regular training. We need to be updated with what is going on, new policies and legislations, we need to know all that*". Ncube and Noyoo (2017:5) advice that knowledge should result in skills to address the needs of service users, which is in line with the preferred outcomes of the continuum of care (cf. Puddy and Williams, 2011:67). The participants confirmed these viewpoints and noted that they need training to become able to implement services according to the framework of the continuum of care: "*I think regular trainings are needed for social workers to improve their utilisation of the continuum of care*." While acknowledging the importance of supervision in Category 3.3.1, the participants highlighted the need for effective supervision to support training needs and professional development, which will be described in the category below.

Category 5.1.1: Supervision

The statements below point to a need for individual supervision when working in the SUD field:

> "*More efficient supervision and self-development, and time to better develop yourself*."
>
> "*But with supervision aiding us and giving us a platform where you can just debrief, and also when you are unclear about a certain client or patient… you can use that platform with a supervisor to give input*."

The latter statement highlighted the need for support to address the impact of working within the SUD field on the professional and personal well-being of the social worker. This participant emphasised the need to develop knowledge and understanding through group

discussions. Related to this viewpoint, Engelbrecht and Khosa (2017:4-5) propose that the social constructionist theory be used as a framework for supervision. According to this theory, knowledge and understanding of a SUD and the treatment thereof can be developed through the sharing of ideas about the topic. In this way, supervision can translate "knowledge, skills and principles from direct practice approaches into a supervision model" (Engelbrecht and Khosa, 2017:5). Similarly, the participants suggested that group supervision could be a valuable tool where mutual support, and the sharing of knowledge and practice tools, could assist them to implement the continuum of care effectively, and to the advantage of the service user (cf. Hughes, 2010:59-62; Ncube and Noyoo, 2017:5). The following utterance further describes this viewpoint: "*And also learning from each other how they* (colleagues) *actually do or apply the continuum of care and support the patient*."

In addition to the support provided within the organisation through supervision, networking and collaboration with other role players were identified as an aspect to further develop in practice.

Sub-theme 5.2: Networking and collaboration

Elaborating on the value of information networks (Category 3.2.4), the participants reported that more networks must be developed in an effort to implement the continuum of care effectively, while also ensuring holistic service delivery (cf. UN, 2008:8). In this regard, they reported as follows:

> "*Networking is also important. Social workers need to network so that they will know what other organisations that are in substance abuse filed are doing.*"
>
> "*We need more of those networks. The state can be of assistance and try to establish more networks in the communities*."

Collaboration was identified as an important aspect to ensure that different role players work together to address the needs of the service user within the continuum of care. This will be expanded on in the next category.

Category 5.2.1: Collaboration as an important aspect

Collaboration between different service providers ensures that service users will have access to all services they may require, regardless of which service provider they connect with (Kates, Mazowita, Lemire, Jayabarathan, and Bland, 2011:96). The participating social workers identified community-based and organisational collaboration as key focus areas. They also noted the importance of collaborating with family members to serve as support to the person with SUD. In terms of community-based collaboration, the participants suggested the following:

> "*I think it is important that there must be community participation and collaboration, because you cannot fight this cause as a one man band*."
>
> "*So if a client is homeless chances are high that they will think: 'I will continue what I am doing, because my environment is not promoting my need for change'. So before we tackle the issue of substance abuse with a homeless person, we need to ensure that person has an environment that will facilitate the process of change*."
>
> "*All stakeholders, parents, community members, and community leaders need to come along side you and to impact*… (On social issues that impact on service delivery to persons with a substance abuse disorder); *high unemployment, high school dropout rate… very volatile, so you cannot do it on your own*."

In terms of organisational collaboration, they made the following suggestions:

> "*I think the more organisations that are involved, the higher chance a person can have to sustained recovery*."

"*If the person only has access to one service, you have to consider, is the aftercare programme relevant for that person*?"

The participants' viewpoints that networking and collaboration could support services that provide a broader range of services to address individual needs of service users (cf. Puddy and Wilkins, 2011:67) are confirmed by Kelly and Roche (2014:26-28). These authors postulate that change is more likely to occur when a variety of stakeholders work together to achieve a common goal. They, however, advise that networks and collaborative work require mutual trust and respect, and a clear framework regarding how the collaboration will be implemented.

The participating social workers reflected on their previous descriptions of family involvement (see Categories 2.3.2 and 4.3.1), and suggested that networks and collaboration with families should be formed to ensure effective implementation of the different components of the continuum of care.

"*It's all these people that the client fundamentally has in in his or her life, and I think they can make a huge difference in the continuum of care and also that they will support and maintain the sobriety*."

"*We need to form networks with families so that they can support what we do and help the addicted person to go through the whole process*."

This recommendation is supported by literature that emphasises the importance to involve family members in services so that they become partners in the effort to support the person with a SUD towards sobriety (cf. Wand, 2013:22-23; McDonagh and Reddy, 2015:18; Copello et al., 2010:65).

The next suggestion for practice focuses on the planning of services according to the continuum of care.

Sub-theme 5.3: Planning according to the continuum of care

The participants identified a needs-based approach and the coordination of services as the key components of planning.

Category 5.3.1: Needs-based approach

The viewpoints of the participants point to the importance of planning according to the needs of the individual, as well as on the needs within a community.

> "*If you have a development care programme or care plan for a particular person, then you know you have continued services*."

> "*The best way to do that is you have meetings with your community and find out what worries them at that moment. If there is a need for substance abuse outpatient or inpatient services, coordinate with the current resources that is in the area. And if there is lacking, try and get those resources available to the community or to that area specifically*."

The Framework for Social Welfare Services (Department of Social Development, 2013b:14) refers to the right's-based approach to social welfare, which emphasises the importance of services that are planned according to the needs of service users. This approach supports the practice of social justice, and the principle of respect for the viewpoint and expressed needs of service users. Services from a right's based approach also contribute to the empowering of people so that they can reach their full potential (Department of Social Development, 2013b:12). In terms of community needs, services should be context-related and based on the specific needs of a community (Department of Social Development, 2013:20). Garthwait (2012:14) agrees and notes that the

implementation of the continuum of care in a specific community should be based on the needs of the community as a whole, as well as on the needs of individual service users. This then requires that these needs must be identified to plan services for each component on the continuum of care.

Category 5.3.2: Coordinating services by more than one organisation

Garthwait (2012:14) describes the continuum of care as a "spectrum of services". Similar to the guidelines proposed in the Framework for Social Welfare Services (Department of Social Development, 2013b:27-29) and the Prevention of and Treatment for Substance Abuse Act (South Africa, 2008), the author advises that such services should be integrated to meet all the recovery needs throughout the recovery process. The statements below show the participants' agreement with the above description.

> "*I don't think its necessarily one organisation that can deliver all the services*."
>
> "*Different organisations can help to make services accessible to people*."
>
> "*More than one organisation is needed, because when clients or patients normally show up they present more problems and substance use is just one of them.*"
>
> "*The need for more organisations is that if one service effort collapses, there will remain others to sustain the client*."

These statements emphasise the fact that different service providers can assist with providing a holistic care options that are accessible. In support of the participants' suggestions above, Garthwait (2012:14) notes that coordination of services aimed at the treatment of a SUD prevents duplication of services, which is cost-effective. The participants further suggested that services should be streamlined in that service providers know what other services entail, and that referrals can be done effectively, while all the service providers are working together to ensure an integrated and holistic treatment plan.

"*I think when social workers are more informed about the programme of a rehabilitation centre. Then their motivation for a patient to come in must be better, because we have guys here who come all the way from their hometown and when they come here and I say to them listen our programme is 12 weeks and they will be like, ah no I just want to come for six weeks*."

"*They* (referring social workers) *must give our list of stuff that the patient must bring with to the patient and his family to prepare them*."

"*Clients must be mentally and physically prepared* (for inpatient treatment and aftercare)."

Kelly and Roche (2014:26-28) concur that collaboration assist stakeholders to work together towards a common goal. These authors suggest that collaboration should involve careful planning. The participants in this study supported this line of thought, and suggested that coordination and the monitoring thereof should be planned from a central place. The statements below attest to their viewpoints in this regard.

"*I think there must be an organisation that can follow up if the services are being rendered to that particular person*."

"*But then how are we going to monitor services? So there must be someone that can monitor those services* (referring to different services to address different components of the continuum of care)."

"*There must be an organisation to see if there is continuation of service delivering*."

The last sub-theme relates to Sub-theme 4.1 and reports on funding that could support the implementation of the continuum of care effectively.

Sub-theme 5.4: Funding aimed at supporting the implementation of the continuum of care

The long-term nature of treatment of a SUD (cf. APA, 2013:483) was acknowledged by the statements below. The participants reported that poverty in communities, and therefore that people cannot pay for sustainable services, must be acknowledged.

> "*Funding is needed to render a proper service*."
>
> "*Our community struggles financially and they do not always have that money to pay for sessions and unemployment is a huge thing. So how do we then continue with a client*?"
>
> "*We may say the first four sessions are free, but given that we are an NGO we should keep ourselves afloat and money is needed to render a service to people who cannot afford it*".

In addition to funding, the availability of resources were identified as another aspect that could support the implementation of the continuum of care.

Category 5.4.1: Resources

The participating social workers voiced a concern about the exposure to triggers in the community where persons are functioning while attempting to recover from a SUD. In support of this concern, Haase (2010: 93) refers to the availability of substances and the acceptability of substance abuse on a macro level that can negatively affect the person's response to treatment. The participants recommended that access to inpatient treatment options, as well as the establishment of halfway houses should receive attention.

> "*The other thing is we need safe houses for our clients. A lot of them are on the streets and are homeless and a lot of rehabilitation centres cannot take them as they need to know where they are going after rehabilitation*."

"*And clients cannot wait and sometimes they come and some will complete the programme, while some drop out of our outpatient programme, because they cannot cope with coming for sessions and just going home. So we need more resources in terms of rehabilitation centres*."

"*When we refer clients to rehabilitation centres, especially if it is a state or government facility, they go on a very long waiting list. So I think one of the things that we need is more rehabilitation centres and places that we can send people for inpatient treatmen*t."

Halfway houses, as a transition from inpatient treatment to community-based aftercare, are provided for in Chapter 5 of the Prevention of and Treatment for Substance Abuse Act (South Africa, 2008). The establishment of halfway houses should, according to the participants, be considered an important resource to support the implementation of the continuum of care. In support of this viewpoint, Chandrika (2015:57-58) and Garthwait (2012:14) assert that the continuum of care can only be implemented effectively if the needed resources are developed to address a variety of individual needs. The authors link the continuum of care with social development in that resources should be aimed at providing individuals and communities with service options that will enhance social functioning and independent functioning.

Again focusing on the long-term nature of treatment of a SUD, the participants' final suggestion is that aftercare should receive priority attention.

Category 5.4.2: Addressing aftercare

Findings of a studies by Van der Westhuizen (2010:8), Chetty (2011:59-60) and Swanepoel et al. (2016:431) identify a lack of focus on aftercare as a part of treatment, and highlight the need for the integration of all the service options on the continuum of care, as well as all the role players that affect the treatment process. Wand (2013:23)

identify aftercare needs as ongoing social work support that focuses on: the reintegration in the community; life skills and dealing with triggers; participation in healthy life style options in the community; participation in support groups; the use of a sponsor/peer support; and education of significant others regarding the recovery process. The participants in this study suggested the following regarding a specific focus on aftercare.

> "*In terms of aftercare, the state should provide more aftercare services*."
>
> "*If aftercare can get more attention, the person can continue with treatment and re-adjust in the community better*."
>
> "*They must be in an aftercare service. They must also have other groups or other support systems who must help the person afterwards*."

3.4 CONCLUSION

This chapter presented the viewpoints of social workers in the treatment of a SUD field regarding the implementation of the continuum of care. The participants described their views on what the term 'continuum of care' means, they explained the nature of their services, reflected on factors that promote the implementation of the continuum of care, and they discussed challenges that they experience when attempting to implement the continuum of care. In conclusion, the participants identified aspects that should receive further attention to improve the implementation of the continuum of care. The findings were compared to relevant literature.

The next chapter will present the viewpoints of service users regarding how they experience services to address their SUD.

CHAPTER 4

RESEARCH FINDINGS: THE EXPERIENCES AND PERCEPTIONS OF SERVICE USERS

4.1 INTRODUCTION

The research goal for this study is to develop an understanding of the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD. The previous chapter presented the findings related to the service providers' experiences and perceptions of the research topic. This chapter is dedicated to describing the experiences and perceptions of service providers. For the purpose of this study, a service user is seen as a person older than 18 years, who is dependent on chemical substances, and who is receiving treatment for a SUD from a treatment facility.

The discussion in this chapter will firstly focus on a description of the biographic profile of the participating service users, and secondly on the research findings, which will be described in terms of themes, sub-themes and categories and complimented with a literature control.

4.2 BIOGRAPHIC INFORMATION OF THE PARTICIPATING SERVICE USERS

The participants were sampled from a population of persons who have been receiving services to treat a SUD in the Western Cape. The purposive sampling technique that is viewed as typical of the non-probability sampling method was utilised so as to ensure that the sample is best equipped to represent the viewpoints of the population (cf. Rubin and Babbie, 2010:135; Bless et al., 2013:103-105).

The contextual nature of this study requires that the findings be understood in terms of the biographic profile of the service users who participated, which is illustrated in the table below.

Table 5: Biographical description

Participant	Gender	Age	Substance(s) of choice	Treatment opportunity	Nature of treatment
1	Male	24	Methcathinone and Methamphetamine	2	Residential
2	Male	54	Alcohol	1	Residential
3	Male	35	Methamphetamine and Mandrax	1	Residential
4	Male	18	Marijuana and Mandrax	1	Residential
5	Male	20	Marijuana and Methamphetamine	2	Residential
6	Male	18	Marijuana	1	Residential
7	Male	33	Marijuana	1	Outpatient
8	Male	47	Alcohol	2	Outpatient
9	Male	47	Alcohol	2	Outpatient
10	Male	38	Methamphetamine and Mandrax	2	Outpatient

Ten male service users participated in this study. Data saturation was identified after two focus group interviews. A third focus group interview was conducted to ensure that data saturation did occur. Six of the participants were in the young adult life stage. Benson and Edler (2011:1647) describe this life stage as a stage where the young adult's identity formation is based on interactions with significant others, as well as their contexts or macro environment. The norms and expectations that are typical of these interactions contribute to "internalised mental maps". The authors refer to this identity formation as subjective in nature, meaning that the social influence of interactions on the identity of a young adult is powerful. Four participants were in the middle adulthood stage of development. These participants' life stage is characterised by securing careers and economic stability, developing and maintaining a healthy self-image and maintaining health (Feldman, 2017:290). Based on the characteristics of the above life stages, the researcher concluded that both these life stages are affected by a SUD (cf. WHO, 2014:4; Bezuidenhout, 2008:138-140).

Substances used by the participants were reported to be methamphetamine, methcathinone, mandrax, marijuana and alcohol. NIDA (2014:15) explains that a SUD affects the functioning of the cerebral cortex, which implies that the person with a SUD's ability to think, plan, solve problems, and make decision is impaired. This impairment affects the person's social, emotional, cognitive and spiritual development. In terms of behaviour, the limbic system is activated by the use of substances, which affects emotions and motivations behind behaviour. The mentioned impact of the substance on a person must be taken into consideration when designing a treatment plan (NIDA, 2014:19). The findings in this study should therefore be understood in terms of the fact that the participants' development have been influenced by the SUD. In addition, five participants were able to reflect on previous treatment, as they were in treatment for a second time (cf. Malone et al., 2016:497-499). Their experiences and viewpoints regarding the research topic will be presented in the next section.

4.3 THE EXPERIENCES AND PERCEPTIONS OF THE SERVICE USERS REGARDING THE UTILISATION OF THE CONTINUUM OF CARE FOR TREATMENT OF A SUBSTANCE USE DISORDER

Data from the service users were obtained through focus group interviews. These focus group discussions were audio recorded and field notes were made to document non-verbal data. The transcripts of the focus groups were analysed by means of Tesch's (1990) eight steps for qualitative data analysis (Creswell, 2014:218) by the researcher and an independent coder. The themes, sub-themes and categories, together with a literature control, will be presented below. Table 6 summarises the findings.

Table 6: Themes, sub-themes and categories

Themes	Sub-themes	Categories
Theme 1: Perceptions and experiences of receiving services related to the continuum of care	Sub-theme 1.1: Descriptions of exposure to preventative services	Category 1.1.1: Influences that contributed to substance abuse
		Category 1.2.1: Non-formal early interventions

	Sub-theme 1.2: Descriptions of exposure to early intervention services	Category 1.2.2: Formal early interventions
		Category 1.2.3: Motivation to seek treatment
	Sub-theme 1.3: Descriptions of exposure to formal treatment services	Category 3.3.1 Aspects that worked well
		Category 3.3.2: Aspects that did not work well
	Sub-theme 1.4: Descriptions of exposure to aftercare and family reunification services	Category 1.4.1: Descriptions of previous and previous experiences with aftercare
		Category 1.4.2: Descriptions of a need for aftercare
		Category 1.4.3: Role of the family in recovery
		Category 1.4.4: Dealing with a lack of trust in the community
Theme 2: Participants' descriptions of what they perceive to be the role of social workers in the treatment of substance dependency	Sub-theme 2.1: Preparation for treatment and encouraging internal motivation	Category 2.1.1: Referral
	Sub-theme 2.2: Guidance and support	
	Sub-theme 2.3: Continuation of services	Category 2.3.1: Contact to same social worker who made referral
		Category 2.3.2: Aftercare as a specialisation
	Sub-theme 2.4: Trustful and supportive relationship	Category 2.4.1: Trust
		Category 2.4.2: Support and availability
Theme 3: Descriptions regarding the focus areas in a recovery process	Sub-theme 3.1: Changes experienced since receiving treatment	Category 3.1.1: *Sobriety, spirituality and emotional and social well-being*
		Category 3.1.2: Interpersonal relationships
	Sub-theme 3.2: Specific recovery needs	Category 3.2.1: Sponsors and support groups
		Category 3.2.2: Obtaining social support
		Category 3.2.3: Dealing with emotions

The findings will be discussed in terms of verbatim responses and existing literature on the topic.

Theme 1: Perceptions and experiences of receiving services related to the continuum of care

It must be taken into consideration that the service user participants had no prior knowledge of the theoretical framework that informed this study. For this reason, the interview guide was designed to ask specific questions related to their experiences and perceptions regarding services related to the continuum of care. This theme portrays these experiences and perceptions, and will be presented within the theoretical framework (cf. Department of Social Development, 2013b:27-29). The sub-themes will focus on preventative services, early intervention, treatment interventions, and reunification and aftercare.

Sub-theme 1.1: Descriptions of exposure to preventative services

The Framework for Social Welfare Services (Department of Social Development, 2013b:27-29) describes prevention as services that are aimed at the development needs of individuals, groups and communities. Preventative services focus on areas that could put people at risk, and are aimed at preventing development needs from developing into challenges and risks. The participants reported that they were exposed to preventative services in schools and at church.

> "*I can mention maybe the church, the church leader and the people in the church*."

> "*At school I used dagga and they sent me to a church where I must go and get clean. If I cannot get clean then I will not go to school and I got clean, and went back to school*."

However, the participants reflected that knowledge obtained through preventative services did not prevent them from using and abusing substances: "*I knew about drugs being bad for you, but I just told myself that I will never end up in a place like that* (referring to an inpatient treatment centre). *So I did not worry about it*." Community organisations and the school have been identified as valuable resources for the prevention of substance

use and abuse. Although not confirmed by the participants in this study, the family and peers could also support efforts to prevent substance use and abuse (National Crime Prevention Centre, 2009:1).

Other participants reported that they were not exposed to preventative services, as illustrated by the following statement: "*No one told me about drugs and their effects*." They explained that they received information about the effects of substance abuse for the first time when they entered treatment: "*I ended up at my first treatment centre. That is when I started getting knowledge on everything*."

The participating service users included the reasons behind their substance abuse when reflecting on their experiences and perceptions of preventative services. As these reasons contributed to putting them at risk (cf. Department of Social Development, 2013b:27-29), the next category will be dedicated to the contributing factors to substance abuse.

Category 1.1.1: Influences that contributed to substance abuse

The availability of substances and the acceptability of substance abuse were identified as environmental influences that contributed to the participants' substance use and abuse.

> "*I was exposed to the environment where it was actually normal to use drugs*."
>
> "*I saw that* (substance abuse) *on a daily basis until I started using*."
>
> "*I come out of this area that is infested with drugs. So that is like a norm. So I got into this thing at an early age. I have been doing this for 18 years. There was no support structure, it was like it is a normal thing where I come from*."
>
> "*Not in this society I grew up in. It is not a big deal if a child is caught drinking.*"

Elaborating on the acceptability of substance use, the participants referred to the role of the media through the following comments:

> "*You can see a boss with his briefcase, daily driving a Mercedes Benz while also abusing alcohol. He can even go into the office and drink and nobody knows*."

> "*They* (media) *do not get enough publicity on alcohol as they do on drugs in newspapers*."

> "*Drinking for me was a cool thing and I did not have any problems as it was a good thing to me. On television it was just advertising; there was nothing bad that was said about it*."

Here the participants did identify family and peers as contributing factors (cf. National Crime Prevention Centre, 2009:1). The following utterances describe the influence of peers:

> "*I looked at my friends and I wanted to be cool like them. They smoke, so it is cool to smoke*."

> "*My mother would tell me don`t do this and that, but I would not listen and just continued doing that stuff to be in with my friends*."

With regards to their families, a lack of parental availability and guidance was reported a contributing factor to substance use and abuse.

> "*I did not have a father. So he was not there for me*."

> "*I did feel lonely because I did not have a father. So I started using drugs to fill that emptiness inside me*."

> "*I grew up in a family with no parents. So I started drinking at an early age and my siblings could not say anything as I was the big brother and protector*."

> "*My parents were not there to tell me what to do so I did what I wanted on my own*."

The above statements also highlight emotions that contributed to the substance use and abuse. In addition, a participant explained that the use of substances helped him to deal with anger: "*I got angry and I started smoking so that the stress will be reduced*."

High risk situations that should be the focus of prevention of substance use and abuse include community disorganisation, academic challenges, parental involvement and attitudes, and association with negative peer groups (National Crime Prevention Centre, 2009:1). In this study, the participants also included images of substance abuse portrayed in the media and a lack of life skills as contributing factors. In terms of the role of the media, the Western Cape Government's Alcohol-Related Harms Reduction Policy Green Paper (Western Cape Government, 2016:10) acknowledges the role that the media can play in either preventing or in encouraging substance use and abuse. The participants also described how contributing factors remained triggers that affect the recovery process, highlighting that access to money to buy substances, peer pressure and emotions of frustration continue to challenge their efforts to recover from the SUD. The statements that follow attest to the aspects they identified:

> "*Some of the triggers are when I have money at the end of month, I tend to drink a lot and also my friends when I am with them. Even if I do not have money they always give me something to drink. These two are the dangerous triggers for me*."
>
> "*It is not an easy road as there are a lot of triggers like money and the people around me*."
>
> "*Some people frustrate me and I always want to take something to ease my mind*."

Sub-theme 1.2: Descriptions of exposure to early intervention services

Early intervention is the service on the continuum of care that aims to limit the impact of substance use, and to prevent substance use to escalate to substance abuse and dependency (cf. Department of Social Development, 2013b:27-29). The participants

identified non-formal and formal early interventions that they were exposed to. They also reflected on how these interventions impacted on their motivation to enter treatment.

Category 1.2.1: Non-formal early interventions

The participating service users identified family and peers as persons who intervened during the early onset of their SUD.

> "*When I actually needed help and I asked my aunt to actually talk to my mom for me*."
>
> "*My family, but my close friends also… they tried to encourage me to stop*."

Copello et al. (2010:65) confirms the value of family involvement to prevent and address substance use and abuse. However, for family involvement to have a positive outcome, strong and positive family relationships, as well as sanctions against the use and abuse of substances are needed (cf. National Crime Prevention Centre, 2009:1).

Category 1.2.2: Formal early interventions

When asked to reflect on early intervention, the participants mainly focused on the non-formal interventions described in the previous category. When probed about formal early interventions, a participant reported that he was not aware of such a service: "*None. There are no services out there for our kind of community. Let`s just be honest*." Another participant recalled that he visited support groups at a child and youth care facility, but mentioned that it did not have a positive outcome. "*There was a time I was at a care centre. I underwent some counselling and people were talking about it in support groups. This did not help, as I had many friends using drugs and it had become a culture between us*."

Latchford (2010:3) explains that early intervention is not only educational in nature. The person at risk of moving towards a SUD must obtain knowledge on the one hand, and on the other hand he/she must be guided and supported to implement the knowledge. This, then, means that the person requires skills to move away from a negative lifestyle, to address challenges and to make a choice to cease the use of substances. The author, however, notes that some service users might deliberately choose not to accept this guidance and support. In this regard, the participants in this study reflected on their motivations to enter the treatment process. The category below will elaborate on this.

Category 1.2.3: Motivation to seek treatment

Some participants' descriptions of their motivation to seek treatment point to an internal motivation for change. The statements below attest to this:

> "*Can I start by saying that the decision was mine to get rid of this abuse of alcohol*?"
>
> "*I am going to an inpatient facility in October, so I am working on that* (preparing self for treatment by participating in outpatient programme)."
>
> "*I was in prison for one and half months and I stayed clean there. When I came out I went to work. But when I was in prison I was not using, but when I came out I started using again*. *I started to worry about my situation and got help*."
>
> "*But now I got another job where I am working on my own. I realised that I cannot cope without the drugs and I approached the organisation to help me cope*."
>
> "*I want to change and it helps, as I listen to the social worker and take her advice. But previously it did not help as I did not want to be here*."
>
> "*I am trying to implement everything that they are teaching me, like the triggers so I have to be careful of them. Because I want to have a different kind of life*."

A participant explained that he entered treatment, because of external pressures: "*So at work when they realised my problem the deal was I go to X* (the service provider) *or I lose*

my job." Latchford (2010:20) explains that a movement from external to internal motivation to enter treatment is a normal part of the process of change. The service provider should therefore provide the service user with a space where he/she can contemplate both external and internal motivations. While external motivation can be viewed as a pressure to change, the person moves towards an understanding that the external pressure is in line with his/her own need. The participants supported this viewpoint, and explained that they experienced both external and internal levels of motivation to enter treatment.

> "*I sometimes have temptations, but the thought of my wife, children and work keeps me going and I do not want to mess it up*."

> "*I also tried to stop for the sake of family, and I also then told myself that I should do this for myself, as I have used for a long time and need to stop*."

Sub-theme 1.3: Descriptions of exposure to formal treatment services

Treatment, according to the continuum of care, refers to statutory/residential/alternative care, which entails "…protection services that endeavour to safeguard the well-being of service beneficiaries" (Department of Social Development, 2013b:27-29). The participants discussed formal treatment in terms of what was working well and what did not work well.

Category 1.3.1 Aspects that worked well

The participants accentuated that detoxification assisted them to engage with the treatment process more effectively.

> "*Alcohol plays with our minds and leave us confused and wondering which choices to make. The clear picture of what happens when drunk and when sober makes you think twice about the choices you make*."

> "*The dryness helps a lot, I have been here for two months*."

"*I`m already dried out and I rather stay dry than smoke and have a feeling to smoke again, because I am already dry. My spirit is fresh*."

"*I don`t even get that need to smoke that I had earlier. That demon is out. Now I can focus on my new life*."

The statements above are supported by Proctor and Herschman (2014:3), who view detoxification as a component of formal treatment. These authors note a period of at least five days that should introduce detoxification before other treatment activities commence. Martin (2008:2) also highlights the need for neurological reparation and nutrition, as the first part of treatment interventions. The participants concluded that detoxification assisted them to move towards internal motivation to actively participate in the treatment of their SUD:

"*When I came to this place, I did not think that this place will help me and I had a negative attitude towards this place, because they were telling us what to do. But then I dried out and became able to think. I then I realised that it is not what they want; it is what I want in life and I had to learn a lot of stuff here*."

"*Things were overpowering, but now l left everything* (referring to substances) *and have been clean for three months. I do not know what to say, because l was in this situation before, but now it is different*."

"*Once I felt clean of the stuff* (referring to substances) *I learned how to respect myself and how to communicate with people and then I could start talking to the social worker about my life*."

The participants reported that knowledge about the SUD, spiritual guidance and life skills are aspects that supported their recovery thus far.

"*I have learnt a lot about my abuse. And what it does to me, as well as how recovery works*."

"*I learn a lot on how to create an environment that will allow me not to use again and live by the rules. Something we never did when we were using.*"

"*I learned about doing stuff in a different way that I used to before.*"

"*They* (service provider) *help us in things we did not realise when we were outside. Like bible study, discipline and how to get self-respect and to respect others*."

"*They* (service provider) *give me advice and help me with how to make decisions and solve problems in my life*."

Spiritual growth was identified as an aspect that supported their recovery, which is linked to emotional and social well-being.

"*Spiritually is uplifting me*."

"*The Pastor helps us to show our emotions that we never showed before*."

"*I let the Lord into my life and it helps me doing stuff in a different way*."

"*I have learned that life* (of substance abuse) *is not just about me. It is about everyone and God, and we need to respect one another and not to give up*."

The description of the value of life skills and spiritual well-being is supported by literature. Van der Westhuizen (2010:342) identified a need to develop coping skills to deal with cravings, and the development of life skills such as assertiveness, decision-making and problem-solving skills as a recovery need among persons with a SUD. This author also accentuates the importance of spiritual support as a part of the treatment process (Van der Westhuizen, 2010:151). Similarly, spiritual well-being was identified as an indicator for a successful outcome of treatment by Chen (2006:306). Explaining the reason behind the value of spiritual well-being, Lessa and Scanlon (2006:199) concur that it contributes to a sense of purpose and a related purposeful lifestyle.

Category 1.3.2: Aspects that did not work well

The participants who had previous exposure to treatment reflected on what aspects did not work well. A participant noted that the service was not person-centred: "*The previous centre, umm they really did not care. They were more focused on their own pocket than helping the patients. So by the time I left the centre I was already using again*." Proctor and Herschman (2014:8) reports that outcomes of services are dependent on the extent to which it addresses the individual needs of the service users, including contextual challenges. A participant referred to group sessions that provided the service users with information, while there was a lack of focus on the internalisation of the information. "*In a day we had four classes. We got a lot of information, but later I could not remember what it was about*."

While the participants reported how internal motivation had a positive effect on their willingness to participate in the treatment, they also reflected on past experiences of not being motivated. The statements below align with the participants' descriptions of their level of motivation that moved from external to internal when contemplating to participate in treatment in Category 1.2.3 above (cf. Latchford, 2010:20).

> "*At that time I do not think I was ready yet to receive knowledge*."
>
> "*I was not serious about the recovery*."
>
> "*Honestly speaking, it was because my mom wanted me there and a part of me wanted to be there, but a larger part of me just did not care about it*."
>
> "*I just wanted to get through it and finish*."
>
> "*The first time my company sent me here was 10 years ago and that was not helpful, but I just did it to keep my job as the company said. I basically manipulated the whole setup.*"
>
> "*I received help before, but it was not my decision, I was forced to do it by the company or I get fired. I did not decide to stop alcohol abuse. This time is a different story, because I came because I saw that I need help*."

Sub-theme 1.4: Descriptions of exposure to aftercare and family reunification services

According to the continuum of care, aftercare is aimed at the reintegration into families and communities after formal treatment, and also to build resilience and develop skills to function optimally (Department of Social Development, 2013b:27-29). The service user participants described their previous and present experiences with aftercare, reported a need for aftercare, emphasised the need for family support, and described challenges they experienced with reintegration into the community.

Category 1.4.1: Descriptions of previous and present experiences with aftercare

The participants referred to using a sponsor and visiting support groups when reflecting on their previous experiences with aftercare.

> "*Well, I had a sponsor that I could speak to if I felt like using again*."
>
> "*I would go to meetings with support groups like Narcotics Anonymous. So it helped me stay sober*."

It should be noted that some of the participants in this study were busy with the aftercare component of the continuum of care. Reflecting on present experiences and perceptions of aftercare, the participants focused on their own efforts to recover from their SUD. Firstly, they referred to life style changes, which included time management and participation in recreation activities (cf. Van der Westhuizen, 2010:151), as described below:

> "*I am actually planning what I am going to do to keep myself busy from actually using the substance*."
>
> "*I am working and also spending more time at work and that is helping me, because I am totally away from everything and concentrating on my work, so everything is a big success*."

"*I am focused on my day to day activities; especially when I am working a normal day shift now, I go straight home and do my chores*."

"*Mainly I am reading more*."

"*And I am also making music*."

Secondly, the participants reported that repairing the damage caused by the substance dependency was an important aspect of aftercare and their efforts to reintegrate into their families and society (cf. Van der Westhuizen, 2010:154).

"*Trying to change my life and be a better person, because in the past I did hurt a lot of people*."

"*And I can get home and spend time with my wife unlike going out to the casino*."

Developing and maintaining healthy lifestyles that will contribute to repairing the damage cause by the SUD is emphasised by the Department of Social Development's (2010:6) Reintegration and Aftercare Model. While exploring their experiences and perceptions of aftercare, the participants accentuated a need for aftercare, which will be discussed next.

Category 1.4.2: Descriptions of a need for aftercare

The participants reflected on a previous lack of aftercare, reported a need to include aftercare as part of their treatment plan, and noted that social workers are challenged to provide aftercare services.

"*After my first treatment centre I did not have aftercare, but I am hoping to actually get an aftercare programme*."

"*I would say when I go home I would like to go and attend NA classes and be more intimate with the church*."

"*They* (social workers) *are not able to follow up because there are so many people. Their role in Cape Town is not really effective at the moment, because of the level of drug abuse*."

"*They* (social work service providers) *are under staffed and if they were fully capacitated they would be able to do proper follow-ups*."

"*Most people drop out half way not knowing they are actually doing harm to themselves and they need follow ups and help to realise their mistakes. But the social workers cannot stay in contact with everyone*."

The statements above relate to research findings that identified a lack of manpower as a challenge to effective service delivery (cf. Dlamini and Sewpaul, 2010:469; Chittleburgh, 2010:4).

Category 1.4.3: Role of the family in recovery

This category shows how family support is needed at the different levels of care. The participants discussed how family support was part of informal intervention that motivated their willingness to participate in treatment in Category 1.2.1 (cf. Copello et al., 2010:65; National Crime Prevention Centre, 2009:1). Discussing aftercare, a participant reported that a lack of spousal support resulted in him not participating in aftercare previously: "*I did not do aftercare the previous time, because there were problems with my wife*." Another participant expressed a hope that he will have the support from his spouse to continue with recovery, although admitting that he relapsed despite her support in the past: "*And by getting support from my wife and family who supported me in the past and also not to come back to this facility to get treatment for my abuse I hope that I can start with a new and better life*." It should be noted that the family cannot be responsible for the recovery, and that the individual must move towards an internal motivation to move into recovery (see categories 1.2.3, 1.3.1 and 1.3.2).

Category 1.4.4: Dealing with a lack of trust in the community

Fisher and Harrison (2013:37) explains that stigmatisation of a SUD also affects the person after he/she moves into recovery. This can seriously affect their commitment to and participation in aftercare services. The participants reported that they experienced stigmatisation in the community, and that they relate this with a lack of trust.

> "*I was attacked in my car and I went to the police as my phone was stolen and the police thought I was still on drugs and it was disturbing to me and they tested me and cleared me. I was clean*."

> "*Stigma associated with substance abuse should be removed. There are some things that needs talking and sharing and talking helps a lot. It is not easy to be judged. So it is easier to continue with your sober life if people trust you, or at least if they do not judge you; if they believe that you can change*."

While describing their experiences and perceptions of treatment options, the participants highlighted their expectations of social workers, which will be presented in the next theme.

Theme 2: Participants' descriptions of what they perceive to be the role of social workers in the treatment of substance dependency

Galvani (2015:5) notes that evidence from practice shows a need for social workers to be active role players in the SUD field. The discussion in this theme will portray the participants' experiences regarding contact with social workers, as well as their perceptions of the roles of the social worker. They reported that they would like social workers to prepare them for treatment and to encourage them to become motivated, that social workers provide them with guidance and support on a continuous basis and that their relationships with social workers would be based on trust. The sub-themes below can serve as a guide for such services.

Sub-theme 2.1: Preparation for treatment and encouraging internal motivation

Galvani (2015:7) postulates that the role of social workers is, among others, to motivate service users to enter treatment. Similarly, Maluleke (2013:75) concurs that motivation of service users does not only focus on entering the treatment process, but also to continue with the process into aftercare. These viewpoints are supported by the findings of this study. The participants expressed the value of motivation by social workers, and a need to be motivated and encouraged throughout the treatment process. The utterances below describe their viewpoints.

> "*Social workers are there for motivation*."
>
> "*Also, I met up with a social worker who guided me through this whole process of getting rid of substance abuse*."
>
> "*We had long sessions for about a month or two where she* (social worker) *guided me in how to sustain without abusing substances. Eventually I was admitted at this place* (inpatient treatment), *and started with the 12 steps, and now I can admit that I need help*."

A participant explained that part of motivation requires that the social worker guides the service user to understand the process of change: "*And talk you through the programme and to make it more understandable*." The category below is dedicated to the expressed need of the participants that social workers will refer them to the relevant resources.

Category 2.1.1: Referral

The participants expressed a need that social workers refer them, as well as their families, to relevant resources.

> "*Their role is to find a good facility for a patient*."

"*If you see someone and you want to help them and their family does not know how to go about the whole system of getting their son or daughter into a facility or institution; that is where the social worker comes in*."

"*The role of a social worker is to find a place that can support the person, and also his family who do not know what to do*."

The description of the social worker's role to make referrals is in line with the continuum of care, which should ensure access to the different care options (cf. Department of Social Development. 2013b:29). Garthwait (2012:14) explains that referrals can only be made if resources are available and accessible. In this study, the participating service users particularly referred to a need that social workers should ensure that services are available and accessible.

"*Assistance to get treatment, because a lot of people do not have money*."

"*The need to help people to get into places, but there are always a waiting time or it is too expensive*."

"*It was difficult for me to get into an inpatient programme. I thought the social workers will be able to help, but they also struggled*."

The latter statement shows an experience of social workers who were not able to assist the service user to address his need. Swanepoel et al. (2016:431) also identified a challenge for social workers to do referrals to community-based resources, which then affects the treatment outcomes.

Sub-theme 2.2: Guidance and support

The continuum of care provides service users with different care options to address the unique needs of the individual and his/her family (cf. Puddy and Wilkins, 2011:67). Galvani (2015:10) agrees and continues to state that social workers will engage with

service users during different points in their SUD histories, for instance during early intervention, formal treatment or aftercare. The author explains that the key is to provide motivation and support that will maximise the person's response to treatment on any level of care. In this study, the participants requested that social workers provide them with information associated with early intervention and treatment, skills to develop a sober lifestyle associated with treatment and aftercare (cf. Department of Social Development, 2010:6), and also that the new life skills be integrated during aftercare.

> "*Social workers can pass on information to patients and give tools so that they can help themselves. We need to know what to do and what not to do to help us to become sober. And to stay sober*."
>
> "*They should give you tools and guidance and strategies to stay sober as the onus is on you and your family to help you to stay sober*."
>
> "*Their role is to ease the mind and help us to know how to go about to do things and avoid triggers. How to prevent triggers from happening*."
>
> "*They must help us on how to deal with our social lives and be comfortable in them*."

Sub-theme 2.3: Continuation of services

The participants expressed a need that a social worker be involved throughout the treatment process. They also requested that treatment is long-term in nature, and that aftercare receives special attention.

Category 2.3.1: Contact to same social worker who made referral

Garthwait (2012:14) is of the opinion that coordination of services aimed at the treatment of a SUD prevents duplication of services, while the participants in this study identified a need to build a relationship with one social worker who will guide them through treatment. The participants requested to have a case worker that will guide them through the

process. They specifically asked that the same social worker who did the first assessment and referral act as a case manager.

> "*And if I go home soon that stuff is going to stay here and I am probably never going to see her* (social worker) *again unless if I call her or something*."

> "*To get you a rehabilitation centre. After that the work is for the rehabilitation centre. That is where the connection with the social worker ends. And it begins again when they come to fetch you, then you decide if you want to talk to them. Maybe once a week or something like that*."

Category 2.3.2: Aftercare as a specialisation

Van der Westhuizen (2010:8), Chetty (2011:59-60) and Swanepoel et al. (2016:431) identified a need for aftercare as a specialised focus area of the treatment of a SUD. The long-term nature of the recovery process (cf. APA, 2013:483) requires that aftercare continues until the person is settled in a new, sober lifestyle. In further support, Galvani (2015:14) asserts that a lack of post formal treatment options increases the risk for relapses. These viewpoints were confirmed by the participants through the following utterances:

> "*We need a team for aftercare and they should be focusing on us and nothing else*."

> "*There needs to be another group* (social workers only focusing on aftercare) *that goes out there to see the problems that we go through and this should be made long-term for it to be effective, because for just six weeks you can fall back again. So extra staff is needed for aftercare and it should be ongoing*."

> "*This* (aftercare) *needs to be incorporated with the whole programme so that aftercare is almost non-stop or is made a five year plan. At the moment it is just five to six weeks*."

Sub-theme 2.4: Trustful and supportive relationship

Category 2.4.1: Trust

The need to trust social workers were also noted in a study by Van der Westhuizen (2010:125-126). Due to the harm done during substance abuse, family members and the community often do not trust the person with a SUD. It becomes important that the social worker understands the nature of a SUD, and that he/she is able to trust in the person's potential to move into recovery and to change. This trust is also needed when working with the families and the communities (cf. Maluleke, 2013:78). A participant explained that what is shared with the social worker should be confidential: "*They must keep the stuff that we say to them to themselves*." The participants also reported on the value of trust in the social worker as follows:

> "*I have a social worker. I had to go to her every Thursday. Most of the problems I had I could not speak to my family or trust someone. So she was the one I could go to and confess to. And I know she will not judge me*."
>
> "*So she* (social worker) *was like a mother for me here, she helped me a lot*."

Category 2.4.2: Support and availability

A participant explained that while support from the social worker is needed, it is not always available: "*The role of the social worker is to support someone who is in a situation with drugs. And this is not fully possible as groups come and go and we do not get full attention*." Galvani (2015:8) describes the supportive nature of social work interventions in the treatment of a SUD and identifies three key roles, namely: 1) to *engage* with the topic of substance use and abuse so as to be knowledgeable and skilled to provide support, 2) to *motivate* the person with the SUD to change behaviour, as well as his/her family and the community to support efforts to change, and 3) to *support* the maintenance of change so as to achieve sobriety. However, social workers must be clear about what they can do and how much the service user can expect of them. Ganzer and Ornstein (2008:162) concur that the challenge is to define the line between being reliable and

available on the one hand, and being assertive to ensure that the service user does not manipulate the worker and abuse the relationship on the other hand. In terms of support, the participants requested that they need advice and guidance, and that the social worker must show a genuine interests in them.

> "*They must all be supportive and be able to help you to deal with all your problems*."
>
> "*They need to support you, guide you and be by you during the tough times*."
>
> "*Like if you call for help, they will tell you this is the way you are supposed to do it. They need to guide you on how you think and see life*."
>
> "*They should phone me to ask are you alright are you ok… how are you coping? Those little things can make a big difference at the end of the day, because after getting the call you realise that people help me a lot without thinking that this whole things is falling back.*"
>
> "*They also can pop in at work to check if we are doing well and that is very important and uplifting*."

Theme 3: Descriptions regarding the focus areas in a recovery process

In order to provide in the needs of service users, it is important to take note of specific aspects that they value during the recovery process. The participants in this study described changes that they experienced since they received treatment that point to valuable focus areas in the recovery process. They also identified specific focus areas that should receive attention.

Sub-theme 3.1: Changes experienced since receiving treatment

The service users described how sobriety has been affected by, and affected, their spiritual well-being, as well as interpersonal relationships.

Category 3.1.1: Sobriety, spirituality and emotional and social well-being

The value of spirituality and emotional and social well-being to achieve sobriety that was experienced by the participants focus on self-image, making good decisions, and valuing sobriety (cf. Van der Westhuizen's study, 2010:151; Chen, 2006:306; Lessa and Scanlon, 2006:199).

> "*I am no longer abusing drugs, sobriety is more valuable for me my spiritual growth as well*."
>
> "*What means a lot is my sobriety and to know that I am going out here as a decent person who is sober and know what decisions are wrong and right*."
>
> "*I have got stronger and it feels great to be sober. So I have a new look at life. I`m going to work day by day to keep my sobriety*."
>
> "*I learned to be sober and that you can enjoy life without getting high*."
>
> "*I realise that it is better to be sober than high, because if you are high you will not realise opportunities*."

Category 3.1.2: Interpersonal relationships

The participants reported that they experience a positive change in their relationship with their families, and that they value the support they receive as depicted by the following statements:

> "*I am more connected to my family now*."
>
> "*When I was abusing I tended to isolate myself. I did not want anything to do with my family. But to actually see that the support is still there from the family I actually value that a lot as well*."
>
> "*Support from family and people around you plays a big role. People should not be judgemental, but give you support*."

The latter statement highlights the need to be supported, while the statements below emphasise that support is about care, trust and respect (cf. Copello et al., 2010:65; McDonagh and Reddy, 2015:18):

> "*If you have people to support you and are not lonely, you will not relapse*."
>
> "*I learned to care about and trust other people. Now my family starts to trust can care for me again*."
>
> "*I have learned to respect myself and to look after myself, respect people around you how to work with others. It makes a big difference, because now I have good relationships*."

Sub-theme 3.2: Specific recovery needs

The participants identified support groups, social support and assistance to deal with emotions as areas that need to be attended to.

Category 3.2.1: Sponsors and support groups

The participants identified the need to be linked to support groups as a resource in their recovery process.

> "*I need support to find AA meetings, and also a way to get there. I want to attend more meetings*."
>
> "*The information and the sharing in NA can help me to stay positive and continue to try and make it*."
>
> *"Support groups are also needed to keep you going*."

Support groups have a long history of providing community-based peer support. In such groups, peers provide each other with encouragement, non-judgemental advice, and emotional support (United States Department of Health and Human Services, 2015:20-

21). Another value is that persons act as sponsors for each other, which provide the service user with extra support where the social worker cannot always be available. The participants identified a need to find sponsors as follows:

> "*I need a sponsor. Someone I can communicate to when I feel like I am pushing myself towards the wrong direction*."

> "*To get myself a sponsor that I can go on this sobriety life. That person can give me advice, and also encourage me not to give up*."

> "*Talking to someone and opening up is also a very good form of therapy. With a sponsor you can talk about the things that worry you and they are always there for you*."

Linked to the previous description of the value of spirituality in Category 3.1.1, the participants also identified the church as a resource that could support their recovery.

> "*To go to church more often will be very important. There I can find hope and I will be with people who want be to be well. They will believe in me*."

> "*I think the church is important. If everything has come tight for me I will just go and pray or go speak to my pastor*."

Category 3.2.2: Obtaining social support

Elaborating on the description of how sobriety has affected interpersonal relationships in Category 3.1.2, the participants identified support from family and peers as an important part of their recovery needs. Addressing this need can serve as an important protective factor in the treatment and recovery process (cf. National Crime Prevention Centre, 2009:1). To address social support, the participants noted that stigmatisation should be addressed (cf. Fisher and Harrison, 2013:37).

> "*This is a difficult time to change all my bad habits and to deal with everything. I think it will help a lot to get that comfort from friends and family*."

"*I will say strong family support can help me a lot to stay on this road*."

"*What do I need? Family, friends, unity, love and support*."

"*A lot of black Africans do not use these services because of the stigma and are not free to come as they lack support*."

Category 3.2.3: Dealing with emotions

In this final category, the participants requested to be assisted to deal with emotions that may impact on their behaviour, choices and problem solving.

"*I will need help to deal with emotions*… a*nd not let my emotions take over*."

"*To learn to deal with my emotions and frustrations. That is important, because if I get frustrated I might make the wrong choice, or it will make it difficult to deal with my problems*."

Gouws, Kruger and Burger (2008:98-100) note that dealing with emotions is important to be able to change behaviour. By learning how to express and to make sense of emotions, the person becomes able to make decisions and solve problems effectively. This, then, encourages behavioural change. Maluleka's (2013:75) study also identified a need for emotional support. This author identified therapy, counselling and therapeutic groups as methods to provide emotional support as part of the treatment of a SUD.

4.4 Conclusion

This chapter presented the findings that portray service users' experiences and perceptions regarding the implementation of the continuum of care for the treatment of a SUD. The participants were able to describe their experiences regarding the different components of the continuum of care. In addition, they provided information regarding expectations of social workers when working according to the continuum of care. The participants also identified some focus areas that should be included in services within the continuum of care.

The final chapter will conclude this research study. Conclusions and recommendations regarding the methodology that was employed will be provided, while the findings will be compared with the components of the continuum of care. This comparison will be used to draw conclusions and to make recommendations.

CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The research goal of this qualitative research study was to develop an understanding of the experiences and perceptions of service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD. The researcher therefore drew two samples; one comprising of service providers for the treatment of a SUD, and the other of service users. Data was collected by means of semi-structured individual interviews with service providers, and focus group interviews with service users. The triangulation of data collection methods and sources of information contributed to the credibility of the study. These methods of data collection assisted him to answer the following two research questions:

3) What are the experiences and perceptions of the service providers regarding the utilisation of the continuum of care for treatment of a SUD?
4) What are the experiences and perceptions of the users of services regarding the utilisation of the continuum of care for treatment of a SUD?

A description of key concepts related to the research topic, a discussion of existing information pertaining to the topic, as well as the theoretical framework and research problem from which the study was conducted was presented in the first chapter. The second chapter provided an in-depth description of the chosen research methodology and how it was implemented to support the transferability and dependability of this study. Chapters 3 and 4 presented the findings respectively, together with a literature control. The method of data analysis, as described in Chapter 2, the use of transcripts of the verbatim responses of the participants, the use of an independent coder, and the literature control enhanced the conformability of this qualitative research findings.

This chapter addresses the last objective of the research, namely to draw conclusions and make recommendations about the experiences and perceptions of service providers and service users regarding the utilisation of the continuum of care for the treatment of persons with a SUD. The findings will be compared to the theoretical framework and conclusions will be drawn, followed by recommendations for social work practice. The chapter will be concluded with recommendations regarding further research related to the research topic.

5.2. CONCLUSIONS AND RECOMMENDATIONS

The continuum of care was used as a theoretical framework from which to explore the research topic, and to draw conclusions and make recommendations. In this section, each of the components of the continuum of care will be presented. Each discussion will be introduced with a description of the particular component of the continuum of care, followed by conclusions drawn from the findings related to each of the two samples. This will be followed up with recommendations for practice regarding the component under discussion.

5.1.1 Conclusions and recommendations regarding prevention

> **Prevention**: "Preventing development needs from developing into social challenges or risks" (Department of Social Development, 2013b:29).

5.1.1.1 Conclusions related to the experiences and perceptions of service providers

The social workers who represented the population of service providers in this study linked prevention and early intervention when describing their perceptions about the components of the continuum of care. Psycho-education and community awareness programmes were identified as the methods used to prevent substance use and abuse.

It further appears that preventative services are primarily rendered at schools, while it was also noted that the participants used community platforms to inform families about the risks of substance use and abuse. The educational nature of preventative services is in line with the prevention component of the continuum of care, in that it has the potential to create an awareness of how substance use and abuse can develop into a developmental challenge. However, it is concluded that education should be complimented by practical ways and skills to further support the prevention of substance use and abuse.

5.1.1.2 Conclusions related to the experiences and perceptions of service users

While some participants could not recall any exposure to preventative services, other participants identified schools and churches as community-based structures where they were exposed to preventative services. It appears that services were mainly educational in nature, and that the information did not deter participants to continue using and abusing substances (cf. National Crime Prevention Centre, 2009:1). It is concluded that the descriptions of preventative services by the social worker participants correspond with the findings related to the service users' description thereof. It is important to note that the service users confirmed the conclusion that information alone is not enough to prevent substance use and abuse.

The findings highlight a need to acknowledge context related aspects that contribute to substance use and abuse to ensure that risk factors inform the nature of preventative services (cf. Department of Social Development, 2013b:27-29. In this study, availability of substances; the acceptance of substance use and abuse in the family and community, as also portrayed in the media; lack of strong family and peer relationships; and problems to deal with emotions were noted as aspects that should be considered (cf. National Crime Prevention Centre, 2009:1).

5.1.1.3 Recommendations for practice

It is recommended that prevention should not only focus on a macro level, but could also be addressed through educational group work on mezzo level in high risk areas. Such groups could be introduced to schools, at churches, and at community family and youth programmes. Context related topics that address high risks in the specific communities should guide preventative services on mezzo and macro level, so as to prevent development needs to escalate into social challenges.

Educational and life skills groups with families and peers, where community members are at risk of developing a SUD, could serve as a valuable tool to empower community members to support sober living lifestyles so as to prevent substance use and abuse.

5.1.2 Conclusions and recommendations regarding early intervention

Early intervention: "Limiting the impact of the risk and preventing the development/progression of social problems" (Department of Social Development, 2013b:29).

5.1.2.1 Conclusions related to the experiences and perceptions of service providers

Similar to preventative services, the social work participants reported that they make use of psycho-education when delivering early intervention services (cf. Latchford, 2010:3). However, where prevention is aimed at macro level, early intervention focuses on micro and mezzo levels. It is concluded that early intervention occurs mainly among children and youth, and that this also requires family involvement.

Drug testing, as a requirement from schools, appears to form part of early interventions. It is thus also concluded that social workers become involved once a school, parents, or an employer, suspect substance use and abuse and request drug testing. It is concluded

that a drug test could be a negative first encounter with social workers, as the person using or abusing the substance might experience this first contact as judgemental and intrusive in nature.

5.1.2.2 Conclusions related to the experiences and perceptions of service users

Contrary to the descriptions by the social work participants regarding early intervention services, the participating service users did not recall early social work interventions. However, similar to the descriptions by the social workers that families made referrals, they identified families and friends who intervened in their substance use and abuse for the first time (cf. Copello et al., 2010:65.

The participants highlighted the importance of internal motivation to seek treatment, and explained how they moved from external levels of motivation to internal levels of motivation. It is concluded that motivation to change is an important aspect to consider during early intervention services (cf. Latchford, 2010:3). They continued to request that they should be prepared for what to expect from the treatment process, and motivated throughout the process (cf. Galvani, 2015:7; Maluleke, 2013:75).

5.1.2.3 Recommendations for practice

As drug testing is often the first contact between the service provider and service user, it should not be seen as the only focus of the first encounter. Social workers should explain their role, and show interest in and concern about how the service user is experiencing the contact with the social worker. In terms of the long-term nature of the continuum of care, this will inform the service user's expectations of services to address substance use and abuse. Thus, a trusting, non-judgemental relationship should be part of the aims of early intervention.

Early intervention should focus on the development of an internal level of motivation to change thoughts and behaviour that encourage substance use and abuse. However, a lack of motivation, or an external level of motivations should not be seen as negative. Motivational interviewing can be used to assist service users to develop an understanding of why they would want to choose sobriety, and skills to make behavioural changes to support a healthy life style. In this way, internal motivation can be stimulated and an escalation of the substance use and abuse can be prevented.

5.1.3 Conclusions and recommendations regarding treatment services

> **Treatment**: "Statutory/residential/alternative care, which entails protection services that endeavour to safeguard the well-being of service beneficiaries" (Department of Social Development, 2013b:29).

5.1.3.1 Conclusions related to the experiences and perceptions of service providers

The participants referred to in- and outpatient treatment programmes as treatment options, and explained that treatment is aimed at those aspects that contributed to the SUD. It was reported that services are planned based on a psycho-social assessment to identify individual needs of the service users. The continuum of care is aimed at addressing individual needs to ensure the well-being of the service user (cf. Puddy and Wilkins, 2011:67). It is therefore concluded that treatment services are based on individual treatment plans that address the recovery needs of the individual. The unique needs of the service user is used to make referrals, which provides the user with treatment that will address his/her needs the best.

The social worker participants noted that treatment periods vary, and that treatment should be closely linked to aftercare to ensure that services continue after formal treatment (cf. Van der Westhuizen, 2010:8). The 12-Steps programme of AA and NA is used by some of the participating organisations to draw the link between treatment and

aftercare. In line with the description of treatment as a component of the continuum of care (cf. Department of Social Development, 2013b:29), the descriptions of the content of treatment point to addressing aspects that influence the well-being of service users.

Treatment services make use of individual and group work methods of intervention. Where the individual method is focused on the unique needs of individual service users, group work is used to provide information, to develop life skills, and to obtain peer support. Motivational interviewing and cognitive-behavioural methods were noted to be used during treatment. This points to a link with the continuum of care's aim to provide client-based services, which are aimed at creating opportunities for internalised change that is needed for recovery from a SUD (cf. Puddy and Wilkins, 2011:67; Latchford, 2010:6-9; Walitzer et al., 2009:392). The focus of services, as described by the participants in this study, is on providing education so that the service users can understand the impact of substances on them, and on their significant others. Furthermore, services are aimed at developing life skills to assist the service users to develop healthy, sober lifestyles (cf. Proctor and Herschman, 2014:8). It was also noted that treatment entails the development of a self-image. Drug testing, as a part of treatment was reported as a requirement of families and employers. It was concluded that the social workers use drug testing as a motivational tool during treatment (cf. Martin, 2008:2-3). In addition, harm reduction is, to a limited extend, included in services. Methadone, as an option to assist heroin users to deal with withdrawal symptoms is offered by one of the participating organisations (cf. Proctor and Herschman, 2014:12). This is a further indication that services are aimed at addressing the individual needs of service users.

The importance of including families in treatment was emphasised (cf. Chandrika, 2015:57-58). Services to families are primarily aimed at restoring relationships with the person with a SUD so as to ensure that families will support the person in the recovery process; thereby acting as informal role players in the implementation of the continuum of care. It is concluded that services to the family is mainly educational in nature, while it

also includes motivational aspects to ensure family involvement. The effect of the SUD on the family members receives limited attention (cf. McDonagh and Reddy, 2015:6).

Considering that the continuum of care is aimed at providing service users with a variety of treatment options, the participating social workers identified a variety of role players that are included in services to address the different needs of service users holistically (cf. Puddy and Wilkins, 2011:67). Pastoral caregivers/councillors, psychologists and medical, psychiatric, and child and youth care service providers were noted as role players. These role players are available in one organisation, and form a multi-disciplinary team, or service users are referred to other specialised service providers when needed. The participants also noted that they form networks with other service providers to share SUD-related knowledge and to streamline referrals. It is concluded that the descriptions of treatment of a SUD is aimed at individual needs, and that a variety of services are provided to ensure the holistic well-being of the service user.

5.1.3.2 Conclusions related to the experiences and perceptions of service users

The service users confirmed the need to be referred to services that will address their treatment and recovery needs (cf. Department of Social Development. 2013b:29). However, the participants reported that social workers do not always have access to resources that will address their needs, and that availability of social workers is restricted due to a lack of manpower. It is concluded that treatment services must be planned according to the contextual needs of service users, while the extent to which SUDs are prevalent should be taken into account to ensure that manpower to address treatment needs are available (cf. Swanepoel et al., 2016:431; Garthwait, 2012:14).

The participants accentuated that detoxification assisted them to engage with the treatment process more effectively, and that they were able to respond better to therapeutic services once detoxification took place. It is concluded that the cognitive-

behavioural approach and the motivational interviewing technique will have better outcomes if detoxification is addressed as a focus area for treatment (cf. Proctor and Herschman, 2014:3).

Education regarding a SUD, as well as the recovery process, spiritual guidance, and life skills are valued by service users as aspects that assisted them well during treatment. This corresponds with the descriptions of the social worker participants of the content of treatment services. It was, however, reported that group work and educational components pose the threat that the individual needs are not being addressed. It is concluded that treatment should include individual work in order to address individual needs and personal aspects related to the recovery process (cf. Proctor and Herschman, 2014:8).

The participants identified specific expectations from social workers. They firstly requested guidance and support that will assist service users and their families to enter treatment, to complete treatment, and to continue with aftercare. It is concluded that both the social workers and service users that participated in this study drew a link between treatment and aftercare, and the long-term nature of involvement in these two components (cf. Galvani, 2015:10). Secondly, they reported that they need long-term, trusting relationships with social workers (cf. Maluleke, 2013:78 Van der Westhuizen, 2010:125-126).

5.1.3.3 Recommendations for practice

Services to families should include a focus on addressing the harm caused by the SUD. The aim would be to assist families to recover from the effects of living with a person with a SUD as part of empowering them to become able to support the recovery process.

Treatment must not only focus on the psychosocial component of recovery, but should acknowledge the importance of detoxification. It should be noted that the impact of cognitive-behavioural and motivational services will be affected negatively if detoxification did not take place.

In order to ensure that treatment is based on service users' needs and contextual challenges, resources should be made available and manpower should be established to ensure that services are accessible and available. In terms of manpower, the need to receive individual care based on a trusting and on-going relationship with the social worker must be acknowledged when planning of services are done, and when funding is considered.

5.1.4 Conclusions and recommendations regarding aftercare of a SUD

Reunification and aftercare: "Enable service beneficiaries to regain self-reliance and optimal social functioning in the least restrictive environment possible" (Department of Social Development, 2013b:29).

5.1.4.1 Conclusions related to the experiences and perceptions of service providers

Aftercare entails that the service user's needs after treatment be assessed and that an aftercare plan is developed to address these needs. The findings highlight the need for an emphasis on aftercare as a part of treatment, with the focus on integrating the changes made during treatment in the lifestyle of service users. The long-term nature was accentuated (cf. Van der Westhuizen, 2010:14; Martin, 2008:3). The inclusion in support groups, as well as the use of sponsors, as a form of aftercare was noted, which relates to the focus on assisting service users to become reintegrated in their communities (cf. United States Department of Health and Human Services, 2015:20-21). The participants emphasised that service users must be prepared for aftercare as a part of treatment. It is concluded that aftercare is seen as vital for maintaining sobriety and for relapse

prevention. The findings, however, indicate that aftercare is often underemphasised and that it is viewed as optional by service users (cf. Van der Westhuizen, 2010:8; Chetty; 2011:59-60; Swanepoel et al., 2016:431).

5.1.4.2 Conclusions related to the experiences and perceptions of service users

The participants referred to using a sponsor and visiting support groups when reflecting on their previous experiences with aftercare. They also highlighted the fact that their own motivation to make changes, as part of post treatment work affect their ability to remain sober positively. Lifestyle changes, and repairing interpersonal damage caused by substance abuse were noted as key aspects in aftercare (cf. Van der Westhuizen, 2010:151, 154; Department of Social Development, 2010:6).

In this study, the participating service users reported that they previously did not continue with aftercare, and that they now realised that this will be an important factor in their recovery. Motivation to continue with aftercare after treatment on the long-term, and social workers who specifically avail themselves for aftercare services were reported as aspects to consider during the planning of aftercare services. It is concluded that aftercare requires a workforce that specialises in relapse prevention and reintegration into families and the community (cf. Swanepoel et al., 2016:431; Chetty, 2011:59-60; APA, 2013:483; Van der Westhuizenm 2010:8). The need for the availability of social workers for individual support during aftercare was identified, while the participants requested assistance to deal with emotions, and to be supported to master life skills that will support a sober lifestyle (cf. Maluleka, 2013:75).

Resources that could support aftercare services were identified as churches or spiritual groups, and family and peer support. The importance of the inclusion of family members in aftercare services were highlighted by the participants. It is concluded that aftercare should be a formally planned service that forms part of the overall treatment plan, and

which also places the focus on reintegration with families and the community. The participants noted that they are negatively affected by stigmatisation in their communities. The conclusion may be drawn that the social worker will have to fulfil an advocacy role, where the nature of a SUD, as well as the recovery process are presented to community members in an effort to address stigmatisation (cf. Fisher and Harrison, 2013:37).

5.1.4.3 Recommendations for practice

It is recommended that, when individual treatment plans are developed prior to identifying the relevant treatment options to address the individual needs of service users, aftercare should be included as part of the treatment plan, and not as a separate or follow-up option.

Based on the long-term nature of the treatment process, it should be considered to develop a workforce that specialises in aftercare. Such services should include micro level of support in terms of socio-emotional well-being, mezzo level of support to include families and peers in the recovery process, and macro level of support to link service users to community resources and to address stigmatisation through awareness programmes.

5.1.5 Conclusions and recommendations related to enabling factors and challenges regarding the implementation of the continuum of care

5.1.5.1 Conclusions

The findings indicate that the continuum of care is not seen as a hierarchy, and that it lists different options to be used depending on the needs of the service users (cf. Department of Social Development. 2013b:29). Individual treatment plans that are based on the assessment of the service users' unique needs contributes to implementation of the continuum of care in that it explores different treatment options for a SUD. Other aspects

that contribute to the service providers' ability to implement the continuum of care were identified as accessibility of community-based services, as well as the inclusion of different care options within the continuum of care by either the same organisation, or by networks that streamline referrals. Community structures, such as hospitals, support groups and spiritual support options, as well as governmental initiatives, such as employment programmes were identified as important contributors to assist service users with the reintegration in their communities (cf. UN, 2008:5). It is concluded that the aspects that support the implementation of the continuum of care aligns with the Department of Social Development's Framework for Social Welfare services in that it is aimed at the individual needs of service users, and supports accessibility of services (cf. Department of Social Development, 2013b:29).

Expertise of service providers was also noted as an important factor to ensure that the continuum of care is used effectively as a framework for the treatment of SUDs. It was noted that training options at local universities, as well as opportunities to share knowledge and skills through service provider networks can support the development of expertise (cf. Slabbert, 2015:551). Supervision that aims to build on expertise, and also to provide a platform for peer support was also identified as a valuable contributor to service providers' ability to effectively implement the continuum of care (cf. Hughes, 2010:59-62).

It is concluded that factors that support the implementation of the continuum of care includes treatment plans that address the unique needs of service users, accessible community-based services, accessible community structures that could support reintegration that addresses holistic well-being, availability of a variety of care options, and service delivery that is based on expert knowledge and skills regarding the treatment of a SUD.

Funding, manpower, service user's level of motivation, and dual diagnosis were identified as challenges that negatively impact on the implementation of the continuum of care. The lack of resources appears to be a continuing challenge for service providers in South Africa (cf. Dlamini and Sewpaul, 2010:469; Alpaslan and Schenck, 2012:367-386). This does not only affect the ability to deliver services, but also poses challenges for the service users. For example, transport problems and the lack of ability to pay for services contribute to service users not continuing with aftercare. Funding by government is also a challenge, as the requirements entail that only certain services can be provided by certain service providers. This, then, contributes to a fragmented service delivery system that is not supporting the implementation of the continuum of care (cf. Mokwena, 2016; Setlalentoa et al., 2015:98; Strebel et al., 2013; Van der Westhuizen, 2010). Coordination and case management were noted by both samples as needed to ensure effective treatment outcomes. Furthermore, a lack of funding results in limited manpower, which hampers service delivery in terms of availability and the ability to address the individual needs of service users (cf. Dlamini and Sewpaul, 2010:469; Chittleburgh, 2010:4).

The motivational levels of service users to complete the treatment process and to access aftercare services also challenge the outcomes of treatment through a continuum of care (cf. Groshkova's, 2010:494). In addition, unsupportive family members contributes to service users not committing to the treatment process (cf. McDonagh and Reddy (2015:6). The fact that service users are becoming younger requires a new approach to treatment services that also focuses on the development needs of children and youth (cf. Brotnow and Sinha, 2014:70). Social work service providers are further challenged by dual diagnoses, which requires access to psychiatric service providers, and also collaboration between service providers (cf. NIDA, 2010:2).

It is concluded that, the continuum of care should not be seen as a hierarchy, and that it rather list different options to be used depending on the needs of the service users. Service users have different needs and they need to be helped based on those needs. One service user might start with an out-patient treatment before going to an in-patient

treatment. On the other hand, one patient might skip out-patient treatment and go straight to in-patient treatment.

5.1.5.2 Recommendations for practice

Ongoing training can support the development of a specialised workforce. Universities can be encouraged to provide short courses and workshops, and to conduct research in areas identified by service providers where they need more information. Such research should build on knowledge and skills that addresses the unique needs of service users.

It is recommended that formal networks and collaboration between service providers be further developed and monitored to ensure that service providers are able to provide a full range of context related services on the continuum of care. Different professions involved in services should develop a shared vision of the implementation of the continuum of care. For instance, addressing dual diagnosis should be based on a collaborative effort between the relevant disciplines.

The coordination of services to a specific service user should be assigned to one organisation/social worker that tracks the service user's progress. This requires that the networks mentioned in the previous recommendation should share information about services that are rendered, and that these services should align with one another to guide the service user between the different treatment options. This coordination of services should also be aimed at preventing duplication of services, supporting the mobilisation of community-based resources, and encouraging cost-effective and affordable service delivery in a particular community.

5.2 RECOMMENDATIONS FOR FURTHER RESEARCH

Based on the findings of this study, it is recommended that further research on the topic focuses on the following topics:

- A variety of previous studies explored treatment and aftercare needs of persons with a SUD. It is recommended that the findings of these studies be analysed, and that policy makers, funders and systems involved in the planning of treatment services should be made aware of the findings so as to include this in the planning of services.
- The extent to which the Department of Social Development acknowledges or supports the National Drug Master Plan should be acknowledged and linked to the need for preventative and early intervention services..
- Funding of services to address a SUD, or the prevention thereof, should support the integration of service options. It is recommended that further research explore how funding structures support or hamper the implementation of the continuum of care and the integration of service options, and how it is based or not based on the contextual needs of a specific community.
- It is also recommended that further research be conducted regarding the needs of service users and their families related to early intervention services.
- An exploration of services and focus areas that will support the prevention of substance use and abuse is recommended.

5.3 CONCLUSION

This qualitative research supported the researcher's aim to develop an understanding of the experiences and perceptions of service providers and users of services regarding the utilisation of the continuum of care for treatment of a SUD. The objectives of the study guided the process, which resulted in a description of both the social workers and service users that participated in this study. Based on the findings, conclusions could be drawn, and recommendations could be made to contribute to the knowledge base of the SUD field.

The researcher envisages that the findings, conclusions and recommendations will support services that utilise the continuum of care for treatment of a SUD, that it could encourage service providers to plan and implement services according to the continuum of care, and that policy makers and funders of treatment services will take note of the conclusions and recommendations so as to support the implementation of the continuum of care.

REFERENCE LIST

Agee, J. 2009. Developing qualitative research questions: a reflective process. *International Journal of Qualitative Studies in Education*, Vol. 22(4):431-447.

Alpaslan, A.H. and Schenck, C. 2012. Challenges related to working conditions experienced by social workers practicing in rural areas. *Social Work/Maatskaplike Werk*, Vol. 48(4):367-386.

American Psychiatric Association (APA). 2013. *Diagnostic and statistical manual of mental disorders*. 5th Edition. Arlington: American Psychiatric Association Publishing.

Babbie, E.R. and Mouton, J. 2009. *The practice of social research*. 4th Edition. Cape Town: Oxford University Press.

Benson, J.E. and Edler, G.H. 2011. Young adult identities and their pathways: A developmental and life course model. *Development Psychology*, Vol. 47(6):1646-1657.

Bezuidenhout, F.J. 2008. *A reader on selected social issues*. 4th Edition. Pretoria: Van Schaik Publishers.

Bickman, L. and Rog, D. 2009. Applied research design: A practical approach. In L. Bickman and D. Rog (Eds.), *Handbook of applied social research methods*. 2nd Edition. Thousand Oaks, CA: Sage: 3-43.

Bless, C., Higson-Smith, C. and Sithole, S.L. 2013. *Fundamentals of social research methods: An African perspective*. Cape Town: Juta.

Boudah, D.J. 2011. *Conducting educational research: Guide to completing a major project*. East Carolina University: Sage.

Brotnow, L. and Sinha, R. 2014. A developmental approach to prevention and intervention. In Leyton, M. and Stewart, S. (Eds.). *Substance abuse in Canada: Childhood and adolescent pathways to substance use disorders*. Ottawa, ON: Canadian Centre on Substance Abuse.

Bulpitt, H. and Martin, P.J. 2010. Who am I and what am I doing? Becoming a qualitative research interviewer. *Nurse Researcher*, Vol. 17(3):7-16.

Carcary, M. 2009. The research audit trial – enhancing trustworthiness in qualitative inquiry.” *The Electronic Journal of Business Research Methods*, Vol. 7(1):11 – 24.

Carroll, K. 1998. *A cognitive-behavioural approach: Treating cocaine addiction*. New Haven, Connecticut: Yale University.

Chandrika, K.B. 2015. Need and intervention of social workers in public health care services and social development. *International Journal of Humanities and Social Sciences*, Vol. 4(1):57-62.

Chen, G. 2006. Social support, spiritual program, and addiction recovery. *International Journal of Offender Therapy and Comparative Criminology*. Vol. 50:306-23.

Chetty, M. 2011. Causes of relapse post treatment for substance dependency within the South African police services. Unpublished thesis for a Master of Social Work degree. Pretoria: University of Pretoria, Department of Social Work and Criminology.

Chittleburgh, C. 2010. The impact of providing a continuum of care in the through-care and aftercare process. *Scottish Journal of Residential Child Care*, Vol. 9(1):1-7.

Cohen, L., Manion, L. and Morrison, K. 2011. *A guide to teaching practice*. 7th Edition. London: Routledge Falmer.

Copello, A. Templeton, L. and Powell, J. 2010. The impact of addiction on the family: Estimates of prevalence and costs. *Drugs: Education, Prevention and Policy*, Vol. 17: 63-74.

Creswell, J.W. 2009. *Research design: qualitative, quantitative, and mixed methods approaches*. 3rd Edition. Los Angeles: Sage Publications Inc.

Creswell, J.W. 2014. *Research design: Qualitative, quantitative and mixed methods approaches*. 4th Edition. Los Angeles: Sage.

Crowe, S., Creswell, K., Robertson, A., Huby, G., Avery, A. and Sheikh, A. 2011. The case study approach. *BMC Medical Research Methodology*, Vol. 11(100):2-9.

Dada, S., Erasmus, J., Harker Burnhams, N., Parry, C., Bhana, A., Timol, F., Fourie, D. Kitshoff, D., Nel, E. and Weimann, R. 2015. *SACENDU Research Brief*, Vol. 18(1):1-26.

Denscombe, M. 2008. G*round rules for good research: A 10 point guide for social researchers*. London: Open University Press.

Denscombe, M. 2010. *Ground rules for social research: Guidelines for good practice.* London: Open University Press.

Denzin, N.K. and Lincoln, S.L. 2011. *Handbook of Qualitative Research.* 4th Edition. Thousand Oaks: Sage.

Department of Social Development. 2010. *Reintegration and aftercare model*. Cape Town: Department of Social Development.

Department of Social Development. 2012. *National Mental Health Summit*: *Substance Use and Abuse in South Africa*. Pretoria: South African Department of Social Development and the Central Drug Authority.

Department of Social Development. 2013a. *National Drug Master Plan. 2013-2017*. South Africa, Department Social Development and Central Drug Authority. Pretoria: Government Printer.

Department of Social Development. 2013b. *Framework for social welfare services*. Pretoria: Department of Social Development.

Department of Social Development. 2015. *Policy on the Funding of Non-Government Organisations for the Provision of Social Welfare and Community Development Services as amended in October 2015*. Pretoria: Department of Social Development.

Department of Trade and Industry. 2015. *Liquor Policy Review*. Government Gazette No. 38808. 20 May 2015. Pretoria. Government Printers.

De Vos, AS, Strydom, H, Fouche, CB and Delport, CSL, 2011. *Research at grass roots: for the social sciences and human services professions*. 4th Edition. Van Schaik: Pretoria.

Dissanayake, D.M.N.S.W. 2013 .*Research, research gap and the research problem*. Sri Lanka: University of Kelaniya, Faculty of Commerce and Management Studies.

Dlamini, T.T. and Swepaul, V. 2015. Rhetoric versus reality in social work practice: Political, neoliberal and new managerial influences. *Social Work/Maatskaplike Werk*, Vol. 51(4): 467-481.

Elias, S.C. 2016. Rehabilitated substance abusers' experience of aftercare following completion of inpatient treatment. Unpublished thesis for the degree of Magister Artium (Clinical Psychology). University of the Western Cape: Department of Psychology.

Engelbrecht, L. and Khosa, P. 2017. *A constructionist approach to restoring the definition of social work supervision*. Presentation at the Association of South African Social Work Education Institutions (ASASWEI) conference: 9-11 October 2017, Johannesburg.

Etikan, I., Musa, S.A. and Alkassim, R.S. 2016. Comparison of convenience sampling and purposive sampling. *American Journal of Theoretical and Applied Statistics*, Vol. 5(1): 1-4.

Fabricius, C., Roux, D., Barendse J. and Currie B. 2014. *Writing a research proposal: Just do it*. Stellenbosch: SUN Press.

Falletisch, L.A. 2008. Understanding the legacy of dependency and powerlessness experienced by farm workers on wine farms in the Western Cape. Unpublished Master's Degree in Social Work dissertation, University of Stellenbosch.

Farrugia, P., Petriso, B.A., Farrokhyar, F. and Bhandari, M. 2009. Research questions, hypotheses and objectives. *Continuing Medical Education*, Vol. 54(4):278-281.

Feldman, R.S. 2017. *Life span development: A topical approach*. 3rd Edition. United States: Pearson Education.

Fisher, G.L. and Harrison, T.C. 2013. *Substance Abuse*. 5th Edition. Boston: Pearson Education.

Fouché, C.B. and Delport, C.S.L. 2011. 'Introduction to the research process'. In De Vos, A.S., Strydom, H., Fouché, C.B. and Delport, C.S.L. (eds.), *Research at grass roots, for the social science and human service profession.* 4th Edition. Pretoria: Van Schaik: 73.

Fox, T.P., Oliver, G. and Ellis, S.M. 2013. The destructive capacity of drug abuse: An overview exploring the harmful potential of drug abuse both to the individual and to society. Addiction, Online publication available at https://www.ncbi.nlm.nih.gov/pubmed/25938116 (Accessed on 8 November 2017).

Ganzer, C. and Ornstein, E.D. 2008. In and out of enactments: a relational perspective on the short- and long-term treatment of substance abuse. *Clinical Social Work Journal*, Vol. 36:155-164.

Galvani, S. 2015. *Alcohol and other drug use: The roles and capabilities of social workers*. England: Department of Public Health.

Garthwait, C. 2012. *Dictionary of social work*: *School of social work.* The University of Montana: United States of America.

Goliath, V. 2014. Practice guidelines for culturally sensitive drug prevention interventions. Unpublished Doctoral Thesis (D Phil) at the Nelson Mandela Metropole University, Port Elizabeth.

Gomba, T. 2013. *There is a 90 percent relapse rate*. Gauteng Department of Social Development Webpage. Available at http://www.socdev.gpg.gov.za/Media/News/Pages/There-is-a-ninety-percent-addiction-relapse-rate.aspx (Accessed on 5 June 2017).

Gouws, E.; Kruger, N. and Burger, S. 2008. *The adolescent*. 2nd Edition. Sandown: Heineman Publishers.

Grandy, G. 2010. 'Instrumental case study'. In Mill, A.J., Durepos, G. And Wiebe, E. (Eds), *Encyclopedia of case study research*. Thousand Oaks: Sage Publications: 474-475.

Grinnell, R.M. and Unrau, Y.A. 2008. *Social work research and evaluation: foundations of evidence-based practice*. New York: Oxford University Press.

Groshkova, T. 2010, Motivation in substance misuse treatment. *Addiction Research and Theory*, Vol, 18:494-510.

Guest, G., Namey, E., Taylor, J., Eley, N and McKenna, K. 2017. Comparing focus groups and individual interviews: findings from a randomized study. *Online International Journal of Social Research Methodology*, Sage. Available at http://www.tandfonline.com/doi/abs/10.1080/13645579.2017.1281601?scroll=top&needAccess=true&journalCode=tsrm20 (Accessed on 31 July 2017).

Guetterman, T.C. 2015. Descriptions of sampling practices within five approaches to qualitative research in Education and the Health Sciences. *Forum: Qualitative Social Research*, Vol. 16(2):1-23.

Haase, T. 2010. *Risk and protection factors for substance use among young people*. Dublin: Government Publications.

Hansen, A.H. 2013. A population-based study of health care utilisation according to care level, socio-economic group, and continuity of primary care. Unpublished thesis for the degree of Philosophiae Doctor. Norway: University of Tromsø.

Houston, M. 2016. *The ethics of research in the social sciences: An overview*. Glasgow: The University of Glasgow.

Hughes, J.M. 2010. The Role of Supervision in Social Work: A critical analysis. *Critical Social Thinking: Policy and Practice*, Vol. 2:59-77.

International Association of Schools of Social Work (IASSW). 2014. *Global definition of Social Work*. Available at http://ifsw.org/policies/definition-of-social-work/ (Accessed on 19 September 2017).

Irvine, A., Drew, P. and Sainsbury, R. 2013. 'Am I not answering your questions properly?' Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research*, Vol. 13(1):87-106.

Kelly, L. and Roche, C. 2014. *Partnerships for effective development*. Australia: Australian Council for International Development.

Khunou, G., Pillay.R, and Nethononda, A. 2012. Social Work is “women’s work”: an analysis of student’s perceptions of gender as a career choice determinant. *The Social Work Practitioner-Researcher*, Vol. 24(1):120-135.

Krefting, L. 1991. Rigor in qualitative research: the assessment of trustworthiness. *American Journal of Occupational Therapy*, Vol. 45(3):214-222.

Kumar, R. 2011. *Research methodology: A step-by-step guide for beginners*. 3rd Edition. London: Sage.

Latchford, G. 2010. *A brief guide to motivational interviewing*. Leeds: The Leeds Teaching Hospitals.

Leedy, P.D. and Ormrod, J.E. 2013. *Practical Research: Planning and Designing*. 10th Edition, New Jersey: Pearson Education Limited.

Lessa, N.R. and Scanlon, W.F. 2006. *Concise guide to mental health: substance use disorders*. New Jersey: John Wiley and Sons Ltd.

Lindoor, M. *Substance Abuse among Rural Youth***.** South African Catholic Bishop's Conference. Briefing Paper, Parliament Liaison Office, 2 May 2011. Cape Town: 261:

1-3.

Madras, B.K. 2015. *Update of cannabis and its medical use*. Belmont: World Health Organization and the Harvard Medical School Alcohol and Drug Abuse Research Program.

Malone, J.C., Liu, S.R., Vaillant, G.E., Rentz, D M, and Waldinger, R.J. 2016. Midlife Eriksonian psychosocial development: Setting the stage for late-life cognitive and emotional health*. Developmental Psychology*, Vol. 52(9):496-508.

Maluleke, T.F. 2013. Perceptions of social workers regarding their role in aftercare and reintegration services with substance-dependent persons. Unpublished thesis for a Master of Social Work degree. Pretoria: University of Pretoria; Department of Social Work and Criminology.

Marinus, D.R. 2014. Adolescents' experiences and coping strategies with parental substance addiction within a rural farming community. Thesis for a Masters in Social Work degree. Pretoria: University of South Africa.

Martin, A.T. 2008. *Recovering from addiction with a continuum of care*. Available at: www.Serene.Center.com (Accessed on 30 October 2018).

Matsimbi, J.L. 2012. The perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation centre about being reintegrated into their family systems. Thesis for a Masters in Social Work degree. Pretoria: University of South Africa.

McDonagh, D. and Reddy, J. 2015. *Drug and alcohol family support needs analysis report*. Galway, Ireland: Western Region Drugs Task Force.

McLoughlin, J.A., Little, F., Mazok, C, Parry, C. and London, L. 2013. Prevalence of and associations with papsak wine consumption among farm workers in the Western Cape Province, South Africa. *Journal of Studies on Alcohol and Drugs*, Vol. 47(6):879-888.

Merriam, S.B. 2009. *Qualitative Research, a Guide to Design and Utililisation*. United Stated of America. B Jossey-Bass.

Mikėnė, S., Gaižauskaitė, I. and Valavičienė, N. 2013. Qualitative interviewing: Field-work realities. *Socialinis Darbas*, Vol. 12(1):50-61.

Mogorosi, L. 2009. Substance abuse at the work place: the problem and possible solutions. *Social Work/Maatskaplike Werk*, Vol. 45(4):406-512.

Mokwena, K. 2016. 'Consider our plight': A cry for help from nyaope users. *Health SA Gesondheid*, Vol. 21:137-142.

Monette, D.R.; Sullivan, T.J. and DeJong, C.R. 2010. *Applied Social Research: A Tool for the Human Services*. 6th Edition. Canada: Brooks/Cole, Thomson Learning, Inc.

Moriarty, J.2011.*Qualitative methods overview: Improving the evidence base for adult social care practice*. London: School for Social Care Research.

Mudavanhy, N. and Schenk, R. 2014. Substance abuse amongst the youth in Grabouw Western Cape: Voices from the community. *Social Work/Maatskaplike Werk,* Vol. 50(3):370-391.

Myers, F.J. 2010a. *Psychostimulants: The facts about the effects*. Alaska: Citizens Commission on Human Rights.

Myers, N. 2010b. An exploration of gender-related tensions for male social workers in the Irish context. *Critical Social Thinking: Policy and Practice*, Vol. 2:38-58.

National Crime Prevention Centre. 2009. *School-based drug abuse prevention: Promising and successful programs*. Ontario Canada: National Crime Prevention Centre.

Ncube, M. and Noyoo, N. 2017. *Social work supervision and the decolonisation discourse: What role for South African social work practitioners?* Presentation at the Association of South African Social Work Education Institutions (ASASWEI) conference: 9-11 October 2017, Johannesburg.

Nevid, J.S., Rathus, S.A. and Greene, B. 2006. *Abnormal psychology in a changing world*. 6th Edition. New Jersey: Pearson Education, Inc.

Nicholls, D. 2009. Qualitative research: Part three – Methods. *International Journal of Therapy and Rehabilitation*, Vol. 16(12):638-647.

NIDA (National Institute on Drug Abuse). 2010. *Comorbidity: Addiction and other mental illnesses*. Washington: National Institute on Drug Abuse.

NIDA (National Institute on Drug Abuse). 2014. *Drugs, brains, and behaviour: The science of addiction*. Washington: National Institute on Drug Abuse.

Nutt, D., King, L. A., Saulsbury, W. and Blakemore, C. 2007. Development of a rational scale to assess the harm of drugs of potential misuse. *The Lancet*, Vol. 369 (9566):1047–1053.

Onwuegbuzie, A.J., Dickinson, W.B., Leech, N.L. and Zoran, A.G. 2009. A Qualitative Framework for collecting and analyzing data in focus group. *International Journal of Qualitative Methods*, 2009, Vol. 8(3):1-22.

Palinkas, L., Horwitz, S.M., Green, C.A., Wisdom, J.P., Duan, N. and Hoagwood, K. 2015. Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. *Administration Policy in Mental Health*, Vol. 42(5):533-544.

Pandey, P. and Pandey, M. 2015. *Research methodology: Tools and techniques*. Marghiloman, Romania: Bridge Center.

Plüddemann, A., Dada, S., Parry, C., Bhana, A., Bachoo, S., Perreira, T., Nel, E., Mncwabe, T., Gerber, W. and Freytag, K. 2010. Monitoring Alcohol and Drug Abuse Trends in South Africa. *SACENDU Research Brief*, 13(2): 1-9.

Popescu, D., Popescu, G., Lupu, G., Panus, V., Neagu-Sadoveanu, S. and Buda, O. 2010. Drugs effects on the central nervous system. Forensic implications. *Romanian Journal of Legal Medicine*, Vol. 18: 231-236. DOI: 10.4323/rjlm.2010.231.

Proctor, L. and Herschman, P.L. 2014. The continuing care model of substance use treatment: What works, and when is ‘‘enough,’’ ‘‘enough?’’ *Psychiatry Journal Online*, Available at https://www.hindawi.com/journals/psychiatry/2014/692423/cta/ (Accessed on 31 October 2018).

Puddy, R. W. and Wilkins, N. 2011. *Understanding evidence Part 1: Best available research evidence. A guide to the continuum of evidence of effectiveness***.** Atlanta, GA: Centres for Disease Control and Prevention.

Pullen, E. and Oser, C. 2014. Communities: A Counsellor Perspective. *Substance Use Misuse*, Vol. 49(7): 891-901.

Reeves, C.L. 2010. A difficult negotiation: fieldwork relations with gatekeepers. *Qualitative Research*, Vol. 10(3):315–331.

Remler, D.K. and Van Ryzin, G.G. 2011. *Research methods in practice: Strategies for description and causation*. United States of America: Sage.

Roller, M.R. 2015. *Qualitative research design: Selected articles from Research Design Review published in 2014*. Available at www.rollerresearch.com (Accessed on 7 March 2018).

Roller, M.R. and Lavrakas, P.J. 2015. *Applied qualitative research design: A total quality framework approach*. New York: Guilford Press.

Rubin, A. and Babbie, E. 2010. *Essential research methods for social work*. New York: Brooks/Cole Cengage Learning.

SACENDU (South African Community Epidemiology Network on Drug Use). 2018. *Alcohol and other drug use trends: January – June 2017 (Phase 42)*. Cape Town: South African Medical Research Council - Alcohol, Tobacco and Other Drug Research Unit.

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

Schurink, C.B.; Fouché, C.B. and de Vos, A.S. 2011. 'Qualitative data analysis and interpretation'. In De Vos, A.S., Strydom, H., Fouché, C.B. and Delport, C.S.L. (eds.). *Research at grass roots for the social sciences and human service professions*. 4th Edition. Pretoria: Van Schaik: 397-430.

Setlalentoa, M., Ryke, E. and Strydom, H. 2014. The influence of binge drinking on social support networks. *Social Work/Maatskaplike Werk*, 50(3):349-367.

Setlalentoa, M., Ryke, E. and Strydom, H. 2015. Intervention strategies used to address alcohol abuse in the North West Province, South Africa. *Social Work/Maatskaplike Werk*, 51(1):80-100.

Slabbert, I. 2015. Reflective learning in social work education in the field of substance abuse. *Social Work/Maatskaplike Werk*, Vol. 51(1): 549-563.

Smook, B., Ubbink, M. Ryke, E. and Strydom, H. 2014. Substance abuse, dependence and the workplace: A literature overview. *Social Work/Maatskaplike Werk*, 50(1):59-83.

South Africa. 1994. *Liquor Act No. 59 of 2003*. Pretoria: Government Printer.

South Africa. 2008. *Prevention of and Treatment for Substance Abuse Act No. 70 of 2008*. Cape Town: Government Printer.

South African National Council on Alcohol and Drug Addiction (SANCA), Western Cape. 2017. *Annual Report: 2016-2017*. Bellville: SANCA Western Cape.

Strebel, A., Shefer, T., Stacey, M. and Shabalala, N. 2013. Lessons from the evaluation of a public out-patient substance abuse treatment programme in the Western Cape. *Social Work/Maatskaplike Werk*, Vol. 49(1):38-52.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions, in *Research at grass roots for the social sciences and human service professions*, by De Vos, A.S., Strydom, H., Fouchè, C.B. and Delport, C.S.L. 4th Edition. Pretoria: Van Schaik Publishers: 113-129.

Sue, D., Sue, D. and Sue, S. 2010. *Understanding Abnormal Behaviour*. Boston: Wadsworth, Cengage Learning.

Sutton, J. and Austin, Z. 2015. Qualitative Research: Data collection, analysis, and management. *The Canadian Journal of Hospital Pharmacy*, Vol. 68(3):226–231.

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/Maatskaplike Werk*, Vol. 52(3):414-438.

Tesch, R. 1990. *Qualitative research*. New York: Falmer Press.

Thomas, D.R. and Hodges, I. 2010. *Designing and planning your research project: Core skills for Social and Health Professionals*. Los Angeles: Sage.

Thomas, E. and Magivy, J.K. 2011. Scientific inquiry: Qualitative Rigor or Research Validity in Qualitative Research. *Journal for Specialists in Paediatric Nursing,* Vol. 16: 151-155.

Trochim, W.M.K. and Donnelly, J. 2007. *The research methods knowledge base*. 3rd Edition. Mason, OH: Thomson Custom Publishing.

Tshitangano, T.G. and Tosin, O.H. 2016. Substance use amongst secondary school students in a rural setting in South Africa: Prevalence and possible contributing factors. *African Journal of Primary Health Care and Family Medicine*, Vol. 8(2): 934.

United Nations (UN). 2003. *Economic and social commission for Asia and the Pacific United Nations: office on drugs and crime*. New York: United Nations Publications.

United Nations (UN). 2008. *Community based treatment and care for drug use and dependence*. New York: United Nations Publications.

United Nations (UN). 2014. *Terminology and information on drugs*. 3rd Edition. Vienna: United Nations Office on Drugs and Crime; Publishing and Library Section.

United Nations (UN). 2016. *Terminology and information on drugs*. 3rd Edition. Vienna: United Nations Office on Drugs and Crime; Publishing and Library Section.

United States Department of Health and Human Services. 2015. *Substance abuse treatment: group therapy: A treatment improvement protocol*. Rockville, MD: United States Department of Health and Human Services; Substance Abuse and Mental Health Services Administration.

Van Der Westhuizen, M.A. 2007. Exploring the experiences of chemically addicted adolescents regarding relapsing after treatment. Thesis for a Magister Diaconiologiae (Social Work) degree. Pretoria: University of South Africa.

Van Der Westhuizen, M.A. 2010. Aftercare to chemically addicted adolescents: Practical guidelines from a social work perspective. Unpublished DPhil thesis, University of South Africa, Pretoria.

Walitzer, K. S., Dermen, K. H. and Barrick, C. 2009. Facilitating involvement in Alcoholics Anonymous during out-patient treatment: A randomized clinical trial. *Addiction*, Vol. 104(3):391-401.

Wand, G.C. 2013. The benefits of family involvement in substance abuse treatment for adolescents. Unpublished thesis for the degree of Master of Arts – Integrated Studies. Alberta: Athabasca University.

Western Cape Department of Social Development. 2010. *Reintegration and aftercare model*. Cape Town: Department of Social Development.

Western Cape Government. 2016. *Western Cape Alcohol-Related Harms Reduction Policy: Green Paper*. Cape Town: Department of the Premier.

Williams, N.J. and Mcelhiney, W. 2011. *Substance abuse – chemical dependency*. 2nd Edition. California: Access Continuing, Education, Inc.

Winters, K.C., Botzet, A.M. and Fahnhorst, T. 2011. Advances in adolescent substance abuse treatment. *Current Psychiatric Report*, Vol. 13(5):416-421.

World Health Organization (WHO). 2006. *Health service delivery*. Geneva: World Health Organization.

World Health Organization (WHO). 2014. *Interpersonal violence and alcohol*. Geneva: World Health Organization; Alcohol and violence - WHO policy briefing.

Yegidis, B.L. and Weinbach, R.W. 2009. *Research Methods for Social Workers*.5th edition. Boston: Pearson/Allyn & Bacon.

ANNEXURE

ANNEXURE A: PERMISSION TO CONDUCT RESEARCH AND LETTER OF INVITATION TO ORGANISATIONS

For attention: _____

I am a social worker with a special interest in the field of a substance use disorder. I am currently doing research on the following topic: The utilisation of the continuum of care for treatment of persons with a substance use disorder: Service providers' and service users' experiences and perceptions. I am doing this research under the guidance of the University of South Africa.
I am hereby requesting to do research at your treatment centre/organisation. The research proposal will be made available for you to make an informed decision. The social workers and users of services at your treatment centre/organisation will be requested to participate as participants in this project, regulating access to possible participants. The goal of this research study is:

- To develop an understanding of the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a substance use disorder.

Inclusion criteria for the population of service providers:

- Social workers,
- Working in the Western Cape,
- Who have been working in the a substance use disorder field for at least two years, and
- Currently employed by treatment centres and/or organisations who focus on the treatment of a substance use disorder.

Inclusion criteria for the population of users of services:

- Adults (i.e. persons older than 18 years) who are
- Dependent on chemical substances and who
- Are receiving treatment for the a substance use disorder from
- A treatment facility.

The reason why your treatment centre/organisation was chosen to be invited to assist me with my research is the fact that social workers at your treatment centre will be requested to participate as experts to provide a clear picture on the utilisation of the continuum of care for treatment of a substance use disorder. These social workers will also be requested to assist me to obtain access to the users of services. An important aspect is that, based on the sensitive nature of this study, participants may need debriefing and further assistance after the interviews. The treatment centre will therefore also be requested to either appoint a social worker to be available for the debriefing of participants or to ask the social workers to conduct debriefing sessions with their clients after the interviews. I intend to provide the social workers with the information they will need to understand what this project will be about during an introduction interview with them. I will then explain how the interviews will be conducted and the possible questions participants will be asked. They will then be provided with an opportunity to ask questions and raise concerns to be attended to before they identify and contact potential participants. Please also take note of the attached invitation letter to the participants.
If you are unclear about anything in this letter, you are welcome to contact me 084 269 5351, or my study supervisor Dr M.A. van der Westhuizen at mvdw@hugenote.com.

Thank you
Watson Moyana

ANNEXURE B: LETTERS OF INVITATION

Social Work Participants

For attention: _____

I am a social worker with a special interest in the field of a substance use disorder. I am currently doing research on the following topic: The utilisation of the continuum of care for treatment of persons with a substance use disorder: Service providers' and service users' experiences and perceptions. I am doing this research under the guidance of the University of South Africa. You are hereby requested to participate as a participant in this research study.

The goals of this study is:

- To develop an understanding of the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a substance use disorder.

The reason why you were chosen to be invited to assist me with my research is the fact that you have the necessary knowledge and experience to give me a better understanding of the utilisation of the continuum of care for treatment of a substance use disorder.

Inclusion criteria for the population of service providers:

- Social workers,
- Working in the Western Cape,
- Who have been working in the a substance use disorder field for at least two years, and
- Currently employed by treatment centres and/or organisations who focus on the treatment of a substance use disorder.

I intend to provide you with the information you will need to understand what this project will be about during an introduction interview. I will then explain how the interviews will be conducted and the possible questions that will be asked. Be assured that your opinion and views will be respected and appreciated and that it will make a valuable contribution to this research project. Participation is voluntary and you will be requested to complete the attached consent form. However, you have the right to withdraw from the project at any time.

If you are unclear about anything in this letter, you are welcome to contact me at 084 269 5351, or my study supervisor Dr M.A. van der Westhuizen at mvdw@hugenote.com.

Thank you
Watson Moyana

Users of Services Participants

For attention: _____

I am a social worker with a special interest in the field of a substance use disorder. I am currently doing research on the following topic: The utilisation of the continuum of care for treatment of persons with a substance use disorder: Service providers' and service users' experiences and perceptions. I am doing this research under the guidance of the University of South Africa. You are hereby requested to participate as a participant in this research study.

The goals of this study is:

- To develop an understanding of the experiences and perceptions of the service providers and users of services regarding the utilisation of the continuum of care for treatment of a substance use disorder.

The reason why you were chosen to be invited to assist me with my research is the fact that you have the necessary knowledge and experience to give me a better understanding of the utilisation of the continuum of care for treatment of a substance use disorder.

Inclusion criteria for the population of users of services:

- Adults (i.e. persons older than 18 years) who are
- Dependent on chemical substances and who
- Are receiving treatment for the a substance use disorder from
- A treatment facility.

I intend to provide you with the information you will need to understand what this project will be about during an introduction interview. I will then explain how the interviews will be conducted and the possible questions that will be asked. Be assured that your opinion and views will be respected and appreciated and that it will make a valuable contribution to this research project. Participation is voluntary and you will be requested to complete the attached consent form. However, you have the right to withdraw from the project at any time.

If you are unclear about anything in this letter, you are welcome to contact me on 084 269 5351, or my study leader Dr M.A. van der Westhuizen at mvdw@hugenote.com.

Thank you
Watson Moyana

ANNEXURE C: INFORMED CONSENT FORMS

TITLE OF RESEARCH PROJECT: The utilisation of the continuum of care for treatment of persons with a substance use disorder: Service providers' and service users' experiences and perceptions.

REFERENCE NUMBER OF PARTICIPANT: _____

PRINCIPAL RESEARCHER: Watson Moyana
Contact number: 084 269 5351

Declaration by participant:

I, _____, ID/date of birth _____, hereby confirm as follows:
I am not forced to participate and understand that I enter voluntary and can change my mind at any time. I have been informed by _____ of the following:

- The purpose and structure of the interview;
- What the information will be used for;
- Where and when the interview will take place;
- That I can speak in my preferred language;
- That the researcher will make use of translators, should the interviews not be conducted in Afrikaans or IsiXhosa.

The interview guidelines and list of possible questions were explained to me.
I understand the content of the above and have no questions. I understand that, should I have any questions, I am invited to contact the above-mentioned researcher.
I understand that the research topic is sensitive and that my participation might cause some distress. I also understand that my participation might put me at risk for being identified. The researcher did explain how privacy and confidentiality will be managed. In addition, I identify the following concerns and possible risks in this study:

_____

_____

_____

I understand that my participation in this study could lead to the improvement social work services and that my voice in this regard will be heard. I also understand that voicing my experiences may result in a form of debriefing. In addition, I identify the following possible benefits in this study:

_____

_____

_____

I understand that I will have access to the results of this project. My permission to tape-record the interviews was obtained. I am aware that only the researcher, translator (if needed), editor,

independent coder and the researcher's supervisor and joint supervisor will have access to the tape recordings and transcripts. I understand all the information given to me. No pressure was placed on me to give my consent.

Declaration by researcher:

I,_____ (name of researcher), declare that I have explained the information given in this document to_____ (name of participant); he/she was encouraged and given ample time to ask me any questions; this conversation was conducted in Afrikaans/English and no translator was used

Signed at _____ (place) on_____ (date)
Signature/Thumb print: _____ (participant)
Signature: _____ (researcher
Witness: _____

ANNEXURE D: FOCUS GROUP CONFIDENTIALITY DECLARATION

Focus group: ____

We hereby confirm that we take note of the importance of confidentiality in this research project: The utilisation of the continuum of care for treatment of persons with a substance use disorder: Service providers' and service users' experiences and perceptions.

We agree that the discussion in this focus group session will be treated confidentially and that we will not share the information given by members of this group outside of this group. We understand that we are making our contributions voluntary.

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

Signed: _____ Date: _____

ANNEXURE E: AGREEMENT WITH SOCIAL WORKER WHO WILL ACT AS DEBRIEFER

I, _____, ID (_____) hereby confirm that I am a registered social worker (SACSSP Registration number: _____). I am willing to commit myself to debrief participants in the research study: "T The utilisation of the continuum of care for treatment of persons with a substance use disorder: Service providers' and service users' experiences and perceptions". I will be available for such sessions at times agreed upon between myself and the researcher. I will provide my Curriculum Vitae to the researcher's supervisor and this agreement will be approved by my supervisor at the treatment centre.

Signed: _____

Witness: _____

Date: _____

ANNEXURE F: INTERVIEW GUIDES

Social work participants

Biographical information

- Gender
- Age
- Social Work qualification
- Years of experience working as a social worker
- Years of experience working with persons who are affected by a substance use disorder
- The municipal boundaries where the organisations that the social workers are working for is located

Research interview questions

- What is your understanding of the concept continuum of care for treatment of a substance use disorder?
- Can you describe to me the nature of the service you render to persons who are affected by a substance use disorder?
    - Methods and techniques that are being used
    - Resources and networks utilised
- How do you think your current services relate to or support the utilisation of the continuum of care?
- What are the enabling factors and conditions you experience in applying the continuum of care for treatment of a substance use disorder?
- What are some of the challenges you experience in applying the continuum of care for treatment of a substance use disorder?
- From your point of view, how can social workers be assisted in improving the utilisation of the continuum of care for treatment of a substance use disorder?

Service user participants

Biographical information

- Gender
- Age
- Substance of choice
- Treatment opportunity (how many times)
- Nature of treatment (level of care according to continuum of care)

Research interview questions

- Tell me about your efforts to address substance dependency so far.
- Tell me about the type of social services that you have received previously to address your substance dependency.
- In probing further, the following questions could be considered:
    - Tell me about experiences where you were exposed to preventative services before your dependency started (Continuum of care: Prevention).
    - Tell me about the nature of the first services you received? (Continuum of care: Early intervention).
    - What in- and/or out-patient services did you receive? (Continuum of care: Residential/statutory/alternative care).
    - What services in terms of aftercare and reunite with your family have you received?
- What do you think is the role of social workers when people are supported/receive treatment for substance dependency?
- What are the aspects that you find valuable in your recovery process?
- What other aspects do you think should be included to assist you on your road to recovery?

ADDENDUM G: RISK ASSESSMENT TOOL

RESEARCH ETHICS - RISK ASSESSMENT TOOL		
Does your research include the direct involvement of any of the following groups of participants?	**YES**	**NO**
Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]		
a) Children or young people under the age of 18		***X***
b) Persons living with disabilities (physical, mental and/or sensory)		***X***
c) Persons that might find it difficult to make independent and informed decisions for socio, economic, cultural, political and/or medical reasons		***X***
d) Communities that might be considered vulnerable, thus finding it difficult to make independent and informed decisions for socio, economic, cultural, political and/or medical reasons		***X***
e) People who might be vulnerable for age related reasons e.g. the elderly		***X***
f) Unisa staff, students or alumni		***X***
g) Persons whose native language differs from the language used for the research		***X***
h) Women considered to be vulnerable (pregnancy, victimisation, etc.)		***X***
i) Plants		***X***
j) Molecular or cell research		***X***
k) Animals		***X***
l) Environmentally related research		***X***
m) Other. Please describe.		***X***
Comments:		
Does your research involve any of the following types of activity?	**YES**	**NO**
Place an 'x' in the tick box [if yes, provide details in the space allocated for comments]		
a) Collection, use or disclosure of information WITHOUT the consent/assent of the individual or institution that is in possession of the required information, i.e. will be conducted without the knowledge of the participants (with the exception of aggregated data or data from official databases in the public domain)		***X***
b) Causing discomfiture to participants beyond normal levels of inconvenience		***X***
c) Deception of participants, concealment or covert observation		***X***
d) Examining potentially sensitive or contentious issues that could cause harm to the participants		***X***
e) Research which may be prejudicial to participants or may intrude on the rights of third parties or people not directly involved		***X***
f) Using intrusive techniques e.g. audio-visual recordings without informed consent		***X***

g) Study of or participation in illegal activities by participants that could place individuals and/or groups at risk of criminal or civil liability or be damaging to their financial standing, employability, professional or personal relationships.		***X***
h) Innovative therapy or intervention		***X***
i) Personal information collected directly from participants	***X***	
j) Personal (identifiable) information to be collected about individuals or groups from available records (e.g. staff records, student records, medical records, etc.) and/or archives		***X***
k) *Psychological inventories / scales / tests		***X***
l) Activities which may place the researcher(s) at risk		***X***
m) Collecting physical data from the participants such as body measurements, blood samples, etc.		***X***
n) Collecting physical samples from animals such as blood, etc.		***X***
o) Harvesting indigenous vegetation		***X***
p) Harvesting vegetation or soil from privately owned land		***X***
q) Other. Please describe.		***X***
Comments:		
DOES ANY OF THE FOLLOWING APPLY TO YOUR RESEARCH PROJECT?	**YES**	**NO**
Place an ' x' in the tick box [if yes, provide details in the space allocated for comments]		
a) Reimbursement or incentives to any participants.		***x***
b) Financial obligations for the participants as a result of their participation in the research.		***x***
c) Financial gains to be anticipated by any of the involved researchers.		***X***
d) Any other potential conflict of interest for any of the researchers (real or perceived personal considerations that may compromise a researcher's professional judgement in carrying out or reporting research, such as conducting research with colleagues, peers or students).		***X***
e) Research will make use of Unisa laboratories.		***X***
f) Research will be funded by Unisa or by an external funding body.		***X***
Comments:		

Guided by the information above, classify your research project based on the anticipated degree of risk. ***[The researcher completes this section. The ERC critically evaluates this benefit-risk analysis to protect participants and other entities.]***

Place an 'x' in the tick box

Category 1 **Negligible**		**Category 2** **Low risk**	***X***	**Category 3** **Medium risk**		**Category 4** **High risk**	

(a) Briefly justify your choice/classification The participants in this proposed study will be informed of the research procedures and will participate voluntary. They will also be able to withdraw from the project at any given time. Additionally, their privacy and confidentiality pertaining to the data obtained will be managed. In case of a need for debriefing after data collection, a social worker will be made available to participants to provide a debriefing service.
(b) In medium and high risk research, indicate the potential benefits of the study for the research participants and/or other entities.
(c) In medium and high risk research, indicate how the potential risks of harm will be mitigated by explaining the steps that will be taken (e.g. referral for counselling, debriefing, etc.).

ANNEXURE H: APPROVAL TO CONDUCT RESEARCH

UNISA university of south africa

DEPARTMENT OF SOCIAL WORK RESEARCH AND ETHICS REVIEW COMMITTEE

6 December 2017

Ref#: R&EC: 26/1017/46515070_08
Name of Applicant: Moyana, W
Student#: 46515070

Dear Mr Monyana

DECISION: ETHICAL APPROVAL

Name: **Mr W Moyana**

Address & contact details: **14 Camdebo Street, Loevestein, Bellville, Cape Town, 7530**

Contact No: **084 269 5351**

Supervisor: **Dr MA van der Westhuizen**

Title of Proposal: **THE UTILISATION OF THE CONTINUUM OF CARE FOR TREATMENT OF PERSONS WITH A SUBSTANCE USE DISORDER: SERVICE PROVIDERS' AND SERVICE USERS' EXPERIENCES AND PERCEPTIONS**

Qualification: **Master of Social Work**

Thank you for the application for research ethics clearance by the Department of Social Work Research and Ethics Review Committee.

The application was reviewed in compliance w ith the UNISA Policy on Research Ethics by the abovementioned Committee at a meeting conducted on 27 October 2017.

Final approval is granted for the duration of the project.

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