Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder

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DECLARATION

I, Jonathan Cupido, declare that this dissertation titled "**Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder**" is my own work and all sources that were utilised have been acknowledged in-text and in the reference list.

This dissertation is being submitted for a Master of Social Work degree in the Faculty of Community and Health Sciences, Department of Social Work at the University of the Western Cape. This work has never been submitted to any other institution for examination.

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ABSTRACT

Substance use and abuse is a global problem that impact the person, the family, community, and society at large. Continuous abuse of substances may result in substance use disorders (SUDs). Changes to the brain, withdrawal symptoms, cravings, as well as repeated unsuccessful attempts to cease the use of substances, contribute to persons with a SUD being unmotivated and resistant to entering treatment. The Transtheoretical Model (TTM) of Change has been identified as framework that could assist social workers to support the development of internal motivation, and thereby voluntary participation in treatment options. However, it is not known how social workers utilise this framework, what their experiences with the use of the TTM are, and what challenges they experience within the South African context. Thus, this study aimed to explore and describe the experiences of social workers regarding the use of the TTM of Change in involuntary treatment of a SUD in the Western Cape.

The study was conducted from a constructivist paradigm and followed a qualitative approach, and framed by a combination of the contextual, explorative, and descriptive research designs. Non-probability purposive sampling was used to select registered social workers in the Western Cape who had experience in the field of SUD. Individual semi-structured interviews were employed to collect the data, which was analysed through Tesch's (in Creswell, 2014) eight steps for qualitative data analysis. The data was verified through the criteria of credibility, transferability, dependability, confirmability and reflexivity. Ethical considerations included avoidance of harm, debriefing, voluntary participation, informed consent, privacy, anonymity, confidentiality, and the management of the research data. The findings highlighted the practice experiences of the participants, their perceptions of voluntary and involuntary treatment, and their perceptions and experiences of those aspects within the different stages of the TTM that may support social workers to guide involuntary clients towards a motivation for change.

KEYWORDS: Social Work, Involuntary Treatment, Services, Substances, Substance Use Disorder (SUD), and Transtheoretical Model (TTM) of Change.

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This study is dedicated to all previous, current and future clients and their families that are struggling with substance use disorders.

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
APA	American Psychiatric Association
CDA	Central Drug Authority
COVID-19	Coronavirus
DBE	Department of Basic Education
DPME	Department of Planning, Monitoring and Evaluation
DSD	Department of Social Development
FAS	Foetal Alcohol Syndrome
HIV	Human Immunodeficiency Virus
MI	Motivational Interviewing
NA	Narcotics Anonymous
NDMP	National Drug Master Plan
NGO	Non-Governmental Organisation
NIDA	National Institute on Drug Abuse
SACENDU	South African Community Epidemiology Network on Drug Abuse
SACSSP	South African Council for Social Service Professions
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
TB	Tuberculosis
TTM	Transtheoretical Model of Change
UCT	University of Cape Town
UNODC	United Nations Office for Drugs and Crime
WHO	World Health Organisation

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CHAPTER 1
INTRODUCTION TO THE STUDY

1.1 INTRODUCTION

Substance use disorders (SUDs) are, according to Stoke et al. (2018), characterised by a compelling physical, psychological, and emotional compulsion to use substances that alter the mind and mood. These authors outline key features of SUDs, including an increased tolerance to the substance, withdrawal symptoms when discontinued, and continued use despite negative consequences.

The American Psychiatric Association (APA) further emphasises that an "important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification" (2013, p. 483). Additionally, Hall et al. (2014) highlight the challenges individuals with SUDs face in making informed decisions, leading to resistance or reluctance to seek treatment.

In light of the aforementioned description of a SUD, it is evident that some individuals exhibiting SUD symptoms may choose not to pursue treatment or resist available treatment options. As a result, they, along with their families and communities, continue to bear the effects of the disorder. While social workers often provide support services to families and significant others, individuals with SUD who resist treatment are often without adequate assistance.

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This study therefore focused on social workers' experiences of the involuntary treatment of a SUD, using the Transtheoretical Model of Change, known as the TTM, with the aim of developing an understanding of how individuals with a SUD who resist treatment can be supported to move from involuntary to voluntary participation in treatment services. By exploring the perspectives of social workers, valuable insights can be gained to address the challenges and barriers faced by individuals who are resistant to treatment.

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The chapter begins by presenting the key concepts that are central to the study's focus. This is followed by a discussion on the preliminary literature review, the theoretical framework of the study, and the problem statement. Subsequently, the research question, aims, and objectives are outlined. The significance of the study is then explained, emphasising its potential contribution to the field. The penultimate section provides an overview of the forthcoming chapters, with a brief summary concluding the chapter.

1.2 DEFINITION OF KEY CONCEPTS

The key concepts that provide a focus for this study are 'social work', 'involuntary treatment', 'services', 'substances', 'substance use disorder' (SUD), and the 'Transtheoretical Model (TTM) of Change'. These concepts are defined below.

1.2.1 Social Work

This study focused on the involuntary treatment of a SUD by social workers. *Social work* is a profession that is both academic and practice-based, with an emphasis on the integration of theory and practice. Social work interventions are aimed at empowering individuals, families, groups, and communities. Emphasis is placed on the enhancement and restoration of capacity, resources, and societal conditions to assist service users to address challenges, to develop potential, and to experience well-being (Garthwait, 2012).

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In South Africa, a social worker needs to be registered with the South African Council for Social Service Professions (SACSSP) in terms of the Social Service Professions Act, No. 110 of 1978 (South Africa, 1978). This registration is a prerequisite to practicing and rendering a service in the social services sector (Department of Social Development [DSD], 2019). Relevant to this study, social workers are indicated as service providers for the treatment of a SUD by the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008 (South Africa, 2008).

1.2.2 Involuntary Treatment

Involuntary or compulsory treatment of a SUD can be described as the mandatory enrolment of individuals, who are often but not necessarily dependent on substances,

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in a treatment programme (Werb et al., 2017). In this study, involuntary treatment refers to the provision of in- or outpatient treatment of a SUD where the person is participating involuntarily. As such, the person did not request treatment and/or verbalised that they are not receiving treatment voluntarily. Such treatment would be aimed at social and psychological services provided by, among others, social workers (South Africa, 2008).

1.2.3 Services

The DSD (2019, p. 50) refers to "social service practice contexts" and distinguishes between primary and secondary environments for service delivery. The focus of this study was on primary environments, which may include all institutions or organisations whose core business is the provision of treatment services for a SUD. Such services include:

- Prevention,
- Early intervention,
- In- or outpatient treatment services for individuals who are abusing substances to the detriment of themselves and others, and
- Aftercare and reintegration services (South Africa, 2008).

1.2.4 Substances

For the purpose of this study, the term '*substance*' refers to chemical or psychoactive substances that are prone to be abused, including tobacco, alcohol, over-the-counter drugs, and prescription drugs (South Africa, 2008). These substances can be categorised as:

1) Depressants: These substances suppress the central nervous system, such as alcohol and heroin.
2) Stimulants: These substances arouse the central nervous system, such as amphetamines, ecstasy, and cocaine.
3) Hallucinogens: These substances cause changes in perceptions that could lead to hallucinations, such as LSD and magic mushrooms.
4) Combination substances: These substances have a combination of the impacts related to the first three categories, such as cannabis (Department of Basic Education [DBE], 2013).

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1.2.5 Substance Use Disorders (SUD)

The World Health Organisation (WHO) describes 'substance abuse' as the harmful use of psychoactive substances (WHO, 2020). A SUD is a cluster of cognitive, behavioural, and physiological symptoms where the individual continues using the substance despite significant substance-related problems (APA, 2013). In this study, the focus was on persons who portray symptoms associated with a SUD, and who do not enter treatment voluntarily.

1.2.6 Transtheoretical Model (TTM) of Change

The TTM provides a solid theoretical foundation upon which innovative treatment approaches for SUD can be developed. The model recognises that some individuals with a SUD may require support to move towards voluntary participation in treatment services. It encompasses several key concepts, including:

- Stages of change,
- A process of change,
- Decisional balance, and
- Self-efficacy (Velasquez et al., 2005).

In this study, the TTM served as the theoretical framework guiding this research. The aforementioned key concepts informed the preliminary literature review, which is presented next.

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1.3 PRELIMINARY LITERATURE REVIEW

In this section the term 'substance use disorder' will be discussed, followed by a discussion of the prevalence and consequences of a SUD. Treatment of a SUD will be unpacked with a specific focus on involuntary treatment.

1.3.1 Substance Use Disorder (SUD)

Deepmala (2014) describes the progression of a SUD as follows: It begins with experimentation, then transitions to casual use of substances, progresses further to regular use, and ultimately leads to a disorder where the individual requires treatment to support the cessation of substance use.

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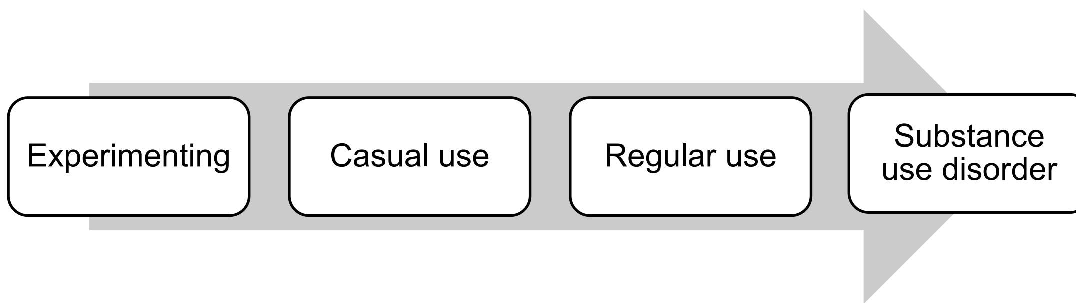

Figure 1: Progression of a SUD (cf. Deepmala, 2014)

A SUD refers to the excessive use of substances that result in short- and long-term effects. Short-term effects include intoxication and overdoses, which can potentially result in death. Long-term use of the substance leads to changes in the brain, impacting mood, thoughts, and behaviour, and giving rise to specific symptoms associated with a SUD (Rehm et al., 2013). The APA (2013) provides a description of these symptoms, which are utilised in the diagnosis of a SUD. The symptoms can be summarised as:

- Hazardous use,
- Social, interpersonal, physical, or psychological problems,
- Neglected major roles within families, employment, and society,
- Withdrawal symptoms and cravings,
- Tolerance to the substance and increased use,
- Repeated unsuccessful attempts to quit or control use,
- Much time spent using substances, and
- Giving up healthy activities (Rehm et al., 2013; APA, 2013).

The focus of this study was on changes in the brain (cf. Rehm et al., 2013), cravings, and withdrawal symptoms, which often contribute to the hesitance or resistance of individuals with a SUD to voluntarily engage in treatment. This focus was based on the prevalence of substance use and abuse, which will be discussed next.

1.3.2 The Prevalence of Substance Use and Abuse

The increase in global drug supply and demand poses a variety of challenges for systems aimed at preventing and treating a SUD such as law enforcement, health, and social service systems (United Nations Office for Drugs and Crime [UNODC],

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2020). The World Drug Report (UNODC, 2020) estimates that 35.6 million people globally suffer from a SUD, and highlights that while a SUD is more prevalent in developed countries, the use of substances is increasing more rapidly in developing countries. Africa is emerging as a target for the production and trafficking of illicit substances with severe ramifications for crime, health, and development-related challenges (Armiya'u, 2016).

In South Africa, the prevalence of substance use is twice the global average, and the country ranks among the top 10 nations in terms of alcohol consumption worldwide (DSD, 2017). It is estimated that 15% of the South African population has a SUD (Monyakane, 2018; Van Wyk, 2011). South Africa is further thought to be the largest synthetic drug consumer and producer in Africa, and substance-related crimes have increased (Fellingham et al., 2012). Importantly, the UNODC (2020) reports that those who experience poverty in South Africa are more likely to have a SUD than those who are not. As such, substance use and abuse in South Africa is considered a central threat to development, and specific concerns exist regarding substance use and abuse among youth (Monyakane, 2018).

Contributing factors to a SUD include:

- Unemployment,
- Poverty,
- Lack of good parenting,
- Peer pressure,
- Lack of appropriate knowledge,
- Genetics,
- Availability of substances, and
- Mental illness (DSD, 2017).

In the Western Cape, where this study was conducted, a higher proportion of persons in treatment programmes suffer from hypertension and mental health problems than in the rest of the country, and 47% received a dual diagnosis. Alarmingly, the mean age of persons receiving treatment is 29 years, indicating a decrease in the age of persons diagnosed with a SUD. Alcohol, methamphetamine, and cannabis were the

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most commonly used substances in the province in 2019 (Dada et al., 2019). In order to fully comprehend the seriousness of the situation, the consequences of substance use and abuse must be considered.

1.3.3 Consequences of Substance Use and Abuse

Moyana et al. (2019) distinguish between the physical, psychological, and social consequences of a SUD.

- *Physical consequences* include malnutrition, heart disease, neurological disorders, liver disease, and physical weakness.
- *Psychological consequences* encompass withdrawal symptoms like anxiety, stress, depression, and personality changes, including aggression and compulsiveness.
- *Social consequences* are reported to include isolation from close relationships with family and friends, and greater association with other substance users.

Continued concern about the prevalence of a SUD and the lack of progress to address substance use and abuse to limit consequences is reported by the Department of Planning, Monitoring, and Evaluation (DPME) (DPME, 2019). In a review of the implementation of the National Drug Master Plan (NDMP) for 2013 to 2017, the need for research to "ensure effective and efficient services for the combating of substance abuse and to strengthen mechanisms for implementing cost-effective interventions to empower vulnerable groups" (DPME, 2019, p. 3) is highlighted.

SUDs are viewed as a major contributor to:

- Poverty,
- Reduced productivity,
- Unemployment,
- Dysfunctional family life,
- Political instability,
- The escalation of chronic diseases such as HIV (human immunodeficiency virus), AIDS (acquired immune deficiency syndrome), and TB (Tuberculosis),
- Injury, and
- Premature death (Monyakane, 2018; Van Wyk, 2011).

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These consequences, among others, serve as the Central Drug Authority's (CDA) motivation behind the formulation of the ultimate goal for South Africa to become a country free of substance abuse (CDA, 2019). Involuntary committals for a SUD are a form of intervention that speaks directly to the identified goal. It entails that a person who portrays SUD symptoms can be pressured to receive treatment, which may include statutory actions.

1.3.4 Treatment

According to the CDA (2019), treatment is defined as a structured process involving individuals with a SUD engaging with a service provider and being presented with a range of intervention choices tailored to their specific requirements. The treatment journey concludes when the individual's health and well-being have been restored to the greatest possible extent. In addition, the Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008 (South Africa, 2008) describes treatment as a specialised service rendered by health practitioners, mental health practitioners, and social workers, focusing on social, psychological, and medical services. This study focused on services by social workers.

A *service user*, for the purpose of this study, is viewed as any person with a SUD who is accessing treatment, either voluntary or involuntary. Kaloiya and Sonkar (2018) describe treatment as a process that includes five focus areas:

1) The development of a therapeutic relationship between the service provider and service user,
2) The assessment and monitoring of the SUD and the individual's personal context,
3) Management of intoxication and withdrawal states,
4) Developing a treatment plan based on the assessment outcomes, and
5) Preventing relapses.

The CDA (2019) further refers to two concepts related to treatment. The first concept is the *continuum of care* that has to do with a variety of intervention options. Moyana et al. (2019) concur that the continuum of care is based on the individual needs of service users and that it includes a spectrum of services that will support a person towards recovery from a SUD. The DSD (2013) identifies prevention, early

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intervention, treatment, aftercare, and reintegration as types of interventions that are included in this continuum.

The second concept has to do with *recovery management*, which is aimed at a long-term client-directed way of providing services within the continuum of care. Elements of treatment in terms of recovery management include client empowerment, assessment, recovery resource development, recovery education and training, ongoing monitoring and support, recovery advocacy, and evidence-based treatment and support services (CDA, 2019). The focus of this study was on the way in which service providers approach involuntary treatment, which can be viewed as the first element of client empowerment.

1.3.4.1 Involuntary treatment

The Prevention and Treatment of Substance Abuse Act, No. 70 of 2008 (South Africa, 2008) does not explicitly define 'involuntary treatment'. However, it does outline the characteristics of an *involuntary service user*, which include:

- Being a danger to themselves or to the immediate environment,
- Causing a major public health risk,
- Doing harm to their own welfare or the welfare of others, and/or
- Committing a criminal act to sustain their dependence on substances (South Africa, 2008).

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Opsal et al. (2019) expand on the above description, explaining that one of the primary reasons for involuntary treatment is to protect an individual from self-destructive behaviour and/or behaviours that can cause harm to others or the environment.

During involuntary treatment, an individual may be compelled to participate in a treatment programme due to various factors such as statutory actions, family influence, or workplace pressure. Despite this pressure, the person may express their lack of willingness to actively engage in the treatment process (Werb et al., 2017). On the one hand, Scheibe et al. (2020) argue that treatment should include self-determination. On the other hand, Opsal et al. (2019), while also agreeing that self-determination is being impacted on through involuntary treatment, describe the reason

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behind involuntary treatment as a short-term intervention aimed at saving the life of the person or protecting others from harm caused by the SUD-related consequence. A long-term goal is to encourage a movement towards a motivation to participate voluntarily.

Kaloiya and Sonkar (2018) argue that treatment outcomes are dependent on the level of motivation of the client to engage with treatment interventions. However, the authors postulate that this does not mean that unmotivated persons who are at risk of harming themselves or others are being left behind. On the contrary, the authors concur that client-centred treatment should also make provision for interventions aimed at motivating persons with a SUD to voluntarily participate in treatment.

The preliminary literature review assisted the researcher to identify a suitable theoretical framework from which this study could be approached.

1.4 THEORETICAL FRAMEWORK

A theoretical framework provides the researcher with a viewpoint from which to approach the research to increase the validity of the findings (Lederman & Lederman, 2015; Grant & Osanloo, 2014). The Transtheoretical Model (TTM) of Change was identified as the most appropriate theoretical framework for this study. The TTM is used in the treatment of a SUD (Velasquez et al., 2005) to facilitate and encourage behavioural changes required to improve physical, psychological, and social health (Hoy et al., 2016). Behavioural change, however, requires an internal motivation to change, which is associated with satisfying experiences. Contrary to internal motivation, external motivation is associated with change due to external stimuli, such as pressure from an employer.

The researcher was interested in ways to support individuals with a SUD to actively engage in treatment by focusing on their personal motivation to pursue recovery, rather than relying on external pressures that may involuntarily push them into treatment services (Legault, 2016). According to Serafini et al. (2016), understanding how motivation supports the SUD and decision to participate in treatment can provide valuable insights for service providers. This understanding can assist in effectively

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supporting individuals who may initially be involuntary service users, helping them develop the motivation necessary to actively engage in treatment. By recognising and addressing motivational factors, service providers can effectively guide individuals towards embracing a genuine desire to participate in treatment.

The TTM includes five stages within a process of motivation to change:

1) Precontemplation (not considering change),
2) Contemplation (considering change),
3) Preparation (developing change plan),
4) Action (implementing change plan), and
5) Maintenance (sustaining change) (Serafini et al., 2016).

Motivational interviewing (MI) as a technique within this process has demonstrated efficacy in enhancing the motivation of the client system and improving treatment outcomes (Serafini et al., 2016). For the purpose of this study, the researcher was interested in exploring if and how the TTM is included in services, and to develop an understanding of how this model can be used effectively to support involuntary treatment services.

Social work places a focus on social justice, which means that a primary task is to help those who cannot readily help themselves (Osborne-Leute et al., 2019). Bell-Moratto (2019), exploring how the TTM can assist social workers to support individuals who are unable to help themselves, however, found that the use of the TTM faces challenges arising from both practitioner- and client-related factors. These challenges underscore the importance of further exploration to discover innovative solutions that facilitate the effective implementation of the TTM in practical settings. The value of this framework was that, for the purpose of this study, and with the understanding of the consequences of a SUD, the researcher concluded that those who are suffering from a SUD and in need of treatment due to harm caused to themselves or others should not be excluded from services, but rather supported to be able to engage effectively with services.

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1.5 PROBLEM STATEMENT

A research problem is viewed as essential to ensure that the research has a clear focus and that there is a rationale behind the study. It then guides the researcher's decisions regarding the methodology that will be employed (Kumar, 2014). The research problem that was identified through the preliminary literature review was formulated as follows:

> The prevalence of substance use has been on an increase globally with the drug supply and demand causing challenges for the prevention and treatment of a SUD (UNODC, 2020). Alarmingly, the production and trafficking of illicit substances are emerging in Africa, and result in health, crime, and development-related challenges (Armiya'u, 2016). South Africa has particularly been affected in that substance use is twice the global norm, and a SUD has been observed in 15% of the population (Monyakane, 2018; DSD, 2017; Van Wyk, 2011).
>
> A SUD results in short- and long-term physical, social, and psychological effects that impact the person with the SUD, the family, community, and society at large (Deepmala, 2014; APA, 2013). Changes to the brain, withdrawal symptoms, cravings, as well as repeated unsuccessful attempts to cease the use of substances, contribute to persons with a SUD being unmotivated and resistant to entering treatment (APA, 2013).
>
> Treatment is referred to as recovery management (CDA, 2019), and includes prevention, early intervention, treatment, aftercare, and reintegration as interventions on the continuum of care (DSD, 2013). The mentioned resistance to treatment may lead to involuntary treatment that results from pressure from the workplace or family members, and statutory interventions (Werb et al., 2017). While internal motivation and self-determination are identified as key to successful treatment outcomes (Scheibe et al., 2020), the need to include MI as a part of the long-term goal of treatment has been argued for by various authors (Opsal et al., 2019; Kaloiya & Sonkar, 2018). Kaloiya and Sonkar (2018) emphasise that service providers must be careful not to exclude

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unmotivated persons in service delivery by focusing on the family only. Services should also include these individuals' needs, and therefore have to make provision for assisting them to move towards motivation to enter treatment voluntarily.

The TTM has been established to support the development of internal motivation, and thereby voluntary participation in treatment options. However, it is not known how social workers utilise this framework, what their experiences with the use of the TTM are, and what challenges they experience within the South African context. The lack of knowledge that exist was the rationale behind this study. There was a need for further exploration of how the TTM is perceived and implemented by social workers to develop an understanding of how involuntary treatment can be approached through a client-centred method of intervention.

The research problem informed the formulation of the research question, aim, and objectives of this study.

1.6 RESEARCH QUESTION

A research question emerges from the desire to gain a better understanding of a phenomenon, which informs the choices regarding the methodology to use to best answer the identified question (Kross & Giust, 2018). In this study, the research question that emanated from the research problem was:

> "What are the experiences of social workers regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder in the Western Cape?"

The above research question guided the formulation of the research aim and objectives to ensure that the research problem would be addressed.

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1.7 AIM & OBJECTIVES

1.7.1 Aim

The aim of this study was to explore and describe the experiences of social workers regarding the use of the TTM of Change in involuntary treatment of a SUD in the Western Cape.

1.7.2 Objectives

The objectives of this study were to:

1) Explore the experiences of social workers regarding the use of the TTM of Change in involuntary treatment of a SUD through individual qualitative interviews.
2) Develop an in-depth understanding of the experiences of social workers regarding the use of the TTM of Change in involuntary treatment for SUDs through the analysis of the findings and literature control.
3) Make recommendations regarding the effectiveness of the TTM of Change for involuntary treatment of a SUD.

1.8 SIGNIFICANCE OF THE STUDY

Individuals with SUDs in South Africa are often also exposed to poverty and a lack of access to resources. While SUDs impact negatively on the individual, family, community, and society, the nature of a SUD may result in the person with this disorder not being motivated to seek treatment. As a consequence, interventions frequently prioritise supporting the family, inadvertently leaving the individual with the SUD behind. The development of the TTM aims to address this issue by assisting individuals in finding motivation to actively pursue treatment options for their SUD. However, the literature studied as well as the researcher's own experiences point to a lack or ineffective use of this framework in the involuntary treatment of SUDs. The researcher hoped to identify how this framework can be used effectively to ensure a client-centred treatment that also makes provision for interventions aimed at motivating persons with a SUD to voluntarily participate in treatment. It was envisaged that this could lead to better treatment outcomes.

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1.9 OUTLINE OF CHAPTERS

Chapter 1: This chapter introduced the topic of this study and provided a description of the key concepts, a preliminary literature review, the theoretical framework, the problem statement, and the research question, aim, and objectives.

Chapter 2: An in-depth literature review is presented to further describe the focus of this study. This was also used as a literature control to verify the findings of the study.

Chapter 3: The research methodology implemented to answer the research question is presented in terms of the choices and implementation of the research approach, design, methods, and techniques, as well as the ethics that guided the study.

Chapter 4: This chapter presents the demographical description of the participants in the study and the findings.

Chapter 5: The final chapter provides a summary of the research findings, a description of the conclusions that were drawn, and the recommendations that are made which are based on the conclusions of the study.

1.10 CONCLUSION TO THE CHAPTER

Chapter 1 introduced the study by defining and exploring the key concepts. A preliminary review of the literature was conducted to examine existing knowledge on the research topic, and the selected theoretical framework was discussed.

Based on these discussions, the research problem was formulated, the research question was identified, and the research aim and objectives were established. The chapter concluded by highlighting the significance of the study and providing an overview of the research document's structure.

Chapter 2 that follows next is dedicated to an in-depth review of the literature.

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CHAPTER 2
LITERATURE REVIEW

2.1 INTRODUCTION

The previous chapter introduced the study through a preliminary review of literature that guided the identification of the research problem. In order to further unpack what is known about the research topic, this chapter presents an in-depth review of the literature. This review was used to verify the research findings through a literature control after the data were analysed. According to Machi and McEvoy (2016, p. 5), "[A] literature review is a written argument that supports a thesis position by building a case from credible evidence obtained from previous research". It can be considered a comprehensive study and interpretation of literature that relates to the research findings (Aveyard & Bradbury-Jones, 2019).

In this chapter, the discussion encompasses several key aspects. Firstly, it delves into the concept of a SUD, providing an overview of the prevalence of substance use and abuse, as well as the associated consequences. Secondly, the chapter explores the treatment of SUDs, examining treatment frameworks and both voluntary and involuntary treatment options. Thirdly, it provides a detailed description of the TTM. Fourthly, the chapter concludes the literature review with an examination of social work services in SUD treatment and the legislative framework that governs these services. This is flowed by a brief conclusion that brings the chapter to a close.

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2.2 SUBSTANCE USE DISORDER (SUD)

According to Pettersen et al. (2019), a SUD does not only affect the individual but also places a burden on society. As mentioned in Chapter 1, a SUD can be described as a compulsion to use mind- and/or mood-altering substances. This compulsion could be physical, mental, and/or emotional in nature (Stoke et al., 2018). Therefore, a SUD comprises of a cluster of cognitive, behavioural, and physiological symptoms experienced by service users (Bruijnen et al., 2019).

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Psychoactive substances are classified into various categories, including depressants, stimulants, and hallucinogens. Additionally, some psychoactive substances can exhibit a combination of depressant, stimulant, and hallucinogenic effects (DBE, 2013). The consumption of these substances leads to unique physical and psychological effects that vary based on the specific category to which they belong (Kozlowska & Marzec, 2017). Therefore, a SUD is determined by the type of substance being used. The APA (2013) identifies various SUDs based on specific substances of choice that have the potential to result in a SUD:

- Alcohol Use Disorder,
- Phencyclidine Use Disorder,
- Inhalant Use Disorder,
- Stimulant Use Disorder,
- Cannabis Use Disorder,
- Other Hallucinogens Use Disorder,
- Opioid Use Disorder,
- Sedative, Hypnotic, or Anxiolytic Use Disorder, and
- Tabaco Use Disorder.

A SUD is a result of substance use that ends up in a dependency on the substance. As mentioned in Chapter 1, Deepmala (2014) outlines the stages of substance use that culminate in a SUD as follows: 1) experimentation, 2) casual use of substances, 3) progression to regular use, and 4) ultimately leading to a SUD where the individual requires treatment to facilitate the cessation of substance use. This description underscores the fact that a SUD arises as a consequence of persistent substance use and abuse.

An important aspect of a SUD is the disruptive impact of substances on the sending, receiving, and processing of signals among neurons through neurotransmitters. Certain substances, such as marijuana and heroin, possess chemical structures that mimic those of natural neurotransmitters. As a result, these substances can cause abnormal messages to be sent, received, and processed in the brain. Other substances, such as amphetamine and cocaine, result in the release of abnormally large amounts of neurotransmitters, or in the prevention of the normal recycling of

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brain chemicals that then interfere with the transmission processes in the brain (Volkow et al., 2016). Watkins (2022) reports that the brain stem, the limbic system, and the cerebral cortex are all affected in some way when substances are used. The author explains that cravings and resistance to cease the use of substances can be impacted when the limbic system is affected. This system controls emotions and manages the reward system within the brain. The substance creates messages in the brain to ensure that the substance is experienced as a reward.

September (2015) provides further elaboration and explanation by highlighting that psychoactive substances elevate the levels of dopamine, a neurotransmitter, in the brain's pleasure or reward circuit. Consequently, individuals with a SUD experience intense pleasure as a result of substance use, which further motivates them to continue using the substance. This perpetuates a cycle of craving the pleasurable effects, leading to resistance in seeking treatment. In addition, the impact on the cerebral cortex can significantly influence the decision-making abilities of individuals with a SUD. This can have implications for how they respond to opportunities for treatment. Volkow et al. (2016) propose that the impact on the brain plays a significant role in driving compulsive substance use, indicating an individual's dependency on the substance, which can potentially impede their response to interventions. Building on this, Bruijnen et al. (2019) highlight that a SUD's effect on the brain remains evident even long after chronic use has been stopped.

Based on the above description of the influence of substances on the brain, the researcher considered the fact that some individuals with a SUD experience resistance to voluntary access to treatment opportunities. Also focusing on the impact of a SUD, Marchand et al. (2019) emphasise the need for additional research to elucidate the different effects of SUDs to develop more effective strategies for intervention. To gain a deeper understanding of SUDs, the following sub-sections will explore the contributing factors, prevalence rates, and associated consequences of SUDs.

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2.2.1 Factors Contributing to a SUD

According to Volkow et al. (2019), repeated exposure to substance use is a requirement for the development of a SUD (cf. Deepmala, 2014). In addition, the interactions of environmental, psychological, and biological factors play a pivotal role in the use and abuse of substances, as well as in the development of a SUD (Volkow et al., 2019). The risk for substance use might be attributed to the neighbourhood characteristics, for example, urban cities have higher rates of smoking, cannabis, and alcohol use (Pasman et al., 2020).

Ng et al. (2018) refer to the risk and protective factors and assert that there are more risk factors for vulnerability to a SUD than protective factors. Table 1 below lists some risk and protective factors for children's vulnerability to a SUD, as described by Volkow et al. (2016),

Table 1: Risk and protective factors for children's vulnerability to a SUD (Volkow et al., 2016)

Risk factors	Protective factors
▪ Aggressive behaviour in childhood	▪ Self-efficacy (belief in self-control)
▪ Lack of parental supervision	▪ Parental monitoring and support
▪ Low peer refusal skills	▪ Positive relationships
▪ Experimentation with substances	▪ Extracurricular activities
▪ Availability of substances at school and neighbourhood	▪ School anti-drug policies
▪ Community poverty	▪ Neighbourhood resources

Ng et al. (2018) provide a comprehensive overview of the various risk factors that contribute to an individual's vulnerability to substance use and abuse. These risk factors can be categorised into four domains: individual, family, community, and societal factors. The summarised details are presented below.

- On an *individual level,* risk factors include mental health problems, genetic vulnerabilities, poor health or development, behavioural problems such as anti-social behaviours, positive attitudes towards substances, exposure to a substance at an early age, prenatal alcohol exposure, and poor mental, physical and sexual health.

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- On a *family level,* risk factors include poor parenting styles or practices such as low parental involvement and poor bonding and attachment, domestic violence, conflict and or abuse, and negative role modelling, for example, parents that use substances.
- On the *community level,* risk factors include poor social integration and social influence, poor academic and or work performances, lack of access to support services, accessibility of substances, and work-related stress and bullying.
- On a *societal level,* risk factors include unemployment, poverty, lack of housing, inequality, and discrimination (Ng et al., 2018).

Similarly, Sajjadi et al. (2015) report that personal, family, and environmental factors are to be considered to be included in interventions, instead of removing the person with the SUD from the family or environment. In support of this statement, the National Institute on Drug Abuse (NIDA) advises that those environmental factors that increase the risk for the use of substances must be considered and included in interventions (NIDA, 2014). For example, in the home environment where parents or adults that use substances portray symptoms of a SUD, children are put at risk of substance use, and therefore the exposure to substances in the home makes them vulnerable to SUDs. Similarly, exposure to substances in peer and school environments also increases vulnerability to SUDs. Additionally, academic failure or poor performances, as well as poor social skills, further contribute to the risk of substance use among children.

NIDA (2014) reports that the reasons why people use substances can vary. However, the following reasons are to be considered:

- *Pleasure*: Substance use produces intense feelings of pleasure, leading to a sense of euphoria and relaxation. These positive sensations are often associated with the use of the substance.
- *Improved sense of self-worth*: The substance user experiences an enhanced ability to cope with negative feelings. This is often the case with persons suffering from mental health disorders such as social anxiety, stress-related disorders, and depression.
- *Performance enhancements*: The use of substances is associated with the improvement of performances at work or with a sport.

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- *Experiments*: Experimentation is a characteristic of adolescence, and often a result of peer pressure to engage in risky behaviours to impress their friends.

Furthermore, NIDA (2014) highlights the significant role of genetics as a contributing factor, accounting for approximately 40% to 60% of the inheritable vulnerability to SUDs. Reed and Kreek (2020) further affirm that various studies have indicated the presence of genetic risk factors in the development of SUDs (cf. Prom-Wormley et al., 2017; Ducci & Goldman, 2012). Genetics is also referred to in terms of inheritability factors that increase vulnerability to a SUD based on family history (Volkow et al., 2016). Dingel et al. (2019) refer to the term 'genetic predisposition'. Popescu et al. (2021) acknowledge genetics as a causal factor behind SUDs, but assert that internal, behaviour, and external factors should not be underestimated as causal factors.

2.2.2 The Prevalence of Substance Use and Abuse

Substance use is a significant global public concern. It contributes to 4% of the total Disability Adjusted Life Years globally, and, as such, affects the health and well-being of millions of people (Hawlader et al., 2020; Ayala et al., 2017).

According to Volkow et al. (2021), substance use at an early age has proven to be an associated factor with a faster transition to a SUD. This is an important aspect to consider when looking at the prevalence of SUDs. For example, a study conducted by Murphy and Dennhardt (2016) revealed that young adults between the ages of 18 and 25 years have higher rates of substance use, including alcohol, surpassing other age groups by a margin of 22%. This description points to a high risk for SUDs among this age group.

As previously mentioned, substance use in South Africa is twice the global norm, and the country is among the 10 countries consuming the most alcohol globally (DSD, 2017). Cupido (2021) refers to the global COVID-19 pandemic and asserts that there was a high demand for alcohol in South Africa in the midst of the national lockdown where alcohol trading was prohibited, leading to home-brewing. This behaviour demonstrates a troubling relationship between alcohol and South Africans. In terms of

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gender, the prevalence of SUDs in South Africa is reported to be higher among males than females (Thungana et al., 2019).

The South Africa Stress and Health Study found that the Western Cape, where this study was conducted, had a higher lifetime prevalence rate for substance abuse and dependency (18.5%) than the national average (13.3%) (Harker-Burnhams et al., 2012). Studies that were conducted in the Western Cape and KwaZulu-Natal further documented high comorbidity of substance use in individuals with mental disorders (Thungana et al., 2019). According to The South African Community Epidemiology Network on Drug Abuse (SACENDU) (2020), the commonly used substances in the Western Cape reported by 37 treatment centres during July and December 2020 are methamphetamines (40%), cannabis (17%), alcohol (17%), and heroin (14%).

2.2.3 Consequences of Substance Use and Abuse

The use and abuse of substances have different consequences that are dependent on the type of substances being used. Ekse (2020) identified general consequences, such as relationship problems, poor work or academic performances, and a loss of interest in formally enjoyable activities. SUDs are also considered major contributors to a range of issues, including poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases such as HIV/AIDS and TB, injury, increased risk of suicide, and premature death (Monyakane, 2018; Poorolajal et al., 2015; Van Wyk, 2011).

Ekse (2022) further distinguish between short- and long-term consequences, as indicated in Table 2 below:

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Table 2: Short- and long-term consequences of substance use and abuse (Ekse, 2022)

Short-term	Long-term
▪ Intoxication, ▪ Increased blood pressure ▪ Drowsiness ▪ Shallow breathing ▪ Constipation ▪ Changes in appetite ▪ Sleeplessness or insomnia ▪ Slurred speech ▪ Loss of coordination ▪ Changes in cognitive ability, and ▪ A temporary sense of euphoria.	▪ Depression ▪ Anxiety ▪ Panic disorder ▪ Increased aggression ▪ Paranoia ▪ Hallucinations, and ▪ Memory, learning, and concentration difficulties.

According to the CDA (2019), the consequences in the South African context include poverty, inequality, unemployment, conflict with the law, engagement in risky sexual behaviour, and social breakdown with increased incidents of family violence.

The following sub-sections discuss the medical, substance-related crime, social, and emotional effects of a SUD.

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2.2.3.1 Medical consequences

Medical consequences of substance use and abuse include changes in the brain, viral infections, and various outcomes that are specific to the type of substance being used. Bruijnen et al. (2019) report that psychoactive substances may change brain function and structure as a result of chronic use. In support of this assertion, the authors report that a prevalence of 31% for cognitive impairments was found in addiction care.

The relationship between substance use and viral infections is described by NIDA (2019) as the sharing of needles for injection or other equipment, and unprotected sex occurring while under the influence of substances. Globally, people who inject substances are 28 times more likely to contract HIV than the general population, and

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higher rates of Hepatitis C and TB have been reported for those who inject substances (UNODC, 2017). Lowinson (2005) further notes that injecting substances can cause infections such as cellulitis or abscess, and inhalation of drugs can cause respiratory distress, including pneumothorax (collapsed lung). A link between SUDs and sexually transmitted infections (STIs) has been found by Murali and Jayaraman (2018). The authors assert that one cannot treat one condition without treating the other, but postulate that resistance to treatment of a SUD contributes to increased morbidity and mortality. More recently, Baillargeon et al. (2021) concur that persons with a SUD have an increased risk of adverse outcomes when contracting COVID-19.

The literature also identifies specific medical consequences associated with different substances. Focusing on alcohol use, Ritchie and Rosen (2022) refer to multiple organ system dysfunctions that have been directly linked to excessive alcohol intake or high-risk drinking. These can include vascular disease, liver failure, alcohol-related dementia, and pancreatitis. Delirium termer is a state of confusion and disorientation, which can be experienced when a person is intoxicated or withdrawing from alcohol, and is considered life-threating. In addition, alcohol intake during pregnancy can result in a miscarriage or premature delivery, low birth weight, congenital malformation, dyslexia, autism, hyperactivity, and foetal alcohol syndrome (FAS). Nicotine, a central nervous system stimulant, can cause hypertension and vascular diseases, including heart attacks and stroke. Smoking has also been linked to lung cancer (Pogun & Arman, 2021). Methamphetamines cause severe dental problems, also known as meth-mouth, whereby the teeth and gums are affected, which can lead to other medical conditions (De-Carolis et al., 2015).

2.2.3.2 Substance-related crime

Goredema (2011) defines ‘substance-related crime’ as “crime caused or encouraged by the production of illicit drugs or by the influence of such drugs or as a commission of acts of violence in order to support the drug habit or to gain control of or run drug markets” (p. 14). These authors also highlight a link between substance use and social disadvantages, such as low educational attainment, increased difficulty in finding employment and remaining employed, financial instability, and poverty. These social disadvantages are more likely to lead to crime in one form or another (UNODC, 2020).

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Chau et al. (2021) further assert that substance use leads to a higher risk for violent behaviour. In line with this viewpoint, the National Minister of Social Development at the time, Ms Bathiblie Dlamini, highlighted in 2013 that both the user and non-user of substances are exposed to violent crime in South Africa. Therefore, one of the keys to reduce substance-related crimes identified in the NDMP 2013–2017, was to reduce the use and abuse of substances by targeting the production, manufacturing, and distribution of substances (CDA, 2013).

2.2.3.3 Social consequences

Moyana et al. (2019) outline the social consequences of substance use and abuse in terms of isolation from close relationships with family and friends, which subsequently leads to a greater association with substance-using peers and a greater distortion of the social support structure. In this way, a SUD negatively affects individual social functioning and creates an additional burden on society (Pettersen et al., 2019). According to Pettersen et al. (2019), supportive relationships with caring family and friends have proven to be helpful in abstaining and maintaining sobriety. The absence or exclusions from these supportive relationships can have adverse consequences for service users attempting to move into recovery.

Social isolation, in the context of this study, refers to loneliness or being without any social networks that provide positive support as a result of the use of substances (Setlalentoa et al., 2010). Isolation from positive support may lead to association with substance-using peers and negative social interactions (Hoopsick et al., 2020). Negative social interactions can also arise from parental substance use and SUDs, which can have detrimental effects on children. For instance, these children may experience abuse and/or neglect, putting them at heightened risk of developing a SUD themselves (Lipari & Van Horn, 2017).

Those who suffer from a SUD also encounter greater challenges, including housing instability, food insecurity, and economic uncertainties, in comparison to the general population (Melamed et al., 2020). Bryden et al. (2013) report a link between adult unemployment and increased levels of alcohol use. Homelessness and SUDs are

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linked in that those who are homeless are hard to reach, socially excluded, and experience poor physical health, poor mental health, and problems with substance use (Miler et al., 2020). This is in line with the assertion by Catalano et al. (2011) that unemployment may lead to psychiatric problems, including SUDs. Wang et al. (2019) highlight the significant public health challenge of youth homelessness, particularly among individuals aged 13 to 24, on a global scale. They advise that substance use is a factor to consider when addressing the issue of youth living on the streets.

2.2.3.4 Emotional consequences

According to McHugh and Goodman (2019, p. 1), "[S]ubstance use disorders are characterized by disruption in the processes such as reward functioning, impulse control, and harm avoidance". This, then, affects emotions. Emotional consequences can also be linked to the type of substance. For example, long-term effects of cannabis use have been associated with mental illnesses such as depression, suicide, and anxiety among adolescents (Paruk & Burns, 2016), and a connection has been identified between substance-induced psychosis and methamphetamines (Petit et al., 2012).

Comorbidity describes two or more disorders occurring in the same person at the same time or one after the other. There is a strong link between SUDs and psychiatric comorbidities, and there are common risk factors that contribute to mental health disorders and SUDs (UNODC, 2020). Kronenberg et al. (2014) report that approximately 50% of patients with severe and continuous mental disorders are also affected by a SUD. In this regard, NIDA (2018) concludes that substance use and abuse may change the brain in ways that make a person more likely to develop a mental illness. Alarmingly, persons with comorbidities have low rates of access to treatment for their SUDs, and an integrated treatment regime can be considered as best practice (Moulin et al., 2018).

2.3 TREATMENT

While a variety of types of treatments for a SUD, such as behavioural and pharmacotherapy treatments, are available (Teeters et al., 2017), it does not mean that access to such treatments is ensured. The need for treatment is reflected by the

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global estimation that one out of every six people or less who need SUD treatment receives it (Marchand et al., 2019). South African communities face inequitable and limited availability of substance abuse treatment services (Harker-Burnhams et al., 2012), which is a growing public health concern (Myer et al., 2012).

Miller et al. (2019) emphasise the life-threatening nature of SUDs and express concern that, despite the severe consequences mentioned earlier (cf. Section 2.2.3 above), they frequently go unnoticed and untreated. These authors argue that all health care and social services professionals should be knowledgeable and skilled to provide treatment for SUDs. In agreement with this viewpoint, Pettersen et al. (2019) add that "SUD treatment providers should involve clients' networks to a greater extend when designing new treatment approaches" (p. 7). This places the emphasis on the inclusion of families, peers, employers, etc., in treatment services.

The Continuum of Care is proposed by Moyana et al. (2019) as a framework that provides a variety of options to prevent and treat SUDs. The continuum promotes services that are relevant to different needs of service users and aims to prevent SUDs from developing, early interventions when substance abuse is identified, a variety of types of treatments, and ongoing support following treatment of a SUD. Osborne-Leute et al. (2019) describe the continuum of care for SUD services as follows:

- *SUD Health Promotion and Prevention Initiatives*: The focus is on prevention through an emphasis on health promotion. The aims are to create supportive environments, to strengthen community action and response to substance use and abuse, and to support personal health and coping skills.
- *Primary Care Services*: These services are focused on early interventions through healthcare and social services provided by physicians and specialists such as psychiatrists, psychologists, nurse practitioners and other health services providers, and social workers.
- *Outpatient Clinics for SUD Treatment*: This service encompasses office- and community-based services, which include medical consultation; assessments; referrals; psycho-education; individual, group and family counselling; and case management.

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- *Short-Term Residential Treatment*: This kind of treatment lasts for 30 days and includes assessments and psycho-education, as well as individual, group and family counselling, in a safe, structured, and substance-free living environment.
- *Long-Term Residential Treatment*: This treatment is similar to the short-term residential treatment, but lasts for 90 days.
- *Support Recovery*: This last type of treatment on the Continuum of Care focuses on temporary residential settings, providing safe housing and a basic level of support appropriate for longer recovery from SUD.

Similar to the Continuum of Care and focusing on social work services in general, the DSD (2013, pp. 32–35) identified the following levels of intervention that are determined by the specific development needs of service users:

- *Prevention*: Strengthening and building capacity, self-reliance, and resilience of service beneficiaries while addressing individual, environmental, and societal factors to create conditions that support wellness.
- *Early Intervention*: Early identification of risks, behavioural problems and symptoms in individuals, groups, and organisations that could negatively impact on social well-being.
- *Statutory/Residential/Alternative Care*: Statutory intervention is a result of the service beneficiaries' lives being compromised, and could require formal and/or residential forms of care (voluntary or involuntary) to protect and restore their well-being.
- *Reunification and Aftercare*: This follows statutory, residential, or alternative care to regain self-reliance and optimal social functioning in the least restrictive environment. The aim is to facilitate reintegration to family and community life after separation due to treatment.

The framework provided by the DSD (2013) above distinguishes between voluntary and involuntary treatments, which will be discussed next.

2.3.1 Voluntary Treatment

The Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008 (South Africa, 2008) describes 'voluntary treatment' as a service provided to someone who

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has applied for admissions, and/or who submitted themselves for admissions. Where a parent/guardian applied for admissions for a minor, it is also viewed as a voluntary treatment intervention. In other words, voluntary treatment takes place when a service user acknowledges the substance use and/or abuse problem, and agrees that the best course of action would be to get professional help. However, in the case of minors where the parent/guardian asked for admission to treatment, the minor might be resistant to engage with the treatment activities.

Voluntary treatment assumes that the person's motivation for change is higher than that of involuntary service users, and that the treatment outcomes would therefore be better (Opsal et al., 2019). While voluntary treatment remains the first choice and major gateway for treatment, it does not mean that service users cease the pattern of substance use and abuse, or that treatment will lead to recovery. Treatment success is primarily dependent on a service user's ability to develop insight and judgement regarding their use of substances, and therefore a willingness to undergo treatment. Therefore, the principle of autonomy can be considered as the foundation for service users accessing treatment voluntarily (Pasareanu et al., 2017). Varkey (2021) asserts that autonomy has to do with the power to make a rational decision and moral choice. In this study, however, it is considered that the impact and consequences of SUDs may lead to an inability to make a rational choice to engage with treatment voluntarily.

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2.3.2 Involuntary Treatment

An 'involuntary service user' refers to a person who did not willingly choose to participate or engage in treatment. On the one hand, it may have implications that have to do with power dynamics, coercion, and control within the provision of services (Cousins, 2020). On the other hand, it may be needed in cases where a person is not able to make a sound decision that will impact on their own well-being or the well-being of others (New South Wales Government, 2019). In this regard, the Mental Health Care Act, No. 17 of 2002 (South Africa, 2002) describes involuntary treatment as "the provision of health interventions to people incapable of making informed decisions due to their mental health status and who refuse health intervention but require such services for their own protection or for the protection of others and involuntary care, treatment and rehabilitation services" (p. 6).

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Reflecting on the two positions on involuntary treatment above, Saya et al. (2019) concur that it carries advantages and disadvantages for both the experiences of service users and treatment outcomes. In line with this, Chau et al. (2021) reflect on the WHO's position that involuntary treatment may be necessary in some cases, and that such services require that adequate legal protection, provisional follow-ups, and safeguards are in place. Similarly, Jain et al. (2018) postulate that while involuntary treatment may reduce the increase in the number of overdose deaths, it must take into consideration that the individual needs to pose a substantial risk of harm to themselves or others. Sant'Ann et al. (2020) add that involuntary treatment may enable treatment with the aim to prevent harm such as violence, suicide, delirium termers, liver failure, heart disease, and central nervous effects. Van Kranenburg et al. (2019) refer to long-term involuntary treatment as an alternative treatment option for those who continually drop out of voluntary treatment, those who are homeless, and those who are exposed to communities affected by drug abuse. Social workers working in the field of substance use and abuse therefore have to consider the need to include involuntary treatment methods and techniques in cases where a person is not able to decide to engage with treatment, but where the harm caused by the SUD is of such a nature that interventions are required.

2.4 SOCIAL WORK SERVICES IN SUD TREATMENT

Social work in South Africa is practiced by registered social workers. They function under the auspices of a statutory body – the South African Council for Social Service Professions (SACSSP) – which regulates code of conduct, education and training, and service requirements. The aim of the profession is to promote change in society through the building of capacity in human relationships and networks, and the enhancement of social functioning (DSD, 2019).

Considering the components of the Continuum of Care (Osborne-Leute et al., 2019) and the Framework for Social Welfare Services (DSD, 2013) that were described in section 2.3 above, social workers are required to deliver a range of services, depending on the needs of the service users. However, social workers have traditionally focused on treatment rather than prevention. In recent years, there has been a move towards services that respond to various demands that can be delivered

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on the Continuum of Care for SUDs (Osborne-Leute et al., 2019). Within the Continuum of Care, services are rendered through three primary methods of intervention, namely micro, meso, and macro social work, described by the DSD (2005) as follows:

- *Micro social work* is a method that makes use of skills and techniques to facilitate service user participation in decision-making to improve social functioning. Related to the Continuum of Care for SUDs, social work services related to this method of intervention include assessments, psycho-education, psycho-social support, treatment (therapeutically), and aftercare and or recovery management services.
- *Meso social work* as a method of intervention is directed to group processes and interventions, addressing the shared needs and challenges of a small number of service users. In terms of this study, group work activities can be included within the different components of the Continuum of Care for SUDs to address the service users' needs within a specific component. Social work services related to this method of intervention are psycho-educational groups, psycho-social support groups, treatment groups, and aftercare and or recovery management groups for service users and their social networks.
- *Macro social work* is a collaboration, planned action or functional community that works towards the promotion of the social functioning of the entire community. Such services are specifically relevant in terms of SUD health promotion and prevention initiatives and recovery support on the Continuum of Care of SUDs. Social work services related to this method of intervention are awareness campaigns, research, and psycho-educational events, for example, imbizos.

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Within the specific frameworks and levels of interventions, social work services in the treatment of a SUD are provided within a specific legislative framework, which will be discussed next.

2.4.1 Legislative Framework

The Constitution of the Republic of South Africa (South Africa, 1996), which is the supreme law of South Africa, provides the legal foundations for the rights and duties of its citizens (DSD, 2019). As such, the Constitution guides services by social workers. Social Workers are required to uphold the Constitution of South Africa,

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especially when it comes to service delivery with their client system. The following important views from the Constitution should be considered in the treatment of SUDs:

- The right to human dignity and the importance of human dignity being respected and protected entirely.
- The right to life and how life should be preserved.
- The right to access health care, food, water, and social security for all (South Africa, 1996).

There are three main legislative domains for the foundation of involuntary treatment of SUDs, namely: Mental Health Care Acts, Social Services Acts, and Criminal Justice Acts (Chau et al., 2021; Opsal et al., 2019). The criminal law approach in South Africa against substance abuse is a punitive punishment of imprisonment. Monyakane (2018) asserts that this approach has not improved the situation and has no impact on rehabilitation for service users. Section 33 of the Prevention and Treatment of Substance Abuse Act, No. 70 of 2008 (South Africa, 2008), however, provides another alternative in terms of involuntary treatment. As such, the legal framework within which social workers provide services to persons with SUDs is noted in the objectives of the Prevention of and Treatment of Substance Abuse Act (South Africa, 2008). Focus areas for services to persons with SUDs and their families can be categorised as follows:

- Strategies and principles for demand and harm reduction,
- Prevention and early intervention services aimed at addressing the values, perceptions, expectations, and beliefs associated with substance use,
- Community-based services provided to individuals with SUDs *and* those affected, while they remain within their families and communities,
- In-patient and out-patient services, encompassing residential treatment services offered at treatment centres and non-residential services provided by treatment centres for the purpose of holistic treatment services,
- Aftercare and reintegration services, which involve continued professional support to service users after formal treatment to support the maintenance of sobriety, personal growth, and the enhancement of self-reliance and proper social functioning, and
- Admission, transfer, and referral to treatment centres (South Africa, 2008).

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The above focus areas support the framework of the Continuum of Care of SUDs, as well as the DSD (2013) Framework for Social Welfare Services that were discussed in section 2.3. In terms of the admission of involuntary service users, the Act makes provision for the committal of persons to treatment centres. This can only be arranged through a sworn statement –

> submitted to a public prosecutor by a social worker, community leader or person closely associated with such a person, alleging that the involuntary service user is within the area of jurisdiction of the magistrate's court to which such prosecutor is attached and is a person who is dependent on substances and—
> (a) is a danger to himself or herself or to the immediate environment or causes a major public health risk;
> (b) in any other manner does harm to his or her own welfare or the welfare of his or her family and others; or
> (c) commits a criminal act to sustain his or her dependence on substances (South Africa, 2008, p. 40).

Stemming from the above Act, the NDMP 2019–2024 (CDA, 2019) is a comprehensive plan with a vision for South Africa to be substance free. The NDMP 2019–2024 acknowledges that a coordinated and multi-sectoral approach is needed to address the problem of substance use. Treatment, according to this document, refers to a process provided by a variety of service providers aimed at restoring the highest possible level of health and well-being. A community-based approach is advised in terms of a mission to;

1) Provide integrated and evidenced-based services that address substance use and abuse,
2) Develop safe communities through prevention and harm reduction services,
3) Address the demand and supply of substance use and abuse, and
4) Effectively control the use and distribution of substances for therapeutic use.

The following important views related to the treatment of SUDs that are held by the NDMP are to be considered by social workers:

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- Situational analysis: A situational analysis is required to define and describe the contributing factors, prevalence, and consequences of SUDs in terms of different substances in an international and South African context.
- Understanding SUDs: Services providers should adopt a scientific approach in understanding the concept of SUDs with the aim of meeting the demand for services in addressing SUDs effectively.
- Stakeholder engagement: Services by different stakeholders, such as different national departments, and other organisations and services providers engaging in combating substance use in South Africa, accentuate the need to work in collaboration with all role-players in the SUD field (CDA, 2019).

For the purpose of this study, involuntary treatment within the TTM framework was considered as a guide for social work services that align with the legislative framework.

2.5 TRANSTHEORETICAL MODEL OF CHANGE

Velasquez et al. (2005) identify the TTM developed by Prochaska and DiClemente (1984) as one of the most influential models in the field of substance use and abuse. This model is particularly focused on addressing the challenge of change, which is a significant hurdle in the treatment of SUDs. Furthermore, Hachtel et al. (2019) provide additional support for the use of the TTM by explaining that the model suggests that service users' engagement with treatment and recovery tasks is not a linear process. Instead, it involves movement back and forth between stages to support changes in their perceptions. The TTM serves as a theoretical foundation that facilitates intentional behaviour change. Table 3 below describes the major dimensions of this model, which are instrumental in the change process.

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Table 3: Dimensions of the Transtheoretical Model of Change

(Velasquez et al., 2005)

Dimension of the TTM	**Description**
Stages of change	Stages move between precontemplation to enter treatment towards recovery and the maintenance of achieved recovery. Five stages are indicated: 1) Precontemplation, 2) Contemplation, 3) Preparation, 4) Action, and 5) Maintenance.
Process of change	The movement between the stages of change implies behavioural change is supported through a process that requires a variety of inputs through a variety of cognitive and behavioural change strategies. The process of change, therefore, involves stage-based interventions, with specific strategies to be utilised within each stage.
Decisional balance	Service users are guided to make decisions based on a decisional balance of so-called pros and cons, which stimulate cognitive and motivational shifts within the different stages of change.
Self-efficacy	Self-efficacy is aimed at the maintenance of recovery. It includes the confidence to abstain from behaviour that could contribute to a relapse, as well as the ability to resist temptations to engage with such behaviour.

The five stages of change mentioned above are viewed as levels of motivation essential for positive treatment outcomes. The TTM attempts to use existing levels of motivation for a positive change by facilitating the stages of change to produce behavioural change (Robinson & Vail, 2012). The stages are further unpacked below.

- *Precontemplation*: In this initial stage, there is little or no consideration of changing risk-behaviour in the near future. There is limited motivation to change due to a lack of insight or recognition of the consequences of the SUD (Opsal et al., 2019).
- *Contemplation*: In this stage, the service user begins to assess the risks associated with their behaviour and considers the option of change. They may seek and

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evaluate information, but they are not fully committed to engaging in change (Opsal et al., 2019).

- *Preparation*: The information gathered and the considerations made during the previous stage leads to readiness for change. In this stage, the service user starts planning how and when to change their behaviour (Hoy et al., 2016).
- *Action*: The plan developed in the preparation stage is put into action. The service user actively takes steps to change their risky behaviour and is able to enter and engage in treatment interventions. As a result, a new behavioural pattern is established, and new skills are developed to prevent a return to the risky behaviour (Opsal et al., 2019).
- *Maintenance:* This stage involves strengthening and sustaining the behavioural changes made during the action stage. Self-efficacy plays an important role during this stage (Hoy et al., 2016).

Hall et al. (2012) refer to MI as a guide for service providers to facilitate the TTM. The authors explain that MI supports the principle of autonomy, while acknowledging that decision-making requires support and guidance. As such, the service provider places high value on a collaborative relationship with the service user. The tasks related to each stage are described in Table 4 below.

Table 4: Motivational interviewing (Hall et al., 2012)

Stage of change	Description	Practitioner's tasks
Precontemplation	Not ready	The practitioner points out risks and consequences to raise doubt and to increase the service user's perception of the risks and problems with their current behaviour. At this stage, harm reduction strategies are being introduced, and the service user is supported to continue to reflect on how behaviour affects one's own well-being and the well-being of others. The outcomes of harm reduction are also examined.
Contemplation	Getting ready	Once it is clear that the service user starts to acknowledge the negative consequences of behaviour, they are guided to weigh up the pros and cons of change.

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		The practitioner assists them to tip the balance from cons to pros by: ▪ Exploring ambivalence and alternatives, ▪ Identifying reasons for change and/or risks of not changing, and ▪ Increasing the service user's confidence in their ability to change.
Preparation & action	Ready	Once service users recognise the primary benefits of behaviour change, they are encouraged to: ▪ Set clear goals, ▪ Develop plans to attain those goals, ▪ Identify and engage with necessary support, ▪ Implement their plans and utilise the support.
Maintenance	Sticking to it	Service users are supported to develop maintenance plans that involve identifying possible risks and challenges; identifying and utilising strategies; and accessing ongoing support services to prevent relapse. Service users are also equipped with the necessary preparation and support to anticipate and address the possibility of relapse, including the development of a relapse prevention plan.
Relapse	Learning	If a service user has relapsed, the practitioner supports them to implement the relapse plan that was developed, and to assist them to re-engage with the different stages to reach the stage of maintenance again. An important aspect is that the service user must be supported to not becoming stuck in the relapse or to become demoralised.

Table 4 above combines the planning and action stages, and indicates relapse as another stage to consider during the treatment of a SUD. Hall et al. (2012) refer to relapse as being normalised in the MI framework. It is viewed as an opportunity to learn, to identify vulnerabilities and risks, and to develop further skills to maintain behavioural change in the future.

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Both the TTM and the MI frameworks guided the researcher to interpret the findings of this study, as presented in Chapter 4.

2.6 CONCLUSION TO THE CHAPTER

This chapter expanded on the preliminary literature review that was presented in Chapter 1, which was used to identify the research problem, formulate the research question, and establish the study's aim.

In this chapter, the term 'Substance Use Disorder' was thoroughly examined, along with the factors that contribute to substance use and abuse. The prevalence of substance use and abuse, as well as the consequences associated with it, were also explored. Furthermore, the chapter delved into the treatment of SUDs, focusing on different treatment frameworks and distinguishing between voluntary and involuntary treatment options. The role of social work services in SUD treatment and the legislative framework governing these services were also presented. The chapter concluded with a description of the TTM as the theoretical framework guiding this study. The synthesised literature in this chapter was used to compare and contrast the findings of the current study.

The next chapter describes the research methodology that was chosen and implemented in this study.

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CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

The research aim of this study was to explore and describe the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape. The first chapter introduced the topic of the study, outlined the key concepts, established the theoretical framework, identified the problem statement, formulated the research question, and stated the study's aim and objectives. Chapter 2 expanded on the key concepts through a comprehensive literature review. The current chapter focuses on the research methodology employed to address the research question and achieve the study's aim. It encompasses the research paradigm, approach, designs, as well as the research methods and techniques utilised. Additionally, the ethical considerations that guided the study and the limitations of the research are presented.

3.2 RESEARCH PARADIGM

This study aimed to answer the question of what the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape are. To answer this question, the study was conducted from a constructivist paradigm. Bryman (2016) explains that this paradigm acknowledges the importance of discovering the different processes within specific communities, and it assumes that social realities occur within a variety of layers. In order to answer the research question, the constructivist paradigm provided the researcher with a worldview to:

1) Choose participants who could answer the research question and contribute to the attainment of the aim of the research,
2) Explore their experiences to describe the realities they face, and
3) Organise and interpret the data to construct meaning (Bisman & Highfield, 2012).

Through the above characteristics, the research problem could be addressed effectively.

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3.3 RESEARCH APPROACH

The quantitative approach to research has to do with data that are gathered in a structured and objective manner, using predetermined instruments that are being subjected to statistical analyses (Boeren, 2018). Contrary to this description, the qualitative research approach is about exploring and understanding the meaning people give to their lived experiences (Creswell, 2014). From the constructivist paradigm, and in order to explore the realities experienced by social workers regarding the involuntary treatment of a SUD, this study was positioned as a qualitative study.

Tuffour (2017) argues that qualitative research is valuable for uncovering the meanings that individuals involved in the situation under investigation ascribe to the research problem, and it delves into the complexities of their social world. In line with this perspective, a qualitative research approach was chosen for this study, with further justification based on the following characteristics outlined by Robson and McCartan (2016) and Jensen (2016) that are relevant to this particular investigation:

- The qualitative research approach aims to address a research question, which, in the case of this study, was formulated as follows: What are the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape?
- The research question is aimed at using language through verbal data on the experiences and perceptions of people that describe the answer to the question.
- Qualitative research is often contextual in nature. In the case of this study, the contexts were the SUD field, involuntary treatment, and the Western Cape.
- The procedures are less structured, and the findings less objective as the researcher is viewed as a research tool.

In this study, the researcher was interested in exploring the experiences of social workers relating to the use of the TTM in involuntary treatment of a SUD in order to interpret the findings to develop an understanding of how involuntary treatment can be approached through a client-centred method of intervention. For this reason, the research designs selected to support this qualitative study were chosen to fit the qualitative research approach.

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3.4 RESEARCH DESIGNS

The research design serves as the framework that guides the selection of research methods and techniques (Robson & McCartan, 2016). The researcher employed a combination of the exploratory and descriptive research designs to inform the choice of research methodology for the purpose of this study.

Swedberg (2018) refers to the *exploratory research design* as the discovery of new information to address the research problem. This design was used to identify the research population, and sampling method and technique, to ensure that data were obtained from insiders in the situation, and also to identify a method for data collection that would ensure that the research problem is fully explored.

The *descriptive research design* was included to support the explorative research design, as it is used to describe a specific situation or phenomenon in such a way that it gives details and characteristics that can be used to construct a new understanding of the research problem (Nassaji, 2015; Ritchie & Ormston, 2014). The descriptive design enabled the researcher to obtain a thick description of the use of the TTM to motivate persons with a SUD to voluntary participate in treatment. This design influenced the choices of methods for data collection and analysis.

The researcher envisaged that he would be able to answer the 'what', 'how', and 'why' of the research problem when employing the explorative and descriptive designs from a qualitative approach. These approaches, then, informed the decisions related to the research methods and techniques to utilise in this study.

3.5 RESEARCH METHODS AND TECHNIQUES

This section provides an overview of the choices and implementation of the research population, sampling method and technique, as well as the methods for data collection, analysis, and verification. This description serves as an audit trail to enhance the dependability and transferability of the data (Anney, 2014).

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3.5.1 Population and Sampling

3.5.1.1 Research population

A research population encompasses all the people, objects, and/or events of interest to the researcher (Bryman, 2016). To investigate the research question and explore the lived experiences of individuals closely connected to the research problem, the research population in this study consisted of registered social workers in the Western Cape region. The Western Cape was identified as the research setting due to the fact that the research lives and work in this region, and that accessibility to could be enhanced in this way.

3.5.1.2 Sampling

The non-probability sampling method was used together with the purposive sampling technique to access and recruit participants. *Non-probability sampling* refers to sampling “that will not bid a basis for any opinion of probability” (Etikan & Bala, 2017, p. 1). This meant that the researcher could not pre-determine who the participants would be prior to the implementation of the study.

Purposive sampling, also referred to as subjective sampling, relies on the researcher’s judgement when selecting participants who will be able to answer the research question best (Sharma, 2017). Therefore, the researcher chose the following criteria for inclusion and exclusion of participants that were representative of the population:

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3.5.1.3 Inclusion and exclusion criteria

Inclusion criteria

- Registered social workers
- Possessing more than two years of experience in working with individuals with a SUD, and
- Employed in in- and outpatient treatment facilities.

Exclusion criteria

- Social workers with less than two years of experience, and
- Who are not working in the SUD field.

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3.5.1.4 The study's sample

The sample size was guided by data saturation, which is used in qualitative research to determine the achievement of intended research objectives. The researcher therefore continues to select participants and to collect data until no new information is identified when analysing the data (Fusch et al., 2018). In this study, data saturation was detected after eight interviews. The researcher then conducted one more interview to confirm that data saturation was reached, resulting in a sample size of eight participating social workers.

After obtaining ethical clearance from the University of the Western Cape to conduct this study (Annexure A), the researcher proceeded to sample participants from the research population. The researcher reached out to organisations that render in- and/or out-patient services to treat SUDs via telephone and email. When contact was made, the researcher provided the organisations with an invitation letter that requested permission to do research at the organisations (Annexure B). The organisations who agreed to participate then provided the researcher with the names and contact numbers of possible participants. The researcher emailed the participants to invite them to participate in the study, and provided them with an information sheet that described the aim of the study and the nature of their participation (Annexure C). This was followed-up by a telephone call to 1) determine if the person was willing to consider participating in the study, and to 2) discuss any questions they might have. Those who agreed to participate in the study were provided with a consent form (Annexure D) to be signed and returned to the researcher. Thereafter, arrangements were made to collect the data from those who indicated their willingness to participate in the study.

3.5.2 Data Collection

Individual semi-structured interviews with eight participants were used as the method of collecting data. While Mishra (2016) highlights that focus groups can provide rich data due to the interactions inside the group, the researcher considered the fact that COVID-19 regulations could impact on the planning and implementation of focus groups, and also that participants may feel imposed on when discussing challenges in a group of peers. Through individual interviews, the researcher was hoping to

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develop a rapport with the participants by showing interest and attention, and in this way generate rich data (Irvine et al., 2013). This choice is supported by Mikėnė and Gaižauskaitė's (2013) argument that individual interviews ensure that the participants' descriptions of their experiences, perspectives, and actions inform the findings, and that the researcher becomes the key data collection instrument. The latter is used to increase the validity of the study, and therefore data verification in qualitative studies is an important factor to be included (see section 3.5.4).

Semi-structured open-ended questions guided the interviews to ensure that participants were given the opportunity to explore and describe their views, opinions, experiences, and knowledge fully, thereby increasing the richness of the data (O'Keeffe et al., 2016; Mikėnė & Gaižauskaitė, 2013). The participants were guided through the interview process using an interview guide (see Annexure E) that was framed within the TTM, as discussed in Section 2.5. This guide served as a tool to structure and direct the interviews. The following questions were asked:

General questions

- In your opinion, what is the difference between the treatment of a voluntary and involuntary client?
- Have you ever used the Transtheoretical Model of Change?
    - If yes, what would be, in your opinion, the advantages of this model?
    - If yes, what would be challenges in the implementation of this model?

TTM-related questions

- In your experience, what should be the focus of intervention during the precontemplation phase when a client is not ready for treatment?
- In your experience, what should be the focus of intervention during the contemplation phase when a client is considering participating in treatment?
- In your experience, what should be the focus of intervention during the preparing for change phase when a client is planning to participate in treatment?
- In your experience, what should be the focus of intervention during the action phase when a client is participating in treatment?

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- In your experience, what should be the focus of intervention during the maintenance phase when a client is supported to sustain changes that were made?

Sub-questions for each phase

- What techniques have you used to assist a client in this phase?
- What works well?
- What challenges do you experience?

Majid et al. (2017) explain that piloting is an integral component of the data collection process as it supports the researcher to improve on the method and techniques used. Based on a pilot interview with one social worker who adhered to the inclusion criteria, the researcher reflected on the sampling technique, selection criteria, and interview questions to make amendments where needed prior to collecting the data. In this study, after analysing the data obtained in the pilot study, the researcher discussed the outcome with his supervisor. It was found that the questions were adequate to attain the aim of the study. The pilot study did not form part of the research findings.

The researcher obtained the participants' consent to record the interviews, and field notes were concurrently taken during the interviews to capture non-verbal data such as facial expressions and silent moments, etc. (Harding, 2019). After each interview, he transcribed the data and incorporated the field notes. Both the researcher and an independent coder collaboratively analysed the data.

3.5.3 Data Analysis

Thematic content analysis was used to analyse the data. This method follows an inductive approach, which involves identifying emerging themes within the data (Harding, 2019). The researcher followed the eight steps for qualitative data analysis proposed by Tesch (in Creswell, 2014), which included the following:

1) Forming an overall picture of the data that was obtained by reading through all the transcripts. Here, the researcher made some notes on a separate page of key ideas coming to the fore.

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2) Reading all the transcripts again, and plotting down the main ideas that were identified in the margin next to the texts.
3) Making a list of all the main ideas that were placed in the margin. The researcher then grouped related topics together, and identified sub-topics under each, where such sub-topics were identified.
4) Giving codes to the topics and sub-topics.
5) Selecting the most descriptive wording for topics in terms of themes, sub-themes, and categories.
6) Making a final decision regarding which themes, sub-themes, and categories to be included, based on the research question and aim.
7) Placing corresponding data under each theme, sub-theme, and category.
8) Verifying the themes, sub-themes, and categories with literature, and describing and discussing the findings.

The researcher analysed each transcript after the interviews. Once data saturation was observed, he proceeded with the final analyses as described above. An independent coder also analysed the data through the same steps indicated above. The researcher, independent coder, and supervisor then discussed the two sets of data analyses to determine what themes, sub-themes, and categories to include. The aim was to make sure that the research question was answered without excluding relevant information shared by the participants (O'Keeffe et al., 2016).

Throughout this study, the researcher placed a strong emphasis on data verification criteria to ensure the scientific value of this study.

3.5.4 Data Verification

Data verification in qualitative research focuses on the trustworthiness of the results or findings of the research (Kumar, 2014). The researcher employed credibility, transferability, dependability, confirmability, and reflexivity as the criteria to verify the data obtained in this study.

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3.5.4.1 Credibility

Credibility is aimed at ensuring that the research findings are a true representation of the participants' descriptions, and that the researcher's own perceptions, experiences, and interpretations do not influence the findings (Anney, 2014). Lietz and Zayas (2010) note that qualitative researchers must be cognisant of their own reactivity and/or bias when presenting the findings. In order to enhance the credibility of the study's findings, the researcher employed various measures, including an interview guide, transcripts of the interviews, verbatim quotes, and made use of an independent coder (cf. Anney, 2014).

3.5.4.2 Transferability

Transferability in qualitative research refers to the extent to which the research findings can be applied or transferred to other contexts and participants (Anney, 2014). Lietz and Zayas (2010) explain that "qualitative research studies are not generalizable according to quantitative standards, because probability sampling is not employed. Instead, qualitative studies typically use purposive sampling to seek a specific group of participants who have experienced the phenomenon being studied" (p. 195). To promote transferability, non-probability purposive sampling was used in this study. In addition, to ensure that the findings of this study could be used in the SUD field of practice, a comprehensive description of the implementation of the research methods and techniques was provided in this chapter.

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3.5.4.3 Dependability

Dependability has to do with the stability of the research findings over time (Anney, 2014). Lietz and Zayas (2010) refer to this criterion as 'auditability', emphasising the importance of maintaining a clear audit trail that documents how the study was conducted, thus ensuring the dependability of the findings. In this study, the researcher, as with transferability, described the choices of research methods, and the implementation thereof to support the dependability of the findings.

3.5.4.4 Confirmability

According to Anney (2014), *confirmability* has to do with the truth value of the findings, and whether the findings could be confirmed by other research findings. In this study,

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the researcher made use of relevant and recent literature to compare and contrast the findings of this study with. In addition, the thick description of the research methodology contributed to the confirmability of this study's findings (cf. Lietz & Zayas, 2010).

3.5.4.5 Reflexivity

According to Finefter-Rosenbluh (2017), *reflexivity* is a crucial strategy in qualitative research, as it allows the researcher to take the role of the insider/outsider with a continuous internal dialogue and critical self-evaluation. Lietz and Zayas (2010) assert that reflexivity is one way to further enhance the creditability of qualitative research findings. In this study, the researcher continuously reflected on the implementation of the research methods, and how this contributed to a scientifically sound way of ensuring that his own possible reactions or bias did not affect the construction of meaning provided by the contributions of the participants (cf. Anney, 2014).

3.6 ETHICS

This section focuses on the ethical practices that aligned with the ethical clearance (Annexure A) implemented in this study, namely avoidance of harm and debriefing, voluntary participation and informed consent, anonymity, confidentiality, privacy, and data storage and management.

3.6.1 Avoidance of Harm and Debriefing

Strydom (2011) suggests that social research may result in physical, emotional, and/or social harm, and that the research plan must be aimed at avoiding and limiting any potential harm to participants. In this study, the researcher made use of voluntary participation, informed consent, confidentiality, privacy, and anonymity to avoid and limit potential harm.

When invited to participate, the participants were afforded the opportunity to voice concerns so that potential harm could be identified and addressed. However, Devlin (2018) warns that some participants might experience emotional reactions during the research, which cannot be known beforehand. Therefore, the research made provision

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for a social worker that was available to conduct debriefings should the participants require it. However, no participant requested debriefing.

3.6.2 Voluntary Participation and Informed Consent

According to Devlin (2018), possible participants must be able to make a cognitive decision to participate in a study or not. This requires that they receive information relevant to the study prior to their decision to participate. To ensure that the participants in this study based their decisions to participate on relevant information, the researcher provided them with an information sheet (Annexure C) that described the nature of the study, including possible risks so that they were able to make an informed decision if they wanted to participate in the study or not. The researcher also ensured that the participants understood that they could withdraw from the study at any time without any consequences. The researcher obtained written consent from the participants to partake in this study (Annexure D).

3.6.3 Anonymity, Confidentiality and Privacy

Harding (2019) explains that anonymity, confidentiality, and privacy are interrelated concepts in social research. In this study, the researcher was guided by Novak's (2014) description of the terms. Anonymity was ensured through the use of pseudonyms in the transcripts. A separate list of the names of the participants linked to the pseudonyms was stored in a safe place accessible only to the researcher and his supervisor. Both anonymity and confidentiality were upheld by excluding any personal information of the participants in the research reports, and by describing the findings as a collective story. Privacy was ensured by conducting the interviews at venues where the participants were not exposed, and where they felt comfortable to share their experiences and perceptions. Therefore, they were asked to determine where and when the interviews should take place.

3.6.4 Data Storage and Management

The protection of personal information, accurate and unbiased reporting, and the opportunity for feedback on the findings are all integral aspects of upholding the rights to anonymity, confidentiality, and privacy (Webster et al., 2014). Hard copies of all documents were stored in a locked cabinet accessible only to the researcher and his

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supervisor. Digital documents were saved on a password-protected computer, and the researcher and his supervisor were the only persons with access to this information. The personal information of the participants will be destroyed in an ethical manner after five years, as per the requirements of the university. Hard copies will be shredded, and digital copies will be deleted. The transcripts of the interviews, without the any personal identifying information of the participants, will be stored in the digital data management system of the university to ensure that the findings can be verified and disseminated.

3.7 LIMITATIONS OF THE STUDY

This section acknowledges the limitations of the study:

1) Generalisability: The aim of this study was to explore and describe the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape. Therefore, the findings of this study cannot be generalised to other contexts or populations. The study's scope was limited to the Western Cape region.

2) Regional representation: The study was only conducted in the Western Cape and no other regions of South Africa are represented in this study. This limits the ability to make broader claims about the experiences of social workers in the entire country.

3) Sample size and participant representation: While data saturation was achieved within the small sample population of social workers, it is important to acknowledge that the findings may not capture the full range of perspectives. The study focused exclusively on social workers, and the perspectives of clients with SUD were not included, potentially limiting the understanding of the topic.

4) Pilot study inclusion: The decision to include data from the pilot study participant may introduce some limitations. While the participant was able to answer the questions, it is important to consider the potential impact on the

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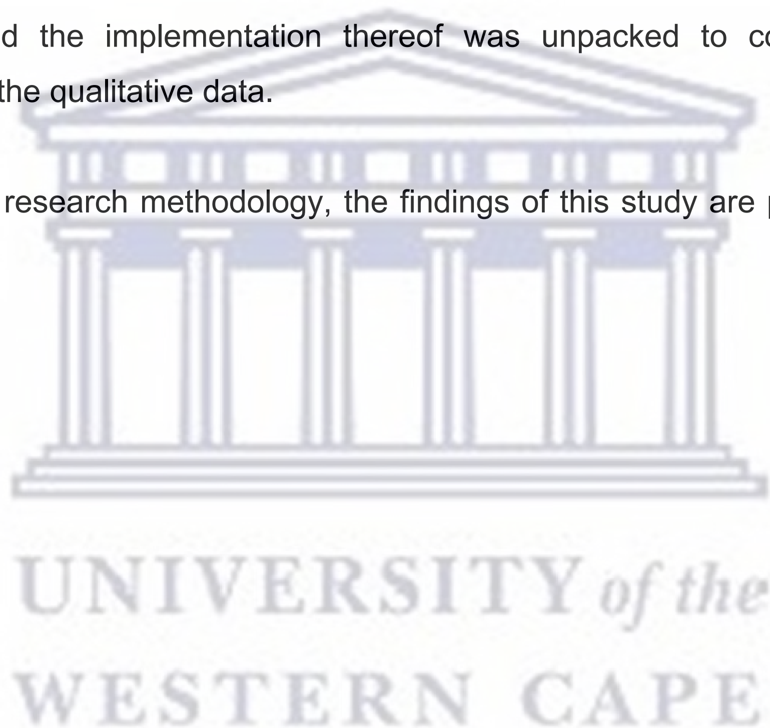
overall findings and ensure that the inclusion does not unduly influence the results.

Overall, it is crucial to interpret the findings of this study within the specific context of the Western Cape, considering the limited sample size, participant representation, and the qualitative nature of the research design.

3.8 CONCLUSION TO THE CHAPTER

This chapter provided a thick description of the research methodology that was employed in this study. The choices of research methods and techniques were explained, and the implementation thereof was unpacked to contribute to the verification of the qualitative data.

Based on the research methodology, the findings of this study are presented in the next chapter.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CHAPTER 4
PRESENTATION AND DISCUSSION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

The aim of this study was to explore and describe the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape. To achieve this aim, several objectives were formulated. This chapter responds to the first two objectives:

- Objective 1: To explore the experiences of social workers regarding the use of the TTM of Change in involuntary treatment of a SUD through individual qualitative interviews.
- Objective 2: To develop an in-depth understanding of the experiences of social workers regarding the use of the TTM in involuntary treatment for SUDs through the analysis of the findings and literature control.

The subsequent section provides a biographical profile of the participants, thus contextualising the findings of the study. Following this, the study's findings are presented by discussing the identified themes and sub-themes. A brief conclusion sums up the main points of the chapter.

4.2 BIOGRAPHICAL DESCRIPTION OF THE PARTICIPANTS

The sample population of this study was registered social workers within the Western Cape province. The researcher used purposive sampling in the selection of social worker participants in the field of SUD. The inclusion and exclusion criteria, together with the methods to access participants have been described in Chapter 3. Eight participants participated in the study. Data saturation was detected after six interviews. The researcher then conducted two more interviews to confirm that no new themes or sub-themes were included in the descriptions provided by these two participants. Table 5 below summarises the biographical profile of the participants in this study in terms of age, gender, geographical area, focus of service delivery to persons with a SUD, years of experience, and ethnicity.

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Table 5: Participants' profile

Participant number	Age	Gender	Race	Geographical area	Level of Intervention	Years of experience
P1	57	Female	White	Plettenberg Bay	Early intervention & aftercare	20
P2	32	Male	Coloured	Bellville	Prevention & early intervention	5
P3	26	Female	Coloured	Worcester	Prevention, early intervention & aftercare	4
P4	35	Female	Coloured	Ceres	Prevention, early intervention, statutory & aftercare	8
P5	28	Female	Coloured	Bellville	Early intervention & aftercare	3
P6	34	Male	Coloured	Cape Town	Prevention, early intervention & aftercare	14
P7	30	Female	African	Hermanus	Early intervention & aftercare	6
P8	37	Female	Coloured	Paarl	Early intervention & aftercare	2

Two male and six female social workers participated in this study, and their ages ranged from 26 to 57 years. The racial profile included White, Coloured and African ethnic groups. The geographical areas in the Western Cape represented by the participants are Paarl, Worcester, Ceres, Hermanus, Plettenberg Bay, Cape Town and Bellville. The participants worked in prevention, early intervention, treatment, statutory and aftercare services to their respective client systems. Their years of experience ranged from 2 to 20 years in the field of SUD. This description points to social workers

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providing a range of services on the continuum of care (cf. Osborne-Leute et al., 2019) that are included as services to be offered to persons with a SUD and their families (South Africa, 2008).

The demographic profile of the participants informed the way in which the findings below were interpreted.

4.3 FINDINGS

The data were collected by means of individual semi-structured interviews that were recorded using a recording device. After each interview, the data were transcribed and field notes were added. The recordings and transcripts were stored on a password-protected computer, and the participants' personal details were not included in the transcripts. Each participant was assigned a number, and their personal information was included next to the relevant number on a separate document that was stored on a password-protected computer to which only the researcher had access. Thematic analysis was used to analyse the data, following the steps proposed by Tesch (in Creswell, 2014) as described in Chapter 3. A total of eight themes emerged from the data analysis. Sub-themes were identified within some themes. Table 6 below summarises the themes and sub-themes that emerged from the data analysis.

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Table 6: Themes, sub-themes, and categories

Themes	**Sub-themes**
Theme 1: Descriptions of experience in the field of SUDs	Sub-theme 1.1: Specialised education and training
	Sub-theme 1.2: Work experience
Theme 2: Perceptions regarding the difference between voluntary and involuntary treatment	Sub-theme 2.1: Voluntary clients
	Sub-theme 2.2: Involuntary clients
Theme 3: Description of experiences related to what works well,	Sub-theme 3.1: What works well when using the TTM

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challenges, and requirements regarding the use of the TTM	Sub-theme 3.2: Challenges when using the TTM
	Sub-theme 3.3: Requirements for the use of the TTM
Theme 4: Description of experiences and perceptions related to intervention in the precontemplation stage	Sub-theme 4.1: The inclusion of families
	Sub-theme 4.2: Awareness through education
	Sub-theme 4.3: Motivational interviewing
Theme 5: Description of experiences and perceptions related to intervention in the contemplation stage	Sub-theme 5.1: Clients' reasons for change
	Sub-theme 5.2: Support systems
Theme 6: Description of experiences and perceptions related to intervention in the preparation stage	Sub-theme 6.1: Setting goals
Theme 7: Description of experiences and perceptions related to intervention in the action stage	
Theme 8: Description of experiences and perceptions related to intervention in the maintenance stage	Sub-theme 8.1: Aftercare services
	Sub-theme 8.2: Employment opportunities

The findings are presented through verbatim quotations from the participants, and also through a comparison with existing literature.

4.3.1 Theme 1: Descriptions of Experience in The Field of SUDs

While describing their backgrounds related to working in the field of SUDs, the participants explained that they have a specific interest and passion for the field.

> "*I am a social worker for almost 34 years with a passion for substance abuse*" (P1).

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"I always liked a challenge. So, my team [previous employment doing generic social work] *would always look at me like the substance abuse champion because I would like to go for it*" (P8).

In terms of the theoretical framework of this study, Wells et al. (2013) accentuate that the TTM is a complex intervention strategy that requires not only an understanding of SUDs, but also an attitude of empathy based on a belief in the potential for recovery among client systems. In addition, competencies are needed to provide structure and direction, and to build a collaborative relationship with the client (cf. Hall et al., 2012; Velasquez et al., 2005). In this theme, the participants described their competencies in the field in terms of specialised education, training, and work experience, as described in the sub-themes that follow.

4.3.1.1 Sub-theme 1.1: Specialised education and training

According to Alpaslan (2019), the social work education and training curriculum in South Africa is generic in nature, and, as a result, social work graduates often enter various fields of social work without specialised training. With this in mind, Unegbu (2020) and Wells et al. (2013) assert that social workers are among the primary service providers for persons with SUDs. They further emphasise that this work requires specialised education and training, as most social workers are underprepared to work in the field after graduation. Some participants in this study obtained diplomas in addiction care from two universities in the Western Cape, where this study was conducted.

"*I have a Postgraduate Diploma in Addiction Care from Stellenbosch University*" (P1, P4).

"*I did a course at UCT* [University of Cape Town], *which was focusing on Postgraduate Diploma in Addiction Care"* (P7).

Unegbu (2020) advocates for a focus on continued professional development in the SUD field. One way of achieving continued professional development is through specialisation via postgraduate studies. Participant 5 was busy with a Master of Social

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Work degree, focusing on SUDs: "*I am currently also doing my postgraduate studies for a Masters of Social Work*". Participant 6 reported that he has obtained a Master of Social Work degree focusing on SUDs, and that he was currently enrolled for a doctor's degree in this field: "*I am currently in private practice, and I hold a BSW degree in Social Work, and then I have a Master's degree in Social Work with specialisation in substance use. Currently I am busy with a PhD in Social Work, also with a specialisation in substance use*". This participant continued to report on further qualifications in the field: *"I am also an international credential addiction practitioner certified by the Global Centre for Credentialing and Certification Addiction Professionals*".

While the above descriptions point to expertise obtained through education and training, the participants also referred to work experience that results in specialised competencies.

4.3.1.2 Sub-theme 1.2: Work experience

Participant 7 explained that she is doing generic social work, but that the primary focus of her work is substance use and abuse:

> "*I worked in the substance use field for three years and now I am doing generic work. But, I mostly do early intervention only on substance use, and then add to the referrals to the inpatient treatment centres. I do aftercare as well after the client has been discharged*" (P7).

> "*I am currently specialising in substance abuse* [at current employer]" (P8).

The following utterances indicate work experience in the SUD field at non-governmental organisations (NGOs), psychiatric hospitals, the DSD, and treatment facilities.

> "*I have worked all over. I have a lot of experience, mainly the last 20 years in substance abuse. In 2008 I started to work in a rehabilitation centre,*

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and then moved to X [an NGO focusing on substance use]. *From there I moved to psychiatric hospitals where I was responsible for the substance abuse programme for them*" (P1).

"*I worked at the DSD as an Intake Social Worker. This is where clients are assessed, and inpatient rehabilitation applications are done for them*" (P2).

"*I currently work at a Community Centre. I am the community-based treatment social worker, and I am also doing aftercare*" (P3).

"*I worked at DSD, X* [an NGO focusing on substance use], *and at a rehabilitation centre*" (P4).

"*I am placed at an outpatient rehabilitation programme at X* [an NGO focusing on substance use]. *We provide services to those who struggle with substance and alcohol addiction*" (P5).

The utterances above point to services on micro, meso, and macro levels of intervention. Some participants worked with individuals (micro level), while others indicated work in a treatment centre (micro and meso levels), and others worked at NGOs that also worked within communities (macro level) (cf. DSD, 2005).

Participant 1 indicated that she has a private practice focusing on the treatment of SUDs: "*So, also in my private practice, that is mostly the clients that I see, which is substance related"* (P1). Participant 6 further reported his expertise in the field in terms of work for the CDA: "*I currently also sit on the Central Drug Authority of South Africa, which is the highest decision body [in] the country in response to substance use*".

The next theme describes the participants' perceptions regarding voluntary and involuntary clients.

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4.3.2 Theme 2: Perceptions Regarding the Difference Between Voluntary and Involuntary Treatment

In this theme, the participants referred to the topic of willingness to engage in treatment versus resistance to participate in treatment. They highlighted that voluntary participation requires clients to acknowledge that substance use and abuse causes problems in their lives, while involuntary clients are in denial regarding such problems.

> "*So, the difference there for me is the willingness. If a client comes voluntarily, he is willing to be there, and if he is involuntary, he doesn't want to be there*" (P1).

> "*So, in my understanding, 'voluntary' is when a client is willing to go for treatment, and 'involuntary' is when the client is not yet at the point where he recognises or realise[s] that he has a problem*" (P2).

> "*Alright, voluntary clients are those that are willing to participate within a treatment programme. They are aware of the problem, and they are ready to move towards change. Whereas someone who is involuntary does not necessarily come out of their own will and are the ones that are in denial or unaware of the problem of their addiction*" (P5).

The above statements indicate that voluntary treatment refers to when clients are willing to participate in treatment. Pasareanu et al. (2017), confirming this viewpoint, note that successful treatment outcomes are primarily dependent on a service user's ability to develop insight and judgement regarding their substance use. Therefore, a willingness to undergo treatment, i.e., voluntary treatment, is crucial. Consequently, the principle of autonomy serves as the foundation for service users accessing treatment voluntarily. When comparing voluntary with involuntary treatment, the participants in this study highlighted that service users typically exhibit a lack of desire to be in the treatment programme, an inability to recognise the problem, and/or a limited awareness of the problem due to poor insight. Cousins (2020) adds that the unwillingness to participate in the treatment programme may have implications that

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have to do with power dynamics, coercion, and control within the provision of services, which then affects the relationship between the service user and the service provider.

The following sub-themes further describe the participants' descriptions of their understanding of voluntary and involuntary clients and treatment.

4.3.2.1 Sub-theme 2.1: Voluntary clients

Voluntary participation in treatment may be viewed as interventions where clients request services themselves (South Africa, 2008), and it is assumed that clients who ask for help will have higher levels of motivation to move into recovery than those who are receiving services that are enforced on them (Opsal et al., 2019; Pasareanu et al., 2017). Related to the latter comment in Theme 2 above, Participant 3 referred to the intrinsic motivation to change that motivates voluntary clients: "*For me, a voluntary client is someone that asks or comes to us for help out of his own. He wants to be helped".* Intrinsic motivation was also referred to by other participants, and linked to a motivation to participate in treatment interventions:

> "*Voluntary clients basically want treatment and to help themselves because they want to better their lives*" (P3).

> "*OK, 'voluntary', I would say, is your client who is aware of his problem or addiction and wants to be helped and is motivated to some level to be help*".

> "*So, in my opinion, voluntary clients have the motivation to be treated. They are … they basically accepted that they have substance use disorder or [a] substance use problem. There is a desire to basically enter the process of change, and they are willing, and there is to some degree of understanding of the problem and what the process of rehabilitation or change will entail. Involuntary clients are reluctant/resistant to the process for change*" (P6).

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Intrinsic motivation to change is based on insight regarding the benefits of making changes (cf. Legault, 2016). However, Serafini et al. (2016) acknowledge that extrinsic motivation to change can guide the process of developing insight, which, in turn, can result in intrinsic motivation to change.

The above comment by Participant 6 also alludes to insight among voluntary clients. This was further supported by Participant 7 who described a voluntary client as follows:

> "*A voluntary client is a person [who] understands that there is a problem and that made a decision that they have a problem, and they're seeking help towards their addiction*".

4.3.2.2 Sub-theme 2.2: Involuntary clients

The participants further mentioned that a difference between voluntary and involuntary treatment could be viewed in terms of consent:

> "*An involuntary client… to my knowledge, there are two types of involuntary clients. The first one is referred from the court who is a mandated client. Then there are involuntary clients that have been sent by their families or employers to come for help with their addiction problem*" (P3).

> "*With involuntary clients, they did not give consent per se*" (P7).

> "*And then involuntary is for me like a forced situation. Where the client is doing it for some reason to please people, or the court is sending him. It's a must*" (P8).

The literature recognises that the self-determination of clients should be respected (cf. Varkey, 2021), but that interventions aimed at supporting involuntary clients must be considered when the consequences of a SUD could be harmful to the person or others, and where a person is not able to make an informed decision as a result of the

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SUD (cf. Sant'Ann et al., 2020; New South Wales Government, 2019; South Africa, 2002). However, Participant 1 alluded to the fact that it is challenging for social workers to work with involuntary clients: "*It is difficult to treat an involuntary client. It takes out everything out of you because the person doesn't want to be there*". This statement was further expanded on by statements highlighting the need for the use of TTM to assist involuntary clients to move towards an internal motivation to participate in interventions:

> "*And that makes change very difficult because if you force me to go somewhere, I will not change at all. I've seen it so many times. They will relapse because they are not ready for change*" (P1).
>
> "*I would even go so far to say that to a certain extent they* [involuntary clients] *don't have insight with regards to the substance use disorder they are experiencing in their lives, which basically makes them reluctant. They are not at the point yet where they are motivated and that they have insight with regards to what it is that is happening in their lives*" (P6).

Wells et al. (2013) emphasise that utilising the TTM requires knowledge, experience, and skills. The next theme will delve into the participants' personal accounts of employing this model, providing further insight into their experiences.

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4.3.3 Theme 3: Description of Experiences Related to What Works Well, Challenges, and Requirements Regarding the Use of the TTM

This theme encompasses the participants' reflections on their utilisation of the TTM, outlining what they considered as the advantages, challenges, and requirements for effectively implementing this model.

4.3.3.1 Sub-theme 3.1: What works well when using the TTM

Referring to the previously mentioned issue of insufficient insight which leads to the lack of motivation to change, Participant 1 added that an advantage of the TTM is that the person is guided to understand the impact of the SUD:

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"Advantages for me is that a client himself can start to see where is the problem and when it is the problem".

Other participants indicated that interventions are based on where the person is at in their understanding of their situation, and that the focus is on what is needed for this person to engage actively with treatment to become able to move towards recovery.

"The advantages of this theory are that you get to understand where the client is, and you get to treat the client actually where the client is" (P7).

"Yes, we do use stages of change. Especially in screening because we need to identify where they are at in terms of the readiness for the programme" (P5).

According to Jimenez-Zazo et al. (2020), motivation for change serves as the basis for the TTM. The various stages within the TTM dictate the necessary interventions that are needed to ensure motivation for change and the movement to recovery, and the maintenance thereof. These authors explain that the TTM acknowledges the stage of change in which the client is, and how it is important to identify where the clients are at in order for treatment to be responsive to the client's readiness for change. As such, the TTM considers a decisional balance where the client is being guided to make a decision to engage in treatment aimed at changing their situation.

In addition to the advantages of the use of the TTM in general described above, the table below summarises the participants' descriptions of what works well in each of the stages of the TTM.

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Table 7: What works well during the different stages of the TTM

Stage in the TTM	Descriptions of advantages
Precontemplation	*"But for me, what works well here is that you educate them first of all on what substance is in a manner that would not be judgemental or degrading for them"* (P2). *"So, I think in the precontemplation stage where the client is not ready to accept treatment, you must use motivational interviewing to try to convince the client or show the client that these are the things you have lost, or this is what happened to you when you were using"* (P3).
Contemplation	*"I would focus on letting the client see the benefits of getting sober for something you can use as leverage. So, I would want the client to see that I don't want that old life. I am not ready to change, but I do not like the sick feeling afterwards"* (P1). *"Here I involve the family and the church. Not friends. Support groups, yes. Also, to have sessions on a weekly basis to get them into a routine"* (P4).
Preparation	*"So, I think in this phase the client is starting to realise that changing their life or their behaviour can lead to a happier or a healthier life for them. They will be able to achieve more things if they change their behaviour in this phase. So, now you are starting to work on the client's behaviour"* (P3). *"I think it's really important that you include the family from the stage to support the decisions that the client is making"* (P8).
Action	*"I think the focus should be on the client strengths because now the client is already here, the client is ready and needs to see successes in the changes being made"* (P7). *"The action stage is where you go actively into treatment. So, for me, in this stage, it's important that you, the practitioner, is involved as well as the family. So that they don't feel that they are alone and that you forgot them* (while in the treatment facility)*"* (P8).
Maintenance	*"This is about aftercare. This is where you connect the client with a support group or with his religion like a church"* (P3). *"So, the focus right now should be on support services for the client to continue with the changes that were made*" (P7).

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The descriptions point to the importance of education and or raising awareness to increase the motivation of clients in the **precontemplation** stage. Through this focus, the social worker aims to strengthen and build capacity with the client system (DSD, 2013). The **contemplation** stage particularly focuses on causing discrepancies between the client's current lifestyle and future possibilities. According to Opsal et al. (2019), the client starts to engage in introspection regarding their risky behaviours and the associated consequences, and as a result considers the possibility of change as a viable option. This stage also emphasises the importance of involving and seeking support from family and the church, as well as consistently accessing services.

In the **preparation stage**, the focus is on promoting positive behavioural changes to address ambivalence, while once again emphasising the need for family involvement and support. Decisional balance is where clients evaluate pros and cons to reinforce their decisions for behavioural change (Velasquez et al., 2005).

In the **action stage**, a strength-based approach is accentuated, highlighting the importance of ongoing support from both the social worker and the client's family while actively engaging in treatment services. Opsal et al. (2019) assert that the aim is to provide support so that the person can develop skills to change behaviour that will prevent a return to substance use.

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In the **maintenance stage**, the focus shifts to the significance of aftercare services and continued support in order to prevent relapses. This stage relies on the client's self-efficacy, which plays a crucial role in strengthening and sustaining the changes achieved (Hoy et al., 2016).

4.3.3.2: Sub-theme 3.2: Challenges when using the TTM

The TTM is not without challenges, as illustrated by the following statements:

> "*It* [the process] *just takes long and families don't understand why you are taking so long. With this process, everybody needs to buy in"* (P1).

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"Time. It can cost a lot of time. For instance, you are in the contemplation stage where the client is indicating he is ready to go for treatment, and then all of a sudden he goes back to the precontemplation stage" (P8).

These statements indicate the time-consuming nature of the TTM, especially when clients move between the stages. Furthermore, it underscores the importance of families comprehending the process so that they can actively and patiently participate in the different stages. This viewpoint is supported by Prochaska and Prochaska (2019) who note that the TTM suggests that behaviour change is a process that unfolds over time. Similarly, Rodgers et al. (2021) postulate that the TTM conceptualises intentional change as a movement through a series of stages to become ready to make the change. These authors support the idea that the TTM is a model that takes time for clients to move and behavioural changes to take effect.

Similar to the descriptions of what works well described in the previous sub-theme, challenges were also described in terms of the specific stages of the TTM, as summarised and described below:

Table 8: Challenges experienced during the different stages of the TTM

Stage in the TTM	**Descriptions of challenges**
Precontemplation	*"The client doesn't pitch for appointments, or the parents must come with the clients to see that the client did show up. The client is resistant, doesn't want to change, or doesn't want to attend any group sessions as well"* (P4). *"So, I think clients will be resistant to such an extent that they don't even want to engage you"* (P6).
Contemplation	*"A lot of families are at the point of 'we are not doing anything, we are not going to assist, not going to a support group. We have done this before'"* (P5). *"It's an inconsistency first of all. In this stage, they're not consistently moving forward, and they're not yet committed"* (P7).
Preparation	*"One of the challenges are that the client is willing and preparing, but now the client doesn't have the finances to pay for the options available"* (P2).

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	"In the preparation stage, they still feel like you're giving them too much work. It's too much work, it's too much effort" (P8).
Action	*"The challenge is that people get jobs. Then they feel halfway through they are in a routine, they are happy, the family is happy, the work is happy. So, they can't come to the sessions and then it is a drop out"* (P4). *"Now they are ultimately without substances, and I have seen depression in some clients and then there can be a desire to revert back to old behavioural patterns"* (P6).
Maintenance	*"So, the clients need to deal with that boredom, how to keep themselves busy and also to stay consistent, attending groups"* (P2). *"Clients can have an easy relapse in this stage because they do not attend sessions anymore. They feel like they are now a recovering addict, so they don't need our services anymore"* (P4).

The descriptions point to the unwillingness of clients to take responsibility for their SUD and resistance to participate in any form of services within the precontemplation stage. The resistance to access treatment can be linked to the consequences of psychoactive substances on the brain's reward system as explained by September (2015). Subsequently, Volkow et al. (2016) conclude that the ability to respond to intervention often indicates a person's dependency on a substance. In the contemplation stage, the absence of family involvement (cf. Pettersen et al., 2019) and inconsistency in accessing services hinders progress towards the preparation stage. To address this concern, Sajjadi et al. (2015) propose that services should encompass a broader perspective, considering factors such as personal, family, and environmental aspects as focal points for intervention. The lack of funding, resources to access services for clients, and the client struggling to cope with the demand for recovery is, according to the participants in this study, evident in the preparation stage.

Furthermore, Harker-Burnhams et al. (2012) assert that the lack of availability and access to SUD treatment services are inequitable and limited across South African communities. The participants pointed out that, during the action stage, clients drop out from services because of a routine that appears to work for them and/or psychological difficulties, e.g., depression. The latter is supported by Ekse (2022) who confirms that a long-term consequence of a SUD can include psychological difficulties

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such as depression. The participants reported further that, in the maintenance stage, clients are unable to manage their time effectively, to avoid feelings of boredom, and to commit to the continuation of services. Therefore, Velasquez et al. (2005) argue for a focus on self-efficacy where clients become able to manage high-risk situations that could lead to relapses.

Apart from the above descriptions of what works well and the challenges when working according to the stages in the TTM, the participants also referred to certain requirements for effectively utilising this model.

4.3.3.3: Sub-theme 3.3: Requirements for the use of the TTM

The participants noted that the context of client systems need to be considered, as described by the following statement:

> "*The challenge for me is [the] context of the client. We need to understand where the client comes from. You see, because most specially in the communities where we work in people are not as advantaged. There are so many socioeconomic issues that make them not be ready, not be at the action or preparation stage yet, and they stay at the contemplation stage forever"* (P7).

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This statement highlights how socioeconomic circumstances might impact on the movement between the stages in the TTM because of the impact of the issues/challenges faced by persons living in disadvantaged communities. According to Volkow et al. (2019), repeated exposure to substance use in the environment may result in the development of a SUD (cf. Pasman et al., 2020; Deepmala, 2014). In addition, the interactions of environmental, psychological, and biological factors play a pivotal role in the use and abuse of substances, as well as in the development of a SUD (Volkow et al., 2019). Also referring to the contextual impact on the perseverance of SUDs, Ng et al. (2018) postulate that there are more risk factors for vulnerability to a SUD than protective factors.

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Other participants referred to realistic and attainable goals in the contemplation and preparation stages so that the clients can benefit from experiences of achievements they were able to make.

> *"So, I think in this phase* [contemplation] *the client is starting to realise that changing their life or their behaviour can lead to happier or a healthier life for them. They will be able to achieve more things if they change their behaviour. In this phase you are working on the client's behaviour"* (P3).

> *"Finding realistic changes that they can make. Finding realistic goals… It's during the preparation phase because sometimes clients can get really pie in the sky* [referring to guide clients to find realistic steps that could be achieved]. *So, for me it will be finding realistic changes"* (P1).

Similarly, Pennington (2021) posits that the TTM constructs stages of change, which is a representation of movement from a lower stage to a higher stage of change. The importance of assisting clients to move from the precontemplation phase is highlighted by Hall et al. (2012). They advise that the emphasis should be on highlighting risks and consequences to raise doubt regarding the continuation of substance use and/or abuse. Next, the contemplation stage can be used to explore ambivalence, alternatives, and reasons for change, as well as increase confidence to change. The participants in this study referred to acknowledging the context, assisting clients with finding realistic goals, and supporting them to make relevant behavioural changes. In terms of working with involuntary clients, they specifically referred to the precontemplation and contemplation phases in their descriptions.

The next themes describe the participants' experiences and perceptions of all the different stages of the TTM.

4.3.4 Theme 4: Description of Experiences and Perceptions Related to Intervention in The Precontemplation Stage

This stage entails working with a person with a SUD who does not show insight in the consequences of substance use and abuse, and who is not ready to engage with

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treatment interventions. The aim is to create an awareness of the risks and consequences of the continued use/abuse of substances (Hall et al., 2012). Participant 3 summarised the precontemplation stage as follows:

> *"So, I think in the precontemplation stage, where the client is not ready, you must use motivational interviewing to try to convince the client or show the client that these are the things you have lost, or this is the thing that happened to you when you were using"*.

Participant 4 further described the focus of this stage in terms of assisting the client to explore the advantages and disadvantages of substance use:

> *"If the client is in a precontemplation stage then I would look at what is the advantages [and] disadvantages of using drugs"* (P4).

Similar to the above descriptions, Opsal et al. (2019) advise that this stage should focus on creating awareness so that the person becomes able to recognise the consequences of substance use on them and their families.

While discussing their experiences and perceptions of the precontemplation phase, the participants referred to three aspects that are presented as sub-themes, namely: 1) The inclusion of families, 2) education to raise awareness, and 3) the use of MI techniques.

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4.3.4.1 Sub-theme 4.1: The inclusion of families

Hall et al. (2012) explain that the focus of intervention in the precontemplation phase is on creating awareness of the impact of the substance abuse on the person, the family, the workplace, and community. For this reason, the inclusion of families can be a vital way to provide the person with facts and descriptions of what happens during substance use, as well as the consequences. In this study, the participants acknowledged that families are often not included in services, while the involvement of families is viewed as an advantage of the TTM:

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"…many times, we do neglect to involve the family within the precontemplation stages. The family can play a very pivotal or important role in the stage as well as in the motivation of the client…" (P6).

"… and then also having the family support to go forward with changing" (P7).

The latter statement illuminates how the inclusion of families can also contribute to ensuring their involvement in treatment and recovery. Pettersen et al. (2019) assert that family support can assist in initiating abstinence during the precontemplation and contemplation phases, while Wangithi and Ndurumo (2020) further state that increased family support throughout treatment could reduce the chances of relapse among recovering clients in the maintenance phase.

4.3.4.2 Sub-theme 4.2: Awareness through education

According to Jimenez-Zazo et al. (2020), the precontemplation stage is characterised by the absence of any observed intention to engage. Therefore, the focus in this stage should be on creating awareness and providing education about the benefits of harm reduction. Adding to this description, Hall et al. (2012) elaborate that education during the precontemplation stage is intended to cultivate awareness, with the goal of reducing substance use and modifying behaviours that impact both personal well-being and the well-being of others. Therefore, the inclusion of awareness through education can be a highly effective strategy to assist involuntary clients to start considering change. In this study, the participating social workers acknowledged that awareness through education is mostly included in services to create discrepancies:

"Okay. I think for me, the focus of intervention would be to, first of all, educate the client about, or creating awareness, what substance is what. How different substances have negatives. And the positives, because some persons could see positives in substance use" (P2).

"I think the focus there should be on education to give the client information about what is substance abuse, what are the negative

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consequences of it, and what are available resources out there that can assist them" (P7).

The strategy to assist clients to explore advantages and disadvantages to create an awareness among involuntary clients mentioned by the participants in this study, is further supported by Hall et al. (2012), who explain that highlighting the risks and consequences may raise doubt about their current behaviour.

4.3.4.3 Sub-theme 4.3: Motivational interviewing (MI)

Evoking motivation to change by exploring and reinforcing the client's reasons for change forms part of the spirit of MI (Bischof et al., 2021). This was also highlighted by the participating social workers, who reported on the importance of MI, and how it is helpful in the precontemplation stage of the client system:

"…usually we do motivational interviewing where you ask the client or help the client see that how his or her substance use problem has affected the person's life. To show the client this and this is what happened when you were using substances" (P3).

"Like I said, we sometimes implement motivational interviewing just for them [the clients] *to realise where they are at but also for them to create their own internal or external motivation. What I like about MI is that working with resistance is kind of working at their pace"* (P5).

The participants' descriptions indicate that MI is useful for clients to explore what is happening to them, and to look at alternatives at their pace. Bischof et al. (2021) note that MI focusing on creating awareness, as described in Sub-theme 4.2, may strengthen motivation to change behaviour, which may in turn promote treatment adherence in later stages. In this regard, Jimenez-Zazo et al. (2020) explain that the goal of the precontemplation stage is to enhance awareness about the benefits of change. This increased knowledge can potentially serve as a motivation to move towards contemplating participation in treatment options. The next theme discusses the experience related to intervention in the contemplation stage.

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4.3.5 Theme 5: Description of Experiences and Perceptions Related to Intervention in the Contemplation Stage

In this stage, the client progresses from a state of not considering behaviour change to a point where they are thinking of the positive and negative consequences of substance use or abuse. This contemplation allows them to make informed decisions about their next course of action. Pennington (2021, p.14) explains that "…clients now begin to consider the positive and negative effects of persistent undesirable behaviour". In line with this description, Participant 1 summarised the contemplation stage as follows:

> *"So, when they are contemplating, I would focus on, um, let the client see the benefits of getting sober or something you can use as leverage. So, I would want the client to see that I don't want that old life. I am ready to change"*.

Participant 3 added that, apart from becoming aware of the consequences of substance use, the person also starts to consider changing behaviour. This participant emphasises the inclusion of family members in this stage (cf. sub-theme 4.1):

> "*Ok. This is the phase where they are starting to see that they have a problem and that they must start working on it. The family must be part of the process because it is not only the client. The family also went through trauma because of the client that uses. So, get the family to support the client during this phase onwards"*.

According to Zebrowski et al. (2021), it is crucial to acknowledge that the contemplation stage involves individuals considering taking action in the near future, although they are not yet committed to making plans and taking concrete steps. While discussing their experiences and perceptions of the contemplation phase, the participants identified two aspects that can facilitate progress towards action. These are presented as sub-themes below: 1) clients' reasons for change, and 2) support systems.

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4.3.5.1 Sub-theme 5.1: Clients' reasons for change

Pennington (2021) refers to a decisional balance where the advantages for changing outweigh the disadvantages for clients contemplating to make changes. Confirming this line of thought, the participants describe their experience relating to the contemplation stage in terms of exploring with the client why behavioural change would be beneficial.

> *"I think you use exploring if the client is willing and want to make that change. So, you look at how we can get him to the point where he can see and is ready to take the next step"* (P2).

> *"For me, the client must find his own reasons for why he wants to change. Not just the leverage thing, but why he wants to change for himself. Like, I like smoking, but I don't like the feeling of how it makes me feel; the sick feeling"* (P1).

Supporting the latter statement, Pennington (2021) asserts that individuals' reasons for change can be contributed to self-efficacy, which is the confidence to make and maintain changes.

4.3.5.2 Sub-theme 5.2: Support systems

The inclusion of support systems to assist clients in the contemplation phase is highlighted by Mahlangu and Geyer (2018) who conclude that those with a SUD have a need for family members to be included and educated about how to support them. Similarly, and in line with the discussion in Sub-theme 4.1 above, the participating social workers described their perceptions of the importance of the inclusion of families in the contemplation stage, adding the church and support groups as other systems to include.

> *"Maybe also get involved the family… to support the client during this phase onwards"* (P3).

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> *"To involve the family, to involve the church. Not friends. Support groups, to have sessions on a weekly basis to get them into a routine"* (P4).

Notably, Participant 4 emphasised that friends should not be viewed as a support system during this stage. However, according to Azmi et al. (2018), family, friends, and community support are considered psychosocial factors that can either facilitate the client's preparation for change or contribute to the risk of relapse. The next theme discusses the experience related to intervention in the preparation stage.

4.3.6 Theme 6: Description of Experiences and Perceptions Related to Intervention in The Preparation Stage

In this stage, the client is preparing to embark on making changes in their lives that will show readiness for change. Zebrowski et al. (2021) describe the preparation stage in terms of where clients are taking the beginning steps to embark on the process of change. For example, scheduling an appointment with a social service professional for intervention. Participant 7 added that the intervention focuses on preparing the client to enter treatment: *"I believe that the focus in the preparation stage is preparing the client now to go to therapy".* As in the descriptions of the previous two stages, Participant 8 accentuated the importance of including the family: *"I think it is really important that you include the family in the preparation stage; starting to make certain changes in the family will help the client".*

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In this theme, the participants explained how the preparation stage is marked by a need to make changes, awareness of the benefits of sobriety, planning for what is needed to successfully engage with changes, and clients making small changes in their behaviour.

> *"So, I think in this phase the client is starting to realise that changing their life or their behaviour can lead to happier or a healthier life for them. They will be able to achieve more things if they change their behaviour. Thinking of things that he or she maybe have lost along the way can serve as a guide in order for him or her to set boundaries. This phase is about getting things like that in place for the client"* (P3).

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> *"So, in the preparation stage, I say it is always the easiest when clients come to us and say they are ready to either reduce their use or they are two weeks clean, they are a month sober. Or in the preparation stage, some say, 'you know what, I was using three substances, and I only use one substance now since implementing lifestyle changes'"* (P5).

The latter statement indicates small changes that can be viewed as victories that may encourage further change. This, then, requires setting goals.

4.3.6.1 Sub-theme 6.1: Setting goals

As also indicated by Participant 5 above, the preparation stage may start with small changes that are part of their behavioural changes or goals that has been set by the clients themselves (Pennington, 2021). The participating social workers, in the statements below, confirm that realistic changes can become a motivation for further change, and that the goals in this stage should be based on short-term actions which require regular contact between the social worker and the client.

> *"Finding a realistic change that they can make. Finding realistic goals"* (P1).

> *"I mean, that everybody has dreams. So, to let them see where he wants to be in five or ten years, so you start with small steps to that dream. It is constant interview on a weekly basis, motivating, supporting"* (P4).

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Goal setting as a strategy to reduce substance use is further accentuated by Williams et al. (2019). Small successes and the achievements of goals is one way of motivating clients to move to the action stage.

4.3.7 Theme 7: Description of Experiences and Perceptions Related to Intervention in the Action Stage

In this stage, working with someone with a SUD refers to someone that is willing to make the necessary changes to address the SUD. In terms of this study, it would mean that the client moved from being an involuntary to a voluntary client. The action stage

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is characterised by the intention and active engagement of changing the environment and/or behaviour of the client (Zebrowski et al., 2021). Further clarifying this stage, Participant 2 summarised the action stage as follows: *"So here in the action stage is where the client actually is in and busy with the treatment"*. Furthermore, Participant 7 refers to self-efficacy and indicates that the client becomes more independent during this stage of the TTM: *"In this stage, the client can keep on working for themselves to succeed in recovery".*

Despite the statement by Participant 7 above, other participants highlighted that the use of support groups, and regular contact with the client and the family are still required.

> *"So, those who are in the action stage we refer to NA* [Narcotics Anonymous]. *Here we try to encourage them to find sober peer support because that will help them maintain sobriety and to stick to the new healthy behaviours that they have implemented"* (P5).
>
> *"It is important that you, as the practitioner, are visible, accessible, and are there and not forgetting about the client; and always monitoring. So for me, in this stage, it is important that you, the practitioner, is involved, as well as the family. So that they don't feel that they are now alone and that you forgot them. That is, for me, important in this stage"* (P8).

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The action stage is characterised by a modification of both the environment and behaviour, and a "consistent effort to act" (Zebrowski et al., 2021, p. 2494). Once this leads to a sober lifestyle, the next and final stage has to do with the maintenance thereof.

4.3.8 Theme 8: Description of Experience and Perceptions Related to Intervention in the Maintenance Stage

This stage may be viewed as an extension of the action stage, with a focus on maintaining sobriety to prevent relapse. Underscoring the significance of this stage, Azmi et al. (2018) assert that relapse remains a long-term risk and challenge, and that

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this stage assists clients to develop strategies to prevent relapses. This viewpoint is further reinforced by the participants in this study.

> *"We all know that after six months they can hit the wall again or they can relapse. Normally, this occurs after six months and forces the client to think back to what works while you were sober; what are the things that work?"* (P1).

> *"Once the client is out of rehabilitation, determining how to support the client will be helpful for the client to stay in the maintenance stage, otherwise the client will relapse"* (P2).

> *"In the maintenance stage I will check in with the client how they are doing, and find out if there are any struggles or challenges, because maintenance is an ongoing process*" (P4).

Participant 5 concurred that relapse prevention strategies should be included in the action stage already so as to prepare the client for the maintenance stage. *"So, in [the] maintenance stage, we focus on primarily relapse prevention even though it is also implemented in the action stage. The main focus is on the relapse prevention, especially in the earlier stages of recovery"* (P5). The findings confirm that the maintenance stage is characterised by sustaining the changes made during the action stage and actively preventing relapse (Zebrowski et al., 2021). Furthermore, while discussing their experiences and perceptions of the maintenance stage, the participants referred to two aspects that are presented as sub-themes, namely: 1) aftercare services, and 2) employment opportunities.

4.3.8.1 Sub-theme 8.1: Aftercare services

According to Ritonga et al. (2022), aftercare services provide programmes to respond to high cases of relapse. Mahlangu and Geyer (2018) advise that these programmes must include therapeutic interventions to assist clients to deal with life challenges without reverting back to the use of substances. The participants in this study explained that their understanding of this stage is that the client is assisted with

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services that ensure that support is available in times of need. Additionally, this stage helps with implementing further changes necessary to maintain sobriety.

> *"Aftercare services focus on support groups for a client, finding a job, focusing on all those things. And in like a family, family relations as well. So, if the client is integrated to the community, there is support like in AA* [Alcoholics Anonymous]*, NA, and our office. We have an aftercare group every Thursday"* (P2).

> *"So now you are providing aftercare services so that they can maintain their lifestyle"* (P7).

In support of the above descriptions, Ritonga et al. (2022) describe the purpose of aftercare services as strengthening behavioural changes and social changes in the family environment. As mentioned in this sub-theme, the focus is on preventing relapses. However, Participant 4 also described the focus of this stage as management of relapses: *"Clients can easily have a relapse, because they do not attend sessions anymore. They do not come to an individual session, and they feel like they are now a recovering addict, so they don't need our services anymore"*. This is affirmed by Wangithi and Ndurumo (2020) who advise that "relapse is a key area that requires further investigation" (p. 153), because younger adults have a higher relapse tendency. In their contribution, Kabisa et al. (2021) argue against confining the management of relapse to detoxification alone. Instead, they advocate for a stronger focus on providing extended follow-up services. These authors base their viewpoint on research that has shown that "more that 50% of persons with a SUD relapse after treatment" (Kabisa et al. 2021, p. 10).

4.3.8.2 Sub-theme 8.2: Employment opportunities

Wangithi and Ndurumo (2020) assert that the employment status of clients is significantly linked to relapse. This line of thought is supported by Mahlangu and Geyer (2018) who report that unemployment contributes extensively to social issues like substance use and abuse. The authors explain that unemployment can become a risk factor in the maintenance stage, while employment opportunities can serve as a

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protective factor that may prevent relapses. As a final description of the participants' perceptions and experience, the role of the social worker in the maintenance stage was also described in terms of assistance to find employment.

> *"You can connect them. If you see employment opportunities, you help the client with their CVs. You tell them: 'look here, there is an opportunity; therefore, you take your CV'. You do not do it for the client, but you help look for opportunities for the client, and also, that they can get their CV updated"* (P3).

> *"It is support from [a] practical perspective. Assistance with job hunting, assistance with compiling a CV using a computer, getting educated in whatever way. Just that extra practical assistance to clients"* (P7).

4.4 CONCLUSION TO THE CHAPTER

The findings of this study were contextualised in this chapter by providing a biographical description of the eight participating social workers. Their perceptions and experiences were framed by the findings that describe their experiences of working in the SUD field, followed by their differentiation between voluntary and involuntary clients.

The participants' experiences of utilising the TTM were introduced by discussing what they perceived works well and the challenges they encountered when using the TTM. Additionally, the requirements for considering the theoretical framework were addressed. The findings were then presented in terms of the perceptions and experiences of the participating social workers within each of the stages of the TTM.

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This study focused on employing the TTM to assist involuntary clients to enter treatment. The findings underscored how the precontemplation, contemplation, and preparation stages can aid involuntary clients in developing intrinsic motivation to change. However, the descriptions of the action and maintenance stages indicate the ongoing need for clients to stay motivated, to continue with behavioural changes, and to prevent relapses. The final chapter provides a summary and conclusion of this study, along with recommendations for further research and the application of the TTM.

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CHAPTER 5
SUMMARY, CONCLUSIONS & RECOMMENDATIONS

5.1 INTRODUCTION

The aim of this study was to explore and describe the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape. This focus was based on reports indicating a high prevalence of substance use and abuse in South Africa (Monyakane, 2018; DSD, 2017). SUDs, as a result of the use and abuse of substances, may lead to a variety of short- and long-term problems that impact the person, as well as families and communities, and the society at large (Deepmala, 2014; APA, 2013). SUDs also lead to, *inter alia*, changes to the brain, withdrawal symptoms, cravings, and repeated unsuccessful attempts to cease the use of substances. These factors may contribute to demotivation and a resistance to enter treatment and to change behaviour to support recovery from a SUD (APA, 2013). Consequently, individuals with SUDs often enter treatment involuntary due to familial pressure, workplace issues, and clashes with the law (cf. Werb et al., 2017).

MI has been identified as a way to support the development of internal motivation and self-determination as key indicators for successful treatment outcomes (Scheibe et al., 2020; Opsal et al., 2019), and to ensure that unmotivated clients are not being excluded from services (Kaloiya & Sonkar, 2018). The TTM, which includes MI as a technique, was chosen as the theoretical framework for this study, as it aims to support the development of internal motivation, and thereby voluntary participation in treatment options (Serafini et al., 2016). However, studies on the implementation of the TTM to support involuntary persons with a SUD in South Africa are limited. Through this study, the researcher hoped to contribute to social services in the field of substance use in terms of a better understanding of how the TTM could be used effectively.

This thesis consists of five chapters to present the rationale of the study, a review of existing literature, the choices and implementation of the research methodology, the findings of the study, and the conclusions drawn as well as recommendations made.

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Chapter 1 introduced the research topic and provided a description of the key concepts related to the focus of this study. These concepts included social work, involuntary treatment, services, substances, SUDs, and the TTM. The chapter incorporated a preliminary literature review and a description of the theoretical framework (TTM), which informed the formulation of the problem statement, the research question, aim, and objectives. It concluded with a discussion of the significance of the study.

Chapter 2 presented a comprehensive literature review that aimed to provide a detailed understanding of the study's focus. This was also used as a literature control to verify the findings of the study. To begin, SUDs were described in terms of the factors contributing to their development, the prevalence of substance use and abuse, and the consequences associated with them. Extensive descriptions were provided of the medical consequences, substance-related crime, and the social and emotional consequences of substance use and abuse. The chapter then delved into a discussion on treatment, specifically focusing on voluntary and involuntary treatment approaches of SUDs, social work services in the field of SUDs, and the legislative framework surrounding these issues. The chapter concluded with a discussion of key aspects of the TTM that served as the theoretical framework of this study.

Chapter 3 provided a thorough description of the research methodology employed in this study. It encompassed details regarding the research design, sample selection, data collection methods, and data analysis procedures. The chapter aimed to establish a clear understanding of how the study was conducted.

In **Chapter 4**, the findings of the study were presented, along with a discussion of the study’s themes and sub-themes. This chapter addressed research Objectives 1 and 2.

Chapter 5, the final chapter, serves as a culmination of the study. It offers a summary of the research methodology and the key findings. Additionally, it presents conclusions drawn from the findings, emphasising their significance and implications. Furthermore, recommendations for future research and practice are provided based on the study's

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conclusions. In line with Objective 3 of this study, these recommendations aim to guide further exploration and inform practical applications within the field.

5.2 SUMMARY

The research question guiding this study was: “What are the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape?” In order to answer this question, the researcher endeavoured to explore and describe social workers’ experiences of the use of the TTM in involuntary treatment of a SUD in the Western Cape. The objectives identified to achieve this aim were formulated as follows:

- Objective 1: To explore the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD through individual qualitative interviews (addressed in Chapter 4).
- Objective 2: To develop an in-depth understanding of the experiences of social workers regarding the use of the TTM in involuntary treatment for SUDs through the analysis of the findings and literature control (addressed in Chapter 4).
- Objective 3: To make recommendations regarding the effectiveness of the TTM for involuntary treatment of a SUD (addressed in Chapter 5).

With the above objectives in mind, this section presents a summary of the research methodology and the findings to introduce the conclusions and recommendations.

5.2.1 Summary of the Research Methodology

The constructivist paradigm was employed as the framework for this study to facilitate the selection of participants who could offer valuable insights into the utilisation of the TTM by social workers in their work with involuntary clients (cf. Bisman & Highfield, 2012). Within this paradigm, the researcher explored the different social realities as experienced by social workers working at different organisations in the field of substance use, and with different levels of experience in the field (cf. Bryman, 2016).

To construct the meaning that social workers attach to the use of the TTM to support involuntary clients (cf. Tuffour, 2017), the researcher followed a qualitative approach to explore and describe their experiences and perceptions regarding the research

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topic. To support the qualitative approach, the exploratory and descriptive research designs were used to guide the identification of the research population, as well as methods and techniques for sampling, data collection, and data analysis.

The population of this study was social workers registered with the SACSSP in the Western Cape. The sample for this study was obtained using non-probability sampling with the purposive technique. Data saturation guided the determination of the sample size, resulting in a total of eight participants. Semi-structured interviews were conducted as the primary method of data collection (refer to Annexure E: Interview guide). Thematic content analysis was employed to analyse the data, allowing for the identification and description of the themes and sub-themes that emerged from the data (cf. Harding, 2019).

Data verification aimed to ensure the trustworthiness of the results or research findings (Kumar, 2014). The following techniques (cf. Anney, 2014) were employed to verify the data: *Credibility* was reinforced through the inclusion of an interview guide, transcripts of the interviews, verbatim quotes, and an independent coder. *Transferability* was enhanced by employing non-probability and purposive sampling. *Dependability* was enhanced through the utilisation of an interview guide and transcripts of the interviews. *Confirmability* was promoted by comparing the transcripts of the interviews with relevant literature. *Reflexivity* was upheld by ensuring that the researcher's own perspectives and experiences did not compromise the interpretation of the findings, thereby maintaining the integrity of the participants' perspectives.

The ethics employed in this study focused on avoidance of harm to the participants and debriefing opportunities. Participation in this study was voluntary, and all the participants provided informed consent, and signed consent forms. Anonymity, confidentiality, and privacy received particular attention, as well as the storage and management of data.

The limitations of this study encompassed the use of a qualitative approach and the geographical scope confined to the Western Cape Province, which may restrict the generalisability of the findings to other contexts or populations. However, the

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comprehensive description of the research methodology in Chapter 3 partially mitigated this limitation. Additionally, while the sample size was small, data saturation was achieved, ensuring the acquisition of rich and comprehensive data.

5.2.2 Summary of the Research Findings

Two male and six female social workers participated in this study, and their ages ranged from 26 to 57 years. The racial profile included White, Coloured and African ethnic groups. The geographical areas in the Western Cape represented by the participants were Paarl, Worcester, Ceres, Hermanus, Plettenberg Bay, Cape Town, and Bellville. The participants worked in prevention, early intervention, treatment, statutory, and aftercare services to their respective client systems.

The eight themes and their related sub-themes that emerged in this study are summarised below:

Theme 1 elaborated on the biographical profile of the participants through a description of their experiences in the field of SUDs. The sub-themes describe specialised education and training and work experience as the areas that provided the participants with competencies to work in the field.

Theme 2 focused on the participants' perceptions of the difference between voluntary and involuntary treatment. These perceptions were further unpacked in two sub-themes, focusing on their descriptions of voluntary and involuntary clients.

In **Theme 3**, the participants' description of experiences using the TTM were described in terms of three sub-themes. In these sub-themes, descriptions of what works well, challenges when using the TTM, and requirements for the use of the TTM were provided.

Themes 4 to 8 provided detailed descriptions of the experiences and perceptions of the participating social workers when working in the different stages of the TTM.

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Theme 4 discussed the experiences and perceptions of the participants regarding the precontemplation stage of the TTM. The descriptions were further elaborated on in three sub-themes, namely: the inclusion of families, awareness through education, and the use of MI.

In **Theme 5**, the descriptions related to the contemplation stage were supplemented by two sub-themes, namely: the clients' reasons for change and their support systems.

Focusing on the preparation stage, **Theme 6** highlighted the importance of setting realistic goals.

Theme 7 unpacked the participants' descriptions of their perceptions and experiences of what is required within interventions in the action stage.

The presentation of the findings was concluded with the final theme, **Theme 8**, which explored the maintenance stage. This theme emphasised the importance of giving special attention to aftercare and employment opportunities.

The conclusions, which were derived from the findings, are noted below.

5.3 CONCLUSIONS

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In this section, the researcher presents conclusions regarding the suitability and effectiveness of the chosen research methodology for this study, as well as the conclusions drawn from the research findings.

5.3.1 Conclusions to the Research Methodology

The constructivist research paradigm aptly assisted the researcher to select suitable participants who were considered experts to answer the research question of this study. Within this paradigm, the first two objectives of this study were to explore the experiences of social workers regarding the use of the TTM in involuntary treatment of a SUD through individual qualitative interviews (Objective 1), and to analyse the data to be able to develop an in-depth understanding of the how the TTM is and can be used to provide services to involuntary clients with a SUD (Objective 2) (cf. Bisman

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& Highfield, 2012). This paradigm supported the choice of the qualitative research approach that enabled the researcher to explore and describe the social realities experienced by social workers in the field of substance use (cf. Bryman, 2016). Through this approach, the researcher was able to fully explore the research question through verbatim data, and to achieve Objectives 1 and 2 of this study. This, in turn, provided a basis for the conclusions and recommendations, thereby addressing the Objective 3, which is presented in this chapter.

The exploratory research design was valuable to the researcher as it guided the identification of the research population, and the choices of the sampling method and technique, as well as the method of data collection. As such, this design worked well to ensure that the researcher could obtain new information and insights to address the research problem, and to achieve Objective 1 of this study (cf. Swedberg, 2018). The descriptive research design supplemented the exploratory research design, as it assisted the researcher to construct meaning and insights for the use of the TTM in the field of substance use (cf. Nassaji, 2015; Ritchie & Ormston, 2014). Through the use of this design, the choices of methods for data collection and analysis were made, which contributed to the attainment of Objective 2.

The non-probability sampling method and the purposive sampling technique assisted the researcher to access and recruit participants. *Purposive sampling,* as also confirmed by Sharma (2017), supported the researcher to use his judgement to select participants who could best provide data that would answer the research question of this study. The semi-structured interviews, framed in the stages of the TTM, proved to be an effective way to obtain data that explored what the experiences and perceptions of social workers are regarding the use of the TTM in involuntary treatment of a SUD in the Western Cape. This ensured that the overall research question could be answered. The framework proposed by Tesch (as cited in Creswell, 2014) aided the researcher in identifying the themes and sub-themes that elucidated the findings.

Based on the aforementioned conclusions regarding the research methodology, it can be inferred that the methods and techniques employed effectively supported the aim of this study and contributed to the achievement of the research objectives. The

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findings of the study effectively addressed the research question. The conclusions regarding the findings are described next.

5.3.2 Conclusions to the Findings

In this section, the conclusions based on the findings of the study are presented based on the themes that emerged from the data analysis.

Theme 1: Descriptions of experience in the field of SUDs

- Social workers in the field of substance use exhibit a strong interest and passion for working with clients affected by a SUD.
- Possessing knowledge and understanding of the TTM and the field of SUDs contributes to effective practices.
- Ongoing education and training play a crucial role in keeping social workers up to date with the latest developments in the field of SUDs.
- Specialised education and training are considered beneficial for social workers working in the field of SUDs.
- Experience is gained through working within organisations such as NGOs, treatment centres, and the DSD.

Theme 2: Perceptions regarding the difference between voluntary and involuntary treatment

- Voluntary treatment, according to the participants in this study, refers to services provided to individuals who request such services, or who show some form of insight that they may benefit from services.
- Involuntary treatment is described by the participants as services provided to individuals who did not request these services but are compelled to do so by external factors, such as families, employers, or the law.
- Voluntary clients are those who have insight and who acknowledge that they have a substance use problem, which leads to a willingness to receive the intervention based on a motivation for change.
- Involuntary clients are those who are in denial about their problem, with poor insight into the problem, and an unwillingness to participate in interventions. These clients may be mandated by the court or pressured by their families to participate

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in services. Social workers experience working with involuntary clients as a challenge due to their reluctance to engage with interventions and their resistance to change.

Theme 3: Description of experiences related to what works well, challenges, and requirements regarding the use of the TTM

- As an advantage, the TTM supports social workers to guide involuntary clients to develop insight into their substance use problem.
- A further advantage is that the social worker is enabled to develop an understanding of where the client is at in terms of the stages of change, and providing services that are aligned with the stages of change.
- When using the TTM, one can identify the client's readiness to change.
- A challenge when using the TTM is that it is time-consuming, and that social workers need to accept that clients will progress and regress between the stages of change.
- Requirements for using the TTM are that social workers need to understand the context of the client system for realistic goal setting, to provide assistance so that clients can reach goals, and to focus on behaviour modification that will support recovery.

Theme 4: Description of experiences and perceptions related to intervention in the precontemplation stage

- The inclusion of the family in the precontemplation stage is important because SUDs impact the family as a subsystem and not only the individual.
- Creating awareness through education in the precontemplation stage could initiate harm reduction while the client is still not ready for change. This is also needed to create awareness about the impact and negative consequence of the substance on the client system and others, including the family.
- The use of MI can play a significant role in the precontemplation stage to explore internal and external motivation, and to support a movement towards the contemplation stage.

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Theme 5: Description of experiences and perceptions related to intervention in the contemplation stage

- In this stage, clients exhibit a growing willingness to consider the potential benefits of change. This could support a movement towards voluntary contemplation of change.
- Through contemplating the benefits and disadvantages of both continued use and abuse of substances and the option of change, clients start to develop insight into the consequences of substance use and abuse.
- Social workers play a crucial role in this stage by focusing on the client's motivation for change, encouraging a thorough consideration of the benefits associated with behavioural changes.
- The support system surrounding the client holds great importance during this stage, as it aids in fostering insight, contemplating the possibility of change, and facilitating the transition towards the preparation stage.

Theme 6: Description of experiences and perceptions related to intervention in the preparation stage

- Once the benefits of change inform a readiness to pursue change, the client starts to become motivated.
- This stage is characterised by the client starting to explore options and to plan on how to start implementing behavioural change.
- In this stage, clients will make appointments with the social worker, and/or attend sessions based on their own choices and not due to being pressured to do so.
- In the preparation stage, the role of the family is again accentuated in terms of addressing how they have been affected and obtaining their involvement and support when their family member actively engages with treatment interventions.
- To support motivation for change and a full movement towards voluntary participation in interventions, realistic goals to take small steps are aimed at the client experiencing victories.

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Theme 7: Description of experiences and perceptions related to intervention in the action stage

- Upon expressing readiness for change, the client progresses into the action stage. Here, they transition into a voluntary role and actively participate in planned interventions at micro, meso, and macro levels.
- Clients in the action stage continue their recovery journey through inpatient or outpatient treatment, actively working towards achieving their self-defined recovery goals. This process directly relates to the client's sense of self-efficacy.
- Social workers, alongside the support of the client's family and community, play a crucial role in providing assistance and support during this stage. Their collective efforts aim to prepare the client for behavioural changes that promote and maintain their sobriety.

Theme 8: Description of experience and perceptions related to intervention in the maintenance stage

- The maintenance stage is a continuation of services that assist clients to maintain sobriety.
- Levels of support required during this stage must be identified and planned for by both the social worker and the client.
- Because clients are trying to reintegrate into their families and society during this stage, they might not view this stage as an essential part of the TTM. Therefore, social workers should regularly check in with the client to identify challenges that could lead to a relapse, and to find solutions for these challenges. As such, relapse prevention should be a central focus in the maintenance stage.
- As in the previous stages, the family needs to be involved in this stage to maintain lifestyles that support sobriety.
- Employment opportunities are important in the maintenance stage to provide clients with a daily routine and to achieve independence. Clients require social workers to support them in this regard through, for example, networking with opportunities in the community.

The findings highlighted how involuntary clients can be accommodated within the TTM, and how a movement towards voluntary participation in interventions can be

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stimulated in the precontemplation, contemplation, and preparation stages. Table 9 below provides a framework for the use of the TTM when working with involuntary clients.

Table 9: Conclusions to the findings

TTM stage	**What works well**	**Challenges to address**	**Things to avoid**	**Relevant literature**
Pre-contemplation	▪ Motivational interviewing and a non-judgemental attitude towards the client. ▪ Education towards awareness. ▪ Exploring advantages and disadvantages of using substances. ▪ Identifying losses due to substance use. ▪ Including families.	▪ Refusal to participate or to engage. ▪ Not attending appointments. ▪ Families not being willing to support the process towards change.	▪ Judgement of the client. ▪ Not considering where the client is at.	Bischof et al. (2021); Wangithi & Ndurumo (2020); Jimenez-Zazo et al. (2020); Rodgers et al. (2021); Prochaska & Prochaska (2019); Pettersen et al. (2019); Opsal et al. (2019); Volkow et al. (2016); September (2015); DSD (2013); Hall et al. (2012).
Contemplation	▪ Developing insight regarding the impact of substance use. ▪ Evaluating positives and negatives of usage.	▪ Uninvolved families. ▪ Inconsistency in moving forward.	▪ Impatience. ▪ Judgement when the client is inconsistent.	Pennington (2021); Zebrowski et al. (2021); Mahlangu & Geyer (2018); Azmi et al. (2018).

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	▪ Exploring positives and negatives of change. ▪ Exploring reasons for change. ▪ Identifying and including support systems.			
Preparation	▪ Preparing clients to enter treatment. ▪ Including families. ▪ Setting goals.	▪ Not having resources to support recovery. ▪ Avoid giving clients too much work.	▪ Setting unrealistic goals. ▪ Not taking the context into consideration.	Pennington (2021); Zebrowski et al. (2021); Williams et al. (2019);
Action	▪ Client engages with treatment. ▪ Self-efficacy. ▪ Support groups. ▪ Including families.	▪ Dropping out of treatment. ▪ Psychiatric conditions such as depression.	▪ Ignoring context-related recovery needs. ▪ Not addressing other conditions through interdisciplinary work.	Zebrowski et al. (2021).
Maintenance	▪ Relapse prevention. ▪ Aftercare services. ▪ Employment opportunities.	▪ Relapse. ▪ Not attending sessions. ▪ Boredom.	▪ Not checking in even if clients indicate that they are not requiring further services.	Ritonga et al. (2022); Zebrowski et al. (2021); Kabisa et al. (2021); Wangithi & Ndurumo (2020); Azmi et al. (2018); Mahlangu & Geyer (2018);

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The above conclusions informed the recommendations that are presented next.

5.4 RECOMMENDATIONS

As a conclusion to this research document, this section presents a set of recommendations based on the findings of the study. These encompass areas for further research as well as suggestions for social work practice.

5.4.1 Recommendations for Further Research

The following recommendations are proposed for further research:

- Conduct similar studies in regions outside of the Western Cape Province in South Africa.
- Explore the application of the TTM in the field of substance use from a multidisciplinary perspective, involving various disciplines to promote an interprofessional approach.
- Investigate the experiences and perceptions of clients and their families regarding the use of the TTM.
- Conduct research focusing on individuals with substance use disorders who transitioned from being involuntary to voluntary clients, aiming to identify successful strategies and factors that facilitated their positive outcomes to contribute to the effective use of the TTM.
- Explore the experience and perceptions of voluntary clients in the field of SUD regarding the use of the TTM.

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5.4.2 Recommendations for Social Work Practice

The following recommendations are proposed for social work practice:

- Social workers to use the TTM as an intervention strategy and MI as a technique for involuntary clients referred for interventions in terms of Section 33 of the Prevention and Treatment of Substance Abuse Act 2008.
- Continuous professional development opportunities be made available for social workers in the field of substance use to develop knowledge, understanding, and skills to use the TTM and IM effectively.
- Specialised training and education to be viewed as a requirement for social workers rendering services in the field of substance use.

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- Organisations in the field of substance use to have policies and practices in place to ensure services are rendered to involuntary clients, considering that resistance to change is a characteristic of a SUD.
- Consideration of clients' contexts when providing services using the TTM to guide macro services that address contextual needs and challenges.
- Families to be included and motivated to participate in services throughout the interventions in the stages of the TTM.
- Networking to ensure collaboration with other stakeholders in the support of clients' recovery journey, such as churches, support groups, and organisations that could support the creation or networking with employment opportunities.
- The maintenance stage be considered as an integral and not an optional part of the intervention process.

5.5 CONCLUDING REMARKS

In conclusion, the literature highlights that SUDs negatively affect the individual, family, community, and society at large. Within the South African context, the exposure to poverty and the lack of resources are often prevalent among individuals who are affected by a SUD. The recovery process may be influenced by the clients' contexts and also hindered by a lack of motivation to change based on the characteristics of SUDs. Therefore, services are often directed towards supporting the family, while those suffering from SUDs are left behind due to their unwillingness to engage in these services. The findings of this study demonstrate the significant role the TTM can play in enhancing treatment accessibility for involuntary clients and facilitating a transition towards voluntary participation in interventions. The TTM enables clients to move through the different stages of change, starting where they are and guiding them to develop insight into the consequences of their SUD, consider behavioural changes, and ultimately become motivated to voluntarily participate in treatment and the maintenance of recovery. Moreover, the findings underscore the crucial influence of the clients' families on treatment outcomes. With a sound understanding of the TTM and IM, social workers, who are often the first line of service delivery, can effectively support involuntary clients to become motivated to change. This study sheds light on substance use as a specialised field in social work, emphasising the necessity for specialised education and training in this area.

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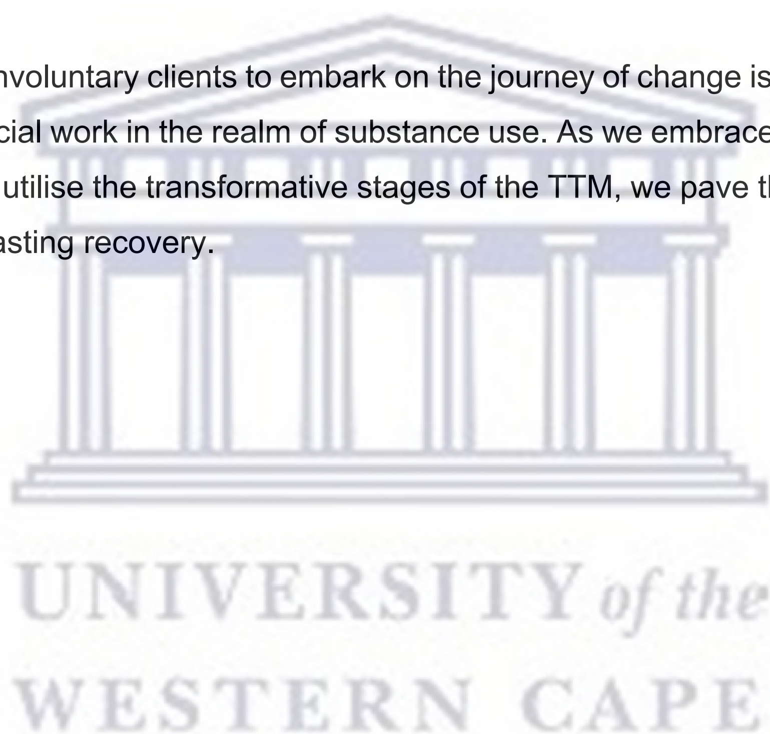
The growing demand for and supply of substances, along with the associated health, crime, and developmental challenges linked to SUDs, underscore the significance of including involuntary clients in service provision. In light of this, social workers should adopt a more client-centred approach when working with involuntary clients. The utilisation of the precontemplation, contemplation, and preparation stages of the TTM can greatly support social workers' endeavours in assisting involuntary clients and encouraging their active involvement in the action and maintenance stages. It is the researcher's aspiration that this study contributes to the knowledge base of the social work profession, enabling the delivery of effective services in the field of substance use.

Empowering involuntary clients to embark on the journey of change is the cornerstone of effective social work in the realm of substance use. As we embrace a client-centred approach and utilise the transformative stages of the TTM, we pave the way for hope, healing, and lasting recovery.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WESTERN CAPE

http://etd.uwc.ac.za/

REFERENCES

Alpaslan, N. (2019). Promoting social work graduates' employment through the social work curriculum: Employers' perspectives on the employability of Unisa's newly qualified social workers. *Social Work*, *55*(3), 341–358. https://dx.doi.org/10.15270/52-2-744

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

Anney, V. N. (2014). Ensuring the quality of the findings of qualitative research: Looking at trustworthiness criteria. *Journal of Emerging Trends in Educational Research and Policy Studies (JETERAPS), 5*(2), 272–281.

Armiya'u, A. Y. (2016). *Drug abuse and crime in West Africa: What prospects*. Jos University Teaching Hospital.

Aveyard, H., & Bradbury-Jones, C. (2019). An analysis of current practices in undertaking literature reviews in nursing: Findings from a focused mapping review and synthesis. *BMC Medical Research Methodology*, *19*(105), 1–9. https://doi.org/10.1186/s12874-019-0751-7

Ayala, E. E., Roseman, D., Winseman, J. S., & Mason, H. R. C. (2017). Prevalence, perceptions, and consequences of substance use in medical students. *Medical Education Online,* *22*(1), 1392824.https://doi.org/10.1080/10872981.2017.1392824

Azmi, A. A., Hussin, H., Ishak, S., & Fhiri, N. S. D. (2018). Drug addicts: Psychosocial factors contributing to relapse. *Malaysia Technical Universities Conference on Engineering and Technology,* *150*(6), 05097. https://doi.org/10.1051/matecconf/201815005097

Baillargeon, J., Polychronopoulou, E., Kuo, Y., & Raji, M. (2021). The impact of substance use disorder on COVID-19 outcomes. *Psychiatric Services, 72*(5), 578–591. https://doi.org/10.1176/appi.ps.202000534

Bell-Moratto, A. J. (2019). *Back pain beliefs and their impact on treatment seeking behaviour* [Master's thesis]. University of Alberta.

Bischof, G., Bischof, A., & Rumpf, H. (2021). Motivational interviewing: An evidence-based approach for use in medical practice*. Deutsches Ärzteblatt International, 118*(7), 109–115. https://doi.org/10.3238/arztebl.m2021.0014

http://etd.uwc.ac.za/

Bisman, J. E., & Highfield, C. (2012). The road less travelled: An overview and example of constructivist research in accounting. *Australasian Accounting, Business and Finance Journal, 6*(5), 3–22.

Boeren, E. (2018). The methodological underdog: A review of quantitative research in the key adult education journals. *Adult Education Quarterly, 68(1), 63–79.* https://doi.org/10.1177/0741713617739347

Bruijnen, C. J. W. H., Dijkstra, B. A. G., Walvoort, S. J. W., Markus, W., VanDerNagel, J. E. L., Kressels, R. P. C., & De Jong, C. A. J. (2019). Prevalence of cognitive impairment in patients with substance use disorder. *Drug and Alcohol Review, 38*(4), 435–442. https://doi.org/10.1111/dar.12922

Bryden, A., Roberts, B., Petticrew, M., & McKee, M. (2013). A systematic review of the influence of community level social factors on alcohol use. *Health & Place, 21*, 70–85. https://doi.org/10.1016/j.healthplace.2013.01.012

Bryman, A. (2016). *Social research methods* (5th ed.). Oxford University Press.

Catalano, R., Mellor-Goldman, S., Saxton, K., Margerison-Zilko, C., Subbaraman, M., LeWinn, K., & Anderson, E. (2011). The health effects of economic decline. *Annual Review of Public Health, 32*, 431–450. https://doi.org/10.1146/annurev-publhealth-031210-101146

Central Drug Authority (CDA). (2013). *National Drug Master Plan 2013–2017: South Africa free of substance abuse* (3rd ed.). Department of Social Development.

Central Drug Authority (CDA). (2019). *National Drug Master Plan 2019–2024: South Africa free of substance abuse* (4th ed.). Department of Social Development.

Chau, L. W., Erickson, M., Vigo, D., Lou, H., Pakhomora, T., Winston, M. C., McPherson, D., Thomson, E., & Small, W. (2021). The perspectives of people who use drugs regarding short term involuntary substance use care for severe substance use disorders. *International Journal of Drug Policy, 97*, 103208. https://doi.org/10.1016/j.drugpo.2021.103208

Cousins, C. (2020). Supervising social workers in involuntary contexts: Some considerations. *Australian Social Work, 73*(3), 347–356. https://doi.org/10.1080/0312407X.2019.1695867

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage.

http://etd.uwc.ac.za/

Cupido, J. (2021). *The demand for alcohol in South Africa during the national lockdown*. https://www.issup.net/knowledge-share/publications/2021-02/demand-alcohol-south-africa-during-national-lockdown#:~:text=South%20Africa%20female%20drinkers%20each,has%20become%20a%20noteworthy%20concern

Dada, S., Harker Burnhams, N., Erasmus, J., Lucas, W., Parry, C., Bhana, A., Pretorius, S., Weimann, R., & Keen, H. (2019). *Monitoring alcohol, tobacco and other drug abuse treatment admissions in South Africa*. South African Community Epidemiology Network on Drug Use (SACENDU).

De-Carolis, C., Boyd, G. A., Mancinelli, L., Pagano, S., & Eramo, E. (2015). Methamphetamine abuse and "meth mouth" in Europe. *Medicina Oral Patología Oral y Cirugía Bucal, 20*(2), e205–e210. http://dx.doi.org/doi:10.4317/medoral.20204

Deepmala, D. (2014). *Substance related disorders in children and adolescents*. Arkansas Department of Human Services.

Department of Basic Education (DBE). (2013). *National Strategy for the Prevention and Management of Alcohol and Drug Use Amongst Learners in Schools*. Department of Basic Education.

Department of Planning, Monitoring and Evaluation. (2019). *Implementation Evaluation of the National Drug Master Plan*. Office of the Presidency.

Department of Social Development (DSD). (2005). *Integrated Service Delivery Model (ISDM)*. Department of Social Development.

Department of Social Development (DSD). (2013). *Framework for Social Welfare Services*. Department of Social Development.

Department of Social Development (DSD). (2017). *Policy for Social Service Practitioners*. Department of Social Development.

Department of Social Development (DSD). (2019). *Social Service Practitioners Draft Bill*. Department of Social Development.

Devlin, A. S. (2018). *The research experience: Planning, conducting and reporting research*. Sage.

Dingel, M. J., Ostergren, J., Koenig, B. A., & McCormick, J. (2019). "Why did I get that part of you?" Understanding addiction genetics through family history. *Public*

http://etd.uwc.ac.za/

Understanding of Science, 28(1), 53–67. https://doi.org/10.1177%2F0963662518785350

Ducci, F., & Goldman, D. (2012). The genetic basis of addiction disorders. *Psychiatric Clinics of North America, 35*, 495–519. http://dx.doi.org/10.1016/j.psc.2012.03.010

Ekse, J. (2022, April 17). *What Are the Effects of Drug Abuse*? https://www.medicalnewstoday.com/articles/effects-of-drug-abuse

Etikan, I., & Bala, K. (2017). Sampling and sampling methods. *Biometrics & Biostatistics International Journal, 5*(6), 215–217. https://doi.org/10.15406/bbij.2017.05.00149

Fellingham, R., Dhai, A., Guidozzi, Y., & Gardner, J. (2012). The 'war on drugs' has failed: Is decriminalisation for drug use a solution to the problem in South Africa? *South African Journal of Bioethics and Law, 5*(2), 78–82. http://www.sajbl.org.za/index.php/sajbl/article/view/219/228

Finefter-Rosenbluh, I. (2017). Incorporating perspective taking in reflexivity: A method to enhance insider qualitative research processes. *International Journal of Qualitative Methods, 16*, 1–11. https://doi.org/10.1177%2F1609406917703539

Fusch, P., Fusch, G., & Ness, L. (2018). Denzin's paradigm shift: Revisiting triangulation in qualitative research. *Journal of Social Change, 10*(1), 19–32. https://doi.org/10.5590/JOSC.2018.10.1.02

Garthwait, C. (2012). *Dictionary of social work*. University of Montana.

Goredema, C. (2011). Drugs and violent crime in southern Africa. *SADC Law Journal, 1*, 175–188. https://www.kas.de/c/document_library/get_file?uuid=c514a70f-937a-79f5-d3fa-4741762e56a7&groupId=252038

Grant, C., & Osanloo, A. (2014). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house". *Administrative Issues Journal: Connecting Education, Practice and Research, 4*(2), 12–26. https://doi.org/10.5929/2014.4.2.9

Hachtel, H., Vogel, T., & Huber, C. (2019). Mandated treatment and its impact on therapeutic process and outcome factors. *Frontiers in Psychiatry, 10*, 219. https://doi.org/10.3389%2Ffpsyt.2019.00219

http://etd.uwc.ac.za/

Hall, K., Gibbie, T., & Lubman, D. (2012). Motivational interviewing techniques: Facilitating behaviour change in general practice settings. *Australian Family Physician, 41*(9), 660–667. https://pubmed.ncbi.nlm.nih.gov/22962639/

Hall, W., Farrell, M., & Carter, A. (2014). Compulsory treatment of addiction in the patient's best interest: More rigorous evaluations are essential. *Drug and Alcohol Review, 33*(1), 268–271. https://doi.org/10.1111/dar.12122

Harding, J. (2019). *Qualitative data analysis: From start to finish* (2nd ed.). Sage.

Harker-Burnhams, N., Dada, S., & Myers, B. (2012). Social service offices as a point of entry into substance abuse treatment for poor South Africans. *Substance Abuse Treatment, Prevention, and Policy, 7*(22), 1–12. https://doi.org/10.1186%2F1747-597X-7-22

Hawlader, M. D. H., Nabi, M. H., Hussain, A., Al Amin, S. A., Zaman, S., & Masud, I. (2020). Legal and social consequences of substance use: Results from a nationwide study in Bangladesh. *Journal of Ethnicity in Substance Abuse*, *21*(4), 1327–1337. https://doi.org/10.1080/15332640.2020.1846008

Hoopsick, R. A., Vest, B. M., Homish, D. L., & Homish, G. G. (2020). Problems with social acceptance and social victimization predict substance use among US reserve/guard soldiers. *Stress and Health, 36*(3), 311–321. https://doi.org/10.1002/smi.2934

Hoy, J., Natarajan, A., & Petra, M. M. (2016). Motivational interviewing and the transtheoretical model of change: Under-explored resources for suicide intervention. *Community Mental Health Journal, 52*(5), 559–567. https://doi.org/10.1007/s10597-016-9997-2

Irvine, A., Drew, P., & Sainsbury, R. (2013). Am I not answering your questions properly? Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research, 13*(1), 87–106. https://doi.org/10.1177/1468794112439086

Jain, A., Christopher, P., & Appelbaum, P. S. (2018). Civil commitment for opioid and other substance use disorders. Does it work? *Psychiatric Services, 69*(4), 374–376. https://doi.org/10.1176/appi.ps.201800066

Jensen, E. A. (2016). *Doing real research: A practical guide to social research*. Sage.

Jimenez-Zazo, F., Romero-Blaco, C., Castro-Lemus, N., Borado-Suarez, A., & Aznar, S. (2020). Transtheoretical model for physical activity in older adults:

http://etd.uwc.ac.za/

Systematic review. *International Journal of Environmental Research and Public Health*, *17*(24), 9262. https://doi.org/10.3390/ijerph17249262

Kabisa, E., Biracyaza, E., Habagusenga, J. D'A., & Umubyeyi, A. (2021). Determinants and prevalence of relapse among patients with substance use disorders: Case of Icyizere Psychotherapeutic Centre. *Substance Abuse Treatment, Prevention, and Policy, 16*(13), 1–12. https://doi.org/10.1186/s13011-021-00347-0

Kaloiya, G. S., & Sonkar, M. K. (2018). *Alcoholism: Causes, symptoms, effect and treatment*. Manakin Press.

Kozlowska, E., & Marzec, A. (2017). Health and social consequences of the use of psychoactive substances. *Journal of Education, Health and Sport, 7*(9), 377–388. http://dx.doi.org/10.5281/zenodo.1000122

Kronenberg, L. M., Slager-Visser, K., Goossens, P. J. J., Van Der Brink, W., & Van Achterberg, T. (2014). Everyday life consequences of substance use in adult patients with a substance use disorder (SUD) and co-occurring attention deficit/hyperactivity disorder (ADHD) or autism spectrum disorder (ASD): A patient's perspective. *BMC Psychiatry, 14*, 264. https://doi.org/10.1186/s12888-014-0264-1

Kross, J., & Giust, A. (2018). *Elements of research questions in relation to qualitative inquiry.* Florida International University.

Kumar, R. (2014). *Research methodology: A step-by-step guide for beginners* (4th ed.). Sage.

Lederman, N. G., & Lederman, J. S. (2015). What is a theoretical framework? A practical answer. *Journal of Science Teacher Education, 26*(7), 593–597. https://doi.org/10.1007/s10972-015-9443-2

Legault, L. (2016). Intrinsic and extrinsic motivation. In V. Zeigler-Hill & T. K. Shackelford (Eds.), *Encyclopedia of personality and individual differences* (pp. 1–5). Springer International Publishing.

Lietz, C. A., & Zayas, L. L. (2010). Evaluating qualitative research for social work practitioners. *Advances in Social Work, 11*(2), 188–202.

Lipari, R. N., & Van Horn, S. L. (2017). *Children living with parents who have a substance use disorder. The CBHSQ Report*. Center for Behavioural Health

http://etd.uwc.ac.za/

Statistics and Quality. Substance Abuse and Mental Health Services Administration (US).

Lowinson, J. H. (Ed.). (2005). *Substance Abuse: A Comprehensive textbook*. Lippincott Williams & Wilkins.

Machi, L. A., & McEvoy, B. T. (2016). *The literature review: Six steps to success* (3rd ed.). Corwin Press.

Mahlangu, S., & Geyer, S. (2018). The aftercare needs of Nyope users: Implications for aftercare and reintegration services. *Social Work/ Maatskaplike Werk, 54*(3), 327–345. http://dx.doi.org/10.15270/52-2-652

Majid, M. A. A., Othman, M., Mohamad, S. F., Lim, S. A. H., & Yusof, A. (2017). Piloting for interviews in qualitative research: Operationalization and lessons learnt. *International Journal of Academic Research in Business and Social Sciences, 7*(4), 1073–1080. http://dx.doi.org/10.6007/IJARBSS/v7-i4/2916

Marchand, K., Beaumont, S., Westfall, J., MacDonalds, S., Harrison, S., Marsh, D. C., Schechter, M. T., & Oviedo-Joekes, E. (2019). Conceptualizing patient-centered care for substance use disorder treatment: findings from a systematic scoping review. *Substance Abuse Treatment Policy, 14*(1), 37. https://doi.org/10.1186/s13011-019-0227-0

McHugh, R. K., & Goodman, F. R. (2019). Are substance use disorders emotional disorders? Why heterogeneity matters for treatment. *Clinical Psychology Science and Practice, 26*(2), e12286. https://doi.org/10.1111/cpsp.12286

Melamed, O. C., Hauck, T. S., Backley, L., Selby, P., & Mulsant, B. H. (2020). COVID-19 and persons with substance use disorders: Inequities and mitigation strategies. *Substance Abuse, 41*(3), 286–291, https://doi.org/10.1080/08897077.2020.1784363

Mikėnė, S., & Gaižauskaitė, I. (2013). Qualitative interviewing: field-work realities. *Socialinis Darbas/Social Work, 12*(1), 49–62.

Miler, J. A., Carver, H., Foster, R., & Parkes, T. (2020). Provision of peer support at the intersection of homelessness and problem substance use services: A systematic 'state of the art' review. *BMC Public Health, 20,* 641. https://doi.org/10.1186/s12889-020-8407-4

Miller, W. R., Forcehimes, A. A., & Zweben, A. (2019). *Treating addiction. A guide for professionals* (2nd ed.). The Guilford Press.

http://etd.uwc.ac.za/

Mishra, L. (2016). Focus group discussion in qualitative research. *International Journal of Educational Technology, 6*(1), 1–5. https://doi.org/10.5958/2249-5223.2016.00001.2

Monyakane, M. (2018). A rehabilitative South African criminal law response to Nyaope, drug addiction: A recommendation for health orientated Nyaope drug weaning. *Research in Paediatrics and Neonatology, 3*(1), 206–214.

Moulin, A., Evans, E. J., Xing, G., & Melnikow, J. (2018). Substance use, homelessness, mental illness and Medicaid coverage: A set-up for high emergency department utilization. *Western Journal of Emergency Medicine, 19*(6), 902–906. https://doi.org/10.5811%2Fwestjem.2018.9.38954

Moyana, W., Van der Westhuizen, M., & Alpaslan, A. H. (2019). Windows of opportunity: Service users' experiences of the continuum of care for the treatment of a substance use disorder. *Journal of Addiction and Recovery, 2*(1), 1–10.

Murali, V., & Jayaraman, S. (2018). Substance use disorders and sexually transmitted infections: A health perspective. *BJPsych Advances, 24*(3), 161–166. https://doi.org/10.1192/bja.2017.14

Murphy, J. G., & Dennhardt, A. A. (2016). The behavioral economics of young adult substance abuse. *Preventive Medicine, 92*, 24–30. http://dx.doi.org/10.1016/j.ypmed.2016.04.022

Myers, B., Petersen, Z., Kader, R., & Parry, C. D. H. (2012). Moving beyond access: Towards a quality-orientated substance abuse treatment system in South Africa. *South African Medical Journal, 102*(8), 667–668. https://doi.org/10.7196/samj.5990

Nassaji, H. (2015). Qualitative and descriptive research: Data type versus data analysis. *Language Teaching Research, 19*(2), 129–132. https://doi.org/10.1177%2F1362168815572747

National Institute on Drug Abuse (NIDA). (2014). *Drugs, brains, and behavior: The science of addiction*. NIH Pub No. 145605.

National Institute on Drug Abuse (NIDA). (2018). *Common comorbidities with substance use disorders*. https://www.drugabuse.gov

National Institute on Drug Abuse (NIDA). (2019). *Drugs and viral infections (HIV and Hepatitis)*. https://www.drugabuse.gov

http://etd.uwc.ac.za/

New South Wales Government. (2019). *The Involuntary Drug and Alcohol Treatment Program Information Sheet*. Ministry of Health. http://www.health.nsw.gov.au/aod/pages/contact-service.aspx

Ng, B., Kaur, J., & Kalra-Ramjoo, S. (2018). *Understanding the determinants of substance misuse. A rapid review*. Region of Peel.

Novak, A. (2014). Anonymity, confidentiality, privacy, and identity: The ties that bind and break in communication research. *Review of Communication, 14*(1), 36–48. https://doi.org/10.1080/15358593.2014.942351

O'Keeffe, J., Buytaert, W., Mijic, A., Brozovic, N., & Sinha, R. (2016). The use of semi-structured interviews for characterisation of farmer irrigation practices. *Hydrology and Earth System Sciences, 20*(5), 1911–1924. https://doi.org/10.5194/hess-20-1911-2016

Opsal, A., Kristensen, Ø., & Clausen, T. (2019). Readiness to change among involuntarily and voluntarily admitted patients with substance use disorders. *Substance Abuse Treatment, Prevention and Policy, 14*(1), 47. http://dx.doi.org/10.1186/s13011-019-0237-y

Osborne-Leute, V., Pugatch, M., & Hruschak, V. (2019). Social work: Addressing substance use in the 21st century. *Substance Abuse, 40*(4), 435–440. https://doi.org/10.1080/08897077.2019.1690090

Paruk, S., & Burns, J. K. (2016). Cannabis and mental illness in adolescents: A review. *South African Family Practice, 58*(S1), S18–S21. https://doi.org/10.1080/20786190.2014.978106

Pasareanu, A. R., Vederhus, J., Opsal, A., Kristensen, Ø., & Clausen, T. (2017). Mental distress following inpatient substance use treatment, modified by substance use; Comparing voluntary and compulsory admissions. *BMC Health Research, 17*(5), 1–9. https://doi.org/10.1186%2Fs12913-016-1936-y

Pasman, J. A., Verweij, K. J. H., Abdellaoui, A., Hottenga, J. J., Fedko, I. O., Willemsen, G., Boomsma, D. I., & Vink, J. M. (2020). Substance use: Interplay between polygenic risk and neighborhood environment. *Drug and Alcohol Dependence, 209*, 107948. https://doi.org/10.1016/j.drugalcdep.2020.107948

Pennington, C. G. (2021). Applying the transtheoretical model of behavioral change to establish physical activity habits. *Journal of Education and Recreation*

http://etd.uwc.ac.za/

Patterns (JERP), 2(1), *11–20.* https://www.jerpatterns.com/index.php/jerp/article/view/6/15

Petit, A., Karila, L., Chalmin, F., & Lejoyeux, M. (2012). Methamphetamine addiction: A review of literature. *Journal of Addiction Research and Therapy*, *S1:006*, 2–7. https://doi.org/10.4172/2155-6105.S1-006

Pettersen, H., Landheim, A., Skeie, I., Biong, S., Brodahl, M., Oute, J., & Davidson, L. (2019). How social relationships influence substance use disorder recovery: A collaborative narrative study. *Substance Abuse: Research and Treatment, 13*, 1–8. https://doi.org/10.1177/1178221819833379

Pogun, S., & Arman, A. R. (2021). Understanding nicotine addiction and the health effects of nicotine use. In S. B. Ravara, E. Dagli, P. Katsaounou, K. E. Lewis & C. Pisinger (eds.), *ERS monograph supporting tobacco cessation* (pp. 18–32). European Respiratory Society.

Poorolajal, J., Haghtalab, T., Farhadi, M., & Darvishi, N. (2015). Substance use disorder and risk of suicidal ideation, suicide attempt and suicide death: A meta-analysis. *Journal of Public Health, 38*(3), 82–91. https://doi.org/10.1093/pubmed/fdv148

Popescu, A., Marian, A., Dragoi, A. M., & Costea, R. (2021). Understanding the genetics and neurobiological pathways behind addiction (Review). *Experimental and Therapeutic Medicine 21*(5), 544. http://doi.org/10.3892/etm.2021.9976

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice, 19*(3), 276–288. https://psycnet.apa.org/doi/10.1037/h0088437

Prochaska, J. O., & Prochaska, J. M. (2019). Transtheoretical model. In J. M. Rippe (ed.), *Lifestyle Medicine* (3rd ed, pp. 219–229). Taylor & Francis.

Prom-Wormley, E. C., Ebejer, J., Dick, D. M., & Bowers, M. S. (2017). The genetic epidemiology of substance use disorder: A review. *Drug and Alcohol Dependence, 180*, 241–259. https://doi.org/10.1016/j.drugalcdep.2017.06.040

Reed, B., & Kreek, M. J. (2020). Genetic vulnerability to opioid addiction. *Cold Spring Harbor Perspectives in Medicine*, *11*(6), 1–15. https://doi.org/10.1101/cshperspect.a039735

http://etd.uwc.ac.za/

Rehm, J., Marmet, S., Anderson, P., Gual, A., Kraus, L., Nutt, D. J., Room, R., Samokhvalov, A. V. Scafato, E., Trapencieris, M., Wiers, R. W., & Gmel, G. (2013). Defining substance use disorders: Do we really need more than heavy use? *Alcohol and Alcoholism, 48*(6), 633–640. https://doi.org/10.1093/alcalc/agt127

Ritchie, H., & Rosen, M. (2022). *Alcohol consumption*. Our World in Data. https://ourworldindata.org/alcohol-consumption

Ritchie, J., & Ormston, R. (2014). The applications of qualitative methods in social research. In J. Ritchie, J. Lewis, C. McNaughton Nicholls & R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers* (2nd ed., pp. 27–46). Sage.

Ritonga, F. U., Arifin, A., Atika, T., & Fauzan, I. (2022). Should aftercare programs be in drug addiction social rehabilitation? *Journal of Positive Psychology & Wellbeing, 6*(1), 586–600.

Robinson, L. M., & Vail, S. R. (2012). An integrative review of adolescent smoking cessation using the transtheoretical model of change. *Journal of Pediatric Health Care, 26*(5), 336–345. https://doi.org/10.1016/j.pedhc.2010.12.001

Robson, C., & McCartan, K. (2016). *Real world research* (4th ed.). John Wiley & Sons Ltd.

Rodgers, N. H., Gerlach, H., Paiva, A. L., Robbins, M. L., & Zebrowski, P. M. (2021). Applying the transtheoretical model to stuttering management among adolescents: Part II. Exploratory scale validation. *American Journal of Speech-Language Pathology, 30*(6), *2510–2527*. https://doi.org/10.1044/2021_AJSLP-21-00108

Sajjadi, H., Harouni, G., & Sharifian, M. (2015). Personal, familial and environmental determinants of drug abuse: A causal comparative study. *Global Journal of Health Science, 7*(4), 367–374. https://doi.org/10.5539%2Fgjhs.v7n4p367

Sant'Ann, W. T., Mitsuhiro, S. S., Figlie, N. B., Diehl, A., Pillon, S. C., & Caranjeina, R. (2020). Relapse in involuntary substance treatment: A transversal study. *Revista Colombiana de Psiquiatría, 49*(4), 255–261. https://doi.org/10.1016/j.rcp.2019.02.004

Saya, A., Brugnoli, C., Piazzi, G., Liberato, D., Di Ciaccia, G., Niolu, C., & Siracusano, A. (2019). Criteria, procedures, and future prospects of involuntary treatment in

http://etd.uwc.ac.za/

psychiatry around the world: A narrative review. *Frontiers in Psychiatry, 10*(271), 1–22. https://doi.org/10.3389/fpsyt.2019.00271

Scheibe, A., Shelly, S., & Versfeld, A. (2020). Prohibitionist drug policy in South Africa – reasons and effects. *International Development Policy (Revue internationale de politique de développement).* https://doi.org/10.4000/poldev.4007

September, U. (2015). *Experiences of family members caring for female patients with a co-morbid diagnosis bipolar and substance abuse admitted in a psychiatric hospital in the Western Cape* [Master's thesis]. University of the Western Cape.

Serafini, K., Shipley, L., & Stewart, D. G. (2016). Motivation and substance use outcomes amongst adolescents in a school-based intervention. *Addictive Behaviors, 53*, 74–79. https://dx.doi.org/10.1016%2Fj.addbeh.2015.10.004

Setlalentoa, B. M. P., Pisa, P. T., Thekisho, G. N., Ryke, E. H., & Loots, Du T. (2010). The social aspects of alcohol misuse/abuse in South Africa. *SA Journal of Clinical Nutrition, 23*(3), 11–15. https://doi.org/10.1080/16070658.2010.11734296

Sharma, G. (2017). Pros and cons of different sampling techniques. *International Journal of Applied Research, 3*(7), 749–752.

South Africa. (1978). *Social Service Professions Act 110 of 1978*. Government Gazette.

South Africa. (1996). *Constitution of the Republic of South Africa*. Government Gazette.

South Africa. (2002). *Mental Health Care Act 17 of 2002 [Amended].* Government Gazette.

South Africa. (2008). *Prevention of and Treatment for Substance Abuse Act 70 of 2008*. Government Gazette.

South African Community Epidemiology Network on Drug Use (SACENDU). (2020). *Research brief monitoring alcohol, tobacco and other drugs use trends in South Africa. Phase 49: July 1996 – December 2020*. Vol. 24(1). South African Medical Research Centre.

Stoke, M., Schultz, P., & Alpaslan, A. (2018). Narrating the journey of sustained recovery from substance use disorders. *Substance Abuse Treatment, Prevention and Policy, 13*(1), 35. https://doi.org/10.1186/s13011-018-0167-0

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

Strydom, H. (2011). Ethical aspects of research in the social sciences and human service professions. In A. S. De Vos, H. Strydom, C. B. Fouché & C. S. L. Delport (Eds.), *Research at grass roots for the social sciences and human service professions* (4th ed., pp. 113–130). Van Schaik.

Swedberg, R. (2018). *On the uses of exploratory research and exploratory studies in social science*. Cornell University.

Teeters, J. B., Lancaster, C., Brown, D. G., & Back, S. E. (2017). Substance use disorders in military veterans: Prevalence and treatment challenges. *Substance Abuse and Rehabilitation, 8*, 69–77. https://doi.org/10.2147%2FSAR.S116720

Thungana, Y., Zingela, Z., & Van Wyk, S. (2019). First-episode psychosis and substance use in Nelson Mandela Bay: Findings from an acute mental health unit. *South African Journal of Psychiatry, 25*, 1372. https://doi.org/10.4102%2Fsajpsychiatry.v25i0.1372

Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: A contemporary qualitative research approach. *Journal of Healthcare Communications, 2*(4), 1–5. https://doi.org/10.4172/2472-1654.100093

Unegbu, R. O. (2020). Exploring the role of social workers in substance abuse treatment [Doctoral dissertation]. Walden University.

United Nations Office for Drugs and Crime (UNODC). (2017). *World drug report 2017: Global overview of drug demand and supply: Latest trends, cross-cutting issues*. United Nations.

United Nations Office for Drugs and Crime (UNODC). (2020). *World drug report 2020: Socioeconomic characteristics and drug use disorders*. United Nations.

Van Kranenburg, G. D., Van Den Brink, R. H. S., Mulder, W. G., Diekman, W. J., Pijnenburg, G. H. M., & Mulder, C. C. (2019). Clinical effects and treatment outcomes of long-term compulsory in-patient treatment of treatment-resistant patients with severe mental illness and substance-use disorder. *BMC Psychiatry, 19*(1), 270. https://doi.org/10.1186/s12888-019-2254-9

Van Wyk, C. (2011). The burden of disease: Substance abuse in South Africa. *African Journal of Psychiatry*, *14*(1), 80–84.

Varkey, B. (2021). Principles of clinical ethics and their application to practice. *Medical Principles and Practice, 30*, 17–28. https://doi.org/10.1159/000509119

http://etd.uwc.ac.za/

Velasquez, M. M., Von Sternberg, K., Dodrill, C. L., & Kan, L. Y. (2005). The transtheoretical model as a framework for developing substance abuse interventions. *Journal of Addictions Nursing, 16*, 31–40.

Volkow, N. D., Han, B., Einstein, E. B., & Compron, W. M. (2021). Prevalence of substance use disorders by time since first substance use among young people in the US. *JAMA Pediatrics, 175*(6), 640–643. https://doi.org/10.1001/jamapediatrics.2020.6981

Volkow, N. D., Koob, G. F., & McLellan, T. (2016). Neurobiologic advances from the brain disease model of addiction. *The New England Journal of Medicine, 374*, 363–371. https://doi.org/10.1056/NEJMra1511480

Volkow, N. D., Michaelides, M., & Baler, R. (2019). The neuroscience of drug reward and addiction. *Physiological Reviews, 99*(4), 2115–2140. https://doi.org/10.1152/physrev.00014.2018

Wang, J. Z., Mott, S., Magwood, O., Mathew, C., McLellah, A., Kpade, V., Gaba, P., Kozloff, N., Pottie, K., & Andermann, A. (2019). The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: A systematic review. *BMC Public Health, 19*(1528), 1–22. https://doi.org/10.1186/s12889-019-7856-0

Wangithi, I. K., & Ndurumo, M. M. (2020). Relationship between family support, self-efficacy and relapse occurrence among youth recovering from drug addiction in selected rehabilitation centres in Limuru sub-county, Kenya. *African Journal of Education, Science and Technology, 6*(1), 1–11. https://doi.org/10.2022/ajest.v6i1.471

Watkins, M. (2022). *How drugs affect the brain central nervous system*. American Addiction Centers. https://americanaddictioncenters.org/health-complications-addiction/central-nervous-system

Webster, S., Lewis, J., & Brown, A. (2014). Ethical considerations in qualitative research. In J. Ritchie, J. Lewis, C. McNaughton Nicholls & R. Ormston (Eds.), *Qualitative research practice: A guide for social science students and researchers* (2nd ed., pp. 77–110). Sage.

Wells, E. A., Kristman-Valente, A. N., Peavy, K. M., & Jackson, T. R. (2013). Social workers and delivery of evidence-based psychosocial treatments for substance

UNIVERSITY of the WESTERN CAPE
http://etd.uwc.ac.za/

use disorders. *Social Work in Public Health, 28*, 279–301. https://doi.org/10.1080/19371918.2013.759033

Werb, D., Kamarulzaman, A., Meacham, M. C., Rafful, C., Fisher, B., Strathdee, S. A., & Wood, E. (2017). The effectiveness of compulsory drug treatment: A systematic review. *International Journal of Drug Policy, 28*, 1–9. https://doi.org/10.1016/j.drugpo.2015.12.005

Williams, A. R., Nunes, E. V., Bisaga, A., Levin, F. R., & Olfson, M. (2019). Development of a cascade of care for responding to the opioid epidemic. *The American Journal of Drug and Alcohol Abuse. 45*(1), 1–10. https://doi.org/10.1080/00952990.2018.1546862

World Health Organisation (WHO). (2020). *Substance abuse*. https://www.who.int/topics/substance_abuse/en/

Zebrowski, P. M., Rodgers, N. H., Gerlach, H., Paiva, A. L., & Robbins, M. L. (2021). Applying the transtheoretical model to stuttering management among adolescents: Part I. Scale development. *American Journal of Speech-Language Pathology, 30*, 2492–2509. https://doi.org/10.1044/2021_AJSLP-20-00186.

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ANNEXURE A: ETHICAL CLEARANCE LETTER

UNIVERSITY *of the* WESTERN CAPE

14 October 2021

Mr J Cupido
Social Work
Faculty of Community and Health Sciences

HSSREC Reference Number:	HS21/8/11
Project Title:	Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder
Approval Period:	**14 October 2021 – 14 October 2024**

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology, and amendments to the ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report by 30 November each year for the duration of the project.

For permission to conduct research using student and/or staff data or to distribute research surveys/questionnaires please apply via:
https://sites.google.com/uwc.ac.za/permissionresearch/home

The permission letter must then be submitted to HSSREC for record keeping purposes.

The Committee must be informed of any serious adverse events and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
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NHREC Registration Number: HSSREC-130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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ANNEXURE B: LETTER OF PERMISSION TO CONDUCT RESEARCH

UNIVERSITY *of the* WESTERN CAPE

FACULTY *of* COMMUNITY AND HEALTH SCIENCES
UNIVERSITY *of the* WESTERN CAPE

DEPARTMENT OF SOCIAL WORK

Title of Research Project: Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder.

Dear Sir/madam

My name is Jonathan Cupido, I am a Masters of Social Work (MSW) student in the Department of Social Work at the University of Western Cape. For the purpose of this degree, I am conducting a research study that has been approved by the University of the Western Cape's Humanities and Social Sciences Research Ethics Committee. The research aim is to explore and describe the experiences of social workers regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder in the Western Cape.

I am requesting permission to gain entry into the community through your organisation. This would entail that you provide me with an opportunity to have an information session at your organisation with social workers to provide them with information regarding the project and to invite them to participate. Those who are interested will be provided with an information letter that will also be provided to you. Those who agree to participate will then be requested to meet with me to discuss the nature of the project, and to arrange a time and place for me to interview them. Please note that participation is voluntary and that ethical practice of limitation of harm, availability of debriefing opportunities, privacy, confidentiality and anonymity, as well as the management of data will be implemented.

Your willingness to support me will be much appreciated. I am also providing you with the information letter to the participants, as well as proof of ethical clearance for you to be able to make an informed decision to support me.

You can also contact the University of the Western Cape's Humanities and Social Sciences Research Ethics Committee: (ref **HS21/8/11**). Tel: 021 959 4111; E-mail: research-ethics@uwc.ac.za.

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Should you have any further questions regarding this study and the rights of the research participants or if you wish to report any problems you have experienced related to the study, please contact:

Prof Marichen van der Westhuizen Department of Social Work: Head of Department Faculty of Community and Health Sciences University of the Western Cape Tel: 021 9592851 Email: mvdwesthuizen@uwc.ac.za	Prof Anthea Rhoda Dean: Faculty of Community and Health Sciences University of the Western Cape Private Bag X17 Bellville 7535 chs-deansoffice@uwc.ac.za

Thank you for your consideration and support.

Thank you.

Mr Jonathan Cupido
E-mail: 3114659@myuwc.ac.,za

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ANNEXURE C: INFORMATION LETTER

DEPARTMENT OF SOCIAL WORK

Title of Research Project: Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder.

What is this study about?
This research project will be conducted by Jonathan Cupido, for a Master of Social Work degree at the Department of Social Work at the University of Western Cape. The research aim is to explore and describe the experiences of social workers regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder in the Western Cape. You are invited to participate in this study because you have been identified as a person who could provide relevant information on the topic to assist the research to attain the aim of this study.

What will I be asked to do if I agree to participate?
You will be requested to sign a consent form which confirms your decision to participate voluntary. The researcher will conduct an individual interview with you, which will last between 40 to 60 minutes. You will be asked to share your experiences and perceptions on the topic of the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder.

Would my participation in this study be kept confidential?
You will be asked permission that the researcher can audio-record the interview. Should you choose not to give permission for this, your answers and contributions be recorded by means of field notes. The recording will be transcribed immediately after interview, and the recording will be locked into a safe space to which only the researcher and his supervisor will have access. The researcher undertakes to protect your identity and the nature of your contribution. To ensure your anonymity, your name will not appear on the transcript of the interview. A number will be assigned to your name, for example 'Participant 1", and a list will be made that links the numbers to the identity of the participants. This list will be stored on a password computer to which only the researcher will have access. All documents will be destroyed five years after that study was completed. If I write a report or article about this research project, your identity will be protected.

In accordance with legal requirements and/or professional standards, any disclosure of abuse or harm made during the research process by you or any other participant,

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has to be reported. In this event, I will inform you that I have to break confidentiality to fulfil my legal responsibility to report to the designated authorities.

What are the risks of this research?
Discussing personal experiences and perceptions carry some amount of risks. The researcher will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention. Participants has the right to withdraw from the study at any time.

What are the benefits of this research?
This research is not designed to help you personally, but the results may help the researcher to make recommendations for the use of the Transtheoretical Model of Change for involuntary treatment of substance use disorder in the Western Cape. In this way, social workers and service users could benefit from your participation.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised in any way.

Is any assistance available if I am negatively affected by participating in this study?
Should you feel, at any stage during the interview uncomfortable or afraid to continue, your participation will be stopped even though you consented. Even though your experience and insight are valuable to this research, the researcher will respect your decision to terminate. Should you wish to terminate your participation because you feel uncomfortable due to any form of disclosure, the researcher will refer you for counselling.

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What if I have questions?
This research is being conducted by Jonathan Cupido under the auspices of the Social Work Department at the University of the Western Cape. If you have any questions about the research itself, please contact the researcher at: 081 717 9265 (cell phone number) or at 3114659@myuwc.ac.za (email address). You can also contact the University of the Western Cape's Humanities and Social Sciences Research Ethics Committee: (ref **HS21/8/11**). Tel: 021 959 4111; E-mail: research-ethics@uwc.ac.za.

Should you have any further questions regarding this study and the rights of the research participants or if you wish to report any problems you have experienced related to the study, please contact:

http://etd.uwc.ac.za/

Prof Marichen van der Westhuizen Department of Social Work: Head of Department Faculty of Community and Health Sciences University of the Western Cape Tel: 021 9592851 Email: mvdwesthuizen@uwc.ac.za	Prof Anthea Rhoda Dean: Faculty of Community and Health Sciences University of the Western Cape Private Bag X17 Bellville 7535 chs-deansoffice@uwc.ac.za

Thank you for your consideration and support.

Mr Jonathan Cupido
E-mail: 3114659@myuwc.ac.,za

http://etd.uwc.ac.za/

ANNEXURE D: CONSENT FORM

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DEPARTMENT OF SOCIAL WORK

Title of Research Project: Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder.

The study has been described to me in a language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

I agree to participate in the research study ____________________
I do not agree to participate in the research study ____________________
I agree to be audio-recorded ____________________
I do not agree to be audio-recorded ____________________

Participant's name………………………..
Participant's signature……………………………….
Date………………………

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ANNEXURE E: INTERVIEW GUIDE

Title of Research Project: Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder.

The aim of this interview is to explore and describe your experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder.

The Transtheoretical Model of Change consists of 5 stages to support a client to engage with the treatment of a substance use disorder, namely: Precontemplation (not considering change), 2) contemplation (considering change), 3) preparation (developing change plan), 4) action (implementing change plan), and 5) maintenance (sustaining change). For the purpose of this study, I am particularly interested in the first three stages, but would like to hear your opinion on the implementation of all the stages.

The following questions will be asked during this interview:

General questions:

- In your opinion what is the difference between the treatment of a voluntary and involuntary client?
- Have you ever used the Transtheoretical Model of Change?
  - If yes, what would be, in your opinion, the advantages of this model?
  - If yes, what would be challenges in the implementation of this model?

Transtheoretical Model of Change-related questions:

- In your experience what should be the focus of intervention during the precontemplation phase where a client is not ready for treatment?
- In your experience what should be the focus of intervention during the contemplation phase where a client is considering to participate in treatment?
- In your experience what should be the focus of intervention during the preparing for change phase where a client is planning to participate in treatment?
- In your experience what should be the focus of intervention during the action phase where a client is participating in treatment?
- In your experience what should be the focus of intervention during the maintenance phase where a client is supported to sustain changes that were made?

<u>Sub questions</u>:

- What techniques have you used to assist a client in this phase?
- What works well?
- What challenges do you experience?

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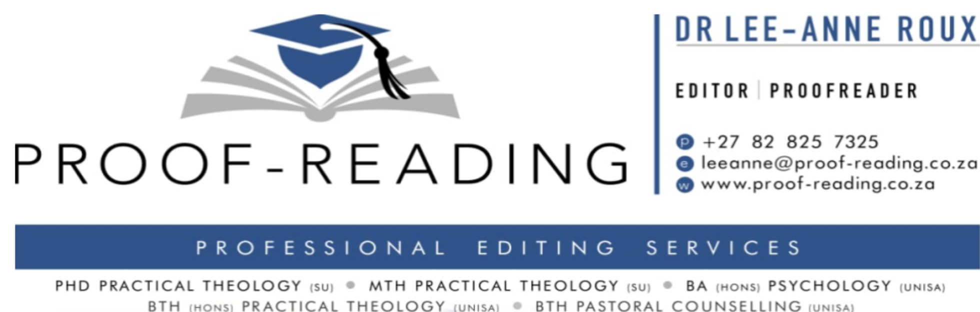
ANNEXURE F: EDITOR'S LETTER



6 July 2023

TO WHOM IT MAY CONCERN

RE: LANGUAGE EDITING

This letter serves to confirm that I have edited the thesis titled:

Social workers' experiences regarding the use of the Transtheoretical Model of Change in involuntary treatment of a substance use disorder

By

Jonathan Cupido

Note: This certificate does not cover any alterations made subsequent to the editing process.

Please feel free to contact me if you need any further information.

Yours sincerely,

Dr Lee-Anne Roux

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