Windows of opportunity: Service users' experiences of the continuum of care for the treatment of a substance use disorder

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Abstract

Objectives: The continuum of care for the treatment of a substance use disorder provides a framework within which a variety of options are available to prevent and treat a substance use disorder [3]. Within the South African context, there is a lack of information regarding how service users perceive and experience the different options within the continuum of care. Therefore, the aim of the study that informed this article was to explore the experiences and perceptions of service users in South Africa regarding the utilization of the continuum of care to inform the planning of treatment services.

Method: A qualitative approach was followed and purposive sampling was employed to collect data through focus group discussions with service users. A thematic data analysis process was followed. For ensuring the trustworthiness of the research process and findings, strategies to enhance the credibility/authenticity, transformability, dependability and conformability were employed. Informed consent, confidentiality and debriefing of participants were considered to ensure ethical practice.

Results: The results provided information regarding the participants' experiences regarding access to, and the utilization of, preventative, early intervention, formal treatment and aftercare and reunification services. Perceptions of the role of professional service providers were described, while focus areas to be included in the recovery process were identified.

Conclusions: The findings showed that, within the South African context, the implementation of the continuum of care requires that the unique contextual needs of service users should inform services. This entails individualized treatment plans instead of generalized treatment plans. Case managers are needed to provide continuity, based on supportive and trustful relationships. Accessibility to the different care options and community structures were highlighted as important to address holistic well-being, availability of a variety of care options, and service delivery that is based on expert knowledge and skills.

Introduction

Substance abuse is characterized by dysfunctional behaviors that create physical, emotional and social problems, as well as financial and employment difficulties. An important aspect is that substance abuse continues despite these negative consequences [1]. Substance abuse may result in addiction, which is associated with a higher tolerance level where more of the substance is needed to experience the desired effect and withdrawal symptoms when the person attempts to stop using the substance. Painful and uncomfortable withdrawal symptoms and exposure to substances or substance-related stimuli can trigger a relapse, which negatively impacts not only on the substance dependent person, but also on the family and community [2]. Puddy and Wilkens [3] support the above-mentioned description of substance abuse and addiction, and argue for the inclusion of multiple components in a comprehensive treatment plan.

The United Nations Office on Drugs and Crime (UNODC) [4] advises that the term 'addiction' be replaced with 'substance dependence'. This term includes both descriptions of abuse and addiction provided above. The UNODC describes dependence on a substance(s) as the continued use of a psychoactive substance(s) where the person exhibits signs of intoxication, periodically or chronically, experiences a compulsion to take the preferred substance(s), lacks control to cease or modify substance use voluntarily, and is determined to obtain the preferred substance(s) by any means regardless of the consequences [4]. For the purpose of this article, a chemical substance refers to a psychoactive substance that may lead to physical and psychological dependency, and characterized by the fact that regular use leads to higher tolerance levels and withdrawal symptoms [5].

Confirming the above description, the American Psychiatric Association [2] describes a substance use disorder (SUD) in terms of a variety of cognitive, behavioral and physiological symptoms that are characterized by the continued use of a substance, despite significant substance-related problems. A further important characteristic of a SUD is "an underlying change in brain circuits that may persist beyond detoxification" [2]. This characteristic demonstrates the long-term effect of substance abuse that needs to be considered when seeking to provide effective treatment. A vulnerable brain can experience intense cravings for the substance when exposed to substance-related stimuli, increasing the risk for multiple relapses; therefore emphasizing the need for a long-term approach to treatment [2]. Similarly, the UNODC [4] distinguishes between psychological and physical dependency. 'Psychological dependence' refers to the impaired control over substance abuse, while 'physical dependence' involves the development of tolerance to the substance(s) and withdrawal symptoms when the

use of the substance is ceased. This is a result of changes within the body to adapt to the continued presence of a substance(s). These two forms of dependency should also be considered in the treatment of a SUD, which points to a need to provide a variety of service options, depending on the individual needs of service users.

A SUD is mostly determined by genetic, physiological, biochemical, and emotional vulnerability [6]. Haase [7] identifies a number of high risk factors that may contribute to a SUD at the following levels:

* *Micro level*: Lack of self-esteem, inability to deal with stress, trauma, general feeling of hopelessness due to poverty, violence and unemployment

* *Meso level*: Loneliness, lack of support systems, significant others abusing substances, domestic violence

* *Macro level*: Poverty, unemployment, availability and affordability of substances

These levels of risks refer to both the risk to develop a SUD, or to relapse during efforts to recover from a SUD.

The effects of a SUD are another aspect to consider when treatment is planned. The *physical effects* include malnutrition, heart disease, neurological disorders, liver disease and physical weakness. This causes the person to underperform in daily tasks. *The psychological effects* refer to psychological withdrawal symptoms that include anxiety, stress and depression. Personality and behavioral changes are also observed, for example aggressiveness and compulsiveness. These changes, in turn, have a negative effect on relationships. The long-term *cognitive effects* of substance abuse include cognitive problems such as the inability to achieve full occupational and/or educational performance due functional impairment, as well as memory and concentration problems. This often results in dismissal from one's workplace, which negatively affects the financial situation of the family. *The social effects* refer to isolation from close relationships with family and friends, and greater association with substance-using/abusing persons. Changes in behavior and the substance dependent person's nonconformity to family rules and expectations, in turn, contribute to family conflict and violence [8, 9, 10].

The treatment of a SUD is described by Walitzer, Dermen and Barrick [11] as a behavior modification therapy for those who use substances to the detriment of themselves and others. Behavior modification, in the context of the treatment of a SUD, requires that the specific needs of the person with such a disorder must direct the nature of services. The authors, therefore, accentuate the need to address different treatment needs and explain that treatment may vary between low-level professional inputs to a high-level input. The continuum of care is one framework within which these different inputs can be implemented based on the individual needs of the service user. Puddy and Wilkins [3] describe the continuum of care as a framework for the treatment of a SUD where individual needs are catered for. The authors assert that it refers to an integrated system of care options, consisting of a comprehensive variety of services related to specific needs with the aim of guiding a person towards recovery from a SUD. Garthwait [12] also refers to the continuum of care as a "spectrum of services", and adds that services should be integrated in such a way that all the recovery needs can be met throughout the recovery process, while duplication of services is minimized. Treatment, according to the continuum

of care, is long-term in nature and it guides and tracks a person over time [3]. In this article, the continuum of care relates to the framework for the treatment of a SUD provided by the South African Department of Social Development [33], and includes prevention, early intervention, treatment, and aftercare and re-integration services.

In an effort to obtain information regarding current treatment interventions of a SUD in the South African context, the topics and findings of recent research studies were explored. Mudavanhy and Schenck [13] investigated substance abuse among youth in a rural area, while Marinus [14] explored the experiences of children of farm workers who are dependent on substances. These studies identified the need for access to services and long-term interventions to ensure the holistic treatment of substance dependent youth or the children of substance dependent persons in rural areas. In line with the latter study, Schultz and Alpaslan [15] investigated the need for services and support to siblings of substance dependent youth. Mogorosi [16] and Smook, Ubbink, Ryke and Strydom [17] focused on substance abuse and dependency in the workplace and explored some solutions aimed at the development of Employee Assistance Programs. Matsimbi [18] explored the perceptions, expectations, fears and needs of chemically dependent youth in a rehabilitation center about being reintegrated into their family systems. In terms of treatment, Strebel, Schefer, Stacey and Shabalala [19] evaluated intervention strategies implemented in specific provinces in South Africa. It was noted that these intervention strategies were focused on specific services, such as prevention, treatment or aftercare, and not the integration thereof. The mentioned studies covered a range of focus areas. However, an investigation and description of how the continuum of care is implemented in practice and how service users view this continuum were not found in recent literature pertaining to the South African context.

Hansen [20] asserts that, on the one hand, when a service provider utilizes a specific framework for services, it does not necessarily mean that the users of the services will utilize it effectively. On the other hand, the utilization of a service by service users does not necessarily mean that the nature of services are in line with a prescribed framework. This author therefore highlights the need to explore the utilization of services from the perspectives of both the provider and the user. The study that informed this article investigated the experiences and perspectives of both groups. This article will focus on the experiences and perspectives of service users.

The *research goal* that guided the discussion that follows was to explore and describe the experiences and perceptions of service users regarding the utilization of the continuum of care for treatment of a SUD to inform the planning of services. The methodology used to attain this goal will be described in the next section.

Methodology

In order to attain the abovementioned research goal, a *qualitative research approach* was chosen to develop a better understanding of the real-life experiences and perceptions of service users regarding the utilization of the continuum of care for treatment of a SUD [21]. The *explorative research design* guided the research as it was aimed at identifying specific characteristics, problems and interrelated components of the participants' lived experiences [22]. This design guided the choices regarding the population and methods and techniques for sampling

and data collection. In order to ensure that the experiences and perceptions of the participants were well described to obtain a deeper understanding of the research topic, the *descriptive research design* was chosen to be used together with the explorative research design [22]. This design guided the choices regarding methods for data collection and analysis. The study was conducted in the Western Cape in South Africa, which directed the choice to also use the *contextual research design* [23]. This design informed the choices of population and sampling method and technique.

As this research was concerned with the participants' view of the research topic, their verbal expressions were of key interest. Therefore, it was important to ensure that the sample would be drawn from a *population* that would include those persons, who are representative of the focus of this study, namely persons who have been receiving services to treat a SUD in the Western Cape.

In order to obtain a sample from the population, purposive sampling as *non-probability sampling technique* was chosen, to ensure that participants that were best equipped to answer the research questions were selected [24]. The criteria to be included into the sample was adult persons older than 18 years who are dependent on chemical substances and who are receiving treatment for a SUD from a formal service provider. The *sample size* was determined by data saturation to contribute to the effort to obtain information-rich data [25]. A total of 10 service users participated in this study.

Interviewing was chosen as the method of *data collection*, meaning that the researcher who conducted the fieldwork, as the research tool, entered the natural setting where experiences and perceptions could be reported [26]. Interviews took place within focus groups, based on the benefit that people in a similar context are provided with a platform to discuss and explore perceptions, ideas, opinions and thoughts based on shared and individual experiences [27]. An interview-guide was used to describe the logistics of the focus group interviews, how ethical practice would guide the process, and to provide a framework for semi-structured questions. The questions that guided the focus group interviews were:

* Tell me about experiences where you were exposed to preventative services before your dependency started (Continuum of care: Prevention).

* Tell me about the nature of the first services you received? (Continuum of care: Early intervention).

* What in- and/or out-patient services did you receive? (Continuum of care: Residential/statutory/alternative care).

* What services in terms of aftercare and reunite with your family have you received? (Continuum of care: Aftercare and reintegration)

* What do you think is the role of professional persons when people are supported/receive treatment for substance dependency?

* What are the aspects that you find valuable in your recovery process?

* What other aspects do you think should be included to assist you on your road to recovery?

In order to analyze and interpret the qualitative data, Tesch's (1990) eight steps for *qualitative data analysis*, described by Creswell [28], was utilized as a scientific framework from which themes, sub-themes and categories could be identified.

Credibility/authenticity, transformability, dependability and conformability were considered to ensure the scientific value of the qualitative research process and findings. *Credibility* was addressed by means of an interview guide and interviewing techniques, as well as methods of data recording and analysis. *Transferability* was enhanced through a clear description of the methodology that was followed. Additionally, the contextual research design and the criteria for inclusion into the sample guided how the findings of the study were interpreted and compared to other contexts. A clear description of the research methodology also supported the *dependability* of findings, while a literature control contributed to the interpretation of the findings. *Conformability* was achieved through the use transcripts and field notes to document the findings, the scientific process of the analysis of the data and a literature control [29].

Informed consent to participate based on a clear understanding of the nature of the research, confidentiality to ensure privacy and anonymity, and access to debriefing guided the ethical practice during the research process [30].

Limitations

The findings that will be presented next must be viewed together with the limitations experienced. Firstly, the study was conducted in the Western Cape Province in South Africa. The findings are therefore contextual in nature. Secondly, all the participants were older than 18 years of age, and therefore the voices of children and youth are not reflected in this study. The decision to only include adult participants was based on ethical challenges related to minor participants.

Findings

Six of the participants were in the young adult life stage. Benson and Edler [31] describe this life stage as where the young adult's identity formation is based on interactions with significant others, as well as their contexts or macro environment. The norms and expectations that are typical of these interactions contribute to "internalized mental maps". The authors refer to this identity formation as subjective in nature, meaning that the social influence of interactions on the identity of a young adult is powerful. Four participants were in the middle adulthood stage of development. These participants' life stage is characterized by securing careers and economic stability, developing and maintaining a healthy self-image and maintaining health [32]. Both these life stages are affected by a SUD. Substances used by the participants were reported to be methamphetamine, methcathinone, mandrax (a chemical substance mainly used in combination with marijuana in South Africa), marijuana and alcohol. The National Institute on Drug Abuse (NIDA) [33] explains that a SUD affects the functioning of the cerebral cortex, which implies that the person with a SUD's ability to think, plan, solve problems, and make decision is impaired. This impairment affects the person's social, emotional, cognitive and spiritual development. In terms of behavior, the limbic system is activated by the use of substances, which affects emotions and motivations behind behavior. The mentioned impact of the substance on a person must be taken into consideration when designing a treatment plan [33]. The findings in this study should therefore be understood in terms of the fact that the

participants' development has been influenced by the SUD. In addition, five participants were able to reflect on previous treatment, as they were in treatment for a second time.

It must be taken into consideration that the service user participants had no prior knowledge of the theoretical framework that informed this study. For this reason, the interview guide was designed to ask specific questions related to their experiences and perceptions regarding services related to the continuum of care. Their experiences and viewpoints regarding the research topic will be presented in terms of the main themes that emanated from the data analysis process.

Theme 1: Descriptions of the continuum of care

Preventative services focus on areas that could put people at risk, and are aimed at preventing development needs from developing into challenges and risks [34]. The participants in this study reported that they were exposed to preventative services in schools and at church: "*I can mention maybe the church, the church leader and the people in the church.*" "*At school I used dagga* (marijuana) *and they sent me to a church where I must go and get clean. If I cannot get clean then I will not go to school and I got clean, and went back to school.*" However, the participants reflected that knowledge obtained through preventative services did not prevent them from using and abusing substances: "*I knew about drugs being bad for you, but I just told myself that I will never end up in a place like that* (referring to an inpatient treatment center). *So I did not worry about it.*" Community organizations and the school have been identified as valuable resources for the prevention of substance use and abuse. Although not confirmed by the participants in this study, the family and peers could also support efforts to prevent substance use and abuse [35]. Other participants reported that they were not exposed to preventative services, as illustrated by the following statement: "*No one told me about drugs and their effects.*" They explained that they received information about the effects of substance abuse for the first time when they entered treatment: "*I ended up at my first treatment center. That is when I started getting knowledge on everything.*"

Although not specifically asked, the participating service users included the reasons behind their substance abuse when reflecting on their experiences and perceptions of preventative services. The availability of substances and the acceptability of substance abuse were identified as environmental influences that contributed to the participants' substance use and abuse: "*I was exposed to the environment where it was actually normal to use drugs.*" "*I come out of this area that is infested with drugs. So that is like a norm. So I got into this thing at an early age. I have been doing this for 18 years.*" "*There was no support structure. It was like it is a normal thing where I come from.*" Elaborating on the acceptability of substance use and abuse, the participants referred to the role of the media: "*Drinking for me was a cool thing and I did not have any problems as it was a good thing to me. On television it was just advertising; there was nothing bad that was said about it.*" Here the participants did identify family and peers as contributing factors. The following utterances describe the influence of peers: "*I looked at my friends and I wanted to be cool like them. They smoke, so it is cool to smoke.*" "*My mother would tell me don`t do this and that, but I would not listen and just continued doing that stuff to be in with my friends.*" With regards to their families, a lack of parental availability and guidance was reported a contributing factor to substance use and abuse: "*I did feel lonely, because I did not have a father. So I started using drugs to fill that emptiness*

inside me." "*I grew up in a family with no parents. So I started drinking at an early age and my siblings could not say anything as I was the big brother and protector.*" The above statements also highlight emotions that contributed to the substance use and abuse. In addition, a participant explained that the use of substances helped him to deal with anger: "*I got angry and I started smoking so that the stress will be reduced.*"

Early intervention is the service on the continuum of care that aims to limit the impact of substance use, and to prevent substance use to escalate to substance abuse and dependency [34]. The participants identified non-formal interventions by family and peers during the early onset of their SUD: "*My family, but my close friends also… they tried to encourage me to stop.*" Copello, Templeton and Powell [36] confirm the value of family involvement to prevent and address substance use and abuse. However, for family involvement to have a positive outcome, strong and positive family relationships, as well as sanctions against the use and abuse of substances are needed [35]. Similarly, in the above description of contributing factors, the participants in this study mentioned the acceptability of substance use and abuse in their communities, and also referred to a lack of strong family bonds.

When asked to reflect on early intervention, the participants mainly focused on the non-formal interventions described above. When probed about formal early interventions, a participant reported that he was not aware of such a service: "*None. There are no services out there for our kind of community. Let`s just be honest.*" Another participant recalled that he visited support groups at a child and youth care facility, but mentioned that it did not have a positive outcome: "*There was a time I was at a care center. I underwent some counselling and people were talking about it in support groups. This did not help, as I had many friends using drugs and it had become a culture between us.*" Latchford [37] explains that early intervention is not only educational in nature. The person at risk of moving towards a SUD must obtain knowledge on the one hand, and on the other hand must be guided and supported to implement the knowledge. This means that the person requires skills to move away from a negative lifestyle, to address challenges and to make a choice to cease the use of substances. The author, however, notes that some service users might deliberately choose not to accept this guidance and support.

Treatment, according to the continuum of care, refers to statutory/residential/alternative care, which entails "…protection services that endeavor to safeguard the well-being of service beneficiaries" [34]. While discussing their experiences of treatment, the participants reflected on past experiences of not being motivated: "*At that time I do not think I was ready yet to receive knowledge.*" "*Honestly speaking, it was because my mom wanted me there and a part of me wanted to be there, but a larger part of me just did not care about it.*" On the one hand, continuing on the topic of motivation, a participant explained that he entered treatment, because of external pressures: "*So at work, when they realized my problem, the deal was I go to X* (the service provider) *or I lose my job.*" On the other hand, some participants' descriptions of their motivation to seek treatment point to an internal motivation for change: "*Can I start by saying that the decision was mine to get rid of this abuse of alcohol?*" "*I am trying to implement everything that they are teaching me, like the triggers so I have to be careful of them. Because I want to have a different kind of life.*" "*I want to change and it helps, as I listen to the social worker and take her advice. But previously it*

did not help as I did not want to be here.*" In support of the latter statement, Latchford [37] explains that a movement from external to internal motivation to enter treatment is a normal part of the process of change. The service provider should therefore provide the service user with a space to contemplate both external and internal motivations. Similarly, Stokes, Schultz and Alpaslan [38] assert that both external and internal motivators can contribute to sustained recovery from a SUD. While external motivation can be viewed as a pressure to change, the person moves towards an understanding that the external pressure is in line with a personal need for recovery [37]. The participants supported this viewpoint, and explained that they experienced both external and internal levels of motivation to enter treatment: "*I also tried to stop for the sake of family, and I also then told myself that I should do this for myself, as I have used for a long time and need to stop.*"

The participants discussed formal treatment in terms of what was working well and what did not work well. They accentuated that detoxification assisted them to engage with the treatment process more effectively: "*Alcohol plays with our minds and leaves us confused and wondering which choices to make. The clear picture of what happens when drunk and when sober makes you think twice about the choices you make.*" "*That demon is out. Now I can focus on my new life.*" "*Once I felt clean of the stuff* (referring to substances) *I learned how to respect myself and how to communicate with people and then I could start talking to the social worker about my life.*" Proctor and Herschman [39], in support of these statements, view detoxification as a key component of formal treatment. These authors note a period of at least five days that should introduce detoxification before other treatment activities commence. Martin [40] also highlights the need for neurological reparation and nutrition as the first part of treatment interventions.

The participants reported that knowledge about the SUD, spiritual guidance and life skills are important components during the treatment: "*I have learnt a lot about my abuse. And what it does to me, as well as how recovery works.*" "*I learn a lot on how to create an environment that will allow me not to use again and live by the rules. Something we never did when we were using.*" "*I learned about doing stuff in a different way that I used to before.*" "*They* (service provider) *give me advice and help me with how to make decisions and solve problems in my life.*" Spiritual growth was identified as an aspect that supported their recovery, which is linked to emotional and social well-being: "*Spiritually is uplifting me.*" "*I have learned that life is not just about me. It is about everyone and God, and we need to respect one another and not to give up.*" In support of these viewpoints, Chen [40] identifies spiritual well-being as an indicator for a successful outcome of treatment as it contributes to a sense of purpose. This is supported by Stokes et al. [38] who found that spirituality contributes to a meaningful change in lifestyle that contributes to recovery.

The participants who had previous exposure to treatment reflected on what aspects did not work well. A participant noted that the service was not person-centered: "*The previous center, they really did not care. They were more focused on their own pocket than helping the patients. So by the time I left the center I was already using again.*" Similarly, Proctor and Herschman [39] report that outcomes of services are dependent on the extent to which it addresses the individual needs of the service users, including contextual challenges. A participant furthermore referred to group sessions that provided the service users with

information, while there was a lack of focus on the internalization of the information: "*In a day we had four classes. We got a lot of information, but later I could not remember what it was about*."

According to the continuum of care, aftercare is aimed at the reintegration into families and communities after formal treatment, and also to build resilience and develop skills to function optimally [34]. The participants referred to using a sponsor and visiting support groups when reflecting on their previous experiences with aftercare: "*Well, I had a sponsor that I could speak to if I felt like using again*." "*I would go to meetings with support groups like Narcotics Anonymous. So it helped me stay sober*." A previous lack of aftercare was described: "*After my first treatment center I did not have aftercare, but I am hoping to actually get an aftercare program*." As also portrayed in the last part of this description, a need to include aftercare as part of their recovery was voiced. The following statement further supports this viewpoint: "*When I go home I would like to go and attend NA* (Narcotics Anonymous) *classes and be more intimate with the church*."

The participants also focused on their own plans to engage with aftercare and reintegration activities to recover from their SUD. Firstly, they referred to life style changes, which included time management and participation in recreation activities: "*I am actually planning what I am going to do to keep myself busy from actually using the substance*." "*I am focused on my day to day activities; especially when I am working a normal day shift now, I go straight home and do my chores*." Secondly, they reported that repairing the damage caused by the substance dependency was an important aspect of aftercare and their efforts to reintegrate into their families and society [42]. "*Trying to change my life and be a better person, because in the past I did hurt a lot of people*." Thirdly, the participants further elaborated on the need to reintegrate with their families and communities, and highlighted the need for family support as part of aftercare: "*And by getting support from my wife and family I hope that I can start with a new and better life*." Family support and the ability to build healthy relationships form an integral part of aftercare as it contributes to reintegration [36]. Fourthly, as also supported by literature [5], the participants noted that an important aspect of reintegration is that stigmatization and a lack of trust by the community affect the individual in recovery: "*I was attacked in my car. I went to the police as my phone was stolen and the police thought I was still on drugs. It was disturbing to me and they tested me and cleared me. I was clean*." "*Stigma associated with substance abuse should be removed. Being able to talk helps a lot. It is not easy to be judged. So it is easier to continue with your sober life if people trust you, or at least if they do not judge you; if they believe that you can change*."

The participants drew a link between the previously mentioned contributing factors and triggers that affect the recovery process while exploring their experiences and perceptions of aftercare and reintegration. They highlighting that access to money to buy substances, peer pressure and emotions of frustration continue to challenge their efforts to recover from the SUD: "*Some of the triggers are when I have money at the end of month, I tend to drink a lot and also my friends when I am with them. Even if I do not have money they always give me something to drink. These two are the dangerous triggers for me*." "*Some people frustrate me and I always want to take something to ease my mind*."

Theme 2: The role of professional service providers

In this study, the participants focused on social workers as service providers. Galvani [42] postulates that evidence from practice shows a need for social workers to be active role players in the SUD field. The participants expressed the value of motivation by social workers, and a need to be motivated and encouraged throughout the treatment process: "*Social workers are there for motivation*." "*Also, I met up with a social worker who guided me through this whole process of getting rid of substance abuse*." A participant explained that part of motivation requires that the social worker guides the service user to understand the process of change: "*And talk you through the program and to make it more understandable*." Similarly, Maluleke [44] concurs that motivation of service users does not only focus on entering the treatment process, but also to continue with the process into aftercare.

The participants continued to express a need that social workers refer them, as well as their families, to relevant resources: "*If you see someone and you want to help them and their family does not know how to go about the whole system of getting their son or daughter into a facility or institution; that is where the social worker comes in*." Garthwait [12] explains that referrals can only be made if resources are available and accessible. In this study, the participating service users particularly referred to a need that social workers should ensure that services are available and accessible: "*Assistance to get treatment, because a lot of people do not have money*." "*The need to help people to get into places, but there are always a waiting time or it is too expensive*." "*It was difficult for me to get into an inpatient program. I thought the social workers will be able to help, but they also struggled*." The experiences reported above are confirmed by Swanepoel, Geyer and Crafford [45] who identified a challenge for social workers to do referrals to community-based resources, which then affects the treatment outcomes.

The continuum of care provides service users with different care options to address the unique needs of the individual and the family [3]. Galvani [43] agrees and continues to state that social workers will engage with service users during different points in their SUD histories, for instance during early intervention, formal treatment or aftercare. The author explains that the key is to provide motivation and support that will maximize the person's response to treatment on any level of care. In this study, the participants requested that social workers provide them with information associated with early intervention and treatment, skills to develop a sober lifestyle associated with treatment and aftercare, and also that the new life skills be integrated during aftercare: "*Social workers can pass on information to patients and give tools so that they can help themselves. We need to know what to do and what not to do to help us to become sober. And to stay sober*." "*They should give you tools and guidance and strategies to stay sober as the onus is on you and your family to help you to stay sober*." "*Their role is to help us to know how to go about to do things and avoid triggers*." "*They must help us on how to deal with our social lives and be comfortable in them*."

Garthwait [12] is of the opinion that coordination of services aimed at the treatment of a SUD prevents duplication of services, while the participants in this study identified a need to build a relationship with one social worker who will guide them through treatment. They requested to have a caseworker that will guide them through the process: "*To get you a rehabilitation center. After that the work is for the rehabilitation center.*

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

Van der Westhuizen [42], Swanepoel et al. [45] and Chetty [46] identified a need for aftercare as a specialized focus area of the treatment of a SUD. The long-term nature of the recovery process [2] requires that aftercare continues until the person is settled in a new, sober lifestyle. In further support, Galvani [43] asserts that a lack of post-formal treatment options increases the risk for relapses. The participants in this study confirmed these viewpoints through the following utterances: "*We need a team for aftercare and they should be focusing on us and nothing else.*" "*There needs to be another group* (social workers only focusing on aftercare) *that goes out there to see the problems that we go through and this should be made long-term for it to be effective, because for just six weeks you can fall back again. So extra staff is needed for aftercare and it should be ongoing.*" "*This* (aftercare) *needs to be incorporated with the whole program so that aftercare is almost non-stop or is made a five year plan. At the moment it is just five to six weeks.*"

Due to the harm done during substance abuse, family members and the community often do not trust the person with a SUD. It becomes important that the social worker understands the nature of a SUD, and that he/she is able to trust in the person's potential to move into recovery and to change [42]. This trust is also needed when working with the families and the communities [44]. The participants also reported on the value of trust in the social worker as follows: "*I have a social worker. I had to go to her every Thursday. Most of the problems I had I could not speak to my family or trust someone. So she was the one I could go to and confess to. And I know she will not judge me.*" "*So she* (social worker) *was like a mother for me here, she helped me a lot.*" However, a participant explained that while support from the social worker is needed, it is not always available: "*The role of the social worker is to support someone who is in a situation with drugs. And this is not fully possible as groups come and go and we do not get full attention.*" Galvani [43] describes the supportive nature of social work interventions in the treatment of a SUD in terms three key roles.

* To *engage* with the topic of substance use and abuse so as to be knowledgeable and skilled to provide support,

* To *motivate* the person with the SUD to change behavior, as well as his/her family and the community to support efforts to change, and

* To *support* the maintenance of change so as to achieve sobriety. However, social workers must be clear about what they can do and how much the service user can expect of them.

Theme 3: The focus areas in a recovery process

The participants identified the need to be linked to support groups as a resource in their recovery process: "*The information and the sharing in NA can help me to stay positive and continue to try and make it.*" "*I need a sponsor. Someone I can communicate to when I feel like I am pushing myself towards the wrong direction.*" "*Talking to someone and opening up is also a very good form of therapy. With a sponsor you can talk about the things that worry you and they are always there for you.*" Support groups have a long history of providing community-based peer support. In such groups, peers provide each other with en-

couragement, non-judgmental advice, and emotional support [47]. Another value is that peers act as sponsors for each other, which provides the service user with extra support where the social worker cannot always be available [42; 45]. The participants also identified the church as a resource that could support their recovery [41]: "*To go to church more often will be very important. There I can find hope and I will be with people who want be to be well. They will believe in me.*"

Once again, the participants identified social support from family and peers as an important part of their recovery needs: "*This is a difficult time to change all my bad habits and to deal with everything. I think it will help a lot to get that comfort from friends and family.*" Addressing this need can serve as an important protective factor in the treatment and recovery process [47]. To further address social support, the participants noted that stigmatization should be addressed [5]: "*A lot of black Africans do not use these services because of the stigma and are not free to come as they lack support.*"

Finally, the participants requested to be assisted to deal with emotions that may impact on their behavior, choices and problem solving: "*I will need help to deal with emotions… and not let my emotions take over.*" "*To learn to deal with my emotions and frustrations. That is important, because if I get frustrated I might make the wrong choice, or it will make it difficult to deal with my problems.*" Maluleke's [44] study also identified a need for emotional support. This author identified therapy, counselling and therapeutic groups as methods to provide emotional support as part of the treatment of a SUD.

The next section is dedicated to conclusions and recommendations for practice based on the findings and literature control.

Conclusions & recommendations

This section is sub-divided into sections that focus on each treatment option in the continuum of care. The discussion will firstly focus on conclusions drawn from the findings, followed by recommendations for the planning of treatment of a SUD.

Conclusions and recommendations regarding prevention

In terms of prevention of a SUD, while some participants could not recall any exposure to preventative services, other participants identified schools and churches as community-based structures where they were exposed to preventative services. It appears that services were mainly educational in nature, and that the information did not deter participants to continue using and abusing substances [35]. The findings highlight a need to acknowledge context related aspects that contribute to substance use and abuse to ensure that risk factors inform the nature of preventative services [34]. In this study, availability of substances; the acceptance of substance use and abuse in the family and community, as also portrayed in the media; lack of strong family and peer relationships; and problems to deal with emotions were noted as aspects that should be considered [35].

It is recommended that prevention should not only focus on a macro level, but could also be addressed through educational group work on meso level in high-risk areas. Such groups could be introduced to schools, at churches, and at community family and youth programs. Context related topics, such as the availability and/or acceptance of substance use in a community, that address high risks in the specific communities should guide pre-

ventative services on meso and macro level, so as to prevent development needs to escalate into social challenges. Educational and life skills groups with families and peers, where community members are at risk of developing a SUD, could serve as a valuable tool to empower community members to support sober living lifestyles so as to prevent substance use and abuse.

Conclusions and recommendations regarding early intervention

The participating service users did not recall formal early social work interventions. However, they identified families and friends who intervened in their substance use and abuse for the first time [36]. The participants highlighted the importance of internal motivation to seek treatment, and explained how they moved from external levels of motivation to internal levels of motivation. It is concluded that motivation to change is an important aspect to consider during early intervention services [37; 38]. They continued to request that they are prepared for what to expect from the treatment process, and motivated throughout the process [42; 43].

During first contacts to service users, professional service providers should explain their role, and show interest in and concern about how the service user is experiencing the contact. In terms of the long-term nature of the continuum of care, this will inform the service user's expectations of services to address substance use and abuse. Thus, a trusting, non-judgmental relationship should be part of the aims of early intervention. Early intervention should focus on the development of an internal level of motivation to change thoughts and behavior that encourage substance use and abuse. However, a lack of motivation, or an external level of motivations should not be seen as negative. Motivational interviewing can be used to assist service users to develop an understanding of why they would want to choose sobriety, and skills to make behavioral changes to support a healthy life style. In this way, internal motivation can be stimulated and an escalation of the substance use and abuse can be prevented.

Conclusions and recommendations regarding treatment services

The service users confirmed the need to be referred to services that will address their treatment and recovery needs [34]. However, they reported that social workers do not always have access to resources that will address their needs. It is concluded that treatment services must be planned according to the contextual needs of service users, while the extent to which SUDs are prevalent should be taken into account to ensure that manpower to address treatment needs are available [12; 45]. The participants accentuated that detoxification assisted them to engage with the treatment process more effectively, and that they were able to respond better to therapeutic services once detoxification took place. It is concluded that the cognitive-behavioral approach and the motivational interviewing technique will have better outcomes if detoxification is addressed as a focus area for treatment [39]. The participants value education regarding a SUD, as well as the recovery process, spiritual guidance, and life skills as aspects that assisted them well during treatment. It is concluded that treatment should include individual work in order to address individual needs and personal aspects related to the recovery process [39]. The participants identified specific expectations from social workers. They firstly requested guidance and support that will assist service users and their families to enter treatment, to complete treatment,

and to continue with aftercare [39]. Secondly, they reported that they need long-term, trusting relationships with social workers [42; 44].

Services to families should include a focus on addressing the harm caused by the SUD. The aim would be to assist families to recover from the effects of living with a person with a SUD as part of empowering them to become able to support the recovery process. Treatment must not only focus on the psychosocial component of recovery, but should acknowledge the importance of detoxification. It should be noted that the impact of cognitive-behavioral and motivational services will be affected negatively if detoxification did not take place. In order to ensure that treatment is based on service users' needs and contextual challenges, resources should be made available and manpower should be established to ensure that services are accessible and available. In terms of manpower, the need to receive individual care based on a trusting and on-going relationship with the social worker must be acknowledged when planning of services are done, and when funding is considered.

Conclusions and recommendations regarding aftercare of a SUD

The participants referred to using a sponsor and visiting support groups when reflecting on their previous experiences with aftercare. They also highlighted the fact that their own motivation to make changes, as part of post treatment work affects their ability to remain sober positively. Lifestyle changes and repairing interpersonal damage caused by substance abuse were noted as key aspects in aftercare [34; 42]. In this study, the participating service users reported that they previously did not continue with aftercare, and that they now realized that this will be an important factor in their recovery. Motivation to continue with aftercare after treatment on the long-term, and social workers who specifically avail themselves for aftercare services were reported as aspects to consider during the planning of aftercare services. It is concluded that aftercare requires a workforce that specializes in relapse prevention and reintegration into families and the community [2; 42; 45; 46]. The need for the availability of social workers for individual support during aftercare was identified, while the participants requested assistance to deal with emotions, and to be supported to master life skills that will support a sober lifestyle [43]. Resources that could support aftercare services were identified as churches or spiritual groups, and family and peer support. The importance of the inclusion of family members in aftercare services was highlighted. It is concluded that aftercare should be a formally planned service that forms part of the overall treatment plan, and which also places the focus on reintegration with families and the community. The participants noted that they are negatively affected by stigmatization in their communities. The conclusion may be drawn that the social worker will have to fulfil an advocacy role, where the nature of a SUD, as well as the recovery process is presented to community members in an effort to address stigmatization [5].

It is recommended that, when individual treatment plans are developed prior to identifying the relevant treatment options to address the individual needs of service users, aftercare should be included as part of the treatment plan, and not as a separate or follow-up option. Based on the long-term nature of the treatment process, it should be considered to develop a workforce that specializes in aftercare. Such services should include micro level of support in terms of socio-emotional well-being, meso level of support to include families and peers in the recovery

process, and macro level of support to link service users to community resources and to address stigmatization through awareness programs.

The authors hope that the findings, conclusions and recommendations presented in this article will support services that utilize the continuum of care for treatment of a SUD. It is further envisaged that it could encourage service providers to plan and implement services according to the continuum of care, and that policy makers and funders of treatment services will take note of the conclusions and recommendations so as to support the implementation of the continuum of care.

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