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Understanding the work experiences, coping strategies and organisational retention of social workers in Gauteng in-patient substance abuse treatment centres.

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2009-01-07T09:51:22Z
http://hdl.handle.net/10539/5924

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CHAPTER 1

OVERVIEW OF THE RESEARCH REPORT

1. INTRODUCTION TO THE STUDY

The social work profession has experienced a critical decrease of social workers in South Africa. This was discussed at an Indaba held in April 2006 which was led by the Deputy Minister of Social Development, Dr. Jean Benjamin and the Social Development Portfolio Committee. The purpose of the Indaba was to develop strategies to retain and recruit social workers and to address the increasing complex social problems facing South Africa (Social Work Indaba, 2006). The Recruitment and Retention Strategies for Social Workers included: developing generic job descriptions; improving the remuneration packages for social workers; providing 190 social work scholarships; and implementing additional training for social workers (Social Work Indaba, 2006).

The retention of social workers is problematic not only for South Africa but for many different countries as described in studies conducted in The United States of America and The United Kingdom (Strolin-Goltzman, Auerbach, McGowan and McCathy, 2008; Simons and Jankowski, 2008; Schwartz, Tiamiyu and Dwyer, 2007; Findler, Wind and MorBarak, 2007; and Bride, 2007). The problem of retention of social workers is also experienced in specialised social work fields such as substance abuse treatment. This could be attributed to numerous factors such as the challenges in dealing with substance abusers, i.e. the high relapse rate of clients, the changing profile of clients as well as inadequate preparation and orientation to the field through a lack of training, supervision and organisational support. The work experiences of these social workers could affect and influence their coping strategies, stress and burnout levels and might even lead to high staff turnover. Ryder (2008) explained that South African non-governmental organisation (NGOs) need to realise that skills shortages and high staff turnover reflect the global situation and that organisations have to replace their entire workforce nearly every four years. Moreover, NGOs experience a general shortage of managerial and leadership competencies as well as high costs to recruit and train new staff (Ryder, 2008). There has been a paradigm shift in the way that organisations and staff interact with each other; previously jobs were scare, now it seems that talented and committed staff are scare; previously employees were loyal, now staff are more mobile and their commitment is short term;

previously staff accepted a standard package, now they expect higher salaries; previously staff needed organisations, now it has changed to organisations appearing to need staff (Ryder, 2008).

This study therefore proposed to examine several in-patient treatment centres in the Gauteng province to ascertain the work experiences, coping strategies and organisational retention strategies of these social workers who chose to work in this demanding field. This chapter provides an outline of the rationale for this study; key concepts are identified and a structure for the research report is given.

2. STATEMENT OF THE PROBLEM AND RATIONALE OF THE STUDY

The researcher had identified the following reasons for conducting this research:

- The researcher wanted to understand the reasons for the high staff turnover in the substance abuse field and in particular in the in-patient treatment centres. Moreover, she wished to identify strategies to help retain social workers in this field. Staff retention has been identified at a Social Work Indaba (2006) as problematic due to an increase in demands for social work services but, a shortage of social workers in South Africa to address these demands. This was confirmed by a recent Human Research Council (HRCS) study conducted by Earle (2008);
- An increase in demand for treatment and changes in the profile of clients seemed to have had an impact on the work experiences and burnout of social workers in South African organisations. Ross (1997) identified that stress and burnout were experienced by social workers and Earle (2008) attributed these high burnout rates to the poor working conditions and lack of support for social workers in South Africa;
- A decrease in the average age of clients appeared to place additional challenges on the social worker, as innovative therapeutic methods needed to be developed in order to deal holistically with clients, their families and their environments (SACENDU, 2007);
- Motivational counselling to change behaviour through cognitive behavioural therapy (cause and effect) with younger clients was made difficult by the fact that younger clients appeared not to perceive the consequences associated with their addictive behaviour in a negative light, placing greater demands on the social workers' therapeutic skills. In addition, perceived lack of insight on the side of the younger clients, significantly reduced the success rate for recovery among these clients (Collins, 1990);
- The high staff turnover would impact on service delivery to clients, as the therapeutic process was interrupted and the continuum of care could not be consistently provided;

- The cost of recruitment and training to appoint new social workers was costly for these clinics; and
- The constant change in social worker team members would affect the morale and dynamics between colleagues.

3. PRIMARY AIM AND RESEARCH QUESTIONS

The primary aim of this study was to understand the work experiences, coping strategies and organisational retention of social workers in Gauteng in-patient substance abuse treatment centres.

The following research questions guided the study:

- Are newly qualified social workers adequately prepared to provide specialised services to substance abuse clients?
- What are the coping strategies and resilience factors to stress of senior social workers with more than five years work experience in the substance abuse field that could assist with staff retention?
- What do social workers and organisations identify as the causes and extent of social work turnover in the substance abuse field?
- What are the differences and similarities in work experiences and coping strategies between social workers from the following three categories: newly qualified social workers, more experienced social workers and social workers who had left the profession?
- What retention strategies can be implemented by organisations, managers and supervisors to reduce staff turnover and increase organisational commitment and job satisfaction of social workers in Gauteng in-patient treatment centres?

4. KEY WORDS

Abuse (alcohol, drug, medication, substance, psychoactive substances) is defined in the DSM-VI "…as a maladaptive pattern of substance use to clinically significant impairment or distress, as manifested by one (or more) of the following over a 12-months period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home;
- Recurrent substance use in situations in which it is physically hazardous;
- Recurrent substance-related legal problems; and

- Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substances" (DSM-IV, 1994).

Client is "the general name for someone receiving non-casual help, willing or unwilling, from a social worker" (Timms, 1982:34).

Counselling is "…a personal relationship in which the counselor uses his own experiences of living to help his client enlarge his understanding- and so make better decisions" (Timms, 1982: 49).

Drug Dependence is "…an uncontrollable urge to satisfy a need and as a result of repetitive use there is an impairment of functioning of the individuals either physically, socially or emotionally" (Collins, 1996: 2).

For-Profit Facilities for the purpose of the study are facilities that are either privately owned companies or registered as Section 21 companies.

Non-Profit Facilities are registered with the Department of Social Services and under the Non-Profit Organisation Act 70 of 1997 and receive partial subsidy for service delivery.

***Psychoactive* drugs** are "…chemicals substances that alter the functioning of brain cells (neurons)" (Griffin in Rach, 1993: 175).

Social work administration is "…the action of staff members who utilise social processes to transform social policies of agencies into the delivery of social services" (Skidmore, 1995:3).

Social Work Management is "…a process of organizing resources to get work done" (Coulshed and Mullender, 2001:5).

Supervision is "…the educational and professional oversight of social work students and trained professionals…and is a specific social work contribution to the development of professional excellence" (Timms, 1982: 188).

State Rehabilitation Facilities are registered under the Alcohol and Drug Treatment and Rehabilitation Act 20 of 1992 and are fully subsidized by the Department of Social Services and Population Development.

5. ASSUMPTIONS UNDERLYING THE STUDY

The following assumptions underlie this study:

- Entry level social workers may leave the field of substance abuse treatment as they may not feel adequately prepared for the challenges of working in the field despite the orientation programmes, training and supervision received (Leckie cited in Collins, 1990);
- The challenges or demands placed on social workers in this field, such as the high relapse rate of clients, may affect the workers' own sense of professional and personal failure (Collins, 1990);
- In order to work in the field of substance abuse treatment for an extended period of time, social workers need to have developed resilience and coping strategies to overcome the challenges and demands placed on them (Barber, 2001: 50). These coping strategies may even be negative and could include long term burnout symptoms, such as the depersonalization of clients (Maslach cited in Cooper, Dewe and O'Driscoll, 2001);
- The high staff turnover of social workers was not necessarily unique to the substance abuse treatment field and may be experienced in other fields of social work practice (Ross, 1997 and Ryder, 2008);
- In-patient substance abuse treatment centres possibly do not provide the support and training for social workers that is required to retain these professionals in the substance abuse field (Collins, 1990 and Myers, 2004).

6. RESEARCH DESIGN AND METHODOLOGY

The research design used in this study was an exploratory- descriptive design which incorporated both quantitative and qualitative aspects. A questionnaire which was comprised of both qualitative and quantitative questions was sent to the directors of 8 organisations. The researcher received four completed questionnaires; hence a 50% response rate was obtained. Seven social workers were then interviewed: two that had recently entered the field; three that had been working in the field for more than five years and two that had left the field more than two years ago. In-depth interviews were conducted with these seven social workers to create an understanding of the daily challenges

that they faced in their work environments. It was a challenge for the researcher to recruit three participants from each of the three categories as the social workers that have left were difficult to trace. As a result, only two social workers from the first and last categories were interviewed and not three as initially intended. The results of the quantitative data were analyzed using descriptive statistics, which were illustrated via tables, charts and graphs and the qualitative data were analysed using thematic content analysis.

7. ANTICIPATED VALUE OF THE STUDY

This study identified and explored the perceptions of social workers dealing with substance abuse treatment as their primary therapeutic function. The anticipated value of the study included:

- To provide social workers and employers with a level of insight into the variables that affect the retention of social workers in the field of in-patient substance abuse treatment;
- To provide guidance for the orientation, supervision and in-house training programmes in order to support and help retain social workers in the field of in-patient substance abuse treatment; and
- To identify organisational factors that impact on social workers within these settings, and recommend strategies to reduce the negative impact of organisational factors as well as identifying possible future research areas.

8. LIMITATIONS OF THE STUDY

The limitations of the study included:

- The interpretation of the emotional content and data could be influenced by the subjectivity of the researcher. The researcher overcame this limitation by recording all her feelings, personal views and perceptions in a research journal and attended regular supervision sessions;
- When conducting qualitative research it is often difficult for the researcher to adopt the role of an objective observer. The researcher made use of an interview schedule to keep track of questions during the in-depth-interviews with participants. The researcher also made use of a quantitative research questionnaire that was send to the representatives of the organisations to ensure objectivity and for the purpose of triangulation;
- In qualitative research, a small sample is often used for data gathering, thus average trends and representation of larger population can not be made, as is often the case with a quantitative research design. Hence, the researcher also used quantitative research

questionnaires to ensure that the sample size included the perceptions of the directors of the organisations where these social were employed; and

- Other limitations could be that only Gauteng in-patients clinics were approached excluding other in-patient clinics from other provinces and out-patient clinics in Gauteng. The challenges for social workers might be different in these two types of treatment settings. This report did not compare these differences. The recommendations include the extension of the research to other provinces.

9. OUTLINE OF THE RESEARCH REPORT

The research report is divided into six chapters:

Chapter 1:

This chapter provides an outline of the research report: the introduction contextualises the topic explaining the nature of the problem; the overall aim and research questions are clarified; the rationale and value of the study is explained; key words are defined; underlying assumptions are given; the research design and methodology are described and finally an overview of the research report is clarified.

Chapter 2:

In Chapter two, the world of work and work stress are discussed. Various theoretical models of stress and work stress are compared and linked to helping professions such as social work. Organisational aspects such as: corporate culture; socio-cultural diversity; compensation of pay; communication; leadership, influence and power structure; roles and socialisation are elaborated upon and linked to the impact these processes have on the individual in terms of work stress and job satisfaction.

Chapter 3:

This chapter specifically focuses on work stress experienced by social workers both internationally and nationally within the South African context. Two main occupational hazards for social workers, namely burnout and compassion fatigue are discussed to indicate the causes and effects of work stress. The causes, effects and strategies to overcome staff turnover are elaborated upon. The management of social workers is further discussed, highlighting the effective processes that are needed to create healthy organisations and job satisfaction for social workers. Substance abuse as a specialised field is explored, especially the challenges that social workers practising in the field may encounter.

Chapter 4:

In this chapter, the research design and methodology is explained; the strengths and weaknesses of the research design are discussed; aspects such as trustworthiness, sampling procedures, inclusion and exclusion criteria, the research instruments, research procedures, data analysis methods and ethical aspects of the study are also explained.

Chapter 5:

In chapter five data collected through the questionnaires and in-depth interviews are analysed and discussed in relation to existing literature. The researcher combined the analysis of the quantitative and qualitative data; using tables, figures and quotations from the participants to answer the research questions.

Chapter 6:

In this final chapter the main findings of the data analysis are linked to the aims and objectives of the study, conclusions are discussed. Recommendations for future research, practice and theory are identified. The researcher designed a retention model based on the summary of the findings to illustrate the causes, effects and retention strategies of social workers in the substance abuse field of practice.

CHAPTER 2

LITERATURE REVIEW OF THE WORLD OF WORK AND THE IMPACT ON THE INDIVIDUAL

1. INTRODUCTION TO THE WORLD OF WORK

Work is an integral part of adulthood, and is therefore an activity which the majority of adults will engage in. Freud (cited in du Plessis 1990:199) describes “work as being a component of adult normality”. Akabas (cited in du Plessis 1990) explains that the work environment has a vital developmental function by assisting with the person’s social and emotional growth. He further explains that the workplace functions as an environment which governs human behaviour through rules, roles and responsibilities. Moreover, the work environment acts as a functional community which can provide security, support, a sense of self and a sense of self-worth for its members. Work is linked to the identity of the person and contributes to the growth of an individual and creates meaning in their life.

However, the work environment can also have a negative impact on individuals and can cause mental health problems such as stress. Ramanathan (1992) explains that stress experienced either personally, and/or due to the workplace can cause physical and/or mental disorders such as chronic respiratory ailments, cardiovascular diseases, gastrointestinal disorders, depression, anxiety and even some cancers. These problems are divided either into individual personal problems (employee-as-person) or problems experienced due to the work environment (person-as-employee) (Du Plessis, 1990).

Work stress is part of any work environment and mainly experienced in helping professions such as nursing, paramedics, teaching, police work and social work (Cooper and Marshall, 1980). This research focuses specifically on the effects that work stress has on social workers in the field of substance abuse treatment.

2. THE MEANING OF WORK

The meaning of work has been linked to the identity of the person by du Plessis (1990:) and is characterized by the "the effort or activity of the individual that is undertaken for the purpose of providing goods and services of value to others and one self".

Five core job dimensions assist a person to feel a sense of job satisfaction and meaningfulness from work namely whether there is ***skills variety*** to explore and implement a number of skills; ***task identify*** where you can derive meaning out of completing a task; ***task significance*** to provide a service or do a task that will assist others; ***autonomy*** to make decisions about one's work and tasks and finally to receive ***feedback*** on your performance and being able to learn from that experience. The individual experiences some work dissatisfaction when one or more of these five core job dimensions are that leads to work stress (du Plessis, 1990). Other factors also play a role in influencing the individual such as personal problems and family life and will be further discussed in this chapter.

3. THE HISTORY OF WORK

Work evolved with the invention of technology that led to the start of factories, urbanization and the shifting of power from the ordinary farmers/craftsmen to wealthy landowners. In Great Britain, in the 18th Century the industrial revolution brought about dramatic changes in the organization of work (Chmiel, 2000 and Munchinsky, Kriek and Schreuder, 2005). Chmiel (2000) identified three stages of development of technology at work, namely:

- Power provision or primary mechanization where traditionally manufacturing technology is used as a work aid for physical jobs. Water and steam power was used during this period in history to relieve the physical and manual labour performance to produce products out of raw material. It is important to note that machinery was still controlled by people;
- The second stage is called automation of function or secondary mechanization. This refers to machinery that became more advanced and sophisticated by using electricity. Assembly lines began to take over some of the manual functions performed by people. In 1911, Frederick W. Taylor developed his approach or philosophy to work called "scientific management". He linked the motivation of people with money and believed that the harder people work the more they will benefit. Employees were paid according to the amount of work they had done and all the knowledge and expertise lay with management. People were micro managed and there

was no room for creativity and taking initiative. This was the start of the process of supervisors. Henry Ford introduced the production line, whilst this increased productivity it created its own set of problems such as lack of job satisfaction and stunted career development. The second influence on the link between work and employees was a study that was conducted from 1924 to 1932 at the Hawthorne plant of the Western Electrical Company in the United States of America (USA). This study showed that people are also motivated by social interactions and relationships that they establish in the work environment and that these factors are linked to productivity (Chmiel, 2000).

- The third stage, the information and control of processes or the tertiary mechanization stage included the development of electronic-based computerized machinery to coordinate and control production and therefore have limited human involvement. This approach has dominated work since 1945.

4. SOUTH AFRICAN WORKPLACES

In South Africa, the workplace prior to 1994 was characterized by apartheid principles of discrimination and unfair practices. Labour was seen as a commodity and part of mass production and controlled through strict rules and work performance. ‘Monitoring’ was clearly taking out the human aspects of initiative, creativity and spontaneity. Workers became increasingly unhappy with the state of affairs and this gave birth to the start of the trade unions in the mining industries. This was considered the start of the South African Industrial revolution in the nineteenth century and contributed to political transformation of the country (Munichinsky, Kriek and Schreuder, 2005). Since the post-apartheid period the workplace has undergone dramatic changes to reduce the harm caused during the apartheid era. In the current South African workplaces, legislation pertaining to affirmative action, employment equity, labour relations and black economic empowerment have shaped workplaces to reduce the wrongs from the past (Mdladlana, 2008). The challenge of integrating different people from various educational and economic backgrounds as well as cultural, gender and sexual orientation are the main focal points of many human resource departments (BEE Strategy, 2004 and Sacht, 2008). Sacht (2008) argues that there has not been enough diversity in South African workplaces. (He explains businesses lack of investing in cultural diversity due to another thing imposed by government.) In the mean time, black employees and women are still largely excluded from senior positions and levels in companies (Sacht, 2008). The rights of employees need to be protected according to the Constitution of South Africa to ensure fair and equal opportunities for all in the workplaces. Different legislations and legal regulations ensure

that these concepts and principles are implemented and adhered to, namely the Broad-Based Black Empowerment Act, 53 of 2003, the Labour Relations Act, 1877 of 1995, The Employment Equity Act, 55 of 1998 and the Occupational Health and Safety Act, 85 of 1993.

The history of work demonstrates that the meaning individuals derive from work can be positive or negative. Moreover, work can affect personal development and/or the mental well-being of employees. The negative impacts of work-home interface causes job strain and stress.

5. STRESS AND WORK

5.1 DEFINING STRESS

For centuries, the concept "stress" has been a topic of research by numerous researchers and academics (Furnham, 2005). The Latin word for stress is *stringere* that means "draw tight" that was used to describe hardships. It was only later in the 18th century that stress was associated with people under strain or used as an engineering and physics term to explain the pressure placed on an object. This first definition of stress looked at the concept being created by an outside stimulus and then caused a fight-or-flight reaction in both animals and people (Cartwright and Cooper, 1997).

It was only in 1946 that Selye linked stress, physical illness and disease together. Seyle described the reaction of a person under stress according to three stages: alarm reaction, resistance and exhaustion. Selye's work in the 1930's and 1940's reignited the studies on stress. Selye introduced the motion of stress-related illnesses popularly known as general adaptation syndrome (GAS), which suggests that "…stress is a non-specific response of the body to any demand made upon it" (Cooper, Dewe and O'Driscoll, 2001 and McQuade and Aikman, 1976). The biggest criticism against Seyle's theory is that it only explores the cause of stress as an external stimulus that affects a person. It excludes individual differences and doesn't explain why people react differently to the same stimulus. It does however explain the physical link between stress and the body and the impact this has on a person exposed to long term stress and physical illnesses.

Basowitz, Persky, Karchin and Grinker (cited in Cartwright and Cooper, 1997: 5) define stress by focussing on the interaction between a person and their environment and say stress is "…a response to internal or external processes which reach those threshold levels that strain its physical and psychological integrative capacities to, or beyond, their limit". This definition includes the internal

reasons to explain different reactions, but fails to explain that stress can have a positive influence on a person.

Doyle (2003: 115) defines ‘a stressor’ as “…the cause or source of pressure that is perceived to be a threat, a danger or damaging that is mainly physical such as work conditions (noise, heat, vibration) or psychological such as poor management, problematic interpersonal relationships with colleagues”. This can lead to a stress reaction or strain that can manifest physically such as cardiovascular disease or psychologically such as anxiety or depression. A person’s negative reaction to the stressor can manifest on a secondary level, for example through smoking or abusing substances excessively. This can lead to an individual experiencing negative stress which is called distress (Doyle, 2003). The focus here is again on the negative and this explanation does not lean itself to explain that stress is needed to motivate people and mobilise people to change and perform. Therefore, stress is seen as a natural and unavoidable part of human life and is not always negative. Eustress, positive stress, can be used to motivate oneself to achieve and reach deadlines. It is when distress is experienced over a long period of time that a person can be severely psychologically and physiologically affected by stress (Doyle, 2003).

The researcher’s understanding of the concept stress incorporates all the classical and modern explanations of stress into one definition:
Stress is influenced by internal (personality type, values, previous experiences, beliefs) or external processes (intensity of the threat, length of threat, nature of the threat, environmental factors), that place a demand on a person to respond in a positive or negative way. This response is based on a person’s own perceptions and analysis of the extent of the threat that can manifest in specific physical and/or psychological outcomes. The response determines the outcome of the stress strategy used by a person which can decrease the impact and the demand that stress is placing on a person.

5.2 DEFINING WORK STRESS

The term ‘work stress’ has been difficult to define and this is possibly due to so many disciplines being touched by this concept. There are three areas that all the researchers and academics agree with and that is that stress is caused by a stimuli followed by a response and that stress is a process. Chmiel (2000) explained the interaction between stress and work according to these three concepts:

- *Stress as a stimulus:* the stimulus has a negative effect on a person and can be categorised in four work related areas: job content, working conditions, employment conditions and social interaction at work.
- *Stress as a response:* Stress is seen as a psychological and/or physiological response of a person to a threat. Selye's classical research comes into play here, namely general adaptation syndrome (GAS). Emotions and thoughts are not considered to change the response of the individual (during these earlier stress research models).
- *Stress as a mediational process:* The focus of Lazarus and Folkman (1984) is on the cognitive, evaluative and motivational processes between the stimulus and response, referring to a person's interaction with their environment. The individual differences between people are highlighted here to explain that people will react differently to stressful situations due to appraisal or interpretation of the stressor and the coping resources they have available (Chmiel, 2000).

The term job burnout used by Veninga and Spradley (1981) explains the final stage of Seyle's exhaustion stage in the GAS process. Job burnout is defined by Veninga and Spradley (1981: 6) as "…a debilitating psychological condition brought about by unrelieved work stress, which results in:

- Depleted energy reserves;
- Lowered resistance to illness;
- Increased dissatisfaction and pessimism and
- Increased absenteeism and inefficiency at work".

This definition illustrates some of the vital symptoms that are identified in the diagnosis of burnout such as fatigue and decreased psychological and mental well-being. This could impact on the individual's personal, professional and/or work environment.

Wheaton (cited in Chmiel, 2000) explains that there are two types of stress, namely event and chronic stressors (stressful stimuli) that have consequences called stress reactions or strains. Event stressors are bound to time and have a clear beginning and end. Chronic stressors are continuous and occur over long periods of time without resolution or ending. However, in a workplace a person will due to job demands and roles use their coping strategies over long periods of time. This can lead to burnout. Chmiel (2000) lists examples of chronic work stress that are caused by: excessive task or role demand, excessive complexity, uncertainty, restriction of choice and under-reward.

French, Caplan and Harrison (cited in Chmiel, 2000: 158) explained the definition of work stress according to the person-Environment (P-E) fit model as "…either a misfit between a person's opportunities and environmental supplies or a misfit between a person's abilities and the environmental demands". This definition explains the different coping adapted by various people in the workplace situation and incorporates the impact that the workplace can have on the individual.

Work stress or job stress is defined by the American National Institute for Occupational Safety and Health (2006:4) as "…the harmful physical and emotional responses that occur when the requirements of the job do not match the capabilities, resources, or needs of the worker". There is a difference between stress, pressure or challenges in the workplace. This difference is explained by the International Stress Management Association in the United Kingdom (2005: 2) as being when a person experiences too much pressure without the opportunity to recover, that he or she experiences work stress.

Some work stress in South African companies can be ascribed to the integration of cultural, gender and educational differences as well as ensuring equal and fair labour practices (Sacht, 2008). Employees are also affected not only by the political changes the country has experienced but also by the social problems such as poverty; unemployment; inadequate housing and sanitary services; HIV/AIDS; crime; substance abuse and other social ills. The management style and power structures of companies have changed and employees have to adapt to the changing demands and pressures from their leaders as well as consumers. The non-governmental organisations have had to change with the times and social workers have been affected by funding policies of the Department of Social Development that determine salary scales (Earle, 2008). The demands for service delivery and the prevalence and extent of the social problems have intensified in the post-apartheid era placing social workers under more pressure to provide services (Earle, 2008).

5.3 OVERVIEW OF THE STRESS AND WORK STRESS MODELS AND THEORIES ON STRESS

Cox (cited in Furnham, 2005) and Cooper, Dewe and O'Driscoll (2001) divided the models to explain stress into response-based; stimulus-based; interactional and transactional models:

- Response-based models explain stress as being caused by an external force that initiates a reaction or response from a person to a stressor. This external force can be seen as a dependent variable. Selye's GAS model dominated this way of thinking for many years. His model was developed from his research on rats (Furnham, 2005).

- The stimulus-based models are concerned with identifying potential sources of stress as environmental variables (Goodell, Wolf and Rodgers cited in Cooper et al, 2001). McQuade and Aikman (1976) explain the physiological effects of a stimulus on the body and the mind. Then the pituitary and adrenal glands produce hormones such as adrenocorticotrophic hormones, cortisone and cortisol. These hormones trigger the protective bodily reactions called the fight or flight response.
- The interactive model of stress combines peoples' interactions within their environment, their stimulus, their reaction and even incorporates personal differences. Lazarus (cited in Furnham, 2005) was one of the first to promote and support the interactional model. Cox and McKay (cited in Furnham, 2005) supported the interactive model but varied from it by identifying four areas of interaction between a person and their environment. The environment places demands and constraints on a person and a person has their own belief and value system that also places demands on the individual. This effects the coping resources that a person possess. There is then a constant battle between demands and coping resources that are influenced by a person's cognitive appraisal of the stress situation. The ways in which a person copes is interpreted through cognitive reappraisal, physiological responsibility and behavioural activity (Furnham, 2005).
- The transactional, homeostatic and balance models of stress are non-interactive and concerned with the outcomes after the interaction, such as the coping strategies adopted by a person. The transactional model identifies that there is a dynamic cognitive state; a disruption or imbalance occurs that affects a person's normal functioning; and then a stage to resolve or restore the imbalance (Cooper et al, 2001).

These definitions provide some background to the theories that have been developed since the 1930's to understand stress as part of human behaviour and illness. Cooper and Payne (1989) place emphasis on the role that individual differences play in dealing with stress. People will handle the same stressful event in different ways and therefore there is not one model that can completely explain the human response to stress.

The overall theory on stress that underpins this study is the ecological model of stress that states that stress affects and impacts on all systems in a person's life such as physical, psychological, social, intellectual and even spiritual level. The following table explains some of these theories.

Table 1: Theories and Models on Stress and Work Stress

CATEGORY	NAME OF THE THEORY/ MODEL	DESCRIPTION OF THE THEORY/ MODEL
BIOLOGICAL STRESS THEORIES	**General Adaptation Syndrome (GAS)**	This theory of Selye suggests that there are three identifiable stages in the development of stress. Selye named this response pattern, the General Adaptation Syndrome with three phases, namely: • The initial **alarm reaction** which is the initial shock, followed by a counter shock phase; • The stage of **resistance** is marked by defence strategies being activated, creating an emergency reaction that triggers the fight-or-flight response in the body and • The **exhaustion stage** when the response is not successful and continues over long periods of time, or varies in intensity, and depletes the energy levels of a person, leading to exhaustion, collapse and even death (Furnham, 2005 and Rice, 1999). The term "disease of adaptation" was coined by Selye as part of his observations when a person did not cope with the initial stress but still adapted to the stressor.
	Genetic-Constitutional Theories	This theory looks at the genetic make-up of a person and physical characteristics can affect how a person resists and copes with stress (Rice, 1999). This is also supported by the research of Friedman and Rosenman (cited in McQuade and Aikman, 1976) on the individual differences in temperament that influence people's reactions to stress. This is known as Type A and B personality types.
	The Diathesis-stress Model	This theory attempts to explain the different ways in which stress affects people as a combination of heritage and environment (Rice, 1999). Cox (1978) explains the transactional model of stress as stress is a part of a complex and dynamic system of transaction between people and their environments. Stress is caused when an imbalance appears between the demands placed on a person and their perception of their ability to deal with the stress agent. This perception differs from person-to-person depending on their personality, and coping resources.
PSYCHOLOGICAL STRESS THEORIES	**The Psychodynamic Model**	Freud identified two kinds of anxiety: **signal anxiety** caused by an external danger, and **traumatic anxiety** caused by instinctive or internal drives that can place a strain on the psychic functioning of a person (Rice, 1999).
	Learning Theory	Pavlov's classical conditioning theory is important to explain stress in that a person will avoid or escape a stressful situation. A person can learn new ways to confront stress if exposed to it (Rice, 1999).
	Cognitive Transactional Model of Stress and Coping	Lazarus (cited in Cartwright and Cooper, 1997) and Furnham (2005) moved away from attributing stress to environmental causes towards a more individual perception of threat and response to perceived threats. It is about how a person feels they can cope depending on the severity and intensity of the threat and their inability to cope which can cause helplessness and a person feeling overwhelmed. For the first time, this definition focussed on the individual being a variable in the stress-reaction process. The cognitive process to recognise the imagined or real threat was identified as the appraisal strategies such as attention, perception and evaluation through which a person labels a situation as stressful (Furnham, 2005).

WORKPLACE STRESS MODELS	**Michigan Models and Person-Environment Fit Model**	The basic models to explain work stress originated from the Institute for Social Research (ISR) of the University of Michigan, hence the name, ISR or Michigan Models. The person-environment (P-E) fit model is another version of the basic model and was summarized by Caplan in the 1980's (Furnham, 2005). This model emphasised the link between the environmental factors and the individual's properties that determines work stress (Chmiel, 2000). The P-E model focuses on two types of fit, namely: the needs and values of a person and the environmental supplies and opportunities created by the employer to meet these needs and values. The second type of fit is regarding the subjectivity and objectivity of a person such as self awareness, temperament and abilities of the employee (P) and the environmental awareness (E) such as demands and type of job requirements (Furnham, 2005). Objectivity comes when reality indicates that an employee doesn't have the temperament or ability to perform specific tasks. Subjectivity comes from perceptions of the employee and what is expected of them within the work environment. Strain is caused when there is a lack of fit between P and E (Furnham, 2005).
	Vitamin Model	Warr's vitamin model was developed in the 1980's and compares an employee's mental health in the workplace with vitamins needed for physical health. Warr identified three main parts of the vitamin model, namely that there are nine categories that interact with each other to impact on the well-being of the employee; the three-axial model of affective well-being and then the employees and job characteristics interact to predict the mental health (Chmiel, 2000). This three-axial model works on in the absence of certain job characteristics (vitamins) and an employee's mental health can be affected. Then after taking enough vitamins, a consistency is reached and if there is an increase in vitamins that can harm the mental health of the employee or it can maintain the consistency. The nine job characteristics are availability of money; physical security; valued social position; opportunity for control; opportunity for skill use; externally generated goals; variety; environmental clarity and opportunity for interpersonal contact (Chmiel, 2000). The excess or lack of these characteristics can affect the employee's well-being or mental health status. The well-being of employees can be measured according to three levels, namely displeasure to pleasure; anxiety to comfort and depression to enthusiasm (Chmiel, 2000). The individual differences are taken into account to determine what effect these job-related characteristics can have on the well-being of employees. The individual characteristics are the values of a person; abilities and baseline mental health of a person.
	Job Demand-Control-support Model	In1979, Karasek and Theorell (cited in Chmiel, 2000) introduced the job demand-control (JD-C) model. This evolved to the point where workplace social support was added in 1988 and so was subsequently called the demand-control-support model (DCS). This model links high psychological stress and low decision latitude to poor health such as cardiovascular disease (Furnham, 2005).
	Effort-Reward Imbalance Model	Siegrist (cited in Chmiel, 2000 and Furnham, 2005) introduced the effort-reward imbalance (ERI) model which moved away from job demands and job control to being rewarded for work creating a sociological focus. The employee's self-esteem is linked with societal structures. The ERI model can be explained according to the following (Chmiel, 2000 and Furnham, 2005): • High effort with low reward may lead to work stress; • Effort can be extrinsic effort (job demands) that allow the employee to

		deal with external demands or intrinsic demands (over-commitment) meaning the employee's own internal motivation to fulfil their expectations; • Rewards are provided on three levels namely monetary, esteem and security/career opportunities; • This model explains that younger employees with less work experience might experience strain due to their high level of commitment.
	A stressor-strain model of Occupational Stress	In 1984, Lazarus and Folkman (cited in Doyle, 2003) introduced the stressor-strain relationship model to explain that the causes of a stress reaction can be due to a person's own variables such as beliefs/ expectations as well as environmental variables such as demand. A person's appraisal to view this as a threat can create immediate effects or long-term effects and provoke attempts to cope. The short-term effects can be a feeling of anxiety and fatigue while long-term effects include decrease in well-being and poor health. The work-home interface is highlighted as being a rotating cause of stress.

THE STRESS PROCESS

The human being's instinct to deal automatically with stress is remarkable in order to ensure the basic need of survival and/or safety. This is called the fight-or-flight reaction (Veninga and Spradley, 1981). The stress response can be explained as follows:

- It starts with the body mobilising itself for muscular activity by the hypothalamus sending alarm signals to the nervous system. The muscles tense, blood vessels constrict and two hormones are sent to the thyroid and adrenal glands to increase the energy to cope with the stress;
- The alarm rate consumes large amounts of energy. Selye called this adaptation energy as the body uses up special fuel sources. Prolonged usage of this special fuel explains the exhaustion that people feel and the burnout they experience if they haven't removed themselves from the stress;
- Muscular action takes place to either confront or escape the stress situation;
- The stress response only returns back to a state of equilibrium after the action has taken place.

CAUSES OF WORK STRESS

This section provides an overview of the organisational causes; personal causes and work-home-interface which may lead to work stress fro employees.

Organisational Causes

Fontana (1993) identifies the following organisational stressors as causes of stress: insufficient back-up; long and unsociable work hours; shift work; poor status, pay and promotion prospects; unnecessary meetings; uncertainty and insecurity in the workplace; unclear role specifications; role conflict; perfectionism and high unrealistic self-expectations; powerlessness to influence decision-making; frequent clashes with superiors; isolation from colleagues' support; overwork and time pressures; lack of job variety; poor organizational communication; inadequate leadership; conflict with colleagues; inability to finish a job; and fighting unnecessary battles that could have been better planned. Dobson (1982) also included the following organizational causes that can impact on an employee such as transport to and from work; job fit with skills and attitudes of a person; workplace noise; illumination and lighting; and relationships at work.

Cooper et al (2001) divides the causes into intrinsic job characteristics, organizational roles, work relationships, career development, organisational factors and the work-home interface. These causes are similar to the causes identified by Fontana (1993), but include more recent challenges, such as the impact of technology on work stress. Herewith the causes as id3ntified by Cooper et al (2001):

- **Intrinsic Job Characteristics:** These include physical demands of the job such as noise, temperature and vibrations; workloads; work hours; new technology and exposure to risks and hazards.
- **Organisational Roles:** These refer to role ambiguity, role conflict, role overload and levels of responsibility.
- **Work relationships:** These include abrasive personalities, autocratic and authoritarian leadership styles.
- **Career Development:** These refer to aspects such as job insecurity (threat of unemployment), perceived under- or over-promotion within the organization, and lack of achievement of one's goals or ambitions.
- **Organisational factors:** These include hierarchical bureaucratic structures that do not allow for employees to be part of the decision-making process; lack of effective consultation and communication; office politics; organisational culture and a sense of not belonging.
- **Work-Home Interface:** This refers to demands on time and energy, such as single-parent families and the increase of women in the workforce. Technology, such as portable computers and cellular telephones, also affects the boundaries between work and home.

Fontana (1993) identifies task-related causes relating to the work environment such as difficult clients or subordinates; insufficient training; emotional involvement with clients or subordinates; the responsibilities of the job and the inability to help or act effectively.

Roythorne-Jacobs (2000) illustrate the various social processes within organisations that can affect the workers and cause work stress. Authors such as Cooper and Marshall (1976), Dobson (1982), Fontana (1993) and Cooper and Robertson (2001) all agree that there are specific influences that organisations have on the individual that may affect their well-being as a person and a worker. Some of these influences can be found in the organizational culture of the workplace. The culture of an organization is shaped and influenced by various factors such as the sociocultural diversity, communication, power structures, socialisation processes, rewards and appraisal of employees, competition, conflict management, organizational roles and structures, change management and career development of employees. This section explores the main concept of organizational culture that is described by Smircich (cited in Drenth, Thierry and de Wolff, 1998) as consisting of five perspectives namely cross-cultural management; corporate culture; organizational cognition; organizational symbolism as well as unconscious processes and organization.

5.5.1.1 Defining the Term: Culture

Every organization has a set of overt and covert rules, values, norms and beliefs that create a sense of group identity. This creates and maintains a specific culture within the organization that influences the employees. Schein (cited in Drenth, Thierry and de Wolff, 1998: 118) who is considered one of the most influential authors on the subject of organizational culture, defines culture as “a pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think and feel in relation to those problems”. This definition highlights that culture affects the way a group thinks, feels and perceive things and is not always linked to concrete overt messages given by an organization. The culture of an organization is also influenced by external factors such as the national culture of the country within which the organization operates.

5.5.1.2 Sociocultural Diversity

The cross cultural management of employees from different backgrounds is influenced by a country's national culture as supported by Furnham (2005). Companies and industries throughout the world are influenced by their country's national culture according to time, leadership and legislation on labour issues within a particular country. The Eastern and Western Industries have similarities pertaining to human behaviour principles such as to motivation of employees; deal with work stress; rewarding of employees and establishing of effective teams. Cultural differences arise and are evident in the following aspects: how rewards are given; the way in which negotiations are conducted, how conflict is resolved, and decisions are made. Furnham (2005) demonstrated these differences through an example of time and punctuality where some countries are more time-bound such as Germany and Great Britain and others are time-blind such as Spain, Portugal and Greece. This impacts on how business is conducted. Countries that are time-bound are more competitive where 'fast is better' and 'time means money'. These companies with be very structured and goal orientated. This is the opposite for the other industries in countries such as Spain where they differentiate between sacred and profane time. Sacred time is for family and family time comes first before work time.

Roythorne-Jacobs (2000) mentions other cultural factors that organisations need to manage such as gender, race and ethnicity. These are challenges for managers to ensure that there is healthy interaction between different gender, race and ethnic groups in a company. As South Africa is a rich culturally diverse society, this is a particular difficult task as there are 11 official languages (Sacht, 2008).

5.5.1.3 Organisational Culture

Organisational culture is formed by three influences, namely: the founders of an organization that impacted on the norms and values; finding a niche in the external environment which creates a sense of the core values and beliefs of the organization; and lastly to have effective working relationships within the organization (Furnham, 2005). Schein (cited in Furnham, 2005) adds that culture is mostly visible during crisis periods by observing the leadership of an organization and how they deal with: the crisis; appraise the employees; act as role models and provide coaching during the crisis period.

Schein (cited in Drenth, Thierry and de Wolff, 1998) identified three levels of organizational culture. The first level refers to visible overt artifacts such as the logo, symbols, verbal and non-verbal language, technology, myths, stories, greeting, and group behaviours. The second level is on a deeper level of the values and norms that functions as morale anchors to assist employees to deal with specific situations and the correctness of one's behaviour. The last and most difficult level to observe and to change is the underlying assumptions that guide the unconscious behaviour of the group. The function of organizational culture is to ensure that that the organization reaches its objectives and deals with outsiders. This process is called external adaptation. The second function is to ensure that there is internal integration of a collective identity (Drenth, Thierry and de Wolff, 1998). Furnham (2005) sees the internal integration as the "social glue" of the organization which creates a sense of group identity.

Schabracq, Winnubst and Cooper (2003) emphasised that organizational culture can cause stress to employees due to the following reasons:

- The content of the culture can cause stress when new comers follow old values for example to have a front of perfection and not admitting to mistakes and asking for advice;
- Inconsistent and internal discrepancies occur when change happens only on a cognitive level and the individual will give lip service to agree with the changes but doesn't internalize and accept the changes immediately;
- Failure to keep up with changing developments;
- Conflict between the values of a person and the organization's values, and
- Leadership can influence the individual on an unconscious level such as paradoxical messages about work performance and expectations.

5.5.1.4 Compensation of Work

Companies are often faced with problems related with pay. This is illustrated when employees strike demanding higher pay. The compensation of pay relates to three aspects: pay flexibility which reflects the success of the company; differentiation of payment for different positions and pay is linked to what the market orientation dictates outside the organization such as profit sharing (Drenth, Thierry and de Wolff, 1998). The individual receives a salary or wage to be compensated for the work that they do and has a meaning for a person such as self worth and self esteem. When an individual receives their pay it should fulfill their basic needs of food, shelter and security as suggested by

Maslow's hierarchy of needs. Moreover it should reduce their anxiety and further motivate the individual's behaviour, performance and job satisfaction (Drenth, Thierry and de Wolff, 1998).

Skinner (cited in Drenth, Thierry and de Wolff, 1998) emphasised that pay should be linked to the work performance of the individual and that this is more effective than receiving a fixed salary. Receiving a salary based on a person's performance, stimulates and motivates the individual to increase their work performance when their salary is linked to that. Other theories like that of Hertzberg (cited in Drenth, Thierry and de Wolff, 1998) supports Skinner's theory by stating that there are intrinsic and extrinsic motivational factors also need to be considered to understand the importance that pay has on job satisfaction. Intrinsic motivation is linked to performance and the recognition that one receives for job performance. It creates feeling of self-fulfillment and competence in the individual (Drenth, Thierry and de Wolff, 1998). When the motivation is controlled by external sources, outside of the individual, the intrinsic motivation will decrease (Drenth, Thierry and de Wolff, 1998). The compensation of work for social workers forms a large part of the discussions when looking at the retention of social workers in all fields of practice.

5.5.1.5 Organisational Communication

The organizational culture of an organization may also differ in terms of ways of communication. Communication is considered by Drenth, Thierry and de Wolff (1998) as a way of sending and receiving verbal and/or non-verbal messages through symbols such as letters, faxes, e-mails, memorandums, newsletters, meetings, workshops. The process of communication as explained by Roythorne-Jacobs (2000) consists out of the following six stages:

- The communication process begins with the feelings and ideas of the sender of the message;
- Then the sender encodes their feelings and ideas into words;
- The message is then sent through a medium to the receiver (this is where there can be a breakdown in transmission due to filtering parts of the message, rephrasing of the message by a number of people who distort the meaning of the message);
- The receiver then interprets the message and misunderstandings can be made when there is a large volume of information and the receiver's psychological state can affect the meaning of the message. Stress and problematic work relationships can cause the negative interpretations of the message;
- The receiver then acts and behaves according to the perceived message; and
- Lastly, feedback is given on the message that was received and the message is clarified.

Communication is considered to be the center of any organization as it clarifies roles and tasks of employees so that there is more coordination within the organization. Hicks (cited in Drenth, Thierry and de Wolff, 1998: 395) emphasised the importance of effective communication within organisations by stating that "…when communication stops, organized activity ceases to exist. Individual, uncoordinated activity returns". Drenth, Thierry and de Wolff (1998) further link this type of communication with the four different organizational climates:

- Supportive Climate: The organisation is focussed on the individual rather than the group and communication is mostly verbal and informal;
- Innovative Climate: These organisations are fast changing and very objectively orientated and communication is discussed verbally and then followed in writing;
- Respect for Rules: Authority, order and systematic procedures are more important than achieving objectives in such organisations, and
- Goal-orientated Information Flow: The organization focuses on tasks and the achievement of goals.

Most organisations have a mixture of organisational communication strategies and don't have one specific organizational climate (Drenth, Thierry and de Wolff, 1998).

5.5.1.6 Leadership, Influence and Power Structures

The leadership structures within organisations can influence the type of power leaders have over employees to ensure the attainment of goals of the organisation. Leadership is defined by Drenth, Thierry and de Wolff (1998: 323) as "…that part of the role of a (appointed or elected) leader that is directly linked to influencing the behaviour of the group, and that is expressed through the direction and coordination of activities that are important in connection with the tasks of the groups (within the organization)". Some of the leadership styles mentioned by Drenth, Thierry and de Wolff (1998) are social-emotional focusing on individuals and work relationships; task-orientated focuses on achieving the objectives of the organization and participative management ensures mutual decision-making and communication. The amount of social power that a person or a group has affects the degree of influence they have on another person's or groups' behaviours, attitude and/or perceptions.

Roythorne-Jacobs (2000) lists five different types of power that exists between a person with social power and a person being influenced:

- Reward Power: refers to monetary incentives which may be influenced by the manager;
- Coercive Power: this type of power relates to punishments and threats used to keep others in line and to make them follow rules;
- Legitimate Power: the appointed leader is seen as having the authority to make decisions;
- Referent Power: this power relates to the attraction that a person being influenced has towards a person doing the influencing; and lastly,
- Expert Power: leader has special skills and expert knowledge and therefore allowed to influence others.

5.5.1.7 Competition, Conflict and Cooperation

Conflict can occur when employees are depending on each other to complete tasks; when they have to compete for scare limited resources within an organization or when there is ambiguity regarding work responsibilities and duties. Cooperation has been identified by Roythorne-Jacobs (2000) as the most effective way to reduce conflict. Competition is viewed to be the least effective strategy to reduce conflict.

5.5.1.8 Organisational Roles

Each employee normally receives a job description that sets out work expectations and clarifies the accountability and responsibilities of an employee. Roythorne-Jacobs (2000) explains that when a person is unclear about their work expectations, this may cause role conflict; role loading; role ambiguity which may cause stress. Role conflict can be experienced on three levels: intrapersonal role conflict when values of a person clashes with that of the work they are expected to undertake; intrarole conflict starts when other people have different role expectations and a person can't fulfill all the different expectations of others, and lastly interrole conflict when a person has more than one role such as work-home roles (Roythorne-Jacobs, 2000). Role loading refers to either being over worked or having too little to do and role ambiguity affects the individual's job satisfaction and causes work stress and tension.

5.5.1.9 Organisational Socialisation

Greenberg and Baron (cited in Roythorne-Jacobs, 2000: 271) defined organizational socialisation as "the process through which newcomers to an organization become full-fledged members who share its major values and understand its policies and procedures". The newcomer is orientated to both covert and covert rules, norms and values of the organization and so become part of the culture of the organization and conforms to behaviour that is accepted in the organization. Roythorne-Jacobs (2000) identify three stages of socialisation of new comers, namely: **anticipatory socialisation**- when there is a fit between the skills, knowledge and abilities of the individual and the job offered at the organization; **accommodation**- when a person adjusts to a new job by forming new work relationships and clarifying and evaluating their role expectations and lastly the individual needs to balance work roles and home roles called **role management**. A successful socialisation process will ensure that the employee is integrated within the organizational culture through the following methods:

Table 2: Organisational Socialisation Stages, Methods and Techniques

Stages of Socialisation Process	Methods or Techniques
Effective Anticipatory Socialisation	Recruitment, selection and placing programmes
Effective Accommodation Socialisation	Orientation, introduction to all the employees, initially training programmes. Performance evaluation and feedback sessions, assignment of challenging work to newcomers which would allow them to demonstrate their abilities and skills.
Effective Management Socialisation	Work-home Interface which could have an impact on job satisfaction and resignations of employees.

5.5.2 Personal Causes

McLean (1979) emphasised the stress caused by life transitions that cause vulnerabilities in individuals such as the age and stage in a person's life, i.e. first-time workers and employees facing retirement. Eckenrode (1991) explores the vulnerabilities that can impact on an individual's level of stress such as chronic life strains, major life events or just daily hassles and/or due to the social relationships, social support and self-esteem of a person. Fontana (1993) identifies personal causes such as family problems; health problems; cardiovascular and coronary heart disease; type "A" personalities; temperament; neurotic and obsessive personality types; low risk-taking and sensation

seeking behaviour; over-identification with the job and excessive personal blame for failures or mistakes.

5.5.3 Stress and Personality

Friedman and Rosenman (cited in Monat and Lazarus,1977) were the first authors to link Type A behaviour pattern to being prone to stress and health problems, and highlighted the risks of a Type A personality being prone to coronary artery and heart disease. Friedman and Rosenman (cited in Monat and Lazarus, 1977: 203) defined Type A behaviour pattern as "…an action-emotion complex that can be observed in any person who is aggressively involved in a chronic, incessant struggle to achieve more and more in less and less time, and is required to do so, against the opposing efforts of other things or other persons". The Type A personality characteristics that can lead to stress include a sense of urgency when it comes to time; setting ones own deadlines; substituting repetitive urgency for creative energy; competitive; insecurity about their status and potential to be hostile and aggressive.

5.5.4 Work-Home Interface

The separation of work and home has been a topic of debate and discussion since the start of the industrial revolution in the twentieth century. The development of occupational alcohol programmes (OAP) was an indication that the separation of work and home is not possible and that personal problems do indeed have an impact on the workplace. Many authors, such as Cooper and Robertson (2001); Halford, Savage and Witz (1997) and Isaksson, Hogstedt, Erickson and Theorell (2000) agree that work and home can not be separated and consider it a utopian ideal.

The term work-home interface is best described by Halford, Savage and Witz (1997) not to only be in terms of male and female roles, but rather as 'public' and 'private' roles. The public side explains a person in work roles and the private person in family roles. Stichter (1990: 62) describes the work-family role system according to Joseph Pleck as "…the individual behaviours and psychological states are structured by roles, clusters of norms which make up social institutions…the mayor role sets for individuals as occupational roles and family roles making a work-family role system". This definition agrees with the first one by Halford et al (1997) in that it has to do with roles that people play in their different social settings such as work and home. The term work-home interface is a complex phenomenon as it differs for each person and in each occupational setting.

All these factors may influence employees within their workplaces and in their personal lives. These causes may differ from each person according to organisational influences such as type of management styles and roles, socialisation and relationships within the workplace and the personality of the employee determines their responses to the demands and stressors from both home and work. There is however often difficulty in finding the balance between personality, relationships at work and at home as well as coping with work stress that can have effects on the individual, their family and work life.

5.6 COGNITIVE, EMOTIONAL, PSYCHOLOGICAL AND BEHAVIOURAL EFFECTS OF WORK STRESS

The table below, Table 3, explains the various consequences of work stress on an employee:

Table 3: Cognitive, Emotional, Psychological and Behavioural Effects of Work Stress

CONSEQUENCES	DESCRIPTION
COGNITIVE EFFECTS	Fontana (1993) identified a decrease in concentration and attention span; increase in distractibility; deterioration of short- and long-term memory; unpredictable response speed; increase in error rate; deterioration of organizational and planning skills and an increase in delusions and thought disorders as the cognitive effects of long term stress on a person.
EMOTIONAL EFFECTS	The emotional effects caused by stress include an increase in physical and psychological tensions; increase in hypochondria; personality trait changes; increase in existing personality problems; weakened moral and emotional constraints; depression and learned helplessness and a decrease in self-esteem (Fontana, 1993).
PHYSIOLOGICAL EFFECTS	Schabracq, Winnubst and Cooper (2005) identified the link of work stress and high blood pressure, increase in cholesterol levels and an increase in uric acid that can all lead to coronary heart disease and other illnesses. Schabracq, Winnubst and Cooper (2005) illustrated the health consequences of stress at work in a general framework.
BEHAVIOURAL EFFECTS	General behavioural effects include an increase in speech problems; diminished interests and enthusiasm; increase in absenteeism; increase in alcohol and/or drug use/abuse; lower energy levels; disrupted sleep patterns; increase in cynicism about clients and colleagues; inability to assimilate new information; shifting responsibility onto others; problems solved on a superficial level; bizarre behavioural patterns and suicidal thoughts or actions (Fontana, 1993). Schabracq, Winnubst and Cooper (2005) also noted an increase in smoking of cigarettes, increase in caffeine intake, sleep disturbances and absenteeism as behavioural

	effects of work stress. Another consequence for external or internal stress experienced by social workers and other professions could be the high incidence of the concept of "brain drain" experienced in South Africa. Meyer, Brown and Kaplan (2000) in their study found that over 50% of all emigrants are professionals and this is due to the incentives offered by other countries to recruit South African professionals. Dilworth (2004) compiled a fact sheet on the subject and estimated that the three categories that are severely affected the humanitarian occupations, engineers and architects and top executives and managerial personnel in South Africa.

5.7 COPING AND RESILIENCE

5.7.1 Defining Coping, Resilience and Hardiness

The literature on stress changed from exploring the nature of stress to looking at how people cope with stress. The coping process was defined by Menninger (cited in Monat and Lazarus, 1977: 142) as "…the ego employs coping techniques appropriate to the degree of threat that is perceived". Folkman and Lazarus (cited in Monat and Lazarus, 1991: 210) define coping as "…cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of a person". Coping is summarised by Saldwin (1994: 107) as "…the use of strategies to deal with actual or anticipated problems and their attendant negative emotions". Eckenrode (1991) emphasised that to be able to define coping the relationship between a person and the environment effects the cognitive appraisal of the stress situation as significant and exceeding their coping resources to manage or alter the stress. Thune-Boyle, Stygal, Keshtgar and Newton (2006) further agree with the definitions of coping but added that there are individual differences in the reactions or responses to stress.

A person exposed to on-going stress can developed resilience and that is seen as coping with the stress in positive ways. This is also called hardiness and described by Weiten (cited in Ross and Deverell, 2004: 18) as "a syndrome marked by commitment, challenge and control that is purportedly associated with stress resistance". There have been numerous research studies done on the concept of 'hardiness'. Hardiness relates to a person's commitment, control and challenge when coping with stressful situations (Schabracq, Winnubst and Cooper, 2003). A person can then cope with stress without the harmful effects. There are three factors that come into play when looking at resilience (Ross and Deverell, 2004):

- Individual traits such as positive outlook and attitudes towards life, sociable personality, goal driven, calculated risk taking, responsible, efficient and accepts challenges;

- Family characteristics as found in healthy family environments such as nurturing, caring, consistent and stabile parents and support systems;
- Extra-familial context such as positive experiences with their education, teachers, religious leaders, sports couches and other social organisations.

5.7.2 Coping Responses and Coping Resources

Thune-Boyle, Stygal, Keshtgar and Newton (2006) identified coping responses which are divided into three general categories, namely: responses to alter the problem experienced; changing the way a person sees the problem; and managing the emotions evoked by the stress situation. The coping resources assist with the coping responses and explain the differences in coping responses of individuals which include internal or psychological resources and external or environmental resources (Ross and Deverell, 2004). The internal resources may include: the personality type A or B; traits of hardiness; self-efficacy; resilience to stress; sense of personal control and a person's spiritual beliefs. Eckenrode (1991) expanded on these internal resources which are the skills and abilities of a person to analytical and cognitively appraise the stress situations as harm/loss, threat or challenge as well as psychological resources (sense of self control and self-efficacy). The external resources depend on the support a person receives from their immediate or extended family, religious organisations, community organisations or professional institutions (Ross and Deverell, 2004). The social support or 'coping assistance' acts as a buffer between a person and the negative affects of prolonged stress. The coping assistance allows a person to seek help either from personal or professional relationships which helps them to vent their feelings, replenish their energy and confirms their sense of self-control and improves their self-esteem (Eckenrode, 1991). Moreover, external resources may include physical resources and tangible resources such as health and financial security and institutional, cultural and/or political resources (Eckenrode, 1991). A person experiences stress when they perceive that these resources are not adequate to deal or cope with the stress.

5.7.3 General Coping Strategies

Mechanic (cited in Monat and Lazarus, 1977) identified two strategies for a person to cope with and adapt to transient life crises, namely dealing with the situation directly (called coping) and the second one is to deal with the feelings evoked by the situation (called defence). Stress management programmes have been guided by one of the two definitions of stress, namely the response definition of Seyle or cognitive-relational definition of stress (Eckenrode, 1991). The response definition

explains coping as a set of bodily defences against stress and programmes which focus on relaxation, meditation or control measures. Eckenrode (1991) criticised these stress management programmes by stating that they don't address the cause of the stress and that there are sometimes external threats that are out of the control of a person. Stress management programmes based on the cognitive-relational definition of stress take into account a person as well as the environment or situation and acknowledge the individual differences in coping. Cognitive appraisal assists a person to assign meaning and extent to the stress as well as possible interventions to change the situation depending on the level of harm/loss, threat or challenge (Eckenrode, 1991).

Folkman and Lazarus (cited in Millward, 2005) identified two coping strategies that are related to Mechanic (cited in Millward, 2005), namely having a problem orientated attitude and deal directly with the situation. These "mastery" strategies include diagnosing the problem then finding solutions to the problem. The second type of strategy is emotion focussed when there is nothing we can do to change the situation. These strategies include positive and negative reactions such as anger venting, drinking alcohol, seek emotional support or reviewing the situation. The table below, Table 4, identifies the different stress management interventions according to problem-focussed coping and emotion-focussed coping (Eckenrode, 1991):

Table 4: Problem-Focussed Coping and Emotion-Focussed Coping Strategies

PROBLEM-FOCUSSED STRATEGIES	EMOTION-FOCUSSED STRATEGIES
The focus is on altering the problem that is causing the stress through the following strategies: • Problem solving • Decision-making • Interpersonal conflict resolution • Information gathering about the problem • Advice seeking • Time management • Goal setting • Problem-orientated behaviours to change the problem	The focus is on managing the emotional responses to the stress through cognitive efforts or behavioural efforts: Strategies to change the meaning of the stress situation rather than the environment through cognitive efforts: • Cognitive reframing; • Social comparisons; • Minimisation; and • Having a positive outlook on life. Strategies to reduce stress through behaviour efforts: • Physical exercise; • Relaxation; • Meditation; • Support groups; • Religion; • Humour; • Communication with other about the problem; and/or • Escaping the problem (e.g. drugs, alcohol, gambling)

5.8 STRATEGIES TO COPE WITH WORK STRESS

Latack and Hadlovic (cited in Chmiel, 2000) developed a framework to help people identify how they can cope with work stress. Strategies can either focus on what is causing the stress (problem-orientated) or focus on the emotions stress evokes in a person (emotion-orientated) as discussed in Table 4. Problem-orientated strategies focus on changing the interaction between the individual and the environment through less or more interaction such as confrontation, conflict resolution, mediation or resignation. Emotion-orientated coping methods aim at reducing the emotional impact of stress on a person either through avoidance or cognitive strategies like relaxation exercises.

Compton, Galaway and Cournoyer (2005) stressed the importance of self care strategies for social workers to deal with the demands, frustrations and conflict of the profession. They further highlighted that social workers need to be self aware of their own expectations of themselves, their clients and the actual outcomes or reality of the work they do. Social workers should take responsibility for their own personal needs within their personal lives and develop a sense of meaning. Compton, Galaway and Cournoyer (2005) identified that control issues may lead to social workers violating the principles of collaboration and partnership; they reduce the client's power and increases risk of personal and professional distress leading to burnout. Self awareness may be the key to ensure that social workers identify and reduce work stress (Compton, Galaway and Cournoyer, 2005). Social support may be another way to address work stress through regular informal or formal meetings with colleagues. At these meetings, social workers can share their complex feelings and thoughts, share their successes and failures, give/receive advice and feel connected to the profession (Compton, Galaway and Cournoyer, 2005).

Thompson, Murphy and Stradling (1994) emphasised that previous stress management strategies focussed on individual coping and causes, but neglected to emphasis that the organisation has a role to play with stress management strategies for in especially social workers. Social workers are vulnerable to the stress experienced by their clients as they may at times 'mirror' the client's distress (Thompson, Murphy and Stradling, 1994). The organisation may be able to support the social worker and increase their level of coping through appraisals, supervision, team support, training and development and debriefing (Thompson, Murphy and Stradling, 1994). Gibson, Swartz and Sandenbergh (2002) agree that social workers are influenced by their clients and organisations. Personal factors further play a role in the coping of social workers which include the degree of control they feel to change things in a person's life; adapting to change within the organisation and the utilisation of available resources (Gibson, Swartz and Sandenbergh, 2002). A study conducted with

36 counsellors dealing with domestic violence in a South African NGO indicated that creative and art group work sessions and individual debriefing reduces work stress and assisted with the coping strategies of these counsellors (Janse van Rensburg, 2006). The challenges confronting social workers are further discussed in more detail in Chapter 3.

6. CONCLUSION

Work plays an important part of ones life and gives one a sense of belonging and identity. The workplace could also be a source of stress for the individual due to organizational and personal factors. These causes or reasons for work stress are described in various theories and models that focus on the environment and personality of a person to explain that stress is part of human behaviour and illness. The causes of work stress need to be understood in the context of the South African workplaces and the challenges employers face in addressing sociocultural diversity, gender issues, affirmative action, black economic empowerment and employment equity. The impact of work stress on the individual occurs at all levels of functioning such as cognitive, emotional, behavioural and psychological. The coping and resilience of individuals differ from person-to-person and this can also affect the type of strategy a person chooses to use to reduce the stress or tension they experience. Social workers affected by work stress experience very specific consequences on a personal and professional level. The consequences of work stress may include burnout, compassion fatigue and even affect the retention of social workers in all fields of practice. The management of social workers and the organizational structures governing social workers are explored in Chapter 3. Moreover, stress factors that influence social workers and possible retention strategies for social workers in especially the substance abuse field are explored.

CHAPTER 3

LITERATURE REVIEW OF WORK STRESS EXPERIENCED BY SOCIAL WORKERS IN THE SUBSTANCE ABUSE FIELD

1. INTRODUCTION

Since 1994, the social work profession has undergone many changes since the new democracy in South Africa (Earle, 2008). Social workers were often seen as the “foot soldiers of apartheid” which cause a stigma that social work was part of the oppression. However, this has changed as social workers have been the foot soldiers of implementing the new democracy. Some of these changes have included moving away from services offered only to white minority groups to the black disadvantaged majority. Social problems such as HIV/Aids, crime, domestic violence, poverty, unemployment, violence, abuse, substance abuse and many more have also escalated causing an increase in the demand fro social work services (Earle, 2008). The White Paper encouraged changes to policy from being residual to a more developmental approach to deal with these social issues; and a strained relationship between the government and Non-Government organisations (NGOs) has developed (Earle, 2008). The challenge in the social work profession has been to recruit and retain social workers to implement these changes and provide welfare services to the increasing demands from communities as the pool of professionals are shrinking. This has been confirmed by a number of studies conducted in the United States and United Kingdom indicating that this is a global phenomenon (Strolin-Goltzman, Auerbach, McGowan and McCathy, 2008; Simons and Jankowski, 2008; Schwartz, Tiamiyu and Dwyer, 2007; Findler, Wind and MorBarak, 2007 and Bride, 2007).

The social worker can choose different fields of practice to work within and can also have opportunities in management, education, corporate and the private sectors. Furthermore, social workers are emigrating to other countries or studies further in other professions such as psychology. The study by Earle (2008) indicated that over 20% of social workers are not practicing social work in any form and that social workers in South Africa are feeling disillusioned which leads them to explore these alternative options.

Earle (2008) identified the challenges for the NGO sector:

- Funding of salaries from government and donors has been reduced;
- There is an increased client group due to the escalation in social problems;

- Services need to transform in terms of taking the services to the clients from disadvantaged communities and underdeveloped areas;
- A personnel and management must reflect the population demographics of South Africa, but the transformation is hampered due to black social workers moving to government departments for higher salaries and better benefits;
- The working conditions further add to the social work staff turnover due to the overwhelming demands in communities and lack of resources to address these demands, and
- This leads to high work loads, work stress and anxiety, burnout, compassion fatigue, even malpractice and staff turnover in NGOs and even in government departments.

The change in the policy towards a developmental approach moved away from the other two social work methods namely case work and group work to community development. Specialised fields such as substance abuse need all three social work methods to address this escalating social problem on micro, meso and macro levels in communities. This chapter will further explore these challenges that cause work stress and staff turnover in particularly the substance abuse field as well as retention strategies.

2. WORK STRESS AND SOCIAL WORK

Social work is a rewarding profession, but at times one experiences stress and tension, ambiguity and confusion, frustration, even disappointment and conflicts of various kinds. This may lead to work stress, burnout and compassion fatigue and even staff turnover of social workers. These following factors are seen as occupational hazards for social workers:

2.1 BURNOUT

Cherniss (1980) was one of the first authors to acknowledge burnout in the helping professions particularly social work. Cherniss (1980: 24) defined burnout in the helping professions as "…a process in which a service provider psychologically disengages from the work in response to job-related stress". This definition acknowledges the impact that job burnout can have on service delivery to the clients and to the organization as a whole. A person loses interest in their clients, co-workers and the organization as a means to cope with the demands. Pines, Aronson and Kafry (cited in da Costa, 2001: 21) defines burnout as "physical, mental and emotional exhaustion" that manifest as "physical depletion, feelings of helplessness, hopelessness, emotional drain and the development of a negative self-concept and negative attitudes towards work, life and other people".

Job burnout has been identified as another consequence caused by prolonged unresolved stress and is defined by Veninga and Spradley (1981:6-7) as "…a debilitating psychological condition brought about by unrelieved work stress, which results in depleted energy reserves, lowered resistance to illness, increased dissatisfaction and pessimism and increased absenteeism and inefficiency at work".

Maslach is recognized in Cooper et al (2001) as the foremost researcher on the concept of job burnout and has identified three components of burnout, namely emotional exhaustion; depersonalization of others in the workplace such as clients and colleagues and a reduced sense of personal accomplishments. Cherniss (cited in da Costa, 2001) indicated that burnout might be caused more due to organisational sources than individual differences. Moreover that specific work settings and job characteristics may induce work stress and strain that can lead to burnout. Some of these causes for work stress include:

- Problematic and demanding clients;
- Very high case loads;
- Organisational conflict and lack of support from the organisation;
- Inadequate supervision and
- The organisational design such as role clarification, power structures and normative structures.

Coulshed and Mullender (2001) agree with Cherniss (1980) and recognize the difficulties that social workers experience in working with various social issues and that it is not always possible to deal with such things on a professional level as this can lead to what they term as 'battle fatigue', more commonly known as burnout or compassion fatigue. Cherniss (1980) identifies the four effects of burnout of the social worker:

- It affects the morale and well-being of a person;
- The quality of service delivery and treatment provided to clients;
- Influences administrative functioning and
- Creates havoc in programs.

The Doctoral study conducted by Ross (1997) on stress and burnout experienced by social workers in the South African context confirms the role that stress and burnout have played on the field of social work. One of Ross's (1997) recommendations was that future studies need to identify specific stressors associated with specific job contexts. From the results of her studies, Ross (1997) made

significant recommendations for future management and social work personnel. These management guidelines can be used in this study to determine whether these aspects are currently implemented to ensure the professional growth and self care for social workers.

Thompson, Murphy and Stradling (cited in Ross,1997:30) summarize “social work as an occupation that is characterized by a wide range of pressures and dilemmas, involving emotional demands, potential conflicts and threats or even actual violence. In addiction, there is the frequent exposure to the pain, suffering and distress of others, the full weight of the human condition. All this needs to be seen in the context of resource constraints, legal requirements, organizational pressures and media attention. Given this scenario, it is not surprising that social work and social care are often experienced as stressful.”

This quote gives a brief insight into the world of a social worker and the perceived experiences of the social workers and managers within an external environmental subsystem of the work milieu. Ross (1997) further explains that the work milieu includes the physical working conditions, the job content, the client systems and organizational structure and policy.

Matlhabe in Johannesburg (2000) conducted a research study on the work experiences of social workers in their first year of practice. Most (60%) of the participants had negative experiences with the bureaucratic hierarchical structures and felt ill equipped to confront organizational constraints. The results of the study indicated that some of the participants already showed signs of burnout, frustration, conflict-avoidant behaviour and considered leaving their positions and even the profession.

The research dissertation by Ntsanwisi (2002) conducted with a local Gauteng NGO indicated that most of the 30 social workers interviewed were experiencing burnout symptoms. The main reason provided in this research report indicated that the social workers did not receive adequate support which could largely be attributed to financial constraints. The research report further identified some of the coping strategies utilised by the social workers such as supervision, case consultations and colleague support.

The study of Schwartz, Tiamiyu and Dwyer (2007) conducted in the United States indicated that burnout declines with more years of work experience and this confirms the findings of the two studies conducted by Matlhabe (2000) and Ntsanwisi (2002) with newly qualified social workers entering South African workplaces. Schwartz, Tiamiyu and Dwyer (2007) emphasised that newly qualified

social workers experienced less personal accomplishments; more psychological strain that leads to work stress; more depersonalisation of clients; less psychological resilience towards work stress and fewer job mastery skills than more experienced social workers.

2.2 COMPASSION FATIGUE

Burnout and compassion fatigue have many similarities in terms of common symptoms and both are caused by prolonged strain. The biggest difference between the two concepts is that burnout can be experienced in the absence of secondary traumatic stress disorder but not with compassion fatigue (da Costa, 2001). Bride (2007) confirmed that social workers working with trauma experience secondary traumatic stress, as an occupational hazard for social workers which contributes to the premature leaving of the field. Compassion fatigue is normally associated with the trauma field and has been found to be prominent in trauma counsellors in specific practices such as Aids patients and victim empowerment programmes. Compassion fatigue is compared to burnout and secondary traumatic stress disorder (STSD) experienced by trauma counsellors. The defining of the term illustrates that compassion fatigue is both “a natural and disruptive by-product of prolonged exposure to compassion stress” and causes a state of “biological, social and psychological exhaustion and dysfunction” (Figley cited in da Costa, 2001: 45).

Figley (cited in da Costa, 2001) demonstrates the process of development of compassion fatigue through “the trauma transmission model”. The trauma transmission model explains the interaction between six variables that eventually leads to compassion fatigue due to exposure to long term compassion stress as:

- The first level of the model focuses on *the empathy ability* of the counsellor that can connect and recognise the pain in the client;
- Then *the empathic concern* of the counsellor is triggered and they are motivated to act to reduce the pain of the client;
- The counsellor then identifies with the emotional state of the client called *emotional contagion*;
- The empathic concern and emotional contagion determines *the empathic response* of the counsellor to the client’s situation to reduce the emotional pain experienced by the client. This is done through the counselling process of working through the trauma or pain;
- The counsellor assess the effectiveness of their efforts and either feels *a sense of achievement* if they have been successful or compassion stress when their efforts was unsuccessful in reducing the suffering of the client; and

- The unsuccessful efforts of the counsellor may lead to them *disengaging* from their clients when continuously exposed to compassion stress without any feeling of helping the clients. Prolonged exposure to compassion stress without results of alleviating the clients suffering may lead to compassion fatigue (Figley cited in da Costa, 2001).

Rosenbloom, Pratt and Pearlman (cited in da Costa, 2001) explain that the counsellor may experience intra-subjective and inter-subjective responses when confronted with compassion fatigue. The intra-subjective responses include a sense of helplessness, feeling vulnerable, powerlessness, anger, frustration, guilt, shame, anxiety, irritability and feelings of inadequacy and incompetence. Furthermore all these responses can affect the quality of the work done by counsellors due to them not being able to adequately listen to their clients; they disengage from their clients' reality; they can hamper the counselling process by inadvertently discourage clients to work through their own feelings and they might experience physical ailments. The inter-subjective responses of compassion fatigue include withdrawal and alienation from others; relationship problems and even high absenteeism from work. Tett and Meyer (cited in da Costa, 2001) suggests that compassion fatigue and burnout may be responsible for the turnover of counsellors.

This does not explain why some of the workers then stay at organisations for many years and why some workers cope with the same difficulties in healthier and constructive ways. The next section aims to explain the variances in coping with stress by different people.

3. STAFF TURNOVER AND RETENTION OF SOCIAL WORKERS

The social work profession is experiencing a global staff turnover and shortage throughout the world and the studies indicate that this is experienced in all social work fields of practice such as child welfare agencies and medical social work fields. In South Africa, the same concerns are noted by organisations and the Department of Social Development has even developed retention strategies to address this threat to the implementation of policies and addressing the social problems in South African communities (Indaba, 2006). In a study conducted with 25 child welfare agencies, 820 social workers in the United States indicated that three factors caused the high staff turnover. These areas were identified as due to organizational, setting (rural, urban, semi-rural work settings), individual and supervisory factors leading to staff turnover (Strolin-Goltzman, Auerbach, McGowan and McCathy, 2008).

3.1 CAUSES OF STAFF TURNOVER

The causes of staff turnover cover a wide range of factors. Strolin-Goltzman, Auerbach, McGowan and McCathy (2008) identified that social workers in rural setting experience higher staff turnover due to lack of resources. One of the resources includes access to effective supervision. Westbrook, Ellis and Ellett (2006) identified the following causes of staff turnover as:

- Inadequate compensation;
- Large caseloads;
- Long working hours and on-call responsibilities;
- Personal safety of the social worker;
- Involuntary clients with complex problems;
- Lack of promotional opportunities;
- Voluminous paperwork;
- Frequent policy changes and expectations;
- Inadequate training and supervision; and
- Lack of adequate resources to deliver services to clients.

Earle (2008) identifies the causes of social work turnover in South African organisations as poor salaries; lack of resources; poor working conditions; and high workloads.

3.2 EFFECTS OF STAFF TURNOVER

Numerous organizational costs were identified in the study conducted by Strolin-Goltzman, Auerbach, McGowan and McCathy (2008). These includes: economic costs in terms of training and orientation programmes, and social costs in terms of quantity and quality of service delivery. The study of Westbrook, Ellis and Ellett (2006) with “committed survivors” meaning social workers with long term work experiences in the child welfare agencies in the United States further indicated the direct and indirect costs to organisations. The direct costs included financial loses due to selection, recruitment and training whereas the indirect costs are even more devastating in terms of the impact on morale and workloads of colleagues; quantity, quality and continuity of client services are affected by staff turnover and the loss of human capital deprives the organization of an experienced workforce that have the knowledge, skills and abilities to be competent and transfer skills to each other (Westbook, Ellis and Ellett, 2006).

3.3 RETENTION STRATEGIES FOR STAFF RETENTION

The retention strategies were developed to reduce staff turnover by improving the overall job satisfaction of social workers. Job satisfaction is achieved by ensuring that the following retention strategies are implemented:

- **Continued professional development opportunities:** Strolin-Goltzman, Auerbach, McGowan and McCathy (2008) stated that social workers need variety in their job design and this can be achieved through professional development. The professional development involved clinical supervision; attending formal and informal educational workshops or meetings in order to network with other social workers and learn to balance administrative and operational duties. Simons and Jankowski (2008) link job satisfaction to the relationships that social workers have with their supervisor and other colleagues that leads to greater organisational commitment to reduce staff turnover.
- **Organisational leadership:** Strolin-Goltzman, Auerbach, McGowan and McCathy (2008) identified that organisational leadership must be flexible and aware of the organizational issues that affects turnover. Leaders should allow social workers to work independently and autonomously. Laird (2008) focuses on the authority of an organization and emphasised how leadership must be able to provide structure, routine and take charge during stressful and difficult times.
- **Organisational Culture:** Schwartz, Tiamiyu and Dwyer (2007) stated that organisations must build a supportive and hopeful organisation that believes in their mission and vision.
- **Diversity Management:** Findler, Wind and MorBarak (2007) focus on managing diversity in the workplace and creating inclusive strategies to ensure a sense of group identity.
- **Supervision:** Supervision needs to focus on proactive and educational functions instead of crisis management. Both individual and group supervision were identified by Findler, Wind and MorBarak (2007) as effective ways to support staff. Group supervision allows social workers to improve on decision-making skills; increase in social support; sense of self-efficacy; sense of reward and achievement.
- **Organisational Policies:** The implementation of policies must be fair in terms of promotions, salaries and remunerations, recruitment, training opportunities and mentorship to include all diversity groups such as women, ethnic and racial groups, immigrants and non-professional staff (Findler, Wind and MorBarak, 2007).
- **Salaries Increases and Bursaries for Students:** The Department of Social Development has identified salaries as a main threat to staff retention and have increased the salaries to

acknowledge the educational level of the social work degree (Indaba, 2006). This was not extended to the NGO sector leading to many, especially black social workers leaving for Government Departments with higher salaries, more benefits and promotion opportunities (Earle, 2008). Social work bursaries are also now implemented for students to encourage recruitment of social workers to the profession (Indaba, 2006).

- **Improving Working Conditions:** Earle (2008) identified that the demands from communities are overwhelming and that social workers need resources to deliver services. These resources include adequate supervision; stationary; office space and furniture; information technology; administrative and language support; vehicles and networking and liaison with other organisations and professionals.

Retention strategies are mainly implemented by individual organisations and therefore the management of social workers may be vital in combating staff turnover.

4. MANAGEMENT IN SOCIAL WORK

4.1 DEFINING THE TERM: SOCIAL WORK MANAGEMENT

Coulshed and Mullender (2001) explain that the terms ‘manager’, ‘administrator’ and ‘leader’ are interchangeable, depending on what needs to be completed or what specific tasks need to be addressed. Administration is explained by Coulshed and Mullender (2001) and Skidmore (1995) as a generic process that provides direction, management and supervision to staff. The directive, managing and supervising functions can be done by a single person depending on the size of the organisation or can be divided into top, middle and line management. Top management has a directive function and looks at long-term planning and setting of objectives. Middle management has a managing function and should ensure that the whole system/organisation achieve the objectives. Line management has a supervisory function and ensures that policy instructions are followed and that job performance is up to standard (Coulshed and Mullender, 2001).

4.2 MANAGEMENT PRACTICES FOR HEALTHY ORGANISATIONS

Brody (1993) explains that interpersonal and emotional problems can negatively impact upon work performance. Organisations become sidetracked by such issues and deflect from achieving their goals and spend a lot of time and resources on addressing these concerns. Managers have to work with such issues in the most effective ways as these personal problems are part of everyday life. This

section focuses on the responsibilities of organisations and more specifically the managers managing social workers.

The human resources management of social workers is highlighted in Coulshed and Mullender (2001) as an extremely important aspect to protect staff through supervision, staff development and staff care. It is further explained by Coulshed and Mullender (2001:186) that "…we cannot work with other people's pain, grief and (sometimes violent) anger without an impact on ourselves". Coulshed and Mullender (2001) recognize the difficulties social workers experience in working with various social issues and that it is not always possible to deal with such things on a professional level as this can lead to 'battle fatigue'. This term, 'battle fatigue' refers to social workers chronically dealing with unmet needs of clients that can make one become negative towards clients and become cynical. The risk here is that people will stop caring. Coulshed and Mullender (2001) identify the important role that managers can play in preventing "battle fatigue" to continue or develop through effective supervision where a social worker can vent and express effects and impacts of clients on him/her. Gillespie (1987) and Cherniss (1980) discussed the phenomenon of stress and burnout extensively as a threat to social workers in all areas of practice.

Poor management styles and mistakes were identified by Coulshed and Mullender (2001) that could lead to "a culture of stress" in an organisation that doesn't only affect the individual, but the whole of the workforce. These include: unrealistic expectations; too little or no supervision; supervision not used as an opportunity for praise; expects work or allows work to interfere with non-work time; poor or no motivation and support of staff; can't help staff organize and plan their work and are stressed out themselves. Brody (1993) added to the above list by emphasizing the role ambiguity (Unclear about their objectives and tasks); overload or underload of work; contradictory expectations; poor planning; laid-back atmosphere and poor match between staff and jobs.

Brody (1993), Newton (1995) and Coulshed and Mullender (2001) further also identified the antidotes to mitigate occupational stress of social workers and they are as follow:

Table 5: Antidotes for Occupational Stress Relief of Social Workers

ANTIDOTES FOR OCCUPATIONAL STRESS RELIEF OF SOCIAL WORKERS	
• Preventative training on stress management and time management	• Develop work habits that will reduce unnecessary tension, frustrations and anticipate crisis.
• Flexi time to balance professional and personal demands;	• Streamlining paperwork and computerized recording systems;
• Teambuilding to assist teams to become cohesive and consistent;	• Help staff to identify their coping styles;
• Tips for survival;	• Promote physical exercise;
• Link staff with outside resources and networks;	• Personal career plans or new projects for staff who feel stagnant in their jobs;
• Improving salary levels and providing incentives;	• Participatory management;
• Clear policies and procedures to deal with inequality, harassment, code of conduct, discriminations, etc.;	• Staff care programme offered to staff.
• Help staff to reconnect with the aspects that they enjoy about their work;	• Help identify and change what ever is causing stress and

Coulshed and Mullender (2001:194) emphasise that "…cared-for staff are more likely to care for the users they serve". This explains the importance of staff care and why organisations should invest in their social workers. Ross and Altmeier (cited in Ross, 1997) described coping resources and responses into two categories, internal psychological resources that are determined by personality traits and external environmental resources that are determined by social support systems. For the purpose of this study, the researcher will focus on the external environmental resources of social workers in the substance abuse field of practice. The responsibility of managers and organisations is a focus point for further investigation. Maslach (cited in Ross, 1997:52) summarizes the role that organisations play: "…some work contexts can crush the best intentions of a professional provider who brings to the job high ideals and a desire to help others."

Most of the research studies found by the researcher were related to the client systems that social workers in the substance abuse field work with. It included studies on specific drugs, relapse rates and evaluation of treatment programmes. Many of the studies on the retention of social workers were from the United States and United Kingdom and a few South African studies on burnout among social workers such as Ross (1997); Matlhabe (2000) and Ntsanwisi (2002).

5. SOCIAL WORK AND SUBSTANCE ABUSE

5.1 AN OVERVIEW OF THE PREVALENCE OF SUBSTANCE ABUSE: THE SOUTH AFRICAN CONTEXT

Following South Africa's re-entry into the international community on 24th April 1994, the country seemed to experience a rapid increase in substance abuse. Starfield (2000) and Steinberg (2005) argue that this was primarily due to geographical positioning of South Africa as an ideal transit country on most major drug trafficking routes between East Asia, the Middle East, USA and Europe (Drug Master Plan, 1999). Two parallel research studies conducted in Durban and Pretoria schools (Rajab 2005) indicated that 12% of the participant learners were able to purchase LSD, Ecstasy, Cocaine or Heroin during the course of their school day. In addition, the 2004 publicized statistics from South African Community Epidemiology Network on Drug Use (SACENDU, 2004) indicate a 20% increase in admissions to treatment centres between 2001 and 2004, and that 22% of the admissions in 2004 were for the age group of 10 to 19 years of age.

These statistics highlight the serious impact that increased accessibility to psychoactive substances has had on our most vulnerable population group, the children and the youth. Drugs and Crime Brief (2000) emphasises the link between substance abuse and other social problems such as crime, HIV/AIDS, domestic violence and street children. These findings emphasise the crucial role that substance abuse prevention and treatment has to play within the South African society.

The demands on social workers in the prevention and treatment of substance abuse are tremendous not only from the dynamics of the client system, but also other external factors which influence the social workers such as staff turnover. This chapter then strives to outline the field of substance abuse treatment and the challenges experienced by social workers working in this field.

Starfield (2000) did an extensive study into the reasons for these changes experienced in South Africa and explained that through globalization, opportunities were created for the movement of drugs, arms, illegal aliens and dirty money. The negative illegal global relationships have contributed to an increase of the export of South Africa cannabis to the UK. It is estimated that since 1998, South African cannabis supplies to the UK have doubled from the previous supplier, Jamaica (Steinberg, 2005). The negative contributions of South Africa becoming part of the global village are explained by Starfield (2000) as due to tourism and free movement between countries; increase in migration from other countries to South Africa; international fugitives; growth of import and export creates

opportunities to transport illicit in licit form; active global financial systems; large cosmopolitan populations in inner cities; extensive networking and communication systems through technology and decrease in strict border controls.

The amount of illegal immigrants from other war torn and impoverished countries from all over Africa have severely affected our economy and thus increased the demand and need for jobs, housing, food, education, etc. The unemployment rate is estimated at 42% and encourages people to be hooked into the supply and cultivation of dagga as it is popular and in demand throughout Europe. Over 500 foreigners were arrested for drug-related crimes in South Africa during 1999 (Drugs and Crime Brief, 2000).

5.1.1 South African Statistics and Trends

Parry, in the SACENDU research brief (South African Community Epidemiology Network on Drug Use, 2007) highlights that alcohol and dagga (cannabis sativa) are still the dominant substances treated in the various centres throughout the country. Alcohol abuse accounts for between 50-65% of all admissions and has increased for clients less than 20 years of age. Cocaine, heroin and methcathinone have increased in especially Gauteng. Cocaine accounts for 25% of all admissions to the treatment centres in Gauteng and 35% of Heroin users are injecting the herion meaning that there is a higher risk of HIV transmission and other medical conditions. In Gauteng, 68% of heroin users are African due to nayope or sugers being used in informal settlements. Inhalants/solvent abuse is still a problem throughout South Africa and Tik is reaching epidemic prepositions in the Western Cape. It appears that Gauteng had the highest admission rate of all the provinces during 2007 and this reflects the availability and affordability of psychoactive substances in this province meaning more demands for service delivery and prevention initiatives from organisations are requested by the communities.

5.1.2 Current Legislation

The Drug Master Plan was developed from the principles as set out in the Prevention and Treatment of Drug Dependency Act 20 of 1992 and Sections 10 to 12 (1) of the Constitution of the Republic of South Africa Act 108 of 1996. The aim of the Drug Master Plan was to provide guidelines and identify strategies that can be used to reduce the demand and supply of legal and illegal substances in South Africa. Legal substances are not prohibited by law but have conditions attached in terms of the sell of alcohol and cigarettes. Illegal or illicit drugs have been listed as banned substance on the medicines control act and are prohibited for anyone to sell, manufacture and to use. The two sections in the last-mentioned Act state that citizens have the right to have their dignity respected and protected, the right

to life and the right to freedom and security. This Plan sets out guidelines and makes powerful recommendations for reducing both the supply and demand for illegal substances (Drug Master Plan, 2006).

5.2 EFFECTS OF SUBSTANCE ABUSE ON SOUTH AFRICAN SOCIETY

The strong link between alcohol and other drugs and various crimes was reported in a research conducted by SACENDU at nine police stations in Cape Town, Durban and Gauteng. This supports the idea that legal and illegal substances play a major role in societal problems like crime, domestic violence and child abuse (Drugs and Crime Brief, 2000). The survey on HIV and substance abuse conducted by the Human Sciences Research Council (HSRC) in 2002 was reported by Parry as providing a link between frequent alcohol and drug use and high risk sexual behaviours like multiple partners, poor condom use and sexual activities. A joint study between the Department of Transport and CSIR conducted during November 2001 and January 2002 indicated that 20% of the 400 professional drivers tested positive for at least one substance while driving (Mynhardt in SACENDU, 2003). This has implications for high accident rates and mortality rates of pedestrians and road users.

5.3 DEFINING SUBSTANCE ABUSE

The Greek work for “drug” is Pharmokon that refers to either a remedy or a poison. This is an apt statement for the benefits and devastation that psychoactive drugs can play in the lives of people through out the history of man. A drug is described by Barber (1995: 2) as “…any chemical entity or mixture of entities, other than those required for the maintenance of normal health, the administration of which alters biological function and possible structure.” Durrant and Thakker (2003) explain that a drug is artificial or natural and effects a person’s perception, cognition, emotion and behaviour. Stevens and Smith (2001: 20) define a drug as “…any nonfood substance whose chemical or physical nature significantly alters structure, function, or perception (vision, taste, hearing, taste, and smell) in the living organism”. Psychoactive drugs are divided into categories according to their effects on the central nervous system (C.N.S.) as C.N.S. Stimulants, C.N.S. Depressants and C.N.S. hallucinogens (Schuckit, 2000 and Perkinson, 2002).

The dependency process is explained by Barber (1995), Schuckit (2000) and Perkinson (2002) as a person using, abusing, becoming dependent and eventually becoming addicted. Addiction is when a person becomes pre-occupied with the drug and Barber (1995) identifies seven stages to explain alcohol addiction. These stages are narrowing the drinking repertoire; salience of drink-seeking behaviour; increase tolerance to alcohol; repeated withdrawal symptoms; relief or avoidance of

withdrawal symptoms by continuing to drink; subjective awareness of compulsive drinking and relapse after abstinence (Stevens and Smith, 2001).

Griffin (cited in Rauch, 1993) provides a clear description of the development of an addiction by identifying three basic stages or levels. The first stage is the using of a substance that changes a person's mood and sense of well-being. A person might even be able to stop in between episodes after experiencing negative consequences. The abuse stage is when the effects of using the substance start interfering with a person's life. The last stage is the dependency that develops on the substance. A person becomes pre-occupied with using despite the negative consequences. Tolerance and withdrawal symptoms develop in the body indicating that physical dependency is present (Perkinson, 2002).

5.4 THE HISTORICAL OVERVIEW OF PSYCHOACTIVE SUBSTANCES

Mesopotamian clay tablets dated back to 3000 B.C. displayed recipes for beer and it seems that earliest form of drug abuse dates back to 5 500 years. Opium appears in written form in Sumeria in 3400 B.C. and was known as the "joy plant" suggesting the pleasure qualities of this drug. Beer was used in the early days of Egyptians and Mesopotamian cultures as a form of medicine, connected to nutritional value and as part of religious affairs (Durrant and Thakker, 2003).

In 1859, Albert Niemann isolated cocaine from the coca leaves and this was the start of using cocaine by authors, artists and Sigmund Freud during the 1880's. Cocaine was used in medicines, for the treatment of alcohol and morphine addictions, local anesthetic, in wines and tonics. Durrant and Thakker (2003) further explain that opium was used for various medicinal purposes. In 1803, Morphine was made from opium that was seen as a medical break through in the treatment of severe pain and in 1853; the hypodermic syringe was introduced and used to administer morphine. The morphine addiction became problematic and this led to a German pharmaceutical company making heroin to counteract the side effects of morphine and for dependency. Cocaine became an epidemic in the late 1800's and in the early 1900's. Alcohol dependency also is seen as problematic during this time. Over the years, countries like England and America started banning substances like cocaine, heroin, cannabis and even alcohol in the prohibition period in the 1920's in America. The use of recreational drugs became popular during the 1960's as part of the "flower power" era (Durrant and Thakker, 2003).

Substance abuse and addiction seems to be prominent for the last 6 000 years and has affected all cultures through out the ages. This indicates that substance abuse is not a new phenomenon and that all psychoactive drugs have been applauded for their medical purposes and later have become enemies to mankind.

5.5 CAUSES AND THEORIES OF SUBSTANCE ABUSE

The causes of substance abuse has been debated for the last two decades as various scientists aim at understanding what makes people use drugs. The Reward Deficiency Syndrome is explained by Blum (cited in Durrant and Thakker, 2003) and Barber (1995) as a genetic predisposition that is connected to a specific dopamine receptor gene. This theory aims at explaining the prevalence of sons of alcoholics becoming addicted (Galanter and Kleber, 1999). The genetic model was explained by Stevens and Smith (2001) as the cause of substance abuse due to heredity rather than environment.

Barber (1995) provides another theory to explain addiction as a social learned behaviour and claims that people learn through direct observation and communication with parents, media, peers and other mediums. This means that people learn through experience about drinking alcohol and smoking cigarettes. People learn that there is pleasure in repeating the drug use and those unpleasant consequences can be avoided by drinking or using a substance. This theory has three key elements and they are as follow:

- Addictive behaviours are socially acquired and determined by repetition;
- Addiction occurs on a continuum of abstinence and addiction and
- Addiction develops to control internal and external demands.

Stevens and Smith (2001) summarise the various theories of substance abuse in the moral theory; the disease theory; the genetic theory; the systems theory; the behavioural theory; the sociocultural theory and lastly the biopysychosocial theory. The moral theory started in the 19th Century when alcohol consumption caused some individuals to act disorderly and was confirmed during the Civil War in America. The individual with an alcohol problem was seen as weak willed, sinful and immoral. This changed to the disease model when Alcoholics Anonymous was started in 1935 and the individual was given the responsibility of seeking their own recovery. Jellinek (cited in Stevens and Smith, 2001) defined alcoholism in the 1950's as a disease with three stages of early, middle and late. The early stage is when the individual uses a substance like alcohol to relieve physical or emotional pain. Then the middle stage develops over time and visible changes are seen and lastly during the

late stage where there is an overall deterioration of physical and mental abilities. The systems theory was explained by Stevens and Smith (2001) in that the environment is a causal factor of substance abuse such as dysfunctional families. Alcoholic families undergo specific role changes to adapt and cover for the alcoholic such as parental and children's role reversals. Stevens and Smith (2001) agrees with Barber (1995) that substance abuse is learned socially behaviour and that rewards are linked to substance abuse such as stress relieve and mood-altering changes.

Other causal factors are identified by the United Nations as socio-economic and political causes for the increase of substance abuse in the continent of Africa. The United Nations reported in a research article in Drugs and Crime Brief (1999) that economic, political and social instability is the cause for the increase in illicit drug use and trafficking in Sub-Saharan Africa. Over 50% of drug offenders that were arrested were unemployed and looking for "a quick buck". It appears that the increase in the abuse of substances is due to it becoming a coping mechanism to deal with the harshness of daily life. The youth was identified as the most vulnerable due to social changes in family structures, especially parent-child relationships.

5.6 SUBSTANCE ABUSE TREATMENT

5.6.1 Defining the Treatment of Substance Abuse

The concept treatment of substance abuse is defined by Durrant and Thakker (2003: 225) as involving "…the use of biological and/or psychosocial interventions that eliminate (or substantially reduce) the symptoms associated with substance abuse or dependence". This definition explains the importance of using a variety of approaches to treat addiction and that harm reduction is a form of treatment. It is my experience that it is difficult for most treatment centres in South Africa to accept harm reduction as most programmes are based on the 12 STEP principles that focuses on total abstinence.

5.6.2 Historical Overview of Substance Abuse Treatment

The disease concept of especially alcohol developed in the beginning of the nineteenth century and the belief was "…that habitual heavy drinking constituted a disease rather than a sin or vice" (Durrant and Thakker, 2003: 194). The concept of other substances being viewed as a disease was established late in the same century when Edward Livinstein published a book in 1875 about the abuse of morphine by physicians. This book reflected the uncontrollable urge and cravings for the use of morphine and helped to define other drugs other than alcohol as an addiction disease. The earlier for of abstinence from alcohol in the nineteenth century was established by the Washingtonians that

preached total abstinence from any form of alcohol. The Washingtonians provided the foundations for some of the principles of Alcoholics Anonymous. “Inebriate asylums” started becoming popular as providing medical treatment for substance abuse. By 1878, over 30 of these asylums were opened in the United States. The treatment regime included hydrotherapy in the form of steam baths, wet packs and body sponging as well as moral suasion and induced aversion. Other controversial treatments were used during this century like Keeley’s “Double Chloride of Gold”, water cures, spinal puncture, insulin injections, massage and various medications. (Durrant and Thakker, 2003).

The period during 1914 to 1935 is characterized as a time when addicts were transformed from patients to criminals due the Harrison Narcotic Act of 1914 that banned opiates and cocaine. Addiction was viewed as a neurotic, sociopath model due to personality defects in the individual. This changed the face of treatment for addictions as addicts were placed into quarantine, meaning they were locked away in institutions for detoxification and isolation from their communities. In these institutions a range of other medicines were used to wean them of their substance. These institutions were closed and “narcotic farms” were opened that was described as a hospital, farm and prison all in one (Durrant and Thakker, 2003).

Durrant and Thakker (2003: 201-202) emphasised the development of the Minnesota model in the late 1940’s, therapeutic communities in the early 1950’s and Narcotics anonymous in 1953. The ideas were moving away from personal defects to addiction becoming a disease. The argument is that an addict needs his substance in the same way that a diabetic needs insulin. This leads to the concept that addicts need to maintain on their drugs as it is impossible to expect them to adhere to total abstinence as suggested by the 12 STEPS programme of A.A. and N.A. This is where harm reduction became prominent through methadone maintenance programmes and needle exchange programmes.

The twentieth century sees addiction treatment as using multiple approaches to deal with the complexity of addiction. The various approaches range from treating people from the medical model (biology factors) to psychological factors. The diagnostic classification of addiction has changed from deviant sociopathical personality disorders to becoming described on it’s own in the DSM IV.

5.6.3 Current Approaches in Substance Abuse Treatment

Durrant and Thakker (2003) compares the treatment of addiction with the understanding of addiction in the twenty-first century as a combination of explanations from psychological, psychological, social, biological, cultural factors instead of focusing on only one set of factors. They suggest that treatment of addictions are diverse and this is an indication of there has been no breakthrough in the treatment for the last 200 years. The variety in approaches used for treatment is different from treating specific diseases and illnesses in the medical field. The example used by Durrant and Thakker (2003) is that a person with cancer will not be given the choice between going for chemotherapy or group therapy and told that they are equally effective in treating cancer.

5.6.3.1 Types of Treatment Approaches

The categories of current treatment approaches in the twenty-first century are divided into biological and psychosocial treatment approaches; Natural recovery and holistic approaches. It appears that the treatment approaches are determined by the type of substance used and the characteristics of the individual. Durrant and Thakker (2003) outline the three categories as follow:

- The biological approaches focuses on specific medications like naltrexone and antabuse to reduce the incident of relapses and other medications are used for relieving withdrawal symptoms like benzodiazepines and methadone.
- The psychological and social treatment methods focus on alternative approaches like cognitive-behaviour therapy; social skills training; family therapy; twelve-step facilitation; motivational enhancement therapy.
- Natural recovery occurs when an individual doesn't undergo any formal treatment and challenges the belief that addiction become progressively worse over time and that it is a chronic relapsing disorder.
- The holistic approach suggests that the change in self-concept can overcome addiction. A person sheds their substance abuse identity, social networks and psychological relationship with the drug and becomes a new person.

The role that the substance played in a person's life must be explored and alternatives to replace drug-taking behaviour needs to be explored. Some authors believe that people use drugs because they need an altered state of consciousness and that healthy methods can assist people in changing. Transcendental meditation (TM) seems to be an effective way to treat substance abuse through relaxation, deep breathing and self hypnosis. TM offers something in place of the drug due to a

reduction in psychological stress; enhance person's well-being; increases ones self esteem and gives life meaning (Durrant and Thakker, 2003).

5.6.3.2 Reasons for Changing Addictive Behaviour

Prochaska, DiClemente and Norcross (cited in Durrant and Thakker, 2003) and Barber (1995) motivate reasons for people overcoming their addictions by exploring the stages of change model. This model identifies five stages that people move through to change their addictive behaviours, pre-contemplation; contemplation, preparation, action and maintenance.

- **Pre-contemplation:** Person is resistant to change and in denial about the existence of the problem.
- **Contemplation:** A person becomes aware of the problem and plays with the advantages and disadvantages in quitting and experiences self-doubt and discomfort.
- **Preparation:** A person makes small behavioural changes like cutting down on intake.
- **Action:** a person has clear strategies of changing their addictive behaviour.
- **Maintenance:** A person has made progress, but is still drawn to using substances.

Another approach to why people quit is provided by Sobell (cited in Durrant and Thakker, 2003) that include health concerns, social and family problems, employment difficulties and economic problems. Edwards (cited in Durrant and Thakker, 2003) gave suggestions that the "mysterious essence of treatment" is the belief that change is possible; to develop support networks and finding new ways of living.

5.7 SOCIAL WORK AND SUBSTANCE ABUSE TREATMENT

5.7.1 Specific Training in the Treatment of Substance Abuse

Leckie (cited in Collins, 1990) acknowledges that social workers are trained in the basic intervention skills derived from systems theory, Rogerian counselling, crisis intervention and task-centered work to provide services to clients with alcohol and drug problems. Rauch (1993) suggests that social workers need more specific skills that are not received through generic training, such as the assessment of substance abusers that differs from other situations and is more directive and specific in the type of information that is needed.

In a study conducted by Du Plessis in Stellenbosch (1986) about the knowledge, skills and attitudes of junior social workers towards alcohol and related problems, it was found that social work students

were not adequately trained in handling substance abuse as part of the curriculum at their university. The results of the study suggest that the respondents had a negative attitude toward people with alcohol problems.

More than 15 years ago, Leckie (cited in Collins, 1990) discussed the social work perceptions of working with clients who have alcohol problems and portrayed the ambivalence of society towards alcohol. This can lead to social workers complicating treatment by bringing in their own experiences, feelings, prejudices and attitudes towards clients with alcohol problems. Leckie (cited in Collins, 1990) believes that these attitudes can lead to poor service delivery to alcoholics and their relatives.

Hall, Amodeo, Shaffer and Van der Bilt (2000) did a study with 1,590 social workers working in registered New England substance abuse treatment centres. They highlighted the training needs that social workers working with substance abuse have due to not being sufficiently trained in substance abuse during their studies. Further, they found that very little is offered in terms of continued professional training in the field. Hall et al (2000) found that social workers have stereotyped substance abusers and are pessimistic about their recovery rate due to the high relapse rate of clients.

Myers (2004), in the latest audit conducted on the various treatment facilities in South Africa, established that 36 clinics existed in the Gauteng Province. The aim of the study was to compile a comprehensive list of all the service providers and the various services that each one offers. It was part of the financial strategy of the Department of Social Services to identify gaps in service delivery by these clinics.

The study of Myers (2004) indicates that the number of social workers working in private non-profit organization was more than in private for-profit organisations. The staff development was further explored, and it was found that nearly 84% of the 36 centres offered training workshops to staff and 61% offered computers to staff. In addition, staff of private, non-profit and state in-patient facilities were expected to attend more case conferences, CPD workshops and regular supervision than private for profit and private non-profit out-patient facilities (Myers, 2004). The study of Myers (2004) only identified the resources available to social workers in substance abuse facilities in Gauteng and not the specific stressors and challenges. The resources to support staff and encourage development were identified by Myers (2004) and included access to the library, resource centre, computers, internet, training, computerized client systems, and participation in research (Myers, 2004).

5.7.2 Social Work Interventions for the Treatment of Substance Abuse

The theory of social work substance abuse interventions is based on social learning theory that includes not just the biological factors of addiction, but the situational and environmental factors such as family history, peer pressure, beliefs, culture and attitudes of a person and past learning experiences (Baldwin cited in Collins, 1990 and Barber, 1995). Cognitive-behavioural approaches are the most effective in ensuring that change is maintained over a period of time (Baldwin cited in Collins, 1990). Perkinson (2004) describes the interventions that can be used, such as motivational interviewing; assessment; treatment matching and crisis intervention based on cognitive-behavioural therapy. Relapse prevention is seen by Baldwin (cited in Collins, 1990) and Velleman (2001) as the core intervention in dealing with substance abusers as it involves creating an action plan to deal with high-risk situations and triggers. Barber (1995) focuses on creating change within the substance abuser through the following methods:

- Consciousness-raising: awareness of consequences of drug-taking behaviour;
- Self-liberation: increase a person's ability to choose;
- Social liberation: re-integration of a person into the environment to increase functioning;
- Counter-conditioning: identify triggers and learn new responses to drug-seeking behaviour;
- Stimulus control: restructuring the environment to avoid triggers;
- Self re-evaluation: the emotional and rational thoughts of the benefits to quit using substances;
- Social re-evaluation: the effects of drug behaviour on others;
- Contingency management: aftercare and support systems to maintain sobriety;
- Dramatic Relief: catharsis of emotional baggage to create insight; and
- Helping relationships: meaningful healthy relationships to encourage a person to life a drug and/or alcohol free life.

Wanberg and Milkman (1998) describe the characteristics of an effective substance abuse counselor that could influence the therapeutic relationship. These characteristics include the values, attitudes, perceptions, theoretical orientation, personal experiences of the counselor, or in this case, the social worker.

5.7.3 Challenges in Working with Substance Abuse

The demands on the social worker are tremendous in the field of substance abuse treatment. Collins (1990) describes some of the demands experienced by social workers in this field:

- Caseloads are increasing;
- Financial resources such as subsidies are reduced;
- Lack of knowledge and adequate training on substance abuse interventions;
- Difficult clients who can be devious, manipulative and unpredictable;
- The medical component of treating substance abuse and
- High relapse rate of clients.

The high relapse rate of clients can affect the social worker's motivation to assist and provide help. Service delivery can be impacted as clients can be depersonalized when social workers experience burnout as described by Maslach (1982). The social worker in turn might experience a lack of competence and achievement as the third component in the burnout process. Bernard, Ottenberg and Redl (cited in Monat and Lazarus, 1977) view depersonalization of clients in two ways, adaptive and maladaptive consequences. Adaptive consequences are used by an individual to protect them from being overwhelmed by the stress so that they can perform a task such as a paramedic or a medical doctor. The maladaptive consequences are destructive and can promote feelings of personal failure or helplessness that in return increase the emotional distance from others.

6. CONCLUSION

Staff retention of social workers is a global phenomenon and there are very similar reasons or causes provided for this high turnover of social workers in all the fields of practice. The challenges of South Africa are different in terms of the political and socio-economic climate after democracy was reached in 1994. The welfare services have changed to ensure that services are taken to under-resourced and disadvantaged communities bringing about a stronger emphasis on diversity management within organisations. The social worker is faced with two main occupational hazards, namely burnout and compassion fatigue that could lead to staff turnover. The causes and impact of staff turnover assist to understand the retention strategies needed to retain social workers and create job satisfaction and organizational commitment. The management of organisations plays a vital role in implementation of these retention strategies. A field of practice that further has its own challenges is the specialized field of substance abuse treatment. This research report explored how these challenges affect the social workers providing therapeutic services to this client population.

CHAPTER 4

RESEARCH DESIGN AND METHODOLOGY

1. INTRODUCTION

This chapter provided the structured framework within which this research was conducted. The primary aim and secondary objectives of the research indicated what the researcher was wanting to research. The research design employed both quantitative and qualitative research paradigms. The strengths and limitations of the research design were explained as well as the reason for utilising both methods to ensure soundness and trustworthiness of the research. The research methodology was explained in terms of: the sampling used for the selection and exclusion of organisations and participants; the data gathering instruments and data analysis methods for both the quantitative questionnaire and qualitative in-depth interview schedule; the research process and lastly the overcoming of the ethical constraints identified for this study.

2. PRIMARY AIM AND SECONDARY OBJECTIVES

The primary aim of this study was to understand the work experiences, coping strategies and organisational retention of social workers in Gauteng in-patient substance abuse treatment centres.

The secondary objectives included:

- To explore whether newly qualified social workers are adequately prepared to provide specific services to substance abusers;
- To explore the coping strategies developed by social workers who are employed for more than 5 years by in-patient substance abuse treatment centres;
- To explore the causes and extent of social workers leaving the field of substance abuse treatment;
- To identify and compare the similarities and differences of work experiences and coping strategies between social workers from the following three categories: newly qualified social workers, more experienced social workers and social workers who had left the profession; and
- To formulate recommendations based on these findings with respect to retaining social workers in the field of substance abuse in-patient treatment.

3. RESEARCH DESIGN

3.1 Description of the Research Design

The research design is considered by Punch (2004) as the link between the research question and the data to be collected, from whom and how it will be collected and interpreted to find the answers. The research design for this study was an exploratory-descriptive study utilizing both quantitative and qualitative approaches. This research design was based on the dominant-less dominant approach introduced by Creswell (1994). This meant that the study predominantly made use of a qualitative approach with a small quantitative section.

Punch (2004) states that descriptive and explanatory studies can be done simultaneously when there is already a considerable amount of descriptive information and the researcher then uses an exploratory emphasis to make sense of the information. The reason for adopting an exploratory descriptive study was to identify new variables that were specific to social work practice in the substance abuse field. The factors that may impact on social workers were first explored, and social workers coping styles were described.

3.2 Rationale for the Research Design

The mixture between quantitative and qualitative research designs are discussed in the literature by De Vos (2004) and Creswell (2003) to explain that data can be collected either qualitatively and then analyzed quantitatively or that data can be collected through both quantitative and qualitative methods. The behaviours and emotions that can be evoked while collecting the data can not be observed and recorded for the quantitative research design, whereas in a qualitative study such information could be valuable and recorded. So the researcher recorded observations whilst collecting the qualitative data.

Burton (2000) explains that qualitative research is a way to explore the social process within human relationships and that it's not a "snapshot" of a person's world only a participation in that world through observation that takes time. Qualitative research is seen as common-sense and has an interpretive perspective that allows for the exploration of new variables (Terre Blanche, Durrheim and Painter, 2006). This means that the subjective experiences of people are interpreted to understand the social world we live in by not only looking at variables, but also listening to the power of language (Terre Blanche, Durrheim and Painter, 2006). A quantitative research approach can be broadly

defined as "…the empirical research where the data are in the form of numbers" and therefore qualitative research is not in number form (Punch, 2004: 3).

3.3 Strengths of the Research Design

The strengths of predominantly using a qualitative research design for this research included:

- It allowed for creating an understanding of a person's social life rather than controlled measurements used in quantitative research (De Vos, Strydom, Fouche and Delport, 2002);
- Riessman (1994) explained that social work as a profession has always strived to respect a 'person-in-situation' and that quantitative research does not explain the individual in context, but rather seeks to establish average tendencies that are different from what social workers are taught.
- Social workers as qualitative researchers have an added advantage in that they can create a non-judgmental, open and safe environment for participants to share intense emotional feelings and experiences (Riessman, 1994); and
- The use of an additional quantitative data collection tool allowed for triangulation in this research (Terre Blanche, Durrheim and Painter, 2006).

The strengths of using a quantitative approach as compared to a qualitative approach included:

- More structured;
- The researcher is more objective;
- The focus is on specific questions rather than philosophy;
- The data collection tools are designed in advance and applied in standardized manner;
- Measurements are scientific in nature.

In combining both quantitative and qualitative approaches, this provided the opportunity to use descriptive statistics and also explore the rich inner world of the experiences of the social workers in the field of substance abuse treatment. This also created an understanding of the meanings these social workers attached to their work experiences. The reasons for the researcher combining the two approaches were derived from Punch (2004) and are as follow:

- *Strengths of both approaches*- the mixture of both approaches capitalizes on the strengths of each and the weaknesses of each approach compensates for the other;
- *Logic of triangulation*- the findings can be validated by checking these findings against the each approaches;

- *Provide a general picture*- the researcher can't be in many places at once and combining the approaches allows for gaining a wider perception on a specific matter;
- *Researchers' and subjects' perceptions*- Furthermore, the researcher uses his/her own concerns and perceptions in quantitative research where the subject's perceptions guides the quantitative research;
- *Problem of generalization*- Qualitative research uses smaller sample sizes and by using quantitative research as well, assists with the generalization of a problem; and
- *Relationship between macro and micro levels*- the combination of both approaches bridges the gap between macro and micro levels and allows the researcher to gain an understanding of a problem on both levels.

3.4 Limitations of the Research Design

The limitations to a qualitative research design were as follows:

- The interpretation of the emotional content and data could have been influenced by the subjectivity of the researcher;
- It is more difficult for the researcher to adopt the role of an objective observer than is the case when conducting quantitative research;
- Qualitative research is more time consuming due to the intensity of gathering data through interviews; and
- In qualitative research, a small sample size is used for data gathering and thus can't provide average trends and representation of a larger population as in the case of a quantitative research design.

The limitations to using a quantitative research design were as follows:

- Quantitative research does not record the emotions, feelings or nuances that might be observed with qualitative research;
- The researcher limits the responses of participants with structured questions; and
- The questionnaire can be manipulated or generalised by the participants in terms of providing expected answers and not necessary answers that reflect their own opinions, thoughts or feeling.

3.5 Soundness and Trustworthiness of the Qualitative Study

The validity of qualitative research has been a debate in research circles. Padgett (1998) identified three main reasons that affect the trustworthiness of qualitative research, namely reactivity meaning the distortions caused by the researcher being present in the participant's field; researcher biases meaning the researchers own perceptions and opinions can influence the process and lastly respondent biases meaning that participants can withhold information or lie to protect themselves or can offer answers that they think the researcher wants to hear. Padgett (1998) identified six strategies to increase the trustworthiness of the study:

- *Prolonged engagement* so that participants become more comfortable with the presence of the researcher;
- *Triangulation* by using more than one type of research tool;
- *Peer debriefing/support* for the researcher to ensure objectivity;
- *Member checking* is done by going back to participants to verify information and interpretation of the researcher;
- *Negative case analysis* is about playing "devil's advocate" to predict the worse case scenario and
- *Maintaining an audit trail* by ensuring that every part of the process of data collection and analysis are kept such as field notes, raw data and interview transcripts.

The researcher used four of the strategies to ensure transferability and generalisability of this study, namely triangulation; member checking; an audit trial and prolonged engagement. De Vos, Strydom, Fouche and Delport (2002) suggest that researchers should use a theoretical framework and triangulation to provide the opportunity for qualitative studies to be re-produced in another setting or context.

4. RESEARCH METHODOLOGY

4.1 Sampling Procedures

Mark (1996) and Bailey (1987) define a sample as a portion selected from a population for a specific study. Purposive sampling was selected for the current study. Purposive sampling is defined by De Vos (2004) as a way of sampling that is determined by the researcher according to the characteristics required from a specific group for the study. The researcher selected social workers dealing with substance abuse for the study. This description is supported by Punch (2004) as it targets a specific group or population for a sample and illustrates subgroups and allows for comparisons.

The samples were divided into two groups, namely organizational representatives (directors) and social workers:

SAMPLE 1: The first sample consisted out of representatives of eight organisations which offered in-patient substance abuse treatment centres in the Gauteng area.

INCLUSION CRITERIA

- In-patient substance abuse treatment centres;
- Operating in Gauteng; and
- State Rehabilitation Centre and registered NPO (Not-for profit organisations).

EXCLUSION CRITERIA

- Out-patient substance abuse treatment centres;
- SANCA (JHB) Society was excluded as ethical issues arise from the fact that the researcher is a director of this organisation; and
- FBO's (Faith based organisations) and Registered 21 company, private in-patient substance abuse treatment centres.

SAMPLE 2: The second sample was divided into three categories and the researcher selected two or three social workers from each category: [1]

- Two social workers who had entered the field within the last year;
- Three social workers who had more than 5 years of non-interrupted work experience in the field of substance abuse treatment; and
- Two social workers who had left the field of substance abuse treatment for longer than 18 months.

INCLUSION CRITERIA

- Social workers were eligible for participation if they had obtained a four year degree (BA Soc Sc);
- Eligible social workers had to have been employed specifically in the *treatment* of substance abuse; and
- The participants all voluntarily consented to participate in the study.

[1] The researcher initially wanted to interview three social workers from each category but only interviewed two who had just entered the field and two who had left the field due to limited availability.

EXCLUSION CRITERIA

- Social workers that had three year degrees;
- Social workers that had between one and five years' experience;
- Social workers that had interrupted service or that had worked for another in-patient substance abuse treatment clinic; and
- Social workers employed at SANCA (JHB) Society.

4.2 Research Instruments

4.2.1 Description of the Research Instruments

Two different kinds of research instruments were used in this study: an interview schedule was used as it allowed for the answering of complex questions and giving of opinions that would not always have been possible with questionnaires (Fuller and Petch, 1999). The interview also allowed for a transaction and conversation between the researcher and the participant (Denzin and Lincoln, 2003 and Rossouw, 2003). This research tool complements the research design. Bickman and Rog (1998) stipulated that the use of structured, semi-structured and unstructured interview guide is appropriate when the study uses descriptive and exploratory approaches to find new results.

This study used in-depth interviews as it encouraged participants to be talkative, to share opinions and their experiences openly (Rossouw, 2003). The usage of in-depth interviewing avoided receiving fixed questions and answers and allowed the participant to be an actor with their own understandings and interpretations (Burton, 2000).

Both quantitative and qualitative research instruments were used for this research:

Research Tool 1: Questionnaire for the 8 organisational representatives

The questionnaire to the organizational representatives (directors) focussed on statistically indicating the extent to which social workers had left the field and the impact it had made on organisations. It had seven quantitative questions and five qualitative questions (See attached Appendix A: Questionnaire to Organisations).

Research Tool 2:In-depth interviewing with the six social workers from the three categories

The in-depth interview schedule had five questions that focussed on the work experiences of these social workers. It explored their work experiences and coping strategies. The questions were

designed according to the objectives of the study (See attached Appendix B: In-depth Interview Schedule for Participants).

The organisational questionnaire was pre-tested to ensure that all questions were easy to understand and that it could be completed within the recommended time limit of 30 minutes (De Vos, 1998). The director from SANCA Durban was used to pre-test the questionnaire, as this organisation is not part of the Gauteng organisations. No adjustments to the tool were made (See Attached Appendix C: Letter of Permission to Pilot Questionnaire).

4.2.2 Rationale for Research instruments

Research Tool 1: Questionnaire

The reasons for using the questionnaire as a research tool were as follows:

- To gain descriptive statistical quantitative data from organisations about the staff turnover of social workers; and

- To be able to provide generalised statements about the extent of the social work turnover in substance abuse treatment in-patient clinics in Gauteng.

Research Tool 2: Interview Schedule

The following reasons explained the use of in-depth interviewing by the researcher:

- The interviewing of social workers as research participants seems to be advocated by Shaw and Gould (2001: 64) as it "…mirrors social worker's interviewing of their clients".
- Social workers as researchers have interviewing skills and are more comfortable with interviewing as a method. There are differences between social work client interviews and that of research interviews. Research interviewing is more objective, scientific and controlled by one participant in the interview (Riessman, 1994).
- It is believed by Rubin (cited in Shaw and Gould, 2001) that clinical social work training prepares social workers for research interviewing.

4.3 Research Procedures

The research procedure was conducted in the following sequence:

- The questionnaire was piloted with SANCA Durban's director who completed the questionnaire and provided the researcher with feedback on the length of time to complete the form and the clarity of the questions asked in the document. No changes were made to the tool (See attached Appendix C: Letter of Permission to Pilot Questionnaire);
- The research brief and consent forms were sent to the organisations (See attached Appendix D: Research Brief for Organisational Representatives and Appendix E: Consent Form to conduct interviews and meetings on site);
- The questionnaires were then posted to the eight directors of the identified in-patient treatment centres and follow-ups were conducted;
- Appointments were arranged for 20 minute research information sessions with the social workers to discuss the study. Voluntary consent forms were handed out to the social workers that were interested in the study. Completed consent forms were faxed to the researcher who then arranged interviews with the participants. (See attached Appendix F: Participant Information Sheet and Appendix G: Interview and Recording Consent Form);
- The researcher asked the directors for the contact details of social workers that had left the organisations and asked for permission to contact them. The social workers were contacted by the researcher and appointments were arranged with the ones that voluntary agreed to be interviewed;
- All the quantitative data were analyzed and presented in graphs and tables in this research report;
- The interviews were transcribed and then analyzed to determine themes and categories; and
- The study was presented in a bound research report.

4.4 Limitations of the Research Methodology

The following limitations were identified for this study:

- The purposive sampling method created a limitation in that it decreased the generalization of findings. The study only focussed on social workers working with substance abuse treatment within the Gauteng province and was not representative of social workers in other provinces. The challenges experienced by social workers in other provinces might differ from Gauteng;

- The social workers from the third category were difficult to recruit (social workers who had just joined and social workers who had left organisations) as some of their contact details were not correct. Organisations also could have been selective in whose details they provided the researcher with. As a result, only two social workers were recruited from these two categories; and
- The questionnaire was sent to eight organisations and only a 50% (4 questionnaires) were returned. Some of the organisations had extensive procedures to follow in order to gain permission for the research study which delayed the onset of data collection.

5. ANALYSIS OF DATA

Fuller and Petch (1999) describe the process of making sense of data as two-fold, namely, first coding the data in an orderly systematic form, and then analyzing the data by counting and finding links. All data can be grouped into categories so as to find themes to support the objectives of the study (Denzin and Lincoln, 2003).

Research Tool 1: Questionnaires

The quantitative data were analyzed through descriptive statistics presented in the form of a variety of tables, charts and graphs as illustrated in De Vos (1998). The qualitative questions in the questionnaires were compared and combined with the data collected with the in-depth interviews.

Research Tool 2: Interview Schedule

Qualitative thematic content analysis was used as the method to reduce, condense and group the content of the interviews through open coding, axial coding and theoretical coding in order to gain an overall review of all the data (Henning, 2004). Open coding was the preliminary method used when analysing the data in order to produce provisional concepts that are extracted from the data of the interviews. The connections between these concepts or categories were then analysed through axial coding to understand the complexities of these concepts. The last form of coding used was theoretical coding where underlying similarities, uniformities, and ideas were identified to form a set of concepts (Riessman, 1994).

6. ETHICAL CONSIDERATIONS

De Vos (2004) and Mark (1996) stress the importance of research ethics and the pitfalls that the researcher should avoid in making ethically responsible decisions. Terre Blanch, Durrheim and Painter (2006) account that research ethics were developed after the atrocities committed by the Nazi medical researchers during World War II that led to the Nuremberg Code in 1948 stipulating the importance of individual informed consent. The ethical issues considered for this study were described and ways of addressing these included:

6.1 Possible Emotional Harm to Research Participants

Since this study focussed on the work experiences of the social workers, it was possible that participants might share emotional information that left them feeling vulnerable. De Vos (2004) suggest that this risk be explained beforehand and that everything possible should be done by the researcher to protect the participants. The researcher approached the senior social worker from SANCA JHB who agreed to provide debriefing sessions with participants who might have experienced strong emotions or distress during the interviews. The debriefing session was offered at no cost to the participants (See attached Appendix H: Letter of Permission from Senior Social Worker).

6.2 Informed Consent

The participants were provided with information regarding the purpose of the research; the interview procedure; the possible advantages and disadvantages of being involved as well as who the researcher was and what her credentials were. Informed consent was obtained from the organisations and participants (De Vos, 1998 and Terre Blanche, Durrheim and Painter, 2006). The organization and individual participants consent forms were signed prior to the study commencing.

6.3 Confidentiality

The confidentiality with which information was to be handled was explained in the participant information document. Confidentiality was guaranteed in the following ways:

- Codes were used for the individual participants and organisations to protect anonymity;
- The raw data were only available to the researcher and her supervisor; and
- All raw data will be destroyed six years after submission of the research report, until then it will be stored in a secure place.

6.4 Publication of the Findings

The writing of the findings of the study is important and a copy of the research abstract will be made available to the participants and organisations. De Vos (2004) explains that research can become a learning experience for the participants for future participation. Moreover, researchers have an ethical duty to provide feedback to research participants and apprise to them results of the study.

7. CONCLUSION

This chapter provided the guidelines for conducting the research from the selection of the participants to the final analysis of the data collected. The researcher chose both qualitative and quantitative methods and incorporated the views of organisations and individual social workers in order to enhance the objectivity of the study. The ethical concerns and the strengths and limitations of the study were identified.

CHAPTER 5

DATA COLLECTION AND ANALYSIS OF FINDINGS

1. INTRODUCTION

The research design was exploratory-descriptive and adapted Creswell's (1994) dominant less dominant approach with a predominantly qualitative component and a smaller quantitative component. A structured questionnaire and semi-structure interview schedule were used to gather the data for the research. The data collected via these two research methods are presented and illustrated through verbatim quotations, tables, graphs and figures.

Eight substance abuse in-patient treatment centres within Gauteng were approached and gave written permission for the research to be conducted with their social workers. This allowed the researcher to prepare the organisations for the data collection through a questionnaire which was then followed by in-depth interviews with selected social workers. The questionnaire was posted to the representatives of the eight organisations and follow-up faxes were sent a month later. Four questionnaires were returned to the researcher representing a 50% (4 questionnaires) return rate of the questionnaires.

The social workers employed at the organisations that were approached to complete the questionnaire for the quantitative data, received research presentations at staff meetings arranged by the organizational representatives which invited them to participate in this study. The researcher provided the social workers with a research brief (see attached Appendix I: Research Brief for Social Workers*)* and delivered a presentation on the research objectives and value of the study. Thereafter, the social workers that complied with the inclusion criteria indicated their willingness to participate and had to complete and fax through their consent forms to the researcher (see attached Appendix G: Interview and Recording Consent Form). Appointments were then arranged with each one and seven in-depth interviews were conducted (see attached Appendix B: In-depth Interview Schedule for Participants). The participants who were interviewed complied with the inclusion criteria and represented the three categories identified for this research study: Three of the participants were senior social workers with more than five years experience; two social worker who had left and two social workers occupied junior social work posts.

2. DEMOGRAPHIC INFORMATION

2.1DEMOGRAPHIC INFORMATION IN RESPECT OF THE ORGANISATIONS

2.1.1Type of Organisation

Figure 1 illustrates the type of organisations that participated in the research. All the organisations that participated were registered with the Department of Social Development as a Non-profit organization (NPO); one organization was also registered as a Section 21 company and one organization was affiliated to the South African National Council on Alcoholism and Drug Dependence (SANCA).

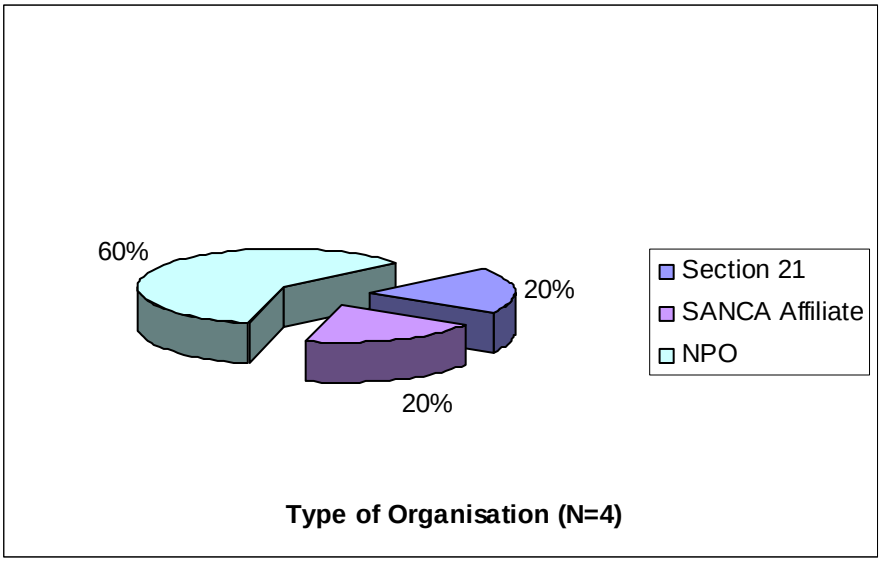


Figure 1: Type of Registrations of Organisations

2.1.2 Description of the Treatment Programmes

The treatment programmes varied for each organization with three of the organisations offering a 28-day treatment programme. Two of the organisations offered a variety of treatment programmes such as detoxification and one organization offered a six weeks programme. Only one of the organisations that participated in the research offered a three month treatment programme. The leanght of programmes was important if one considers the following factors displayed in Table 6:

- The length of the treatment programme could also affect the sense of achievement for the social worker as changes are more visible with a long term treatment programme than with a short to medium term programme;
- The therapeutic relationship between the social worker and the client was likely to be more intense over a longer period and more intensive therapeutic work could be done to deal with past traumas and preparation for future life events that the client may had to have endured;

- It has been the researcher's experience that one of the factors that may play a role in the success rate of clients depends on the amount of 'clean time' they have. With a longer programme the client usually has a better understanding of themselves and their addictive behaviours to make lasting changes and practice the coping skills needed to maintain a sober and clean lifestyle.

Table 6: Description of the Treatment Programmes offered by Organisations

TYPE OF ORGANISATION	LENGTH OF TREATMENT PROGRAMMES
SANCA Associate	• 28- day programme • Detoxification
SANCA Affiliate (Full Membership)	• 28-day progarmme • Six weeks programme
Section 21 Company	• 28-day programme • Detoxification
Non-Profit Organisation	• 3 months programme

2.1.3 Social Work Posts: Filled and Vacant Posts

The organisations that participated in the study indicated that their management and entry-level social work posts are filled by one (8%) newly qualified social workers; eight (67%) senior social workers; and two (17%) by chief social workers. This finding is in line with the number of social workers with more than five years work experience that was identified in Table 9. At the time when the organisations completed the questionnaires, two (17%) of social work posts were vacant and that the majority of the posts, namely ten (83%) social work posts were filled:

- From the questionnaires, it appeared that a social worker needed at least five years work experience in the substance abuse field in order to become a senior social worker;
- The high number of social workers in senior social work posts (67%) suggested that more social workers stayed in this category but the low number of entry-level social workers may have indicated that fewer social workers stayed in this field;
- This could be explained by seeing that most of the social workers employed at the in-patient clinics had more than five years experience indicating a stability of staff maintenance and low levels of staff turnover;
- One organization had never experienced staff turnover for many years which could also be a concern in terms of new information and changes being implemented in the system but also regarding the knowledge and skills transfer to newly qualified social workers to enable them to one day take the lead;

- The concern for the high number of senior social workers employed at the four centres at the time of the study, was that the pool of skills and expertise might dwindle over time and leave a knowledge and skills gap in the field of substance abuse when these social workers with more than 10 years reach retirement; and
- Vacant posts were all for junior social work positions indicating that most of the social workers were in the entry-level/ junior category when they left the organisation.

2.2 DEMOGRAPHIC INFORMATION IN RESPECT OF THE SOCIAL WORKERS

2.2.1 Description of the Participants

The seven social workers' who were interviewed were all women and all had an honors (four year) degree in BA Social Sciences or BA Social Work. The participants were from different cultural groups and each spoke a number of languages. Their age groups ranged from 36 to 59 years. They were at different stages of their lives such as starting a family or on retirement. All the junior social workers that were interviewed were in the beginning stages of starting a family and had external family commitments of a marriage relationship and young children to deal with. Cooper and Robertson (2001) identified that stress in the one world of the work-home interface causes stress and dissatisfaction in the other. This could lead to staff turnover, poor commitment from staff, negative work attitudes and even poor work performance. The senior social workers were winding down from family responsibilities, leaving them with more time to expand their self care strategies.

Table 7: Demographic Information of the Participants according to Race, Home Language, Age and Marital Status (N=7)

DEMOGRAPHIC INFORMATION	DESCRIPTION
Racial Group	Four of the participants were black and three were white
Home Language	Four of the participants spoke Tswana and Zulu Three spoke Afrikaans and English
Age group	One participant was under 30 Three of the participants were under 40 Three of the participants were under 60
Marital Status	Six of the participants were married One of the participants was engaged to be married

2.2.2 Educational Qualifications of the Participants

The participants studied at six prominent Universities in South Africa and their degrees were obtained over many years from 1969 up until 2007. Almost half of the participants (3) indicated an interest in studying further and completed their research reports on topics related to the field of substance

abuse. All the participants had previous work experience and the one organization even stated that they only employed social workers with more than two years work experience so that they have already acquired some basic work skills when entering the field of substance abuse.

Table 8: Educational Qualifications of the Participants (N=7)

EDUCATION BACKGROUND	DESCRIPTION
Educational qualifications	• All seven had an Honors degree BA Social Sciences or BA Social Work • Three of the participants had a Master Degree in clinical social work and all three of their research reports were on substance abuse-related topics • Two of the participants possessed a Masters Degree in Industrial Social work
Work experiences in the field of substance abuse	• Work experiences ranged from 6 months to 29 years experience in the field • Two received their initial experience in their under graduate studies by undertaking practical work at treatment centres; • All seven received their in-depth skills and knowledge on substance abuse while working at substance abuse clinics.
Previous work experiences	• Three of the participants worked for Government Departments like Department of Social Services or the City Council • One participant worked for a National hospital; • One participant had worked for the same treatment centre until she retired; • Two of the participants had worked previously for other treatment centres

3. PREPARATION OF THE SOCIAL WORK STUDENT AND SOCIAL WORKERS IN THE SUBSTANCE ABUSE FIELD

3.1 PREPARATION OF SOCIAL WORK STUDENTS TO WORK IN THE SUBSTANCE ABUSE FIELD DURING UNDERGRADUATE STUDIES

3.1.1 Introduction to Substance abuse Theory and Practice

Most Universities that participants had attended offered brief introductions to the field of substance abuse treatment. The extent of the Universities input varied with each participant. Two of the participants undertook their social work student practical work at a substance abuse treatment centre that established their careers in this field. The other participants received only a brief introduction to substance abuse in their final year at University and all of the participants felt that they were not adequately prepared to work in the substance abuse field due to it being a specialized field of practice.

One participant explained that the University she attended during her pre-graduation:
"… went through it on the surface…we did not really focus on the specifics of addiction per se so that you have an idea of what it is all about... And I think that people that were fortunate were those who were placed at the Cape Town alcohol and drug counselling centre. And they had the experience because they have worked there but if they did not work there you had limited knowledge in terms of the in-depth of the problem and the counselling part and the dynamics that are involved."

3.1.2 How generic training assisted social work students to work with substance abuse

Participants reported that the generic training received as social work students provided them with some basic skills to utilise in the counselling of substance abusers.

A senior participant recalled:
"…when I was just studying there's a module that one of the lecturer's presented about a person-centered approach where we believe in a person's capabilities (and strengths). So I thought that especially the teenagers who were very addicted to dagga…they can get out of the addiction."

3.1.3 Suggestions to Universities regarding the training, screening and support of social work students

One participant suggested that Universities needed to focus on the screening of social work students; providing more intensive and specialized training in therapeutic or counselling skills; and reviewing the training methods used by Universities. The participant indicated that more intense therapeutic training was needed through roleplays demonstrated by the lecturers and students and analysis of tape recorded interviews by the students. The same participant even suggested that students should be selected according to the specialized fields. All the participants felt that more specific training in substance abuse was needed so that students could be aware of the trends and interventions such as relapse management. It was also felt that students needed practical exposure to the substance abuse field as it is related to so many other social problems.

The screening of social worker students was proposed as a method to identify the suitability of students to the profession and their ability to conduct therapeutic work and specialize in a specific field in their fourth year. One participant expressed that there should be a focus on the personal as well as the professional development of the student through individual and group therapy. Morrison (2007) conducted a study on the emotional intelligence of social workers and suggested that students

should be given the opportunity during their undergraduate studies to explore their own attitudes and feelings about seeking help themselves. Such an approach would help students to understand and handle emotions which would assist them with handling their clients' emotions, during all the stages of social work from assessment to intervention. It was suggested by one participant that students should be aware of their own defense mechanisms before entering into a helping conversation with clients.

The one retired social worker identified her experience as a student:

"… You get taught the first interview really well and the last one on how to terminate but not what happens in between."

3.2 WORK EXPERIENCES, EMPLOYMENT STATUS AND TURNOVER OF SOCIAL WORKERS

3.2.1 Work Experiences of the Social Workers in the Substance Abuse Field

The organisations that participated in the study identified the level of work experience in the field of substance abuse of the social workers currently employed by them. Table 9 shows that most social workers were currently employed with more than ten years work experience in the substance abuse field.

- Three of the participants fell into the bracket of having more than 10 years work experience and supported the information provided by the organisations;
- Eleven of the social workers (65%) were employed at the organisations for over 10 years and therefore there was a large specialized expert base in substance abuse treatment clinics in Gauteng at the time of the study. Newly qualified social workers could benefit in terms of training, supervision and skills development;
- The second highest number of social workers, namely five social workers (18%) had between 5 and 10 years of work experience. This indicated that there was a specialized pool of skills available to entry-level social workers; and
- There appeared to be very few social workers with less than 6 months experience in the field. This could indicate that there was a higher staff turnover experienced with junior social workers.

Table 9: Work Experiences of Social Workers (N=17)

YEARS OF WORK EXPERIENCE	NO OF SOCIAL WORKERS IDENTIFIED BY THE ORGANISATIONS	NO OF PARTICIPANTS
0 to 1year	1	1
1 to 2 years	1	2
2 to 5 years	1	1
5 to 10 years	3	0
Over 10 years	11	3
Total:	**17**	**7**

3.2.2 Employment Status and Turnover of Social Workers

Figure 2 illustrates the fact that the highest turnover of social workers, namely three (33%), was experienced in the 2 to 5 year category. The second highest turnover of social workers, namely two social workers from two categories, 1 to 2 years category and also in the 5 to 10 years category were found in these two categories. The lowest staff turnover, namely one social worker (11%) was found within the first year of working or more than 10 years of working in the field of substance abuse. Table 9 supports the fact that most (65%) of social workers employed had more than ten years experience in the substance abuse field and therefore had the lowest staff turnover.

- Most of the social workers (33%) left the organization after 2 to 5 years work experience in the substance abuse field;
- It seems that six (77%) of social workers surveyed left organisations after working for two to 10 years in the organisations;
- One (11%) of the entry-level social workers in the study left the organization within the first year of working;
- It seems that few of the social workers left the organization after working there for 10 years or more which could be due to retirement. This reduces promotion opportunities for staff in all three of the other categories and could be a reason for 33% of the social workers leaving after 2 to 5 years of working at the organization.

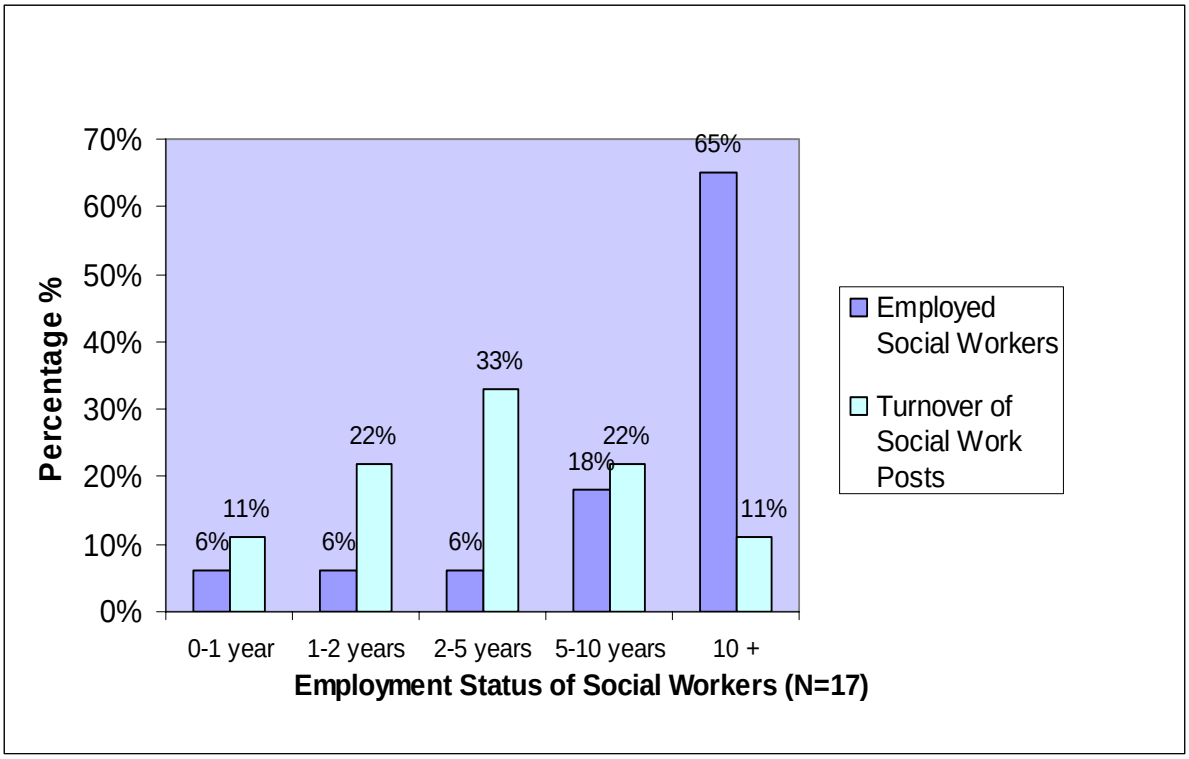


Figure 2: Staff Turnover and Retention of Social Workers according to their Work Experiences

3.2.3 Caseloads of the Social Workers

The organisations varied in terms of the average number of cases per social worker. This ranged from 8 clients, 12 clients to 50 clients per social worker. The average number of cases was 13 clients per social worker for in-patient treatment programmes. There is a discrepancy between treatment clinics regarding the caseload of social workers. The high case load might increase the work stress of the social workers as identified by Cherniss (cited in da Costa, 2001).

Table 10: Caseload per Social Worker

Organisation	Caseload
SANCA Associate	12 clients per social worker
Section 21 Company	8 clients per social worker
SANCA Affiliate	18 clients per social worker
NPO	50 clients per social worker

3.3 REASONS FOR ENTERING THE SUBSTANCE ABUSE FIELD

Four of the participants did not specifically choose the field but it was due to various circumstances that they entered the field. Three of the participants chose to work in the field due to their practical experiences as students or work experiences in previous positions that sparked an interest in the prevention and treatment of substance abuse. The passion for the field of substance abuse played a role in keeping staff involved in the field and one participant even changed workplaces but still stayed in the same field.

Table 11: Reasons for Entering the Substance Abuse Field

REASONS FOR ENTRY	QUOTES FROM PARTICIPANTS
Circumstantial Reasons	*"You don't choose the field it just happened…it came your way and then you developed a passion for it."*
Professional Interest in the Substance Abuse Field	*"I became interested in substance abuse and relapse and interested in the treatment of addiction and it started from there. And then was a vacancy and then I came here".*

3.4 WORKPLACE AND OTHER FORMS OF TRAINING IN SUBSTANCE ABUSE TREATMENT

The participants acquired most of their work experience through on-the job training by implementing the treatment programmes and conducting individual counselling, family and couple counselling. This allowed the social worker to learn from the clients as well as from colleagues. All of the organisations provided the participants with induction/ orientation; in-service training and supervision. Only a few participants (2) indicated that they had learnt from external workshops on substance abuse and other related topics. The participants echoed the efforts recorded by the organisations in Table 12:

Table 12: Workplace and Other Forms of Training for Social Workers

Workplace Training Methods	Quotes from participants
Induction/orientation	*"…three weeks induction programme where I got exposed to different methods, you know, intervention methods, meaning group work, community work and individuals. So I got to observe and attend also information sessions from regarding substance abuse".* *"I was in training for six weeks of learning how things are done and then the other three weeks was doing it while someone was there to observe and assist".*
In-service training	*"…through the internal trainings that we had…inviting other organisations to present".*

	"…in-service training every month with our staff meeting".
Supervision	*"I had more support from my manager…so she taught me everything I knew so being in the community and working with substances became more interesting"*.
Other colleagues	*"…there were volunteers already in the organization and I found that they are more knowledgeable than me because I was new to the field. So I learned a lot from the volunteers regarding substance abuse".*
Staff meetings	*"…we tackle maybe a book and work through the book and each one read a chapter or two and we would discuss it and make a point of discussing if there is difficult patients or how to cope with that or what strategies we can use".*
Self studies and self development	*"Through reading and finding new information. So I kept going and finding out new stuff".* *"I'm the eternal student and it makes it exciting because I can't stagnate…so I make sure there is something new on the horizon all the time…"*
External training workshops, seminars and conferences	*"I think you read more or try and attend what ever course there is or some workshop or seminar then I would always attend that".*
Generic training on related subjects	*"…we also look at a course in trauma counselling…a lot of our patients have traumatic experiences and abuse… it helps tremendously with the work here because a lot of times there are other problems behind the substance abuse".*
Personal therapy	*"…so I thought that self awareness…if you want to do therapy you have to be in therapy yourself, because I don't think that you really don't know yourself when you seeing patients and that helped me and that is how I got most of my experience."*

The activities offered by organisations to support and retain social workers are captured in Figure 3 and indicates that most organisations offer a range of activities to create a safe, secure and caring work environment for social workers. These activities were confirmed by the social workers that were interviewed. Most social workers received bonuses, performance incentives and annual salary increases. New staff underwent induction and orientation programmes when entering the organization. On-going career development is provided through external training, internal training and supervision. Teambuilding activities were held to maintain and build working relationships. Only one of the organisations provided external supervision for staff. These organizational activities assisted with the retention of social workers in the substance abuse field especially because it is considered to be a specialized field of practice. In this report, the effort-reward imbalance model explains that work stress is caused when there is high effort or performance with low rewards in the form of monetary,

self-esteem or career opportunities by the employee (Chmiel, 2000). The social worker receives these rewards in terms of bonuses, incentives and even annual salary increases as seen in Figure 3. The concern seems to be that these salaries are not market related and this increases the competition between NGOs, Governmental Departments and the private business sector for the scares skills of social workers.

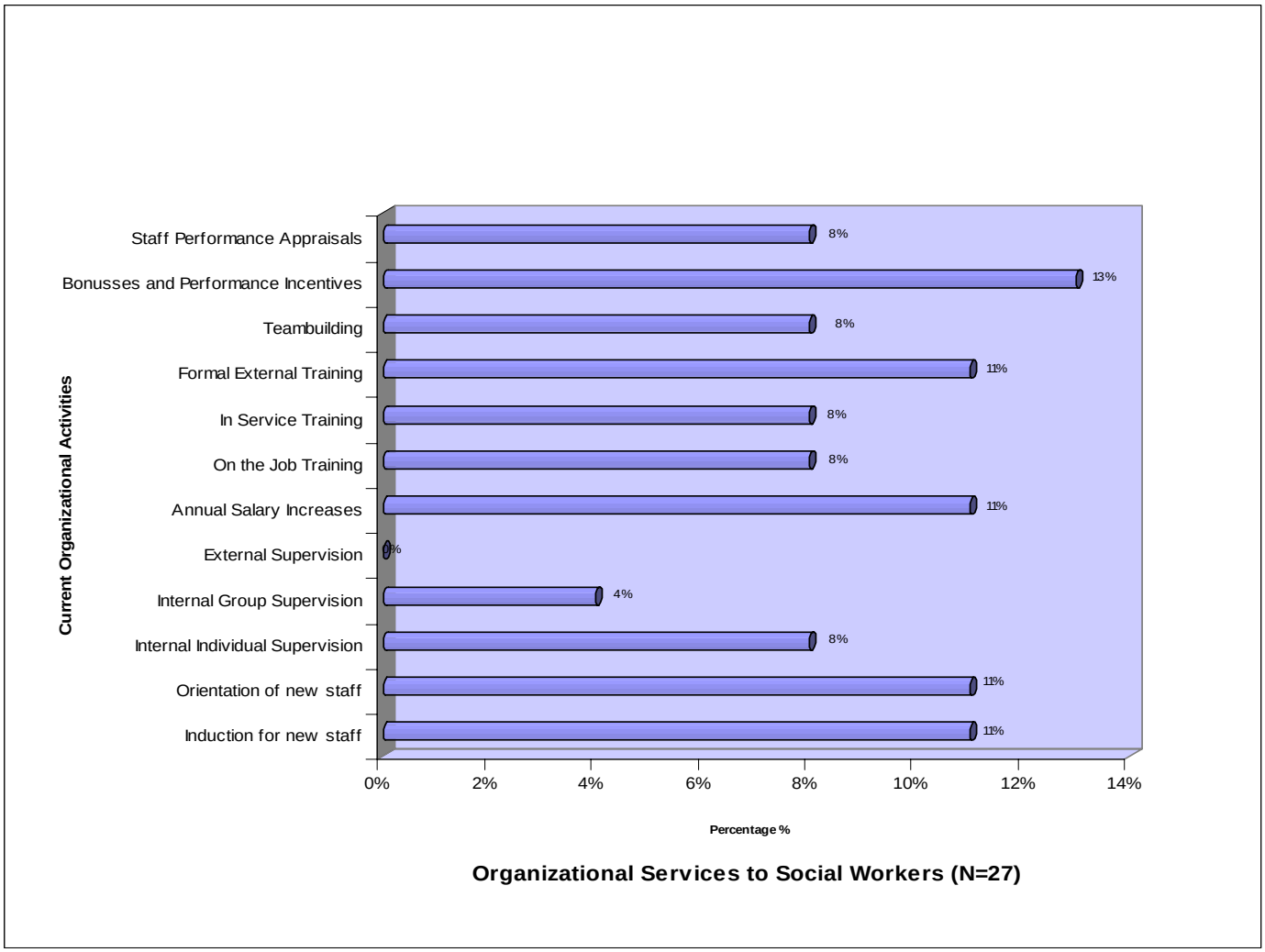


Figure 3: Organisational Activities and Support Services to Social Workers

3.5 KNOWLEDGE AND SKILLS NEEDED BY SOCIAL WORKERS TO WORK WITH SUBSTANCE ABUSERS

The participants identified specific focus areas for therapeutic interventions. The first focus area was for the social worker to keep in touch with the latest developments in therapy and substance abuse treatment due to the changes and complexity in client profiles. All of the participants stated that additional and more specific skills were needed to deal with a wide range of complicated client

problems. These skills needed included therapeutic interventions; trauma counselling; therapeutic group work skills and appropriate interventions with dual diagnosis. The social worker required specific medical knowledge about the detoxification process and the treatment of dual-diagnosis clients.

A social worker with five years experiences commented:
"So I think it's to know as much as you can with new developments, new skills or different ways to address problems. I think that also helps you with burnout because if you don't know what to do and it's tiring."

An entry-level social worker with one year work experience felt that the substance abuse field:
"… involves a lot of therapeutic work. You need time to work with the patient. You need an understanding of the content… It's a specialized field. There are dynamics that are different such as the language is different and your ears are up to catch the stuff that you wouldn't usually know. So it's been a learning experience."

The social worker with 29 years of work experience established that clients' experience a range of problems that increases the complexity of service delivery:
"…a lot of our patients have traumatic experiences, abuse what ever so that course is more specific on the trauma counselling but it helps tremendously with the work here because a lot times there are other problems behind the substance abuse."

These findings highlighted the need for social workers working in the field of substance abuse to gain additional knowledge and skills through training. This training would have enabled them to deal more effectively with the challenges of working with substance abusers. This training should not only focus on substance abuse treatment but also cover related topics to deal with the complexity of the problems experienced by clients. All the participants indicated that social work students are equipped with basic therapeutic skills to conduct individual sessions with clients. However as the substance abuse field is a specialized field of practice, more advanced therapeutic skills and interventions are needed to provide effective treatment of substance abuse.

4. THE REASONS FOR STAFF TURNOVER AND FOR RETENTION OF SOCIAL WORKERS IN THE SUBSTANCE ABUSE FIELD

There were four main themes identified by the researcher when analyzing the reasons why participants left or stayed in the substance abuse field, namely: organizational factors; personal factors; client population and career development.

4.1 ORGANISATIONAL FACTORS THAT IMPACT ON THE STAFF TURNOVER OR RETENTION OF SOCIAL WORKERS

4.1.1 Organisational Factors: Reasons for Staff Turnover

All seven participants attributed the poor salaries offered by non-government organisations (NGOs) as the predominant reason for social workers leaving the substance abuse field. Two organisations identified increased benefits offered by the private and public sectors as a reason for resignation of their social workers. Two participants said that most of the newly qualified social workers leave the organization due to the poor salary packages offered by NGOs. This could be attributed to their life stage where they wanted to start a family and gain some material rewards.

The staff turnover of newly qualified social workers due to poor salaries was explained by a senior social worker as follows:
"One of the mayor things that makes people move around, especially young people…is the fact that our profession doesn't give us a salary that we are able to live on. It's not enough. You could do a job that you love but the challenge is that at the end of the month when you can't pay your bills and you can't pay everything, you have to juggle your bills or your standard of living has to be at a certain point if you are to say that you are surviving. That's the challenge that our organization is facing."

External factors such as the reduction in subsidies from the Department of Social Services also influenced the existence of NGOs to such an extent that one organization closed down. Moreover, how organisations manage crisis situations could affect the trust developed between management and staff. This trust could be improved by involving staff in decision-making; being more transparent and having open communication channels between management and staff. The change management process can be difficult and can have severe affects on the social workers and any changes can cause instability and insecurity within organisations. One participant emphasised that social workers needs to take responsible and use the resources offered by the organisations such as supervision. The following verbatim responses reflected the effects that change management had on some of the participants:

One senior social worker felt that a lack of trust developed between management and staff that led to her resignation:
"…a lot of resentment and you feel that you are not trusted enough. Why did not they trust you enough to tell you that this is what's going on? What did they think you would do? There is no trust now between management and staff."

Another senior social worker felt excluded from decision-making:
"So there was a lot of decisions been made without mutual consultations and I found that the social workers, we were excluded quite a lot from decisions. So you find a lot of isolation taking place. And it is as if the medical staff is not really interested in the therapeutic side."

One of the senior social workers moved to another organization and felt unhappy due to the unmet expectations and staff dynamics:
"…there was also a lot of expectations but when I got there suddenly the office space wasn't there…it was like an enmeshed dysfunctional family, the staff."

A young social worker felt that she did not use her supervision effectively:
"…but what was more disturbing was not talking about what I felt at that time because a person that was teaching me the job I couldn't come out and say that 'I'm not doing well'. I was afraid of that."

The corporate culture of coping was identified by one senior social worker and confirmed by Drenth, Thierry and de Wolff (1998) to affect the group's thinking, behaviour, feelings and perspectives. This participant indicated in the interview that she felt guilty when she took leave and even when she took sick leave. She further reported that one of their senior social workers resigned due to work stress and nobody even knew that she was not coping. Another colleague displayed bizarre behaviour due to not coping. When asked what the responses of the organization and her colleagues were to the colleague that did not cope, the participant reported that she was alienated and tolerated but that it was not acceptable to show that one was not coping. The senior workers compensated for the social worker that was not coping, but felt there was a covert message in the organization that you need to cope no matter what. Drenth, Thierry and de Wolff (1998) identified the three levels of organizational culture as overt artifacts, the values and norms that guide their behaviour and the underlying assumptions that unconsciously guide the behaviour of the group. The culture of coping had also made this particular participant feel that she had lost her sense of identity as she attempted to adapt and adjust to the culture of the organization by wearing uniforms and adhering to the overt and covert

messages. She further reported that she made sacrifices for the organization to her own detriment in terms of her health being affected by the stress and the burnout she experienced. There appeared to be a lot of resentment towards the colleague that did not cope as this meant an increased workload for the other staff due to them compensating for that colleague. The signs of not coping were identified by this participant as a change in attitude and mood of all staff including support staff and nursing staff.

The reasons for the senior social worker feeling resentment towards her colleague were reflected in the following quote:

"…*where one is not coping the others… the older hands that are coping a lot better, because we know the system… but it's the system compensating for them…but still getting upset and really tired too… and enabling them and we've realized you know that it's not working then our workload becomes more and they are still not producing. And this is one of the issues I addressed and I said this is it, I'm not enabling or compensating for anybody else at my cost. "*

Moreover, the culture of coping in the organization was described by the social worker as follows:

"…cope is the thing, where I am, you know…just cope. It was said to me once to by a senior …and to your detriment as well and as long as other people don't see you not coping… It's a very strong message and I have seen a lot of people also from the nursing staff and admin staff, you can see it when people start to crack and not cope well, because of nonsense at work, in their attitudes and moods…I've realized now is kind of the theme, you know, you must cope and when you are not coping that is the last thing you want to hear…I was loosing my own identify because I can't just get stuck in a group identity because then where am I. There's a lot about sacrificing and everything there."

This social worker explained the culture of coping when she stated:

"There is a very strong, can I say, group identity of work and do as much as you can and work till you drop…I think lead to sometimes as well, people feeling bad if they're not coping and they don't say anything. They tolerate it but it's a very unspoken rule as well, give it all, as much as you can because there is…often we have spoken about it you know it's tolerated because it has to be, sick leave and stuff, but you also pick up that there is not really that much tolerance. So there is an overt message that we tolerate it but covertly the feeling is that it's not tolerated. Ja, and it's what you say you feel guilty for take leave or go on a holiday."

4.1.2 Organisational Factors: Reasons for Retention

Three participants identified the fact that organisations also exerted positive impacts on social workers through providing support, supervision and different work opportunities. This helped to retain them for many years so that they could continue working in the substance abuse field. Supervision of staff was offered by all the organisations as stipulated in the questionnaires completed and verified by the participants. Organisations appeared to have provided valuable guidance, support and training to existing staff. Two of the participants reported that they felt challenged and stimulated to create new programmes such as aftercare and culturally sensitive groups. This kept them motivated. Three participants acknowledged that working in the substance abuse field was dynamic and provided diversity in this field due to the wide variety of problems experienced by clients. What was evident was that the social worker needed a wide range of skills and knowledge to address the complexity of the client problems and needed on-going training. This made it a changing and exciting field of practice.

One senior worker that had been in the field of substance abuse but in various organisations emphasised the reasons for her return to this setting:
"I went back and I thought it's actually the diversity and the excitement of the work. It's never any monotony."

4.2 PERSONAL FACTORS THAT IMPACT ON THE STAFF TURNOVER AND RETENTION OF SOCIAL WORKERS

4.2.1 Personal Factors: Reasons for Staff Turnover

One senior social worker felt that some of the social workers left to start a family:
"They work because it's about making money…getting married. It's not about "I love this…I have to go on…how can I change this field or how can I learn more…what do I have to do? For them (the young social worker) it's more about material things than being emotionally secure and loving your job."

A young social worker acknowledged the impact that poor salaries have had on her life by saying:
"I'm thinking that 10 years ago I never thought I would be still be earning this. You think and you hope that you be at a certain point…there are certain things that you don't have that people of your age group or people that you studied with at the same university, the same year different courses that

they have progressed three times more than you have. So the issue is valuing the progress in terms of material but also looking at if I'm happy at the job."

This was echoed by another entry-level social worker who stated:
"Here it is about money, live…they have to start living now…they have to have enough money…".

The personal factors that influenced and motivated the decision of the social worker to leave the substance abuse field were also linked to the stage of life that they were in. Eckenrode (1991) agrees that life transitions causes vulnerabilities such as jobs stress due to the age and stage in a person's life. The young social worker was at a stage of their life where they wanted to compete in the world of work; start a family and progress in material resources and career opportunities. Newly qualified social workers often compared themselves to their friends and felt as though they were lacking behind in the material sense which created uncomfortable feelings of insecurity and unstability. One organization identified that change in family structures such as relocation and motherhood also played a role in the turnover of social workers. One of the participants reached a stage in her life where she was ready for retirement after more than 20 years of working in the substance abuse field.

4.2.2 Personal Factors: Reasons for Retention

The researcher observed that social workers that had been working in the field for more than five years showed a lot of commitment and dedication towards their organisations and the field of practice. They explained the reasons why they loved the work they did. This included the stability and job security they felt when staying at the same place for many years. Swartz, Tiamiyu and Dwyer (2007) agreed that there are individual differences in coping responses of social workers. Furthermore, that more experienced social workers had more resilience to cope with work stress and burnout. The one participant even indicated that this was the difference she had seen with the 'new generation social workers' who only stayed for a maximum of two years and then felt the need to be exposed to a number of different fields of social work practice. Three of the participants indicated that they wanted to specialize in one field and become a subject matter expert. Two of the participants felt that it was a personal calling for them and demonstrated their passion for their work by stating that they were "hooked to addicts" and "addicted to the addicts". The reward of making a difference to even one person's life was another reason given by two of the participants for continuing to work in the substance abuse field.

4.3 THE PROFILE OF THE CLIENT POPULATION

4.3.1 Profile of Clients: Reasons for Staff Turnover

The personal factors discussed in this research report indicated that there were positive and negative effects on the participants that were working with substance abusers and their families. The negative effects could influence social workers to such an extent that they would resign. The negative affects were mainly caused by the high relapse rate of substance abuse clients that affected the social worker's self esteem and self worth. This in turn led to the social worker experiencing negative feelings such as a sense of helplessness; anger; frustration; insecurity and inadequacy. The type of client population social workers dealt with in this field were sometimes abusive especially when their dysfunctional behaviours were confronted and could cause work stress. One participant found it difficult to confront clients due to the social work profession being caring and supportive. These feelings that were evoked led to further stress and even burnout when they were prolonged over a period of time. Da Costa (2001) explained that there were intra-subjective responses to compassion fatigue such as feelings of helplessness, vulnerability and anger caused by problematic and demanding clients. It was also found that all of the participants felt that their personal views of substance abuse had changed for the better after working in the field. Table 13 highlights the negative affects that were identified by some of the participants.

Table 13: Negative Affects of Working with Substance Abusers on the Social Worker

NEGATIVE AFFECTS OF WORKING WITH SUBSTANCE ABUSERS	QUOTES FROM THE PARTICIPANTS
The poor recovery rate and high relapse rate of clients affects the self esteem of the social Worker	*"It really did affect me, it played with my self esteem…, it just dropped…it became low."* *"That is what happened to me you do want to see the end result and the end result must be a positive one. So if it's a negative one then 'something is wrong with me'."* *"I know some social workers will take it personally when a patient relapses, they think it's their fault or they did not do enough. That happens a lot with young social workers and they take it personally. And then I have to tell them that it's part of a whole scenario here…addiction".*
The clients that relapse evokes negative feelings in	*"I become angry…anger and frustration…a lot of frustration."* *" I think it's a feeling of powerlessness. I think it's powerlessness on the one hand and on the*

the social worker	*other hand sometimes I want to shake them to do the work".* *"Initially when I was very young and new at the job, I felt personally responsible, I felt I did not do enough and just very insecure…but also them (the clients) are not giving of themselves and not interested in changing…all those attitudes of them (by the social workers), they don't want to come right, once an addict always an addict and then you miss the bigger picture."* *"Happiness sometimes especially when a client is so violent and they leave…so the feeling is one of joy 'Okay, minus one problem'."*
Display similar behaviour as substance abuser	*"So it affects me because I sometimes get into their pattern also and I'm confused at some stages and I'm mad at some stages because this is a mad house and then I become mad as well. Sometimes I do something then when I look at it I say 'what have I done?' It affects me."*
Working with substance abusers causes stress and burnout	*"I think that you take it a lot more personal, these problems and it can lead to a lot of stress in the interim. You take the stress home but I knew that I could help the people to a certain extend but you can't change maybe all the problems."* *"I think I measured all my inputs and all the work I did against their recovery and if they did not come clean I saw it as me doing something wrong. Or that I look at something you know that feeling that they effects were completely in vain…I think this is where also the burnout and stress comes in because you give and give and give and you expect some result and now I realize that it's not like that."* *"Then at a stage I did not want to see another addict in my life because I thought 'this is just a waist of time'. And I did take a break from work and then I realized the helplessness was there…you work and work, you put so much in but if you measure what you get out if you expect them to stay clean for your effects I think you are going to come short all the time."* *"It's tiring, emotionally tiring. And could be as a result of them (the social workers that have left) doing something different."*
Social workers feel abused and uncomfortable when confronting the destructive behaviour of clients	*"That confrontation and aggression of the people and sometimes they can be very aggressive with you. That can unsettle me not… Then I feel sometimes a bit shaky… I think there is amount of abuse we suffer from our clients and their parents. You see it makes me nervous, that stresses me out. You have to be calm and contain yourself but afterwards you feel tired but you also learn to cope with it."* *"You go through times were you are feeling really abused from clients or their families, they forget that you are people".* *"Sometimes when a person is aggressive then it becomes difficult for me to confront that behaviour, because I fear for my safety."*

The social worker has very few rewards and work satisfaction due to the high relapse rate of substance abusers.	*"You put so much in but if you measure what you get out, if you expect them to stay clean for your effects I think you are going to come short all the time."*

Four of the participants that had been in the field for many years had identified the changes in the profile of clients. This had increased the challenges for social workers especially as more specific and specialized skills and knowledge that were needed to effectively treat substance abuse. The participants agreed that the clients have become more challenging over the years of practice due to the complex nature of their problems.

One social worker with extensive experience in the substance abuse field highlighted the changes she had seen in the patient population over the years by stating:
"I always say that when I started years ago it was straight forward alcohol problems, but if you look at the nature of the problems these days, the alcohol patient and especially the drug patient have complicated problems and traumatic experiences… problems are more complicated and not just a straight forward alcohol problem, drug problem but sometimes personality problems, or very difficult circumstances at home and physical abuse and sexual abuse. So, that is the problem it is as if the problems have become more complicated."

One social worker attributed these changes to the stress experienced by people due to the various systems that impacted on the individual like work and family relationships:
"It seems as if they are becoming more and more complicated. I'm not sure exactly what it is but it's as if the clients…have a range of problems…I think it's stress. It is as if there is more and more stress and with people not working and having family problems. I'm doing a lot of systemic work now and I'm realizing the problem in the whole system and not just with the addict himself."

The high relapse rate of clients had been identified as one of the reasons for people returning for treatment and could have affected the social worker in providing treatment and created a sense of helplessness.

A senior social worker emphasised the revolving-door-syndrome by saying:
"I think you sometimes have a patient who has been in a whole lot of other treatment centres then I get this feeling of 'in what way can I help this person because he was in so many rehabs already and I'm sure other therapists already tried every single thing so what will I do different that can make a change'…They come back all the time but also no motivation from the patient's side and they are so passive and they just come and they go out and come. To me that's difficult for me."

The following two quotes indicated that clients diagnosed with depression caused feelings of frustration and helplessness in the social worker:
"I'll rather work with someone that's aggressive or…but as long as there is some energy. But these people that is so passive or has no energy…that's difficult cases for me if they just sit. These people are so passive. It's really a challenge to me."

A social worker that had one year experience and had undergone external training, felt more empowered to deal with these problems displayed by clients:
"I always have a fear of working with patients that are depressed and now I have one. I just thought that this is one of the patients that a really did not want to work with because I did not know what to do. I just know that they are depressed and don't see anything positive and then to sit with a person… I feel helpless."

In this respect it should be noted that the addictive behaviours of clients could be very destructive and needed to be confronted to create change of such behaviour, but the response of the client could be one of aggression because they had been 'caught out'. They could direct their anger towards the social worker causing uncomfortable feelings.

One senior social worker expressed her discomfort when confronting clients:
"There are a lot of disciplinary meetings with patients when people are doing drugs or drug on the premises or what ever. And that's the part of my work that I don't like."

One of the entry-level social workers identified that working with African men was difficult as they do not express their feelings and emotions. This could be attributed to cultural constraints experienced by the clients:
"The frustrating part that I do the multi-language groups that is our African patients and at time our African men and therapy, they don't go hand in hand…everything it fine with our men even though

they are not fine…and at times you have to get to understand how's a person what are the issues and challenges this person is facing to be able to help…you find that it's difficult for patients to talk about their inner most feelings, frustrations and challenges. Even in group sessions at time, it's quite difficult for them. When you talk about name your feelings, what is it, what does that mean, difficult to get the emotion, name of the emotion. It's something that our men are not used to doing."

Some clients were referred by their workplaces due to disciplinary processes. This could create a distrust of the social worker. The client could view the social worker as being on the side of the employer as one social worker experienced:
"And I think that another thing could also be that they were referred to the clinic by their employer and maybe the report, what will be written in the report, although I will say that our files are confidential… I would still specify what things that will go into the report."

A senior social worker expressed the challenge of patients not attending aftercare:
"Alcoholics don't trust and by the time you have build one they have to go out and they don't always come back for aftercare."

The following quote from one of the participants emphasised the challenges and negative effects that influenced the staff turnover of social workers in the substance abuse field:
"Like I said the work is more…the demands are higher these days and I think also contributed to people leaving now they feel that this is too much now where they can work at another place where the work is not that demanding."

4.3.2 Profile of Clients: Reasons for Retention

The participants identified a number of reasons for staying in the field due to the positive experiences and lessons they have learned from working with the substance abuse client group. For example, it had challenged their previous personal perceptions and attitudes about substance abusers and even created insights in terms of their own gratitude; their acceptance of others; their own survival techniques; empathy and understanding of others. Working with this client population provided some level of job satisfaction especially when change occurred and people stayed 'sober' or 'clean'. That was the reward for working in the substance abuse field.

Table 14: Positive Effects of Working with Substance Abusers for the Social Worker

POSITIVE EFFECTS OF WORKING WITH SUBSTANCE ABUSERS	QUOTES FROM THE PARTICIPANTS
The social worker's own attitudes and beliefs changed over time	*"…it has changed because from an outside perspective we think that people are alcoholics because that they want to be alcoholics. It's a choice they make to drink, but we don't realize that at times they really want to stop but they have lost control of their lives. So, this has shown me that at a certain point they have become powerless, the disease has taken over their lives and they also want to stop but they don't know how."* *"It has in the sense…I'm more accommodating, I'm more empathetic of people that has a problem of alcoholism and I'm able to share information as well."* *"It (attitudes and perceptions) changed the fact that I look at substance abuse differently from what I did before even 10 years back. I always say 'I'm addicted to the addiction field'."*
Learned about other fields of practice	*"And I have learned much wider than addiction, other life problems. So it's actually gave me experience in so many other fields."*
Insights into the social worker's own attitudes and beliefs such as gratitude, acceptance of individual differences, survival and love	*"…to be grateful for what I have and be a bit more patient with people and know that some people have really difficult problems and I have a bit more of an understanding and empathy with people's problems that even when they do relapse, then not to get angry with a person 'what did you do wrong, why can't you stay sober' but have an understanding for some people are really struggling and they don't have the opportunities or circumstances that you have."* *"I've learned that I actually have incredible patience that I thought I never had because I'm often experienced as a very impatient person and basic love for the people and if you don't have that you can't work with them. They test that love all the time."* *"I think maybe it has helped me also to understand that people are different. So I must also learn from other people and listen to other people. People look at things differently so I'm not always right or my perception of things is not always the only perception. So I must have a bit of a broader outlook to accommodate other people's point of view or how they experience things."*
Understanding of addictive	*"I realized how much I have learned from them. They have given me insights. I realized that I could think exactly how they do and that's why it was easier to get to the bottom of things. I*

behaviours	*went back and I thought it's actually the diversity and the excitement of the work. It's never any monotony."*
The survival instincts of substance abusers	*"You know in total, I'm going to say very positively. Because I have learned a lot from the patients. I've learned about their survival, the things they've been through, the things they've done, the things that has happened to them and they survived. It's absolutely incredible."*
Job satisfaction	*"I love working in group set ups and if I see shifts and changes happening it confirms to me that people deep down people can change if they want to."*
Rewards of clients staying 'sober' and 'clean'	*"There's quiet a few people staying sober for many years and that's a reward to see that people have changed and that they stay sober. I try to focus on there and if there are many relapses then I think "what on earth am I doing here?" But I think it's also important to have the balance and see that there are also people making it, staying sober for a long time. I think that is one of the benefits if you stay long then you have the people who stay a long time sober. That's the reward or see that something that you have started, is working."*
Diversity of the work	*"It's the diversity of the work, the diversity of the patients. That there is not one that's the same. Even if you work with addiction, the basic ideas and the theories. It really differs. And every new person is a new reality coming into your world."* *"I realized how much I have learned from them. They have taught me insights they have given me also communicating with me… I went back and I thought it's actually the diversity and the excitement of the work. It's never any monotony."*

4.4 CAREER DEVELOPMENT AND OPPORTUNITIES

4.4.1 Career Development: Reasons for Staff Turnover

Two of the participants had private practices and the one participant used her practice to supplement her salary at the organization. The other participant, a junior social worker felt that she, needed a variety of different experiences in other fields to gain as much knowledge and skills needed for future work opportunities. One of the participant even felt that there were more opportunities available for newly qualified social workers in communities, the public and the private sectors.

One senior social worker made this observation:

"…But I think in later years I don't know if it's the profile of patients changing or the work getting more challenging or if it's just a new generation. I think the new generation they also don't stay that long

and I think they move more from place to place and need more experience from different kind of jobs and different organisations. So I think maybe it's both."

4.4.2 Career Development: Reasons for Retention

Three of the participants explained that they stayed in the substance abuse field because they wanted to specialize in one field**.** Furthermore, they gained a lot of work experience in different interventions due to substance abuse being linked to other social problems such as trauma and abuse.

One senior social worker acknowledged the variety of skills and knowledge gained through the years: *"So it's actually gave me experience in so many other fields when people specialize in addiction."*

4.5 EFFECTS OF STAFF TURNOVER ON THE ORGANISATION, THE STAFF AND CLIENTS

One of the four organisations had not experienced staff turnover due to the social workers being at the organization for 10 years and more. Three of the organisations had experienced a high staff turnover rate. Table 15 shows some of the effects that staff turnover had on three of the organisations and the participants:

Table 15: Effects of Staff Turnover on the Organisation, Colleagues and Social Worker

Impact on Organisations	Impact on Colleagues	Impact on the Individual
Recruitment and training of new staff is time consuming and costly.	Remaining staff has higher work loads. *"And at that time it was pressure because they had difficulty in replacing that social worker. So the case load was extremely high during that period and I was learning and getting to know what was happening around here. It was quite a challenging time for the first three months."*	Evokes uncomfortable feeling in the staff that has resigned
New staff members take a number of months to contribute fully to the programme *"So people come here they first needs in-service*	Remaining staff members feel overworked and experience burnout *"It is a bit of more stress also because there is a vacancy for awhile and people must do the work and you must try and deliver the same quality of*	*"It's a guilt that I'm letting my colleagues down."*

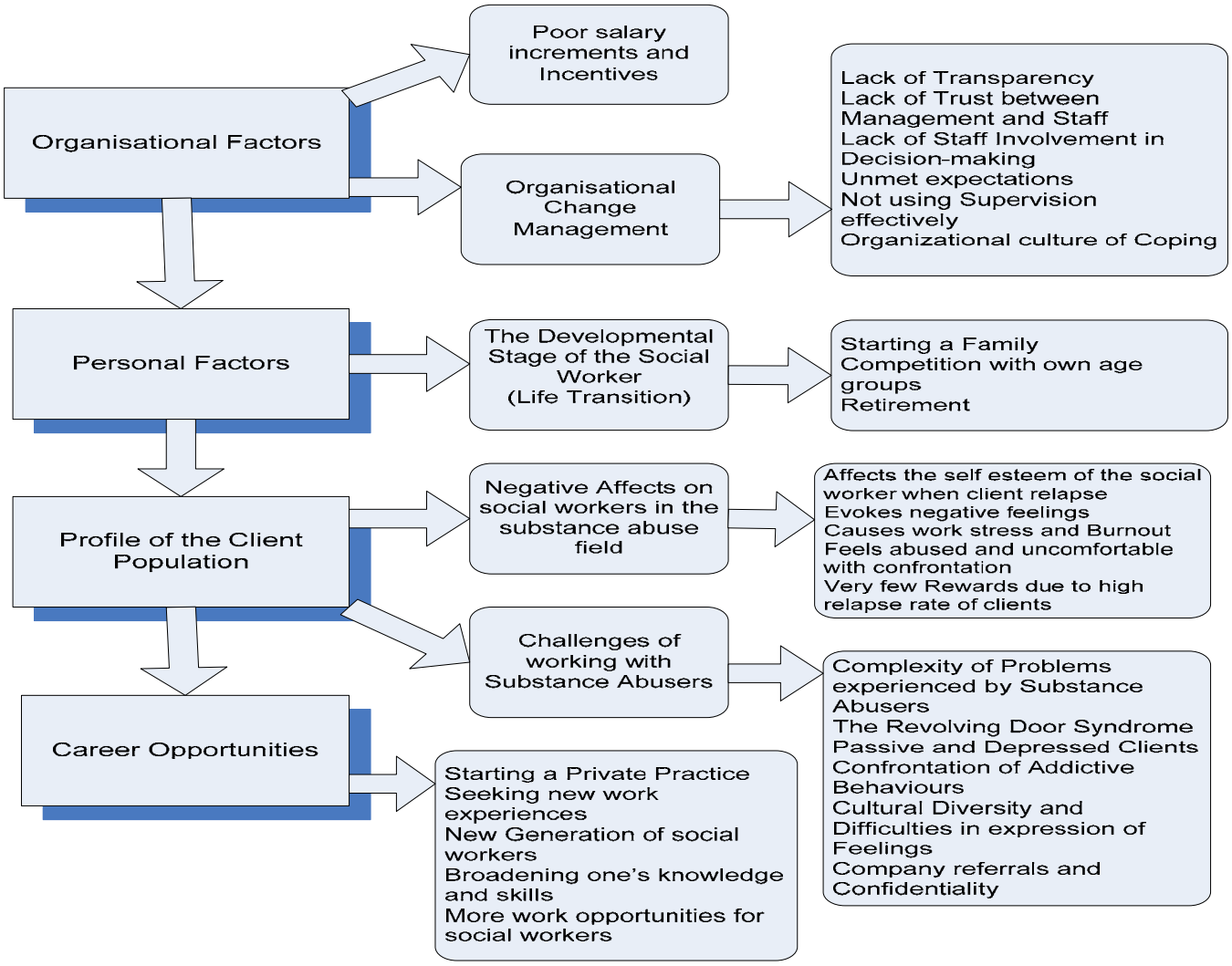
training, that takes time so that takes like two… three months before they can take their own group and go on."	*service.*	
Additional time is spent by management to create healthy team dynamics and a "safe" environment	Remaining staff members feel insecure and overwhelmed	*"…one of our very good therapist…she never spoke and we did not realize how stressed she was and she out of the blue resigned and she left. That was a huge loss and she battled with the same thing, she's going to drop me and the other colleagues."*
New social workers will need intensive training in substance abuse for a further two to three months before they are fully operational staff members.	Team dynamics affected *"So it's a bit unfair to me some times if you have new people all the time and a job to do it and now there is a new one in the team. And that takes time to just sort it out with each other again and form a team again."*	
Affects the Quality of Work *"I think it's got an effect on the quality of work because if you now have to train a new person, it takes time and especially people with a general introduction to substance abuse at University."*	Evokes Uncomfortable Feelings in Existing Staff *"I get more used to people going and coming and going. But still it's like a disappointment. This one is gone and now you have to train the new one."*	

5. BURNOUT AND WORK STRESS OF SOCIAL WORKERS IN THE SUBSTANCE ABUSE FIELD

5.1 SUMMARY OF THE CAUSES OF WORK STRESS AND BURNOUT

All four of the previously mentioned factors could potentially influence staff turnover and retention of social workers. The challenges faced by social workers in the substance abuse field could lead to work stress and eventually burnout. Work stress and burnout could in turn affect a social worker's decision to leave or stay in the field. Figure 4 below displays a summary of these possible causes of work stress and burnout:

Figure 4:
Summary of the Causes of Work Stress and Burnout for Social Workers in the Substance Abuse Field



5.2 EFFECTS OF WORK STRESS AND BURNOUT ON THE SOCIAL WORKER

All the participants indicated that they knew about burnout and some of them even acknowledged displaying some of the signs and symptoms of burnout. The effects of burnout included emotional effects; physical effects; social effects between work and home life and even affected the work performances of the social workers interviewed.

5.2.1 Personal Effects on the Social Worker

Cherniss (1980) and Coulshed and Mullender (2001) acknowledged that demanding or problematic clients could contribute to burnout of social workers. Moreover, Cooper et al (2001) identified a reduced sense of personal accomplishment leading to burnout as well as depersonalization of clients and emotional exhaustion. This could explain that the high relapse rate of clients affects the social worker's self esteem and self worth as they often doubt their own abilities and skills. They might even measure and compare their own inputs against the successes and recovery of their clients that reinforces these negative feelings about their own self worth. This was identified by most of the participants to have occurred when they were young, inexperienced and new to the substance abuse field.

This quote was from one of the newly qualified social workers when they first experienced a relapse of a client:
"It really did affect me, especially…you know…it played with my esteem now…my self esteem, it just dropped…it became low. Doubt obviously brings chaos… you doubt yourself there is chaos. But I think I lacked understanding of the field totally"

A senior social worker confirmed experiencing the same response when she started working:
"…at that stage I think I measured all my inputs and all the work I did against their recovery and if they did not come clean I saw it as me doing something wrong. Or that I look at something you know that feeling that they effects were completely in vain… I think this is where also the burnout and stress comes in because you give and give and give and you expect some result and now I realize that it's not like that."

Life changing events in the social worker's own life could affect the balance between work and home such as the birth of a child. The demands placed on the social worker by her partner and children could also add to the stress experienced by them.

The retired social worker reported that she experienced burnout symptoms during the work-home interface period:
"I did not have the (burnout) symptoms for the first 5-6 years… I think the first time was when my first child was born and I was studying for 7 years while I was working."

One young social worker highlighted the demands from her family:
"… when they (children) want to play, they just want your attention. So I have to do what ever I need to do with them and then when they are all asleep I would quickly do one or two reports so that I could finish…So it was basically the sleeping, giving attention and getting to everyone at that time."

The support systems at home play a vital role in the coping of the social worker with the demands of the job.

The husband of one social worker experienced negative feelings due to the work stress his wife was experiencing:
"(Conflict at work) It had quiet a strong impact… I think the husband felt helpless and he got mad at times. When I came home and start to moan and complain and when…officially he did not want to hear that…you know men comes with the solution…so change your job."

One of the entry-level social workers tried to cope with the pressure and work stress by taking work home and not being able to separate work and home from each other:
"When you are at home and then you remember a particular case where you did not do one-two-three. I don't like taking files home but it was during that period I took a lot of files home that I wanted to update the reports because we have a specific period by when the reports had to be handed in and that the file needed to be closed. So, it was quite a lot of pressure at that time. So most of the time I took work home and I would work late and come in early. It was that type of situation."

Chirness (1980) and Pines, Aronson and Kafry (cited in da Costa, 2001) identified burnout as a risk for people working in the helping professions. These authors explained the physical, mental and emotional symptoms experienced by a person with burnout. The following two verbatim quotations confirmed that physical and emotional strain was taken by the two participants:

Burnout could also lead to social isolation as a way to cope with the negative impact of the stress on the individual as reported by one senior social worker:
"You know just not switching off, not sleeping well…and it made me kind of withdraw from friends and home like weekends, I just want to stay at home and charge my battery and not socialize. So I've actually saw less and less of my friends that is not good."

The one participant reported severe physical affects of work stress that had permanent affects on her health:

"I became so exhausted and I ended up getting pneumonia and that was the first time in my life that I had pneumonia, never had it before…And that is when I did not recover at all and it actually affected my heart muscles. I was very ill. I can relate the stress to …exactly, because when it was pneumonia again I thought 'what is it that is taking my breath away?'…but physically as well beside the other stuff, more aches and pains and stuff like that. You know, all sort of…you go to bed, 'why is my leg sore?' and miraculously it happens to disappear when you've had leave."

5.2.2 Work Performance

Some of the participants indicated that they labeled and depersonalized the clients in that they started to make general assumptions about the clients and did not focus on the individual qualities and attributes of each person. Cooper et al (2001) identified that depersonalization of clients, co-workers and the organization is one of the three components of burnout. The other two components were emotional exhaustion and a reduced sense of accomplishments. The participants identified the impact that work stress and burnout had on work performance with the following quotations:

This quote reflects a senior social worker's burnout symptoms that she identified as:

"…when you start not listening to your patient, not hearing a patient and not listening and they just coming in and out and it's just like routine and your not moving with the process."

The social worker with more than 15 years experience identified that she did not treat each client as an individual:

"So the labeling of people, if you are an addict, the typical behaviour and attitude that you get with an addict…once an addict always an addict."

Some of the participants even reported that they experienced negative feelings towards their colleagues, clients and work due to burnout and work stress. These negative feelings included impatience, intolerance, irritability, anger and de-motivation towards work.

These negative feelings evoked were reported by a senior social worker:

"…emotionally that total… that impatience, the intolerance, not wanting to go to work anymore, can't sleep at night, very difficult to switch off…you know."

The one senior social worker reported that:
"I think initially you don't identify it as burnout. You just feel more stress or more irritated but I think I was at burnout. I think you just get to a stage where you feel I need a break now but in some or other way I coped."

The retired social worker identified her burnout symptoms as:
"I can feel when I'm feeling stressed or get irritated with the people, then I know it's time to get a break. I feel agh, it's just another problem or you get that feeling of I don't want to see this person now, then I know it's time to have a break."

Other burnout symptoms were explained by a senior social worker as:
"…emotionally, I could feel myself just constantly feeling angry and irritated with the patients and the staff. I became quiet intolerable of people around me. You know that feeling that I'm loosing control so I'm trying so hard to get control and then control slips away any way. I did not have much patience with the staff or the patients. I had to really fight hard to keep my professionality because sometimes you just want to explode and tell them something but you know you can't. I did slip one day but I was under immense stress and it had quiet big repercussions."

One senior social worker experienced motivation difficulties:
"I just could feel that I'm waking up but I don't want to wake up. When you don't look forward to the day because you see so much. It's a long day and a lot of things needs to get done but there's little time to do it. I just felt I had actually had enough and I just knew that it's too much and I had the feeling that I was a bit burned out."

5.3 COPING STRATEGIES AND SELF CARE STRATEGIES TO CURB WORK STRESS AND BURNOUT

Ross and Deverell (2004) and Eckenrode (1991) emphasised the various coping responses focusing on changing the problem and/or changing the emotions, feelings and thoughts that the stress had evoked. All seven of the participants provided the interviewer with examples of their coping strategies that they used when they experienced work stress and burnout. Most of the coping strategies were self care strategies that could be used by the social worker to effectively reduce stress, set appropriate boundaries at work and use the resources provided by the organisations. Self awareness and social support was seen by Compton, Galaway and Cournoyer (2005) as effective ways for

social workers to reduce work stress. The emphasis here was on a person taking personal responsibility to change their stress responses and utilise coping resources to reduce stress. Four of the participants were aware of the fact that they did not take proper care of themselves although they knew what to do. Here are some of these examples mentioned by the participants:

Table 16: Coping Strategies and Self-Care Strategies for Social Workers

COPING STRATEGIES AND SELF CARE STRATEGIES	QUOTES FROM THE PARTICIPANTS
Annual leave and regular leave	*"So I'm just giving myself more time and space and being kind to myself. I'm thinking if I take leave somebody can replace me, I'm not irreplaceable. I'm not going to really do my colleagues harm because they've left and we've survived. So it's really putting myself in this whole system and be able to look after myself to."* *"I take also regular leave…you just have to take a break from work and renew your energy and come back and do the work again. I think it's very important to look after yourself to know where your own boundaries are and to know when I'm tired or when it's just time to take off even if it's a weekend. I don't think it's always necessary to take formal leave but take a weekend."*
Administration break	*"Sometimes I would take a whole week just to do admin…don't see a patient. I get my files up to date and my reports up to date, I did all that and then it gives me a break because you can't take leave all the time."*
Time keeping and structuring of work	*"To take care of yourself and I think one must also structure your work because I think one could sometimes waste a bit of time by talking here and there. So I think it's important to do what you can during working hours and not just sort of waste some time and then you have to take work home tonight."* *"I think what is important it your time management and your daily planning is vital."*
Setting boundaries for one's work	*"When I was lying in bed I took stock of myself and I said this is it but it's not worth it. Enjoy your work but set your boundaries and I had to do it as well I can't just say that it's due to all of those things. But I knew for me to survive in this thing I've got to set my boundaries very strictly. So go and set your boundaries and make space for yourself… I'm looking after myself more, really doing things that I really want to do."*
Setting boundaries with clients	*"In the in-patients, you've got to have boundaries, because they (clients) barge into your office, and if they see you they ran to you with a question, or when you arrive at work before you put your bag down, they are there... So your boundaries are violated a lot and I think if you are not able to set your boundaries with the clients as well that can also be a case of you know, people just leaving because it can get too much for them."*
Relaxation and physical exercise	*"I try to exercise I enjoy music and listen to music a lot that's my way of relieving stress."* *"Once in a while just have a manicure… no children to think about…no nothing just to be me and enjoy and be pampered."* *"And I also try and go to the gym regularly so I find that also helps me if I can work it out there."* *"Take care of yourself and let somebody pamper you. We keep on telling others that you need to take care of yourself to take care of others, but when it comes to us we drag our feet and make excuses at times that I have to do this, and do that and that I don't have enough time and then at times we tend to devalue ourselves…by just putting everybody first…when you have to do something for yourself you will find that there are things that are needed…your children need attention, your work needs attention, this and that need attention. I'm slowly trying to get rid of that one. When I need to go to my hair salon, I just drop everything and do that, but it*

	takes an effort because there's something that I'm not doing.." *"I think that it's also important that you remember not to work all the time and that you have your time for yourself and take some time that you can relax and that you do things that you like…otherwise I don't think you will survive in this kind of work."* *"I think it's important to have good support systems like family and friends that you can spend time with and relax and enjoy. I always say create magic moments for yourself."*
Supervision	*"You think you must learn more and you must like you said impress and you don't want to fall over and you want to be on the right track. That's also why I say if also our supervisors extend the hand of help, not feeding us but you know…you can feel that you can just come in and say what ever you want to say. Just to extend, verbally and non-verbally, to extend the hand of help so that the people can talk about what is happening. Because if you don't the work suffers."* *"I struggle every day just to see that this is a person that's going through a difficult stage in his life and support is needed. So that's how I cope…is to see a person in an addict."* *"Go there and talk about what's happening, especially your fears…they must talk about their fears, maybe they get a nice supervisor maybe they don't…but talking, raising awareness about their feelings at that stage…I think that person is mature enough to address the issue. Not to bottle up like I did because it kills you inside."*
Group supervision	*"I managed to speak out because also we had group supervision and I realized that it wasn't only me."*
Individual therapy	*"So I thought that self awareness…if you want to do therapy you have to be in therapy yourself, because I don't think that you really know yourself when you are seeing patients and that helped me and that is how I got most of my experience."*
Further education	*"I took that opportunity to take stock of myself and then I decided to enroll for a Master's degree and people said are you crazy. But for me it was a case that I have given so much, I did not have much more to give and by doing this I was going to receive. It's kind of a nurturing thing I created and it was, it really was. You know it wasn't about the workload that went in it. It was just exciting and so nice the stuff that I felt very nourished doing that."* *"I have expanded my knowledge, especially with this Masters and the systems theory and a new world that has opened…including myself."*
Debriefing and support from colleagues	*"I really don't know how I managed that. Sometimes I thought I'm leaving but I just took a look at myself and think that it's a challenge and if I run I will never be able to look at myself and think I'm strong… So I just had support from colleagues that I talked with and my supervisor was also supportive."*
Personal views of stress and coping	*"So I can cope under stress. Hmmm… that's not good always."* *" I think all work has stress and I don't think that it's not a bad thing, because I think if you have no stress so I think degree of stress it's okay because it keeps you going and keeps you on your toes. I think if it's too much of cause then it's a problem but I think all work has stress and change and things."*
Support systems	*"My husband went so far as to say that if it get so bad, he said I don't really have to work. He can support me financially. So I've got my escape routes… it makes it easier to cope there."* *"My husband he understood that it was very difficult for me and he was supportive and he was there for me. Ja, It made life much easier…The knowledge that there's something else if this doesn't work I have something to fall back on that helped me as well. It's not a case of if I loose this job, my life is over. I've got back-ups and that makes it easier as well."* *"I think I formed good support systems and so helps a lot and when I'm away from work I don't take problems in my mind home and think about all these things at home. Of cause sometimes this happens but I really try and focus on other things when I'm at home and not take these problems with me".*
Spirituality	*"And just I'm a believer So most of the time I just prayed for calm and strength and be able to do it."* *"Because if you believe in God you believe that there is change coming…there's a change*

	coming, so something will happen soon thing will happen soon." *"Because one day I just prayed in the traffic I thought please God gets me out of this I don't want to be here anymore. And then I got the offer for another in-patient."* *"I'm very busy at church which I love very much and because of the Christian background that I have, I sing a lot even at work."*
Work-home Interface	*I would never come from work and say okay now today that this and that has happened. I think that I can switch over very easily. People will ask me why you have these sad times at work and all these people's problems don't bug you that you can't sleep. I could shut off. If I leave work I could leave everything behind. I never took work home. I did not do any reports or anything. I kept everything at work. I did not take any work home."*

6. RETENTION STRATEGIES FOR SOCIAL WORKERS IN THE SUBSTANCE ABUSE FIELD

The quantitative data collected from the organisations emphasised the importance of support services to social workers in the substance abuse field. Thompson, Murphy and Stradling (1994) acknowledged the importance of the role that organisations play in supporting social workers to address work stress. Westbrook, Ellis and Ellett (2006) identified some of the organizational strategies which included ensuring professional development of social workers (promotions, supervision, training, salary increases and job variety); effective management and leadership (flexible, proactive, structured); and organizational culture (supportive and caring). This was echoed by the participants during the qualitative data collection interviews. These support services were already implemented by the organisations as discussed in Figure 3 of this research report. However, both the participants and representatives from the organisations suggested that a few more could have been added to the list. The organisations and participants made the following suggestions and recommendations regarding the retention strategies that could assist to keep social workers working in the substance abuse treatment field:

6.1 Management Needs to be Understanding

Management must have an understanding of the helping profession and the therapeutic processes and systems that social workers need to implement. An example was given by the one participant that top management did not understand the purpose of their request for a one-way mirror for family therapy sessions and training of staff and students and it took them a number of years before her request was granted.

6.2 Transparency and Staff Involvement

Management needed to be more participatory and allow for more staff involvement and transparency. It was also identified that social workers need positive feedback to encourage them. One of the

questionnaires noted was that social workers needed to share in the vision of organization's mission and goals. This could be achieved through strategic planning, team building and regular staff meetings with management. The one participant wanted more team building exercises to re-invigorate them and bring them into contact with the outside world other than the world within the treatment centre.

6.3 Conducive Staff Development Policies

One of the causes for the turnover of social workers was attributed to more work opportunities being offered in other sectors. The organization could design staff development policies to assist social workers to attend workshops, seminars and other training opportunities. Organisations should provide skills development and career growth through training, supervision and promotion opportunities.

6.4 Providing a Variety of Tasks for Social Workers

Two participants acknowledged that the organisations where they currently worked allowed them to be creative and develop new services. This kept them interested and stimulated in the field and provided a variety of responsibilities to curb the boredom and monotony they felt in repeating the same tasks.

"I did not let my staff go and do it all the time. I rotated so the one would do group, the other one would do lectures and the other would do admissions. And then we would rotate otherwise you will get burned out and bored."

"Even the places were we work, influences the differences in our lives. Where I'm working now it's like I'm given more opportunities to touch on new things, to explore and come up with new ideas…when I come up with a thing, I'm given the opportunity to stretch and do what ever I want with that and present it as a tangible thing and it is done as long as I'm responsible for that and I'm doing it. So that's what I needed maybe in my life… to be given the room to move around, trying new things, exploring things doing a project on my own."

"So to start something and see it works that is a challenge to me and that also gives me energy and I think that sometimes work not to do the same thing over and over again, but to see the gap and you to start a service there. That also gives me energy, because I think you can get stuck in doing groups every day, seeing patients every day and listening to the same problems, so I think if you could

develop something new or start a new service or do something new or make a change in the programme and not get into that rut of doing the same thing over and over."

"It is also structured because we run a programme but like I say to touch on new things, new avenues…it's more fulfilling."

"I have developed a whole lot of group interventions and stuff to work with. Often you know what if I felt stagnated they have helped me and pushed me in a way or I have allowed them to. So it's been a creative process for me."

6.5 Effective Internal and External supervision

All the participants emphasised the importance of supervision and that if it was used effectively by staff it could be very effective in dealing with work stress and burnout. Effective regular in-house supervision was identified by all of the participants as an opportunity to express uncomfortable feelings raised by clients or the organization; a learning process; and a vital support where they could debrief. The one organization provided group supervision that was used to discuss an academic book on current client-related topics. Two participants expressed their need for an external supervision for debriefing and training of social workers. This person needed to be outside the system to ensure that they remained objective.

"…getting someone outside now, where we get to be us…where we allowed to be just ourselves and talk what ever like I'm doing now even talking about what we are doing wrong in our work and having that person supporting us."

"…an outside facilitator to come and do burnout and stress management and so on. I believe that it must be an outside person, not someone inside…if you're part of that system you can now step out and do the training and then climb back in. So I think if they definitely do…that kind of…you know have an outside consultant."

6.6 Salary Increments and Incentives

All the responses to the interviews and questionnaires supported the need to increase social work salaries as a way to retain these staff in the organisations. Even the Department of Social Development had apparently acknowledged this and adjustments had been made during the past two years to both NPO and Governmental social work salary scales.

6.7 Improved Working Conditions and Environment

One participant mentioned that the physical and emotional work environment can be conducive to reducing work stress. The work environment should be safe, supportive, caring, flexible and have effective communication between all the structures within the organization. One representative from an organisation also indicated that another retention strategy could be the introduction of flexi-time by social workers.

"We are now in the house next to the clinic which is all lovely and peaceful and we made it all therapeutic next to the pool. That actually makes a big difference in my coping because I can actually withdraw from the system. I don't have to be in the main building all the time so we've got peace there."

"It's quite a wonderful environment to work in…the staff is supportive and understanding…everything is fine…the problem is that the salaries are not enough."

7. CONCLUSION

The data analysis revealed interesting and challenging views on the high staff turnover of social workers in the field of substance abuse. The researcher had expected to find that salaries were the main reason for the staff turnover, but this did not seem to be the only reason. The more challenging reasons encompassed the management of organisations; the type of client population; variety of work experiences; and life transitions. Work stress could be caused by the organization, the clients and the social worker themselves due to life transitions, work-home interface and career aspirations. The preparation of social workers to work with the treatment of substances is mainly through on-the-job training. At the time of the study, most of the in-patient treatment centres had a large number of experienced senior social workers that created a large specialized expert base for training of newly qualified social workers. The organisations utilised a variety of strategies to support and train social workers such as induction programmes for new staff; supervision; in-service training; team meetings; salary increases; bonuses and external training courses. Stress and burnout was experienced by some of the participants and the senior social workers displayed healthy self-care strategies to address work stress.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

The retention of social workers was identified as an emergency situation in South Africa that affected all sectors in both governmental departments and non-governmental departments. The impact of the shortage of social workers on the overall service delivery of social work services in South Africa should be explored further in order to determine the impact and effects on the Welfare system of South Africa. The shortages of social workers in the substance abuse field have had a negative impact on providing affordable and accessible clinical and specialised services to substance abusers, their families and their communities. This has left a gap in service delivery in the future for substance abusers and their families.

2. SUMMARY OF THE MAIN FINDINGS AND CONCLUSIONS

The overall aim of this research report was to understand the work experiences, coping and organisational retention of social workers in Gauteng in-patient substance abuse treatment clinics. The in-depth discussion on each of the five objectives addresses the overall aim of this research report. Each objective IS discussed with reference to the main findings collected during the quantitative and qualitative research instruments and the conclusions made.

Objective 1: To explore whether newly qualified social workers are adequately prepared to provide specific services to substance abusers

All the participants felt that they were not adequately prepared during their undergraduate training to work in the substance abuse field when they qualified. They had only received a brief introduction to this specialised practice. Rauch (1993) advocated that social workers need more intense therapeutic skills and knowledge to deal clients who abuse substances. One participant reported that she had utilised her generic skills that she learned during her studies to assist substance abusers by using the strength-based approach. The majority felt they needed more advanced therapeutic skills to provide intense treatment programmes for individuals and their families and felt that it *"… involves a lot of therapeutic work. You need time to work with the patient. You need an understanding of the*

content… It's a specialized field. There are dynamics that are different such as the language is different and your ears are up to catch the stuff that you wouldn't usually know. So it's been a learning experience."

This led to newly qualified social workers having felt inadequate and incompetence due to a lack of therapeutic skills. This in turn affected their self worth and self esteem.

The preparation of social workers when employed at a substance abuse centre appeared to be very effective through induction, orientation, on-the-job training and internal supervision. Coulshed and Mullender (2001) agreed that the management of social workers entailed protecting the staff through supervision, staff development and staff care. Other support services provided to social workers included in-service training; external workshops on substance abuse and generic topics related to substance abuse; case discussions; staff meetings and self studies. It appears that some organisations provided social workers with the appropriate support, guidance and assistance to help curb work stress and burnout.

Objective 2: To explore the coping strategies developed by social workers who are employed for more than 5 years by in-patient substance abuse treatment centres

When comparing the three categories of social workers there were some observations that the researcher made in terms of how uncomfortable feelings and emotions were expressed as well as the manner in which they coped with stress. The participants were all aware of the signs and symptoms of burnout and knew how to reduce stress but did not always take care of themselves. This was captured in this powerful quote from one participant:

"Take care of yourself and let somebody pamper you. We keep on telling others that you need to take care of yourself to take care of others, but when it comes to us we drag our feet and make excuses at times that I have to do this, and do that and that I don't have enough time and then at times we tend to devalue ourselves…".

Social workers with more than five years experience developed resilience and this helped them to stay motivated and focussed on their work and gain personal meaning in their work with substance abusers. The researcher observed differences between the three senior social workers and their stress coping strategies. The hardiness of a person to cope with stress appeared to be linked to their personality and the resources available to them to derive a sense of meaning (Schabracq, Winnumst and Cooper, 2001). The one senior social worker seemed to have developed severe burnout

symptoms that affected her health and even compassion fatigue over a period of time. Da Costa (2001) and Coulshed and Mullender (2001) stated that unsuccessful efforts of the counsellor may have them disengaging from their clients and to eventually experience compassion fatigue or “battle fatigue”. The next quote supported this theory:

“Then at a stage I did not want to see another addict in my life because I thought ‘this is just a waist of time’. And I did take a break from work and then I realized the helplessness was there…you work and work, you put so much in but if you measure what you get out if you expect them to stay clean for your effects I think you are going to come short all the time.”

It was founded that ten (65%) of social workers who had over ten years experience in the substance abuse field indicated that they had developed some resilience to work stress, particularly the challenges of working with substance abusers. Millward (2005) emphasised mastery strategies to cope with stress which included diagnosing the problem and then dealing with the emotions that a stress situation provoked. This could have incorporated both positive and negative coping strategies. Resilience develops over time when a person copes with stress in positive ways (Ross and Deverell, 2004). Resilience was created through self care strategies implemented by the social workers such as exercise, relaxation, regular leave and external support systems. Schwartz, Tiamiyu and Dwyer (2007) indicated that older more experienced social workers had reduced levels of work stress. The senior social worker had a greater understanding of the process of recovery and could understand that relapse was part of recovery. The one senior social worker captured her positive views on stress in this quote:

“ I think all work has stress and I don’t think that it’s not a bad thing, because I think if you have no stress so I think degree of stress it’s okay because it keeps you going and keeps you on your toes. I think if it’s too much of cause then it’s a problem but I think all work has stress and change and things.”

Newly qualified social workers initially saw relapse as a personal reflection on themselves which negatively affected their self worth. This was echoed in the following quote: *“I think I measured all my inputs and all the work I did against their recovery and if they did not come clean I saw it as me doing something wrong. Or that I look at something you know that feeling that the efforts were completely in vain…I think this is where also the burnout and stress comes in because you give and give and give and you expect some result and now I realize that it’s not like that.”*

The combination of their low self worth and lack of therapeutic skills and knowledge leads to them feeling even more incompetent to deal with the complexity of substance abuse. This was confirmed by a younger social worker that felt that *"…you do want to see the end result and the end result must be a positive one. So if it's a negative one then 'something is wrong with me'."*.

A senior social worker has observed the same pattern by stating that:
"I know some social workers will take it personally when a patient relapses, they think it's their fault or they did not do enough. That happens a lot with young social workers and they take it personally. And then I have to tell them that it's part of a whole scenario here…addiction".

Objective 3: To explore the causes and extent of social workers leaving the field of substance abuse treatment

The extent of the staff turnover experienced in the field of substance abuse confirmed the high turnover of social workers with between two and five years experience of having worked in the substance abuse field. The majority seemed to stay for the first year and again after five years of working in the substance abuse field. Weaver, Chang, Clark and Rhee (2007) stated that new social workers left between one and three years of working. The social workers who stayed for many years limit the promotion opportunities for newly qualified social workers social worker. This could be one of the reasons that affected the retention of social workers. Drenth, Thierry and de Wolff (1998) and Fontana (1993) identified poor remuneration and promotion prospects as reasons for work stress and burnout. The transfer of skills and knowledge offered excellent training opportunities for newly qualified social workers due to a very strong basis formed by the existing experienced social workers. Westbrook, Ellis and Ellett (2006) called staff turnover loss of human capital for organisations. The concern would be that with the rapid turnover of social workers this would leave a skills gap in the next ten to fifteen years when these experienced senior social workers retired.

The organisations and social workers that participated in the research report identified the reasons for and the impact of staff turnover on the organisations and colleagues. The reasons for staff turnover were classified in four categories namely organisational factors such as poor salaries and incentives, organisational change management and organisational culture of coping. Fontana (1993) confirmed some of these organisational causes such as leadership styles, career opportunities, lack of job variety and powerlessness to influence decision-making. Westbrook, Ellis and Ellett (2006) and Simons and Jankowski (2008) attributed the problems of staff retention to inadequate compensation;

ineffective management and policies; complexity of the client population and inadequate training, lack of supervision and support for social workers. One senior social worker felt that a lack of trust developed between management and staff that led to her resignation:
"…a lot of resentment and you feel that you are not trusted enough. Why did not they trust you enough to tell you that this is what going on? What did they think you would do? There is no trust now between management and staff."

Another senior social worker felt excluded from decision-making:
"So there was a lot of decisions been made without mutual consultations and I found that the social workers, we were excluded quiet a lot from decisions. So you find a lot of isolation taking place. And it is as if the medical staff is not really interested in the therapeutic side."

The compensation of work is often linked to the meaning a person gives to their work such as, fulfilling their basic needs, reduces their anxiety to survive and motivates a person to perform and creates a sense of job satisfaction (Drenth, Thierry and de Wolff, 1998). The opposite occurs when people do not receive adequate compensation for their survival and creates a decrease in motivation and job satisfaction. The poor salaries of social workers were identified by most of the participants as a reason for the high staff turnover:

"One of the mayor things that makes people move around, especially young people…is the fact that our profession doesn't give us a salary that we are able to live on. It's not enough. You could do a job that you love but the challenge is that at the end of the month when you can't pay your bills and you can't pay everything, you have to juggle your bills or your standard of living has to be at a certain point if you are to say that you are surviving. That's the challenge that our organization is facing".

The second category that was identified incorporated personal factors such as the developmental life stage that the social worker was in. The life transition that a social worker was faced with could influence the sustainability of the social worker in a specific organisation, especially when they compared themselves with their peer groups. This was explained by this one participant:
"I'm thinking that 10 years ago I never thought I would be still be earning this. You think and you hope that you be at a certain point…there are certain things that you don't have that people of your age group or people that you studied with at the same university, the same year different courses that they have progressed three times more than you have. So the issue is valuing the progress in terms of material but also looking at if I'm happy at the job".

The profile of the client population was a third category and focussed on the challenges that were experienced in working with substance abusers. Collins (1990) attributed some of the challenges to high case loads; reduced financial resources; lack of adequate training; difficult clients; utilisation of the medical approach to treatment and lastly the high relapse rate of clients. This study supported Collin's (1990) findings and in particular participants identified the high relapse rate of clients and the complexity of problems were:

"Like I said the work is more…the demands are higher these days and I think also contributed to people leaving now they feel that this is too much now where they can work at another place where the work is not that demanding."

The social worker needed a wider range of knowledge and skills to deal with substance abuse:

"…when I started years ago it was straight forward alcohol problems, but if you look at the nature of the problems these days, the alcohol patient and especially the drug patient have complicated problems and traumatic experiences… problems are more complicated and not just a straight forward alcohol problem, drug problem but sometimes personality problems, or very difficult circumstances at home and physical abuse and sexual abuse. So, that is the problem it is as if the problems have become more complicated."

Newly qualified social workers' need for career development also contributed to staff turnover.

The impact of these resignations on the organisation, colleagues and individual social workers, were identified by the representatives of the organisations and participants as having had financial, emotional and physical affects on all three sub groups. The organisation was financially affected when they had to recruit and train new social workers which in turn affected the quality of services provided to clients. One participant felt that new social workers took up to three months before they were optimally productive and contributed to the treatment programme:

"So people come here they first needs in-service training, that takes time so that takes like two… three months before they can take their own group and go on".

During the time of adjustment and training of the new comers, the senior social workers had higher case loads and might have experienced increased burnout symptoms such as feeling overwhelmed, overworked, insecure and uncomfortable feelings towards new comers. This could have also resulted in some of them leaving.

"And at that time it was pressure because they had difficulty in replacing that social worker. So the case load was extremely high during that period and I was learning and getting to know what was happening around here. It was quite a challenging time for the first three months".

This in turn strained the team dynamics so that this needed to be addressed by management to ensure healthy team work. One social worker summed it up by saying: *"So it's a bit unfair to me some times if you have new people all the time and a job to do it and now there is a new one in the team. And that takes time to just sort it out with each other again and form a team again".*

The feelings towards new comers to the organization were often strained as was reflected in this following quote*: "I get more used to people going and coming and going. But still it's like a disappointment. This one is gone and now you have to train the new one".* This in turn affected the welcoming of new staff into the organization as discussed by Grobler, Warnick, Carrell, Elbert and Hatfield (2002).

The individual that resigned also experienced uncomfortable feelings of letting their colleagues down. This created a sense of guilt for leaving and could have contributed to the culture of coping experienced in helping organisations. This is illustrated by the following quote: *"…one of our very good therapist…she never spoke and we did not realize how stressed she was and she out of the blue resigned and she left. That was a huge loss and she battled with the same thing, she's going to drop me and the other colleagues."*

The culture of coping may have also prevented social workers experiencing burnout from dealing with this during supervision. Coulshed and Mullender (2001) identified that poor management styles often led to a culture of stress which was characterised by: unrealistic expectations; too little or no supervision; non-supportive supervision; expected to woadditional hours; poor or no motivation; and little support to staff that are stressed themselves. The organisational culture is the collective group identity, internal integration or social glue and external image to outsiders (Drenth, Thierry and de Wolff, 1998).

"…cope is the thing, where I am, you know…just cope. It was said to me once to by a senior …and to your detriment as well and as long as other people don't see you not coping… It's a very strong message…I've realized now is kind of the theme, you know, you must cope and when you are not coping that is the last thing you want to hear…I was loosing my own identify because I can't just get stuck in a group identity because then where am I. There's a lot about sacrificing and everything there."

The one senior social worker explained the culture of coping as:

"There is a very strong, can I say, group identity of work and do as much as you can and work till you drop…I think lead to sometimes as well, people feeling bad if their not coping and they don't say anything. They tolerate it but it's a very unspoken rule as well, give it all, as much as you can because there is…often we have spoken about it you know it's tolerated because it has to be, sick leave and stuff, but you also pick up that there is not really that much tolerance. So there is an overt message that we tolerate it but covertly the feeling is that it's not tolerated. Ja, and it's what you say you feel guilty for take leave or go on a holiday."

The senior social workers provided a number of positive reasons that they remained in the field; their own perceptions and attitudes towards substance abusers; learning about related fields of practice; developing insights into own beliefs and gratitude; rewarding when clients stay sober and clean; and the diversity of the work.

"It's the diversity of the work, the diversity of the patients. That there is not one that's the same. Even if you work with addiction, the basic ideas and the theories. It really differs. And every new person is a new reality coming into your world."

Objective 4: To identify and compare the similarities and differences of work experiences and coping strategies between social workers from the following three categories: newly qualified social workers, more experienced social workers and social workers who had left the profession

The younger generation social worker's choices to specialise in a specific field such as substance abuse and their job satisfaction were strongly influenced by financial gain and rewards. This was different from the views of the older generation of social workers that saw social work as a 'calling' or a spiritual process of altruism. The young social worker had a hunger for exploring different social work practices and gaining more skills and knowledge that could be utilised in any environment. This could be attributed to the focus of undergraduate studies and the White Paper highlighted community development as the future intervention method of social work practice. Fields such as substance abuse still needed strong therapeutic interventions and newly qualified social workers were not fully equipped with the therapeutic skills and knowledge to function effectively in a therapeutic setting. This challenged the self worth and the competence of the young social worker, which often led them

to resign. This combined with the poor rewards received such as salaries and low success rates with clients became a lethal combination and often resulted in newly qualified social workers resignations. Schwartz, Tiamiyu and Dwyer (2007) agreed that newly qualified social workers are more vulnerable to work stress as they experience lower personal accomplishments; more psychological strain and stress; more depersonalisation of clients; less psychological resilience and have lower job mastery skills than more experienced social workers. The findings of this study supports the effort-reward Imbalance Model explaining that high effort with low rewards led to work stress (Furnham, 2005). These rewards were measured in terms of monetary, self-esteem and career opportunities for the employee.

"You put so much in but if you measure what you get out, if you expect them to stay clean for your effects I think you are going to come short all the time."

Many social workers did not use the supervision provided as they felt embarrassed to acknowledge their short-comings. This made it more difficult for the organisation to support newly qualified social workers during their adjustment period. One participant acknowledged this by saying "*… what was more disturbing was not talking about what I felt at that time because a person that was teaching me the job I couldn't come out and say that 'I'm not doing well'. I was afraid of that."*

Differences in the coping strategies were important to note as it seemed that the social workers with more work experience had developed a support system both at work and at home to cope with the challenges and stress caused by working with substance abusers. The newly qualified social worker did not have the support systems at home due to the stage of their life that they were in. Another observation from the interviews was that the older social workers showed more defence mechanisms when it came to them sharing uncomfortable emotions and feelings and it took a longer time for the researcher to extract these emotions and feelings. This could also be ascribed to the culture of coping that had been instilled in the social workers with more experience. This was different with the newly qualified social workers as they were open about feeling incompetent and other negative feelings. The personal experiences or views of substance abuse had since changed as reported by the social workers that were interviewed. These changes had been positive and created an understanding of substance abuse as a disease instead of a willpower issue and that the circumstances or social problems are strong reasons for the onset of substance abuse.

Objective 5: To formulate recommendations based on these findings with respect to retaining social workers in the field of substance abuse in-patient treatment.

Organisations appeared to have provided the supportive activities to the social workers. The retention of social workers was not only linked to their remuneration but other factors played a role such as 'personal calling' to work in the field and support of colleagues. The organisation on a macro level could support the social worker by lobbying for higher salaries with the Department of Social Services and by designing and implementation of self-care and staff development policies that addresses aspects stress management, promotion opportunities, strategic planning and performance management. The workplace could further motivate and stimulate social workers by creating variety in the work they do and encourage creativity to design new programmes or groups. The physical work environment was mentioned as an important factor that organisations should focus on to create a comfortable space for social workers. The gaps identified on the macro level by this study include transformation of management in terms of promotion opportunities for newly qualified social workers and ineffective change management: lack of transparency and participative management. Another important observation during the research was that there was a culture of coping created in some of the organisations did not allow for social workers to deal with burnout and stress in a constructive way. This enforced the message that social workers were not allowed to show human emotions. Some of the social workers portrayed signs of burnout and stress during the interviews that led to their resignation. The organisation could on a meso level develop prevention strategies for stress and burnout such as effective in-house and on-the-job training through group supervision, group debriefing, team building and in-service training. Socialisation strategies to integrate new comers to the substance abuse field through induction and orientation programmes are important to create team work and healthy team dynamics. The development of the social worker's knowledge and skills is another retention strategy to increase the social workers competency and self-worth through in-house and external training workshops, courses and conferences. The micro level retention strategies include supervision and coaching of social workers not only to provide education but to support and guide newly qualified social workers.

3. RECOMMENDATIONS

RECOMMENDATIONS FOR PRACTICE

The following recommendations to Universities include:

- *Pre-screening of social work students*- The selection and screening of social work students seem to be important to ensure that the profession of social work survive. The pre-screening of students to determine suitability for the profession could involve resilience to stress; expectations and reasons for entering the profession and personality type testing. Some Universities offer social worker as an extra subject for other professional fields such as psychology and sociology meaning that not all students will continue obtaining their honours degree in social work and practice as a social worker. This hampers the screening process of social workers;
- *Providing more intensive training on therapeutic skills*- This may assist to address the demanding social problems experienced in South Africa. The substance abuse field and other fields such as child abuse, domestic violence, HIV/Aids and crime prevention need specific knowledge and skills applicable to each field in order to provide appropriate micro and meso therapeutic interventions;
- *Specialisation*- Allowing for subject choices during fourth year to specialise in a specific area or field of practice. Although this is an recommendation, there might be practical limitations with specialisation at undergraduate level which are it might limit the already scares skills of social workers in providing services in a wide range of communities and workplaces making the social work profession diverse and adaptable to deal with any social problem. This is especially appropriate in light of the shortage of social workers currently experienced in South Africa and specialisation might even limit social workers even further; and
- *Individual therapy for students*-Lastly, encouraging individual therapy for students to identify their own self defences, to create self awareness around counter transference and transference issues that might develop in a therapeutic relationship between the counsellor and the client and their personal limitations when it comes to providing therapeutic services to clients.

RECOMMENDATIONS FOR ORGANISATIONS

Organisations play a vital role in the retention of social workers in the substance abuse field and need to explore the following:

- *Their management style, organisational culture and the impact upon employees*- the management style needs to be conducive to encourage participation of staff in decision-making and open communication between management and staff to build a relationship of trust and transparency;
- *Effective change management*- change management is part of the management of NGOs in that organisations are more business orientated than welfare orientated to ensure financial sustainability, stability and security. Change management processes need to be implemented and consider the individual staff members response to change, ensuring that social workers understand the purpose and benefits of change and participate in creating positive change;
- *Advocacy and lobbying*- The poor salaries of social workers were identified as the biggest reason for staff turnover and advocacy and lobbying is needed to encourage competitive salaries for social workers in acknowledgement of their academic qualifications;
- *Explore own organisational culture*- The organisational culture of coping can mask and even contribute to burnout and work stress of social workers. The culture of caring that is portrayed to clients should be transferred to the social workers as they need the same care as what they give to their clients. This can be done through staff development policies that encourage self-care strategies and professional development of social workers;
- *The supervision of social workers*- This has an educational, administrative and supportive function for the social worker. This process can assist to identify and explore the extent of work stress and burnout of the supervisee and implement stress-reduction interventions, namely regular leave, teambuilding, debriefings with external supervisor, team meetings; and
- *Contingency planning and risk management*- This is needed to ensure that senior social workers transfer skills to newly qualified social workers and create promotion opportunities for them.

RECOMMENDATIONS FOR SOCIAL WORKERS

The social worker is responsible for developing resilience and mastering skills to increase their coping and reduce work stress. These mastering skills include:

- *Self awareness of the social worker's* -This is needed to identify internal and external factors that contribute to work stress. This self awareness can be obtained through educational lectures and/or personal developmental workshops and/or supervision on work stress and burnout.
- *Explore own coping responses and coping resources*- Social workers need to realise that there are personal differences to how people respond to stress and explore their own coping responses and coping resources during individual therapy and/or supervision. These internal factors can be attributed to the personality type of the social worker; the life transition stage that they are experiencing; the age of the social worker; and resilience and coping strategies adopted to reduce stress;
- *Learn self care/ coping strategies*- These internal factors can be mastered through relaxation, time management and finding personal meaning to work with substance abusers. Furthermore, the social worker needs to be aware of external or environmental factors that could impact on burnout and work stress. These factors are not always in the control of the social worker such as life changing events, support systems and organisational changes or culture can increase or reduce work stress. The way that the social worker responds or address these situations differ and allows for developing skills such as effective communication skills, conflict resolution, assertiveness, setting boundaries, setting goals and ;
- *Education and information on substance abuse* – Substance abuse education is important to understand the disease of addiction, where relapse fit into the recovery process and what therapeutic interventions can be used with clients. The social worker would learn that relapse is part of recovery and not a personal reflection on the social worker;
- *Balancing work and home*- The work-home interface has changes for all women during the years and currently there is more pressure on women to be the primary bread winner of the family especially because there are a lot of single-parent family systems. The social worker needs to explore healthy ways of balancing their personal and professional roles through flexi-time; supportive family, friendship and colleague structures and relationships; utilising supervision at work; reliable child care services and quality self care strategies.

RECOMMENDATIONS FOR THEORY

The Figure 6 indicates the factors, causes and strategies to deal with the retention of social workers in the substance abuse field of practice. The stages of the diagram create an understanding of the challenges that organisations and social workers need to be aware of when developing retention strategies.

The model is divided into five stages that described the preparation and introduction of social work students and social workers to the substance abuse field; the challenges and work experiences they face when working in the field; and the social workers coping strategies to deal with work stress which led either to retention or staff turnover.

Stage 1 described the reasons why social work students became involved in the substance abuse field and indicated that an interest might be born either from: a personal experience; a belief about substance abusers or through practical placements of students at substance abuse treatment centres. The personal experiences, attitudes and beliefs could possibly also negatively influence the social work student's choice, views and/or perceptions about working with substance abusers. Most social workers accidentally become involved as they sought a work opportunity and didn't specifically want to work in this field of practice. Some viewed working in this field as a calling such as described by senior social workers with many years of work experience. Some of the newly qualified social workers might develop a professional interest for this specialised field, but most might see it as a stepping stone to gain the additional therapeutic and group work skills they might not have received adequately during their undergraduate studies.

Stage 2 indicated that the new social work possibly needed extra attention and intense additional therapeutic and group work skills and specialised knowledge on the treatment of substance abuse provided through induction or orientation programmes offered by organisations. During this stage, the new social worker might have needed to be eased into the field to prevent them feeling overwhelmed with difficult or high case loads. The problem could possibly arise when the organisation is in crisis mode and might struggle to replace social workers for a long time. The more experienced social workers felt overworked and were under a lot or pressure. The new social worker was often seen to assist to reduce the pressure experienced in the organisation. New comers possibly needed time to adjust to the organisational culture; the overt and covert socialisation messages; the change in the team dynamics with a new comer on board; a demanding and difficult client population. This client

population did not always want the help offered by the social worker and had a high relapse rate. Supervision could have played a vital role during the initial adjustment stage and needed to be more pro-active and educational to prepare the new social worker for different situations and encourage personal growth as well as professional maturity.

Stage 3 identified the factors that led to either retention or turnover of social workers at organisations. The external environmental influences also impacted on the organisations: more stringent expectations and demands from governmental departments and policies to address the increasing demands from communities and to transform services to comply with the changes implied by the new democracy and policies of equity and transformation of welfare services. These challenged the leadership of organisations to be diverse and to or castrate change. Subsequently social workers may have felt excluded and unwelcome in organisations due to management focussing on crisis management. The perceived negative views from society towards the social work profession could have further affected and reduced the number of social work students enrolling, which caused a shortage of practitioners able to implement programmes to address the increasing social problems experienced in communities. In addition, the pressure from society to become successful is often measured by monetary value instead of the emotional rewards of altruism and helping a fellow human being as described by the senior social workers. Furthermore, significant changes in the views of work between different generations could have resulted in newly qualified social workers needing constant variety and change in their work experiences. The work-home interface could further have impacted upon single parent families requiring higher paid employment. They needed to cope with the economic pressures of increasing costs of living. The developmental stage of the social worker also influenced social workers to seek alternative employment, such as where there were less work demands so that they could focus on family demands.

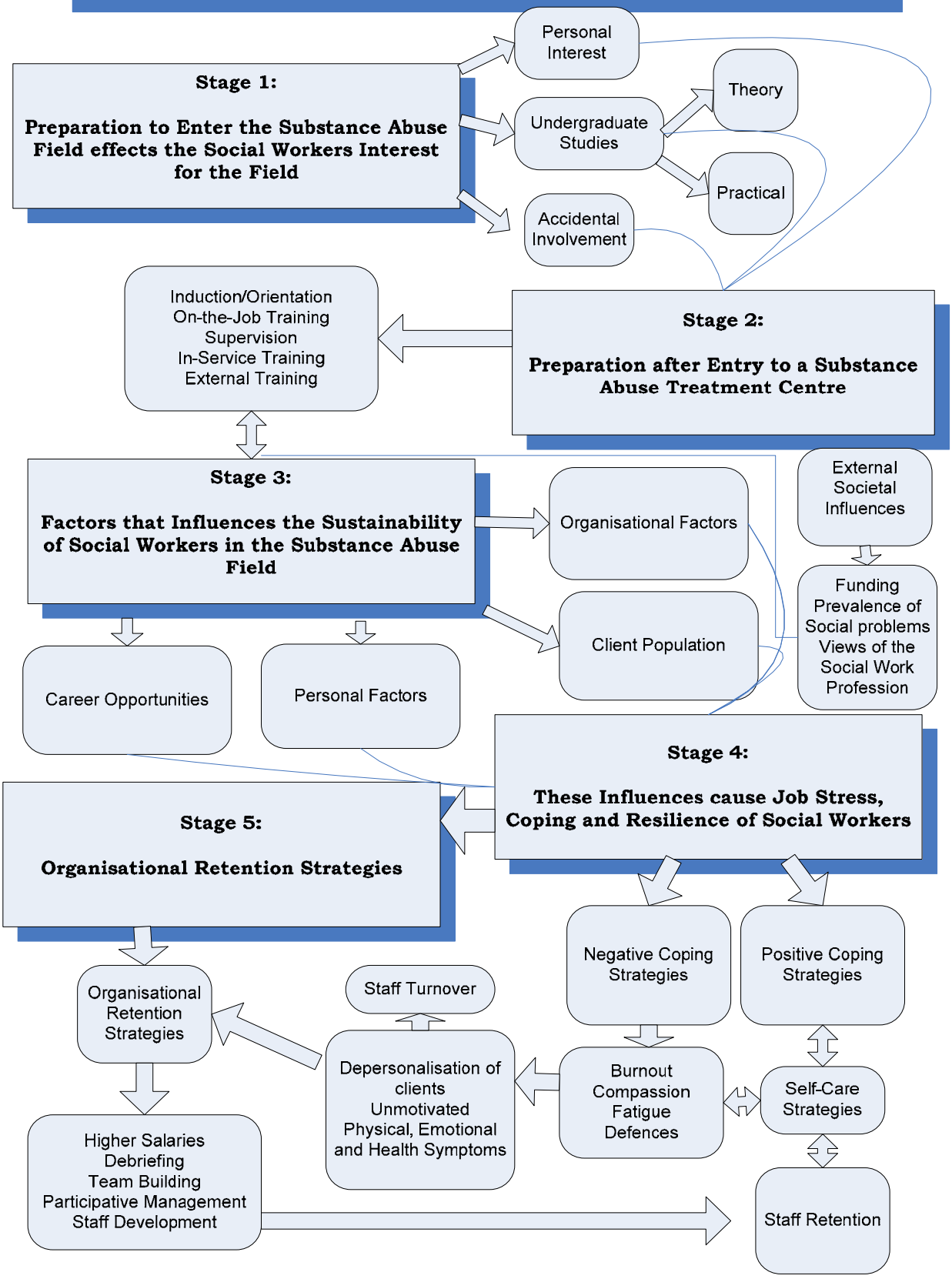
Stage 4 focussed on the possible flight and/or flight reactions and responses of social workers to the various factors identified influence the retention and turnover of social workers. Therefore, this model mainly supports Seyle's theory on reducing the stress by either addressing it head on (fight response) or avoiding (flight response) the stress situation. The social worker will appraise the stress situation and depending in the degree of the threat chose a fight or flight reaction. The social worker may have had to take personal responsibility for the ways they choose to react to the challenges and work pressures of working in the substance abuse field. This also depended on the personality and coping strategies of the social worker. It appeared that the more experienced social workers had developed more resilience and coping to deal with works stress through self care strategies. This

could have explained the reason for their retention. More experienced social workers may also have had more opportunities to develop self awareness regarding their own personal burnout signs and symptoms. They could implement strategies to reduce work stress and also experienced professional rewards when clients stayed ‘sober’ and ‘clean’. There might be negative coping strategies displayed by the senior social workers that are more difficult to detect such as generalisation of addiction, depersonalisation of the client population, disillusioned and pessimistic about recovery of clients and even being harder and stricter with clients. These senior social workers might influence the views and enthusiasm of newly qualified social workers and could even be closed to new ideas and treatment approaches. Long-term and consistent burnout and compassion fatigue symptoms might eventually affect the staff retention of social workers.

Stage 5 identified possible organisational retention strategies which implied that organisations should take responsibility to reduce or even curb staff turnover. These retention strategies could include support and assistance to social workers in terms of debriefing; individual and group supervision; internal- and external training; team building; participative management; diversity and change management; organisational culture; socialisation of new comers; promotion opportunities; competitive salaries and benefits; job variety and design; job appraisals and acknowledgement of achievements and staff development policies and programmes. Some of these retention strategies were not the sole responsibility of the organisation. Governmental departments also needed to focus on creating opportunities for organisations to implement some of these strategies: competitive salaries; study bursaries for both government and NGO sectors; improvement of the working conditions of social workers (resources) and promotion of the social work profession to communities.

This model could also be used in any social work field of practice to demonstrate the challenges the social work profession has faced in terms of staff turnover not only in the NGO sector, but even in Government departments. As social work was a scares skill, many other countries such as the United Kingdom, New Zealand and Australia employed them leading to permanent or temporary emigration. The model also demonstrated the challenges faced by other social work fields such as child welfare, domestic violence, crime prevention and HIV/Aids.

Figure 5:
RETENTION MODEL FOR SOCIAL WORKERS IN THE SUBSTANCE ABUSE FIELD



RECOMMENDATIONS FOR FUTURE RESEARCH

The following recommendations are made for future research:

- A literature review of the South African research on substance abuse highlighted gaps in terms of research exploring the impact that working with substance abusers had on the helper as compared to other fields such as HIV/Aids, where this was well documented and researched;
- This research report further indicated that research is needed on how the characteristics of a specific client population could affect the organisational dynamics, management styles, organisational culture of coping and management responses of organisations. Future research could link these two variables, the organisation and the client population, and explore correlations and differences;
- The impact of the high staff turnover of social workers on the future of social welfare services in South Africa needs to be examined to determine the survival of social work as a profession. Moreover, the impact of the high turnover rates on service delivery to people needing social work services needs to be explored. The general public's opinions and understanding of the role of social workers are not well known and research will indicate whether there is a future for the social work profession;
- The retention strategies for social workers adopted at the Social Development Indaba (2006) need further investigation and evaluated;
- The future of clinical social work needs to be explored as this field of social work practice appears to be disappearing; and
- The generational gaps between younger and older social workers could be an interesting study to determine what these gaps might be and what impact it might have on the social work profession. These gaps could include changing jobs frequently; job security; loyalty and commitment; job satisfaction differs; coping strategies and resilience and impact of life transitions.

4. CONCLUSION

This research report did manage to proof all five of the objectives as set out in the beginning of the study and explored the richness of the work experiences of the social workers during the in-depth interviews as well as from the side of the organisations through questionnaires. The retention of social workers is influenced by a number of factors but the most important factor had to do with feeling valued and acknowledged as a social work profession not only in terms of remuneration but also in terms of specialised skills and services that can only be performed by this profession. The influence of the clients on the social worker has both positive and negative affects depending on the personal experiences and outlook of the social worker as a person. The organisation further has a role to play in motivating and supporting social workers and to create a nurturing and caring environment for social workers. The resilience and coping of senior social workers are not always that affective and there are situations that call for extra care and support. When comparing the three levels of social workers, it seems that there are generational gaps in terms of how job changes are viewed from the younger and older social workers perceptions.

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APPENDIX A: QUESTIONNAIRE FOR ORGANISATIONS

QUESTIONNAIRE

IN-PATIENT SUBSTANCE ABUSE TREATMENT CENTRES WITHIN GAUTENG

Questionnaire No:_____
Date received:_____
Organisation's Code: _____

SECTION A: ORGANISATIONAL DETAILS

1. Type of Organisation

Please tick with an X to indicate which one describes your organization.

State Rehabilitation Centre	SANCA Affiliated Clinic	Not-for Profit Organisation (NPO)	Other

Please specify if you have answered Other:_____

2. Length of Programme

Please tick with an X to indicate which one of the categories below describes the treatment programme offered by your organization

Detoxification programmes	28-day programme	6 weeks programme	Three months programme

SECTION B: STATISTICS

3. Profile of Social Workers

Please complete the following table to provide the number of social workers currently employed at your organization.

No. of Entry Social workers between 0-12 months experience	No. of social workers with 13 months to 2 years experience in the field	No. of social workers with 2 years to five years experience in the field	No. of social workers with 5 years to 10 years experience in the field	No. of social workers with 10 years and more experience in the field

4. What is the average caseload per social worker? _____

5. How many social work posts are available in your organization?

Entry Social work Posts	Senior Social Work posts	Chief social work posts	Management social work posts

No. of Entry Social workers between 0-12 months experience	No. of social workers with 13 months to 2 years experience in the field	No. of social workers with 2 years to five years experience in the field	No. of social workers with 5 years to 10 years experience in the field	No. of social workers with 10 years and more experience in the field

6. Number of Vacant Posts

Please complete the following table to provide the number of social workers posts that are currently vacant at your organization.

No. of Entry Social workers between 0-12 months experience	No. of social workers with 13 months to 2 years experience in the field	No. of social workers with 2 years to five years experience in the field	No. of social workers with 5 years to 10 years experience in the field	No. of social workers with 10 years and more experience in the field

7. Number of Social Workers that have left

Please complete the following table to provide the number of social workers that have left your organization in the last two years.

SECTION C: THE REASONS FOR STAFF TURNOVER

8. What do you think are some of the reasons for social workers leaving the field of in-patient substance abuse treatment centres?

_____
_____
_____
_____
_____

9. Have you perceived any impact on the organization due to staff turnover of social workers? Circle your answer YES / NO

10. Please motivate your answer in the previous question.

_____
_____
_____
_____

_____
_____
_____
_____

SECTION D: RETAINING OF SOCIAL WORKERS

11. What can organisations do to retain social workers in the field of substance abuse treatment?

_____
_____
_____
_____
_____
_____
_____
_____

12. The organization offers the following to their social workers:

Please tick where applicable to your organization.

Induction		**On-the job training**	
Orientation		**In-service training**	
Internal Supervision (Individual)		**Formal external training workshops**	
Internal Supervision (Peer group)		**Team building**	
External supervision		**Bonuses and performance incentives**	
Annual salary increases		**Staff performance appraisals**	
OTHER:		**OTHER:**	

Thank you for your participation in this research report!

APPENDIX B: IN-DEPTH INTERVIEW SCHEDULE FOR PARTICIPANTS

INTERVIEW SCHEDULE

DATE OF INTERVIEW:_____
LENGTH OF INTERVIEW:_____
CATEGORY:_____
VENUE:_____
PSEUDO NAME: _____

SECTION A: PERSONAL DATA
In this section, I will ask a number of questions relating to personal factors which might influence your work experiences.

1. GENDER M F
2. ETHNIC GROUP BLACK COLOURED ASIAN WHITE
3. AGE
4. HOME LANGUAGE
5. RELIGION / DENOMINATION
6. EDUCATION:

UNIVERSITY ATTENDED:
YEAR GRADUATED
DEGREE ATTAINED

WHAT ATTRACTED YOU TO THIS LINE OF WORK?

DO YOU FEEL THAT YOU WERE PREPARED FOR WHAT YOU HAD TO FACE?

HOW HAS WORKING WITH SUBSTANCE ABUSERS AFFECTED YOUR LIFE?

HOW HAVE YOU MANAGED SO FAR?

WHAT DO YOU THINK NEEDS TO CHANGE ON ALL LEVELS?

APPENDIX C: LETTER OF PERMISSION TO PILOT QUESTIONNAIRE

From: Carol du Toit [lulama@mweb.co.za]
Sent: 02 October 2006 12:25 PM
To: 'Adrie'
Subject: FW: Research : Work experiences and retention of social workers in in-patient treatment centres

Dear Adrie

Herewith completed questionnaire, as requested.

I thought that the questions were very clear and relevant to the research topic. The questionnaire did not take me long to complete after our admin person had given me the stats you required – approx 30 minutes. The time spent on getting together the stats will depend on how the organization arranges their internal records, so I think that this will be difficult for you to estimate. Probably 30 minutes max.

Good luck with the research!

Kind regards
Carol

From: Adrie [mailto:adrie.v@sanca-jhb.org.za]
Sent: 04 September 2006 02:07 PM
To: 'Carol du Toit'
Subject: RE: Research : Work experiences and retention of social workers in in-patient treatment centres

Hi Carol

Thank you for assisting me with my research. Can I please ask you to time yourself and tell me how long it took to complete and can you please give me feedback on the clarity and relevance of the questions.

Enjoy your day
Adrie

> -----Original Message-----
> **From:** Carol du Toit [mailto:lulama@mweb.co.za]
> **Sent:** Monday, August 28, 2006 2:11 PM
> **To:** 'Adrie'
> **Subject:** RE: Research : Work experiences and retention of social workers in in-patient treatment centres
>
> Dear Adrie
>
> Sure.
>
> Kind regards
> Carol

> **From:** Adrie [mailto:adrie.v@sanca-jhb.org.za]
> **Sent:** 25 August 2006 02:59 PM
> **To:** 'Carol du Toit'
> **Subject:** RE: Research : Work experiences and retention of social workers in in-patient treatment centres
>
> Dear Carol

I had a supervision meeting yesterday and it was decided that I will only send through my research questionnaire for you to pilot because with the qualitative interview, it will differ from person-to-person. So can I please send you my research questionnaire via e-mail to fill in?

Thanks for your prompt reply and enjoy the weekend
Adrie

-----Original Message-----
From: Carol du Toit [mailto:lulama@mweb.co.za]
Sent: Thursday, August 24, 2006 2:59 PM
To: 'Adrie'
Subject: Research : Work experiences and retention of social workers in in-patient treatment centres

Dear Adrie

Further to your request in the above regard, we confirm that it would be in order for you to pilot your research questionnaire at Lulama Treatment Centre. Please would you contact us with regard to possible dates for your visit to our Centre in order that we can arrange a mutually convenient time.

Kind regards
Carol du Toit
Director : SANCA Durban Alcohol and Drug Centres

APPENDIX D: RESEARCH BRIEF FOR ORGANISATIONAL REPRESENTATIVES

INFORMATION SHEET

FOR THE ORGANISATIONS

ATTENTION: Director

TEL NO:

FAX NO:

Dear Director

RE: PERMISSION FOR CONDUCTING RESEARCH WITH SOCIAL WORKERS

My name is Adrie Vermeulen and I'm currently registered for a Master of Arts Degree in Industrial Social Work at the University of the Witwatersrand, Johannesburg. It is part of my degree requirement to conduct a research dissertation. I have a keen interest in conducting a research study that will document the work experiences of social workers working in the treatment of substance abuse. My interest in this topic comes from a personal place as I am working in the field of substance abuse for the last ten years with SANCA Johannesburg and have my own understanding of what the daily challenges are in dealing with this client system.

The aim of the study is to identify the work experiences of, coping strategies and demands placed on social workers that are working in the field of treatment of substance abuse.

This study will be a qualitative-quantitative research design and will be using an interview schedule (qualitative instrument) to collect the relevant data from the identified social workers. The first sample will be selected only from treatment centres registered with the Department of Social Services that fall within the provincial boundaries of Gauteng. The sample size consists out of 9 participants that are selected out of each category, namely three each from entry social workers, experienced social workers and social workers that have left the field. The second sample consists out of the organisations and a short questionnaire (quantitative instrument) will be posted to the various directors to establish the extent of and the impact that staff turnover has on this field.

I am requesting your cooperation in providing me with the relevant permission to approach your social work staff members at a staff meeting to present them with my proposal and request their voluntary participation to this study. Further, I will need the organization to allow the voluntary participants from the organization to set aside a mutually appropriate time and a secure space for the conducting of the interviews that are between 60-70 minutes long. Please advise your staff that not all the volunteers that come forward might be selected as participants to the research as it is just a small sample that will be purposively selected.

The ethical issues that might arise are:

- Confidentiality will be strictly adhered to so that staff will feel free to express their views and opinions.
- All raw data will be strictly confidential and will be destroyed after submission of the bound dissertation.
- Some of the questions in the interview schedule might evoke some past traumas and strong feelings. In such cases the researcher has contracted with a senior social worker from SANCA JHB to assist with providing debriefing sessions to participants where necessary at no cost to the participant.

The organization and the participants will be invited to a feedback session after completion of the research at one of the Gauteng Substance Abuse Forum meetings to present the general findings and provide possible recommendations.

Please be so kind as to inform me in writing as to whether or not your organization would be willing to participate so that arrangements for the presentation can be made by signing the attached consent form. Should you not wish to participate however and I would be grateful for a written response.

Your assistance and cooperation will be greatly appreciated in conducting this exciting research.

Yours sincerely

_____	_____
Adrie Vermeulen	Francine Davies
Student No: 0516704G	Research Supervisor
	WITS: School of Social Work

APPENDIX E: CONSENT FORM TO CONDUCT INTERVIEWS AND MEETINGS ON-SITE

CONSENT FORM FOR ON-SITE MEETINGS AND INTERVIEWS

I, _____(NAME AND SURNAME) in my capacity as _____(POSITION) of _____ (NAME OF ORGANISATION) hereby give permission for the following:

- That Adrie Vermeulen can conduct her research on the " Understanding of the Work Experiences, Coping and Organisational Support of Social Workers in Gauteng In-patient Substance abuse treatment centres";
- That the director will make themselves available for a 20 to 30 minutes meeting with Adrie Vermeulen to discuss the purpose, objectives and overview of the research;
- That the director will arrange for a 30 minutes staff meeting on the same day for the social workers to be briefed on the research;
- That the director understand that if a social worker from their organization is selected, they will be seen in a safe and quiet environment at the organization for the in-depth interview lasting 60 to 80 minutes or even longer.
- The director gives permission for the secretary of the organization to contact these social workers that have left the organization to ask them permission for the researcher to contact them to ensure confidentiality.

Signed at _____(PLACE) on the _____day of _____2006.

_____ _____

NAME OF DIRECTOR SIGNATURE

APPENDIX F: PARTICIPANT INFORMATION SHEET

SUBJECT INFORMATION SHEET FOR THE SOCIAL WORKERS

Dear Social Worker

Research Title:

"To Understand the Work Experiences, Coping and Organisational Retention of Social Workers in Gauteng In-patient Substance abuse treatment centres"

My name is Adrie Vermeulen and I'm currently registered for a Master of Arts Degree in Industrial Social Work at the University of the Witwatersrand, Johannesburg. It is part of my degree requirement to conduct a research dissertation. I have a keen interest in conducting a research study that will document the work experiences of social workers working in the treatment of substance abuse. My interest in this topic comes from a personal place as I have been working in the field of substance abuse for the last ten years with SANCA Johannesburg and have my own understanding of what the daily challenges are in dealing with this client system.

The aim of the study is to identify the work experiences of, coping strategies, and demands placed on social workers that are working in the field of treatment of substance abuse.

This study will be a qualitative-quantitative research design and will be using a short questionnaire (quantitative instrument) that will be handed to the director of the organization to be completed. The questionnaire will provide statistical data to establish the extent of and the impact that staff turnover has on this field. The researcher will then also use in-depth qualitative interviews with purposive randomly selected social workers to create an understanding for their work experiences.

Please take note that not all social workers that agree to participate might be selected as I'm using a small sample size of 9 participants. Then in-depth interviews (qualitative instrument) of 60 to 80 minutes will be conducted to gain an understanding for the challenges these social workers face in working or having worked with substance abusers. The three participants will be randomly selected from of each category, namely

- Three entry level social workers within the first year of working,
- Three social workers with more than five years work experience and
- Three social workers that have left the field after an 18 months period.

The ethical issues that might arise will be dealt with in the following ways:

- Confidentiality will be strictly adhered to so that staff will feel free to express their views and opinions and all raw data will be strictly confidential and will be destroyed after submission of the bound dissertation. Pseudo names for individual social workers and codes for organisations will be used on all the documents.
- The director will have to give permission for the secretary of the organization to contact these social workers that have left the organization to ask them permission for the researcher to contact them to ensure confidentiality.

- Some of the participants might express a need for debriefing after the in-depth interviews and in such cases the researcher has contracted with a senior social worker from SANCA JHB to assist with providing debriefing sessions to participants where necessary at no cost to the participant. The participant can be referred for long-term counseling by the debriefing counselor.
- Informed consent from the organisations and participants must be in writing and any organization and/or social worker can decide to not be part of the research at any stage of the process without prejudice.
- The research will make an abstract of the research results available to the participants and the organisations after the completion of the study.

Steps to Give Informed Consent:

1) Please complete the Consent form in the sealed envelop that you received at the staff meeting;
2) Fax through your consent form to Adrie Vermeulen at (011) 726-4735 before the said date on the Consent Form and
3) The researcher will telephonically contact you to make the arrangements for the interview.

Your assistance and cooperation will be greatly appreciated in conducting this exciting research.

Yours sincerely

_____ _____

Adrie Vermeulen
Student No: 0516704G

Francine Davies
Research Supervisor
WITS: School of Social Work

ADDENDIX G: INTERVIEW AND RECORDING CONSENT FORM

CONSENT FORM: IN-DEPTH INTERVIEW AND RECORDING

I, _____ (full name) have read the attached brief, and have attended a presentation about the research of Adrie Vermeulen on the work experiences of Social Workers in the substance abuse field.

I understand that my participation in this study is entirely voluntary and that I may withdraw my participation at any point.

By signing this form, I agree to participate in this study and agree that my in-depth interview will be recorded to ensure accurate representation of the data collected. I can be contacted on the following numbers in order to arrange interview times:

Telephone number: _____

Fax number: _____

e-mail: _____

Signed on the _____ day of _____ 2006.

_____ _____

NAME OF PARTICIPANT SIGNATURE

APPENDIX H: LETTER OF PERMISSION FROM SENIOR SOCIAL WORKER

SANCA (JHB) SOCIETY

Out-patient treatment Centre

35 Plantation Road, Rossmore, 2092. PO Box 6041, Johannesburg, 2000
Tel:+27 11 726 4210/01 Fax: +27 11 482 6183.
E-mail: sanca @ sanca-jhb.org.za Practice Number: 047 001 005 1268

In association with The Centre for Alcohol and Drug Studies, Johannesburg-Out-Patient Clinic

17th August 2006

TO WHOM IT MAY CONCERN

Dear Sir/Madam

RE: PERMISSION FOR DEBRIEFING OF SOCIAL WORKERS

I am employed at SANCA (JHB) Society as a senior social worker and have over eight (8) years experience in the field of substance abuse treatment. I was briefed about the research project of Adrie Vermeulen to explore the work experiences of social workers in the field. I think it is a highly appropriate study as I have experienced the high staff turnover in our own organisation.

I hereby give my permission to provide debriefing sessions to the participants that will be interviewed by Adrie Vermeulen.

Please don't hesitate to contact me for any further information.

Yours truly

_____

Frani van Rooyen
Senior Social Worker
SANCA JHB Society

APPENDIX I: RESEARCH BRIEF FOR SOCIAL WORKERS

RESEARCH BRIEF FOR THE SOCIAL WORKERS

Dear Social Worker

My name is Adrie Vermeulen and I'm currently registered for a Master of Arts Degree in Industrial Social Work at the University of the Witwatersrand, Johannesburg. It is part of my degree requirement to conduct a research dissertation. I have a keen interest in conducting a research study that will document the work experiences of social workers working in the treatment of substance abuse. My interest in this topic comes from a personal place as I am working in the field of substance abuse for the last ten years with SANCA Johannesburg and have my own understanding of what the daily challenges are in dealing with this client system.

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I am requesting your voluntary participation in my study to be able to achieve my objectives to understand your working experiences in the field.

It will require the following:

- You signing the consent form to indicate your voluntary participation in the research;
- Making yourself available for two (2) hours for an interview with the researcher, Adrie;
- After the interview, the researcher might contact you to clarify or verify some of your responses;
- That not all social workers that volunteer might be selected as the sample size is very small (4).

The ethical issues that might arise are:

- Confidentiality will be strictly adhered to so that staff will feel free to express their views and opinions.
- All raw data will be strictly confidential and will be destroyed after submission of the bound dissertation.

- Some of the questions in the interview schedule might evoke some past traumas and strong feelings. In such cases the researcher has contracted with a senior social worker from SANCA JHB to assist with providing debriefing sessions to participants where necessary at no cost to the participant.

The organization and the participants will be invited to a feedback session after completion of the research at one of the Gauteng Substance Abuse Forum meetings to present the general findings and provide possible recommendations.

Your assistance and cooperation will be greatly appreciated in conducting this exciting research.

Yours sincerely

Adrie Vermeulen
Student No: 0516704G

Francine Davies
Research Supervisor
WITS: School of Social Work