Rendering services to people with substance use disorders: Perceptions of social workers in Ehlanzeni District, Mpumalanga Province

Thembinkosi Peter Singwane

A full research dissertation presented in fulfilment of the requirements for the degree of

Master of Arts in Social Work Research

in the

Department of Social Work at the School of Human and Community Development, Faculty of Humanities

at the

University of the Witwatersrand

Supervisor: Dr Thobeka Nkomo

March 2020

DECLARATION

I hereby declare that this research report is my own original work and I have referenced all the original sources that I have used. This research report has not been submitted previously for any degree or examination

Thembinkosi Peter Singwane **March 2020**

ABSTRACT

Substance use disorders are a global challenge with detrimental effects on health, wealth and security of nations. Historically social workers have been and continue to be among the primary service providers to individuals who experience Substance Use Disorders (hereafter referred as SUDs). Although substance use disorders are a prevailing treatment issue, addiction remains under-identified as a primary practice area for clinical social workers. Since social workers play a crucial role in the identification and treatment of people with substance use disorders, their perceptions of these patients have consequences on the nature and quality of services delivered to them.

The researcher's interest in the study was informed by the ever-escalating increase of people with SUDs in South Africa. Over the past five years, according to statistics as reported by the South Community Epidemiology Network on Drug Use, the Ehlanzeni District Municipality in Mpumalanga Province has seen an extensive spread of SUDs. For this reason, this study adopted the qualitative approach by employing the multiple case study design to execute this research.

The purpose of the study was exploratory and descriptive in nature. The population consisted of social workers who specialize (or work) on substance/ addiction management from two Non-Governmental Organizations (hereafter referred as NGOs) namely; South African National Council on Alcoholism and Drug Dependence (SANCA) Lowveld and National Institute for Crime Prevention and Reintegration of offenders (NICRO). The study also included social workers (practicing in the substance/ addiction management) from the Department of Social Development (hereafter referred as DSD) who work with SUDs, 4 (four) social workers in the focus group from DSD. Since Social workers from SANCA (6) and NICRO (7) were numerical minority, they were included in two separate focus group respectively. The study made use of focus group discussions for both NGOs and the DSD after participants (Only from Ehlanzeni district) have been identified through the purposive sampling technique. The researcher used thematic analysis for analyzing data.

Key words: Addiction management; substance use disorder; substance use disorder treatment; social worker

ACKNOWLEDGEMENTS

I would like to say a special thank you to my supervisor Dr Thobeka Nkomo for her ever ready support and for pushing me despite personal challenges which compelled me to take my eyes off the ball. May her dedication and support to students continue to grow from strength to strength. I also thank Dr Kathleen Wood who edited this work, may God bless you.

In addition, I would like to thank my family for their support, understanding and encouragement always. My isolation was not in vain.

Furthermore, a special thank you to my colleagues from the Mpumalanga Department of Social Development, SANCA Lowveld and NICRO Nelspruit who gave me much of their time to participate in the study.

Finally, all glory to God who has been with me through this difficult journey.

CONTENTS

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AODs	Alcohol and Other Drugs
BSW	Bachelor of Social Work
CDA	Central Drug Authority
CSTL	Care and support for effective teaching and learning
DoE	Department of Education
DOH	Department of Health
DPSA	Department of Public Service Administration
DSD	Department of Social Development
EH&W	Employee Health and Wellness
EHWP	Employee Health and Wellness Programme
ECD	Early Childhood Development
HIV	Human Immunodeficiency Virus
NDMP	National Drug Master Plan
NGOs	Non-Governmental Organizations
NICRO	National Institute for Crime Prevention and Reintegration of offenders
SACSSP	South Africa Council for Social Service Professionals
SACEND	South African Community Epidemiology Network on Drug Use
SANDF	South African National Defense Force
SANCA	South African National Council on Alcoholism and Drug Dependency
SAPS	South Africa Police Services
SUD	Substance Use Disorders
SBIRT	Substance Brief Intervention and Referral for Treatment
SUDs	Substance Use Disorders
TB	Tuberculosis
UN	United Nations
UNODC	United Nations on Drugs and Crime
WHO	World Health Organization

CHAPTER 1

INTRODUCTION AND OVERVIEW

1.1 Introduction

This chapter provides an overview of the statement of the problem in relation to rendering services to people with substance use disorders while exploring the perceptions of social workers in Ehlanzeni District, Mpumalanga. The chapter also provides the rationale for undertaking the study. Moreover, the chapter describes the purpose of the study and provides definitions of the key concepts, and summarises the limitations of the study. The chapter concludes by detailing the organisation of the report**.**

1.2 Statement of the Problem and Rationale for the Study

Substance use disorders are highly prevalent among South Africans. Estimates suggest that 13.3% of the population will suffer from a substance use disorder in their lifetime. Alcohol is the most commonly abused substance in the country. South Africans are known as a nation of binge-drinkers; about a quarter of the number of current drinkers engage in harmful alcohol use over weekends (Sc Pasche & Stein, 2012).

Substance use disorders and dependence are a global concern and very costly to all societies where they occur (Smook, Ubbink, Ryke & Strydom, 2014). In 2015, about a quarter of a billion people used drugs globally. Of these, around 29.5 million people - or 0.6% of the global adult population - were engaged in problematic use and suffered from drug use disorders, including dependence (World Drug Report 2017, n.d.) An international example of substance abuse patterns can be found in Texas, USA, where alcohol was found to be the primary drug of abuse in terms of dependence, death, treatment admissions and arrests, while cocaine was found to be the primary illicit drug for which Texans commenced treatment (Ramlagan, Peltzer & Matseke, 2010) . Inadequate treatment for Substance Use Disorders (SUD) has been firmly established as a major public health problem plaguing developing countries. Therefore, research into effective and feasible treatment options will inform how to bridge this treatment gap (Salwan & Katz, 2014)

Drug and alcohol abuse in South Africa are cause for alarm as a contributor to many social, health and economic problems afflicting the population. Substance dependency statistics show that drug consumption (cannabis, cocaine, and 'tik') in South Africa is twice the global average and second to none in Africa (UN World Drug Report, 2014).

> There is growing concern about the increased demand for and limited access to substance abuse treatment in South Africa. The government has responded by allocating more money to the delivery of substance abuse treatment, expanding the number of state-funded treatment slots, and training additional health and social workers to deliver these services, particularly in provinces where the prevalence of substance-related problems is high, such as the Western Cape. While these efforts should be commended and continued, steps to improve service availability have occurred without adequate consideration of the quality of services provided. This is not surprising, as there is little or no routine monitoring and evaluation of substance abuse services in the country. It is also disquieting, as access to treatment is necessary but not enough for positive treatment outcomes. Focusing on treatment quality is especially important because of public and consumer concerns about the quality and effectiveness of substance abuse treatment and whether public money is being spent efficiently to achieve the best possible outcomes.

(Myers, Petersen, Kader, & Parry, 2012, p. 667) .

Social workers working in the substance abuse domain normally have limited resources and this may cause neglect to the victims of substance abuse. Social workers regularly encounter individuals, families, and communities affected by substance use disorders (SUDs) (National Standards for Social Work Practice, 2003, p. 5). Drug prevention and

treatment is a specialist field that requires service providers to be adequately trained (National Drug Master Plan [2012-2016] South Africa, 2012).

The South African Community Epidemiology Network on Drug Use (SACENDU) indicates that Social workers who are given little training and support to develop their skills, knowledge and explore their values in relation to substance use perform poorly, and experience their work as stressful and challenging (*South African Community Epidemiology Network on Drug Use ,2017* [Report] - *Google Search,* n.d.))

After four years' experience in the substance/addiction management domain (SANCA, Lowveld) this researcher has noted that the Department of Social Development tend to view the substance abuse field as not deserving the priority that it needs. Instead, the field of child protection normally receives the bigger share of the budget, opportunities or even services. Unfortunately, inadequate attention to SUD is part of a broader trend of underinvestment in mental health care in developing countries, as seen globally in the poorest nations that allocate the smallest portion of their already strained public budgets to mental health (Saxena et al., 2007). This is considered by this researcher to be of huge concern and represents gross neglect to the victims of substance abuse as they also deserve equal services.

Police statistics have shown that 60% of crimes in South Africa are related to substance abuse in which the Nyaope users form a significant portion of the number of perpetrators (gpcommsafety, 2014). South Africa does not have regular representative surveys on substance use and therefore it is hard to describe population-level trends in substance use and changes over time (Sonja Pasche & Myers, 2012). However, more recently there have been several omnibus surveys that have included questions on substance use; namely, the South African Demographic and Health Survey (Department of Health et al., 2007), and the Youth Risk Behavior Survey (Reddy et al., 2010) but these surveys are not repeated frequently enough to track changes in substance use behavior, in addition because of the sensitive nature of the questions, they can often result in the under-reporting of substance use (Sonja Pasche & Myers, 2012; Saxena et al., 2007). Hence the significance of this research project which aims to explore the many barriers to treatment in South Africa. Apart

from an inadequate number of treatment services, (Pasche & Myers, 2012), these barriers are predominantly cost, transport and resource related. Services are also impacted by a small and inadequately trained workforce and poor integration with mental health services (Pasche & Myers, 2012)

In the researcher's observation, services for SUD victims have been growing both in the public and the private sector. However, it remains a concern that the quandary of substance abuse continues to increase, with new the newer drugs such as Nyaope and Mercedes that continue to torture the life of many victims, seemingly while only minimal effort is being done at district level (Ehlanzeni) to curb this scourge. According to a July 2013 report by the South African Community Epidemiology Network on Drug Abuse (SACENDU), the Northern Region of South Africa, which includes the Limpopo and Mpumalanga provinces, has the highest number of drug users who abuse heroin, with 22% of addicts using it as their primary drug (The Write News Agency, 2013).

The perception of social work and Social workers is important, because as LeCroy & Stinson (2004) have stated, social workers cannot fulfill their mission to care for others if the public is uninformed, confused, or hostile toward the profession. When the public's support for the profession declines, the credibility of the profession also declines. Veigel (2009) has indicated that serious consequences could occur if there are negative perceptions of the profession which0 can lead to the following:

- damage their credibility;
- create a social stigma for receiving services from Social workers;
- a decline in the number of people entering the profession; and
- lead to a decrease in services offered.

Furthermore, the researcher feels that there has not been much research done on service providers of SUDs treatment. This is further attested by the works of Myers, Louw, & Pasche (2010a). Substance abuse research has not examined the factors associated with the use of substance abuse treatment within developing countries.(. Myers, Louw, & Pasche, 2010b).

Drug prevention and treatment is a specialist field that requires service providers to be adequately trained. (National Drug Master Plan [2012-2016] South Africa, 2012)Social workers are given little training and support to develop their skills, knowledge and explore their values in relation to substance use, therefore, they perform poorly and experience their work as stressful and challenging (Sikelela , Yomelelani, Ndlela, Ngubane & Ntame, 2016).

Social workers need to play the many roles; broker, enabler, teacher, mediator and advocate as well as case manager. With changes in health care policy and a movement toward integration of health and behavioural health services, social workers will play an increased role vis-a-vis SUD. As direct service providers, administrators, care managers and policy makers, they will select, deliver, or advocate for delivery of evidence-based SUD treatment practices (Wells, Kristman-Valente, Peavy, & Jackson, 2013a). Moreover, social workers are expected to deliver treatment to clients by employing models such as:

- cognitive behavioural therapy;

  - relapse prevention;

- community reinforcement approach;
- twelve-step facilitation;
- family-based treatments; and
- the matrix model, among others (Wells et al., 2013a)

The roles are played through the stages of transition, stabilisation, early recovery, middle recovery, late recovery, maintenance stage (Sikelela et al., 2016). Thus, this requires social workers to have adequate training and skills for the proper quality implementation of their work.

Most social workers (i.e. generic social workers, correctional services social workers, municipal social workers, social workers in a drug addiction field, social workers in the SAPS, Social workers in SANDF, among others) are expected to deliver services to clients who have substance use disorders or to at least refer them to appropriate service providers (Sikelela et al., 2016).

This research might be vital in the Ehlanzeni District as it attempts to influence the district coordinators of services related to SUDs, especially those who have influence on shaping policy and practice. This study furthermore seeks to be relevant to employers of social workers who wish to understand their employee's knowledge, attitudes and skills in terms of rendering services in the field of substance use and addiction management.

1.3 Purpose of the Research

The purpose of the research is to explore, describe and gather data on the perceptions of social workers rendering services to clients with SUDs in the Ehlanzeni District. The purpose is to also to explore if the perceptions of social workers have an impact in the rendering of the said services. The study was influenced by the various challenges that social workers face when rendering substance use services such as institutional barriers to government bureaucratic problems.

1.4 Overview of Research Methodology

The research study explored the perceptions of social workers in terms of rendering service to patients with substance use disorders in the Ehlanzeni district. The qualitative research approach and a multiple case study research design was used in the undertaking of this research study. For the sampling in the research study the research used a type of non-probability sampling which is purposive sampling to select the research participants. The population consisted of social workers who specialise (or work) on substance/ addiction management from two Non-Governmental Organisations (NGOs) namely; South African National Council on Alcoholism and Drug Dependence (SANCA) Lowveld and National Institute for Crime Prevention and Reintegration of offenders (NICRO). The researcher used thematic analysis for analysing data from the study sample which included the following:

- 17 social workers (practicing in the substance/ addiction management) from the Department of Social Development (hereafter referred as DSD) who work with SUDs,
- four social workers in the Focus group from the DSD; and
- two separate focus groups of social workers from both the NGOs (13) SANCA (6) and NICRO (7)

1.5 Definition of Key Concepts

Social Work: a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing *(Global Definition of Social Work – International Federation of Social Workers*, 2014 https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/) .

Substance: any psychoactive compound with the potential to cause health and social problems, including addiction (Mclellan, 2017)These substances may be legal (e.g., alcohol and tobacco); illegal (e.g., heroin and cocaine); or controlled for use by licensed prescribers for medical purposes (Mclellan, 2017) .

According to Mclellan (2017) these substances can be categorised into seven classes based on their pharmacological and behavioural effects:

- Nicotine — cigarettes, vapor-cigarettes, cigars, chewing tobacco, and snuff
- Alcohol — including all forms of beer, wine, and distilled liquors
- Cannabinoids — Marijuana, hashish, hash oil, and edible cannabinoids
- Opioids — Heroin, methadone, buprenorphine, Oxycodone, Vicodin, and Lortab
- Depressants — Benzodiazepines (e.g., Valium, Librium, and Xanax) and Barbiturates (e.g., Seconal)
- Stimulants — Cocaine, amphetamine, methamphetamine, methylphenidate (e.g., Ritalin), and atomoxetine (e.g., Stratera)
- Hallucinogens — LSD, mescaline, and MDMA (e.g., Ecstasy)

Substance misuse: using any of these substances at high doses or in inappropriate situations can cause a health or social problem — immediately or over time. This is called

substance misuse. One important and very prevalent type of substance misuse is binge drinking. Binge drinking for men is drinking five or more standard alcoholic drinks in one sitting (a few hours). For women, it is drinking four or more standard alcoholic drinks in one sitting (Mclellan, 2017).

Substance use disorders: prolonged, repeated use of any of these substances at high doses and/or high frequencies (quantity/frequency thresholds vary across substances) can produce not only the kinds of problems described above, but a separate, independent, diagnosable illness that significantly impairs health and function and may require special treatment. This illness is called a substance use disorder (SUD). Disorders can range from mild and temporary to severe and chronic. Severe and chronic substance use disorders are commonly called **addictions** (Mclellan, 2017).

1.6 Limitations of the Research Study

As with all research this study had its own limitations. The study findings cannot be generalised due to its sampling which is purpose sampling. Only a few social workers from SANCA, NICRO and DSD were used therefore the findings cannot be generalised to all SANCA institutions neither can it be generalised to DSD and NICRO institutions. Furthermore, only social workers from Ehlanzeni district were sampled, therefore, the results cannot be generalised to the whole province of Mpumalanga.

Another, limitation of the study was the use of focus group discussion whereby the presence of other colleagues of participants in the group could have influenced the responses being given by the participants. Some group members were introverted in the group, so the researcher minimized the limitation by probing in an engaged manner to solicit perspectives of those colleagues, but it also could have proved to be a limitation.

1.7 Chapter Outline of the Study

The study is presented in following chapters and order. Firstly, it will discuss chapter 2 as literature review which comprehensively discusses and summarize the literature in this study. This chapter also brings about the gaps in the current literature are and how this

research may help to fill in one or more of these gaps. The research also discusses chapter 3 which is broadly about the research methodology the researcher has used in this study. In this chapter the research has also outlined the methods employed and it also described the data collection instruments which were employed in the data collection process. Moreover, also in this the researcher has outlined the techniques used to analyse the data collected. Just before the last chapter the researcher described the findings of the study under chapter four. In this chapter the researcher has described the respondents and outlined the results of the collected data through the data analyses. Ultimately, in chapter five the researcher discusses the findings of the study and attempts to put up a linkage as to what extent the results support literature reviewed. It also gives a linkage as to what extent it differs from findings of some previous studies. Finally, this report also identifies the limitations of the study and present recommendations for future research. .

CHAPTER 2

LITERATURE REVIEW AND THEORETICAL FRAMEWORK OF THE STUDY

2.1 Introduction

This chapter gives an overview of the relevant research literature that informed this study and the theoretical frameworks underpinning it. The chapter begins by a comprehensive discussion of the policies and legislative guidelines which affect substance use disorder services and related issues. Furthermore, this chapter will provide the insights found in the literature about the impediments to the successful rendering of service to substance use disorder patients; in other words, the knowledge, attitudes and skills of the professionals involved. The chapter will therefore conclude by discussing the predominant theory which underpins this study.

2.2 Policy and Legislative Guidelines in Rendering Service for Substance Use Disorders

The treatment of substance use disorders should meet the common standards of all health care and be consistent with UN Declaration of Human Rights and existing UN Conventions, (Clark, n.d.).

Meanwhile, there is growing concern about the increased demand for and limited access to substance abuse treatment in South Africa. The government has responded by allocating more money to the delivery of substance abuse treatment, expanding the number of state-funded treatment slots, and training additional health and social workers to deliver these services, particularly in provinces where the prevalence of substance-related problems is high, such as the Western Cape (Myers et al., 2012). While these efforts should be commended and continued, steps to improve service availability have occurred without adequate consideration of the quality of services provided. This is not surprising, as there is little or no routine monitoring and evaluation of substance abuse services in the country. It is also disquieting, as access to treatment is necessary but not sufficient for positive treatment outcomes (Myers et al., 2012, p. 667) .

2.2.1 International Standards for the Treatment of Drug Use Disorders

The International Standards for the Treatment of Drug Use Disorders (Standards) were prepared to support member states in the development and expansion of treatment services that offer effective and ethical treatment. The goal of such treatment is to reverse the negative impact that persisting drug use disorders have on the individual and to help individuals achieve a recovery from the disorder as fully as possible that help them to participate fully in society as a member of their community (Clark, n.d.).

According to a Report (2017) by United Nations Office on Drugs and Crime, (UNODC Report, 2017) The main purpose of this interagency programme is to disseminate best-practice examples informed by science and ethical principles in this field, that guarantee drug dependent people the same quality standards and opportunities provided by the health system for any other chronic diseases.

Substance use disorders can be effectively treated using a range of pharmacological and psychosocial interventions. The effectiveness of the majority of these interventions has been tested using scientific methods developed for the treatment of other medical disorders (Clark, n.d.).

The UNODC Report (2017) indicates that the treatment goals of the management of substance use disorders are to:

-reduce drug use and cravings for drug use;

-improve health, well-being and social functioning of the affected individual; and

-prevent future harms by decreasing the risk of complications and relapse.

The UNODC Report further asserts that all member states should abide by these goals when offering services to people in that:

> [M]any interventions that are commonly used in the management of substance use disorders do not meet accepted scientific standards of clinical efficacy. Such interventions may be ineffective or even harmful, or it may be that the necessary clinical trials may not have been conducted, and the effectiveness of the treatment is unknown. Resources available to work with affected individuals are limited, therefore priorities for resource allocation must be carefully evaluated against the goals of treatment.
>
> (UNODC Report 2017, p. 8)

This is pivotal to the study to be undertaken by this researcher as it will try to establish whether the social workers or organisations which employ them meet these international standards (Clark, n.d.). According to (Clark, n.d.) the UNODC (2017) Report emphasises the necessity of meeting the common standards of all health care in the treatment of substance use disorders. These are:

1. To be consistent with UN Declaration of Human Rights and existing UN Conventions;

2. To promote personal autonomy; and

3. To promote individual and societal safety.

Therefore, regardless of the treatment philosophy or the context, the International Standards for the Treatment of Drug Use Disorders define a set of requirements that must be in place before any form of outreach, treatment, rehabilitation, or recovery services may be considered safe and effective care. This is critically important, because individuals with drug use disorders deserve nothing less than ethical and science-based standards of care that are like the standards used in treatment of other chronic diseases (UNODC,2017).These

principles and accompanying standards as enshrined in the UNODC report (2017) are as follows:

Principle 1. Treatment must be available, accessible, attractive, and appropriate

In most cases, drug use disorders can be treated effectively if people have access to a wide range of services that cover the continuum of issues that patients may face. Treatment services must match the specific requirements of the individual patient at the specific phase of their disorder. These services include outreach, screening and brief interventions, inpatient and outpatient treatment, medical and psychosocial treatment (including treatment of common comorbidities), long-term UNODC-WHO International Standards for the Treatment of Drug Use Disorders residential treatment, rehabilitation, and recovery-support services. These services should be affordable, attractive, available in both urban and rural settings, and accessible with a wide range of open hours and a minimal waiting time. All barriers that limit the accessibility of appropriate treatment services should be minimised. Services, therefore, should not only offer addiction treatment, but also provide social support and protection and general medical care. The legal framework should not discourage people with drug use disorders from attending treatment programmes. The treatment environment should be friendly, culturally sensitive and focus on the specific clinical needs and the level of preparedness of each patient, thus providing an environment that encourages rather than deters individuals from attending the programme (Clark, n.d.)

Standards:

- Essential treatment services for drug use disorders should be available at different levels of health systems: from primary health care to tertiary health services with specialised treatment programmes for drug use disorders.
- Essential treatment services include outreach services, brief psychosocial interventions, diagnostic assessment, and outpatient psychosocial treatment, evidence-based pharmacological treatment, services for management of drug induced acute clinical conditions such as overdose, withdrawal syndromes and drug-induced psychoses, inpatient services for the management of severe withdrawal, long-term residential services, and treatment of common comorbidities.
- Essential treatment services for drug use disorders should be within reach of public transport and accessible to people living in urban and rural areas.

  Low threshold and outreach services, as part of a continuum of care, are needed to reach the 'hidden' populations most affected by drug use; people with drug use disorders should have access to treatment services through multiple entry points. These are often people who are unmotivated to take treatment or within a continuum of care.
- Essential treatment services for drug use and drug-induced disorders should be available during a sufficiently wide range of opening hours to ensure access to services for individuals with employment or family responsibilities.
- Essential treatment services should be affordable to clients from different socio-economic groups and levels of income with minimised risk of financial hardship for those requiring the services.
- Treatment services should be gender-sensitive and tailored to the needs of women including specific child-care needs and needs in pregnancy.
- If not otherwise accessible, affordable or available, treatment services should provide access to social support, general medical care and the management of co-morbid health conditions.
- Treatment services for drug use disorders should be orientated towards the needs of the populations they serve, with due respect to cultural norms and involvement of service users in the service design, delivery and evaluation.

- Information on availability and accessibility of essential treatment services for drug use disorders should be easily accessible through multiple sources of information including internet, printed materials and open access information services**.**

Principle 2: Ensuring ethical standards of care in treatment services

Treatment of drug use disorders should be based on universal ethical healthcare standards – including the respect for human rights and the patient's dignity. This includes responding to the right to enjoy the highest attainable standard of health and well-being, ensuring non-discrimination, and removing stigma. Treatment decisions, including when to start and stop treatment, and what kind of treatment, should be made by the individual, to the extent that they have capacity to do so. Treatment should not be forced or against the will and autonomy of the patient. The consent of the patient should be obtained before any treatment intervention. Accurate and up-to-date medical records should be maintained, and the confidentiality of treatment records should be guaranteed. Registration of patients entering treatment outside the health records should not be permitted. Punitive, humiliating or degrading interventions should never be used. The individual affected should be recognised as a person suffering with a health problem and deserving treatment like patients with other psychiatric or medical problems (Clark, n.d.).

Standards

- Treatment services for drug use disorders should in all cases respect the human rights and the dignity of service users and humiliating or degrading interventions should never be used.
- Informed consent should be obtained from a patient before initiating treatment and guarantee the option to withdraw from treatment at any time.
- Patient data should be strictly confidential, and registration of patients entering treatment outside the health records should not be allowed. Confidentiality of patient data should be ensured and protected by legislative measures and supported by appropriate staff training and service rules and regulations.

- Staff of treatment services should be properly trained in the provision of treatment in full compliance of ethical standards and human rights principles, and show respectful, non-stigmatising and non-discriminatory attitudes towards service users.
- Services procedures should be in a place which requires staff to adequately inform patients of treatment processes and procedures, including the right to withdraw from treatment at any time.
- Any research conducted in treatment services involving human subjects should be subject to review of human research ethical committees, and participation of service users in the research should be strictly voluntary with informed written consent ensured in all cases.

Principle 3: Promoting treatment of drug use disorders by effective coordination between the criminal justice system and health and social services

Drug use disorders should be considered primarily as health problems rather than criminal behaviours and as a rule, drug users should be treated in the health care system rather than in the criminal justice system. Even though individuals with drug use disorders may commit crimes, these are typically low-level crimes used to finance the drug purchase, and this behaviour typically stops with the effective treatment of the drug use disorder.

Consequently, the criminal justice system should collaborate closely with the health and social system to encourage treatment in the health care system over criminal prosecution or imprisonment. Law enforcement, court professionals and penitentiary system officers should be appropriately trained to effectively engage with treatment and rehabilitation efforts. If prison is warranted, treatment should also be offered to prisoners with drug use disorders during their stay in prison and after their release as effective treatment will decrease the risk of reoffending following their release. Continuity of care after the release is of vital importance and should be assured or facilitated. In all justice-related cases people should

be provided with treatment and care of an equal standard to treatment offered in the community (Clark, n.d.)**.**

Standards:

- Treatment for drug use disorders should be provided predominantly in health and social-care systems, and effective coordination mechanisms with the criminal justice system should be in place to facilitate access to treatment and social services of people in contact with the criminal justice system.
- Treatment of drug use disorders should be available to offenders with drug use disorders and, where appropriate, be a partial or complete alternative to imprisonment or other penal sanctions.
- Treatment of drug use disorders as an alternative to incarceration or provided within criminal justice settings should be supported by appropriate legal frameworks.
- Criminal justice settings should provide opportunities for individuals with drug use disorders to receive treatment and health care that are available in health and social care systems in a community.
- Treatment interventions for drug use disorders should not be imposed on individuals with drug use disorders in criminal justice system against their will.
- Essential prevention and treatment services should be accessible to individuals with drug use disorders in criminal justice settings, including prevention of transmission of blood-borne infections, pharmacological and psychosocial treatment of drug use disorders and comorbid health conditions, rehabilitation services and the linking with community health and social services in preparation for their release.
- Appropriate training programmes for criminal justice system staff, including law enforcement and penitentiary system officers and court professionals should be in place to ensure recognition of medical and psychosocial needs associated with drug use disorders and to support treatment and rehabilitation efforts.
- Treatment of drug use disorders in the criminal justice system should follow the same evidence-based guidelines and ethical and professional standards as in the community. 3.9 Continuity of treatment for drug use disorders should be ensured in

all cases by effective coordination of health and social services in communities and criminal justice settings (Clark, n.d.).

Principle 4: Treatment must be based on scientific evidence and respond to specific needs of individuals with drug use disorders

The cumulative body of scientific knowledge on the nature of drug use disorders and their treatment should guide interventions and investments in the treatment of drug use disorders. The same high standards required for the approval and implementation of pharmacological or psychosocial interventions in other medical disciplines should be applied to the treatment of drug use disorders. Generally, only the pharmacological and psychosocial methods that have been demonstrated effective by science or agreed upon by the international body of experts should be applied. Where there is reason to believe that other treatment approaches may be useful, they should be provided in the context of clinical trials. The duration and the intensity (dose) of the intervention should be in line with evidence-based guidelines. Multidisciplinary teams should integrate different interventions tailored to each patient. Organisation of treatment for drug use disorders should be based on a chronic care philosophy as opposed to an acute care philosophy. Severe drug use disorders are similar in their course and prognosis to other chronic diseases such as diabetes, HIV, cancer, or hypertension. A long-term model of treatment and care is most likely to promote a long and healthy life. In addition, existing interventions should be adapted to the cultural and financial situation of the country without undermining the core elements identified by science as crucial for effective outcomes. Traditional treatment systems may be unique to a country (Clark, n.d.) or setting and may have limited evidence of their effectiveness beyond the experience of patients and their clinicians. Such systems should learn from and adopt the existing evidence-based interventions as much as possible into their programmes and efforts should be made to formally evaluate whether such treatments are effective and/or carry acceptable risks (Clark, n.d.).

Standards:

- Resource allocation in the treatment of drug use disorders should be guided by existing evidence of the effectiveness and cost-effectiveness of prevention and treatment interventions for drug use disorders.
- A range of evidence-based treatment interventions of different intensity should be in place at different levels of health and social systems with appropriate integration of pharmacological and psychosocial interventions.
- Health professionals at primary health care should be trained in the identification and management of the most prevalent disorders due to drug use.
- In the treatment of drug use disorders health professionals in primary health care should be supported by specialised services for substance use disorders at advanced levels of health care, particularly for the treatment of severe drug use disorders and patients with co-morbidities.
- Where possible, the organisation of specialised services for drug use disorders should be based on multidisciplinary teams adequately trained in the delivery of evidence-based interventions with competencies in addiction medicine, psychiatry, clinical psychology and social work.
- The duration of treatment should be determined by individual needs and there should be no pre-set limits in the duration of treatment that cannot be modified according to the patient's clinical needs.
- Training of health professionals in the identification, diagnosis and evidence-based treatment of drug use disorders should be in place at different levels of education including university curricula and programmes of continuing education.
- Treatment guidelines, procedures and norms should be regularly updated in accordance with accumulated evidence of effectiveness of treatment interventions, knowledge about the needs of patients and service users and results of evaluation research.
- Treatment services and interventions for drug use disorders should be adapted for relevance to the socio-cultural environment in which they are applied.
- Treatment services should attempt to measure their performance against performance standards for comparable services.

- The development of new treatments should be conducted through the clinical trial process and overseen by an authorized human research ethics committee.(Clark, n.d.)

Principle 5: Responding to the needs of specific populations

Several subgroups within the larger population of individuals affected by drug use disorders require special consideration and often specialised care. Groups with specific needs include, but are not limited to adolescents, the elderly, women, pregnant women, children, sex workers, sexual and gender minorities, ethnic and religious minorities, individuals involved with the criminal justice system and individuals that are socially marginalized. Working with those special groups requires differentiated and individualised treatment planning that considers their unique vulnerabilities and needs. For some of these subgroups, special considerations will need to be addressed directly in every setting on the treatment continuum (Clark, n.d., p. 13).

Children and adolescents should not be treated in the same setting as adult patients and rather in a facility able to manage other issues such patients face that encompasses the broader health, learning, and social welfare context in collaboration with family, schools and social services. Similarly, women entering treatment should have special protection and services. Women with drug use disorders are more vulnerable to domestic violence and sexual abuse, and their children may also be at risk of abuse, therefore a liaison with social agencies protecting women and children is helpful. In addition, women may require women-focused treatment in a safe single-sex setting to obtain maximum benefit. Treatment programmes should be able to accommodate children's needs and to allow parents caring for children to receive treatment as well and support good parenting and childcare practices. Women may need training and support on issues such as sexual health and contraception (Clark, n.d., p. 14).

Standards:

- The needs of specific population groups are reflected in service provision and treatment protocols, including the needs of women, adolescents, children, pregnant women, ethnic minorities and marginalized groups such as the homeless.
- Special services and treatment programmes should be in place for adolescents with substance use disorders to address the specific treatment needs associated with this age and to prevent contacts with patients in more advanced stages of drug use disorders. Separate settings for treatment of adolescents should be considered whenever possible.
- Treatment services and programmes for drug use disorders should be tailored to the needs of women and pregnant women in all aspects of their design and delivery, including location, staffing, programme development, child friendliness and content.
- Treatment services should be tailored to the needs of people with drug use disorders from minority groups, and cultural mediators and interpreters should be available whenever necessary to minimise cultural and language barriers.
- A package of social assistance and support should be integrated into treatment programmes for people with drug use disorders who are homeless, or unemployed.
- Outreach services should be in place to establish contact with people who may not seek treatment because of stigma and marginalization.

Principle 6: Ensuring good clinical governance of treatment services and programmes for drug use disorders

Good quality and efficient treatment services for drug use disorders require an accountable and effective method of clinical governance. Treatment policies, programmes, procedures and coordination mechanisms should be defined in advance and clarified to all therapeutic team members, administration, and the target population. A service organisation should reflect current research evidence and be responsive to the service user's needs. Treating people with drug use disorders who often have multiple psychosocial and sometimes

physical impairments is challenging, both for individual staff and organisations. Staff attrition in this field is recognised and organisations should have in place a variety of measures to support their staff and encourage the provision of good quality services (Clark, n.d., p. 14).

Standards:

- Treatment policies for drug use disorders should be based on the principles of universal health coverage, consistent with the best available evidence and developed with the active involvement of key stakeholders including the target populations, community members (families), and non-governmental organisations.
- Written service policy and treatment protocols should be available, known to all staff and guide delivery of treatment services and interventions.
- Staff working in specialised services for drug use disorders should be adequately qualified, and receive ongoing evidence-based training, certification, support and clinical supervision. Clinical supervision, mentoring and other forms of support are needed for
- Policies and procedures for staff recruitment and performance monitoring should be clearly articulated and known to all.
- A sustainable source of funding should be available at adequate levels and proper financial management and accountability mechanisms should be in place. Whenever possible, resources for ongoing staff education, for the evaluation of service quality and performance should be included in the relevant budget.
- Services for the treatment of drug use disorders should network and link with relevant general and specialised health and social services to provide a continuum of comprehensive care to their patients.
- Adequate record systems should be in place to ensure accountability and continuity of treatment and care.
- Service programmes, rules and procedures should be periodically revised, and mechanisms of continuous feed-back, monitoring and evaluation should be developed.

- Patterns of drug use and related health consequences and comorbidities should be regularly monitored, and results made available to help the planning and governance of treatment services.

Principle 7: Treatment policies, services, and procedures should support an integrated treatment approach, and linkages to complementary services must be constantly monitored and evaluated.

As a response to a complex and multifaceted health problem, comprehensive treatment systems must be developed to facilitate effective treatment of drug use disorders and associated health-care problems. Where possible, a treatment system should include and coordinating teams should engage psychiatric, psychological and mental health care, social services (for housing and job skills/employment and, if necessary, legal assistance), other specialist health care (such as services for HIV, HCV, TB and other infections). The treatment system must be constantly monitored, evaluated and adapted. This requires planning and implementation of services in a logical, step-by-step sequence that insures the strength of links between (a) policy, (b) needs assessment, (c) treatment planning, (d) implementation of services, (e) monitoring of services, (f) evaluation of outcomes and (g) quality improvements (Clark, n.d., p. 15).

Standards:

- Treatment policies for drug use disorders should be formulated by relevant governmental authorities on the principles of universal health coverage, best available evidence and with active involvement of key stakeholders including the

target populations, community members (families), non-governmental organisations and religious organisations.

- Links between drug use prevention, drug dependence treatment, and prevention of health and social consequences of drug use should be established and operational.
- Treatment planning should be based on estimates and descriptions of the nature and the extent of the drug problem, as well as of the characteristics of the population in need.
- Roles of national, regional and local agencies in different sectors responsible for the delivery of treatment for drug use disorders and rehabilitation should be defined and mechanisms for effective coordination should be established.
- Quality standards for drug treatment services should be established and compliance should be required for accreditation.
- Mechanisms of clinical governance, monitoring and evaluation should be in place including clinical accountability, continuous monitoring of the patient's health and well-being, and intermittent external evaluation.
- Information on the number, type, and distribution of services available and used within the treatment system should be monitored for planning and development purposes.

The International Standards for the Treatment of Drug Use Disorders as drafted in the UNODC Report (2017) is not only limited to the Principles and Standards of rendering substance use disorder related treatment and services. It goes at extreme length to discuss treatment modalities and Interventions, community-based outreach screening, brief interventions, and referral to treatment (Substance Brief Intervention and Referral for Treatment initiative (SBIRT)short-term in-patient or, residential treatment, outpatient treatment, long-term residential treatment, and details about recovery management.

The International Standards for the Treatment of Drug Use Disorders is also specific about the target populations for such services.

Specific and special populations such as:

- treatment of pregnant women;
- treatment of Newborn Infants Passively Exposed to Opioids in utero;
- children and adolescents with Substance Use Disorder; and
- treatment of people with drug use disorders in contact with the Criminal Justice System, (UNODC, 2017)

These are all discussed at length in the International standards.

Most Importantly, in terms of this research topic, the International Standards for the Treatment of Drug Use Disorders also gives an idea of certain attributes of an effective system to deliver services for the treatment of drug use disorders. It reports that an effective national system for the treatment of drug use disorders requires a coordinated and integrated response of many actors to deliver policies and interventions based on scientific evidence in multiple settings that target different groups at different stages with regard to the severity of their drug use disorder (Clark, n.d.)

According to the report (UNODC, 2017) treatment services should be: (a) available (b) accessible (c) affordable (d) evidence-based (e) diversified.

This means that the availability of treatment services refers to the physical presence of services capable of treating patients with drug use disorders. The accessibility of treatment services refers to their reach or physical accessibility for the whole population. It further means that treatment services must be located conveniently and in geographic proximity to public transport in rural and urban areas (Clark, n.d.)

In addition, access should not be hindered because of attitudes towards certain population groups or other factors. The affordability of treatment services refers to patients and the treatment system. Treatment services should be affordable for patients from different socio-economic groups and levels of income (UNODC, 2017). Overall, the International Standards for the Treatment of Drug Use Disorders recommends that treatment system resources should be invested where they are most needed. It further commends that focus should be on low-threshold and easily accessible treatment and care services as a first step. Essentially, it adds that available data should be used when designing and implementing a

drug dependence treatment system. However, the non-availability of data should not be an obstacle for the implementation and delivery of drug dependence treatment and care services (Clark, n.d.)

Critics of International Standards for the Treatment of Drug Use Disorders

Recently (March, 2018), the International Network of People who use Drugs, along with 188 drug user organisations and working at the national, regional and international level on issues related to drug use, drug treatment, harm reduction and drug policies urged the WHO and the UNODC to revise their guidelines on International Standards for the Treatment of Drug Use Disorders (*CSO Letter on the International Standards FINAL.pdf*, n.d. *2018-03*)

In summary, the organisations criticise the International Standards for the Treatment of Drug Use Disorders by stating the following:

- *The paper contains many assertions not supported evidentiarily or cited.*
- *The phrase 'harm reduction' is entirely missing from the document.*
- *The paper contains crude generalisations and many stigmatising and pathologising assertions.*
- *Notably, the paper contains numerous implications that people who use drugs and have drug dependencies are dangerous; cannot exercise agency and self-determination; are sick; are unreliable; are bad family members; are bad employees. Such crude generalisations are deeply stigmatising and offensive, not to mention unempirical.*
- *The paper fails to identify criminalisation and prohibition as being responsible for driving much drug related harm and harm associated with drug dependency; instead, it myopically asserts that because drugs are harmful, they are criminalised, without noting that it is since they are criminalised that they are so harmful.*

> *The paper's active promotion Naltrexone is very concerning, given its lack of evidence[ce] : Naltrexone is promoted in the document as of equal value to interventions that are (in contrast to Naltrexone) empirically justified and greatly beneficial; this is arguably used to eclipse interventions with proven efficacy, such as methadone, buprenorphine, and diamorphine/morphine prescribing, due to the document's clear advocation of abstinence-based recovery.*

(CSO Letter on the International Standards (2018-03) pdf, n.d.)https://www.inpud.net/sites/default/files/201803%20CSO%20Letter%20on%20the%20International%20Standards%20FINAL.pdf

2.2.2 The Prevention of and Treatment for Substance Abuse Act, 2008 (Act no. 70 of 2008)

South Africa's Prevention of and Treatment for Substance Abuse Act, (2008) was effected in to provide for a comprehensive national response to combat substance abuse; to provide for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes; to provide for the registration and establishment of treatment centres and halfway houses; to provide for the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres; and to provide for the establishment of the Central Drug Authority (Department of Social Development (DSD),2012)

Section 1 of the Act provides a framework for responding to substance abuse, while Section 2 provides strategies for reducing harm. The Act has been the basis of South Africa's many programmes and strategies for combating substance misuse. The Act is supported by the Drug Master Plan (2013-17), which sets out the strategies and measures to be used to combat substance abuse. Interventions proposed in the Plan are based on the supply and demand framework, i.e. reducing demand, harm and supply (DSD, 2012).

It further deals with the establishment and registration of programmes and services, including prevention, early intervention, treatment and reintegration, and after-care; and

facilitate collaboration among government departments and other stakeholders; establishment of the Central Drug Authority (CDA) to monitor and oversee activities of the CDA (DSD,2012).

Most importantly, Chapter 2 of the Act deals with the minimum norms and standards for treatment centres and halfway houses. These standards are also in line with the international standards for the treatment of drug use disorders as enshrined in the UNODC (2017), as discussed in (2) above.

For example, the Act states that programmes that give effect to prevention services must:

- be accessible always;
- be available to individuals and their families;
- link service users with resources to maximise existing strengths;
- create developmental opportunities for new capacities that seek to promote resilience and increase ability of service users;
- discourage experimental use of substances so that experimental use of substances does not lead to substance abuse; and
- promote assessment of the prevalence of substance abuse in the community and any service provider who conducts the said assessment must (DSD, 2012).

This researcher will also seek to establish if the rendering of substance use disorder related services is in line with these standards, from the social workers perspectives at the Ehlanzeni District.

2.2.3 National Drug Master Plan

The National Drug Master Plan (NDMP) 2013 – 2017 of South Africa was formulated by the Central Drug Authority in terms of the Prevention and Treatment of Drug Dependency Act (20 of 1992), as amended, as well as the Prevention of and Treatment for Substance Abuse Act (70 of 2008), as amended, and approved by Parliament to meet the requirements of the international bodies concerned and at the same time the specific needs of South African communities, which sometimes differ from those of other countries (DSD, 2018).

The National Drug Master Plan (2013-2017) indicates that the impact of alcohol and substance abuse continues to ravage families, communities and society (DSD, 2018). It further attest that the youth of South Africa are particularly hard hit due to increases in the harmful use of alcohol and the use and abuse of illicit (DSD, 2018)drugs (DSD, 2018) .

The NDMP is characterised by the need to have all the stakeholders affected by substance use, to join hands and work together in finding a lasting solution to the issues of substance use. From a national level, the CDA is composed of government, private sector and civil society (Maluleke, 2014, p. 19). Government initiated the CDA to consolidate efforts and resources of all the relevant stakeholders in dealing with substance abuse to avoid duplication and fragmentation of services. The NDMP also gives directive or allowance for the provinces to form Provincial Drug Action Committees, where all the relevant government departments together with other stakeholders are represented (Maluleke, 2014).

At a grassroots level, the NDMP gives directions for the establishment of Local Drug Action Committees in communities. All the Drug Action Committees, from the provincial to the local level, are expected to come up with mini drug master plans to address the issue of substance abuse in their areas of jurisdiction in accordance with the NDMP (DSD, 2018). The focus of the Provincial Drug Action Committees is on treatment and aftercare, prevention and education, community development, research and information dissemination. The same focus is also applicable to the Local Drug Action Committees. The NDMP also acknowledges aftercare and reintegration services as focus areas in dealing with substance abuse (Maluleke, 2014, pp. 19–20)

The NDMP further postulates that the provincial substance abuse forums have the responsibility to assign a member of the forums to deal specifically with the portfolio of treatment and aftercare. However, the NDMP is not clear as to which social workers of NGOs and government should take the responsibilities for establishing and rendering aftercare and reintegration services, although it clearly emphasises that the Department of Social Development should take the lead in the substance abuse campaign (Maluleke, 2014) .

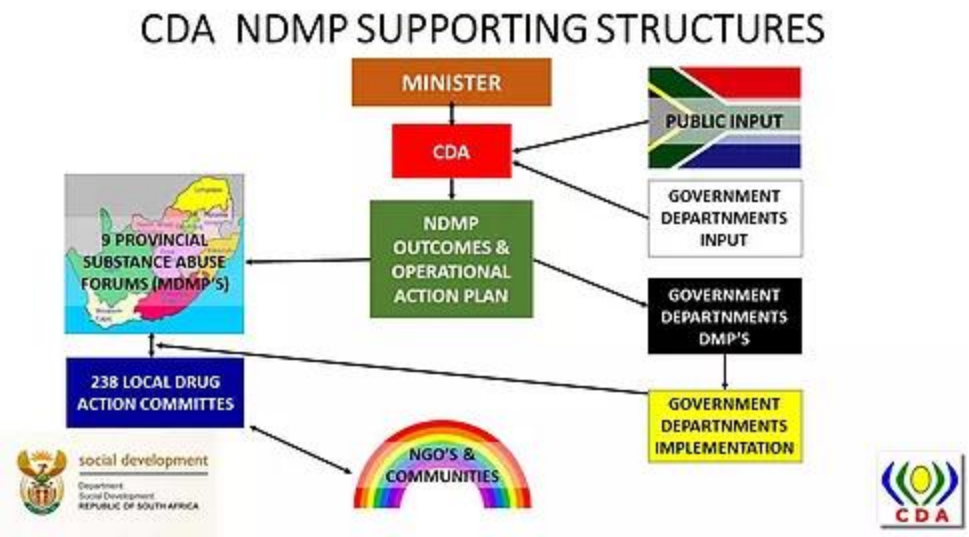
Recently, there have been deliberations on the new National Drug Master Plan (NDMP) for 2018-2022 may include radical changes that drug policy reformers have long been campaigning for (Broughton, 2017). The new NDMP seeks to assist implementers in the field of substance abuse to prevent and treat substance abuse holistically (Carreira, 2017). South Africa is required to combat the substance abuse problem in line with United Nations Conventions.

According to Carreira (2017) the key factors influencing the choice of strategy for the Draft NDMP 2018-2022 are:

1. The recognition of addiction as a brain disease rather than a social illness (and recognition that addiction is a relapsing chronic disease); and

2. The realisation that the total elimination of drug use and abuse is not possible and reaffirmation of UNGASS's vision to 'achieve a society free of drug abuse rather than a drug free society'.

The following structure is how the CDA aims to position itself in order to combat substance when drafting the National Drug Master Plan (NDMP). The NDMP is implemented for a period of 5 years, the current NDMP was implemented in 2013 running from 2013-2018.The NDMP is formulated by CDA in terms of the Prevention and Treatment for Substance Abuse Act 2008. The CDA is a statutory body, reporting to parliament, that is mandated to coordinate all efforts and initiatives to combat substance abuse(Carreira, 2017)



(Source: Carreira, 2017).

Figure 2.1: CDA NDMP Supporting Structures

As Geyer & Lombard (2014, p. 1) have indicated, in a nutshell, if drug policies such as the South African National Drug Master Plan are drafted according to a social developmental perspective, the efforts of stakeholders could be strengthened to mitigate substance abuse, eradicate drug-related crimes, and contribute towards achieving social development goals. It is as yet uncertain the extent which government departments, NGOs and other sectors offering SUDs services, comply with this plan.

2.3 Substance Use Modalities

2.3.1 Perspectives on the cause of substance use disorders

The increasing production, distribution, promotion and easy availability of substance together with the changing values of society has resulted in rising substance abuse related problems emerging as a major public health concern. However, sociologists, social workers, psychiatrists, other mental health professionals, educators, and politicians are increasingly identifying substance use and abuse as a critical public health problem. Despite attempts to limit access to psychoactive substances for the youth, the use of such substances is common among adults, adolescents and demand continue to grow (Sahu & Sahu, 2012) .

The reasons for use of the abusive of substance may vary from person to person and more than one reason could be responsible for it. According to Sahu (2012) the causes of substance abuse can be as follows:

Social factors:

- Peer pressure (One of the most important causes)
- Role-Modeling/imitation
- Easy availability
- Conflicts (usually intrafamilial)
- Cultural/Religious reasons
- Lack of social or familial support
- Social attitudes at celebrations
- Rapid urbanisation.

Psychological Factors:

- Curiosity
- As a novelty
- Social rebelliousness (disobedience)
- Early initiation
- Poor control
- Sensation seeking (feeling high)
- Low self-esteem (anomie)
- Poor stress management
- Childhood loss or trauma
- As a relief from fatigue or boredom
- To escape reality
- No interest in conventional goals.
- Psychological distress.

Biological Factors:

- Family history, genetic predisposition
- Pre-existing psychiatric or personality disorder, or a medical disorder
- Reinforcing effects of drugs
- Withdrawal effects and craving
- Biochemical factors.

2.3.2 Substance use prevention.

Prevention is understood as any activity designed to avoid substance abuse and reduce its health and social consequences. This broad term can include actions aimed to reduce supply (based on the principle that the decreased availability of substances reduces the opportunities for abuse and dependence) and actions aimed to reduce demand (including health promotion and disease prevention) (Medina-Mora, 2005).

> Although South Africa arguably has the most developed substance abuse treatment system in Africa, demand for treatment far exceeds supply. In addition, affordable state-sponsored treatment facilities have long waiting lists and private centres with high standards of care are unaffordable for most of the South African population. Basic logistical barriers also exist for the average South African person in terms of accessing treatment services competing financial priorities, travel costs and the lengthy travel distances to the nearest. These facts, combined with a growing and robust base of scientific evidence for the effectiveness of prevention strategies for AOD abuse point to prevention, rather than treatment, as the best possible strategy for addressing the burden of AOD abuse in South Africa.
>
> (Puljević & Learmonth, 2014, p. 185) .

According to the International Standards for the Treatment of Drug Use Disorders (2017) Outreach programmes vary enormously according to the local situation but typically the following ‘core services’ should be provided:

- Information and linkage to services caring for basic needs (safety, food, shelter, hygiene and clothing);
- Needle exchange and condom distribution;
- HIV/HCV testing and counselling;
- Hepatitis B vaccination;
- Education on drug-effects and risks involved in drug use;
- Basic assessment of substance use disorders;
- Brief Intervention to motivate change in substance use;
- Referral to treatment for substance use disorders
- Basic counselling/social support;
- Referral to health care services as needed; and
- Overdose prevention services including emergency naloxone (Clark, n.d.).

The scope of prevention also includes early intervention with individuals that have experimented with substances but are not severely dependent and may therefore be “reeducated “through learning interventions, as well as treatment of dependence, relapse prevention and social reintegration. It is now recognised that interventions within the whole spectrum reduce the burden of the problem for society (Medina-Mora, 2005).

According to Medina-Mora (2005) the burden of substance abuse can be divided into two areas: intoxication and dependence. The essential components of preventions are limiting the damage to the individual and society from intoxication (i.e. driving under the effects of psychoactive substances); and reducing the risk of exposure to substances and thus of developing dependence. Reduction of harm is a somewhat different approach of prevention. This type of measure has been shown to reduce major health and social consequences (Medina-Mora, 2005)

Research also shows that the most effective prevention strategies or interventions for reducing the burden of alcohol abuse to individuals and society is a multi-focused one. The WHO recommends “a mix of individual- and population-based approaches that target high risk groups and reduce per capita consumption in general (Puljević & Learmonth, 2014).

There are several specific concerns raised regarding the efficacy of prevention interventions in South Africa, these concerns arise largely since there is no national regulating legislation to oversee the training, qualifications and competencies of prevention service providers. There are also no minimum norms or standards to serve as guides for any prevention interventions. Owing to this, not only could the quality of these interventions be compromised, but there is no way of ensuring that prevention services are aware of the latest developments in prevention sciences In conjunction with this lack of an organised regulating framework, there is a paucity of research on the overall content and quality of Alcohol and Other Drugs (AOD) prevention services in South Africa. Consequently, the majority, if not all organisations rendering prevention services are doing so without knowledge of their effectiveness (Puljević & Learmonth, 2014, p. 185) .

Despite the advances in the substance use field, it remains an urgent need to develop more efficient prevention strategies. While support should be given to multidisciplinary research including the evaluation of intervention programmes better prevention strategies can be derived from learning more about how experience modifies the brain and the interdependence between genetic vulnerability and development, especially among children and adolescents exposed to substance use (Medina-Mora, 2005)

2.3.3 Substance use treatment

Globally, it has been estimated that a total of 250 million people, or 1 out of 20 people between the ages of 15 and 64 years, used an illicit drug in 2014 (World Drug Report, 2016). Approximately one in ten people who use illicit drugs are suffering from a form of a drug use disorder, including drug dependence. Almost half of people with drug dependence inject drugs into themselves and more than 10% are living with HIV, the majority of whom are

infected with hepatitis C. Drug use disorders are, therefore, a major global health problem (Clark, n.d.).

Drug use disorders are also a serious health issue and a significant burden for individuals affected and their families. There are also significant costs to society including lost productivity, security challenges, crime, increased health care costs, and a myriad of negative social consequences. The social cost of illicit drug use is estimated at up to 1.7% of GDP in some countries (World Drug Report, 2016). Caring for individuals with drug use disorders places a heavy burden on public health systems of Member States and therefore improving treatment systems by making them the best they can be would undoubtedly benefit not only the affected individuals, but also their communities and society (Clark, n.d.).

In the past, addiction treatment, at least for clients having trouble with alcohol, was considered successful only if the client became abstinent and never returned to substance use following discharge — a goal that proved difficult to achieve. The focus of treatment was almost entirely to have the person stop using and start understanding the nature of addiction. Today, treatment goals include a broad range of biopsychosocial measures, such as reduction in substance use, improvement in health and psychosocial functioning, improvement in employment stability, and reduction in criminal justice activity. Recovery itself is multifaceted, and gains made toward recovery can appear in one aspect of a patient's life, but not another; achieving the goal of abstinence does not necessarily translate into improved life functioning for the client. Treatment outcomes include interim, incremental, and even temporary steps toward ultimate goals (Centres for Substance Abuse Treatment, 1999)

According to the International Standards for the Treatment of Drug Use Disorders (2017).

> An effective national system for the treatment of drug use disorders requires a coordinated and integrated response of many actors to deliver policies and interventions based on scientific evidence in multiple settings and targeting different groups at different stages regarding the severity of their drug use disorder.

> The public health system is best placed to take the lead in the provision of effective treatment services for people affected by drug use disorders, often in close coordination with social care services and other community services. Treatment services should be available, accessible, affordable, evidence-based, and diversified.
>
> (Clark, n.d., p. 83)

This legislation further postulates that the availability of treatment services refers to the physical presence of services capable of treating patients with drug use disorders. The accessibility of treatment services refers to their reach or physical accessibility for the whole population. Treatment services must be located conveniently and in geographic proximity to public transport (including rural and urban areas). In addition, access should not be hindered because of attitudes towards certain population groups or other factors (Clark, n.d.).

> The affordability of treatment services refers to patients and the treatment system. Treatment services should be affordable for patients from different socio-economic groups and levels of income. At the same time treatment systems need to be affordable for the health and social system to be sustainable. The evidence-based approach of treatment services guarantees the quality of treatment services. Given the overall limitations in funding available for the treatment of drug use disorders, treatment interventions should be based on scientific evidence and follow evidence-based guidelines.
>
> (Clark, n.d., p. 84) .

Treatment services should be diversified and offer different treatment approaches. Not one approach fits for all disorders and its various stages. Therefore, a diverse range of

interventions should be in place in various settings to address the needs of patients with drug use disorders adequately. As recovery remains the ultimate goal of all treatment and care services, sustained recovery management services should be an integral part of it.(Clark, n.d.)

2.4 The Roles and Responsibilities of Social Workers in the SUD Field

It is of paramount importance that social workers have meticulous roles and they understand them as the field of addiction is shared amongst many disciplines and involving a plethora of professionals.

> Alcohol and other drug use are embedded in many of our social customs and cultures. Most people who use such substances will do so without harm to themselves or others. Unfortunately, a minority of people will develop problems which can negatively affect their own health and wellbeing and that of their families, friends and community. Social workers work regularly with the complexities of people's lives. The use of substances is often part of that mix and is frequently combined with mental ill health, poverty and domestic abuse. It is also an issue that cuts across all areas of social work practice; it is not just a child protection issue, it is also an issue for our adult service user groups, their families or carers. Social work is both a rewarding and demanding job. However, to do their jobs well they need clarity about what are their roles are and the support of managers to fulfil them.
>
> (Galvani, 2015, p. 2) .

Despite a growing evidence base, social work has struggled to respond adequately to substance use within its service user groups although evidence shows that some social work

educators, local authority workforce, and development training departments have attempted to respond with training on substance use topics.

In this range of physical and geographical environments, social workers in practice regularly support people who are negatively affected by their own, or someone else's, alcohol or other drug use (hereafter 'substance' use). Research evidence shows that, on average, adults' social workers (for example, those specializing in older people, people with learning difficulties or physically disabled people) are likely to be working with two to three people affected by their own substance use or the substance use of someone close to them (Galvani, 2015).

Working with substance use is part of social work practice. It is a social worker's statutory obligation alongside their duty of care. As evidence shows, it is increasingly a feature in the caseloads of all social workers regardless of specialism. Further, it often overlaps with people experiencing mental distress and domestic violence too. While it is more obvious in child protection work and among those working with people experiencing mental distress, they are not alone. Increasingly, social workers working with older people, disabled people, parents (within child protection services), and young people, are encountering substance abuse (Galvani, 2015) .

In essence, according to Galvani (2015) the following three key roles are the starting point for social workers in relation to substance use:

- To engage with the topic of substance use as part of their duty of care to support their service users, their families and dependents.
- To motivate people to consider changing their problematic substance using behavior and support them (and their families and carers) in their efforts to do so.
- To support people in their efforts to make and maintain changes in their substance use. How these are applied to each area of specialist area of social work practice will vary.

Galvani (2015) further adds that the roles will also vary depending on the social worker's level of experience and seniority as well as on their role, service environment, and service

model. As social workers become more experienced and move into management and mentoring roles, their knowledge and skills would be expected to develop and inform their support and supervision of less experienced staff. Advanced and principal social workers and managers would also be expected to take a strategic leadership role ensuring that responses to substance use are embedded in the organization.

2.5 Social Workers Collaboration within the SUD Field

Interprofessional collaboration is increasingly becoming an important factor in the work of social workers. In study by Ambrose-Miller and Ashcroft, (2016) a focus group was conducted with Canadian social work educators, practitioners, and students to identify barriers and facilitators to collaboration from the perspective of social work. Participants identified six themes that can act as barriers to collaboration: culture, self-identity, role clarification, decision making, communication, and power dynamics. These findings carry important implications for interprofessional collaboration with social workers in health practice (Ambrose-Miller & Ashcroft, 2016).

Historically, the substance abuse treatment system was often isolated from mainstream health care, partly because medical professionals had little training in this area and did not recognize or know what to do with substance users whom they saw in their practice settings. Welfare offices, courts, jails, emergency departments, and mental health clinics also were not prepared to respond appropriately to substance misuse. Today there is a strong movement to perceive addiction treatment in the context of public health and to recognize its impact on numerous other service systems. Thanks to the cross-training of professionals and an increase in jointly administered programmes, other systems are identifying substance users and either making referrals for them or providing appropriate treatment services (e.g., substance abuse treatment within the criminal justice system, special services for clients who have both substance abuse disorders and mental health disorders) (Centers for Substance Abuse Treatment, 1999)

Collaborative models bring various health care providers together — such as physicians, nurses, social workers, psychologists, pharmacists, dietitians, and others — to provide team-

based care. Key factors can help influence or deter successful collaboration. Social work has historical experience in team-based care and brings a unique perspective to health-care environments (Ambrose-Miller & Ashcroft, 2016) .

According to International Standards for the Treatment of Drug Use Disorders (2017) where possible, the organisation of specialized services for drug use disorders should be based on multidisciplinary teams adequately trained in the delivery of evidence-based interventions with competencies in addiction medicine, psychiatry, clinical psychology and social work.

In a nutshell, interprofessional collaboration in health care offers many rewards and challenges. Social workers can bring to the team a unique perspective concerning the patients to whom we provide care (Ambrose-Miller & Ashcroft, 2016).

2.6 Lack of Resources as a Barrier to Effective Substance Use Disorder Strategies

As stated above, social workers working in the substance abuse domain normally have limited resources and this may cause neglect to the victims of substance abuse. It is important to note that the increase in Substance abuse globally as reported by WHO (2014) may be caused by various factors, such as lack of funding or limited resources.

Inadequate attention to SUD is part of a broader trend of underinvestment in mental health care in certain countries, as the poorest nations allocate the smallest portion of their already strained public budgets to mental health care dealing with SUDs (Salwan & Katz, 2014). Policymakers have called attention to the need to improve access to treatment for SUDs in developing nations such as Nigeria, Asian countries and Southern African countries (Salwan & Katz, 2014).

The White Paper for Social Welfare (1997) commits the Department of Social Development to the transformation of social services by adopting a developmental approach that emphasises the interdependence between social and economic development (Department of Social Development [DSD], 2014).

The strategic plan of the DSD alludes to the fact that critical poverty relief and community development, child protection services, community services to the elderly, people with disabilities, and support services to victims of domestic violence substance abuse services are chronically under-budgeted (DSD, 2014)

Essentially, the limited capacity both in terms of numbers, skills and finances has required that certain policy shifts be made to ensure that services go to the neediest including services related to substance abuse. For example, the Ehlanzeni District only has one Detox Centre which is in Themba Hospital and it is expected to service the whole district. This implies that substance abuse treatment and prevention services are affected in terms of capacity. The high exodus of social workers from the profession and from both the government and non-governmental sector for better prospects elsewhere as well as the impact of globalisation, have exacerbated the capacity problem. This is often felt in service delivery and in the impact of services in communities served (including substance abuse related services), (DSD, 2014). The constraints are not only felt by government, but also by the non-governmental organisations that provide services to communities (DSD, 2014). However, there has been an inability, especially at provincial level, to increase the subsidies to the non-governmental sector, particularly to new sectors such as religious organisations, volunteers, and community-based organisations that are willing to provide a service to the under-resourced, historically disadvantaged and the poor. This might also be an indication of the increasing substance abuse pandemic as the issue of funding (especially amongst NGOs) is also a barrier to successful substance abuse related intervention.

According to Davis (2012) funding is a major obstacle facing NGOs in South Africa due to the global economic crisis, from which SA has not been spared; the country's NGOs are experiencing funding problems, as donations, particularly from individual and private donors, have diminished substantially thereby affecting substance abuse services (Geyer & Lombard,2014)

According to Lisa (2010) Vetten a PhD Fellow based at the Wits City Institute, University of the Witwatersrand, care is a public good and no society would survive without it. Its neglect sustains and reshapes pre-existing gendered forms of inequality. She further alludes to the

fact that, the proportion of the Department of Social development's budget allocated towards social services is also small: 88% is allocated to grants, with just 10% going towards social welfare programmes. It appears that the department's grants system may be an achievement, but the same cannot be said of their welfare services (Vetten, 2017)

Vetten (2017) reports that budgets have simply not been adequate to addressing decades' worth of under-resourcing, especially in services to black communities. Indeed, when the review of the White Paper for Social Development was released in October 2016, committee chair Professor Vivienne Taylor noted "huge gaps" in the provision of social welfare services (Vetten, n.d.) This has an indirect or direct impact in the rendering of substance abuse services to its victims.

In South Africa, "Care workers in the not for profit sectors are appallingly badly paid. The state's contribution has not kept up with inflation while avenues of supplementing these funds from donors have become increasingly difficult over the past eight years" (Vetten, 2017, p. 1). This might have dire consequences and may affect the perceptions of social workers in the Ehlanzeni district in rendering services to people with SUDs.

2.7 Stigma Towards Substance Users

Stigma can be defined as stereotypes or negative views attributed towards a person or groups of people when their characteristics or behaviours are viewed as different from or inferior to societal norms (Kubiak et al., 2011). Stigma can be internalised by persons with the condition (self-stigma) or communicated directly or indirectly by others (stigmatised attitudes). The degree and impact of stigma may vary depending on the mental or behavioural conditions and who holds the stigmatising view such as family members or health professionals (Kubiak et al., 2011)

Research has found that social workers, social work students, and other mental health providers often have a biased view against working with substance abusing clients. Such social workers may be unaware of internalised stigma that causes an impediment to providing effective care and to practicing proper interventions.

Researchers (JOHNSON et al., 2007) have also shown that Social Workers can have a negative perception when their family members or close relatives are struggling with substance abuse. The beliefs commonly known amongst social workers are, substance abuse clients are homeless, live in poverty, are unemployed, lack morals, and have been referred by the criminal justice system. Such negative attitudes include the idea that treatment will not be effective because of a high likelihood of relapse. Other commonly held negative beliefs social workers have are “clients often do not tell the truth about their substance use,” “time constraints,” “questioning the client’s integrity,” and “not wanting to frighten or anger the client” (Johnson et al., 2007, p. 1077).

Kubiak et al., (2011)In theory, according to Kubiak et al., (2011), one way to reduce this treatment lag involves removal of obstacles such as social stigma that may be a barrier to seeking treatment for individuals with such conditions. The U.S. Surgeon General (1999) and the WHO (2001) cite stigma as one of the greatest obstacles to effective treatment of mental illness.

Social workers provide more mental health services in some areas of the world than psychologists, nurses, and psychiatrists combined and, as such, can either successfully engage or disenfranchise those seeking or in need of services. It is uncertain what social worker’s attitudes and beliefs about clients and/or treating certain conditions are – whether held consciously or subconsciously – and if these beliefs effect successful client engagement and retention (Kubiak et al., 2011)

Kubiak et al., (2011) further postulates that many social workers may feel an embarrassment or discomfort related to their personal histories that might dampen levels of help and practice-related behaviours. This is one of the facets of stigma and negative attitude that can delay interventions directed toward the earliest manifestations of drug dependence, depression, and related neuropsychiatric disturbances. It may also contribute to gaps between need for drug and mental health services and delivery of effective services

In addition, according to Hughes and Kalman (2006), personal attitudes and beliefs play a role in practice behaviours of counsellors. For example, nicotine dependence is closely

related to other alcohol and drug dependences – despite this occurrence, counsellors often do not advise their clients to quit smoking when dealing with a co-occurring addiction.

In essence, Ahmedani et al., (2011) have indicated that the counsellor's own smoking behaviours make them reluctant to confront someone engaging in similar behaviour or with an internalisation of the stigma regarding smoking. Moreover, Siebert (2003) found that social workers who had used marijuana within the past year were less likely to identify marijuana use among their clients as problematic. In addition, recent literature has documented a similar problem among future physicians, in which medical students with depression more often endorsed stigma attitudes than those that were not depressed (Schwenk et al., 2010)

Stigma can be one of the greatest barriers that keep people from seeking or accessing effective psychiatric treatment. People with mental health-related conditions are often avoided or thought to be frightening, unpredictable, and strange. The structural attitudes in society may also be internalised by those affected by neuropsychiatric conditions, a process termed 'self-stigma'. While limited health professional stigma research exists, a few studies have documented its importance. In a survey comparing the attitudes of mental health professionals and individuals in the Swiss general population, Noord and colleague(Ahmedani et al., 2011). found equivalent levels of stigma-related feelings – that is, the professional had stigma-laden feelings equivalent to those in the general population without benefit of professional education (Ahmedani et al., 2011).

2.8 Social Workers Knowledge in Substance Use and Addiction Management

The scope of social work education towards attaining the undergraduate social work degree does not cover a lot in terms of substance abuse treatment. This is particularly worrisome in an epoch where social workers are increasingly in demand for treating clients with SUDs (Wells, Kristman-Valente, Peavy, & Jackson, 2013b).

According to Chikadzi and Pretorius (2011, p. 258) although there has been a change in the focus of social work education over the past six years, the curricula are still predominantly influenced by a Eurocentric world view of technocratic micro-practice and managerialism,

resulting in approaches often inappropriate to address and deal with the uniquely South African and African challenges of underdevelopment. This means that generalists' information is insufficient and social workers do not have a wide array of training in the field of substance abuse (Gresham, 2017)

Historically, social work education (SWE) has not included formal and in-depth training to address substance use in either coursework or fieldwork. Health-care reform offers promise to integrate medical and behavioural health through employment of social work professionals. It is critical that screening, brief intervention, and referral to treatment (SBIRT) be incorporated as basic skills for all trainees, and other evidence-based practices be offered to insure an adequate work force. (Pugatch et al., 2015)

The profession of social work has a history of failing to train and prepare clinicians to work clinically with substance abuse (Hall et al., 2000). Historically, according to Hall et al., (2000) two social work education influencers such as Schlesinger and Barg (1986) reviewed training in social work programmes in New England and concluded that social workers were underprepared for dealing with addiction. Nearly three decades later, studies demonstrate that social workers continue to lack preparedness in treating clients with SUDs, which stems from deficits in education, training and field placements to prepare them for substance use issues (Hall et al., 2000).Several recent surveys of social work degree programme content requirements found that most programmes did not require substance use courses, had limited substance use electives or related field placements, did not have a designated substance use clinical track, nor did they offer an accredited programme in substance use and addiction management (Quinn & Straussner, 2010)

The lack of recognition, training and knowledge about SUD in social work curricula was termed "institutional denial and minimization" by Quinn & Straussner (2010)This notion was supported by Chikadzi and Pretorius (2011) who have indicated that the social work education and training is largely influenced by Western models and Eurocentric views, thus this provides little training in the South African tertiary education.

Some studies (Hall, et al, 2000) have proven that a lack of knowledge and training in schools on substance abuse can affect the way social work students perceive this population, and by not being competent enough decreases their confidence and capability to provide services to this population

Recently, Bachelors and Masters Social Work programmes have begun to focus on the issues of substance abuse in their curricular offerings (Gresham, 2017). Programmes are designed to prepare students to practice with individuals, families, groups, communities, and organisations in rural and urban settings. Students are prepared to engage in prevention, treatment, intervention, clinical practice, research, and administrative activities that promote human well-being (Gresham, 2017).However, this is done on minimal level especially in the African context.

People's beliefs and attitudes are shaped by their personal knowledge of the topic. Previous research has shown that schools of social work should include a mandatory course in the curriculum because it allows students to explore their own biases and attitudes before going out into the field (Amodeo & Fassler, 2000). Research has demonstrated that training social workers appears to increase the likelihood that they will: (a) work with the affected client population; (b) assume roles related to intervention; (c) seek employment involving work with affected clients; (d) perform assessments and intervene; and, (e) be optimistic, confident, and competent about this area of work (Amodeo & Fassler, 2000). This clearly states that knowledge is key; an increase in knowledge regarding a certain population will promote a decrease in negative perceptions of that population. (Soto & Stuart, 2014)

.

As social policy changes and new evidence-based practices (EBPs) for substance use emerge, it is increasingly necessary for social workers to take on implementation and administration of these practices, but the lack of the necessary knowledge to do so is a major concern. To successfully bridge the gap between substance abuse and general social work in line with proposed policy changes, social workers need to increase their skills for serving

those populations who will most likely be affected by these policy shifts, such as clients with Substance use disorders (Gorin, Gehlert & Washington, 2010).

(Stein, 2003) reports that the research and reports from the field have suggested that the way social workers and other clinicians respond to those with substance use disorders indicates that there is a need for adequate training to positively respond to clients with substance use disorder problems. In a study by Richmond and Foster (2003) to investigate mental health professionals' attitudes toward substance use disorder clients, it was found that participants educated to a postgraduate level were less moralistic in their approach and had greater treatment optimism. In another study, by Stein (2003) it was found that shorter-term training programmes do not change social worker attitudes and beliefs. However, Stein found that there was limited change when Master's level social work students participated in short-term educational sessions.

2.9 Attitudes of Social Workers towards Substance Use and Addiction Management

The problem of negative attitudes toward substance misuse and how it impacts the quality of care provided to those with substance use disorder problems is a pervasive one that extends to practitioners who treat mental health patients Gresham (2017). The stigma and unwillingness, or even lack of knowledge and positive attitudes by social workers to effectively engage and treat people with substance use disorder causes instability among many communities, and people with substance use disorders proportionally increase. According to Hills et al. (2016) South African studies have suggested that street children (who are resilient but also suicidal, engage in unprotected sex and another high risk sexual behaviour as a means of survival) have high rates of substance abuse and are physically abused and stigmatized due to their state of homelessness.

According to Burns et al. (2012) social workers can help with substance use disorders by using trauma-informed, attachment-informed, and systems-based approaches to direct practice in individual therapy and family therapy with special attention to multigenerational trauma and substance abuse. The role of the social worker may include providing in-home therapy supporting parents to be more effective with parental supervision, providing

structure, and facilitating healthy caring communication. Burns (2012) further articulates that, social workers may serve on multidisciplinary teams to advocate for a child who is adjudicated, abused, and/or neglected. In addition, social workers may provide expert testimony in courts and participate in permanency planning for children in and out-of-home placements. Lastly, social workers play an essential role in specialised courts (family courts, mental health courts, adult drug courts, and juvenile drug courts) by providing a unique person in the environment and multisystem lens to helping children and families. Specialised drug courts have been shown to produce favourable outcomes for the whole family (Burns et.al, 2012).

Moreover, social workers working in the substance use domain normally have limited resources and this causes some neglect to the victims of substance use. Social workers regularly encounter individuals, families, and communities affected by substance use disorders (SUDs) (National Standards for Social Work Practice, 2003, p. 5). Research has found that social workers, social work students, and other mental health providers often hold some biased views against working with substance abusing clients.

Social workers may be unaware of the internalised stigma that causes an impediment to practising effective and proper interventions. Research has also shown that Social Workers can have a negative perception when their family members or close relatives are struggling with substance abuse. Adverse beliefs that have been commonly known amongst social workers are, substance abuse clients are homeless, live in poverty, are unemployed, they lack morals, and have been referred by the criminal justice system. Social workers' negative attitudes include the idea that treatment will not be effective because of a high likelihood of relapse. Other commonly held negative beliefs are that social workers believe that "patients often do not tell the truth about their substance use," "time constraints," "questioning the patient's integrity," and "not wanting to frighten or anger the patient" (Johnson et al., 2007, p. 1077).

Moreover, many studies have found that mental health clinicians and medical health care professionals often have a negative view of clients who abuse substances (Amodeo & Fassler, 2000). In 1984, Googins (as cited by Soto and Stuart, 2014) suggested that the

attitudes of clinicians, which include social workers, closely mirror that of the public who believe that alcoholics have a moral deficiency. This belief in moral inferiority leads to the assumption that alcoholism cannot be treated. Steen (2012) also noticed that substance abuse treatment providers would “often internalize and transmit dominant values about the lack of innate goodness and worth of substance users” (p. 216). This creates a barrier to positive outcomes for the client and to effective practice for social workers. An earlier study conducted by Stein (1999) expressed a similar argument, stating that even though there has been an increase in accepting addiction as a medical issue that is responsive to treatment; negative attitudes toward substance abusers are still prevalent. Independent later studies also show that professionals and mental health students also believe that clients who abuse substances do not have a good chance at recovering from the addiction. (Soto & Stuart, 2014)

In addition, societal perceptions of female substance abusers generally increase social workers negative beliefs because their attitudes often reflect those of the public. This can impact the substance-abusing women which leads them to feel shame and guilt that can cause barriers to seeking treatment. Furthermore, as research and treatment has originally been done on men, social workers find that their interventions are not as effective with women as it is with men. Unfortunately, this misleads social workers and causes negative beliefs that women do not respond to treatment as effectively as men do. It is apparent, therefore, as mentioned above, that mental health professionals are associated with negative beliefs towards substance abusing clients. (Maluleke, 2016)

2.10 Willingness to Treat Substance Abuse

The profession of social work has a unique role in preventing and treating alcohol and other drug problems. It is important that social work professionals are cognizant of what beliefs they hold and how their beliefs about substance use disorder treatment and prevention may affect practise (Richmond & Foster, 2003)

While the levels of self-stigma as experienced by users of these drugs are major obstacles to successful outreach, early intervention, treatment, and rehabilitation for alcohol, tobacco, and other drug use disorders, this includes family stigma as experienced by family members of the users, and professional stigma as experienced by counsellors or clinicians who provide 'front line' care and are expected to be active participants in initiatives such as the current federal SBIRT initiative (Screening, Brief Intervention and Referral to Treatment). (Ahmedani, Kubiak, Rios-Bedoya, Mickus, & Anthony, 2010)

Straussner (2012, as cited in Gresham, 2017, p.24) emphasises that "the social work profession needs to dispel existing beliefs among educators and practitioners that addiction is a unique social problem to which the profession has little to contribute, according to one of its most prolific researchers", with the researcher's experience in the addiction management fraternity. It was his observation that many social workers are rather reluctant or unwilling to assist people with substance use disorders, as many believe it is a self-inflicted disorder. This is normally an obstacle for social workers who work in the addiction management treatment domain, as referral to other institutions with social workers proves fruitless. Unfortunately, the willingness to treat substance abuse by social workers remains a concern for combating substance abuse in Mbombela.

Richmond and Foster (2003), in their study of 103 mental health professionals, found that postgraduate clinicians were not as moralistic in their approach to substance use disorder and thus were more optimistic about patient outcomes. The researchers also found that licensed social workers were more permissive in their willingness and attitudes than nurses. The study recommended that research should be conducted to determine which elements of postgraduate education can contribute toward a more positive will regarding working with substance use disorder clients. (Richmond & Foster, 2003)

2.11 Theoretical Framework of this Study

This study will be influenced by two theories which have a bearing and a link on the topic. The first theoretical framework which underpins this study is the bio-psycho-social approach. According to Barrio-Carrio, Suchman and Epstein (2004, p.576),the bio-psycho-social

approach is a “way of understanding how suffering, diseases and illnesses are affected by multiple levels of organisation from the societal to the molecular”. (Borrell-Carrió et al., 2004)

Borrell-Carrió et al, (2004) further elucidate that the bio-psycho-social approach systematically considers biological, psychological, and social factors and their complex interactions in understanding health, illness, and health care delivery. In the South African context this may mean that every facet of a person is considered in dealing with a person with a SUD or during early intervention of diagnosis. This theory will allow the social worker to probe certain ecological and social factors in the quest to help a person with SUD, thus this theory best fit this research. This is also paramount in working in a multidisciplinary setting as certain socioeconomic factors can play a role amongst victims of SUDs.

The bio-psycho-social approach will assist in guiding the study to take the angle of multidimensional perspective in interpreting data. This will inform the interrelation aspects of the biological, physical social and cultural perspective, as Du Plessis (2012, p.11) also elucidates that substance abuse can best be understood as a complex disorder determined through interaction the of biological, psychological, and socio-cultural processes and not in isolation.

2.11.1 Health Belief Model

The Health Belief Model was developed in the 1950s by a social psychologist in the United States Public Health Service to explain the widespread failure of people to participate in programmes to prevent and detect disease. The model identifies factors that serve as a barrier to service use. Beliefs and perceptions of diseases vary considerably from practice. The Health Belief Model proposes that individuals who perceive a given health problem as serious, are more likely to engage in behaviours to prevent the health problem from occurring or reduce its severity (Piddennavar & Krishnappa, 2014). Therefore, for social workers to have adequate knowledge about substance use and addiction management they should perceive substance use as a serious chronic disease so that they are able to use effective strategies to address the epidemic on different levels of prevention in communities.

This relates to the topic as the purpose of the research is to reconnoitre or gather if the perceptions of social workers rendering services to clients with SUDs in the Ehlanzeni District hinder the effective delivery of services. According to Piddennavar & Krishnappa, (2014) the barriers to taking an action lies in a person's opinion of the concrete and psychological costs of this advised action. For example, tobacco users should weigh up the benefits (which are going to change his quality of life) with the barriers (which are stopping him from quitting something like tobacco use). This also applies in the perceptions of social workers about the overall attitudes and views of the addiction management domain. Their (social workers) willingness to work with people with SUDs can also have perceived benefits in improving this field of specialisation.

CHAPTER 3:

RESEARCH METHODOLOGY

3.1 Introduction

The research methodology applied during the research study is described in this chapter. The chapter outlines the research questions and both the primary and secondary aims. In

addition, the research strategy, inclusive of the approach and design are explained. The population and sample are defined, and the sampling procedure is described. The method of data collection is discussed, and the research instrument used in the process of data collection is referred to and how that data is analysed is explained. The trustworthiness of the study is then highlighted. In addition, the ethical principles considered during the research study are described.

3.2 Research Questions

Based on the nature of this study. The research question is formulated to answer the 'what' question in relation to the phenomenon that is investigated. The research question is as follows:

> **What are the perceptions of social workers regarding the rendering of services to people with substance use disorders in Ehlanzeni District, Mpumalanga?**

3.3 Primary Aims and Secondary Objectives of the Study

The aim of the study is to investigate the perceptions or views of social workers in relation to services relating to substance use and addiction management in the Ehlanzeni District.

The specific objectives of the study are:

1. To describe the perceptions of social workers in the Ehlanzeni district in relation to substance use and addiction management services
2. To investigate associations between attitude and demographic factors, such as age, experience, professional status, additional training, educational level and in relation to the substance use related services

3.4 Research Strategy

The study adopted the qualitative approach which comprehensively explores human behaviour, feelings and probes for reasons and detailed explanations over the researched

dynamics in question. It is for these reasons, amid others, that the researcher meticulously chose this approach as the best fit for the study. This approach allowed the researcher to observe the respondents' reactions to questions and enabled gathering the data in the respondent's own words to understand the respondent's lived experience which is central to the qualitative approach. A research design is a plan or blueprint of how one intends conducting research (Babbie & Mouton, 2010).

According to De Vaus (2006) research design refers to the overall strategy chosen to integrate the different components of the study in a coherent and logical way. Furthermore, Fouché & Delport, (2005, p.82) refers to "a set of logical arrangements from which prospective researchers can select one that is suitable for their specific research goals". Babbie (2007, p.87) further adds that research is about the plan of a social enquiry. Within a qualitative approach, the use of a multiple case study design was therefore considered relevant for this study.

Case study research design involves the study of an issue. Walliman (2006) states that in the study of a social group, community, system, organisation or social event, it is pragmatic to choose a case study; or one instance or a small number of examples from the list and to study them in detail within their own context to make considerations and judgements (Walliman, 2010). The author (Walliman, 2010) also suggest a multiple case study is needed for more than one case in a study. Therefore, since this research had three different focus groups (DSD, SANCA and NICRO) this researcher used a multiple case study which is basically a combination of more than one case study. Other advantages are outlined by Yin (2003) who explains that when the researcher chooses to do a multiple case study, he can analyse the data within each situation and across different situations, unlike a single case study. Yet another interesting rationale for adopting the multiple case study is that in a multiple case study the researcher studies multiple cases to understand the similarities and differences between the cases (Baxter,2008). Therefore, according to the researcher can provide literature with important influences from its differences and similarities.

Substance use/addiction management is a very broad field in the social sciences. Thus, this design helped the researcher narrow down the substance abuse domain. The key strength

of using multiple sources and techniques in the data-gathering process also influenced the researcher's choice of choosing this research design. (Yin, 2003)

Since the research is exploratory and descriptive in nature it was also the most useful (and appropriate) research design for a study that sought to address a subject about which there are high levels of uncertainty and ignorance; particularly when the problem is not very well understood (such as the perceptions of social workers regarding SUDs) (Chindoti, 2013). The main aim of exploratory research is to identify the boundaries of the environment in which the problems, opportunities or situations of interest are likely to reside, and to identify the salient factors or variables that might be found there and be of relevance to the research (Chindoti, 2013).

The research is descriptive in nature, since it 'describes' a phenomenon which in this case are the perceptions. Descriptive research is used to answer questions of Who? What? When? Where? and How? − the usual factors associated with a research question or problem.The 'what' included the perceptions of social workers in the Ehlanzeni district. The research study was cross-sectional, since the researcher had one-time interaction with the participants. Consequently, the exploratory and descriptive research was most fitting and relevant for the study.

3.5 Population, Sample and Sampling Procedure

According to Walliman (2001, p.276 as cited in Maluleka 2013, p. 41) population is a collective term used to describe the total quantity of cases of the type with which the study deals. Owing to the nature of the study, the population of the study were drawn from the social workers of the Ehlanzeni district, in Mpumalanga Province. These where all qualified social workers, from SANCA Lowveld, NICRO Nelspruit and some of Mpumalanga Department of Social Development at the Ehlanzeni District.

Regarding the sample, which is defined as a smaller (but hopefully representative) collection of units from the population used to determine truths about a population (Bernard, 2012).

The researcher adopted the characteristics of a good sample design by Kothari (2004), which indicates that:

- Sample design must result in a truly representative sample;
- Sample design must be such which results in a small sampling error;
- Sample design must be viable in the context of funds available for the research study;
- Sample design must be such so that systematic bias can be controlled in a better way; and
- Sample should be such that the results of the sample study can be applied, in general, for the universe with a reasonable level of confidence.

Hence for the abovementioned reasons the participants consisted of 4 (four) social workers in the focus group from DSD, SANCA (6) and NICRO (7) in three different focus group discussions.

According to the two types of sampling procedures mentioned by Babbie and Mouton (2010) (probability and non-probability sampling) this study employed the non-probability sampling method. Babbie (2010) defines non-probability sampling as any technique in which samples are selected in some way not suggested by probability theory. Hence, within the range of different non-probability sampling techniques, the researcher made use of purposive sampling. Purposive sampling according to Strydom, (2005, p. 202) is based entirely on the judgement of the researcher and whether the sample possesses the elements that contain the most characteristic, representative or typical attributes of the population. Hence, the researcher has initially obtained three letters of permission from the concerned institutions granting authority to conduct the research study for a social work qualification; and therefore, experience in addiction management domain proved to be the specific criteria for selection.

No participants without certain criteria were granted permission to participate in the study. The purposive selection of participants from the Mpumalanga Department of Social Development, SANCA LOWVELD and NICRO included two distinct criteria as follows:

- participants had to be registered with the South African Council for Social Service Professionals (SACSSP); and be

- currently working on the substance abuse domain, within the Ehlanzeni District.

3.6 Research Instrument

The researcher used focus group (FCG) discussions. A letter summarising the purpose of the study and background was provided to all participants prior to the group discussions. According to Greeff (2005, p.300 as cited in Maluleke, 2014) a focus group can be defined as “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment”. The advantages of focus group discussions are that key issues, ideas, and concerns are identified from multiple respondents at once; the data is qualitative in nature and is thus descriptive. The researcher had three focus group discussions. The discussions were guided by the questionnaire’s guidelines

The predominant reason for employing this research instrument was largely due to the plethora of positive traits for the respondents in the group discussions. The employment of this instrument allowed for different techniques such as open-ended questions. This instrument was also key in ascertaining reliability because the researcher needed to ascertain who answered the question in the group discussion. Ultimately, the researcher was able to read non-verbal cues and body language and other reactions to guide the group discussions. The researcher used direct and non-direct observation to avoid biased information in what the participants proposed.

The FCG techniques were helpful to the researcher in achieving the same level of knowledge and understanding as the respondents and in collecting detailed information from the study’s respondents. The respondents expressed their opinions, thoughts and feelings freely using their own words. Audio tapes recorded the responses of the participants after they provided consent for their use. The FCGs discussions consisted of questions developed according to the study’s objectives which ensured that the researcher achieved the desired goals of the study. The interviews took approximately 45 minutes to 1 hour.

3.7 Pre-testing of the Research Tool

Pre-testing is highly regarded as an effective technique for improving validity in qualitative data collection procedures and the interpretation of findings (Hurst et al., 2015). The researcher pre-test the instrument by providing the group discussion questions to two professionals for their expert opinion in terms of tool and content to guide the discussions.

3.8 Method of Data Collection

According to Burns (2012) data collection is the precise, systematic gathering of information relevant to the research purpose or specific objectives, questions, or hypotheses of a study. Maluleke (2014) indicates that there are different data collection methods, depending on the research approach. Gill, Stewart, Treasure, & Chadwick further add that there are a variety of methods of data collection in qualitative research, including observations, textual or visual analysis (e.g. from books or videos) and interviews (individual or group). However, the most common methods used, particularly in healthcare research, are interviews and focus groups (Gill, et al., 2008)

In this research, focus groups (FCGs) were used. According to Greeff (2005, p.300 as cited in Maluleke, 2014) a focus group can be defined as “a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive, non-threatening environment”. This kind of discussion is guided, monitored and recorded by a researcher, sometimes called a moderator or facilitator (Gill et al., 2008) The advantages of focus groups are that key issues, ideas, and concerns are identified from multiple respondents at once; the data is also descriptive in nature and is thus qualitative (Gill et al., 2008). The researcher’s three focus groups were drawn from the Department of Social Development (Ehlanzeni District), from NICRO Nelspruit and from SANCA Lowveld.

3.9 Method of Data Analysis.

Data analysis is central to credible qualitative research. Data analysis is basically the process of systematically applying statistical and/or logical techniques to describe and illustrate, condense and recap, and evaluate data (Cohen et al., n.d.) . The researcher used

thematic analysis to analyse data by identifying patterns or themes within qualitative data (Maguire & Delahunt, 2017).

There are many other ways to approach thematic analysis. The goal of a thematic analysis is to identify themes, i.e. patterns in the data that are important or interesting, and then use these themes to address the research or say something about an issue (Maguire & Delahunt, 2017). This is much more than simply summarising the data; a good thematic analysis interprets and makes sense of it (Maguire & Delahunt, 2017). That is why in conducting this research, the researcher used the process of Creswell as outlined in De Vos (2005) to identify themes (i.e., thematic analysis). This was be done by following the following nine critical steps of thematic analysis:

- Step 1: Planning for capturing of data.
- Step 2: Data collection and preliminary analysis.
- Step 3: Managing or organising the data.
- Step 4: Reading and writing memos.
- Step 5: Generating categories, themes and patterns.
- Step 6: Coding the data.
- Step 7: Testing emergent understandings.
- Step 8: Searching for alternative explanations.
- Step 9: Writing the report.

The reason for choosing this method was because the researcher wanted to comprehend the phenomenon by looking at how various social workers perceive the addiction management/ SUDs domain; hence the thematic analysis was the most suitable for this research study.

Moreover, the researcher interviewed human beings (social workers) and some values could be not quantifiable without this method of analysis. The unquantifiable variables were qualitatively analysed with the use of thematic analysis. The

variables are inclusive of the opinions that respondents gave regarding the research questions.

3.10 Trustworthiness of the Study

Qualitative research is more about an inquiry into the in-depth, personal and sentimental information on people (Maluleke, 2013). According to Shenton (2004, p. 64) for a qualitative research to be trustworthy, the research must meet the criteria of credibility, transferability, dependability and conformability (Shenton, 2004). The researcher will go to extreme lengths in ensuring that the research is trustworthy. As a result, the issue of the reliability, validity, generalisability, objectivity and reliability of qualitative research has constantly been questioned in several instances by the positivists due to its nature of approach(Sinkovics, Penz & Ghauri, 2008, p.689).

For this study, the researcher took all the necessary measures to ensure trustworthiness (Sinkovics et al., 2008) . The strategies used to ensure this trustworthiness will be discussed below as well as measures taken to ensure that the criteria of trustworthiness were met as directed by Shenton (2004, p.64).

3.10.1 Credibility

Credibility in research ensures that the study measures or tests what is intended to measure. There are various strategies for ensuring the credibility of the research. One strategy in ensuring the credibility of the research is through the adoption of appropriate, well recognised research methods (Shenton 2004, p.64).

In this study, the researcher made use of the conventional and standardised manner of conducting qualitative research by making use of focus group discussions as a method of data collection − which is one of the most widely accepted and credible methods of data collection. Another strategy of ensuring trustworthiness was the early familiarity with the culture of the participating

organisations prior to the FCGs. The researcher had meetings with the Department of Social Development in Mpumalanga, NICRO and SANCA Lowveld to enable familiarity with the institutions for three months prior to the day which the FCGs were done. This frequent briefing between the researcher and the supervisors played a huge role in ensuring the credibility of the research (Shenton, 2004, p.67).

3.10.2 Transferability

According to Maluleka (2013) transferability is the external validity that is concerned with the extent to which the findings of one study can be applied to other situations (Shenton, 2004, p.69). One way of ensuring this transferability is for the study to provide the background data to establish context and a detailed description of the phenomenon in question to allow comparisons to be made (Shenton, 2004, p.73).

To ensure transferability, therefore, the researcher provided comprehensive knowledge and background about addiction management with SUDs for future researchers to make use of the study.

3.10.3 Dependability

According to Shenton (2004, p.71 as cited in Maluleka, 2013) dependability ensures that the same technique in research used in the study can produce the same outcome when used in the same context in the same methods with the same participants.

Shenton (2004, p.71) adds that the researcher would need to clearly reflect on the research design and its implementation as used in the study so that readers of the study can follow the process. This entails a link as to how they are relevant to the research study rather than just defining concepts. This study has been clearly and comprehensively conceptualised and the research methodology used in the

research has been outlined to make sure that the understanding of the readers and future researchers is met.

3.10.4 Confirmability

Confirmability ensures that the research instrument used in the study is not dependent on human skill to be objective (Shenton, 2004, p.72). However, it can also be acknowledged that ensuring objectivity can be a challenge because the data collection instruments are made by humans which make them vulnerable to bias (Shenton, 2004, p, 72). This researcher, therefore, ensured confirmability by application of an audit trail.

For the trial, the researcher detailed the process of data collection, data analysis, and interpretation of the data. Unique and interesting topics were recorded after the data collection. The researcher further merged themes and explained what they actually meant. Moreover, the researcher also ensured confirmability by using the technique called reflexivity. Reflexivity is an attitude that a qualitative researcher adopts when collecting and analysing the data (Shenton, 2004). The researcher applied this technique with diligence.

3.11 Ethical Considerations

Social science research has long been concerned with ethical issues. Social science investigates complex issues which involve cultural, legal, economic, and political phenomena (Fouka & Mantzorou, 2011). This complexity means that social science research must concern itself with “moral integrity” to ensure that research process and findings are “trustworthy” and valid (Mollet, n.d.) .

All social research involves ethical considerations mainly because the sources of data collection are from people who have human rights which must be respected (Fouka & Mantzorou, 2011). According to Flick (2009, p. 36), codes of ethics are formulated to regulate the relations of researchers with the people and the field

they intend to study. For this study, the researcher adhered to the following principles

3.11.1 Informed consent

Voluntary informed consent is a prerequisite for a subject's participation in research. Informed consent is a norm in which subjects base their voluntary participation in research projects on a full understanding of the possible risks involved (Babbie, 2007, p. 64). Informed consent comprises three major elements - information, voluntariness and comprehension (Clewlow, n.d.). When providing information researchers must ensure that participants are given sufficient detail about the nature of the research and the procedures involved; this should highlight the objectives of the study, potential risks and benefits and any alternative treatments must be made clear (Clewlow, n.d.).

Social investigations also require informed consent. Before the commencement of the study the researcher created an agreement that clarifies the obligations and responsibilities for of each of them. Furthermore, the nature of the study was thoroughly and comprehensively explained. The participants were informed about not revealing their personal information. It is imperative that people are informed about the nature of the study and given an opportunity and room to decide if to be part of the investigation. Thus, the participants who agreed to participate in the study were given the informed consent form to sign which encompassed all the information about this research study (See Appendix C).

3.11.2 Anonymity and confidentiality

A researcher guarantees anonymity when a given response is not identified with the relevant respondents; whereas confidentiality is guaranteed when the researcher can identify a given person's responses but essentially promises not to do so publicly (Babbie 2007, p. 64-65). All ethical guidelines for social researchers are clear that confidentiality is an important element of social research and that

research participants should be made aware of who will have access to their data as well as being given the details about the processes of anonymity (Wiles et al., n.d.) .The chief way that researchers seek to protect research participants from the accidental breaking of confidentiality is through the process of anonymity. The researcher sought to abide by this principle by not using names of the respondents during the data analysis or in any part of this research study. The researcher also grouped data in such a way as to disguise identities. The participant's confidentiality was ensured, and all the participants were informed about who will/may have access to the data collected. In terms of over-disclosure the researcher affirmed the limits of confidentiality to participants. It was important for participants to receive adequate advance information about disclosure of confidentiality and its limits.

3.11.3 Release or publications of the findings

It is the responsibility of the researcher to present findings that are accurate and original. According to Strydom (2005, p. 65), researchers should compile the report as accurately and as objectively as possible. The researcher will need to ascertain that the findings of the study are released originally and belong to the researcher himself. Moreover, the researcher avoids plagiarism by acknowledging the work of other authors used in the texts on the study. The research findings may also be submitted for publication in professional journals and be presented at conferences.

3.11.4 Avoiding harm

Social research should never injure the people being studied, regardless of whether they volunteer for the study or not (Babbie, 2007, p. 62). The researcher tried as much as possible to ensure that research participants were not be subjected to any unnecessary risks of harm. This was conveniently done, by going to their offices, rather than making them travel. Furthermore, the participants were informed about the process of research and focus group to avoid harm any

unintended harm through their participation. The researcher also tried to avoid mental harm by treating the respondents with respect and will further report findings in a respectful way in research publications.

In sum, the researcher, as a social worker adhered to various ethical considerations to include key ethical principles such as respect, informed consent, confidentiality, autonomy and avoidance of emotional and/or physical harm as discussed above (Fouka & Mantzorou, 2011). The values such as a non-judgemental attitude, respect for human dignity and cultural diversity were employed with the participants. Confidentiality was considered sacrosanct to this research to avoid negative implications for the employers of the participants. The participants signed informed consent forms and their right to anonymity was guaranteed by using pseudonyms.

With regard to the feasibility, the study consisted of social workers who are rendering SUDs services in the Mpumalanga Department of Social Development in the Ehlanzeni District, SANCA Lowveld and NICRO, all within the Ehlanzeni District Municipality. Hence, the researcher wrote letters, and completed application forms to request permission from management to avail social workers from all the mentioned institutions to participate in the study prior to the research study. Approvals were granted .

3.12 Chapter Summary

The research methodology chapter outlined the process of identifying participants, collecting data and analysing the data as collected. Chapter Four will present that research findings of the data collected.

CHAPTER 4

PRESENTATION AND DISCUSSION OF FINDINGS

4.1 Introduction

This chapter presents the findings in relation to the primary aim and objectives of the study. Firstly, it provides the demographic profiles of the participants forming part of the study, which were social workers rendering SUDs services at Ehlanzeni District in Mpumalanga. The presentation of the findings shows the themes and the sub-themes emerging based on thematic analysis

Relevant quotations from the participants highlighting these themes and sub-themes are presented while also incorporating important literature into the

discussion. Data was analysed using thematic analysis. Social workers from SANCA Lowveld, Mpumalanga Department of Social Development, and NICRO all participated in different focus group discussions.

4.2 Demographic Profiles of Participants

Providing key demographic on research participants is an essential component of research studies because it provides the reader with a clear overview of the characteristics of the research sample from which findings were constructed (Sifers, Puddy, Warren & Roberts, 2002) (Sifers, 2002)

4.2.1 Mpumalanga Province District Municipalities

Mpumalanga Province, in the eastern part of South Africa borders Mozambique and Swaziland. It has three district municipalities (see Fig. 4.1) and 18 local municipalities. Since there are several social issues linked to immigrants in the area social workers each have to deal with high caseloads to bring social change for the Ehlanzeni District Municipality.

Figure 4.1: Three Districts Of The Mpumalanga Province

4.2.2 Ehlanzeni District Municipality

Ehlanzeni District covers a second largest area, the first being Gert Sibande District Municipality and the third is Nkangala District Municipality; however, Ehlanzeni District Municipality has the highest population of all the districts in Mpumalanga (see Figure 4.2)

Figure 4.2: Five Local Municipalities o=Ff The Mpumalanga Province

The capital city of Mpumalanga is Mbombela (formerly Nelspruit) situated in Ehlanzeni Municipality; therefore, this could account for its higher population as it attracts number of people who move into cities in search of jobs. The Census of 2011 (Statistics South Africa 2012) has indicated that Bushbuckridge Local Municipality in the Ehlanzeni District had the largest population of all these local municipalities. Here Social workers handle a wide range of social issues in all communities for the Department of Social Development which means a higher number of clients for Bushbuckridge.

4.3 Key Themes Emerging from Data

4.3.1 Substance use/addiction management services rendered at Ehlanzeni District

4.3.1.1 Availability and accessibility

The United Nations Office on Drugs and Crime (UNODC) (2017) in its report on International Standards for the Treatment of Drug Use Disorders, states that (Principle 1 Treatment must be available, accessible, attractive, and appropriate. This is further supported by the Prevention of And Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008). The findings during the focus group interview showed that treatment in most parts of the Ehlanzeni District is not available and there is also a lack of access to it. The attractive treatment services come at a cost which many people cannot afford. Some verbatim remarks from some of the participants on this theme are provided below: Which are identified as under each quote.

> *[I] also think that the services are unavailable, come at a price and all these in-patient services are quite expensive, so they only cater for a group of people who can afford, and state rehabs are always full, and they are overly populated.*

(Participant A)

I just need to say that in the whole of Ehlanzeni, we are the only out-patient treatment center. We are actually refraining from doing any prevention. There are other fly-by-nights who are doing 'prevention' … they call it religious or holistic approach. There are also some unregistered rehab centres in the area that are cheap, but I can't really tell on the quality of those centres, but I am glad to hear that a Centre is opening in Delmas so probably the pressure will lessen in Swartfontein.

(Participant G)

No, we only know of organisations such as SANCA because we are professionals, but many people still do not know about such organisations and there are people who are in areas where they cannot have access to SANCA.

(Participant E)

When clients are sent to Hospitals, doctors do not treat substance use as a medical condition and sending clients to rehab is always a challenge because there is no adequate space which means it is not available.

(Participant B)

No, there are areas where substance use is a problem but there are no resources. They do not know SANCA office they only rely on Social Development for assistance, and we all know that Social Development is problematic … clients go without being assisted.

(Participant D)

No, because clients have to pay, and private rehab centres are very expensive. A client had to pay R85 000 at a rehab Centre and most of the clients are from poor background[s] and cannot afford to pay.

(Participant F)

4.3.1.2 Staff shortages and lack of resources within the addiction management field

Social workers working in the Substance Use domain normally have limited resources and this may lead to neglect for the victims of substance use. It is important to note that the increase in Substance use globally as reported by WHO (2014) may be caused by various factors, such as lack of funding or limited resources. Again, the UNODC (2017) Report states that Staff of treatment services should be properly trained in the provision of treatment in full compliance of ethical standards and human rights principles, and show respectful, non-stigmatising and non-discriminatory attitudes towards service users.

The participants in the focus group discussion all indicated that there is lack of resources and shortage of staff amongst social workers in general, and this in turn also impacts the services rendered to people with substance use disorders.

Lack of facilities, even when clients are willing to go for treatment there are not enough facilities.

(Participant C)

I think the big challenge is that we are short staffed. We are only three social workers with one colleague coming in as a qualified social worker this year. Our seniors are running for numbers to report for stats…. they don't [know] that we are overworked. Some of the reports come via the management and that is not [how] it is supposed to be done. Because remember they are also social workers and they know how many people a group should encompass. We talked to them about therapy. They have tried to build good sleeping rooms, but the standard of the sleeping rooms does not equate to the standards of the therapy rooms

(Participant I)

From the Focus Group Discussion, it seems as if the shortage of staff and lack of resources greatly impacts the quality of services to service users. The social workers, in turn, chase numbers rather than doing qualitative work. It also appears that the most affected institutions are the in-patient centres where the case loads are very high.

Two institutions (SANCA Lowveld and Swartfontein treatment centres) do not have the complete setup of multidisciplinary teams. This is contrary to the International Standards of the UNDOC Report by the World Health Organisation which states that "Where possible, the organisation of specialised services for drug use disorders should be based on multidisciplinary teams adequately trained in the

delivery of evidence-based interventions with competencies in addiction medicine, psychiatry, clinical psychology and social work" (Clark, n.d., p. 13) .

4.3.1.3 Enactment of prevention services

Substance use Prevention is highly valued today due to individual and public mental health issues (Seçim, 2017). However, according to Puljević and Learmonth, (2014, p. 185). "There are a number of specific concerns raised regarding the efficacy of prevention interventions in South Africa". These concerns arise largely due to the fact that there is no national regulating legislation to oversee the training, qualifications and competencies of prevention service providers (Puljević & Learmonth, 2014).

Data obtained from the focus group discussions show that, while not enough, there is an increase of prevention work done especially from SANCA Lowveld, which has a prevention section doing awareness. The following statements confirm this.

> *Sometimes [we] go out [to] do awareness. Institutions such as churches and come to the centre for awareness.*
>
> (Participant G)
>
> *Yes, because NICRO receives referrals from schools and the court so prevention is working.*
>
> (Participant J)
>
> *In Ehlanzeni there are a lot of preventative methods or prevention work done, but for those who are already suffering from the substance use disorder there is no solution for them.* (Participant H)

While there is consensus about the importance of prevention, there is a lack of agreement over the best way to achieve it. Prevention is understood as any activity designed to avoid substance use and reduce its health and social consequences (Medina-Mora, 2005). “This broad term can include actions aimed to reduce supply (based on the principle that the decreased availability of substances reduces the opportunities for use and dependence) and actions aimed to reduce demand (including health promotion and disease prevention)“ (Medina-Mora, 2005, p. 25) .

Based on their own social work experience, participants in the focus group discussions stated that there is relatively minimal work done on prevention services by the Department of Social Development and NICRO. In addition, in most cases participants concurred that the prevention work is not done by qualified social workers but by social auxiliary workers or even volunteers in communities. This brings into the question of whether the increase of substance use is informed by the inadequate knowledge and qualifications of those providing the prevention services.

As Puljević & Learmonth (2014, p. 131) have indicated, “there is no national regulating legislation to oversee the training, qualifications and competencies of prevention service providers”. This remains a great concern and a grey area in the field of substance use and addiction management in the South Africa

One of the social work participants reasoned as follows:

> *I don’t think they [the department] are doing enough. If enough was done there would be more adequate staff. There is also no proper marketing of rehab centres in Ehlanzeni district, many people still do not know about Swartfontein.*

(Participant F)

Despite the minimal effort in prevention services as reported by the social work participants, it is evident that there is enough information available to orientate further effort towards the prevention of substance use. Firstly, social workers can play a crucial role in developing suitable preventative mechanisms. Secondly, despite the advances in the field, there remains an urgent need to develop more efficient prevention strategies in terms of support given to multidisciplinary research including the evaluation of intervention programmes, which is particularly a grey area in the prevention domain.

As asserted by Puljević and Learmonth (2014):

> There are no minimum norms or standards to serve as guides for any prevention interventions, as a result of this, not only could the quality of these interventions be compromised, but there is no way of ensuring that prevention services are aware of the latest developments in prevention sciences.
>
> Puljević & Learmonth (2014, p. 185):

Therefore, it is difficult to estimate if there would be any difference in the scourge of the increasing substance use if social workers do prevention work themselves.

4.3.1.4 Roles and responsibilities

Functions and responsibilities of the social service practitioners in the public and private sectors need to be clearly spelled out and defined, since lack of clarity on this issue causes role confusion, thereby leading the staff to shift their responsibilities (Skhosana et al., 2014)

Evidence shows that many social work and social care professionals “are not clear what they should be doing in relation to substance use and their role expectations vary according to their specialist area of practice, their knowledge of substance use, and their levels of confidence” (Galvani, 2015, p. 5).

Data from at least 95% of the three Focus groups revealed that social workers are not aware of their precise roles within the addiction management field, at worst they are confusing tasks and procedures in their social work roles. This is attested by the following comments made by participants:

> *Attending panels, assessments, disciplinary, drug testing, outreach, administration. Sometimes go out [to] do awareness …Institutions such as churches … and come to the centre.*
>
> (Participant F)
>
> *We do groups. Life skills. Relapse. Draw IDP and do four phases of group work.*
>
> (Participant G)
>
> *[T]herapeutic intervention because it falls under the treatment programme, so I… it’s hard to know that you are dealing with a relapsing, mental disorder type of a disease, but with the trainings that we get, with the services that we render we need to stay at the top of our game on how to deal with a client and what to do with a client, and what to do*

when what happens, it's what keeps us refreshed in rendering the services.

(Participant I)

One researcher (Galvani, 2015) asserts that social workers are not expected to be experts in everything. Given the breadth of a social worker's reach into the lives of individuals, families and communities, they never will be prepared for every set of circumstances that may arise. However, clarity about one's role when working with issues is vital and working in substance use is one such area. Galvani (2015) further indicates that there are three key roles for social workers in relation to substance use:

- To engage with the topic of substance use as part of their duty of care to support their service users, their families and dependents.
- To motivate people to consider changing their problematic substance using behaviour and support them (and their families and carers) in their efforts to do so.
- To support people in their efforts to make and maintain changes in their substance use.

Moreover, the social workers who continually receive more training appear to be at least having clues on the roles of social workers in the addiction management or substance use domain. The following responses were noted from one participant.

I feel that also the trainings that we have become very helpful because a lot of the new trends or drugs are coming up and we need to be at the top of our game and… ja… also motivate, inform, support and be there and be patient with them [laughs].

(Participant K)

In sum, it is worth noting that the role of social workers within the substance use domain is often misunderstood or wrongly interpreted not only by those working in it but by other social workers working in different domains.

Galvani supports this view: “Social work is both a rewarding and demanding job. However, to do our jobs well we need clarity about what our roles are and the support of managers to fulfil them’’ (Galvani, 2015, p. 1)

4.3.2 Social workers education and training on substance use/addiction management

Historically, social work education (SWE) has not included formal and in-depth training to address substance use in either coursework or fieldwork (Pugatch et al., 2015). It appears, therefore, that the education at undergraduate level is not enough or adequate to deal with the scourge of substance use disorders which are rapidly outweighing the resources directed towards its intervention. However, brief workshops and intensive practice courses are feasible and acceptable methods of incorporating substance use training into SWE.

4.3.2.1 Continuous professional development (training)

Of all the institutions which were a part of the Focus Group Discussion only one seemed to be getting regular and adequate training on substance use despite all

social workers being involved in rendering substance use services or related services. The following are some of the responses noted:

We have never had trainings on any kind of substances, we never had … and [I] can say, we never had any, like, formal training on substances especially conducted by DSD [Department of Social Development].

(Participant F)

I don't have in-depth training as I started as a child and youth care worker. I just qualified as a social worker last year. We don't have in-depth information about this field … we tried getting the training but so far, we are blank.

(Participant B)

So far, no training on substance use and addiction management

(Participant H)

Some of the social workers have been in an institution for more than three to five years but they have never had any training in the substance use and addiction management field. However, in one of the institutions several employees seemed to be up-to-date and conversant with the current discourse of substance use training. Their knowledge on terminologies and information also showed that they are in step with education and training in the field. The participating social workers

recognised that the provision of relevant training will not only improve their capabilities, but it will enhance services to the service users in the districts.

4.3.2.2 Addiction management field as an area of specialisation.

For the treatment of SUDs additional knowledge, skills and expertise over and above the general knowledge and skills obtained at undergraduate level is required. Most of social workers who formed part of the discussion agreed that the field should be a specialised field taking into consideration its nature of work and context. The following articulations were noted from the group discussions.

> *If I recall, in my varsity years we had one module in my 4th year on substance use disorder and that was it… [cross talk]… hmmm that was it. Yeah that was it, so I really think they can maybe put in more effort in developing something maybe from first year or something or a specialised course like for further study… yeah definitely.*
>
> (Participant L)

> *I agree … I think it should be more of an area of specialisation, should be more focus on substance use because it's very broad and you cannot be able to accumulate more information in a short period of time.*
>
> (Participant N)

> *We do need extra training (to be specialist in the field) as in some of the circumstances I must be taught about the drug through the service user.*

It should be something which is continuous not a once off. [In] substance use − we need to be trained at least in 24 months.

(Participant C)

Yes − because social workers at NICRO do receive clients who have substance use problems and it becomes very difficult [in] Swartfontein because of the long process it takes to get a client admitted at the rehab centre. So, if there were social workers who were specialising in substance use then it would help because those social workers would deal with such clients.

(Participant O)

A specialist in Social Work must meet certain criteria, amongst them are the following conditions:

- It is a specific identifiable and definable professional field of practice; It is not regarded as a mode of intervention. The professional field of practice should be the domain of social work, distinct to the social work profession and not form part of the field of services of other professions, which may be the case with the different modes of intervention. Additional knowledge, skills and expertise over and above the general knowledge and skills obtained to practise general social work are required. In terms of section 17C (1) of the Social Service Professions Act, 1978, as amended, the final resolution to register or not to register a specialist in Social Work lies with the SACSSP (Pruis, 2008) .
- From the social workers discussions and analysing the Social Service Professions Act, 1978, as amended, it is evident that the Substance Use

field deserves at least a reconsideration if it can fit to be an area of specialisation. Noting of course, the level of knowledge, skills and expertise required. The most common type of intervention received by clients during their first contact with social services was referral to specialist substance use treatment services for more intensive treatment (Burnhams et al., 2012). This further highlights the need for substance use field to be specialised because there are not many specialists on substance use, thus social workers can be the best professionals to be specialist in this field.

4.3.3 Perceptions regarding legislation and policies on substance use

The legislative framework which gives direction to rendering substance use services is covered by various international and national laws. The United Nations Office on Drugs and Crime, (UNODC Report, 2017) via The International Standards for the Treatment of Drug Use Disorders are prepared to support member states in the development and expansion of treatment services that offer effective and ethical treatment. This concerns the National Drug Master Plans, Substance and Prevention of drug use legislations and the WHO's International legislation.

It appears that social workers go out to assist service users with drug dependency without the understanding of these policies. It also appears that there is no legislation which prescribes how the prevention services should be rendered unlike the rendering of treatment services. This researcher found that most of the social workers can name the legislation which underpins the provision of substance use services; however, they are not able to outline its content, or how it gives direction to the provision of services. This is despite the social workers quoting such Acts in their psychosocial reports. The following is one example of the input from the participant:

No, it's the Child Justice Act, the NPO Act, the Financial Management Act.

(Participant J)

Even social workers who are not involved in the core treatment of substance use ought to know the relevant legislation as they interact with clients who have SUDs or even related disorders. Social workers such as in NICRO should use the SBIRT (Screening, Brief-Intervention and Referral to Treatment) Model as per the World Health Organisation's International Standards for the Treatment of Drug Use Disorders.

Another perspective shared by one of the participants was that the legislation was being contravened across all levels because, as social workers, they are always chasing numbers instead of offering quality services. Generally, the social work ratio should be 1:60; however, many participants seem to deal with cases more than double the minimum requirement, this leads to contravening legislation and poor work delivery, and more. This is attested to by the following response from a participant….

> *It is more like it [[legislation and policies[put[s] us under pressure. Yes, it guides us in some of the things. But it is, like, it is concerned with numbers [quantitative]) rather than qualitative. Because it says we should reach every person in need of substance use services; whereas on the other hand, there are not enough resources to deliver such services.*

(Participant G)

From the comment above, it appears that some social workers believe that the legislation puts them under pressure instead of providing direction as to how the provision of substance use services should be like. This is because of the difficulties of their workloads and lack of adequate staff. Furthermore, many social workers had difficulties linking the precise legislation which underpinned

substance use services within the district. From the focus group discussions, the researcher observed that the new social workers had even more difficulty stipulating the legislation within the substance use terrain. A relevant comment from one of the participants is provided below:

> *As a new qualified social worker who has mostly worked at this centre as a child and youth care worker I cannot answer much on the legislation because I don't have much knowledge on the social work legislations.*
>
> (Participant D)

The Focus Group Discussion also revealed that due to overcrowding of service users At the Inpatient treatment centre sometimes various legislation such as the Prevention of and Treatment for Substance Abuse Act, 2008 (Act No. 70 of 2008) is often not followed. This is particularly in relation to provision of quality services, monitoring and referral of the clients to various institutions. In turn, those with substance use disorders appear to receive compromised services due to the contravention of the Act.

4.3.4 Perceptions of social workers on causes of addiction at Ehlanzeni.

Different views about the nature and etiology of addiction have more recently influenced the development and practice of current treatments for substance use. Differing theoretical perspectives have guided the structure and organisation of treatment and the services delivered (Centres for Substance Abuse Treatment, 1999).

Problematic substance use is a social care issue – it is not just a health or criminal justice issue. People start using for many reasons; among them are experiences of sexual and domestic violence and abuse, feelings of low self-esteem and self-worth, as well as mental and physical distress. People with problematic substance

use will often be socially isolated and are likely to have several co-existing social and health care problems (Galvani, 2015). These are also the sensitive and complex issues that social workers engage with in terms of the possible causes of substance use in the district.

The participants also indicated that the availability of drugs in the district was a major cause of substance use. They pointed to the fact that drugs are easily bought in the streets which are without supervision of police. Sahu and Sahu (2012) have further attested to such perceptions and have cited India, where the increasing production, distribution, promotion and easy availability of substances together with the changing values of society has resulted in rising substance-use related problems emerging as a major public health concern in that country.

In global terms sociologists, social workers, psychiatrists, other mental health professionals, educators, and politicians are ever more identifying substance use and abuse as a critical public health problem. Despite attempts to limit access to psychoactive substances by young persons, the use of such substances is common among adults, adolescents and increasing in some of these groups (Sahu & Sahu, 2012). Participants from the focus group discussion cited several reasons for their own perceptions on the causes of substance use in the Ehlanzeni district that share commonalities with the above authors. The main cause cited was the availability of substances. Owing to boredom and peer pressure certain individuals tend to use drugs as their form of leisure and because they are easily accessible with repeated use, increased tolerance accompanied with severe withdrawals substance use easily develops.

The hesitation of local officials in law enforcement to apprehend those who trade illegal substances also plays a role in causing substance misuse in the district. The participants also cited factors such as boredom, unemployment, stress, as other major causes of substance misuse in the district. The following additional point is given by one of the participants:

> *Like in schools, some vendors sell drugs in schools. The accessibility and the closeness of liquor stores, taverns are close to schools making it more accessible.*
>
> (Participant R)

Interestingly, participants also shared their perspectives about media advertising, especially alcohol misuse, and the trend amongst black people associating alcohol with achievements which at times influences misuse.

4.3.5 Multidisciplinary, integrated and interdepartmental approach

Treatment services for substance use problems have not kept pace with the increase in demand, particularly by younger people who are using. According to Section 6(1)(a) of the Prevention and Treatment for Substance Abuse Act, (2008) the provision for treatment intervention services should comprise a multidisciplinary team that includes a nurse; a medical practitioner; a social worker; a psychologist; a psychiatrist; and an educator.

4.3.5.1 Detoxification services

Participants agreed that detoxification is compulsory prior to admission to an in-patient centre (i.e. Swartfontein Treatment Centre). One researcher has stated in the literature that:

> Patients for whom outpatient detoxification is not appropriate become candidates for inpatient detoxification. Inpatient settings offer the advantages of constant medical care and supervision provided by a professional staff and the easy availability of treatment for serious

> complications. In addition, such settings prevent patient access to alcohol/drugs and offer separation from the substance-using environment.
>
> (Hayashida, n.d., p. 45)

According to the participants from the FCG discussions, there is lack of a multidisciplinary approach especially from the public sector. The lack of or limited number of detoxification services and collaboration was cited as the one worst example which was crippling the provision of substance use treatment services. Furthermore, the participants strongly conveyed the point that without proper detoxification, treatment is almost impossible.

The following comments from participants support the above analysis:

> *Another problem is that our state rehab centre does not have detox services [and] that makes the referral to the centre more complicated and we end up losing the client because client's have to wait longer for detox and the Rob Ferreira Hospital does not do detox, it is only Themba Hospital that does detox and Themba is usually full and they are also not geared to run proper detox.*
>
> (Participant L)
>
> *I think the problem is with the hospital detox. Because in the whole district only one hospital [Themba Hospital] does detox. This becomes a huge problem.*

(Participant M)

It seems as if the problem of detoxification adversely impacts the provision of the necessary services. The Department of Social development and the NGOs do not have any control over this as it falls within the scope of the national Department of Health. Consequently, the social workers appear to have little or no confidence in the detoxification process from the Mpumalanga Department of Health. The participants also outlined several instances where detoxification fails to do its part although it is evident that detoxification plays a crucial role in treatment. Without this paramount service it is difficult to foresee a positive impact, more especially for those with SUDs who cannot afford to go to private hospitals. The following perspectives were shared by participants regarding the state of detoxification and its impact to rendering effective substance use treatment services.

I also have to add the challenges of the detox process: we have just discovered that they use 'wild detoxing' (there are people who come in the centre and give them drugs), so we might help getting them at the centre, but there are no proper security measures around the detox process which is also a big challenge because uhm… services users might find out that they use wild detoxing.

(Participant M)

Other departments do play a role, but the main problem is detox.

(Participant E)

Sometimes the client has not properly detoxed, if they had detox at all. On worst case scenarios you find that the client has used at the hospital

even. Obviously, a client who has not properly detox is likely to abscond or break the palisade and go to smoke. These are the challenges at the centre.

(Participant O)

From these shared perspectives, it is evident that the most paramount element and system is paralysing the whole treatment service by the professionals in the field. There is lack of collaboration between the health and the social institutions within the district, or else a lack of resources from the former to deliver the desired services to the latter.

4.3.5.2 Coordination and collaboration of stakeholders

According to the Systems Theory (which is mostly used by social workers) each system should be viewed as consisting of several elements that make the system a functional whole, and each system should be viewed in relation to the other systems that can cause a change or reaction within the main system (Teater, 2015). Substance use is not only a social issue, but a bio-physical, mental, and a public health issue. Thus, social workers need the other important stakeholders and disciplines, such as medical, safety and security and other social service professionals to curb the scourge of substance use. This is important because when working with clients, social workers should consider the bio-psycho-social aspects of the client by looking at physical and psychological functioning, social relationships, and community or societal structures that impact on the client (Teater, 2015). Interprofessional collaboration is increasingly becoming an important factor in the work of social workers (Ambrose-Miller & Ashcroft, 2016).

Participants in the focus group discussion proposed some minimal coordination amongst key stakeholders and relevant organisations. Without this, it is hard to deliver effective and comprehensive services to those with substance use

disorders. Furthermore, the inability from state institutions to appoint the necessary qualified supportive staff also impedes the progress. Furthermore, participants also indicated that internal organisational politics − especially at public level also render the collaborative services as almost non-existent even though there are many positives within the sector. This has been attested to by Ambrose-Miller and Ashcroft (2016) who have stated that organisational structure influences interprofessional collaboration and can have an impact of negating the desired services. The following proposals by participants support the above analysis:

> *I believe that our local DSD is trying their level best but there are a lot of things going on − it is the politics, the management of resources and a lot of challenges. I feel sorry for them, but I don't believe it is unwillingness and that they are aware of the challenges, but they are also handicapped or restricted and also believe the Department of Health is absent in our province because the relationship between Health and addiction is close and they do not support.*
>
> (Participant D)

According to the participants, organisational structures and bureaucracy should play a pivotal role in the implementation of quality services to people with SUDs in the Ehlanzeni district. Ambrose-Miller and Ashcroft (2016), however, caution that interprofessional collaboration can be facilitated or hindered by overt and covert power differentials; power dynamics must be considered when developing and implementing a collaborative model. The participants further elucidated that at "meeting'' level with the management, stakeholder collaboration is possible but at implementation level it is null and void for some key stakeholders. This sentiment was made clear by one of the participants:

At meetings it happens but at implementation level it doesn't happen. Like Themba hospital does detox but the other big hospitals don't do detox. The centre doesn't have the other complementary staff.

(Participant E)

From the discussion with the participants it is evident that lack of resources and the necessary staff compliment plays a very large role in terms of multidisciplinary and multilevel intervention. Social worker shortages are amongst the many factors negating this desired service delivery. This is supported by the following assertions from the participants.

I don't think they are doing enough. If enough was done there would be more adequate staff.

(Participant K)

I agree. Its skeleton staff at the centre. The department is not doing enough work. Previously we had challenges, but nothing changes.

(Participant F)

Stakeholder collaboration is increasingly being viewed as a necessary component in the delivery of health care services (Ambrose-Miller & Ashcroft, 2016, p. 107). This researcher also found collaborative care to involve both challenges and rewards. However, according to Ambrose-Miller (2016) challenges arise when social workers take part in interprofessional teams without a clear understanding of their role and the roles of their interprofessional colleagues. Social workers have also identified how power differentials have been exposed when opportunities arise for team decision making. Therefore, there remains a need for clarity in the

roles of social workers on interprofessional teams while still maintaining a sense of flexibility for them to look at the teams' specific needs (Ambrose-Miller & Ashcroft, 2016, p. 107).

4.3.6 Barriers to substance use services at Ehlanzeni

According to Isobell (2013) structural barriers to treatment is one of the predominant hurdles. In the Cape Town metropole Isobell has identified three salient structural barriers to treatment:

> (1) disjointed service delivery; (2) limited availability of cost-effective services resulting from a restricted distribution of resources to substance use treatment, restricted allocation of resources also led to limited the ability of existing services to match the growing demand for services; as well as (3) infrastructural issues (poor intersectoral partnerships, limited conversing with service providers and lack of information) and poor capacity which contribute to problems in constructing and enacting a tactical plan relating to substance use problems.
>
> (Isobell, 2013, p. 30) .

In the focus group participants identified four themes that can act as barriers to substance use services: (a) staff shortage; (b) lack of coordination; (c) client's motivation; (d) lack of attention to problems in the field (namely, lack of infrastructure, waiting periods, staff shortages, and lack of collaboration). These findings carry important implications in the domain of substance use, as they might or might not have an impact in on the rise of substance use and low success in treatment rate in the province.

4.3.6.1 Waiting period move down section?

> Patient waiting times in health facilities are internationally recognised as a key indicator of the functional status of health system. It is a very tangible factor that impacts on patient's perception and experience of care. Long patient waiting times are common in health facilities in South Africa and have clearly been identified as a key health system challenge. Patient waiting time is therefore included in the six Ministerial priority areas for patient-centred care in striving towards the goal to achieve Universal Health Care and implement National Health Insurance.
>
> (Draft National Guideline for Management of Patient Waiting Times at Health Facilities, 2019, p. 2)

Discussions in the focus group revealed that it takes approximately 3-6 months for a client seeking inpatient admission to an inpatient centre, especially for the underprivileged without medical aid or financial support. This, in turn, catapults those with SUDs to give up treatments within the waiting period and to even continue using more at times. They sometimes perceive the waiting period as secondary calamity. The following comments from the group discussions attest to this.

> *[W[e then experience a higher level of dropouts from the service users that are not able to get access to medical services [cross talk] also the waiting period in state rehab centres, clients lose motivation along the way.*
>
> (Participant F)

I think just to add on what a participant has said; man, power is there but feel like the resources are very little . uhm… like for example: I faxed a report to Swartfontein and [the] sister said for the whole of October there is no space so now she is looking into November and December and that is one facility that we refer to.

(Participant P)

I would speak about the waiting period to get our services users rather to inpatient treatment that is a very common one for everyone who has to… and as a result there is a lot of challenges in the middle because you try to motivate them and in the period of that happening you don't know where they stand with the whole thing, some would try to back out just as they are about to go so, ja… I think that is the common problem.

(Participant L)

These findings from the focus group reveal that the waiting period for admission to rehab facilities plays a huge role in deterring those who need services from getting these much-desired services. Not only does this have a lasting impact on the primary clients but also on their families who support and source help for the victims of substance use. It is important to note that, the waiting period is largely influenced by, firstly the lack of public inpatient centres in the district, secondly the failure to properly plan and collaborate, and thirdly by staff shortages.

4.3.6.2 Lack of infrastructure

The South African government, through the three tiers of government, is mandated to provide its citizens with basic infrastructure, education, health and security. Access to infrastructure is considered a basic human right, irrespective of where people live, their race, gender or income level. Accordingly, the three tiers of government have to plan to ensure the citizens' basic human rights and to comply with the Bill of Rights (Gnade, 2013). Social workers often work in dire conditions and sometimes with limited infrastructure and resources to do their work.

Often the will of clients with SUDs is very high in motivation but the structural barriers and desired services propel service users to stay using. The participants in the research study agreed that the District of Ehlanzeni is short of proper infrastructure and proper tools of trade to render effective substance use services, let alone rendering quality services, especially in the public sector. Evidence from the focus group discussion also revealed that the private sector fees for substance use are exorbitantly high, and most people who are using cannot afford it. For this analysis, the lack of infrastructure impacts the lack of appropriate treatment facilities such as inpatient treatment centres, half-way houses, tools of trade and so on. The following are statements stemming from the focus group that support this analysis.

[T]here are not enough resources to deliver such services.

(Participant J)

[W]e don't get time to have that one-on-one as we are supposed to [due to overcrowding].

(Participant Q) *[N]o, halfway houses [cross talk]: they really thank us as a place of support but it's not enough, there is definitely lack of support.*

(Participant P)

The participants further highlighted that in the whole Mpumalanga Province there are no halfway houses. Meaning that, the likelihood of those using substances is much more likely. Many people who are using find it hard to adapt when coming back from rehabilitation centres. Many of them are without employment but the lack of facilities such as halfway houses would prove vital in curbing the scourge of substance use while also scaling down the relapse rate.

4.3.6.3 Staff shortages

As previously documented in the first phase of this chapter, the participants cited staff shortages as a pivotal barrier to proper service delivery. The comments supporting this are also quoted above. Further evidence to support these views by social workers is well documented. This factor accompanied by lack of infrastructure and lack of attention to the substance use field has grossly contributed to the ever-escalating incidence and prevalence of substance use disorders

The former Minister of Social Development, Bathabile Dlamini, once indicated that 66 329 social workers are required to implement the Children's Act 38 of 2005 alone. A further 2 169 are needed to cover substance use and the Older Person's Act. Thus, a total of 68 498 social workers is currently needed in South Africa. Investigating these figures, the Democratic Alliance (DA) issued a statement in August 2013 that stated that there was a 77% shortage of social workers.(Broughton, 2017)

This significant shortage of social workers has detrimental effects on the output of services rendered. A social work shortage translates into higher caseloads for existing social workers, and ultimately undermines the effectiveness of welfare interventions. Owing to this, recruitment and retention of social workers has become a significant focus of government as well as various stakeholders, and the

issue of the scarcity of the skill has been commented on significantly in academic, government and media publications (Joseph & Engelbrecht, 2017).

In one of their studies Joseph and Engelbrecht (2017) have indicated that the significant shortage of social workers has several detrimental effects on the output of services rendered. A social work shortage translates into higher caseloads for existing social workers, and ultimately undermines the effectiveness of welfare interventions. Consequently, recruitment and retention of social workers has become a significant focus of government and various stakeholders, and the issue of the scarcity of the skill has drawn the attention of academic, government and media circles (Joseph & Engelbrecht, 2017).

Despite repeated attempts by the South African government to increase retention of social workers, it is apparent there is seepage of attrition at various junctures; namely, low output of graduates, emigration and exiting the profession for a career in the private sector. To successfully increase retention, it is essential to gain an understanding of the push and pull factors of retention and attrition within the profession, and specifically those that provide the essential service of working within the NGO sector

The focus group discussion also mentioned that lack of adequate staff, accompanied by extended period of waiting periods also serves as barrier to treatment services around the district.

4.3.6.4 Lack of coordination

According to Lombard (2010) strong partnerships depend on partners and role players understanding their roles and contributions relating to their specific fields of expertise or experience. Various departments must work together to ensure the delivery of effective child protection services, including the Departments of Social Development, Justice, Education, Health, the National Prosecuting Authority (NPA) and the South African Police Service (SAPS)

These “further caution that poor coordination between such different departments impacts negatively on the provision of effective and comprehensive child-protection services so that networking, capacity building and joint funding between service providers may be systematically promoted” (Skhosana et al., 2014, p. 222)

This barrier has been discussed as a main theme in this chapter, and the relevant comments from participants was quoted. The focus group discussion also raised the issue of a lack of adequate staff, accompanied with extended times to waiting periods also impedes and serves as barrier to treatment services around the district.

4.3.6.5 Client’s motivation

In substance use treatment, clients’ motivation to change has often been the focus of clinical interest and frustration. Motivation has been described as a prerequisite for treatment, without which the clinician can do little. Similarly, lack of motivation has been used to explain the failure of individuals to begin, continue, comply with, and succeed in treatment (Centres for Substance Abuse Treatment, 1999, p. 2) .

The participants in the group discussion cited motivation as a huge barrier to rendering proper services to the desired clients. Many clients, as alleged by the participants, are forcefully or compelled to treatment by significant others, law enforcement, family members, or other professionals. It is, therefore, overly difficult to start from Motivational Interviewing for the participants, as there is shortage of staff, inadequate resources, or mostly a time-consuming activity albeit to the benefit of the clients.

The following comments are some of the participant’s opinions:

> *I think it’s one and the same thing regarding lack of motivation. You can tell by the body language in the group sessions. Sometimes the service*

user is an Article 36. Some service users are Mentally I; and act strange without motivation. Sometimes the client has not properly detox, if they had detox[ed] at all. On worst case scenarios you find that the client has used at the hospital even. Obviously, a client who has not properly detox is likely to abscond or break the palisade and go to smoke. These are the challenges at the centre.

(Participant A)

Having worked as a child and youth care worker before qualifying as a social worker [I can say that] motivation has an impact in the services being rendered at the centre. The clients who are not motivated tend to have a lot of demands than those who are motivated.

(Participant G)

I believe also that a challenge is people's motivation, readiness for people for treatment is important as well.

(Participant N)

The Centre for Substance Abuse Treatment supported the views by the participants, when it stated that an increasing number of clients are mandated to begin treatment by an employer or employee assistance program. Others are influenced to enter treatment because of legal pressures. In such cases, failure to enter and remain in treatment may result in specified sanctions or negative consequences (e.g., job loss, probation or parole revocation, prosecution, prison),

often for a specified time or until satisfactory completion (Centre for Substance Abuse Treatment, 1999) .

Another major finding from the participants is that the referring professionals, social workers, medical professionals and so on, just refer clients without proper motivational interviewing, nor screening or brief intervention. This in turn defeats the purpose of referral, because most of them are demotivated, in withdrawal, or show a lack of interest, and are uninformed about the whole purpose of the referral process. The following are some extracts from participants to auxiliary the analysis.

> *Sometimes you will be shocked as the clients say 'The social workers never told me about what you are telling me' and there will be conflict between the inpatient social worker and the service user because of lack of information from the referring social worker. If we say a client should come in ready, then the client should come motivated. Some referring social workers do not know Swartfontein, but they have been referring for years. Even if you call for scheduling joint sessions they cannot be there. They even state on the report that due to distance they won't be able to attend, and you cannot communicate important issues over the phone, especially since the joint sessions should be between the family member and the referral social worker.*
>
> (Participant H)

According to Clark (n.d.), in terms of the standards of treatment, professionals should use the SBIRT Model in motivational interviewing and for the purpose of rendering quality services. The Screening, Brief Intervention, and Referral to

Treatment (SBIRT) model is an evidence-based practice used to identify, reduce, and prevent drug use disorders, particularly in health settings, which are not specialised in the treatment of drug use disorders (i.e. primary care, emergency care, hospitalized patients, antenatal care, social welfare services, school health services, prison health services, mental health facilities etc.). Screening and Brief Interventions (SBI) can be implemented in a rapid and cost-efficient manner that causes minimal interference with the provision of other services (WHO, 2012).

It appears that from this analysis, every professional involved in the substance use services should at least motivate clients prior to referring to treatment, for quality services of substance use to be effective in the district.

Several authors also support the outcomes and analysis of the group discussion on client's motivation and how best professionals can help through motivation to achieve the desired outcomes. Motivational intervention is any clinical strategy designed to enhance client motivation for change. It can include counselling, client assessment, multiple sessions, or a 30-minute brief intervention. To understand what prompts a person to reduce or eliminate substance use, investigators have searched for the critical components — the most important and common elements that inspire positive change — of effective interventions (Centres for Substance Abuse Treatment, 1999)

> Research has shown that simple motivation enhancing interventions are effective for encouraging clients to return for another clinical consultation, return to treatment following a missed appointment, stay involved in treatment, and be more compliant. The simplicity and universality of the concepts underlying motivational interventions permit broad-scale application in many different settings and offer great potential to reach individuals with many types of problems and in many different cultures.

> This is important because treatment professionals work with a wide range of clients who differ about ethnic and racial background, socioeconomic status, education level, gender, age, sexual orientation, type and severity of substance use problems, physical health, and psychological health

(Centre for Substance Abuse Treatment, 1999, p. 20) .

4.3.7 Social workers' attitudes on addiction management.

4.3.7.1 Willingness and stigmatisation.

Stigma can be one of the greatest barriers that keep people from seeking or accessing effective psychiatric treatment. People with mental health-related conditions are often avoided or thought to be frightening, unpredictable, and strange. The structural attitudes in society may also be internalised by those affected by neuropsychiatric conditions, a process termed 'self-stigma' (Ahmedani et al., 2011) . Major obstacles to successful outreach, early intervention, treatment, and rehabilitation for alcohol, tobacco, and other drug use disorders include levels of (a) self-stigma as experienced by users of these drugs, (b) family stigma as experienced by family members of the users, and (c) professional stigma as experienced by counselors or clinicians who provide 'front line' care and are expected to be active participants in initiatives such as the current Federal Screening, Brief Intervention, and Referral to Treatment (Ahmedani et al., 2011)

All the participants in the study showed positive attitudes and willingness to work with those with substance use problems. The participants were also found to be devoid of stigma in relation to the clients with substance use problems, instead they expressed compassion and understanding towards them. It also seems that

the participants' profession as social workers have also shaped their personal views. The following comments provide an auxiliary to this analysis.

It's a human being, its someone who uses substances to not to deal with a personal problem. That's my personal and professional view. They use substances I use food. I understand them.

(Participant O)

I believe being exposed to this institution has shaped me to understand the person more. It made me understand that this person is sick and has an illness. It has changed my views personally. While previously I would call them names 'drunkards" and judging them. While now I personally understand more.

(Participant B)

Working here made me understand personally, prior to working here I would judge the people and expect chaos around them. But by working here made me understand that these people are human beings same as us, they just chose to live through these substances.

(Participant I)

Although addiction might be viewed by some as a set of behaviours that violate religious, moral, or legal codes of conduct, the participants in these groups held positive attitudes regarding those with addictions.

4.4 Combined Findings

The researcher conducted three focus group discussions for the data collection. The participants were social workers from the Department of Social Development, SANCA, and NICRO. A comparison of the findings is presented in the sections below.

4.4.1 Similarities of the three institutions

Participants from the three institutions SANCA, NICRO, and Department of Social Development all shared the following views:

- there is no proper multidisciplinary coordination in the field of substance use.
- substance use should be an area of specialisation within the social work profession.
- there is a great deal of staff shortages, lack of infrastructure and resources within the field of substance use which creates a barrier to proper service delivery in the district.

All the participating social workers did not stigmatise or have negative attitudes towards those with substance use disorders. However, all social workers showed little knowledge on the legislation underpinning the substance use.

4.4.2 Differences in the three institutions.

There were clear differences in the level of knowledge between the participants from the three institutions. Those who attended further training seemed to have more comprehensive knowledge on linking the appropriate Acts of legislation. Furthermore, those who were only involved in the SBIRT approach seemed to be

devoid of any knowledge of paramount legislation which underpinned the field of substance use. However, social workers from SANCA showed a great deal of knowledge on the subject matter.

4.6 Chapter Summary

This research study provides the researcher with the opportunity to explore the perceptions of social workers in rendering substance use services. The social workers weigh in many factors that enable as well as impede the service delivery of such an important field in social work. More importantly, the social workers have shown great will and commitment to assisting those with substance use disorders. However, structural dysfunction at management and political level affect the service delivery.

The two NGOs (NICRO and SANCA) seem more equipped with the necessary knowledge and tools, while the Department of Social Development needs to do more to address some shortcomings such as staff shortages and resources.

CHAPTER FIVE

MAIN FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1. Introduction

Substance use in South Africa has seen a drastic rise, especially in urban to semi-urban areas. Social workers in South Africa are amongst some professionals who are supposed to render substance use services. The primary aim of this study is to investigate the perceptions or views of social workers in relation to services for substance use and addiction management in the Ehlanzeni District. This chapter completes the research. Thus, as a point of departure, it will summaries the findings, conclusions and recommendations of the study. This researcher will then propose how the goal and objectives of the study are to be achieved, and subsequently will answer the main research question.

5.2 Research Goal and Objectives

The goal of this study is to investigate the perceptions or views of social workers in relation to services relating to substance use and addiction management in the Ehlanzeni District

The goal of the study is to be achieved by accomplishing the two pivotal objectives. Firstly

Objective1: To describe the perceptions of social workers in the Ehlanzeni district in relation to substance use and addiction management services.

In Chapter 3 of this research study the researcher has illustrated the processes which were followed to explore and describe the perceptions of social workers in the Ehlanzeni district in relation to substance use and addiction management services.

Three focus groups discussions were conducted, firstly, one with social workers at the employed at Mpumalanga Department of Social Development (Ehlanzeni District), secondly with social workers from SANCA Lowveld, and thirdly with social workers in the employ of NICRO Nelspruit.

The perceptions from social workers in the employ of the Mpumalanga Department of Social Development revealed that substance use and addiction management services cannot be optimally achieved solely by social workers. There needs to be proper multidisciplinary collaboration from various institutions of government in terms of aftercare and reintegration services which are part of holistic support to the substance-dependent persons.

Furthermore, the perceptions from social workers at the province's DSD are that, they are a part of the operations and the department is not doing enough to accelerate institutional and infrastructural changes which will bring about the desired alleviation of work to be done in the substance use domain.

Social workers from DSD are also aware of the high fraction of substance use prevalence in the district. They also feel that the substance use or addiction field management should be a specialised field as it needs special skills and training. The DSD social workers' awareness and perceptions of current discourse in the substance use field is derailed by the lack of training afforded to them by their employer in comparison to the other social workers.

The knowledge of the Mpumalanga DSD social workers regarding the relevance of the Prevention and Treatment of Substance Abuse Act 70 of 2008 and other legislation is fair. However, their perceptions regarding their roles and roles and responsibilities is poor, although their level of awareness in the field was high.

On the other hand, the perceptions of social workers from SANCA reveal that the substance use and addiction management field services should be rendered holistically and in a multidisciplinary way. These SANCA social workers also have a very high level of awareness in the field of substance use. Similarly, noting the level of knowledge and training needed to do therapy within this field, social workers from DSD perceive that the field should be made a specialized. Most of the participants despite being involved in the roles technically they were not able to identify their precise role within the field.

All participants perceptions regarding the legislative underpinning the field was also inadequate even though they operate within and are guided by those actions. In terms of the substance use in the district, SANCA's Lowveld social workers somehow have a distinct view in that many people are left unattended due to inaccessibility in some areas, and the deficiency of public-private partnership is paralysing the systems in place as set out by the respective legislation.

The NICRO social workers' perceptions are that the field is not receiving as much attention as it should; those with substance use disorders are not aware where to get help, and services are not accessible or available at some of the district's outskirts. These NICRO social workers, like all the other participants in this study, share the sentiment that substance use services should be a specialised field as it is a very distinctive are of work. Furthermore, while they agree that a holistic approach is needed for the treatment of substance use, their perceptions of the social work services rendered are considered inadequate, disjointed as they believe a blanket approach is being used for its treatment. Their awareness of their roles in this field was also vague, especially since they should play the vital role of being a broker of the application of the SBIRT model. Their perceptions regarding this subject matter differed distinctly from the other two institutions. However, the NICRO social workers also share similar perceptions regarding the lack of collaboration at the national departmental level. Unsurprisingly, their perceptions between linking the legislative framework unfinished.

Overall, the social workers from all the institutions perceive the field of substance use and addiction management field as a critical one which needs more resources to combat the scourge. They further perceive this field to be getting less attention from other professionals, who perhaps hold some degree of stereotypical stigma, or even 'self-imposed' bias against those who are victims of substance use. One of the most important findings also is that, within the welfare departments, the substance use field receive less budget in comparison to the other fields even though it requires so much resources.

The study also gathered significant perceptions or rather views on the additional training and educational level of substance use related services. The second goal of the study was achieved by accomplishing the next objective.

Objective 2: To investigate associations between attitude and demographic factors, such as age, experience, professional status, additional training, educational level and in relation to the substance use related services

Using the methodology described in Chapter 3, the findings of this research reveal that there is a clear level of correlation and association between the level of training after the social work qualification and the level of knowledge and understanding.

Social workers from SANCA exhibited profound knowledge of the subject matter that owes much to the intense and vigorous training they frequently attend.

1. These more experienced social workers understandably displayed various levels of knowledge and practical knowhow. Social workers from SANCA Lowveld also reveal positive attitudes and a willingness to work with substance use disorders, thereby adding to the compassion they exhibited.

- It appears, therefore, as if the more training they receive the more they became knowledgeable and are able to deliver more efficient services, than otherwise at present. Furthermore, the SANCA social workers are well informed on the current changes and discourse in terms of terminologies currently being used (i.e., addiction management, substance use, Diagnostic Statistical Manual five(DSM5) Their extensive training has also catapulted the call for the field of substance use to be considered as a specialised field. Findings from the social workers, also indicate that services at Ehlanzeni are not generally available to the local population, taking into consideration that SANCA is the only outpatient centre in the district.
- However, it appears that how the lack training on legislation in the field of substance use cannot be used to estimate how this affects their service delivery and perceptions. The social workers were also unable to identify with their roles in this field as set out by various authors in the literature(see Chapter 4) .Moreover, as an NPO the organisation is being evaluated and monitored by the local DSD officials; however, some contentions regarding the Monitoring and Evaluation processes being followed reveal most of the representatives from DSD are either inexperienced or not knowledgeable on the subject matter. This is a serious in flaw the whole process as it means that SANCA then must guide the evaluation process as there is lack of input from the department's personnel.

2. Looking at findings from NICRO against this objective, it is noteworthy that NICRO is mainly involved with the SIBIRT Model in the SUDs field. In addition, they are more intensely involved with road offenders with alcohol use. In comparison, NICRO's knowledge in the subject matter (alcohol and substance use disorders) was moderate compared to that of SANCA's social workers.

- Most importantly, NICRO also held positive attitudes regarding clients who have substance use disorders. Their lack of constant training was also evident, more especially on the legislative framework of the field. Among them was one participant with less experience (0 years) who was evidently unaware of current terminologies within the substance use ambit. This further indicates the importance of training and emphasizes the call for the field to be specialised. Participants from NICRO also shared similar sentiments with those from SANCA, and DSD about the field being specialised.
- No evidence of stigmatisation was found among the NICRO social workers, which many researchers have previously found to be a barrier to services (see Chapter 2). Professionally, the social workers from NICRO do not think that there are enough experienced social workers to deal with the scourge of substance use as they also cited that most services are neither accessed nor appropriate for the field of substance use. Furthermore, social workers also believe that their colleagues in the field use a blanket approach when dealing with clients which makes the services rendered more of a deterrent than one of life enhancement.

3. The Mpumalanga Department of Social Development social workers stationed at Swartfontein Treatment Centre also shared important findings in the study. Interestingly, they were the most experienced group in the three focus group discussions. This was manifested in their knowledge of legislation. Their lack of training was cited as a contributing factor for their almost outdated knowledge on substance use.
   - Other findings from the DSD group shows that they do not attend vigorous training despite the ever demanding and changing dynamics within the field. At one instance the participants indicated that they even learn about new substances from the clients they are supposed to serve. This was very detrimental especially taking cognizance of the fact that this was the only inpatient centre in the district.

- Most of these social workers rely on their experience to render services but their manuals for treatment are outdated which is a very disturbing factor.

- Other findings from the province's DSD, were the issues of:
  - overcrowding;
  - drug test cheating;
  - being short staffed;
  - the lack of management engagement;
  - poor resource planning; and
  - outdated material.
- As stated in the combined findings of Chapter 4, there are also common problems experienced such as lack of collaboration and deviation from policies and Acts. These social workers also maintain that the field of substance use should be a specialised field. They hold very positive attitudes with the service user they serve despite many of them having experienced disappointing results from several clients over the years.

Based on the nature of the study, the research question was formulated to answer the 'what' question in relation to the phenomenon that was investigated. The research question of the study is as follows:

What are the perceptions of social workers regarding the rendering of services to people with substance use disorders in Ehlanzeni District, Mpumalanga?

The research question is answered using the two objectives as per results in Chapters 4 and 5.

5.3 Key Findings

The key findings are a summary of the data collected from Mpumalanga Department of Social Development, NICRO and that of the SANCA as follows:

Mpumalanga Department of Social Development (Swartfontein Treatment Centre)

- Substance abuse relapse is due to a lack of relevant social infrastructure and the existence of certain triggers for substance abuse.
- There is lack of training provided for the social workers hence their knowledge becomes outdated.
- Referring social workers are not doing their part regarding motivational interviewing.
- There is lack of client motivation from clients entering the centre.
- There is no multidisciplinary collaboration because staff is not divided into complements as set out in the legislation about the delivery of services.
- There is overcrowding at the centre. Overcrowding at the centre impacts effective service delivery which then impacts on client outcomes.
- The factors which stifle effective SUDs are often the external locus of control, among the recovering substance-dependent persons, shortage of skills development centres, and inadequate services in treatment centres.
- The DSD social workers are not aware of their actual roles although they are doing part of them, but they are not conscious of them.
- There is a lack of various resources at the centre, amongst them updated human resource treatment manuals.
- The social workers are not paying much attention to the legislation although they are aware of it.

- Owing to increased pressure from management, social workers end up deviating from normal substance use treatment standards and legislation. Instead they strive for numbers instead of quality service to clients.
- The main cause of relapse is the client's reluctance to attend aftercare.
- Family involvement is critical in the treatment of substance use. The government needs the communities and families to play a part.
- The causes of substance abuse are mainly due to a lack of support from family, lack of aftercare services, boredom, and stigmatisation. Every institution (in government, private and non-governmental should play an active role in this scourge of substance use.Detoxification is a huge problem for clients in the Ehlanzeni district prior to inpatient admission.

SANCA

The following are key findings from the focus group discussion conducted with social workers from SANCA:

- The awareness/perceptions of social workers on the international /local legislation on the rendering of substance use services is very minimal.
- The level of training received by these social workers is comprehensive, developmental and up to standard to a certain degree.
- The social workers are aware of current terminologies and the current discourse surrounding the field, with the exception of the legislation.
- So far, no prior knowledge is required to be employed as a social worker, except a degree in social work from a university or being a registered social worker.
- There is a need for the field of substance use to be specialised in terms of the SACSSP mandate.

- There is no proper collaboration between the relevant stakeholders which are supposed to work together in the field. The detoxification or medical services in the district is dysfunctional instead of it being a critical part of treatment. Other departments and stakeholders do not play their roles as they are supposed to. Hence the high numbers of client dropouts and low treatment success.
- Being the only outpatient treatment centre in the district, there is a dire need for more resources for increased efficiency.
- SANCA is in a better position to take the lead as a key player in the treatment and training of the prevention fraternity in the whole district, provided they receive the necessary resources.
- The treatment model being used by SANCA is updated and comprehensive and includes the modus operandi for prevention.
- There is no prevailing form of stigmatisation of clients. The nature of the work shapes both the social worker's personal and professional perceptions of victims of substance use. Hence stigma is not a barrier to receiving or providing treatment.
- The causes of substance misuse are mainly due to availability of some substances and accessibility to treatment.
- The SANCA social workers are more familiar with the Prevention and Treatment of Substance Abuse Act 70 of 2008. It is quoted in their inpatient admission report. There is, however, limited knowledge on how the legislation links with actual treatment services.
- Good supervision framework is fundamental to rendering quality and effective services.

There are also several impediments which impact the delivery of substance use services, such as:

  - Lack of detox facilities

- Lack of family support
- No half way houses in the district
- Lack of client motivation
- Family stigmatisation
- Disjointed detoxification services
- Lack of collaboration and multidisciplinary collaboration.

- Social workers are not clear about their definite roles in the field of substance use.
- Compared to other services, the field of substance use functions by working with children, HIV/AIDS, ECDs, among others. There is not enough money being invested to combat the misuse of substances. This probably has had an impact on drug related activities.
- Reconfiguration of the Department of Health and Social Development probably might ease up the pressure to make necessary detoxification services operational.
- There is contravention of the Prevention and Treatment of Substance Abuse Act 70 of 2008, especially by the Department of Health, when it comes to detoxification and their role in the field of addiction. As the act indicate that no person should be denied the right to access treatment services and the department at the district is doing minimal work to accommodate those with substance use disorders.

NICRO

- Only a few Social workers in the organisation have had training on substance use. However, the social workers are working with those with substance use disorders, involved in referral to various institutions but the training has a negative effect in their service delivery.
- There is collaboration with other key role players/institutions in the field, such as SANCA Lowveld.

- According to the social workers in this institution, the field of addiction should be specialised. They acknowledge the difficulties experienced when referring to institutions dealing with substance use. There is also a need for current knowledge training in the field for social workers at NICRO.
- According to the perceptions of social workers in substance use services, contrary to the international standards, the service is neither accessible, appropriate nor attractive; public rehabilitation centres are always full while private rehab centres are exorbitantly highly priced. Medical professionals are not treating substance use as an emergency or as needing the attention it deserves.
- There should be proper marketing of services at inpatient centres because the general public is not aware of services being offered.
- The prevention of substance use services at Ehlanzeni is visible and should be enhanced.
- Many people at Ehlanzeni have alcohol use disorders but are not aware of their condition as alcohol is perceived as a “trend setter”, “achievement”, and associated with “prestige”.
- This contributes to the many possible causes for SUDs in the district; namely, stress, easy accessibility to the substances, underage drinking, black people associating alcohol with achievements, and media advertising hype.
- There is lack of proper coordination amongst government departments and institutions. Many social workers still consider alcohol misuse as an offence instead of viewing it as a disorder which should be treated. For example: those with SUDs and within the correctional facilities or justice system do not have access to treatment. The officials do not understand the process of treatment and they often seek so-called ‘quick fixes’.
- Linking the appropriate legislation to practical work seems to be difficult for NICRO social workers, although the social workers know such legislation.

- Lack of facilities and resources bars the public from accessing treatment. The recent legalisation of dagga will have serious repercussions to the residents of the district.
- There are serious challenges from the Department of Social Development at Ehlanzeni district as social workers at their various offices are reluctant to assist those who need treatment. Instead of rendering the services themselves they refer to other offices despite their capacity to offer the desired services such as admission referral to inpatient centres.
- It is the responsibility of everyone in the community to eradicate substance misuse, together with the public and private institutions.
- Client motivation is very important for treatment especially those going for treatment via the justice system.

5.4 Conclusions

Conclusions are drawn in the section below from the key findings of the study in terms of the above Mpumalanga Department of Social Development, NICRO and SANCA findings respectively.

Mpumalanga Department of Social Development

- A collaborative approach and perspective are the most effective methodology of rendering treatment services to those with substance use disorders. Without professionals from various institutions working together

the mission of each institution cannot be achieved. In sum, employing multi-professionals in every institution should be prioritised.

- It can be concluded that Family Support (as a first point of socialisation) and Client Motivation are very pivotal aspects of treatment. This should be enhanced going forward for proper service delivery and to avert relapse.
- It can further be concluded that the aftercare services as part of treatment are key amongst recovering substance users as without aftercare treatment clients cannot be measured as failed or successful.
- The shortage of social workers, skills development centres, outdated treatment plans, and inadequate services in treatment centres remains a threat in rendering effective substance use services.
- The inpatient centre in the district needs more support from the Provincial and National office for smoother operations and to meet its mandate.
- Social workers should be adequately, regularly and vigorously trained on the current developments and knowledge on the field of substance use. Training should also be inclusive of the relevant legislation and amendments as such.
- Issues of staff welfare and continuous professional development should be prioritised within the department for effective service delivery.

SANCA

- There is a dire need for halfway houses, recreational facilities, skills development centres for those who are ready to quit substance use. This is essential as boredom, family and community stigma makes it impossible for total recovery for those with SUDs if left to their own devices.
- Social workers have limited knowledge regarding the different legislation which underpins the field of substance use. Regular training on legislation can improve service delivery.

- Treatment manuals should be continuously improved and be translated to vernacular languages for proper comprehension.
- SANCA has the capacity to render effective treatment and aftercare services. There is also a need to look at strengthening their services to broaden inpatient facilities.
- Proper collaboration with DSD for the provision of training and consultations can be very impactful for service delivery
- Other alternatives and approaches should be brainstormed amongst NGOs to alleviate the notion of the dysfunctional detoxification centres, even rendering their own detoxification services, although expensive. This should include the Department of Health instead of SANCA relying on the state for detoxification services.
- If NGOs (such as SANCA) had enough capacity and resources, they could solely render substance use services. The deficiency of such resources requires the Department of Social development to lead and facilitate the field in the district.
- Services should be extended to make it more accessible for those in rural areas. Currently services are centralised at the inner city of the district.

NICRO

- It can be concluded that NICRO is in a better position to implement the (SIBIRT) Model taking into consideration the nature of their work because they do not do treatment of SUDs but they from time to time render related services and come into contact with clients who require SUDs
- Training on substance use and relevant legislation governing usage is necessary for the social workers to adequately perform their work.
- NICRO's prevention measures can be extended for better reach and to alleviate the pressure from those institutions which render substance use services as their core mandate**.**

5.6 Recommendations

The following recommendations are made regarding the rendering of services to the public with substance use disorders compiled from the perceptions of social workers in Ehlanzeni District, Mpumalanga.

5.6.1 Recommendations of social workers in Ehlanzeni District, Mpumalanga:

- DSD, SANCA and NICRO should join forces to advocate the equal collaboration amongst several departments, such as Department of Health, Department of Justice. The eradication of drugs in the district can also be done by enhancing the local drug action committees, alongside CDA, by giving it more powers to enforce certain policies at district level in accordance to relevant legislation. At the moment CDA appears to be ineffective and toothless. These institutions should also advocate for the establishment of more treatment facilities; namely half-way houses, recreational facilities and other relevant social infrastructure to enable recovery from reduce substance use disorders in the district.
- Treatment facilities should emphasise the importance of aftercare programmes. It should be included as part of the treatment instead of making it optional for people with substance use disorders, as its importance greatly influences the success of treatment programmes.
- Social workers belong to other impeccable professions and skilled to work in the field of substance use/addiction management should be considered as a specialised area in social work similar to forensic social work and other fields of specialization in social work.
- Social workers in the field need to form a strong collaboration with other professionals using the multi-disciplinary approach to enhance and broaden their expertise in the field.
- Social workers need to be trained on applicable local legislation and its application that underpin the field of substance use, including international

legislation. This will influence their awareness and could also contribute to innovation and effective service delivery. Competency tests can also be done to evaluate and identify gaps in terms of knowledge regarding the relevant legislation.

- The Department of Social Development as the government's custodian in the field should increase the availability of basic resources urgently needed by social workers to deliver effective treatment services, e.g., providing more vehicles to allow social workers to do home visits as part of aftercare programme.
- Treatment manuals should accommodate every population and be translated into the vernacular of clients. Furthermore, there is a great need for an evaluation of the effectiveness of 'evidence based' substance use interventions (treatment) in the social work contexts. Many treatment models are out of touch with reality and the development of substance use problems.
- Workshops, roadshows, and conferences to various stakeholders, citizens, and professionals should be undertaken to increase awareness of services.
- Social work education and practice guidance (even for the social workers not working with substance use) on 'essential knowledge and skills' for social workers in adult and children's social work need to include substance use.
- Social work education at tertiary institutions needs be reformed to include in-depth substance use imperative and pivotal knowledge and skills, thus, reviews of social work education should be monitored and evaluated from time to time.
- Relevant legislation on substance use needs to routinely include social worker's roles in working with people with substance use disorders.
- More practically, management needs to support their social workers and subordinates in the delivery of SUDs services, instead of seeing them mere components/ mechanisms'

- NGOs must see each other as collaborators rather than competitive bodies. Thus, a forum of NGOs in each district to address challenges is necessary. Furthermore, institutions contravening various legislation and policies need to be taken to task by the lead custodian, which is the Department of Social Development.

5.6.2 Recommendations for further research

This study was conducted using a qualitative approach and a small sample of social workers working or having worked with substance use at the Department of Social Development, NICRO and SANCA in the Ehlanzeni District in Mpumalanga Province. It is therefore recommended that further research including a larger and representative sample is conducted. The sample can include the other districts, from other departments such as Correctional Services, other NGOs, Department of Health, South African National Defense Force(SANDF), and other relevant departments. Broadening the research study to the whole of South Africa would be even more advisable.

- There needs to be an evaluation of the validity, reliability and effectiveness of treatment models and prevention strategies used by several departments and NGOs on substance use interventions in practical terms.
- Research from the receiving end is needed. Thus, research, investigating the clients' experiences, practices, knowledge of social work interventions in relation to substance use would allow modifications of policies, resources, and relevant treatment interventions.
- Research on the socio-economic impact of substance use from the families of substance users can be very important area of concern. This is especially in terms of the family support systems needed in treatment interventions.

5.7 Concluding statements

In conclusion, the researcher feels that the field of substance use is not given appropriate attention by the South African government despite important comments from political and government officials in budget speeches, national addresses and other conferences. Many current societal problems, such as high violence at schools, high levels of crime, suicide, mental health problems, poverty, and unemployment problems, among others, have an element of substance use involved, yet it is an issue that is too often overlooked.

Furthermore, there is a dire need for treatment interventions conceptualised by social workers working in the African context as many of the treatment models are Western and do not speak to clients at grassroots level in this country. Social workers are willing learners and willing to engage but often become undermined out in the field through ineffective collaboration. While Interprofessional collaboration in this field offers many rewards and challenges, social workers can bring to the team a unique perspective concerning the clients whom they normally service.

REFERENCES

Ahmedani, B. K., Kubiak, S. P., Rios-Bedoya, C. F., Mickus, M., & Anthony, J. C. (2011). Willingness to treat drug dependence and depression: Comparisons of future health professionals. *Substance Abuse and Rehabilitation*, *2*, 43–51. Retrieved from doi.org/10.2147/SAR.S14747

Ambrose-Miller, W., & Ashcroft, R. (2016). Challenges faced by social workers as members of interprofessional collaborative health care teams: Table 1: *Health & Social Work*, *41*(2), 101–109. Retrieved from doi.org/10.1093/hsw/hlw006

Amodeo, M., & Fassler, I. (2000). Social workers and substance-abusing clients: Caseload composition and competency self-ratings. *The American Journal of Drug and Alcohol Abuse*, *26*(4), 629–641. Retrieved from doi.org/10.1081/ADA-100101899

Babbie, E. 2007. The practice of social research. 11th edition. Belmont: Thomson Wadsworth.

Babbie, E. & Mouton, J. 2010. The practice of social research. Oxford: Oxford University Press.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. The Qualitative Report, 13(4), 544-559. Retrieved from http://www.nova.edu/ssss/QR/QR13-4/baxter.pdf

Borrell-Carrió, F., Suchman, A. L., & Epstein, R. M. (2004). The Biopsychosocial Model 25 Years Later: Principles, Practice, and Scientific Inquiry. *Annals of Family Medicine*, *2*(6), 576–582. https://doi.org/10.1370/afm.245

Broughton, I. (2017, August 29). *New drug plan promises shift in policy*. p. 1. Retrieved from https://www.news24.com/SouthAfrica/News/new-drug-plan-promises-shift-in-policy-20170829

Burns, K.; (2012) 'Moving beyond 'case-management' supervision: Social workers' perspectives on professional supervision in child protection' In: Lynch, D. and Burns, K(Eds.). Children's Rights and Child Protection: Critical Times, Critical

Issues in Ireland. Manchester : Manchester University Press. Retrieved from http://www.manchesteruniversitypress.co.uk/cgibin/indexer?product=9780719086274

Burnhams, N. H., Dada, S., & Myers, B. (2012). Social service offices as a point of entry into substance abuse treatment for poor South Africans. *Substance Abuse Treatment, Prevention, and Policy*, *7*(1). Retrieved from https://doi.org/10.1186/1747-597X-7-22

Carreira, B. (2017, July 27). CDA workshop on the draft National Drug Master Plan 2018-2022 [Corporate Website]. Retrieved August 29, 2018, from Home Jericho Rehab Free State long term recovery program for addiction website. Retrieved from https://www.jerichorehab.co.za/single-post/2017/07/27/CDA-WORKSHOP-ON-THE-DRAFT-NATIONAL-DRUG-MASTER-PLAN-2018-2022

Center for Substance Abuse Treatment. (1999). *Enhancing motivation for change in substance abuse treatment*. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK64967/

Chikadzi, V., & Pretorius, E. *(*2011). Unhelpful help: The social work profession's response to mass poverty in South Africa. *Social Work/Maatskaplike Wer :47*(3),

Clark, M. (n.d.). *International standards for the treatment of drug use disorders*. New York: Rem.

Clewlow, C. (n.d.). *Introduction to Ethics*. La: Constat.

Cohen, L., Manion, L., & Morrison, K. (n.d.). *Research methods in Education,* (6th edition). Pretoria: Van Schaik

Delport, C.S.L. & De Vos, A.S. 2005. Professional research and professional practice, in A.S. de Vos, H. Strydom, C.B. Fouché & C.S.L. Delport (eds.). Research at grass roots: For the social sciences and human service professions. 3rd edition. Pretoria: Van Schaik: 44-55.

Department of Health (DoH) (2019). *Draft national guideline for management of patient waiting times at health facilities*. Pretoria: DOH

Department of Social Development (DSD) (2018). National Drug Master Plan 2013 - 2017. Retrieved from South African Government website: https://www.gov.za/documents/national-drug-master-plan-2013-2017

De Vaus, D.A. 2006. Research design in social research. London: Sage

Fouché, C.B. 2005. Qualitative research designs, in A.S. de Vos, H. Strydom, C.B. Fouché & C.S.L. Delport (eds.). Research at grass roots: For the social sciences and human service professions. 3rd edition. Pretoria: Van Schaik: 267-272.

Fouché, C.B. & De Vos, A.S. 2005a. Problem formulation, in A.S. de Vos, H. Strydom, C.B. Fouché & C.S.L. Delport (eds.). Research at grass roots: For the social sciences and human service professions. 3rd edition. Pretoria: Van Schaik: 100- 110.

Fouka, G., & Mantzorou, M. (2011). What are the major ethical issues in conducting Research? Is there a conflict between the research ethics and the nature of nursing? *Health Science Journal*, *5*(1), 12.

Galvani, S. (2015). *Alcohol and other drug use: The roles and capabilities of social workers*. 32. Retrieved from www.mmu.ac.uk/social-care-and-social-work/

Geyer, S., & Lombard, A. (2014). A contents analysis of the South African National Drug Master Plan: Lessons for aligning policy with social development. *Social Work/Maatskaplike Werk*, *50*(3). Retrieved from doi.org/10.15270/50-3-403

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal*, *204*(6), 291–295 Retrieved from doi.org/10.1038/bdj.2008.192

Gnade, H. (2013). *The effect of basic infrastructure delivery on welfare in rural and urban municipalities*. Cape Town:

gpcommsafety. (2014, July 7). Profile of nyaope users and implications for policing. [Blog] Retrieved May 9, 2018, from gpcommsafety's https://gpcommunitysafety.wordpress.com/2014/07/07/profile-of-nyaope-users-and-implications-for-policing/

Gresham, K.L. (2017). A Study of the Attitude, Academic Preparation, and Practice Competence of Social Workers in Relation to Substance Use Disorders in the State of Georgia.

Hall, M. N., Amodeo, M., Shaffer, H. J., & Bilt, J. V. (2000). Social Workers Employed in Substance Abuse Treatment Agencies: A Training Needs Assessment. *Social Work*, *45*(2), 141–155. https://doi.org/10.1093/sw/45.2.141

Hayashida, M. (n.d.). An overview of outpatient and inpatient detoxification. *Research World*, 41 (2) 3

Hillis, S., Mercy, J., Amobi, A., & Kress, H. (2016). Global Prevalence of Past-year Violence Against Children: A Systematic Review and Minimum Estimates. *Pediatrics*, *137*(3), e20154079. https://doi.org/10.1542/peds.2015-4079

Hurst, S., Arulogun, O. S., Owolabi, A. O., Akinyemi, R., Uvere, E., Warth, S., & Ovbiagele, B. (2015). Pretesting qualitative data collection procedures to facilitate methodological adherence and team building in Nigeria. *International Journal of Qualitative Methods*, *14*, 53–64. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4393011/

International Federation of Social Workers. (2014, July). Global Definition of Social Work. Retrieved June 13, 2019, from https://www.ifsw.org/what-is-social-work/global-definition-of-social-work/

Isobell, D. L. (2013). *Referring agents' perceptions of access barriers to inpatient substance abuse treatment centres in the Western Cape*. cape town: University of Cape Town.

Johnson, K., Courser, M., Holder, H., Miller, B., Ogilvie, K., Moore, R., Collins, D., Saltz, B., Ogilvie, D., & Saylor, B. (2007). A community prevention intervention to reduce youth from inhaling and ingesting harmful legal products. *Journal of drug education*, *37*(3), 227–247. Https://doi.org/10.2190/de.37.3.b

Joseph, D., & Engelbrecht, L. (2017). *Perceived contributing factors impeding job satisfaction of social workers in non-government organisations*. New York: Hennover.

Kubiak, S. P., Ahmedani, B. K., Rios-Bedoya, C. F., & Anthony, J. C. (2011). Stigmatizing Clients with Mental Health Conditions: An Assessment of Social Work Student Attitudes. *Social Work in Mental Health*, *9*(4), 253–271. https://doi.org/10.1080/15332985.2010.540516

Maguire, M., & Delahunt, B. (2017). *Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars.* American Journal for research *8*(3), 14.

Maluleke, T. F. (2014). *Perceptions of social workers regarding their role in aftercare and reintegration services with substance-dependent persons* University of Pretoria). Retrieved from http://hdl.handle.net/2263/41576

McLellan, A. T. (2017). Substance misuse and substance use disorders: Why do they matter in healthcare? *Transactions of the American Clinical and Climatological Association*, *128*, 112–130. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5525418/

Medina-Mora, M. E. (2005). Prevention of substance abuse: a brief overview. *World Psychiatry*, *4*(1), 25–30. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414714/

Mollet, J. (n.d.). *EthicaliIssues in social science research in developing countries; Useful or Symbolic*. Lukania: Taipai Press

Myers, B. J., Louw, J., & Pasche, S. C. (2010). Inequitable access to substance abuse treatment services in Cape Town, South Africa. *Substance Abuse Treatment, Prevention, and Policy*, *5*(1), 28. Retrieved from doi.org/10.1186/1747-597X-5-28

Myers, B., Petersen, Z., Kader, R., & Parry, C. D. H. (2012). Moving beyond access: Towards a quality-orientated substance abuse treatment system in South Africa. *South African Medical Journal*, *102*(8), 667. Retrieved from doi.org/10.7196/SAMJ.5990

Pasche, S., & Stein, D. (2012). Dealing with substance use disorders in general practice. *South African Family Practice*, *54*(5), 404–407. Retrieved from doi.org/10.1080/20786204.2012.10874259

Pasche, S., & Myers, B. (2012). Substance misuse trends in South Africa. *Human Psychopharmacology: Clinical and Experimental*, *27*(3), 338–341. Retrieved from doi.org/10.1002/hup.2228

Piddennavar, R., & Krishnappa, P. (2014). Effectiveness of health belief model in motivating for tobacco cessation and to improving knowledge, attitude and behavior of tobacco users. *Cancer and Oncology Research*, *2*, 43–50. Retrieved from doi.org/10.13189/cor.2014.020401

Pruis, S. (2008). *South African Council for social service professions*. Pretoria: SACCSP.

Pugatch, M., Putney, J., O'Brien, K. H. M., Rabinow, L., Weitzman, E., & Levy, S. (2015). Integrating substance use training into social work education. *Addiction Science & Clinical Practice*, *10*(S1). Retrieved from doi.org/10.1186/1940-0640-10-S1-A49

Puljević, C., & Learmonth, D. (2014). Substance abuse prevention in Cape Town's peri-urban settlements: local health trainers' perspectives. *Health Psychology and Behavioral Medicine*, *2*(1), 183–197. Retrieved from doi.org/10.1080/21642850.2013.878659

Quinn, G., & Straussner, S. L. A. (2010). Licensure and Continuing Education Requirements for Substance Abuse Training in Social Work. *Journal of Social Work Practice in the Addictions*, *10*(4), 433–437. https://doi.org/10.1080/1533256X.2010.521084

Ramlagan, S., Peltzer, K., & Matseke, G. (2010). Epidemiology of drug abuse treatment in South Africa. *South African Journal of Psychiatry*, *16*(2), 10.

Richmond, I., & Foster, J. (2003). Negative attitudes towards people with co-morbid mental health and substance misuse problems: An investigation of mental health professionals. *Journal of Mental Health*, *12*(4), 393–403. https://doi.org/10.1080/0963823031000153439

Sahu, K. K., & Sahu, S. (2012). Substance abuse. Causes and consequences. *Journal of Mental Health*, 9.

Salwan, J., & Katz, C. L. (2014). A review of substance use disorder treatment in developing world communities. *Annals of Global Health*, *80*(2), 115–121. Retrieved from doi.org/10.1016/j.aogh.2014.04.010

Saxena, S., Thornicroft, G., Knapp, M., & Whiteford, H. (2007). Resources for mental health: scarcity, inequity, and inefficiency. *Lancet (London, England)*, *370*(9590), 878–889. Retrieved from doi.org/10.1016/S0140-6736(07)61239-2

Seçim, G. (2017). A study on substance abuse prevention. *EURASIA Journal of Mathematics Science and Technology Education*, 21. Retrieved from doi.org/10.12973/eurasia.2017.01236a

Sikelela, C., Yomelelani, M., Noncedo, N. J., Buhle, N. P., & Tandokazi, N. (2016). *The experiences and coping strategies of social workers rendering services in the field of addiction counselling*. 24.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, *22*(2), 63–75. https://doi.org/10.3233/EFI-2004-22201

Siebert, D. C. (2003). Denial of AOD Use:An Issue for Social Workers and the Profession. *Health & Social Work*, *28*(2), 89–97. https://doi.org/10.1093/hsw/28.2.89

Sifers, S. K. (2002). Reporting of Demographics, Methodology, and Ethical Procedures in Journals in Pediatric and Child Psychology. *Journal of Pediatric Psychology*, *27*(1), 19–25. https://doi.org/10.1093/jpepsy/27.1.19

Sinkovics, R. R., Penz, E., & Ghauri, P. N. (2008). *Enhancing the Trustworthiness of Qualitative Research in International Business*. 27.

Skhosana, R., Schenck, R., & Botha, P. (2014). Factors enabling and hampering social welfare services rendered to street children in Pretoria: perspectives of service providers. *Social Work/Maatskaplike Werk*, *50*(2). Retrieved from doi.org/10.15270/50-2-396

Smook, B., Ubbink, M., Ryke, E., & Strydom, H. (2014). Substance abuse, dependence and the workplace: a literature overview. *Social Work/Maatskaplike Werk*, *50*(1), 59–83. Retrieved from doi.org/10.15270/50-1-16

Stein, J. B. (2003). Attitudes of Social Work Students About Substance Abuse: Can a Brief Educational Program Make a Difference? *Journal of Social Work Practice in the Addictions*, *3*(1), 77–90. https://doi.org/10.1300/J160v03n01_06

Soto, S. J., & Stuart, M. J. (2014). *BELIEFS ABOUT SUBSTANCE ABUSING CLIENTS AMONG SOCIAL WORK STUDENTS*. 70.

South African Community Epidemiology Network on Drug Use SACENDU Report (2017) Retrieved May 9, 2018, from https://www.google.co.za/search?rlz=1C1GCEA_enZA775ZA778&ei=HmHzWoejO4iTgAbYhoroCw&q=South+African+Community+Epidemiology+Network+on+Drug+Use+%2C2017+report&oq=South+African+Community+Epidemiology+Network+on+Drug+Use+%2C2017+report&gs_l=psy-ab.12...15225.58350.0.59739.13.13.0.0.0.0.333.2477.2-9j1.10.0....0...1.1.64.psy-ab..3.0.0....0.VTEm_MzLVEQ

Schwenk, T. L., Davis, L., & Wimsatt, L. A. (2010). *Depression, Stigma, and Suicidal Ideation in Medical Students*. 10.

Teater, B. (2015). *28092. Social Work Theories*. City University of New York - College of Staten Island

UN World Drug Report 2017 (2017). Retrieved May 9, 2018, from https://www.unodc.org/wdr2017/

Vetten, L. (2017, February 16). *South Africa isn't budgeting for its care economy. What can be done about it*. The Conversation. http://theconversation.com/south-africa-isnt-budgeting-for-its-care-economy-what-can-be-done-about-it-73066

Walliman, N. (2010). *Research Methods: The Basics* (1st ed.). Routledge. https://doi.org/10.4324/9780203836071

Walliman, N. (2006) Your Research Project: A Step-by-Step Guide for the First-Time Researcher (second edition). London: Sage

Wells, E. A., Kristman-Valente, A. N., Peavy, K. M., & Jackson, T. R. (2013). Social workers and delivery of evidence-based psychosocial treatments for substance use disorders. *Social Work in Public Health*, *28*, 279–301. Retrieved from doi.org/10.1080/19371918.2013.759033

Wiles, R., Crow, G., Heath, S., & Charles, V. (n.d.). *Anonymity and confidentiality*.Southampton : University of Oxford

Write News Agency, The (2013).

Yin, R. K. (2003). Case study research: Design and methods (3rd ed.). Thousand Oaks, CA: Sage.

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

APPENDIX B: APPROVAL LETTERS

8 HOPE STREET
P O BOX 1073
NELSPRUIT
1200

SANCA 60 CELEBRATING Years

TEL: (013) 752 4376 / (013) 755 2710
FAX: (013) 752 5099 / 086 524 0195
CELL: 082 451 3226
E-MAIL: admin@sancalowveld.co.za

LOWVELD ALCOHOL AND DRUG HELP CENTRE

PRACTICE NO.: 047 001 0107344

Thembinkosi Singwane (1366917)
University of Witwatersrand

Dear Sir

With reference to your letter, dated 16 August 2017.

SANCA Lowveld hereby confirm that the organisation will support you in your studies in Social work Research (Master's degree).

You are more than welcome to contact the undersigned with arrangements for your studies at SANCA Lowveld.

Warm Regards

Erasmus

Marina Erasmus
Director SANCA Lowveld

SANCA LOWVELD ALCOHOL & DRUG HELP CENTRE
PO BOX 1073
NELSPRUIT 1200
TEL: 013 752 4376

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

8 HOPE STREET
P O BOX 1073
NELSPRUIT
1200

SANCA

CELEBRATING 60 Years

TEL: (013) 752 4376 / (013) 755 2710
FAX: (013) 752 5099 / 086 524 0195
CELL: 082 451 3226
E-MAIL: admin@sancalowveld.co.za

LOWVELD ALCOHOL AND DRUG HELP CENTRE

PRACTICE NO.: 047 001 0107344

11 September 2019

Thembinkosi Singwane (1366917)
University of Witwatersrand

Dear Sir

With reference to your letter.

SANCA Lowveld hereby confirm that the organisation will support you in your studies in Social work Research (Master's degree).

You are more than welcome to contact the undersigned with arrangements for your studies at SANCA Lowveld.

Warm Regards

SANCA LOWVELD ALCOHOL & DRUG HELP CENTRE
PO BOX 1073
NELSPRUIT 1200
TEL: 013 752 4376

Marina Erasmus
Director SANCA Lowveld

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Nelspruit Office

20 Ferreira Street | Volante House

PO Box 3533 | NELSPRUIT | 1200

Tel: (013) 755 3540/3745 | Fax: (013)755 3541 |

Nelspruit Supervisor e-mail: nomagugu@nicro.co.za

nicro

FOR A SAFE SOUTH AFRICA

NICRO [Association Incorporated under Section 21]
Registration Number: 2006/032333/08
NPO Registration No:003-147 NPO

Date: 22 August 2017

To: Thembinkosi P. Singwane
University of Witwatersrand - Masters in Social Work Research
Student no: 1366917

RE: PERMISSION TO CONDUCT RESEARCH IN THE ORGANISATION.

NICRO Nelspruit acknowledges your request, and gives permission for you to conduct research by interviewing social workers in our Organisation for the purposes of your research study "The perceptions of social workers towards substance abuse and its treatment in the Ehlanzeni district, Mpumalanga".

Yours sincerely,

Nomagugu Dube
Social work supervisor

NICRO NELSPRUIT OFFICE
P.O. Box 3533, Nelspruit 1200
22 AUG 2017
No. 20 Ferreira Street
Tel: 013 755 3540/3745
Fax: 013 755 3541

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

social development
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Building 3, NO. 7 Government Boulevard, Riverside Park, Mbombela, 1200
Mpumalanga Province, Private Bag X 11213, Mbombela, 1200
Tel: +27 (13) 766 3429, Fax: +27 (13) 766 3456/57

Litiko Letekutfutfukisa Tenhlalakahle | UmNyango Wezokuthuthukiswa Kwezokuhlalokuhle | Departement van Maatskaplike Ontwikkeling

Enq. *Ms. S. E. Botha*
Tel.: *013 766 3053*
Ref No.: DSD/12/5/R

14 September 2017

Mr Thembinkosi P Singwane
P.O. Box 1491
Matsulu
1203
ThembinkosiSingwane1@students.wits.ac.za

RE: PERMISSION TO CONDUCT RESEARCH IN THE DEPARTMENT

Correspondence pertaining to this matter has reference.

Permission is hereby granted to Mr. Thembinkosi Peter Singwane, student ID **1366917**, to conduct his research in the department for his fulfillment of the requirements for the **Master of Arts in Social Work** at the University of the Witwatersrand, Johannesburg.

Permission is granted on condition that ethical clearance would be obtained from the university's Research Ethics Committee and all ethical principles in research (for example voluntary participation, confidentiality, anonymity, etc.) would be adhered to.

We look forward to the feedback on the research findings and the value that will be added by the research.

Kind regards,

MS T.E. MHLONGO
ACTING HEAD DEPARTMENT
DATE: 18/09/2017

UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG

social development
MPUMALANGA PROVINCE
REPUBLIC OF SOUTH AFRICA

Building 3, NO. 7 Government Boulevard, Riverside Park, Mbombela, 1200
Mpumalanga Province, Private Bag X 11213, Mbombela, 1200
Tel: +27 (13) 766 3428, Fax: +27 (13) 766 3456/57

Liliko Letekutsutfukiso
Tenhlalakahle

UmNyango WezeKuThuthukiswa
Kwezolu Hlalokuhle

Departement van Maatskaplike
Ontwikkeling

Enq. Ms. S. E. Botha
Tel.: 013 766 3053
Ref No.: DSD/12/5/R

11 SEPTEMBER 2019

Mr. T. P. Singwane,
Email address: 1266917@students.wits.ac.za

Correspondence pertaining your request to collect data has reference.

Permission is bereby granted to Mr. T. P. Singwane, Student number 1366917, to collect data from the department for the academic research project titled "***Rendering Services to People with Substance Use Disorders at Ehlanzeni District – Perceptions of Social Workers***".

This approval is granted with the provision that the researcher will collect data within the parameters of ethics for conducting research.

The department will appreciate feedback on the findings and the value that will be added by the research.

Kind regards,

MR. M. V. MAHLALELA
HEAD: SOCIAL DEVELOPMENT

11/09/2019
DATE

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG | FACULTY OF HUMANITIES

Student Number: 1366917

Mr Thembinkosi Singwane
Stand No 936
Zola Matsulu
1203
Mpumalanga
South Africa

19 September 2018

Dear Mr Singwane

APPROVAL OF PROPOSAL FOR THE DEGREE OF MASTER OF ARTS IN SOCIAL WORK BY RESEARCH

I am pleased to be able to advise you that the readers of the Graduate Studies Committee have approved your proposal entitled "***Rendering services to people with substance use disorders: Perceptions of social workers in Ehlanzeni District Mpumalanga***" However you should take note of warnings and recommendations. I confirm that Dr Thobeka Nkomo has been appointed as your supervisor.

The research report is normally submitted to the Faculty Office by 15 February, if you have started the beginning of the year, and for mid-year the deadline is 31 July. All students are required to RE-REGISTER at the beginning of each year.

You are required to submit 2 bound copies and one unbound copy plus 1 CD in pdf (Adobe) format of your research report to the Faculty Office. The 2 bound copies go to the examiners and are retained by them and the unbound copy is retained by the Faculty Office as back up.

Please note that should you miss the deadline of 15 February or 31 July you will be required to submit an application for extension of time and register for the research report extension. Any candidate who misses the deadline of 15 February will be charged fees for the research report extension.

Kindly keep us informed of any changes of address during the year.

Note: All MA and PhD candidates who intend graduating shortly must meet your ETD requirements at least 6 weeks after your supervisor has received the examiners reports. **A student must remain registered at the Faculty Office until graduation.**

Yours Sincerely

G Kamfer

Genevieve Kamfer (Mrs)
Faculty Officer
Faculty of Humanities
Private Bag X 3
Wits, 2050

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Research Office

HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)
R14/49 Singwane

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: H19/07/36**
PROJECT TITLE	Rendering service to people with substance use disorders: Perceptions of social workers in Ehlanzeni District, Mpumalanga
INVESTIGATOR(S)	Mr T Singwane
SCHOOL/DEPARTMENT	Human and Community Development/
DATE CONSIDERED	19 July 2019
DECISION OF THE COMMITTEE	Approved
EXPIRY DATE	21 October 2022

DATE 22 October 2019

CHAIRPERSON _____
(Professor J Knight)

cc: Supervisor : Dr T Nkomo

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University. Unreported changes to the application may invalidate the clearance given by the HREC (Non-Medical)

I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to completion of a yearly progress report.**

_____ **Signature**

_____/_____/_____ **Date**

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

APPENDIX A: PARTICIPATION INFORMATION SHEET

SOCIAL WORK
THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

PARTICIPATION INFORMATION SHEET (SOCIAL WORKERS)

Rendering services to people with substance use disorders: perceptions of social workers in Ehlanzeni District, Mpumalanga

Good Day,

I am Thembinkosi Singwane , and I am conducting a research for obtaining a Master's degree in SOCIAL WORK at the University of the Witwatersrand. My predominant scope of focus is based on "Rendering services to people with substance use disorders: perceptions of social workers in Ehlanzeni District, Mpumalanga''. South Africa has twice the global average of substance dependency but is number one in Africa. However, access to substance abuse treatment among historically disadvantaged communities (HDCs) in, South Africa is limited, despite a growing demand for services.

Considering the aforesaid I would like to invite you to participate in this study. The reason I have chosen you is because you are a social worker working within the Ehlanzeni District .Participation is voluntary, and no person will be advantaged or disadvantaged in any way for choosing to participate or not participate in the study. Your responses will be kept confidential, as no information that could identify you

would be included in the research report. Participation in this study will basically entail being interviewed by me, at your office, home or any other place and time that is suitable for you.

The interview will last for 45 minutes. With your permission this Focus Group Discussion (FCG) will be tape recorded to ensure accuracy. The interview material (tapes and transcripts) will not be seen or heard by any person in this organisation at any time and will only be processed by myself. You may decline to answer any questions you would prefer not to, and you may choose to withdraw from the study at any point. Results of the study will be written up in the form of a research report and your Department/organisation will also be provided with a summary of the findings of the study. If you choose to participate in the study, please fill in your details on the consent forms. I will in short be in contact with you for arrangements of the interview.

Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report. The results of the research may also be used for academic purposes (including books, journals and conference proceedings) and a summary of findings will be made available to participants on request.

Please contact me on (0720438002) or (1366917@students.wits.ac.za), or my supervisor Dr Thobeka Nkomo on (011 717 4481) or (Thobeka.Nkomo@wits.ac.za) if you have any concerns and complaints about the study. We shall answer them to the best of our ability.

Thank you for taking the time to consider participating in the study.

Yours sincerely

_____

Thembinkossi Peter Singwane

APPENDIX C :INFORMED CONSENT FORM FOR AUDIO RECORDING

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.za

CONSENT FORM FOR AUDIO-TAPING OF THE FOCUS GROUP DISCUSSION

I _____Consent to my participation in the focus group discussion with Thembinkosi Singwane for his study on "Rendering services to people with substance use disorders: perceptions of social workers in Ehlanzeni District, Mpumalanga'' I understand that: The tapes and transcripts will not be seen or heard by any person in this organisation at any time, and will only be processed by the researcher.

The tapes will be kept in a secure place until destroyed two years after any publication arising from the study or six years after completion of the study if there are not publication at the University of the Witwatersrand by the researcher

Confidentiality and anonymity are significant considerations in research, I do understand that a focus group discussion as a method of data collection do not necessarily allow for my anonymity and confidentiality to be strictly guaranteed, and

My identity will be protected, and no identifying information will be used in the transcripts or the research report.

Participant's Signature

APPENDIX D

SOCIAL WORK

THE SCHOOL OF HUMAN AND COMMUNITY DEVELOPMENT (SHCD)

Private Bag 3, Wits, 2050 • Tel: 011 717 4472 • Fax: 011 717 4473 • E-mail: socialwork.SHCD@wits.ac.zaen

Rendering services to people with substance use disorders: perceptions of social workers in Ehlanzeni District, Mpumalanga

CONSENT FORM FOR PARTICIPATION IN THE STUDY

I hereby consent to participate in the research study. The purpose and procedures of the study have been explained to me.

I understand that:

- My participation in this study is voluntary and I may withdraw from the study without being disadvantaged in any way.
- I may choose not to answer any specific questions asked if I do not wish to do so.
- There are no foreseeable benefits risks associated with participation in this study.
- My identity will be kept strictly confidential, and any information that may identify me, will be removed from the discussion script.
- A copy of my discussion transcript without any identifying information will be stored permanently in a locked cupboard and may be used for future research
- I shall not be incentivised/ rewarded and/or remunerated for my participation in the research project.

- I understand that my responses will be used in the write up of a master's project and may also be presented in conferences, book chapters, journal articles or books.

Name of Participant _____

Date _____

Signature _____

APPENDIX C

Rendering services to people with substance use disorders: perceptions of social workers in Ehlanzeni District, Mpumalanga

FOCUS GROUP DISCUSSION

1.What training do you have on Substance use and addiction management?

2. In your view, what are the requirements for being employed as a social worker in your institution in the substance use and addiction management field?

3. Deliberate whether the field of substance use and addiction management a field of specialization.

4. What is your understanding of substance use disorder services around the Ehlanzeni District?

5. What do you consider the causes of substance use disorders amongst people in the Ehlanzeni District from a social service delivery point of view (?

6. What are your personal views on those who have SUDs?

7. What are the obligations of social workers with regards to substance use disorders and related services to substance-dependent persons by legislation and policies?

8. What impediments do you experience in rendering services to your clients?

9. what is the role (including tasks and responsibilities) of social workers in rendering substance use disorders services and related services at your workplace?

10. According to your institution's / programs/ strategies/ procedures/ policies, what does substance use disorders services and related services entail?

11. Are substance use disorders services and related services the responsibility of government departments, NGOs, or both?

12. What are your recommendations for improving the effectiveness of substance use disorders services and related services?


UNIVERSITY OF THE
WITWATERSRAND,
JOHANNESBURG