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SUBSTANCE ABUSE AND THE WORKPLACE - A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

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SUBSTANCE ABUSE AND THE WORKPLACE - A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

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my mother, Ma Saartjie; my sons, Edrich & Ettienne;
and, above all, to
God my Provider – JAHWE JIREH (Gen. 22:14)

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OPSOMMING

SUBSTANSMISBRUIK EN DIE WERKSPLEK - 'N NETWERKPROGRAM VIR WERKGEWERS EN BUITE- PASIËNTESENTRA

Sleutelterminologie: substansmisbruik, werksplek, netwerkprogram, werkgewers, buitepasiëntesentra, samewerking.

Beide werkgewers en buitepasiëntesentra is betekenisvolle rolspelers in die hantering van die misbruik van afhanklikeidsvormende middels soos alkohol en dwelmmiddels. Enersyds word werkgewers direk en indirek deur die geweldige impak van substansmisbruik geraak. Andersyds is buitepasiëntesentra betrokke deur middel van behandelingsprogramme om die probleem van substansmisbruik en/of -afhanklikheid te hanteer. Hierdie probleem is so omvattend dat dit nie net gemeenskaplike optrede verg nie, maar ook spesialiteitsintervensie om die probleem doelreffend te bestuur. Sodanige gemeenskaplike intervensie vereis egter doelgerigte maatreëls en 'n gestruktureerde proses ten einde die beste resultate te verseker.

'n Netwerkprogram tussen die werkgewers en buitepasiëntesentra bied 'n geleentheid vir die implementering van 'n gemeenskaplike intervensieproses. Trouens, samewerking tussen werkgewers en buitepasiëntesentra vorm die grondslag vir die vestiging van 'n netwerkprogram om substansmisbruik en -afhanklikheid in die werksplek te hanteer. Konsolidering van die kragte en hulpbronne van genoemde rolspelers is noodsaaklik vir die vestiging en volhoubaarheid van sodanige program. 'n Netwerkprogram met duidelike riglyne en 'n werkbare struktuur met spesifieke prosesse wat gemeenskaplike voordele vir die betrokke rolspelers inhou, beskik oor die moontlikheid om as 'voertuig' vir die gesamentlike hantering van die probleem te dien.

'n Kwalitatiewe navorsingstudie gegrond in die data wat versamel is, is onderneem om die moontlikhede te verken vir die ontwikkeling van 'n netwerkprogram tussen werkgewers en buitepasiëntesentra om die probleem van substansmisbruik gesamentlik te hanteer.

Artikel 1 is 'n literatuurstudie oor substansmisbruik binne werksverband. Die literatuurstudie fokus op rigtinggewende faktore in die hantering van substansmisbruik binne werksverband. Uit die literatuurstudie blyk dit dat nasionale riglyne en wetlike vereistes wat duidelike riglyne vir die hantering van substansverwante probleme binne werksverband aan werkgewers bied, in plek is en dat beleidsprosedures vir die doeltreffende bestuur van die probleem wel vir

werkgewers beskikbaar is. Daarbenewens is spesialiteitsdienste beskikbaar om werkgewers in staat te stel en by te staan om die probleem te bestuur. Ten spyte hiervan word substansverwante probleme in die werksplek dikwels onafhanklik hanteer deur interne ondersteuningstrukture, sonder om van die beskikbare spesialiteitsdienste gebruik te maak. Navorsingsbevindings dui egter op ‘n inherente onvermoë by meeste ondersteuningsstrukture binne werksverband om die probleem doeltreffend te bestuur.

Die literatuurstudie het uitgewys dat matige alkoholgebruikers en -misbruikers ‘n groter negatiewe impak op die werksplek uitoefen as substansafhanklikes, dat hulle aanleiding gee tot die meeste werksverwante bedryfsongelukke en ook die hoogste afwesigheidsyfer toon. Volgens die studie bestaan meer as die helfte van die werknermersmag uit hierdie groepe. Daar is voorts aangedui dat voorkomende behandeling in terme van susbstansmisbruik die beste resultate lewer en op die totale werksmag gerig behoort te word. Nasionale riglyne lê in die besonder klem op voorkomings- en bewusmakingsprogramme, asook opleiding in vroeë identifisering van substansafhanklikheidsprobleme.

Alhoewel navorsingsbevindings op positiewe behandelingsresultate van werknemers met substansprobleme en/of -afhanklikheid dui, toon statistieke aan dat daar aan die kant van die werkgewers ‘n beduidende gebrek aan verwysings, sowel as identifisering van werknemers met substansprobleme is. Die voorafgaande dui daarop dat werkgewers behandelingsentra onderbenut. Dit skep ‘n leemte in die doeltreffende hantering van substansmisbruik binne werksverband, terwyl spesialiteitsdienste wel beskikbaar is om die probleem aan te spreek.

Artikel 2 bespreek die bevindings van ‘n situasie-analise met betrekking tot die probleme van substansmisbruik, asook die hantering van die probleem binne werksverband. Deelnemers van die besigheidsektor en buitepasiëntesentra is by die ondersoek betrek. Werknemers betrokke by substansbehandelingsprogramme het ook deel van die ondersoek uitgemaak.

Die leemtes wat in die ondersoek na vore gekom het, is ‘n algemene gebrek aan kennis binne die werksplek rakende die negatiewe gevolge van substansmisbruik. ‘n Gebrek aan ondersteuning binne werksverband in die ontwikkeling van ‘n gesonde werksmileu met betrekking tot substansgebruik is ook aangedui. Ten spyte van ondersteunende strukture beskikbaar binne werksverband, is aangetoon dat sulke strukture dikwels nie die probleme doeltreffend hanteer nie. Wetlike maatreëls bepaal dat behandeling in die geval van substansverwante oortredings binne werksverband voorkeur moet geniet. Empiriese bevindings het egter getoon dat werkgewers in die algemeen nie die voordele van sulke maatreëls besef nie en selfs soms onkundig staan in terme van die interpretering van die maatreëls.

Die gebrek aan kontak tussen werkgewers en buitepasiëntesentra is as ‘n opvallende leemte geïdentifiseer. Werkgewers is in die algemeen onbewus van die spesialiteitsdienste wat die sentra in die behandeling van substansmisbruikers en/of -afhanklikes lewer. ‘n Gebrek aan bemarking van die behandelingsdienste aan die kant van die buitepasiëntesentra, onbetrokkenheid en selfs ongeërgdheid aan die kant van werkgewers, asook ‘n groot gebrek aan kennis oor die omvang en impak van die probleem is as oorsake aangedui.

Deelnemers aan die studie het ‘n behoefte uitgespreek vir nouer samewerking tussen werkgewers en buitepasiëntesentra om die probleem aan te spreek. Die ontwikkeling van ‘n netwerkprogram is aanbeveel en spesifieke komponente en prosedures is as riglyne vir die vestiging van so ‘n program geïdentifiseer.

Artikel 3 bespreek eerstens die komponente van ‘n voorgestelde netwerkprogram en tweedens die proses vir die vestiging van sodanige program vir werkgewers en buitepasiëntesentra. Die komponente wat gedurende die situasie-analise geïdentifiseer is, is as raamwerk vir die ontwikkeling van ‘n meer omvattende netwerkprogram aangewend.

‘n Vennootskapsverhouding tussen die werkgewers en buitepasiëntesentra om gesamentlik die probleem van substansmisbruik te hanteer, is as gemeenskaplike doel van die program geïdentifiseer. Die verweefdheid van die behandeling van substansprobleme in werksverband en die netwerkprogram is duidelik uitgewys. Deelnemers het voorts aangedui dat die program voordele vir alle betrokke rolspelers moet inhou, met ander woorde dat werkgewers, werknemers en buitepasiëntesentra by so ‘n program behoort te baat. Die voorgestelde program dui dan ook betekenisvolle voordele aan.

‘n Proses met spesifieke prosedures vir die vestiging van die netwerkprogram is ontwikkel. Prosedures behels onder andere die volgende: assessering van die tekortkominge en kragte van beide die besigheidsektor en die buitepasiëntesentra, veral ter wille van individualisering van dienste aan die besigheidsektor; die sluit van ‘n netwerkooreenkoms wat die rolle en verantwoordelikhede van beide partye aandui; gesamentlike beplanning en implementering van die program en ten slotte ook die gesamentlike evaluering van die program se impak en doeltreffendheid. Die voorafgemelde prosedures geld terselfdertyd vir die diensleweringskomponent ten opsigte van substansprobleme. Die vordering en resultate van die behandelingsprogram behoort dus ook geëvalueer te word. Ten slotte behoort die suksesse en leemtes van die netwerkprogram in oënskou geneem te word en die nodige aanpassings gemaak te word ten einde volhoubaarheid van die program te verseker. Die verantwoordelikheid vir die inisiëring van die netwerkprogram tussen die werkgewers en buitepasiëntesentra is aan die sentra opgedra.

Doelgerigte vestiging van die vennootskapsverhouding tussen die werkgewers en buitepasiëntesentra, asook kwaliteit dienslewering deur die sentra is as krities belangrik geag. Die netwerk is ten slotte beskou as ‘n gemeenskaplike intervensieproses waarby die werkgewer, die werknemer en die buitepasiëntesentra betrokke is om mee te werk om die probleem van substansmisbruik en die effek daarvan op die werksplek te beveg.

Die studie is voltooi met die formulering van riglyne vir die ontwikkeling van ‘n netwerkprogram. Die praktiese doelwit naamlik, om in die behoeftes van buitepasiëntesentra, asook werkgewers en werknemers te voorsien, is in die proses nagestreef. Die netwerkprogram het ten slotte ‘n samevatting verteenwoordig van die volgende: die data soos verwerk in die situasie-analise; die navorser se ervaring as berader in die veld van substansmisbruik; asook betrokkenheid by verskeie netwerkprogamme en laastens, aanvullende teoretiese kennis. Riglyne vir die implementering van die progam, asook voorbeelde van praktiese projekte, is ingesluit in die studie.

SUMMARY

SUBSTANCE ABUSE AND THE WORKPLACE – A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Key concepts: substance abuse, workplace, networking programme, employers, outpatient treatment centres, collaborations

Both employers and out-patient treatment centres are key role players in addressing workplace related substance abuse. On the one hand, employers are directly and indirectly affected by the huge problem of substance abuse. On the other hand, out-patient treatment centres provide, as their core goal, for the treatment of substance abuse and dependency. Due to the extent of the problem of substance abuse, collaborative intervention measures between employers and out-patient treatment centres are essential – especially the involvement of specialists in the treatment of substance abuse. Such a collaboration process requires specific, resolute measures, as well as a structured process in order to ensure sustainability and results.

A networking programme that provides the opportunity to implement this collaborative process is proposed. Sound collaborations indeed provide the foundation to establish the networking programme for combating the problem of substance abuse in the workplace. A collaborative effort to address the problem of substance abuse in the workplace requires not only rallying the strengths and resources of both employers and out-patient treatment centres, but also developing a programme with well-defined processes beneficial to both.

A qualitative research study by means of a grounded theory approach was conducted to explore how networking between employers and out-patient treatment centres might aid in addressing the problem of substance abuse in the workplace.

Article 1 is a literature overview of substance abuse within the workplace and concerns the national directives, legislation requirements and measures of intervention aimed at dealing with the problem. The literature findings reveal clear national directives, legislation requirements and workplace policies, all aimed at providing a well-defined context for employers to manage substance abuse in the workplace. In addition, specialist treatment services are available to assist employers in addressing the problem in the workplace. Internal support structures in the workplace, however, often independently address the problem of

substance abuse without involving the specialists. Literature findings indicate, though, that the personnel involved in the internal support structures are often not equipped to deal effectively with the problem.

Research findings indicate positive treatment outcomes for employees with substance abuse problems. Statistics, however, indicate that the identification of employees with substance abuse problems is limited and that referrals of employees for treatment are infrequent. Underutilisation of out-patient treatment centres is therefore commonplace.

Literature specifically indicates that the majority of employees are moderate drinkers and substance abusers, with only a small number being dependant. It is further indicated that the moderate drinkers and substance abusers account for almost half of the workforce. The critical factor, however, is that these categories of drinkers cause the majority of industrial accidents and are also responsible for the highest absenteeism rate. Prevention measures, sensitising the entire workforce to the early signs and dangers of substance abuse, facilitate the achievement of the best results in combating the problem. With an eye towards this, national directives advocate the following: intensified campaigns to educate people regarding the early signs and dangers of substance abuse, comprehensive prevention measures and increased rehabilitation efforts.

Literature identified a limitation to effectively address substance abuse in the workplace, a problem catered for by specialist treatment centres.

Article 2 reports the findings of a situation analysis regarding both the concerns and problems of employers and out-patient treatment centres, as well as resources needed to combat substance abuse in the workplace. Representatives from the employment sector, and out-patient treatment centres, participated in the situation analysis. Employees involved in substance abuse treatment programmes also participated in the study.

A specific limitation, identified during the situation analysis, was the limited knowledge regarding the negative consequences of substance abuse in general. An unsupportive workplace environment, with regards especially to substance use and abuse, was also identified. Though empirical findings reported the existence of support structures in the workplace, these structures were found to be incapable of dealing with the problem. In the event of substance misconduct, employers are legally obligated to provide treatment and rehabilitation before considering dismissal; however, employers perceived these obligations as additional demands. Employers did not realise the possible benefits of treatment over

dismissal. Misinformation and misinterpretation of the legal obligations were also identified during the research study.

The stand against the problem of substance abuse in the workplace revealed a limited collaboration between employers and out-patient treatment centres. Employers were often not aware of specialist treatment centres and the available services. A lack of marketing and visibility – on the part of out-patient treatment centres – and an indifference and lack of support in the workplace were regarded as some of the causes for the limited collaboration between employers and out-patient treatment centres. Both ignorance in the workplace about the scope of substance abuse and a general lack of knowledge regarding the problem were identified as further limiting factors.

A need for collaboration between employers and out-patient treatment centres was identified, especially if the problems of substance abuse in the workplace were to be successfully addressed. The development of a networking programme for employers and treatment centres was recommended and the core components to establish such a programme were identified.

Article 3 discusses the components which were identified during the situation analysis and presents guidelines to develop a networking programme for employers and out-patient treatment centres. The components identified by the participants served as framework for the proposed networking programme. The programme comprises a specific purpose namely collaboration between employers and out-patient treatment centres, specific characteristics to sustain the programme, and the implementation of distinguishable procedures to establish and ensure sustainability of the programme.

The purpose of the networking programme is to promote, between employers and out-patient treatment centres, a collaboration that will address the problem of substance abuse in the workplace. Involvement in the programme holds significant potential benefits for all relevant role players; the programme, in other words, advocates benefits for employers, employees and out-patient treatment centres.

The proposed networking programme includes specific procedures for establishing and sustaining the programme: Firstly, assessing the limitations, needs and strengths of both the employment sector and out-patient treatment centres; secondly, establishing a network agreement that defines the roles and responsibilities of the role players; thirdly, collectively planning the networking activities and implementation of these plans; and, finally, collaboratively evaluating the impact and effectiveness of the programme. The aforementioned procedures also apply to both the evaluation of the limitations and progress

of the treatment programmes, as well as to the evaluation of service delivery of the treatment centres. As it enables the revision of plans that provide individualised services, the continuous reassessment of the limitations and strengths of the networking programme is important.

Out-patient treatment centres are considered responsible for initiating the networking programme. Effective collaboration between employers and out-patient treatment centres, as well as quality service delivery by the treatment centres, is regarded as critically important. Ultimately, the networking programme – regarded as a collaborative process between employers, employees and out-patient treatment centres – promotes a partnership geared towards combating the problem of substance abuse in the workplace.

The researcher concluded the study with the formulation of a theory regarding the development of a networking programme as its end goal. Also, it is hoped that both out-patient treatment centres and the employment sector (employers and employees) may benefit from it in practice. Eventually, the proposed networking programme was based on the data collected from the situation analysis in this study, the researcher's experience as a counsellor in substance abuse treatment and her exposure to different networking programmes, as well as supportive theoretical knowledge. A guideline for application of the networking programme in practice is included in the study alongside examples of projects to apply the programme.

PREFACE

This manuscript is presented in article format in accordance with the regulation A. 12.2 for the PhD (SW) degree that is set out in the calendar of the North-West University: Potchefstroom Campus.

The content and technical requirements of the accredited Journals Social Work/Maatskaplike Werk, South African Journal of Business Management and Health SA Gesondheid were used as basis to formulate the articles.

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SECTION A: ORIENTATION TO THE RESEARCH

SECTION A: ORIENTATION TO THE RESEARCH

1. CONTEXTUALISATION AND PROBLEM STATEMENT

Substance abuse and dependence is a global concern and problems related to substance abuse are costly to societies throughout the world (Hitzeroth & Kramer, 2010:13; Miller & Weisner, 2002:3). The United Nations Office on Drugs and Crime (UNODC, 2010:7) refers to the estimated 15 to 38 million problem drug users globally in 2010. According to the UNODC (2013:10) approximately one in six persons who need treatment for drug use disorders actually receives the treatment and in Africa, only one in 18 problem drug users access treatment services, predominantly for cannabis use.

The growth in economic opportunities in South Africa (SA) since 1994 has led to an increase in the economically active population and the UNODC (2012:87) states that the concomitant increase in disposable income is largely responsible for the increase in substance consumption. Drug trafficking in SA has also increased exponentially since 1994 (UNODC, 2012:92-93), as has the number of people seeking treatment for drugs and alcohol problems (McCann, Harker Burnhams, Albertyn & Bhoola, 2011:44). A growing concern is the increasing importance and vulnerability of the African continent in terms of drug trafficking routes and the UNODC (2013:ix,23,57) expressed an urgent need to improve the data collection and analysis of countries in this region.

The impact of substance abuse on SA is huge. The Central Drug Authority (CDA) revealed alarming statistics on the situation in SA during the launch of the 2009 United Nations World Drug Report (Anon, 2009:1). These statistics indicate that SA is one of the drug capitals and top ten narcotics and alcohol abuse centres of the world; that the problem poses a bigger threat to the future of the country than the HIV and AIDS pandemic; that the consumption of substances in SA is twice the world norm and that 15% of the population of SA has substance abuse problems (Anon, 2009:1). Alcohol remains the most commonly abused substance in SA followed by cannabis (Department of Social Development, 2010:33-34; Department of Social Development, 2013:5; Eberlein, 2010:32; McCann *et al.,* 2011:46; SACENDU, 2012a:2).

Regarding alcohol use, the World Health Organization (WHO) stresses the heavy burden in most countries of diseases and deaths attributable to alcohol consumption. Almost 4% of all deaths worldwide can be linked to alcohol, which is greater than deaths caused by HIV and AIDS, violence or tuberculosis (WHO, 2011:20). A measurable pattern of alcohol consumption risk is heavy episodic drinking or binge drinking, which is fairly high in SA (Eberlein, 2010:33; WHO, 2011:15-17). A review in 2009 of harmful drinking patterns and levels of consumption

in 20 African countries showed that, in terms of "the proportion of heavy drinkers as a percentage of current drinkers, SA ranked fourth highest" (McCann *et al.,* 2011:23).

Regarding illicit substance use, the CDA annual report (Department of Social Development, 2010:34) reveals that 2.2 million people or 8.4% of the population in SA used cannabis in 2004 against the global norm of 4%. In 2008, approximately 3.2 million cannabis users were recorded in SA indicating an increase of nearly 20% since 2004. According to Hitzeroth and Kramer (2010:39), a recent study among mine workers in SA revealed cannabis use of 9.1%. The World Drug Report (UNODC, 2013:viii) indicates that SA ranks fifth as the most frequently mentioned country of provenance in terms of cannabis. Increased substance abuse among the employed is reported in various literature sources (Grobler, Wärnich, Carrell, Elbert & Hatfield, 2006:404; Hitzeroth & Kramer, 2010:38-39; McCann *et al.,* 2011:45). Estimates on the prevalence in SA of alcohol-dependence problems in the workplace range from 5% to 35% and drug problems from 7% to 20% (Grobler *et al.,* 2006:401; Hitzeroth & Kramer, 2010:37-38; McCann *et al.,* 2011:45).

The economic impact of substance abuse on employers amounts to millions of rands annually in SA. The negative consequences of substance abuse by employees include above average absenteeism from work, injuries, accidents and decreased productivity which all represent actual costs to employers (Eberlein, 2010:178-179; Grobler *et al.,* 2006:401; Miller & Weisner, 2002:3-5; Parry & Bennetts, 1998:57-76). Low to moderate drinkers in particular pose a big risk to companies as, according to the International Labour Organization (McCann *et al.,* 2011:289), this category of drinkers is responsible for much of the absenteeism and accidents in the workplace and accounts for 60-70% of workplace problems. The International Center for Alcohol Policies (ICAP, 2013) substantiates that employees who drink moderately but may occasionally drink excessively are also responsible for much of the alcohol-related productivity losses resulting from absenteeism, accidents, injuries, employee illness, sick leave and mortality.

Literature sources on the outcome of substance abuse treatment for employees reveal significant positive results after in- and out-patient treatment. Slaymaker and Owen (2006:352-353) report major reductions in alcohol and drug use; improved medical and psychological functioning; improved earnings from employment; and substantial reduction in AIDS risk behaviours and drug related crimes. According to Stevens and Smith (2005:355) substance abuse treatment reduces abuse and leads to improvements in employment, lower criminal activity, social adjustment and the better use of healthcare facilities. Gossop and colleagues in Goodman (2007:89) conducted a major research study on drug treatment in Britain, namely the National Treatment Outcome Research Study, and reported significant treatment benefits.

Regarding crime rates, research on reconvictions following treatment shows a “reduction for all offences of 24% after one year, 29% after two years and 50% after five years”. Miller and Weisner (2002:42) indicate that clients who receive more services, and particularly professional services, achieve the best outcomes. Research findings further reveal “that ‘maximum’ aftercare reduced crime by 90 per cent compared to ‘minimum’ aftercare that had a 57 percent decrease” (Goodman, 2007:82,89).

National directives and legislation clearly indicate the importance of employee assistance regarding substance abuse. The significance of sound workplace substance abuse management programmes is highlighted in the new National Drug Master Plan (NDMP) (Department of Social Development, 2013:129). The importance of awareness among employers and employees about the benefits of a drug-free workplace, i.e., superior customer service, higher employee morale, increased productivity, reduced staffing costs and reduction in employee theft is emphasised. The emphasis of the NDMP (2013-2017) is on comprehensive prevention and education programmes, and on treatment, rehabilitation and aftercare. Against this background, an appeal is made in the NDMP (2013-2017) for partnerships between the government and the public sector to implement comprehensive, ethical and sound workplace substance abuse programmes (Department of Social Development, 2013:129). According to the NDMP, South Africa lags behind international standards to manage employee substance abuse as part of occupational health, safety and risk management programmes.

The legal obligations of employees and employers for dealing with substance abuse and dependency in the workplace are also stipulated in several South African Acts such as the Occupational Health and Safety Act (85 of 1993), the Compensation for Occupational Injuries and Diseases Act (130 of 1993), Labour Relations Act (66 of 1995), and the Employment Equity Act (55 of 1998). Employers are legally obligated to allow for treatment and rehabilitation of employees with substance abuse and dependency problems resulting in poor work performance before dismissal is considered.

National directives, legislation requirements and the outcomes of substance abuse and dependency treatment therefore needed to be contextualised within the framework of this research study.

Despite the major impact of substance abuse on the workplace, specialist treatment centres for substance abuse and dependency remain largely underutilised. Data provided by the South African Community Network of Drug Use (SACENDU, 2012a:2) reveal a lower treatment referral rate from employers than from other referral sources for clients with substance abuse

problems nationwide. Inadequate identification of employees with such problems is also reported. The South African Chamber of Mines estimates a 1% identification rate of workers with substance abuse problems (McCann *et al*., 2011:289).

The devastating effect of substance abuse problems on the workplace calls for collaboration between all interested parties to combat the problem. According to Backer (2003), Hepworth, Rooney, Rooney, Strom-Gottfried and Larsen (2010) and Long, Tice and Morrison *(*2006), collaboration involves shared commitment, shared responsibility and shared resources in achieving a common goal. Two of the main role players with a shared interest in combating substance abuse in the workplace are the employment sector and substance abuse treatment centres. Therefore, sharing resources with a common goal to address the problem collaboratively could be a viable option for employers and out-patient treatment centres.

The following framework demarcated the research study:

- ✓ The researcher's involvement as a counselor in substance abuse out-patient treatment with the South African National Council on Alcoholism and Drug Dependence (SANCA Lowveld) in Mpumalanga province.
- ✓ The inclusion of the Limpopo and Mpumalanga provinces, as these provinces are clustered into one region for research and statistical purposes (SACENDU, 2012a:1).
- ✓ A focus on out-patient treatment as recent statistics (SACENDU, 2012b) reveal that most clients in SA receive out-patient treatment.
- ✓ The involvement of SANCA treatment centres as they are the only registered treatment centres that provide substance abuse out-patient treatment in both the provinces.
- ✓ The involvement of employers due to their significant role in combating substance abuse in the workplace and also of employees undergoing treatment for substance abuse.

The two main 'populations' in the study were thus the employment sector and the out-patient treatment centres in the demarcated area.

Research questions

The main research question enquires into the development of a networking programme by which substance abuse in the workplace may collaboratively be addressed by both the employers and out-patient treatment centres.

The following sub-questions were raised:

- ✓ What is the context in terms of substance abuse in the workplace and what are the national directives and intervention measures to combat the problem in the workplace?

- ✓ What are the concerns, needs and resources of the employers and out-patient treatment centres in combating substance abuse in the workplace?
- ✓ What are the essential components in order to develop a networking programme for employers and out-patient treatment centres to address substance abuse in the workplace?

2. AIM AND OBJECTIVES OF THE STUDY

2.1 Aim

The main aim of the research study was to develop a networking programme for employers and out-patient treatment centres to address substance abuse problems in the workplace collaboratively.

2.2 Objectives

The objectives to achieve this aim were:

- ✓ To contextualise substance abuse in the workplace in terms of national directives, legislative requirements for managing the problem and intervention measures to combat the problem.
- ✓ To explore the current concerns, needs and resources of employers and out-patient treatment centres in addressing substance abuse in the workplace.
- ✓ To develop a networking programme for employers and out-patient treatment centres to address substance abuse collaboratively in the workplace.

3. SCIENTIFIC PARADIGM

3.1 Theoretical frameworks

As theoretical frameworks, the ecosystems perspective and macro-level practice guided the research questions and are discussed next.

3.1.1 Ecosystems perspective

The ecosystems perspective emphasises the importance of transactions and the dynamic interaction between systems within the environment (Kirst-Ashman & Hull, 2009:280; Long *et al.,* 2006:35,42). Ecological concepts center around the following: the interrelation of individuals and their environment (person-in-environment); transactions including positive and negative communications within the environment; and an interdependence and mutual reliance on each other and on the environment (Long *et al.,* 2006:35; Poulin & Contributors, 2000:4-5). According to Germain and Gitterman (Segal, Gerdes & Steiner, 2007:13), the ecological systems framework focuses on the larger environment and views people and their

environment as reacting to and changing in response to each other. In terms of this perspective, the interrelatedness between a person's needs, wants and capacities as well as the resources in the environment or community, is acknowledged. The ecological approach encourages active participation of people in their communities and presents opportunities for mutual support, personal growth and a range of relationships (Long *et al.,* 2006:35).

Knowledge about people and their environment forms a cornerstone of social work practice. With the focus on the person-in-environment, an understanding of the nature of interactions between individuals and various systems in the environment is therefore required (Kirst-Ashman & Hull, 2009:9; Long *et al.,* 2006:41; Segal *et al.,* 2007;13-14). Integral to the ecological perspective is the commitment of social workers to provide services in collaboration with members of the environment. Social workers are "in the middle" between the client and the environment and thus act as negotiators (Poulin & Contributors, 2000:5). The ecological approach provides a framework for social workers to assess individuals within the context of their environment (Segal *et al.,* 2007:14,152-153). In this respect, the social worker first needs to identify the systems that affect the individual's life. Secondly, the interaction between the individual and the system(s) needs to be assessed, hence the person-in-environment perspective. The fit between the individual and their environment is examined; the ecological perspective includes addressing both the fit of the individual to the environment and the extent of environmental support. Bartlett describes social work as the profession that aids in societal functionality by helping people to function better within the society and Gibelman refers to the unique contribution of social work practice by focusing on both the person and the environment (Segal *et al.,* 2007:153).

With regards to the present study, the interrelatedness between employees experiencing substance abuse problems and the impact of these problems on the workplace constituted the context for the study. The problems, needs, capacities and resources of both employers and employees, as well as the resultant interaction between employers and employees were examined. The focus was on the employees with substance abuse problems and the impact of these problems on the workplace (external system). The intention ─ that of facilitating a higher degree of employee functionality through the betterment of the employment sector ─ implies a causal link between context and efficacy.

3.1.2 Macro-level practice

Macro practice is described as a means to change the larger environment in ways that will benefit individuals (Segal *et al.,* 2007:65). Macro-level practice focuses on addressing both environmental problems and human needs (Long *et al.,* 2006:41), and involves a larger

number of clients or groups with similar characteristics who receive and benefit from social services (Kirst-Ashman & Hull, 2009:9-10). Macro-level practice is further characterised by three principles (Long *et al.,* 2006:42-43): identifying the strengths and resources present in the community; engaging the social worker by using the "professional self" to form relationships and understand the unique experiences of the community; and utilising relationships and community collaboration to drive the process. The dual professional role of social workers working with and in the community offers multiple opportunities to initiate macro change (Long *et al.,* 2006:40).

With regard to macro-level practice, social workers are particularly valuable in the workplace and can provide a variety of functions: attending to the social needs of the employment community; assisting employers to create substance abuse programmes and policies; and designing and executing appropriate interventions beneficial to both employers and employees. Social workers can assist Employee Assistance Programmes (EAP) to provide short-term therapy, substance abuse treatment and guidance to access specialist treatment services. Furthermore, social workers can empower management into recognising and dealing with substance abuse problems affecting the workplace (Segal *et al.,* 2007:352-360).

In the present study, the macro-level practice was approached with a strengths based perspective in mind. The strengths perspective focuses on the strengths, resources and capacities of the individual, group or community (Poulin & Contributors, 2000:5-9; Van Wormer & Davis, 2008:17-21). Individuals are considered experts in their field ─ in this case, problems of substance abuse in the workplace context ─ and are deemed in possession of necessary resources. Collaboration is central to the strengths-based approach where the role of the social worker is to empower clients and establish collaborative relationships (Poulin & Contributors, 2000:4). Macro practice, from a strengths perspective, requires such collaborations as would maximise the opportunities in the community and effect change beneficial to larger groups of people (Kirst-Ashman & Hull, 2009:10; Long *et al.,* 2006:3).

In this study, problems and strengths between the employers and employees, and between the employment sector and out-patient treatment centres, were to be explored. Furthermore, healthier connections between these systems, as a means of enabling the employment sector to deal more successfully with the problem of substance abuse in the workplace, were to be examined (Long *et al.,* 2006:42). The focus was to enhance the well-being of the employment sector through a collaborative process aimed at improving the social functioning of the workplace (Segal *et al.,* 2007:3,65). Macro-level social interventions were therefore focused on individual employees as well as on work environmental issues.

I, as the researcher in the present study, firmly believe in the inherent resources and capacities (strengths) possessed by people and communities, as well as in such collaboration as would maximise opportunities in the workplace and benefit both employers and employees. The grounded theory approach provided the vehicle for the theoretical frameworks, i.e., the ecosystems perspective (the interrelation between needs and strengths of the employers and employees ─ person-in-environment) and the macro-level practice (addressing substance abuse problems affecting the workplace).

3.2 Description of concepts

3.2.1 Substance abuse

Substance abuse is described as the sporadic excessive or sustained use of substances including the unlawful use of substances (South Africa, 2008). The study primarily focussed on alcohol and cannabis as these substances are the most commonly abused in SA (Department of Social Development, 2013:5; Eberlein, 2010:32; McCann *et al.,* 2011:46;). McCann *et al.* (2011:3) distinguish between different drinking categories, namely social drinkers, excessive drinkers, alcohol abusers and dependent drinkers. In the present study, substance abuse generally refers to sporadic, excessive and/or sustained abuse as well as dependence.

3.2.2 Workplace

Workplace refers to an area where employees are deployed to perform duties for remuneration according to certain working agreements and conditions.

3.2.3 Networking programme

According to Long *et al.* (2006:136) the social work profession has always been concerned with interagency networks, partnerships and service coordination. Kirst-Ashman and Hull (2009:85-86), Long *et al.* (2006:136) and Weyers (2011:362) refer to the influence of social workers to bring about change through networking in order to connect people and achieve a common goal, which would not be possible by working alone. Poulin and Contributors (2000:202) mention that, with regards to network intervention in the social work context, the participation of members of the client's social support networks is necessary. Network intervention focuses both on strengthening these support networks and encouraging a willingness to support and become involved in change efforts.

In the context of the present study, the following concepts related to a networking programme are described: networking, networks, programme.

3.2.3.1. Networking

Pierson and Thomas (2010:360) describe networking as “the process of linking together individuals, groups and/or communities with common interests in order to spread information, knowledge, resource sharing, and mutual support”. The assumption is that networking would increase capacities to solve social problems, meet organisational or individual challenges and promote a general aim. Dalton, Hoyle and Watts (2006:407) refer to networking as a process by which to gain moral support and gather important information in areas outside of one’s own expertise through the development of external and internal contacts.

Networking is described by Kirst-Ashman and Hull (2009:86) as a process to connect people and combine their efforts to achieve a common goal, as well as to develop relationships with the aim to improve the services of the partners. Networking is further regarded as attempts by social workers to “strengthen or develop linkages among people, groups or other organizations” in order to connect clients with resources (Kirst-Ashman & Hull, 2009:85).

Partnership is closely related to networking. Weyers (2011:74) refers to partnerships as an interacting group of organisational representatives involved in the coordination of resources and actions in pursuit of a common goal without the loss of their own identity or autonomy. Community partnering is regarded as a potential vehicle to achieve more efficient services, secure additional support or share resources for programming (Long *et al.,* 2006:137).

Though different descriptions of networking abound, the researcher, for the purpose of this study, subscribed to the concept of networking expounded above.

3.2.3.2 Networks

Networks are described as a number of individuals or organisations that are interconnected to achieve a goal that each believes worthwhile (Kirst-Ashman & Hull, 2009:85). Pierson and Thomas (2010:360) describe networks as a web of social relationships through which people are connected. According to Weyers (2011:362) networks involve a series of interpersonal relationships and tend to bring people together that share a common goal.

Different types of networks exist and a distinction is drawn between ‘networks for getting by’ and ‘networks for getting ahead’ (Pierson & Thomas, 2010:361). *Networks for getting by,* refer to the close supportive networks embedded in daily relationships of family, friends or close-knit communities. *Networks for getting ahead*, are more occasional and episodic in nature and more tenuous than personal relationships. Kirst-Ashman and Hull (2009:85,90) also distinguish between intimate or informal networks and less intimate or more formal networks. Intimate networks refer to people who are very close to each other and will offer help with little expectations of reciprocity. Less intimate networks will more likely function on a basis of quid

pro quo (something for something). Self-help groups or networks such as Alcoholic Anonymous (AA) or Narcotics Anonymous (NA) may be formal or semi-formal and are designed to provide mutual assistance to members facing similar problems. These self-help networks rely on the relationships to provide resources and assistance in times of need. Ad-hoc networks are another type of network that develop from time to time as needs arise. In general, the efficacy and longevity of most networks depend heavily on sound interpersonal relationships.

Kirst-Ashman and Hull (2009:86-90,93) emphasise some important aspects of networks in the context of social work:

- Networks engage with clients who might otherwise not have sought services
- Networks enhance the value of formal resources
- Networks assist in steering formal systems and in this way speed up action-service delivery to clients
- Networks enable the members to recognise problems, as well as the larger reality of possibilities and opportunities to solve the problems
- Networks create referral opportunities
- Networks allow opportunities for sharing and learning from each other
- Networks create opportunities to address needs on a broader level and
- Networks contribute to the improvement and sustainment of quality social work services.

3.2.3.3 Programme

In the context of social services, a programme is described as “an ongoing configuration of services and service provision procedures intended to meet a designated group of clients’ needs” (Kirst-Ashman & Hull, 2009:180). According to Poulin and Contributors (2000:194-195) social workers become involved in programme planning activities with the aim to improve the operation of existing services and programmes, or to develop new services and programmes at the organisation and community level. Part of this process involves evaluating existing programmes and services, conducting needs assessments, identifying funding sources, preparing grant proposals and engaging in public relations to build programme support.

Kirst-Ashman and Hull (2009:180,244) refer to programme development as a macro intervention approach. These authors regard social programmes as the means to provide services to clients; the development of a programme, therefore, will be pursued where necessary programmes do not exist. Weyers (2011:219-230) discusses the social planning model as an interventionist model when adjustments are needed between social welfare services and needs. Adjustments could be created through establishing new services,

improving the quality of existing services or facilitating the community's access to services. Applying the social planning model (Weyers, 2011) requires the following: research should be conducted to acquire evidence of the need for a new service or improvement of the current services; support from formal systems need to be mustered; planning and organising of the new service need to be done; and actual utilisation of the services needs to be ensured.

The steps in programme development are discussed at length by Kirst-Ashman and Hull (2009) and Weyers (2011); they agree that the purpose of programme development is to fill a gap in service delivery to address clients' needs. Although not necessarily always following in the same sequence, the following steps reflect important procedures that need to be considered in the process of programme development (Kirst-Ashman & Hull, 2009:235,244-257; Weyers, 2011:219-230).

Establish collaboration with decision makers and people who will most likely receive the services. Use facts and statistics to properly circumscribe and document the problem; and communicate clearly the background of the problem and unmet needs, purpose of the proposed programme, potential clientele, and suggested action plans or services to develop the programme.

Muster support through the utilisation of concerned, motivated, committed and influential people. Identify incentives to motivate people to become involved. Establish a more formalised task team or committee (action system) to accomplish the proposed macro change and include members of the organisation, as well as the external system. Arrange a meeting with the elected decision makers and present a motivation for the proposed programme, including the research findings on the problem, suggestions to solve the problem and potential roles and responsibilities of the members. Negotiate approval of the relevant parties to become involved in the development of the programme and establish a networking agreement.

Conduct a situation analysis to become familiarised with the context and elements of the practical situation, as these might influence the nature of the service delivery.

Identify and analyse impediments and assets with the assistance of the aforementioned task team. Conduct research regarding possible gaps in available social services and programmes, the nature and impact of impediments, and their causes and negative effects. Escalate the need for the development of a programme in the target group. Identify assets indispensable to the envisioned change, including people in the organisation, as well as in the target group. Assess the weaknesses, as well as the strengths in the organisation before macro change is pursued.

Create an innovative idea(s) about a potential programme to address these needs. Enhance legitimacy through increasing the expertise of staff member(s) responsible for the development of the programme.

Formulate specific goals, objectives and action plans in alignment with individualised needs of the target group. Develop strategic plans to reflect an overview of the entire programme development process - from the beginning to the end. Specify how the programme will provide services to accomplish the goals and objectives. Identify the requirements to execute the plan: select the client system (clientele); prioritise and select the impediments that need attention; formulate objectives in accordance with the individualised needs; identify and select the services most suitable to achieve the objectives; list the necessary resources required to execute the plans and develop plans to obtain and access the resources. Present the macro change goal and action plans to the decision makers for approval. Conduct a feasibility study.

Maintain the motivation levels of participants and remain aware of potential opposition throughout the programme development process. Apply means to neutralise the opposition. Revitalise the process through consistently bolstering the motivation levels of the parties involved, maintaining the interest of the crucial decision makers and acknowledging the successes and gains made by the staff.

Implement the action plans to meet the goals and objectives. Ensure that as much as possible influence is secured at this point. Launch a trial run with a few clients for a brief period of time to identify limitations and successes. Utilise a small group of opinion leaders to showcase the innovation at a lower cost and with much less risk.

Evaluate and monitor the progress and effectiveness of the programme**.** Monitor *effort* ─ measuring the energy, time, or money spent by the participating parties to accomplish its goals; and *outcome* ─ measuring the changes brought about by the programme (Rubin & Rubin *In* Kirst-Ashman & Hull, 2009:256). Investigate the outcomes of the programme to determine whether the programme goals have been met. Observe factual outcomes, for instance the frequency of absenteeism. Evaluate the perceptions and opinions of people concerning the effectiveness of the programme.

Secure sustainability by means of the following: integrate standardised procedures for continued implementation into corporate policies; link the programme with other aspects in the business structure; establish the programme within the context of other programmes and services in the business; and develop a feedback system to evaluate the programme's continued efficacy internally and externally.

The networking programme in the present study refers to a framework comprising procedures to assist employers and out-patient treatment centres in combating substance abuse collaboratively in the workplace. The development of such a networking programme is believed to be a means in adjusting social welfare resources and needs to combat substance abuse in the workplace. Networking in the context of the present study refers to a process of establishing connections and collaborations between employers, employees and out-patient treatment centres with the aim to combine their efforts and connect clients with appropriate services. Networks will be more formal and focused on a quid pro quo nature with the mutual goal of addressing substance abuse in the workplace and accommodating the plights of both employers and employees. The interrelatedness between the needs of employees and employers, and resources to address the needs aligns with the ecosystems perspective. The social worker's role as being the "person in the middle" is to adjust the social welfare resources and the needs of the employment sector within the framework of the macro level environment. The focus on collaboration and the establishing of connections between the employment sector and out-patient treatment centres is in line with the strengths-based approach.

Components and procedures essential for developing a networking programme included an honest assessment of the capacities and resources of the treatment centre to provide services; intentional preparation and orientation of the centre's staff members to increase their expertise and capacities as partners with the employment sector; a specific purpose for establishing a networking programme; purposeful collaboration with members of the employment sector; clarity on expectations from both sides regarding the networking programme; assessment of the needs and strengths of the employment sector; well defined goals and proper planning; implementation and monitoring of the action plans; and consistent evaluation of the progress. Collaboration, a commitment from relevant role-players and benefits for both the employment sector and treatment centres were regarded as indispensable for sustaining the proposed programme.

3.2.4 Collaboration

Networking implies collaboration. Organisational collaboration is described in Hepworth *et al.* (2010:451) as "mutually beneficial well-defined relationships entered into by two or more organisations to achieve common goals." Such relationships include a commitment to the relationship, jointly developed structures, shared responsibilities and sharing of resources. Long *et al. (*2006:169) refer to the importance of an open honest relationship, and the "honest exchange of ideas, plans and resources" as integral to collaboration. Collaboration in the present study refers to coordination, cooperation, teamwork and sharing of resources by employers and out-patient treatment centres to achieve a common goal, namely combatting

substance abuse in the workplace. Sound collaboration is regarded as indispensable for the longevity of a networking programme.

3.2.5 Employers

Employers refer to individuals and/or companies that employ people and include employers in small, medium and macro-businesses (Falkena, Abedian, Von Blottnitz, Coovadia, Davel, Madungandaba, Masilela & Rees, 2011:26). Human resource managers, senior staff members in the health and safety divisions of companies and direct supervisors in the workplace representing employers are included in this category.

3.2.6 Employment sector

Employment sector refers to employers as well as employees.

3.2.7 Out-patient treatment centres

Out-patient treatment centres are described as non-residential, community-based facilities where service users (clients) are required to attend therapy sessions on a regular basis for a specific period of time (SANCA, 2011:108; South Africa, 2008:10). Specialist rehabilitation programmes are offered by professional staff who provide a holistic service. Out-patient treatment centres, in the context of the present study, refer to registered out-patient treatment centres in the Limpopo and Mpumalanga provinces managed by SANCA (see Paragraph 1.).

4. METHOD OF INVESTIGATION

4.1 Literature study

The literature study served two purposes: Firstly, to contextualise substance abuse in the workplace in terms of national directives, legislative requirements for managing the problem and intervention measures to deal with the problem. Secondly, to gather information on the problem of substance abuse in the workplace and on networking between employers and out-patient treatment centres to combat the problem. The literature review helped indicate the relationship between the theories that emerged from the empirical study and existing theoretical knowledge (Delport, Fouché & Schurink, 2011:305). Literature sources in the social work field, as well as in the business management field were consulted as limited sources could be found on the study topic from a social work perspective. A grounded theory approach was adopted to guide the study (Babbie, 2010:307-308; Creswell, 2013:83-89; Fouché & Schurink, 2011:318-320; Monette, Sullivan & DeJong, 2011:225-226).

4.2 Empirical investigation

4.2.1 Design

Grounded theory **(**Babbie, 2010:307-308; Botma, Greeff, Mulaudzi & Wright, 2010:222; Creswell, 2013**:**83-90; Fouché & Schurink, 2011:318-320; Monette *et al.,* 2011:225-226**)** was used in this research study to generate theory based on the viewpoints of participants regarding the phenomenon of addressing substance abuse in the workplace. Key to this approach was the development of a theory 'grounded' in the data provided by the participants who have all experienced the phenomenon. Grounded theory is defined as a "qualitative research design in which the inquirer generates a general explanation (a theory) of a process, an action, or an interaction shaped by the views of a large number of participants" (Creswell, 2013:83). Fouché and Schurink (2011:319) state that, in grounded theory, the researcher does not begin with a theory and then prove the theory; instead, an area of study is identified and data relevant to that area is allowed to gradually emerge. Creswell (2013:88) regards grounded theory as a design suited to revealing the experiences of participants and their views of the process in order to formulate a preliminary framework. Creswell (2013:86) refers to the constructivist approach of Charmaz (2005, 2006) and the systematic procedures approach of Strauss and Corbin (1998) as the two popular approaches to grounded theory.

Creswell (2013:87-88,196,230) explains that the constructivist grounded theory of Charmaz, focuses on theory development that depends on the researcher's views. The researcher decides on the categories throughout the process and advances personal values, experiences and priorities. Charmaz did not support the formal procedures of axial coding, espoused by Strauss and Corbin that organise the data into categories consisting of causal conditions, strategies, interactions and consequences. Charmaz, following a less structured report-written format, eventually focuses more on an argument about the importance of the theory.

The systematic approach of Strauss & Corbin seeks methodically to develop a theory that explains a process, action or interaction, i.e., a process of developing a curriculum or a general framework. The systematic approach involves several visits to the field to conduct interviews – typically 20-30. This approach, referred to as the constant comparative method, requires moving into the field to collect data, periodically stepping back to analyse and interpret the data, again visiting the field to collect data which in turn is analysed and interpreted. Data is therefore further explored by means of theoretical sampling (Babbie, 2010:308; Creswell, 2013:86; Fouché & Schurink, 2011:319; Strydom & Delport, 2011:392) in search of pertinent data until data saturation is reached. Monette *et al. (*2011:225) refer to the continual interplay of data collection, data analysis and theory development. Strauss and Corbin (Fouché &

Schurink, 2011:319) state that grounded theory is discovered through systematic data collection and data analysis.

The researcher considered, for the present study, the grounded theory approach as the most suitable to generate information from participants who have all experienced the consequences of substance abuse in the context of the workplace. Furthermore, the researcher's strong belief in the value of the participants' experiences aligns with the strengths perspective. Long *et al.* (2006:85-86) advocate in this regard the acknowledgement of the power of grounded knowledge and encourage the recognition of the value, as well as the utilisation of participants' life experiences to create change. The systematic approach of Strauss and Corbin (1998), which was subsequently followed, also greatly appealed to the researcher.

The grounded theory, for the present study served two purposes. Firstly, to determine the participants' experiences and concerns regarding substance abuse in the workplace and to identify the resources needed to deal with the problem (the findings are reported in article 2 of the research report). Secondly, to determine the essential components of a networking programme (the findings are reported in article 3).

4.2.2 Sampling

Qualitative exploratory and descriptive research (Babbie, 2010:92-93; Fouché & De Vos, 2011:95-96; Neuman, 2006:33-35) was conducted to gain insight into the phenomenon of combating substance abuse in the workplace and to describe the research findings.

The non-probability theoretical sampling technique used in grounded theory was applied in the study. Participants interviewed were theoretically chosen (Creswell, 2013:86; Fouché & Schurink, 2011:319; Strydom & Delport, 2011:392) to assist the researcher in understanding the situation under study and defining the categories, as well as in seeking pertinent data to develop a theory.

The two main 'populations' in the study were the employment sector and the out-patient treatment centres in the demarcated areas. All participants shared at least one important common factor (Weyers, 2011:309), namely experiencing the phenomenon of dealing with substance abuse problems within the context of the workplace. The increasing interest in the emerging theory served to guide the selection of new sampling cases or contexts of interest (Neuman, 2006:406) and included participants involved in the health and safety division of the employment sector, staff members involved in HIV and AIDS counseling, an expert in networking from a non-government organisation and representatives from the chamber of commerce.

Participants from both these populations were selected on the basis of the following sampling criteria (Appendix 1- sampling criteria).

4.2.2.1 Employment sector

Participants representing the employment sector included employers as well as employees.

Employers

Employers/businesses were selected according to the following criteria: business categories according to the number of employed people; businesses engaging in high-risk and safety sensitive occupations; and accessibility of services to the employees.

As it was not possible to reach all employers in the demarcated area due to practical and cost-effective reasons, market segmentation (Andreasen & Kotler, 2008; Hollensen, 2010; Kurtz & Boone, 2006; Lancaster & Massingham, 2011; Weyers, 2011) was performed. The broad employer population was therefore categorised into specific groups with at least one important common factor (Weyers, 2011:309). In terms of this study, the common factor was dealing with substance abuse in the workplace. Business categories, as set out in the National Small Business Act 102 of 1996, were considered and included the following: very small/small enterprises ─ 10 to 50 employees; medium enterprises ─ 100 to 200 employees and macro-enterprises ─ more than 200 employees (Falkena, *et al.,* 2011:26). Employers representing all these categories were included in the study.

A group identified in the NDMP (Department of Social Development, 2013:76) as one of the priority target groups is the 'occupational groups at risk'. Some occupational groups are regarded as high-risk and safety-sensitive and include occupations that pose a "significant life-threatening danger to the employee so occupied, his fellow employees or the general public" (Pelser, 2011:10). Sectors such as transport, the construction industry, mining and timber companies involving heavy machinery and equipment, and security businesses, were considered especially vulnerable to the impact of substance abuse (McCann *et al*., 2011:70; Pelser, 2011:10).

Employers who could easily access the services of the out-patient treatment centres due to logistical and cost-effective reasons were also included in the sample. Some employers/ business were excluded on the basis of the following factors: businesses in deep rural areas (cost implications); employers using mainly shift workers (logistical problems) and employers using seasonal labour (temporary nature of the contracts).

Employees

Employees were selected with the assistance of SANCA Lowveld according to the following criteria:

Enrolment as clients with SANCA Lowveld in treatment or in aftercare in accordance with logistical and geographical considerations, and willing to participate in the research study. As an employee of SANCA Lowveld, the researcher was situated such that the unanticipated disenrollment of participants could be offset by the selection of new candidates.

4.2.2.2 Out-patient treatment centres

Staff members from the four out-patient treatment centres in the Limpopo and Mpumalanga provinces were selected on the basis of their specialist knowledge and experience in the field of substance abuse and their service delivery to the employment sector. Representatives from these centres were the director, social workers, and medical and other staff members involved with the employment sector, such as EAP specialists and community developers.

4.2.3 Procedures

The research project was implemented as follows:

Firstly, the project was planned with the assistance of SANCA out-patient treatment centres and key informants from the Employers' Organizations. Secondly, a situation analysis was conducted consisting of an orientation phase, a data- gathering phase and a data analysis phase. The employment sector, as well as the out-patient treatment centres was involved in the orientation phase and data gathering phase. The project planning, orientation phase, data-gathering phase and data analysis phase are discussed next.

4.2.3.1 Project planning

Approval from the SANCA Mpumalanga Management Board was obtained to conduct the research study in all SANCA centres in the Limpopo and Mpumalanga provinces, namely Mbombela, Emalahleni (Witbank), Piet Retief and Polokwane (Appendix 2 – SANCA letter of approval). The study was introduced to the out-patient treatment centres concerned, the potential benefits of the study were explained and the participation of the centres was negotiated. A staff member from each out-patient treatment centre was recruited to assist the researcher as the coordinator in his/her specific site with the approval of his/her director. Relevant staff members were also recruited to participate in the research according to the criteria mentioned earlier. It was agreed that each out-patient treatment centre would identify employer participants in its particular community. As an employee of SANCA Lowveld, the researcher was responsible for the roll-out of the research project in the Mbombela area.

The researcher requested two employer organisations in Mpumalanga to assist in the identification of potential employer participants. The management board of the employer organisations officially approved participation of its organisations in the study (Appendix 3 - letter of approval from the Employers' Organisation). Key informants from these organisations assisted in the preliminary planning of the study on the strength of their access to extensive employer databases, their knowledge of labour law requirements regarding substance abuse in the workplace and their advisory capacity in the employment field. These informants, a valuable referral source, assisted the researcher in the selection of employer participants and also initiated contact with employers.

Participants from the employment sector were selected according to the criteria mentioned earlier. Brief contact was made with these participants, rapport was established, the benefits of the study were highlighted and their participation in the study was negotiated.

The situation analysis was planned in collaboration with the site coordinators from the out-patient treatment centres. Firstly, the participants' experiences and concerns regarding substance abuse in the workplace were determined, as well as the resources needed to deal with the problem (the findings and interpretations are reported in article 2). Secondly, the essential components of a networking programme were identified (the findings and interpretations are reported in article 3). An independent research analyst (co-coder) was consistently involved throughout the study in other words during the orientation phase, data collection phase and data analysis phase in order to assist with the implementation of sound research principles (Appendix 4 - co-coder confirmation of involvement).

4.2.3.2 Orientation phase

The main purpose of the orientation phase was to introduce to and discuss the context of the research study with the participants from the employment sector and the out-patient treatment centres in preparation for the data collection phase (Appendices 5 & 6 - orientation discussions). The criteria for selection mentioned earlier were used to select the participants from both populations.

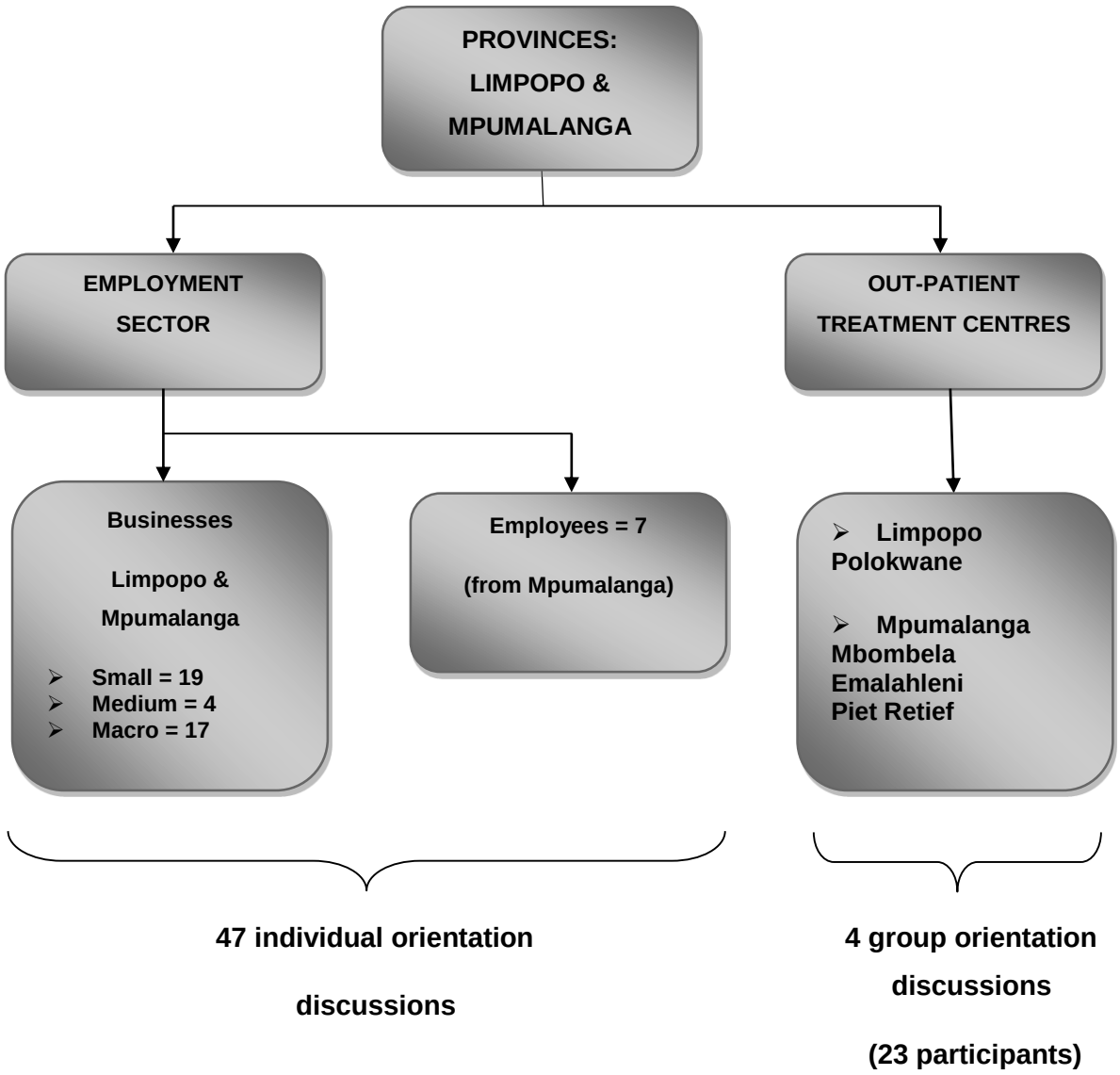
Individual orientation discussions were held with a total number of 47 participants from the employment sector (40 employers and 7 employees). SANCA Polokwane experienced problems in identifying employer organisations and employers in their area for involvement in the study. Individual orientation discussions were held with the employees, either by the researcher or a social worker from SANCA Lowveld, for practical and language reasons. This social worker was also orientated on the purpose and content of these discussions.

Group orientation discussions were held with relevant staff members from each of the four out-patient treatment centres in the Limpopo and Mpumalanga provinces. Staff turnover at two of the treatment centres necessitated repeated follow-up visits and re-orientation of the new director and site coordinators. During the orientation phase, the site coordinators were individually briefed on their roles and responsibilities in their specific sites, on their roles as co-facilitators during focus group interviews, on research interviewing techniques, protocol and importance of confidentiality when conducting interviews with employers, on the importance of maintaining contact with participant employers, and on the importance of giving regular feedback and making recommendations to the researcher regarding the process and progress of the project (Appendix 7 - orientation programme for site coordinators).

It was agreed that each site coordinator would independently commence orientation discussions with the employers in his/her site after completion of his/her induction session. However, eventually all the discussions with the employers (Appendix 8 - introduction letter to employers) were conducted jointly by the researcher and the particular site coordinator at the request of the different coordinators who were involved in the planning, orientation and data gathering phases of the research project. Written consent to voluntary participate in the research study was obtained from these participants after completion of the orientation phase (Appendix 9 - written consent).

The orientation phase was implemented between March 2011 and December 2011. A schematic presentation of the participants involved in the orientation phase can be seen in Figure 1.

Figure 1: Orientation phase



4.2.3.3 Data gathering phase

Data was collected by means of qualitative interviews gleaned from participants with ideas about the emerging theory. Data was constantly compared with those of the new subjects, their recommendations and emerging theories. New participants were selected and information gathered until data saturation was reached (Creswell, 2013:85-86,89; Fouché & Schurink, 2011:318). This grounded theory method of 'thinking comparatively' and gathering multiple viewpoints was implemented to avoid biases which could arise from the initial interpretations (Babbie, 2010:307-308). In this way confidence was demonstrated in the participants as being experts in the area of concern (Long *et al*., 2006:85), which is in alignment with the strengths-based perspective (Van Wormer & Davis, 2008).

Qualitative semi-structured schedules (Greeff, 2011:351-353,369-370) were used in the individual and focus group interviews according to specific protocols to collect the data (Appendices 10 to 14 - protocol and interview schedules). The purpose of the data collection was to identify the main issues concerning substance abuse in the workplace and to explore the capacities and resources of the employers and out-patient treatment centres to deal with the problem (Parker & Bradley, 2007:13,17). The extent of networking between employers and out-patient treatment centres was determined as were the different views on procedures to develop a networking programme. The participants who were engaged in the orientation phase were also involved in the data gathering phase.

Individual interviews with employees were conducted by either the researcher or a social worker from SANCA Lowveld to identify employees' problems and needs in the treatment process. The social worker who assisted with the individual interviews was orientated on the content of the interview schedule and protocol to be followed during the interview. The views of the employees regarding the role of the employers and the out-patient treatment centres in the process were also determined.

A total of 29 face to face individual interviews were eventually conducted with representatives from the employment sector – 22 employers and 7 employees.

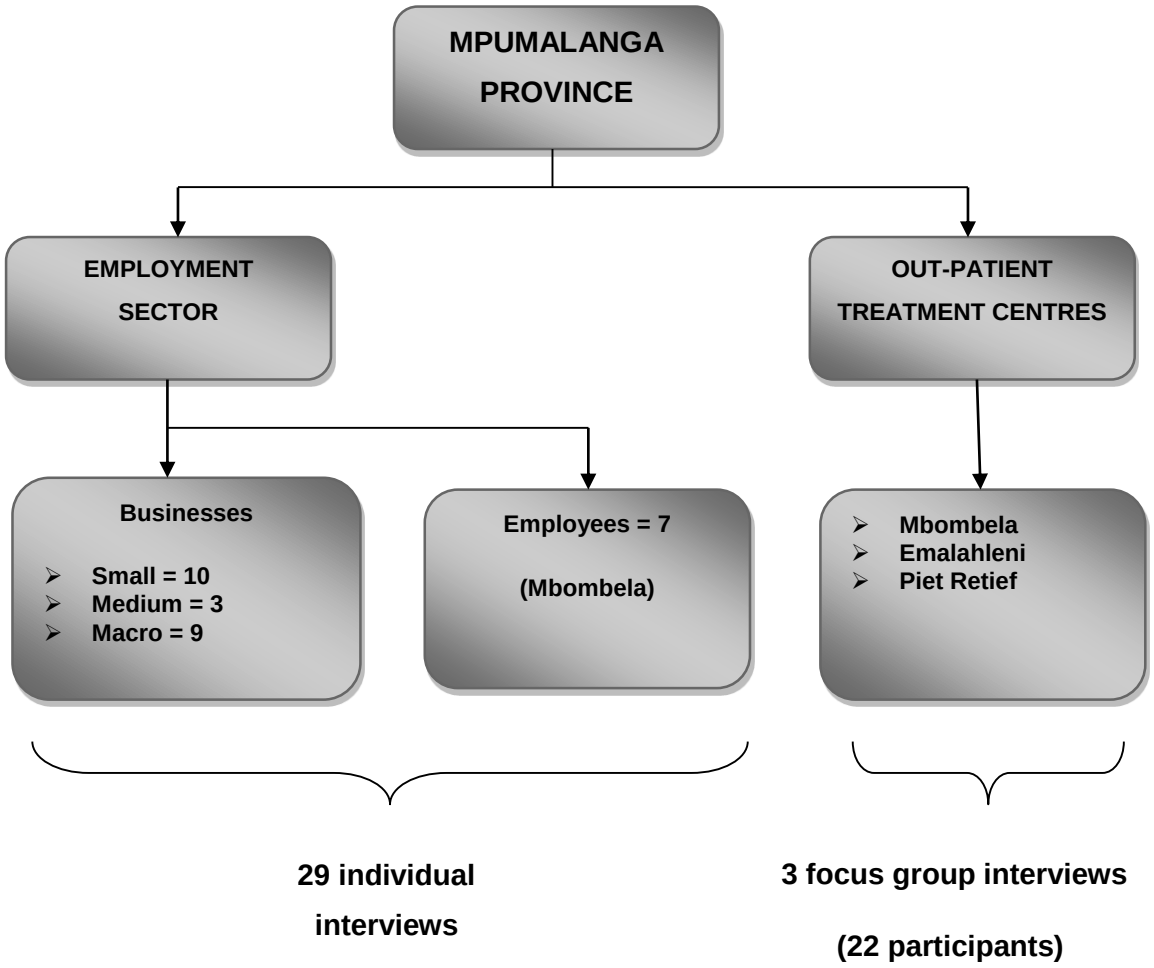
Although SANCA Polokwane was involved in the initial orientation discussions, the centre was experiencing severe financial difficulties at the time and had to withdraw from the study. SANCA Polokwane therefore did not participate in the data collection phase (Appendix 15 - SANCA Polokwane communique). Focus group interviews were accordingly conducted only with the staff members concerned from the three out-patient treatment centres in Mpumalanga. Each of the focus groups had between six and seven participants (Greeff, 2011:366-367).

Debriefing sessions with the participants were held to clarify any misconceptions but due to time constraints, some of these sessions did not take place. Electronic follow-up communication was conducted where possible. Discussions between the researcher and coordinators after individual and focus group interviews allowed time to reflect on limitations and successes and to adjust plans accordingly. Regular meetings with an independent research analyst (co-coder) from the North West University, also created opportunities for the researcher to reflect.

Different viewpoints were obtained through the involvement of the various sampling groups. Qualitative interviews were conducted between January 2012 and June 2012 all of which were recorded on a Dictaphone, transcribed verbatim by an independent party and, finally, ring

bound. The study sample thus comprised 29 participants from the employment sector and three focus groups representing the out-patient treatment centres. The data collection phase is shown in Figure 2.

Figure 2: Data-gathering phase



4.2.3.4 Data analysis

The purpose of the qualitative data analysis was to reduce the extensive volume of raw data, to identify significant patterns and to construct a framework for communicating the results of the analysis (Schurink, Fouché & De Vos, 2011:397). In accordance with the grounded theory, data analysis is described as a step-by-step process that proceeds in stages, namely open coding, axial coding and selective coding (Braun & Clarke, 2006:86-93; Creswell, 2013:86-86,89,195-196; Fouché & Schurink, 2011:319-320). During the open coding stage the transcripts of the interviews, audio recordings and field notes were examined and re-examined. Possible meanings emerged and different topics or themes were identified and

grouped into categories. Categories were saturated through constantly comparing the data until new data did not provide any additional categories or ideas. Single categories that seemed central to the phenomenon, itself composed of sub-categories, were then identified. The central phenomenon, or axial code, was subsequently developed and related categories were identified to indicate the causes that influenced the axial code, the strategies in response to the central code, the intervening conditions that influenced the strategies and the consequences or outcomes of using the strategies. During the final stage, referred to as selective coding, the interrelatedness of the categories was organised and interpreted. The said systematic process was used to determine both the participants' experiences, concerns and resources in dealing with the problem (Appendices 16 to 18 – problems, needs and strengths), as well as the essential components of a networking programme (Appendix 19 - thematic mapping examples).

Although 29 individual interviews were conducted, the analysis of the data from 20 participants resulted in 'data saturation' (Creswell, 2013:89; Fouché & Schurink, 2011:319) and negated the need to include the remaining nine. Data from 20 participants representing the employment sector, as well as from three focus groups representing the out-patient treatment centres, were eventually analysed thematically. Copies of all ring bound transcripts were handed to the independent co-coder for analytic assistance. Both the qualitative data analysis and the data saturation were verified by the co-coder.

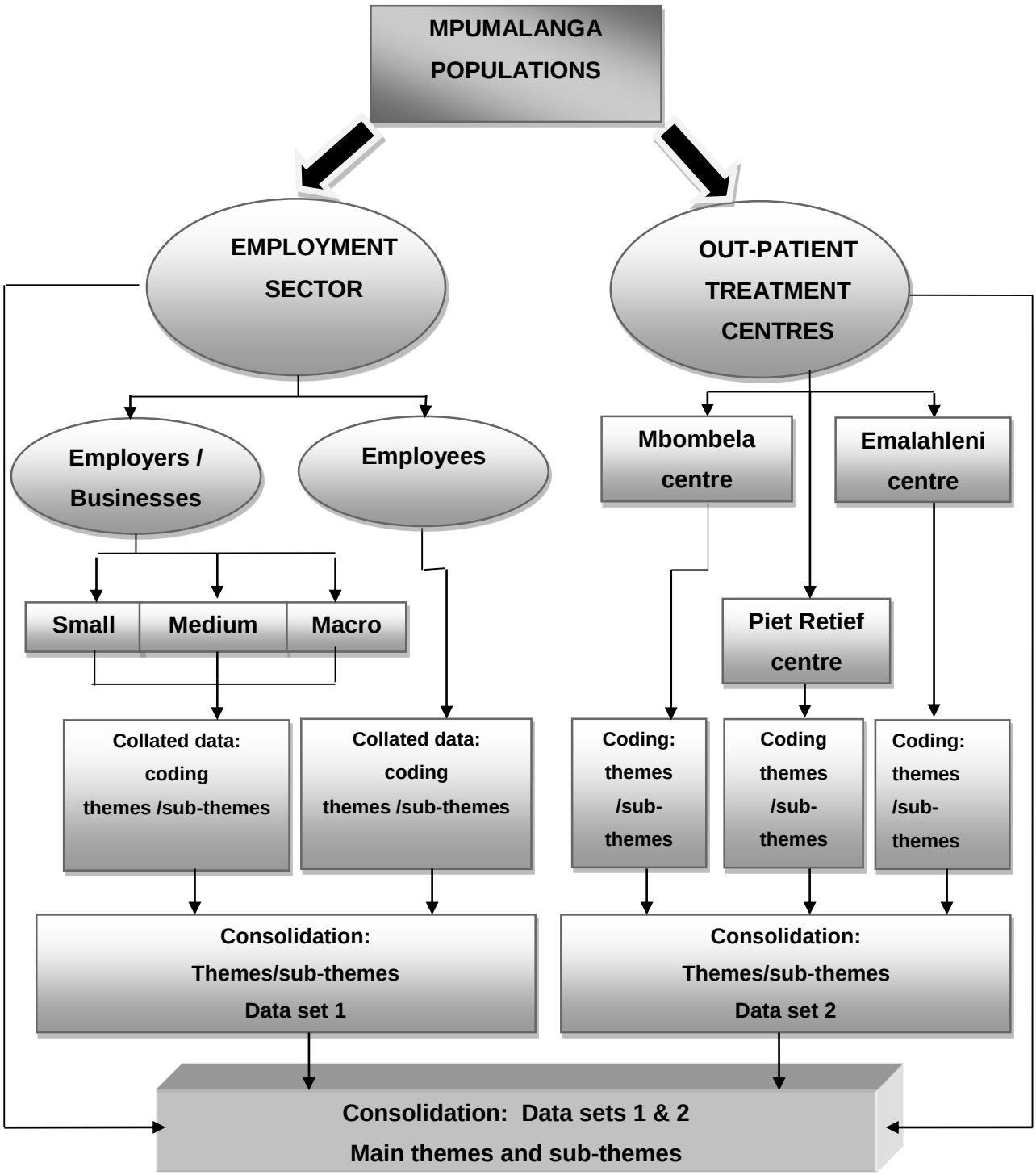
A member-checking meeting (Creswell, 2005:252; Ellingson, 2009:42) was conducted with participants from both populations with the purpose of sharing information on the research findings and to engage the participants in feedback. Feedback from the member-checking meeting was integrated in the research findings on the related themes. The aim of the member-checking process was to enhance the credibility of the data analysis (Botma *et al.,* 2010:231,232; Creswell, 2005:252; Ellingson, 2009:42).

Strauss and Corbin (Creswell, 2013:230) suggest the development of a clear analytic story with the focus on the analytic theory and organisation of the analytic information in a coding paradigm or figure that presents the theoretical model. A substantive-level theory results, in writing, when a researcher close to a specific problem or population collects and analyses specific data. The theory may be tested to determine its generalisability, or alternatively, the study may conclude with the generation of the theory as its end goal (Creswell, 2013:89). The researcher concluded the study with the generation of the theory as its end goal with a practical outcome in mind that the employment sector (employees and employers), as well as the out-patient treatment centres may gain specific benefits from it (Delport & De Vos, 2011:46; Monette *et al.,* 2011:4).

Eventually, the proposed networking programme was based on the data collected from the situation analysis in this study, the researcher's experience as a counsellor in substance abuse treatment and her exposure to different networking programmes, as well as supportive theoretical knowledge. A guideline to apply the networking programme in practice is included in the study, as well as examples of projects to apply the programme (Appendix 20 - examples of projects).

The data analysis process is depicted in Figure 3.

Figure 3: Data analysis process



4.2.4 Trustworthiness

Trustworthiness (Botma *et al.,* 2010:232-234; Ellingson, 2009) was established through obtaining the following:

Truth value, through the use of reflexivity and member checking. The aim of the member-checking process was to enhance the credibility of the data analysis (Botma *et al.,* 2010:231,232; Creswell, 2005:252; Ellingson, 2009:42).

Applicability, through the use of different sampling groups, i.e., the employers from small, medium and macro businesses, employees in treatment and relevant staff members from out-patient treatment centres, as well as data saturation and dense description. The grounded theory method of 'thinking comparatively' and gathering multiple viewpoints was implemented to avoid biases which could arise from the initial interpretations (Babbie, 2010:307-308).

Consistency, through the use of a systematic step by step audit trail and the assistance of a co-coder.

Impartiality, as promoted by the continued involvement of the site coordinators, regular sessions with supervisors and an independent co-coder for feedback and reflecting purposes.

Authenticity, through the use of verbatim transcriptions, direct quotations and reporting the true feelings and experiences as conveyed by the participants. Copies of all ring bound transcripts were handed to the independent co-coder for analytic assistance and guidance regarding the reporting of the data.

4.2.5 Ethical aspects

Ethical approval for conducting the research study was obtained from the North-West University (No. NWU-00125-11-51). Poulin and Contributors (2000:21) state that the core social work values and ethical principles present the standards to which all social workers should aspire. The researcher strived to adhere to the Code of Ethics outlined in Kirst-Ashman and Hull (2009:406-4210), Long *et al. (*2006:252-253,258-271), Poulin and Contributors (2000:21-23), South African Council for Social Service Professions (2012), Segal *et al.* (2007:464-483) and Strydom (2011:115-129). Ethical responsibilities such as responsibilities to clients, colleagues, the social work profession, the employment sector (representing the broader community), as well as those responsibilities pertaining to professional conduct, were taken into consideration. These ethical responsibilities were based on the following core values: service; social justice; dignity and worth of each person; confidentiality; the importance of human relationships and collaboration; competence and integrity.

In accordance with the ecosystems perspective, the researcher was cognisant of the dual responsibility to both employer and employee – the former regarding substance abuse problems in need of treatment, the latter regarding possibilities of treatment. The primary ethical principle was to serve both in addressing the social problem of substance abuse in the workplace (core value of service.) The researcher strived to enhance the accessibility of information, services and resources in dealing with substance abuse in the workplace for both the employers and employees (core value of social justice).

Permission to gain entry to the demarcated areas was granted by the SANCA Mpumalanga Management Board and the Mpumalanga Employers' Organisation Management Board. The researcher obtained permission from participants to use audio tape recordings during the individual and focus group interviews. Written informed consent was obtained from all the participants and their right to withdraw from the study at any time was explained to them (core value of dignity and worth of each person).

Measures were implemented to ensure the confidentiality of the information provided by the participants. Participants were assured of the ethical conduct with regards to confidentiality. This was also stipulated in the written consent. One of the macro-businesses required an additional formal written confidentiality agreement to be signed by the Director of the School of Psychosocial Behavioural Sciences from the NWU (Potchefstroom) and all relevant participants, including the researcher. Extensive additional confidentiality clauses were included in the latter agreement. Interviews (individual and focus groups) were recorded on Dictaphone and transcribed verbatim. All transcripts and records will be stored in the archive allocated for the School of Social Work at the NWU (Potchefstroom) for a period of 5 years. Furthermore, coordinators from the out-patient treatment centres were orientated on confidentiality matters during their induction programme (core value of confidentiality).

In accordance with macro-level practice, the importance of collaboration was demonstrated through the engagement of members from the employment sector and the treatment centres. Furthermore, multi-disciplinary involvement of staff members from the treatment centres such as the medical profession, social workers specialising in the field of substance abuse and various experts (EAP, HIV and AIDS and community development) was ensured. The role of the participants and the researcher was discussed with all the participants as part of the interviewing protocol. Debriefing sessions were held, where possible, to clarify any misunderstandings after the individual and focus group interviews. Some of the participants were, however, often not available to attend these sessions due to time constraints. This was countered through regular electronic follow-up with the participants, promoting open

communication channels and providing feedback to the researcher (core value of the importance of human relationships and collaboration).

The researcher has extended practical experience in social work and has been practising as counsellor in the field of substance abuse treatment since 2009. The researcher continuously shared knowledge regarding substance abuse services acquired during the research process with the coordinators of the out-patient treatment centres as part of their induction programme. This knowledge was also shared with the Mpumalanga Employers' Organisation at their annual general meeting in 2012, as well as with SANCA staff members from Mpumalanga province during a workshop session on the topic (core value of competence).

Social workers are required to behave in a trustworthy manner consistent with the Code of Ethics of the SASSP. The researcher strived to behave in a responsible and honest manner towards the employment sector, out-patient treatment centres and the profession. Credit was also given to the contributions of literature sources and findings were reported unambiguously (core value of integrity).

5. CHALLENGES ENCOUNTERED DURING THE RESEARCH STUDY

The following challenges were encountered in implementing the study in the employment sector and the out-patient treatment sector.

5.1 Practical issues

The location of some of the participants involved in the study posed certain problems, such as transport, time and costs due to vast distances of up to 300 kilometers.

The sampling group consisted of a large number of participants. Extensive volumes of raw data were captured resulting in a lengthy data analysis process. Data collected in respect of different information categories complicated the data capturing, processing and analysis and was extremely time consuming. Constant refinement of the themes was necessary, thus further prolonging the analysis process.

Sources on networking relevant to the research topic were limited and sources in the business field were consulted due to the selection of the employment sector as one of the main populations.

Staff members from out-patient treatment centres were often not familiar with business terminology leading to some confusion in this regard. 'Networking' was for instance sometimes confused with terminology in the electronic media and the term 'partnerships' was accordingly

preferred. The researcher had consistently to ensure that the terminology used was commonly understood.

5.2. Employment sector

The study unintentionally created expectations among some of the participants in the employment sector that immediate intervention would follow the data collection phase. Some of the participants were frustrated and disappointed by the lengthy nature of the study. Human resource shortages did not allow the site coordinators to continue with follow-up contacts and further action plans after completion of the data collection.

Although the involvement of the unions in the research study was recommended, omission of their input from the study followed the decision to honour the sensitive relationship between the employers and the employees at the time. The focus, rather, was on the exploration of collaborative processes involving employers and out-patient treatment centres. Allowance, however, has been made for union involvement in the proposed networking programme as well as in the practical application of the programme.

A critical need to combat substance abuse in the rural areas could not be met due to logistical constraints in the employment sector as well as financial and human resource constraints in the out-patient treatment centres. Outreach programmes were not considered cost-effective at the time.

The unsupportive workplace environment with regard to substance abuse problems was seen as a major challenge in the implementation of the proposed networking programme.

5.3 Out-patient treatment centres

The initial arrangement was that a site coordinator in each out-patient treatment centre would assist with the orientation phase, including the roll-out of the programme in his/her particular site, the orientation discussions and the individual interviews with the employers. Although all the coordinators were briefed on their respective roles and tasks, they said they would prefer to perform the tasks jointly with the researcher. This placed unforeseen high demands on the researcher in terms of time management and financial resources.

Due to staff turn-over at two of the treatment centres, new site coordinators and a director were appointed at Emalahleni resulting in additional orientation sessions and the training of the new participants. Additional time demands and financial costs thus arose.

Non-profit-organisations, including out-patient treatment centres, have traditionally depended heavily on government subsidy, thereby exposing them to financial flux (Andreasen & Kotler,

2008:12; Jobber, 2004:826). Overcoming this requires identifying alternative sources of revenue. Accessing these sources requires marketing. However, the study has found to be a belief among out-patient treatment centres that treatment and marketing are mutually exclusive. Attention to marketing strategies has thus suffered greatly. Aggressive marketing and subsequent implementation of the proposed networking programme may rectify this and simultaneously liberate out-patient treatment centres from the dependence on tenuous financial sources. Sensitising the out-patient treatment centres to marketing will no doubt prove to be a challenge.

6. REPORT LAYOUT

The research report has the following sections:

Section A: Orientation to the research.

Section B: Professional Journal Articles.

- ✓ Article 1: Substance abuse, dependency and the workplace: A literature overview.
- ✓ Article 2: Substance abuse and the workplace: A situation analysis.
- ✓ Article 3: Substance abuse and the workplace: A networking programme for employers and out-patient treatment centres.

Section C: Summary, evaluation, conclusions and recommendations.

Section D: Appendices.

Section E: Consolidated list of references.

6.1 Journals

The author guidelines of the different journals (see list of journals) were taken into consideration in preparation of the aforementioned articles. Each article was structured in accordance with the publication requirements stipulated by the editorial committee of the journals concerned.

The following journals were approached / considered for publication:

- ✓ Social Work / Maatskaplike Werk – Appendix 21 (Article 1 – published March 2014).
- ✓ South African Journal of Business Management – Appendix 22 (Article 2 has been submitted for publication).
- ✓ Health SA Gesondheid – Appendix 23 (Article 3).

REFERENCES

Acts ***see*** South Africa

Andreasen, A.R. & Kotler, P. 2008. Strategic marketing for non-profit organizations. 7th ed. Upper Saddle River: Merrill Prentice Hall.

Anon. 2009. The naked truth – Statistics (SA & Global). http://www.tnt.org.za/index.php/ption=com_content&view=article&id=21&Itemid=51 Date of access: 15 March 2011.

Babbie, E. 2010. The practice of social research. 12th ed. Belmont: Wadsworth, Cengage Learning.

Backer, T.E. 2003. Evaluating community collaborations. New York: Springer.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Pearson Education South Africa.

Braun, V. & Clarke, V. 2006. Using thematic analysis in Psychology. *Qualitative research in Psychology,* 3:77-101. www.QualResearchPsych.com Date of access: 30 May 2012.

Creswell, J.W. 2005. Educational research: planning, conducting, and evaluating quantitative and qualitative research. 2nd ed. Upper Saddle River: Merrill Prentice Hall.

Creswell, J.W. 2013. Qualitative inquiry & research design: choosing among five approaches. 3rd ed. Thousand Oaks: Sage Publications.

Dalton, M., Hoyle, D.G. & Watts, M.W. 2006. Human relations. 3rd ed. Mason: Thomson South-Western.

Delport, C.S.L. & De Vos, A.S. 2011. Professional research and professional practice. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 45-60).

Delport, C.S.L., Fouché, C.B. & Schurink, W. 2011. Theory and literature in qualitative research. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 297-306).

Department of Social Development. ***see*** South Africa. Department of Social Development.

Eberlein, R. 2010**.** Lifestyle changes to beat addiction: a guide to drug-free living**.** Randburg: Knowres.

Ellingson, L.L. 2009. Engaging crystallization in qualitative research: an introduction. London: Sage.

Falkena, H., Abedian, I., Von Blottnitz, M., Coovadia, C., Davel, G., Madungandaba, J., Masilela, E & Rees, S. 2011. SMEs' access to finance in South Africa: a supply-side regulatory review. www.treasury.gov.za/publications/other Date of access: 21 June 2011.

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 89-100).

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 307-327).

Goodman, A. 2007. Social work with drug and substance misusers: transforming social work practice. Wiltshire: Learning Matters.

Greeff, M. 2011. Information collection: interviewing. *(In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L*., eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 341-375).

Grobler, P., Wärnich, S., Carrell, M.R., Elbert, N. F. & Hatfield, R.D. 2006. Human resource management in South Africa. 3rd ed. London: Thomson Learning.

Hepworth, D.H., Rooney, R.H., Rooney, G.D., Strom-Gottfried, K. & Larsen, J. 2010. Direct social work practice: theory and skills. 8th ed. Belmont: Brooks/Cole.

Hitzeroth, V. & Kramer, L. 2010. The end of addiction: a comprehensive South African guide. Cape Town: Human & Rousseau.

Hollensen, S. 2010. Marketing management: a relationship approach. 2nd ed. New York: Pearson Education.

International Centre for Alcohol Policies (ICAP). 2013. Alcohol and the workplace. The ICAP BLUE BOOK: practical guides for alcohol policy and prevention approaches. Module 22. http://www.icap.org Date of access: 10 January 2013.

Jobber, D. 2004. Principles and practice of marketing. 4th ed. Berkshire: McGraw-Hill International.

Kirst-Ashman, K.K. & Hull, G.H. 2009. Generalist practice with organizations and communities. 4th ed. Belmont: Brooks/Cole.

Kurtz, D.L. & Boone, L.E. 2006. Principles of marketing. Mason Thomson South-Western.

Lancaster, G. & Massingham, L. 2011. Essentials of marketing management. New York: Routledge.

Long, D.D., Tice, C.J. & Morrison, J.D. 2006. Macro social work practice: a strengths perspective. Belmont: Thomson Brooks/Cole.

McCann, M., Harker Burnhams, N.H., Albertyn, C. & Bhoola, U., *eds*. 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta.

Miller, W.R. & Weisner, C.M. 2002. Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum.

Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2011. Applied social research: a tool for the human services. 8th ed. Belmont: Brooks/Cole.

Neuman, W.L. 2006. Social research methods: qualitative and quantitative approaches. 6th ed. Boston: Pearson Education.

Parker, J. & Bradley, G. 2007. Social work practice: assessment, planning, intervention and review. 2nd ed. Glasgow: Bell & Bain

Parry, C.D.H. & Bennetts, A.L. 1998. Alcohol policy and public health in South Africa. Cape Town: Oxford University.

Pelser, I. 2011. ETTEx Network: the future of drug testing [e-mail]. 11 February 2011.

Pierson, J. & Thomas, M. 2010. Dictionary of social work. Berkshire: Open University Press.

Poulin, J. & Contributors. 2000. Collaborative social work: strengths-based generalist practice. Belmont: Thomson Brooks/Cole.

SACENDU (South African Community Epidemiology Network on Drug Use). 2012a. Monitoring alcohol and drug abuse trends in South Africa (July 1996-June 2012): *SACENDU Research Brief, 15(2), 2012*. Tygerberg.

SACENDU (South African Community Epidemiology Network on Drug Use). 2012b. Monitoring alcohol and drug abuse treatment admissions in South Africa. November 2012. Phase 32. January to June 2012. Tygerberg.

SANCA (South African National Council on Alcoholism and Drug Dependence). 2011. Out-patient treatment manual. SA [s.l.]: SANCA.

Schurink, W., Fouché, C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 397-423).

Segal, E.A., Gerdes, K.E. & Steiner, S. 2007. An introduction to the profession of social work: becoming a change agent. 2nd ed. Belmont: Thomson Brooks/Cole.

Slaymaker, V.J. & Owen, P.L. 2006. Employed men and women substance abusers: job troubles and treatment outcomes. *Journal of substance abuse treatment,* 31:347-354, May.

South Africa. 1996. The National Small Business Act 102 of 1996.

South Africa. 2008. Prevention of and Treatment for Substance Abuse Act 70 of 2008.

South Africa. Department of Social Development. 2010. Central Drug Authority (CDA) 2010/11. Pretoria.

South Africa. Department of Social Development. 2013. National Drug Master Plan (NDMP) 2013-2017. Pretoria.

South African Council for Social Service Professions (SACSSP). 2012. Policy guidelines for course of conduct, code of ethics and the rules for social workers. 4th ed. Pretoria.

Stevens, P. & Smith, R.L. 2005. Substance abuse counselling: theory and practice. 3rd ed. Upper Saddle River: Merrill Prentice Hall.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 113-129).

Strydom, H. & Delport, C.S.L. 2011. Sampling and pilot study in qualitative research. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 390-396).

UNODC (United Nations Office on Drugs and Crime). 2010. World drug report. Vienna: United Nations Publication, Sales No.E10.XI.13. World_Drug_Report_2010_lo-res Date of access: 17 March 2011.

UNODC (United Nations Office on Drugs and Crime). 2012. World drug report. Vienna: United Nations Publication, Sales No. E.12.XI.1. http:www.unodc.org/documents/data-and-analysis /WDR2012/WDR2012web_small.pdf Date of access: 12 January 2013.

UNODC (United Nations Office on Drugs and Crime). 2013. World drug report. Vienna: United Nations Publication, Sales No. E.13.XI.6. http:www.unodc.org/secured/wdr/wdr2013/World_Drug_Report_2013.pdf Date of access: 8 March 2013.

Van Wormer, K. & Davis, D.R. 2008. Addiction treatment: a strengths perspective. 2nd ed. Belmont: Thomas Brooks/Cole.

Weyers, M.L. 2011. The theory and practice of community work: a Southern African perspective. 2nd ed. Potchefstroom: KEURKOPIE.

WHO (World Health Organization). 2011. Global status report on alcohol and health. Switzerland: WHO Library Cataloguing-in-Publication Data.

SECTION B: ARTICLES

SECTION B: ARTICLES

ARTICLE 1: SUBSTANCE ABUSE, DEPENDENCY AND THE WORKPLACE: A LITERATURE OVERVIEW

ABSTRACT

Substance abuse and dependency among the employed has massive cost implications for South Africa. Employers are legally obligated to provide opportunities for the treatment of substance dependency before dismissal is considered. Problem areas are the following: inadequate identification of employees with substance abuse problems, infrequent treatment referrals, and oversights of substance abuse in the workplace. This article attempts to fill this lacuna by providing a literature overview of the problem of substance abuse and dependency in the workplace. Dealing with this problem calls for specialist intervention measures, which are discussed in the article.

Key words

Substance abuse, workplace, intervention measures

1. INTRODUCTION

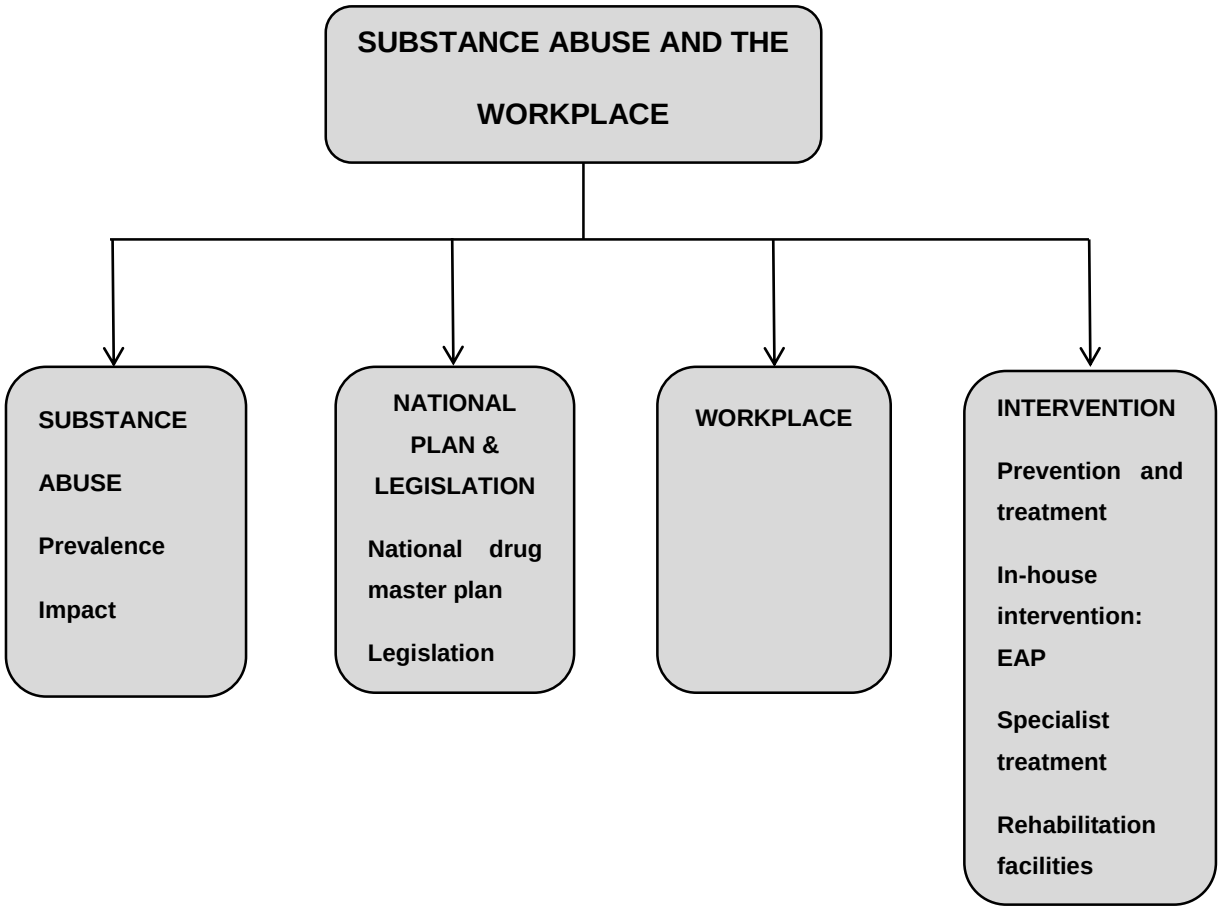
This article overviews the prevalence and negative impact of substance abuse and dependency with specific reference to the workplace; the directives of the National Drug Master Plan (NDMP) for combating substance abuse in South Africa (SA); the legislative requirements for managing substance abuse in the workplace; and guidelines on workplace substance abuse policies. Different intervention measures to combat substance abuse in the workplace, including prevention and treatment programmes, are discussed as is the role of the Employee Assistance Programme (EAP) as a means of in-house intervention. Specialist treatment and rehabilitation facilities such as in- and out-patient treatment centres as external resources are also covered. Findings on treatment outcomes are discussed to indicate the potential benefits of substance abuse treatment for employers, as well as employees. The article ends with a recommendation for a situation analysis to explore the specific needs of employers in addressing substance abuse in the workplace.

Although most research indicates that alcohol abuse is a greater dependency problem than the abuse of other substances, McCann, Harker Burnhams, Albertyn and Bhoola (2011:32) recommend the inclusion of both under the same programme for prevention and treatment

purposes. This article focuses on substance abuse and dependence and includes alcohol as well as other substances. Findings that refer to a specific substance are indicated as such.

The illustration in Figure 1 (adapted from Creswell, 2003:40) shows the key focus areas covered in the article.

Figure 1: Literature overview - key focus areas



2. PROBLEM STATEMENT

Substance abuse and dependence is a global concern and very costly to all societies where it occurs (Hitzeroth & Kramer, 2010:13; Miller & Weisner, 2002:3). Improved economic opportunities in South Africa (SA) since 1994 have led to a rise in alcohol-related problems. The trafficking of substances and the number of people in the workplace seeking treatment for substance abuse problems have also increased over this period (McCann *et al.*, 2011:44; UNODC, 2012:92-93). A growing concern is the increasing importance and vulnerability of the African continent in terms of drug trafficking routes and the UNODC (2013:ix,23,57) expressed an urgent need to improve the data collection and analysis of countries in this region.

Statistics on substance abuse in SA were released by the Central Drug Authority (CDA) at the launch of the United Nations World Drug Report in 2009 (Anon, 2009:1) where it was revealed

that the consumption of substances in SA is twice the world norm; 15% of SA's population has a substance-related problem; substance abuse is costing SA R20 billion a year and poses a bigger threat to the future of the country than the HIV and AIDS pandemic; SA is regarded as one of the drug capitals and top ten narcotics and alcohol abuse centres of the world. Alcohol remains the most commonly abused substance in SA followed by cannabis (Department of Social Development, 2010:33-34; Department of Social Development, 2013a:5; Eberlein, 2010:32; McCann *et al.,* 2011:46; SACENDU, 2012a:2).

Regarding illicit substance use, it is estimated that there are between 119 million and 224 million cannabis users worldwide (UNODC, 2012:2) and remains the most widely used illicit substance globally (UNODC, 2013:xi,1). Although cannabis use is stable and even declining in some developed countries, it is increasing in many developing countries (UNODC, 2012:5). Cannabis use in Africa is reported to be much higher than the global average (UNODC, 2012:17). The CDA annual report (Department of Social Development, 2010:34) reveals that 2.2 million people or 8.4% of the population in SA used cannabis in 2004 against the global norm of 4%. In 2008, approximately 3.2 million cannabis users were recorded in SA indicating an increase of nearly 20% since 2004. According to Hitzeroth and Kramer (2010:39), a recent study among mine workers in SA revealed cannabis use of 9.1%.

Regarding alcohol use, the World Health Organization (WHO) stresses the heavy burden in most countries of diseases and deaths attributable to alcohol consumption. Almost 4% of all deaths worldwide can be linked to alcohol, which is greater than deaths caused by HIV and AIDS, violence or tuberculosis (WHO, 2011:20). Another measurable pattern of alcohol consumption risk is heavy episodic drinking or binge drinking, which is fairly high in SA (Eberlein, 2010:33; WHO, 2011:15-17). A review in 2009 of harmful drinking patterns and levels of consumption in 20 African countries showed that, in terms of “the proportion of heavy drinkers as a percentage of current drinkers, SA ranked fourth highest” (McCann *et al.,* 2011:23).

Against this background, the following questions guided this article: What are the main issues regarding substance abuse in the workplace? What are the legal requirements for managing the problem in the workplace? What resources are available to employers to deal with the problem in the workplace?

3. AIM

The aim of this article is to contextualise substance abuse in the workplace in terms of national directives, legislative requirements for managing the problem and intervention measures to combat the problem.

4. SUBSTANCE ABUSE

The prevalence of substance abuse in the workplace and impact on the employment sector in the South African context are discussed next.

4.1 Prevalence

National data on substance abuse in the workplace are currently unavailable; however, the literature and data sources point to an increase in substance abuse among the employed in SA (Grobler, Wärnich, Carrell, Elbert & Hatfield, 2006:404; McCann *et al.,* 2011:45). Research (Hitzeroth & Kramer, 2010:38; McCann *et al.,* 2011:25) done among farm workers and at a defence force clinic in SA revealed high patterns of hazardous drinking. Also, 9.3% of mine workers who participated in a study in SA were found to use alcohol on a daily basis of whom 15.3% were alcohol dependent (Hitzeroth & Kramer, 2010:38). Data collected by the South African Medical Research Council (MRC) indicate that referrals by employers for substance abuse problems at treatment centres are mainly for alcohol-related problems (McCann *et al*., 2011:25). Grobler *et al*. (2006:404) refer to the growing concern of employers about the increase in drug abuse in the workplace. Estimates on the prevalence of alcohol-dependence problems in the workplace range from 5% to 35%, and other substance problems from 7% to 20% (Grobler *et al.,* 2006:401; McCann *et al.,* 2011:45).

4.2 Impact

The economic impact of substance abuse on employers amounts to millions of rands annually in SA. Substance abuse by employees on-site and/or off-site inevitably results in decreased productivity, work errors, wasted materials and tardiness, all of which translate into massive losses each year (Department of Social Development, 2013a:36-37,43-44; Eberlein, 2010:35-36; Grobler *et al.,* 2006:400-401,404; ICAP, 2013). McCann *et al. (*2011:48) state that an "estimated 50% of accidents in the workplace are substance abuse related; theft and other criminal activities at work are trebled as a result of substance abuse" and that undetected substance abusers cost employers a further 25% of their annual wages.

Above-average absenteeism from work, injuries, substandard levels of productivity and poor quality performance of employees with substance abuse problems are also actual costs to companies (Eberlein, 2010:178-179; Grobler *et al.*, 2006:401; Parry & Bennetts, 1998:57-76). Comprehensive data on substance abuse-related absenteeism are unavailable for SA; however, the results from a sample of male alcoholics of whom 67% were employed revealed that the respondents each lost an average of 86 working days annually due to absence; "66% of the sample was often late for work; 61% reported Monday-morning absenteeism" and 62% occasionally drank alcohol at work while 12% did so regularly (McCann *et al*., 2011:24-25).

Grobler *et al*. (2006:401) report that alcoholic employees are on average absent two to four times more frequently than non-alcoholic employees and cause two to four times more on-the-job accidents. Other findings confirm that harmful drinking is associated with greater absenteeism (ICAP, 2013).

Compared to dependency, substance abuse is less identifiable and result in greater cost implications for employers. Due to this, McCann *et al.* (2011:1-3,45) state that the main problem in the workplace is not so much dependency as abuse. These authors add that a higher number of accidents and instances of absenteeism are attributable to low-to-moderate drinkers, who account for more than half of the workforce. Far more moderate, heavy and troubled problem drinkers than dependent drinkers are encountered in the workplace. An estimated 85% of employees consume alcohol of whom 30% will be heavy, excessive and/or problem drinkers while approximately 6 to 16% will be dependent drinkers. According to the International Labour Organization, 60-70% of workplace problems are caused by moderate to occasional substance abusers (McCann *et al.,* 2011:289). These findings are supported by Dalton, Hoyle and Watts (2006:492) and Segal, Gerdes and Steiner (2007:359) stating that tardiness, absenteeism, workplace fatalities and poor quality work are linked to light and moderate drinking.

The negative consequences of the link between substance use and HIV and AIDS have consistently been pointed out (Department of Social Development, 2013a:37,44; McCann *et al.,* 2011:172; Rose & Zweben, 2002:148-149; UNODC, 2012:97; Van Dyk, 2005:298). A high prevalence of HIV infection is reported among individuals with substance abuse problems due to greater sexually risky behaviour and infection through contaminated needles. The negative influence of substance use on the immune system, the delay in recovery from opportunistic diseases and the interference with the absorption of nutrients during the treatment of HIV and AIDS have also been confirmed (McCann *et al.,* 2011:172-173; Rose & Zweben, 2002:148-149; Van Dyk, 2005:298). Given that companies are already encountering increased labour costs due to 37% HIV-related absenteeism (Barnett & Whiteside, 2006:264), the link with substance abuse places additional pressure on the business sector.

Another group identified in the National Drug Master Plan (Department of Social Development, 2013a:76) as one of the priority target groups is the 'occupational groups at risk'. Some occupational groups are regarded as high-risk and safety-sensitive and include occupations that pose a "significant life-threatening danger to the employee so occupied, his fellow employees or the general public" (Pelser, 2011:10). Sectors such as public transport, the construction and engineering industry, the security industry and financial institutions are considered especially vulnerable to the impact of substance abuse (McCann *et al.,* 2011:7,70). Alcohol and other substances are often used to reduce tension and promote a feeling of well-

being. This could explain the link between substance abuse and individuals employed in high-risk occupations or in jobs with high work demands and high stress levels. Those in high-risk and safety-sensitive occupations are at even greater risk when substances are used during working hours, or when employees report for duty while under the influence of a substance.

To summarise, SA is facing an increase in substance abuse among employed people in the country. The increase in cannabis users and alcohol abusers, especially regarding hazardous drinking patterns, is a major concern. Substance abuse-related accidents in the workplace, theft and other criminal activities at work as a result of substance abuse, and above-average absenteeism from work due to substance abuse, add significantly to the costs of employers. Occupations at risk, which are at even greater risk when substances are used, and the link between substance abuse and HIV and AIDS, place additional pressure on employers.

5. NATIONAL PLAN AND LEGISLATION

The UNODC (United Nations Office on Drugs and Crime, 2012) and the WHO (2011) have called on member states, including SA, to develop preventative programmes and reduce the harmful consequences of substance abuse in their own countries. The WHO (2011:53) has stressed the importance of formal treatment policies and procedures in combating substance abuse. The National Drug Master Plan (Department of Social Development, 2013a) and labour legislation provide national directives to promote effective management of substance abuse in the workplace. The National Drug Master Plan (NDMP) and relevant legislation are discussed below.

5.1 National Drug Master Plan

The NDMP was formulated by the CDA in terms of the Prevention of and Treatment for Substance Abuse Act (70 of 2008) in part to meet South Africa's responsibilities to the United Nations in respect of combating substance abuse in SA (Department of Social Development, 2013a:20). The CDA is the statutory body authorised in terms of the said Act to direct, guide and oversee the implementation of the NDMP as well as monitor and evaluate the initiatives of all relevant stakeholders in their endeavours to realise the goal of "a country free of substance abuse" (Department of Social Development, 2013a:6). The CDA annual report (Department of Social Development, 2010:7-9) covers resolutions aimed at combating substance abuse in SA that were formulated during the 2nd Biennial Anti-substance Abuse Summit in 2011. These resolutions are included in the NDMP and those of relevance to this article are listed below (Department of Social Development, 2013a:86,97-99).

- ✓ Intensifying campaigns to inform and educate people about the dangers of substance abuse

- ✓ Implementing comprehensive prevention programmes
- ✓ Implementing a care and a public health approach that provides for prevention, early identification, treatment, rehabilitation and aftercare services
- ✓ Strengthening aftercare services and
- ✓ Increasing the provision of rehabilitation services.

Certain key changes were identified during the review of the NDMP (2006-2011) and included in the new NDMP (Department of Social Development, 2013a:50-51):

- ✓ A shift from a supply reduction approach to one of primary prevention
- ✓ A change from a top-down to a bottom-up approach
- ✓ The application of "research and development to meet the predicted needs and future changes in the field of substance abuse" and
- ✓ The introduction of proper monitoring and evaluation (M&E) measures.

An integrated, balanced approach to combat substance abuse in SA is advocated and includes the following strategies (Department of Social Development, 2013a:29):

- ✓ Demand reduction – reducing the need for substances through a variety of means including prevention, education and the imposition of restrictions on the use of substances
- ✓ Supply reduction – "reducing the quantity of substances available on the market" and
- ✓ Harm reduction – limiting the damage caused to individuals who are already addicted through treatment, aftercare and reintegration into society.

The application of this integrated strategy requires harmonising and enforcing laws and policies to facilitate effective governance of substance abuse in SA (Department of Social Development, 2013a:30).

The NDMP (Department of Social Development, 2013a:129) highlights the significance of sound workplace substance abuse management programmes. The importance of awareness among employers and employees about the benefits of a drug-free workplace, is also emphasised. An appeal is made in the NDMP (2013-2017) for partnerships between the government and the public sector to implement comprehensive, ethical and sound workplace substance abuse programmes, yet SA lags behind international standards to manage employee substance abuse as part of occupational health, safety and risk management programmes (Department of Social Development, 2013a:129).

5.2 Legislation

Several South African Acts stipulate labour requirements for dealing with substance abuse and dependency in the workplace and emphasise the obligations of employers, as well as

employees in this regard. The Acts relevant to the topic under discussion here include the following:

The Occupational Health and Safety Act (85 of 1993) states that employers of large as well as small companies are liable for managing the negative impact of substance abuse in the workplace, which includes denying employers under the influence access to the workplace. This Act further states that employees have a right to a safe work environment and that substance abuse can become an occupational hazard if not dealt with properly. Employees are themselves also legally bound by protocols governing substance abuse in the workplace. It is the responsibility of employees not to jeopardise the safety of colleagues through the use of substances (Acts see South Africa).

The Compensation for Occupational Injuries and Diseases Act (130 of 1993) holds employers and employees liable for safety precautions – employers are responsible for maintaining an alcohol- and substance-free workplace, and employees may not claim compensation from their employers to cover workplace damages and accidents resulting from their own serious and wilful misconduct due to substance intoxication (Acts see South Africa).

The Labour Relations Act (66 of 1995) makes it illegal to dismiss employees who are incapacitated or unable to work due to ill health resulting from substance dependency (Acts see South Africa).

The Constitution of the Republic of South Africa (108 of 1996) stipulates that no unfair discrimination directly or indirectly may be practised on the grounds of disability, including substance abuse dependency, which can be regarded as a certain kind of incapacity (Acts see South Africa).

The Employment Equity Act (55 of 1998) allows for testing of employees in the light of employment conditions and/or the physical activity involved in the job (Acts see South Africa; McCann *et al.,* 2011:193). This includes testing where employees operate heavy machinery and/or drive trucks, as well as testing to promote a substance-free workplace, and to protect employers, employees and the public from substance-related accidents that may occur (Services SETA, 2003a:28).

The Prevention of and Treatment for Substance Abuse Act (70 of 2008) acknowledges that substance abuse is a chronic and relapsing medical condition (Acts see South Africa). However, the link between HIV and AIDS and substance abuse is not sufficiently stated in the said Act (McCann *et al.,* 2011:195) whereas clear and consistent associations are drawn between substance abuse and HIV and AIDS and tuberculosis in the NDMP (Department of Social Development, 2013a:37,44). The negative consequences of the link between HIV and

substance abuse place additional pressure on the business sector (see the discussion in paragraph 4.2 in this article).

The South African Labour Guide (South Africa, 2011:1-3) emphasises the importance of mutual respect between employers and employees, which also involves employment justice and the efficient operation of businesses. Substance dependency is regarded as a kind of incapacity and not as misconduct. The guide states that dismissal for unsatisfactory performance due to incapacity should be considered only after appropriate counselling and rehabilitation steps for employees have been considered and implemented.

The roles and responsibilities of employers and employees with regard to substance abuse and dependency in the workplace are clearly stipulated in the relevant Acts. A distinction is drawn between dependency, instances of incapacity and misconduct. Employers are legally obligated to facilitate rehabilitative measures and employees to refrain from misconduct. McCann *et al.* (2011:9,211) state that substance abusers should be disciplined and that substance dependence should be dealt with through treatment and continues that "alcohol dependency should be de-stigmatised and alcohol abuse should be stigmatised".

6. WORKPLACE

Because of the detrimental effects of substance abuse and dependency on the workplace, and the legal obligations of employers to manage substance abuse and dependency problems effectively, employers need to "commit time, energy and resources" to deal with the problem (McCann *et al*., 2011:13,29). The workforce is further regarded as a captive population already functioning in a structured working environment, which is considered the most appropriate and potentially successful setting to address the substance abuse problems of employees.

Kemper in Grobler *et al*. (2006:403) maintains that an appropriate belief system, supervisory practices and treatment facilities are important factors in retaining employees before dismissal is considered. Such a belief system should hold, for example, that alcoholism is an "illness and should be treated as such"; that companies "should offer appropriate assistance"; that employees should take responsibility to seek and accept treatment; that early identification and treatment serve the best interests of employers and employees; and that diagnosis and treatment are the responsibility of trained professionals. Strategies recommended by Grobler *et al.* (2006:403) to combat substance abuse in the workplace include minimising stress and anxiety levels in the workplace and implementing rehabilitation policies and programmes.

The negative impact of substance abuse on the workplace and the legal obligations imposed on them have forced employers to develop workplace policies and practices to deal with the

problem. Grobler *et al.* (2006:403-404) and McCann *et al.* (2011:211) refer specifically to the importance of clear policies and procedures for dealing with substance abuse and dependency in the workplace. Various policies have been implemented in SA to deal with substance abuse, especially with regard to alcohol problems and, to a lesser extent, to the problem of illicit substances. Despite the NDMP directives, few drug-related policies have been applied effectively (Department of Social Development, 2013a:59-60).

Services SETA (2003a:41-42) proposes guidelines for a workplace substance abuse policy in terms of which companies should provide the following programmes:

- ✓ "Education and awareness programmes"
- ✓ "Prevention programmes"
- ✓ "Programmes to promote openness, acceptance and care for affected employees" and
- ✓ "Treatment programmes" (which are considered feasible in only very few companies).

Albertyn and Bhoola (2011:292-324) propose the following policy and procedural elements to address substance abuse in the workplace:

- ✓ Application of legislation and statutory authorisation in relevant Acts
- ✓ Definition of roles and responsibilities of management, workers and union members in implementing appropriate policies
- ✓ Information, education and training of personnel on all aspects of substance use
- ✓ Information on warning signs of substance abuse and/or dependency in employees
- ✓ Disciplinary procedures for dealing with substance abuse problems
- ✓ Management of suspected intoxication and testing protocols
- ✓ Referral procedures aimed at advice and/or treatment
- ✓ Counselling and treatment and
- ✓ Employee Assistance Programmes (EAPs).

The NDMP, legislation and guidelines for workplace substance abuse policies indicate how employers should go about handling the problem of substance abuse and dependency in the workplace. Prevention, education, dissemination of information, treatment, counselling and aftercare to combat substance abuse in SA, and more specifically in the workplace, are consistently highlighted as priority measures. Provision is made in the proposed policies and guidelines for training for managers in the early identification of substance abuse problems, referrals to specialist agencies, use of registered in- and out-patient treatment centres, and intervention measures

7. INTERVENTION

Support structures in the workplace in the form of EAPs and external specialist treatment services can assist employers with the identification and resolution of employees' substance abuse problems.

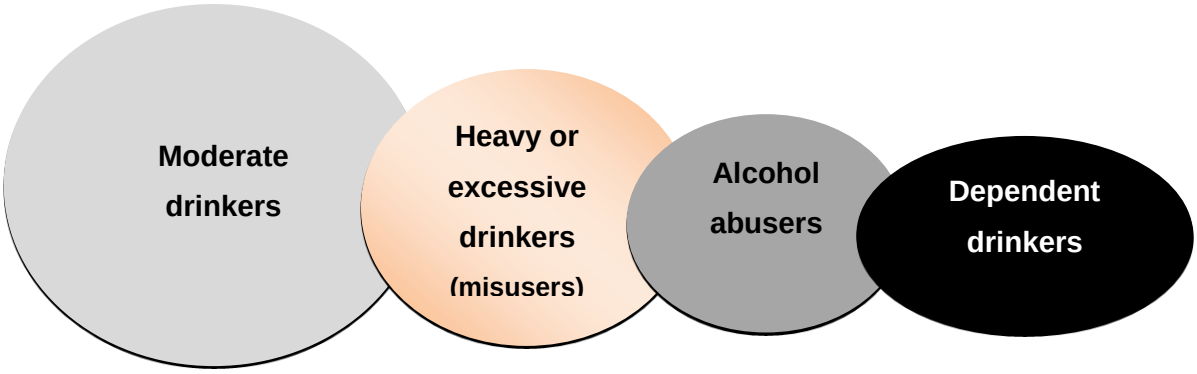
McCann *et al.* (2011:279) refer to intervention measures that could be implemented depending on the stage of substance use. Knowledge of the characteristics of the different drinking categories or stages is needed to understand the risks faced by employers. Different categories of drinkers are distinguished and include social and moderate drinkers, heavy or excessive drinkers, alcohol abusers or problem drinkers and dependent drinkers (Figure 2).

The characteristics of these categories are: social drinkers – no excessive drinking; heavy or excessive drinkers – periodic binge drinking, inappropriate drinking patterns start to emerge; alcohol abusers – less control over use, solitary use begins, repeated promise failure; dependent drinkers – no control, obsessed with alcohol, life becomes alcohol.

Far more moderate, heavy and troubled problem drinkers than dependent drinkers are encountered in the workplace. An estimated 85% of employees consume alcohol of whom 30% will be heavy drinkers, excessive drinkers and/or alcohol abusers while approximately 6 to 16% will be dependent drinkers (McCann *et al.,* 2011:2;3,45).

Drinking categories according to McCann *et al.* (2011:2) is depicted in Figure 2.

Figure 2: Drinking categories



The aforementioned categories of drinkers correlate with the stages of substance use indicated in McCann *et al.* (2011:279). The appropriate intervention measures for each stage of substance use are shown in Table 1.

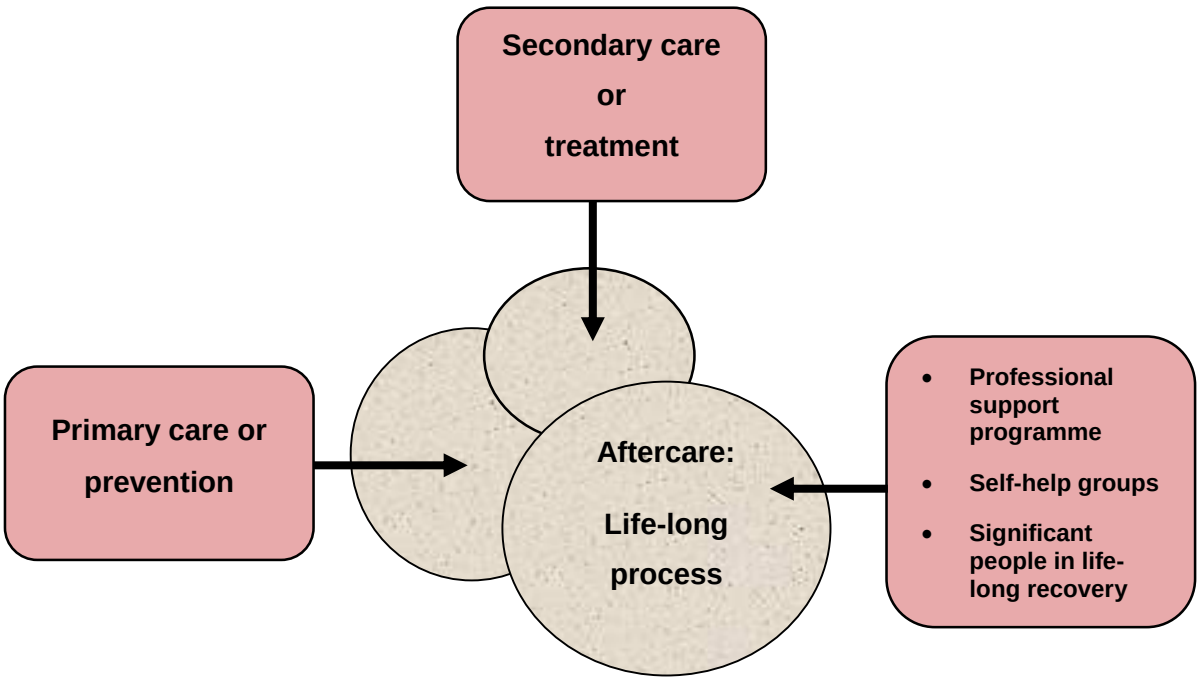
The table below shows that the main intervention measures are prevention and treatment including early or brief intervention and aftercare. In terms of the time relationships, Eberlein (2010:212-213) points out that prevention (referred to as primary care), and the entire treatment process (referred to as secondary care) comprise a relatively small proportion of the intervention programme. Aftercare is regarded as the longest of the recovering phases and referred to as a life-long process to establish a new lifestyle (Eberlein, 2010:215-220; Hitzeroth & Kramer, 2010:114-115).

Table 1: Intervention measures according to the drinking categories

Category of drinkers / stages of substance use	Intervention measures	Intervention measures
No use Use (moderate / social drinkers)	Prevention Prevention – no treatment required	**PREVENTION**
Misuse	Prevention and brief/early intervention	
Abuse	Brief intervention and in- or out-patient treatment services	
Dependence	Detoxification and in- or out-patient treatment services Sometimes mental health services Harm reduction for individuals with chronic dependence Reintegration services ↓ Aftercare services and Continuing support	**TREATMENT**

The time relationships in the care and treatment process mentioned by Eberlein (2010:213) are shown in Figure 3.

Figure 3: Time relationships - Care and Treatment process



The main intervention measures, i.e., prevention and treatment comprising assessment, treatment programmes and aftercare are discussed below.

7.1 Prevention

A key change in the new NDMP (Department of Social Development, 2013a:50-51) is the shift from a supply reduction approach to a primary prevention and demand reduction approach. Reducing the need for substances through, for example, the prevention of and education on the use of substances is advocated in the new NDMP (Department of Social Development, 2013a:29). Findings also indicate that substance abuse in the workplace can be prevented by raising awareness among employees about the impact of substance abuse on workplace performance, and by providing assistance and/or offering appropriate services to employees in need of intervention (ASBTDC, 2011:2). Prevention in the context of substance abuse is defined as a "proactive process that creates and reinforces conditions that promote healthy behaviours and lifestyles" such as activities to "prevent or delay the onset of substance use disorders" (McCann *et al.,* 2011:278).

McCann *et al.* (2011:276) consider the workplace the ideal environment for disseminating prevention messages on substance abuse. Prevention programmes targeting the whole workforce can prevent or dissuade employees from using substances at risky levels. Targeting selected groups in the workforce for prevention programmes is also important, especially with

regards to occupational groups at risk (Department of Social Development, 2013a:76). Services SETA (2003a:41-42) recommends the inclusion of prevention, awareness and education programmes in workplace substance abuse policies. Measures are thus needed to prevent individuals, groups and communities from engaging in substance abuse and developing dependency**.**

7.2 Treatment

Treatment of substance abuse problems in the workplace can be dealt with through in-house corporate staff involvement by means of an EAP (Carroll & Buchholtz, 2006:545) and/or by using external resources. The employer or EAP staff member may decide to refer problem cases for treatment to medical professionals, acute hospital care, detoxification treatment or treatment at a rehabilitation facility such as an in- or out-patient treatment centre (Eberlein, 2010:53-54; McCann *et al.,* 2011:245-250). In-house intervention measures, with specific reference to the role of EAP in dealing with substance abuse and dependency in the workplace, are discussed next followed by a discussion on specialist treatment and rehabilitation facilities.

7.2.1 In-house intervention

The treatment of employees experiencing substance abuse problems is considered crucial, yet McCann *et al.* (2011:228-237) recommend 'treating the company' before attending to the problems of employees. Treatment of a company involves changing possible resistance towards a substance abuse workplace policy; education of the entire workforce including management, employees and shop stewards; assessment of the problem as well as its causes; implementation of possible solutions including disciplinary measures; and the involvement of external service providers such as social workers. The key role of EAPs in dealing with substance abuse and dependency is confirmed by various sources such as Carroll and Buchholtz (2006), Dalton *et al.* (2006), Grobler *et al.* (2006), McCann *et al. (*2011), Roman (2002) and Services SETA (2003b).

- **Employee Assistance Programme**

Initially, EAPs grew rapidly worldwide (Roman, 2002:198), but gradually their impact declined in the USA possibly because funding and federal support were withdrawn; research on workplace interventions for alcohol problems was discouraged; infrastructure for workplace referrals was neglected; and reluctance to address substance abuse in the workplace grew due to stigmatisation (Roman, 2002:197-200). Research findings also indicate a decline in satisfaction with the outcome of EAP referrals in the USA. The number of EAPs with which private substance abuse treatment centres had referral relationships dropped significantly from seven EAPs in 1996 to two EAPs in 1998 (Roman, 2002:203-204).

Dalton *et al.* (2006:374) state that EAPs have recently once again become popular in the USA with most major corporations offering assistance to their employees. These EAPs are designed to assist employees who experience personal problems, including substance abuse problems. The Kemper Insurance Companies in Grobler *et al.* (2006:403-404), one of the first organisations in the USA to implement a formal EAP policy, state that the main aim of an EAP is to retain potential alcoholic employees by assisting them to prevent the development of the condition to a point where they are unemployable.

Grobler *et al.* (2006:397) refer to the growing number of EAPs in SA and attribute this trend to the early identification of substance abuse problems, employer motivation of EAP employees to continue treatment, and follow-up and monitoring to minimise relapses.

The Employee Assistance Professionals Association (EAPA) describes an EAP as "…a workplace program designed to assist in the following: (1) work organisations in addressing productivity issues, and (2) employee clients in identifying and resolving personal concerns, including health, marital, family, financial, alcohol, drug, legal, emotional, stress, or other personal issues that may affect job performance" (EAPA, 2010:6).

Some of the core technologies of the EAP stipulated in the EAPA standards and professional guidelines (EAPA, 2010:6) include the following:

- Consultation with, training of and assistance to management in dealing with troubled employees
- Early problem identification and assessment services for employee clients with personal problems
- Motivation and short-term intervention with employees to address problems that may have an effect on job performance and
- Referral of employees for diagnosis, treatment and assistance, as well as monitoring and follow-up services.

Standards set by the EAPA regarding external resources require that the EAP should establish constructive working relationships with appropriate external resources and ensure the delivery of quality services responsive to the needs of employees. It is also required of the EAP to act as advocate for employees in accessing treatment resources. Furthermore, the active involvement of EAP in the wellbeing of troubled employees, as well as in their reintegration after treatment, is specified in the standards and professional guidelines (EAPA, 2010: 33-35).

An EAP is thus considered a support structure in the workplace that can assist employees with problem solving while at the same time enhancing productivity. However, limitations in EAPs have also been identified. For example, the discrepancy between the prevalence of

substance abuse in the workplace and the low identification rate of substance abuse problems is ascribed to an inability in EAPs to identify employees with such problems. South African Chamber of Mines estimates indicate that the chamber's identification rate of substance abuse in the workplace is 1%, which "occurs mainly at hospitals to which employees have been referred" for problems other than substance abuse problems (McCann *et al.,* 2011:289). Various other reasons are given for the low identification rate such as that most problem drinkers go undetected; reduced work performance develops gradually and is therefore not easily measurable; and identifying alcohol problems among low-to-moderate drinkers is difficult because the early symptoms are less visible than those with dependent drinkers. According to Walker and Shain in McCann *et al. (*2011:289), this low identification rate indicates the "inherent inability of EAPs to identify most employees with a drinking problem".

McCann *et al.* (2011:286) caution against supervisors in the workplace acting as counsellors and diagnosing employees with substance abuse problems. Kemper in Grobler *et al*. (2006:403) states that training of management staff in the early identification of substance abuse problems, as well as referrals to an appropriate treatment facility at the earliest possible stage, will most likely deliver better end results.

Roman (2002:207-208) argues that intervention in the workplace should be reconstructed; that training should be given to EAP staff on the basics of substance abuse treatment; that workplace personnel should not endeavour to induce behaviour change in substance abuse employees; and that employees with substance abuse problems should be referred to appropriate specialists. Goodman (2007:7,93) stresses the importance of specialist social workers in treating substance abuse and dependency in the workplace and adds that social workers have the necessary techniques and skills to engage effectively with clients who have substance abuse problems. Ray Jones (Chair of the British Association of Social Workers) also believes that the core values and competencies of social workers are needed when working with substance abusers (Goodman, 2007:7). Although EAPs are regarded as invaluable support structures in aiding employees with substance abuse problems, it has been consistently recommended that the actual intervention be handled by specialists.

7.2.2 Specialist treatment

The importance of prevention and early intervention in cases of substance dependency is emphasised by Grobler *et al.* (2006) and McCann *et al.* (2011). Figure 2 shows that far more moderate, heavy and troubled problem drinkers than dependent drinkers are encountered in the workplace. Early identification and intervention while in the stage of moderate, heavy and troubled drinking is regarded as far more successful than treatment once dependency has

developed (McCann *et al.,* 2011:13). According to Grobler *et al*. (2006:403) early diagnosis and treatment benefit not only employees but also employers.

Treatment of dependency is a long-term process – Eberlein (2010:53) states that there is "neither instant cure nor instant treatment for dependency". Eberlein (2010:158-160) and Hanson, Venturelli and Fleckenstein (2009:498-499) suggest observance of the following principles when selecting a suitable treatment programme:

- ✓ Treatment should be voluntary
- ✓ Treatment should be individualised
- ✓ Treatment should be accessible
- ✓ Treatment should be holistic and address multiple problems and needs of clients
- ✓ Continuous monitoring and evaluation of and adjustments to the treatment plan should take place
- ✓ Treatment should last long enough to have a significant effect on the dependency – a period of roughly three months is recommended
- ✓ Counselling and medication are important elements of the treatment
- ✓ Treatment should include detoxification (if necessary) as part of the therapeutic programme
- ✓ Treatment should be followed up with long-term aftercare and support and should make provision for relapses and
- ✓ Treatment should make provision for HIV and AIDS testing and counselling.

Treatment of clients with substance abuse problems is usually conducted in phases comprising assessment, therapeutic treatment and aftercare (Hitzeroth & Kramer, 2010:95-115) and is discussed in more detail below.

7.2.2.1 Assessment

❖ **Therapeutic assessment**

Comprehensive assessment of a client's substance abuse problems should be conducted by evaluating the client's work performance and history as well as his or her medical and substance abuse history. Various questionnaires are available for screening possible dependency (Hanson *et al.,* 2009:497; McCann *et al.,* 2011:331-338; Stevens & Smith, 2005:137-144; Van Wormer & Davis, 2008:208-209) of which only a few are mentioned here such as the Alcohol Use Disorders Identification Test (AUDIT), which is widely accepted and commonly used in SA; the CAGE and TWEAK TESTS for alcohol dependence; the Drug Use Disorders Identification Test (DUDIT), which was developed as a parallel instrument to the AUDIT to identify possible drug dependency; and the Drug Abuse Screening Test (DAST), which also screens drug dependency.

Assessment tools are facets of the diagnostic process and may be used either in conjunction or separately, depending on the assessing party's preferred methodology. These tools are freely available to social workers, medical professionals and people involved in human resource management. Limitations of these screening procedures include possible ambivalence of clients towards completing the questionnaires; possible underreported substance consumption behaviour; and possible inconsistent administration of the questionnaires (McCann *et al*., 2010:156-158). It is therefore recommended that diagnosis of substance abuse and dependence should be left to specialists (Grobler *et al.,* 2006:403).

❖ **Medical assessment**

Medical examination includes comprehensive medical assessment, drug testing, and medical guidance and assistance to monitor health and prevent illness. Risks to medical and mental health, and possible deliberate self-harm, violence or suicidality also need to be assessed. In emergencies, intervention should involve either referring the client to a "general practitioner or even the emergency unit at the local hospital" (Hitzeroth & Kramer, 2010:104). The key role of the occupational health professional is discussed in detail in McCann *et al.* (2011:261-275). Medical and health services also include HIV and AIDS testing and counselling due to the link between substance abuse and HIV and AIDS (SANCA, 2011a:127-128; SANCA, 2011b:58).

When clients stop using substances, withdrawal symptoms may develop, which can range from minor to life-threatening conditions. Managing withdrawal symptoms depends on the severity of the condition and may require detoxification. Hitzeroth and Kramer (2010:118) refer to detoxification as a medically supervised programme to assist patients experiencing substance abuse withdrawal. Detoxification is considered an essential element in the treatment programme and should be discussed, evaluated and administered early in the assessment phase (Eberlein, 2010:158,160; Hitzeroth & Kramer, 2010:120). The main objectives of detoxification are to treat the bodily imbalances caused by substance abuse; to alleviate the toxicity due to substance abuse and to wean the nervous system from the dependence (Eberlein, 2010:21-22; Hitzeroth & Kramer, 2010:118; McCann *et al.,* 2011:245). A medically trained healthcare professional should therefore be involved in the assessment, withdrawal and detoxification phase of the treatment (Hitzeroth & Kramer, 2010:118; McCann *et al.,* 2011:247). Detoxification is an integral part of the therapeutic programme and should not be administered in isolation.

7.2.2.2 Therapeutic treatment

Various authors including Abadinsky (2011), Eberlein (2010), Goodman (2007), Hanson *et al*. (2009), Hitzeroth and Kramer (2010), McCann *et al*. (2011), Miller and Weisner (2002), SANCA (2011a), SANCA (2011b), Stevens and Smith (2005) and Van Wormer and Davis (2008) list a range of therapeutic treatment programmes. In this regard, Smith and Capps

(2005:349) refer to a multidimensional approach in dealing with dependence. The general agreement in literature sources is that the choice of programme will depend on the needs and personal circumstances of the client as well as the available resources of the treatment facility (Abadinsky, 2011; Eberlein, 2010; Hanson *et al.,* 2009; Hitzeroth & Kramer, 2010; McCann *et al.,* 2011; Stevens & Smith, 2005).

According to McCann *et al.* (2011:254) the main aim of therapeutic treatment is to stop the harm caused by substance abuse, to prevent further health and social harm related to continuing substance abuse and to help the client regain a sober and balanced lifestyle. Eberlein (2010:158-160) and Hanson *et al.* (2009:498-499) have identified important principles for selecting a suitable treatment programme and ensuring effective treatment. McCann *et al. (*2011:254) maintain that treatment should be goal directed, comply with basic human rights requirements and adhere to evidence-based practices. The Minnesota model, Matrix Intensive Outpatient Treatment Programme (Matrix IOP), Motivational enhancement therapy (MET) and the strengths-based approach are relevant to dealing with substance abuse and discussed briefly:

The Minnesota model advocates the disease concept, namely that substance dependency is the result of a disease with a physiological origin (Hitzeroth & Kramer, 2010:113-114; SANCA, 2011b:24). The model focuses on the implementation of the twelve-step programme proposed by Alcoholics Anonymous (AA), family therapy, peer group support, group therapy and education on substance dependency (Hitzeroth & Kramer, 2010:113-114).

The Matrix Intensive Outpatient Treatment Programme (Matrix IOP) comprises models and methods taken from numerous treatment approaches. The effects of the Matrix IOP have been evaluated frequently and reveal significant reduction in substance abuse (Eberlein, 2010:161; McCann *et al.,* 2011:255; SAMSHA, 2011:1). The Matrix IOP involves an evidence-based treatment approach and includes substance abuse education; individual, family and group therapy; relapse prevention; and aftercare services. A strengths-based and motivational interviewing approach, cognitive behavioural therapy and the twelve-step programme are integral to the Matrix IOP (Eberlein, 2010:160-163; McCann *et al.,* 2011:254-255; Miller & Rollnick, 2002).

Motivational enhancement therapy (MET) is a client-centred approach aimed at initiating behavioural change, motivating clients to engage in treatment and guiding clients through the process of recovery. This approach is based largely on motivational interviewing techniques. An empathetic, non-confrontational and reflective listening approach is followed, and clients are encouraged to use their personal resources to promote behavioural change (Eberlein,

2010:162; McCann *et al.,* 2011:254; Miller & Rollnick, 2002; SANCA, 2011b:25). The MET approach is closely related to harm reduction and clients treated with MET seems more likely to be retained in treatment (Hitzeroth & Kramer, 2010:75-85; McCann *et al.,* 2011:254; Van Wormer & Davis, 2008:27-28).

The strengths-based approach has proven to be an essential component in the treatment of dependency. The basic principles of the strengths-based approach comprise focusing on strengths rather than liabilities, honouring client self-determination, reacting to the client's stage of readiness and tapping into the available resources of the client (Van Wormer & Davis, 2008:86-88). Focusing on the strengths is regarded as a much more effective way of assisting clients to change their addictive behaviour.

Recovery is a continuous, lifelong process and does not end when service users have completed their substance abuse treatment programmes (Department of Social Development, 2013b:4**;** Eberlein, 2010:207-220; Fisher & Harrison, 2009:179; Hitzeroth & Kramer, 2010:114-115). Many life changes probably occurred, often over a lengthy period, due to substance abuse, i.e. physical deterioration, financial problems, conflict with the law, deterioration in relationships, marital problems, loss of support systems, self-care neglect and conflict encounters in the employment sector. After completion of the treatment, service users need to return to their communities facing the same high-risk situations that resulted from a lifestyle of substance abuse. Modifications, therefore, need to be made in order to maintain a substance free lifestyle. This may be extremely overwhelming, cause a lot of stress and conflict and is regarded as high risk situations for relapse (Fisher & Harrison, 2009:175).

The reality of relapse and necessity of relapse prevention have been emphasised by many literature sources (Department of Social Development, 2013b; Eberlein, 2010; Fisher & Harrison, 2009; Hitzeroth & Kramer, 2010; Van Wormer & Davis, 2008). Findings, reported in Fisher and Harrison (2009:166) after 500 alcohol treatment studies have been examined, suggest that 26% is a representative success rate of abstinence and improvement after 12 months of treatment. Hoffman and Harrison followed more than 1900 adults from five in-patient and other treatment programmes. Two years after treatment, findings from this study revealed that 54% achieved total abstinence, 18% experienced slips and 28% had multiple relapses. Fisher and Harrison (2009:174) regard a structured relapse prevention programme essential to coordinate the necessary services and people for successful relapse prevention.

Remaining sober and being reintegrated in the community are extremely difficult (Eberlein, 2010:212). Successful reintegration into the community after the completion of the treatment is critically important. Service users require reintegration services, including relapse

prevention, to enable them to maintain sobriety; these services play a major role in their lives after completion of the treatment programme (Department of Social Development, 2013b:8). To maintain sobriety and prevent relapse, the following services and measures are suggested: a recovery plan (Hitzeroth & Kramer, 2010:190-191); reintegration plan (Department of Social Development, 2013b); life style changes (Fisher & Harrison, 2009); improvements in health, social and legal status, stable marital relationships and support groups (Eberlein, 2010:215-220; Van Wormer & Davis, 2008:30-31)

The reintegration and aftercare model for substance abuse services (Department of Social Development, 2013b) highlights the following aspects in the reintegration process:

The reintegration plan should be developed jointly by the service provider, service users and significant others whilst the service users are still undergoing treatment. The reintegration process should commence while the service users are still in treatment and the implementation should follow immediately after the completion of the treatment programme. Services should provide for the following: reintegration into the families; skills to maintain sobriety and avoid relapses; anticipatory actions to reduce conditions that may result in relapse; establishment of support systems; and the development of new life skills. Reintegration services include linking the service users with external resources and services in preparation for restoration with their families, community and place of employment, as well as empowering service users with coping mechanisms to adapt to the community (Department of Social Development, 2013b:4-5,8). An individual reintegration plan should be developed for each service user and should include the activities, services and resources necessary for continued sobriety.

The employment scene can be a high-risk situation; employees may be reluctant to return to the workplace because their colleagues may be associated with substance abuse, or an unpleasant or unsatisfying job may cause negative emotions (Fisher & Harrison, 2009:177). EAPs are regarded as significant resources and need to be involved in the reintegration process. The EAPA states that Employee Assistance professionals should coordinate and participate in the discharge of an employee from the treatment centre. Attending case conferences at the treatment centre and follow-up visits to the employee, while in treatment, are examples of employee assistance and regarded as part of the reintegration process. The involvement of the union representatives, as support structure for the returning employee after treatment, is further suggested (EAPA, 2010:26). The EAPA also states that the EAP should serve as a key resource for consultation with management, on issues such as reintegration into the workplace, as well as follow- up on job performance and progress after treatment (EAPA, 2010:33).

White, in Fisher and Harrison (2009:180), refers to the cultural stigma as the primary obstacle in the reintegration of people after recovery and advocates a new recovery movement: “If recovering people have not fully returned to their communities, it is as much a cultural failure as a personal one…It is time for a new recovery advocacy movement that, by removing the cultural stigma that continues to be attached to addiction/recovery, can open the doors for recovering people to return to their communities”.

Reintegration services are an integral component and serve as a preface to the aftercare programme; the significant others who will be involved, as a form of support, thus need to be identified and involved in the reintegration plan.

7.2.2.3 Aftercare Programme

A structured aftercare programme is regarded as an important component in the treatment plan of substance dependency and contributes significantly to abstinence (Doweiko, 2006:373; Eberlein, 2010:211-219; Hitzeroth & Kramer, 2010:114-115; McCann *et al*., 2010:257). The Prevention of and Treatment for Substance Abuse Act (70 of 2008), describes aftercare as “ongoing professional support to a service user after a formal treatment episode has ended” aimed at enabling the client to “maintain sobriety or abstinence, personal growth and to enhance self-reliance and proper social functioning” (Acts see South Africa). Aftercare is designed and carried out with the assumption that treatment does not end with the completion of the formal treatment programme.

The goals of an aftercare programme should include relapse prevention, assisting the client to maintain the gains made in the treatment, establishing and monitoring “the habit of sobriety” and developing his or her full potential (Doweiko, 2006:373; Eberlein, 2010:216-220; Hitzeroth & Kramer, 2010:115; McCann *et al*., 2010:257).

Eberlein (2010:208) refers to aftercare as 95% of the solution with a life-long challenge to develop and maintain a new life style and achieve self-fulfilment. This is only possible through the assistance of those involved in the prevention, treatment and aftercare programme, as well as those people involved in the life-long recovering process (Eberlein, 2010:215).

Eberlein (2010:208-227) further discusses aftercare in detail and particularly refers to the importance of developing the individual’s potential during this phase. This author emphasises the importance of physical healing to cure the health damages; intellectual development as preparation for the demands when returning to the workplace; social development in order to take a stance in a society in which sobriety is not the norm, and the development of competencies to cope in the economic world in order to remain abstinent. The importance of involving significant role players in the reintegration process is particularly stressed. A strong

support network, regular visits to treatment counsellors, involvement in a sustainable quality aftercare programme and dedicated implementation of major lifestyle changes by the client are regarded as critically important in reducing the chances of relapse (Eberlein, 2010:208-227; Hitzeroth & Kramer, 2010:114-115; McCann *et al.,* 2011:257).

Furthermore, the importance of professional support and support from self-help groups such as the Alcoholics Anonymous (AA) and the Narcotics Anonymous (NA) to remain abstinent are emphasised by Doweiko (2006:373), Eberlein (2010:54-55), Hitzeroth & Kramer (2010:114-115), McCann *et al. (*2011:256) and SANCA, 2011a (90-92).

8. REHABILITATION FACILITIES

Various rehabilitation facilities are available for the treatment of substance dependency such as halfway house facilities, corporate in-house facilities, and in- and out-patient treatment facilities (Eberlein, 2010:53-54; Hitzeroth & Kramer, 2010:111-113; McCann *et al.,* 2011:248-250). In- and out-patient treatment centres generally follow the previously mentioned phases, namely specialist assessment, therapeutic treatment programmes and an aftercare programme.

In- and out-patient treatment centres are regulated by a number of Acts including the Prevention of and Treatment for Substance Abuse Act (70 of 2008), the Non-Profit Organisations Act (71 of 1997), the Social Service Professions Act (110 of 1978) and relevant Labour Acts (SANCA, 2011a:106; SANCA, 2011b:43). The treatment programmes are based on minimum service standards for in- and out-patient treatment centres and the National Department of Social Development's norms and standards.

In- and out-patient treatment centres use the services of multidisciplinary teams consisting of social workers specialising in substance abuse therapy, medical professionals, psychiatrists, psychologists and spiritual counsellors. Services provided by these centres include comprehensive therapeutic assessment and treatment, medical assessment and treatment, and aftercare services. Treatment programmes may include the Minnesota model, the Matrix IOP model and motivational enhancement therapy (MET)**.** Support for and assistance to family members of the substance dependent is included as part of the treatment. EAP services, HIV and AIDS testing including pre- and post-test counselling, as well as community prevention and awareness programmes are also provided (SANCA, 2011a:17-22; SANCA, 2011b:58-59).

Consideration of both in- and out-patient treatment facilities can provide an overall picture and serve as a guideline for selecting the most appropriate facility. The choice will depend on the needs and preferences of the client, the severity of the dependence, the cost implications for

the company, as well as for the employee (client), and logistical constraints (Eberlein, 2010:53; Hitzeroth & Kramer, 2010:110-113; McCann *et al.,* 2011:248-249).

8.1 Out-patient treatment centres

An out-patient treatment facility is described as a non-residential community-based facility where service users (clients) are required to attend therapy sessions on a regular basis for a specific period of time. Specialist rehabilitation programmes are offered by professional staff who provide a holistic service (South Africa, 2008:10; SANCA, 2011a:108).

Treatment ranges from daily activities to once-a-week meetings at the clinic (McCann *et al*., 2011:249; SANCA, 2011a:17-19; Stevens & Smith, 2005:179; Van Wormer & Davis, 2008:112). The average duration of the programme is two months to 12 months, which includes aftercare group sessions commencing after conclusion of the individual therapy treatment phase (McCann *et al.,* 2011:249; SANCA, 2011a:63; Van Wormer & Davis, 2008:112). The primary advantages of out-patient treatment are the lower cost factor and clients' being able to continue working while in treatment, and to continue functioning within their family environment for the treatment period. The disadvantages are that clients continue to be exposed to stressors and triggers that can stimulate cravings (McCann *et al*., 2011:249). Treatment costs are usually not covered by medical aid funds.

8.2 In-patient treatment centres

In-patient treatment, also referred to as residential treatment, is described as treatment where patients remain in a residential facility for the duration of the treatment, usually for a minimum period of 28 days (McCann *et al*., 2011:248-249; SANCA, 2011b:6; South Africa, 2008:10; Stevens & Smith, 2005:176). The primary advantages of in-patient treatment are the controlled environment, which enables regular observation and assessment of clients' progress, distance from stressors and cravings, and intensive treatment for severe cases. Disadvantages include the higher costs, although in-patient treatment is often covered by clients' medical aid funds, if available. Also, the simulated and institutionalised environment may be difficult for some clients to relate to, and they may experience feelings of vulnerability when returning to 'normal life' (McCann *et al*., 2011:248-249).

Despite the existence of in- and out-patient treatment services, the most recent report of the South African Community Epidemiology Network on Drug Use (SACENDU) indicates a lower referral rate nationwide by employers for treatment in comparison with some other sources of referral as illustrated in Table 2 (SACENDU, 2012a:2). Likewise, the source of payment indicates a similar tendency nationwide, that is, the payment rate by employers is lower in comparison with other sources of payment (SACENDU, 2012b). SACENDU reflects statistics

from all nine provinces in SA for the period January-June 2012 and includes data from both in- and out-patient treatment centres (SACENDU, 2012a; 2012b).

Table 2: Sources of referral rate (%)

Source	*WC	*KZN	*EC	*CR	*GT	*NR
Self/Family/Friends	**50%**	**36%**	**31%**	**37%**	**55%**	**43%**
Work/Employer	**5%**	**21%**	**5%**	**21%**	**11%**	**10%**
Social services/welfare	**15%**	**7%**	**4%**	**14%**	**9%**	**10%**
Health professionals (doctor/psychiatrist/nurse)	**7%**	**6%**	**56%**	**9%**	**6%**	**10%**
Hospital/clinic	**3%**	**3%**	**1%**	**2%**	**1%**	**1%**
Court/correctional services	**6%**	**2%**	**1%**	**2%**	**6%**	**4%**
Schools	**10%**	**13%**	**2%**	**15%**	**9%**	**13%**
Church/religious body	**1%**	**1%**	**<1%**	**1%**	**1%**	**1%**
Other e.g. radio	**2%**	**8%**	**<1%**	**<1%**	**2%**	**4%**
	99%	**97%**	**102%**	**102%**	**100%**	**96%**

*WC – Western Cape *KZN – KwaZulu-Natal *EC – Eastern Cape

*CR – Central Region (comprising Free State, Northern Cape, North West) *GT – Gauteng

*NR – Northern Region (Mpumalanga and Limpopo)

A discrepancy thus exists between the prevalence rate and the identification and referral rate of substance abuse problems in the workplace. See the discussion on the prevalence of substance abuse in the workplace (paragraph 4.1) and also compare the low identification rate reported by the Chamber of Mines. Furthermore, according to the UNODC (2013:10), fewer than six persons who needs treatment for substance dependency actually receives it and only one in 18 problem drug users in Africa access treatment services, predominantly for cannabis. In other words, numerous employees with substance abuse problems are neither detected nor attended to, and few employers make use of specialist treatment centres for employees.

9. TREATMENT OUTCOMES

Since employers are legally obligated to provide for counselling and rehabilitation measures before dismissing substance dependent employees, careful consideration of the cost-

effectiveness and outcomes of treatment are valid concerns. The treatment of dependency can be as successful as the treatment of other long term chronic health conditions such as hypertension, asthma and diabetes if done professionally to meet the needs of clients (Hanson *et al.*, 2009:498; Hitzeroth & Kramer, 2010:187; Van Wormer & Davis, 2008:38-39).

Successful rehabilitation (Goodman, 2007:83) depends not only on the treatment but also on clients' willingness to actively engage and commit. Retaining clients in a treatment programme for a sufficient period of time is needed to enable treatment processes to have an effect. The National Treatment Agency report (2005) on 'Retaining clients in drug treatment' in Goodman (2007:90) identifies useful best practices for retaining treatment:

- ✓ A personal touch and handwritten letters to clients will most likely motivate them to continue with treatment.
- ✓ Personal approaches, handwritten letters and phone calls will most likely improve the attendance of clients in aftercare group programmes.
- ✓ Clear messages on what the treatment programme entails and what is expected of clients in the treatment process will most likely have a reassuring effect on them. It has been found that by spending only 15 minutes on clarifying client expectations of out-patient treatment increased client returns in one study by 40%.

Findings both from 'real world' field studies and controlled clinical experiments reveal that treated clients show major reductions in substance use for at least six months after completion of their treatment programme. Evaluation results indicate improved medical and psychological functioning and substantial reduction in HIV and AIDS risk behaviours and substance-related crimes. Findings also indicate that clients who "receive more services, and particularly more professional services" exhibit the best outcomes (Miller & Weisner, 2002:42).

Slaymaker and Owen (2006:352-353) reported significant gains after in- and out-patient treatment had been implemented with employee substance abusers. Improvements between the time of treatment and one year later were reported on absenteeism and the need for disciplinary action on the job. Almost 65% of the sample continued with employment at the same employer thus indicating the investment value of treatment for employers.

The effectiveness of treatment is discussed at length by Van Wormer and Davis (2008:26-39). According to these authors, the effectiveness of treatment can be measured by evaluating the reduction in healthcare needs, the extent of lower dependence, lower crime rates and successful employment. There is evidence that substance abuse treatment reduces abuse and leads to improvements in employment, lower criminal activity, social adjustment and the better use of healthcare facilities (Stevens & Smith, 2005:355). Gossop and colleagues in

Goodman (2007:89) conducted a major research study on drug treatment in Britain, namely the National Treatment Outcome Research Study, and reported significant treatment benefits. Regarding crime rates, research on reconvictions following treatment shows a “reduction for all offences of 24% after one year, 29% after two years and 50% after five years”. Research findings further reveal “that ‘maximum’ aftercare reduced crime by 90 per cent compared to ‘minimum’ aftercare that had a 57 percent decrease” (Goodman, 2007:82,89).

However, some substance dependents are less fortunate and struggle to remain abstinent. They have difficulty in recovering – they experience repeated relapses, numerous rehabilitation admissions, numerous treatment episodes, exposure to different specialists, huge financial expenditure and little success. Hitzeroth and Kramer (2010:209) advocate the implementation of evidence-based interventions with proven track records to counteract these setbacks. These authors have compiled a list of prerequisites and guidelines for effective treatment outcomes that include a variety of interventions to ensure longer term recovery and the development of a supportive network comprising family, friends, professionals and colleagues (Hitzeroth & Kramer, 2010:209-215).

Significant treatment benefits have been reported with findings indicating that clients who receive more services, and in particular more professional services, have the best outcomes. Limitations in the success rate of rehabilitation can be countered through prevention and proactive measures, early identification and prompt referral of problems for specialist treatment. In other words, a supportive network and collaborative approach is needed between employers and treatment centres.

10. SUMMARY

This article set out to highlight the huge impact of substance abuse on the workplace, on the one hand, and the available specialist resources to deal with substance abuse problems, on the other. However, despite the havoc caused by substance abuse in the workplace, the problem often receives scant attention.

The legal demands on employers to manage substance abuse problems in the workplace include implementing counselling and rehabilitation measures before dismissal of substance dependent employees can be considered.

Employers’ dilemma is thus twofold. Firstly, employees are not permitted to work when under the influence of a substance, and, secondly, employees with substance dependency are entitled to opportunities for counselling and rehabilitation programmes. In both instances, employers face added expenses as a result of reduced production and absenteeism due to the treatment programme. Rehabilitation as the first legal obligation therefore needs to be

beneficial to both employers and employees and requires careful evaluation by employers and treatment centres.

HIV and AIDS and substance abuse entail considerable costs for employers. Given the link between HIV and AIDS and substance abuse, both these issues need to be addressed simultaneously in order to ensure successful intervention.

The workplace culture is often not conducive to combating substance abuse in the workplace, and consequently cultivation of a working environment favourable to a healthier lifestyle regarding substance use should be promoted. Awareness, education and prevention programmes should receive priority attention as indicated throughout this literature review.

EAPs as support structures in the workplace are considered an ideal source for identifying and referring substance abuse problem cases to appropriate facilities for specialist treatment. However, their inability in practice to identify substance abuse problems and to refer cases for specialist treatment are regarded as serious shortcomings. Specialist resources are available to assist employers in dealing with substance abuse in the workplace and therefore, a collaborative approach needs to be considered.

11. RECOMMENDATIONS

A situation analysis of substance abuse and the workplace should be conducted to determine the specific needs of employers in addressing substance abuse in the workplace. Also, employers' views should be explored on a collaborative approach between employers and treatment centres to combat the problem of substance abuse in the workplace.

REFERENCES

Abadinsky, H. 2011. Drug use and abuse: a comprehensive introduction. 7th ed. Belmont: Wadsworth, Cengage Learning.

Acts **see** South Africa.

Albertyn, C. & Bhoola, U. 2011. Proposed substance abuse policy and procedural agreement. (*In* McCann, M., Harker Burnhams, N., Albertyn, C. & Bhoola, U., *eds.* 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta. p. 292-324).

Anon. 2009. The naked truth statistics (SA & Global) http://www.tnt.org.za/index.php/ption=com_content&view=article&id=21&Itemid=51 Date of access: 15 March 2011.

Arkansas Small Business and Technology Development Center (ASBTDC). 2011. Arkansas drug free workplace: facts and figures about drugs and alcohol in the workplace. http://asbtdc.ualr.edu/drugfree/facts.asp Date of access: 24 February 2011.

Barnett, T. & Whiteside, A. 2006. AIDS in the twenty-first century: disease and globalization. 2nd ed. New York: Palgrave Macmillan.

Carroll, A.B. & Buchholtz, A.K. 2006. Business & society: ethics and stakeholders management. 6th ed. Mason: Thomson South Western.

Creswell, J.W. 2003. Research design: qualitative, quantitative, and mixed methods approaches. 2nd ed. Thousand Oaks: Sage Publications.

Dalton, M., Hoyle, D.G. & Watts, M.W. 2006. Human relations. 3rd ed. Mason: Thomson South-Western.

Department of Social Development. ***see*** South Africa. Department of Social Development.

Doweiko, H.E. 2006. Concepts of chemical dependency. 6th ed. Belmont: Thomson Brooks/Cole.

Eberlein, R. 2010**.** Lifestyle changes to beat addiction: a guide to drug-free living. Randburg: Knowres.

Employee Assistance Professionals Association (EAPA). 2010. EAPA standards and professional guidelines for employee assistance programs. http://www.eapassn.org/files/public/EAPAstandards10.pdf Date of access: 8 March 2014.

Fisher, G.L. & Harrison, T.C. 2009. Substance abuse: information for school counselors, social workers, therapists, and counselors. 4th ed. Boston: Pearson Education.

Goodman, A. 2007. Social work with drug and substance misusers: transforming social work practice. Wiltshire: Learning Matters.

Grobler, P., Wärnich, S., Carrell, M.R., Elbert, N.F. & Hatfield, R.D. 2006. Human resource management in South Africa**.** 3rd ed. London: Thomson Learning.

Hanson, G.R., Venturelli, P.J. & Fleckenstein, A.E. 2009. Drugs and society. 10th ed. London: Jones and Bartlett.

Hitzeroth, V. & Kramer, L. 2010. The end of addiction: a comprehensive South African guide**.** Cape Town: Human & Rousseau.

International Centre for Alcohol Policies (ICAP). 2013. Alcohol and the workplace. The ICAP BLUE BOOK: practical guides for alcohol policy and prevention approaches. Module 22. http://www.icap.org Date of access: 10 January 2013.

McCann, M., Harker Burnhams, N.H., Albertyn, C. & Bhoola, U., *eds*. 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta.

Miller, W.R. & Rollnick, S. 2002. Motivational interviewing: preparing people for change. 2nd ed. New York: Guilford Press.

Miller, W.R. & Weisner, C.M. 2002. Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum.

Parry, C.D.H. & Bennetts, A.L. 1998. Alcohol policy and public health in South Africa. Cape Town: Oxford University.

Pelser, I. 2011. ETTEx Network: the future of drug testing (e-mail). 11 February 2011.

Roman, P.M. 2002. Missing work: the decline in infrastructure and support for workplace alcohol intervention in the United States, with implications for developments in other nations. (*In* Miller, W.R. & Weisner, C.M., *eds*. Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum. p. 197-210).

Rose, S.J. & Zweben, A. 2002. Interrelationship of substance abuse and social problems. (*In* Miller, W.R. & Weisner, C.M., *eds*. Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum. p. 145-156).

SACENDU (South African Community Epidemiology Network on Drug Use). 2012a. Monitoring alcohol and drug abuse trends in South Africa (July 1996-June 2012). Phase 32. SACENDU Research Brief, 15(2), 2012. Tygerberg.

SACENDU (South African Community Epidemiology Network on Drug Use). 2012b. SACENDU Report back meetings – November 2012. Monitoring alcohol and drug trends: January – June 2012. Phase 32. Tygerberg.

SANCA (South African National Council on Alcoholism and Drug Dependence). 2011a. Out-patient treatment manual**.** SA [s.l.]: SANCA.

SANCA (South African National Council on Alcoholism and Drug Dependence). 2011b. In-patient treatment model for substance abuse: Draft 5. SA [s.l.]: SANCA National.

Segal, E.A., Gerdes, K.E. & Steiner, S. 2007. An introduction to the profession of social work: becoming a change agent. 2nd ed. Belmont: Thomson Brooks/Cole.

Services SETA. 2003a. Toolkit: managing substance abuse in the workplace. Parktown: s.n.

Services SETA. 2003b. Toolkit: employee assistance programme and the law in South Africa. Parktpwn: s.n.

Slaymaker, V.J. & Owen, P.L. 2006. Employed men and women substance abusers: job troubles and treatment outcomes. *Journal of substance abuse treatment,* 31:347-354, May.

Smith, R.L. & Capps, F. 2005. Research and contemporary issues. (*In* Stevens, P. & Smith, R.L., *eds*. Substance abuse counselling: theory and practice. 3rd ed. Upper Saddle River: Merrill Prentice Hall. p. 339-372).

South Africa. 1978. Social Service Professions Act 110 of 1978.

South Africa. 1993. Occupational Health and Safety Act 85 of 1993.

South Africa. 1993. The Compensation for Occupational Injuries and Diseases Act 130 of 1993.

South Africa. 1995. The Labour Relations Act 66 of 1995.

South Africa. 1996. Constitution of the Republic of South Africa Act 108 of 1996.

South Africa. 1997. Non-Profit Organisations Act 71 of 1997.

South Africa. 1998. The Employment Equity Act 55 of 1998.

South Africa. 2008. Prevention of and Treatment for Substance Abuse Act 70 of 2008.

South Africa. 2011. The South African Labour Guide. http://www.labourguide.co.za/workplace-discipline/code-of-good-practice-dismissal-general-461 Date of access: 24 February 2011.

South Africa. Department of Social Development. 2006. National Drug Master Plan (NDMP): Draft 2006-2011. Pretoria.

South Africa. Department of Social Development. 2010. Central Drug Authority (CDA) annual report 2010/11. Pretoria.

South Africa. Department of Social Development. 2013a. National Drug Master Plan (NDMP) 2013-2017. Pretoria.

South Africa. Department of Social Development. 2013b. Reintegration and aftercare model for substance abuse services. Pretoria.

Stevens, P. & Smith, R.L. 2005. Substance abuse counselling: theory and practice. 3rd ed. Upper Saddle River: Merrill Prentice Hall.

Substance Abuse and Mental Health Services Administration Centre for Substance Abuse Treatment (SAMSHA). 2011. Counsellor's treatment manual: matrix intensive outpatient treatment for people with stimulant use disorders. http://www.kap.samsha.go/products/manuals/matrix/index.htm Date of access: 22 July 2011.

UNODC (United Nations Office on Drugs and Crime). 2012. World drug report. Vienna: United Nations Publication, Sales No. E. 12.XI.1. http:www.unodc.org/documents/data-and-analysis/WDR2012/WDR2012web_small.pdf Date of access: 12 January 2013.

UNODC (United Nations Office on Drugs and Crime). 2013. World drug report. Vienna: United Nations Publication, Sales No. E.13.XI.6. http:www.unodc.org/secured/wdr/wdr2013/World_Drug_Report_2013.pdf Date of access: 8 March 2013.

Van Dyk, A. 2005. HIV/AIDS care & counselling: a multidisciplinary approach. 3rd ed. Cape Town: Pearson Education.

Van Wormer, K. & Davis, D.R. 2008. Addiction Treatment: a strengths perspective. 2nd ed. Belmont: Brooks/Cole.

World Health Organization (WHO). 2011. Global status report on alcohol and health. Switzerland: WHO Library Cataloguing-in-Publication Data.

ARTICLE 2: SUBSTANCE ABUSE AND THE WORKPLACE: A SITUATION ANALYSIS

Abstract

Substance abuse among the employed in South Africa (SA) has increased in recent years with major economic consequences for employers. Specialist out-patient treatment programmes are available to employers, yet few employees are inducted into these programmes. A situation analysis was conducted to explore possible reasons for this state of affairs. This article provides an overview of workplace-related limiting factors in combating substance abuse and also covers the resources needed to deal with the problem of substance abuse in the workplace. Collaboration between employers and out-patient treatment centres is presented as a viable solution.

Key words

Substance abuse, workplace, employment sector, out-patient treatment centres, networking programme

1. INTRODUCTION AND BACKGROUND TO THE STUDY

The researcher's experience as a counsellor in substance abuse with the South African National Council on Alcoholism and Drug Dependence in the Lowveld (SANCA Lowveld) provided the motivation for this research study. SANCA Lowveld is an out-patient treatment centre in Mpumalanga province. In the course of her work, the researcher became increasingly aware of the major negative impact of substance abuse on SA and more specifically on the employment sector. As employers and out-patient treatment centres are both concerned with the problem of substance abuse in the workplace, the need for collaboration between these role players in dealing with the problem seems self-evident. Yet, data provided by the South African Community Epidemiology Network of Drug Use (SACENDU, 2012a:2) reveal a lower referral rate than some other sources of referral of employees with substance abuse problems for treatment nationwide. Accordingly, a qualitative research study was conducted to find possible reasons for this phenomenon.

The study had the following framework.

- ✓ The inclusion of the Limpopo and Mpumalanga provinces as these provinces are clustered into one region for research and statistical purposes (SACENDU, 2012a:1).
- ✓ A focus on out-patient treatment as recent statistics (SACENDU, 2012b) reveal that most clients in SA receive out-patient treatment.

- ✓ The involvement of SANCA centres as they are the only registered out-patient treatment centres that provide substance abuse out-patient treatment in both the mentioned provinces.
- ✓ The involvement of employers due to their significant role in combating substance abuse in the workplace and also of employees undergoing treatment for substance abuse and dependency.

The two main 'populations' in the study were the employment sector and out-patient treatment centres in the demarcated area. For the purposes of this article, the researcher regarded 'out-patient treatment centres' as synonymous with SANCA out-patient treatment centres and used this term throughout the article. Specific references to SANCA indicate a particular context.

A situation analysis was conducted to assess (Parker & Bradley, 2007:13,17) the issues concerning substance abuse in the workplace and to explore the resources and capacities in the two populations to deal with the problem. The need for collaboration and networking between employers and out-patient treatment centres was also determined. The article ends with a recommendation for a networking programme for employers and out-patient treatment centres to deal collaboratively with substance abuse in the workplace.

2. PROBLEM STATEMENT

Statistics on the prevalence of substance abuse indicate that SA is one of the top ten narcotic and alcohol abuse centres of the world (Anon, 2009:1). An increase in substance abuse among the employed is reported in literature sources (Grobler, Wärnich, Carrell, Elbert & Hatfield, 2006:404; McCann, Harker Burnhams, Albertyn & Bhoola, 2011:45). The economic impact of substance abuse on employers is enormous and amounts to millions of rands annually in SA. Substance abuse of employees results into increased absenteeism, decreased productivity, accidents in the workplace, work errors, criminal activities at work and increase in medical expenses, all of which translate into extensive economic losses every year (Eberlein, 2010:35-36; Grobler *et al.,* 2006:400-401,404; ICAP, 2013). An estimated 60% of accidents in the workplace are substance abuse related; criminal activities and theft at work treble as a result of substance abuse; and undetected substance abuse cost employers 25% of their annual wage bill (Dalton, Hoyle & Watts, 2006:492; McCann *et al.,* 2011:48; Segal, Gerdes & Steiner, 2007:359). Substance abuse-related injuries, poor quality work performance of employees with substance abuse problems and above-average absenteeism from work, are all costs to companies (Eberlein, 2010:178-179; Grobler *et al.*, 2006:401; Parry & Bennetts, 1998:57-76).

Furthermore, the negative consequences of the link between substance use and HIV and AIDS have consistently been pointed out (Department of Social Development, 2013a:37,44; McCann *et al.,* 2011:172; Rose & Zweben, 2002:148-149; UNODC, 2012:97; Van Dyk, 2005:298). Given that companies are already encountering increased labour costs due to 37% HIV-related absenteeism (Barnett & Whiteside, 2006:264), the link with substance abuse places additional pressure on the business sector.

However, a low identification rate of substance abuse problems in the workplace occurs (McCann *et al.,* 2011:289) and very few people who need treatment for drug dependency has been reported (UNODC, 2013:10). Furthermore, SACENDU reports (2012a:2) reveal a lower referral rate than some other sources of referral of employees with substance abuse problems for out-patient treatment nationwide.

It thus appeared that numerous employees with substance abuse problems are neither detected nor attended to and that few employers make use of specialist treatment centres for employees. It was against this background that a situation analysis was conducted to explore the reasons for this phenomenon, to assess the issues concerning substance abuse in the workplace and to explore the capacities and resources in the two populations to deal with the problem. The extent of networking between employers and out-patient treatment centres was also assessed.

❖ **Overarching research question in this article**

What are the concerns and resources within the employment sector and out-patient treatment centres to deal with substance abuse in the workplace?

The sub-questions in this article

What are the problems, needs, and the resources within the employment sector to deal with substance abuse and dependency in the workplace?

What are the needs and capacities of out-patient treatment centres to assist employers in dealing with the problem of substance abuse in the workplace?

What is the extent of collaboration and networking between employers and out-patient treatment centres to address substance abuse in the workplace?

3 AIM AND OBJECTIVES

3.1 Aim

The aim of this article is to explore the concerns, needs and resources of the employment sector and out-patient treatment centres in addressing substance abuse in the workplace.

3.2 Objectives

The following exploratory and descriptive objectives (Fouché & De Vos, 2011:95-96) were pursued to achieve the aforementioned aim.

- ✓ To identify the problems, needs and resources within the employment sector regarding substance abuse in the workplace.
- ✓ To identify the problems, needs and capacities of out-patient treatment centres in the Limpopo and Mpumalanga provinces to assist employers in dealing with the problem of substance abuse in the workplace.
- ✓ To explore the extent of collaboration between employers and out-patient treatment centres to address substance abuse in the workplace.

4. RESEARCH METHODS

4.1 Literature study

The literature review was narrowed down to the problem of substance abuse in the workplace and measures to deal with the problem. Literature sources in the social work and business management field were consulted aiming at a better understanding of the extent of the problem in the workplace, the impact and demands on the employment sector, and available resources and measures to deal with problem. The literature served to indicate the relationship between the theories which emerged from the empirical study and existing theoretical knowledge, as well as to substantiate the findings (Delport, Fouché & Schurink, 2011:305).

4.2 Research design

The systematic grounded theory approach of Strauss & Corbin (Babbie, 2010:307-308; Creswell, 2013**:**83-90; Fouché & Schurink, 2011:318-320; Monette, Sullivan & DeJong, 2011:225-226) was used to generate theory based on the viewpoints of participants regarding the problem of substance abuse in the workplace. The development of a theory 'grounded' in the data provided by the participants who have all experienced the phenomenon was a key element in the approach. Long, Tice and Morrison (2006:85-86) advocate in this regard the acknowledgement of the power of grounded knowledge, and the value, as well as the utilisation of participants' life experiences to create change. The approached involved several visits to the field to conduct interviews with a large number of participants. The aim was to constantly compare and analyse the data in search of new sampling cases or contexts of interest (Neuman, 2006:406). Through the systematic collection of data and almost simultaneous analysis of the data, the grounded theory was discovered (Fouché & Schurink, 2011:319). Monette *et al. (*2011:225) refer to the continual interplay of data collection, data analysis and theory development.

4.3 Sampling

Qualitative exploratory and descriptive research (Babbie, 2010:92-93; Fouché & De Vos, 2011:95-96; Neuman, 2006:33-34) was conducted to gain insight into the problem of substance abuse in the workplace and to describe the findings accurately.

Participants from the employment sector and out-patient treatment centres were selected by means of theoretical sampling (Babbie, 2010:308; Creswell, 2013:85-86,89; Fouché & Schurink, 2011:318-319; Strydom & Delport, 2011:392) in search of pertinent data until data saturation was reached.

Participants from the employment sector included both employers and employees. Employers from the small, medium and macro businesses were involved according to the National Small Business Act 102 of 1996 (Falkena, Abedian, Von Blottnitz, Coovadia, Davel, Madungandaba, Masilela & Rees, 2011:26). Businesses engaging in high-risk and safety-sensitive occupations (McCann *et al*., 2011:70; Pelser, 2011:10) such as public transport, security institutions and construction industries, were selected due to the significant life-threatening danger to employees in the workplace and/or the public of these occupations. The NDMP refers in this regard to the occupational groups at risk (Department of Social Development, 2013a:76).

Businesses within the proximity of out-patient treatment centres were included due to cost-effective considerations. Through the constant comparative method (Creswell, 2013:86), participants from the health and safety division of the employment sector, staff members involved in HIV and AIDS counseling, an expert in networking from a non-government organisation and representatives from the chamber of commerce were subsequently included in the sample. Employees involved as clients either for out-patient treatment or in aftercare were included in the sample.

Staff members from the four out-patient treatment centres concerned participated in the study on the basis of their specialist knowledge and experience in the field of substance abuse and their service delivery to the employment sector.

4.4 Method

A situation analysis was implemented between March 2011 and June 2012. The interrelationship of the employees' problems and needs and impact on the employment sector, as well as the resources to deal with the problem was the focus of the situation analysis. Hence an ecosystems perspective focusing on gaining knowledge about the person-in-environment and an understanding of the nature of the interactions between the relevant role

players (Kirst-Ashman & Hull, 2009:280; Long *et al.*, 2006:35,42; Poulin & Contributors, 2000:4-5; Segal *et al.,* 2007:13-14,152-153).

A macro-level practice was followed involving a large number of participants from the employment sector with similar characteristics who could benefit from social services (Kirst-Ashman & Hull, 2009:9-10). The macro-level practice was approached with a strengths based perspective in mind focusing on the strengths, resources and capacities of the employers, employees and out-patient treatment centres (Poulin & Contributors, 2000:5-9; Van Wormer & Davis, 2008:17-21). Participants were considered experts in their field ─ in this case, problems of substance abuse within the workplace context and their contributions were deemed valuable in the study. Macro practice, from a strengths perspective, requires collaboration where the role of the social worker is to empower clients and establish healthier connections between people (Poulin & Contributors, 2000:4). The dual professional role of social workers working with and in the community offers multiple opportunities to initiate macro change (Long *et al.,* 2006:40). The focus in the study was to enhance the well-being of the employment sector through a collaborative process aimed at improving the social functioning of the workplace (Segal *et al.,* 2007:3,65). Macro-level social interventions were therefore focused on adjusting the gap between the needs of employers and employees, as well as on work environmental issues – service thus being the core social work value.

The grounded theory approach provided the vehicle for the theoretical frameworks, i.e., the ecosystems perspective (the interrelation between needs and strengths of the employers and employees ─ person-in-environment) and the macro-level practice with a strengths-based perspective in mind (collaboratively addressing substance abuse problems affecting the workplace).

The situation analysis comprised three phases namely the orientation phase, the data collection phase and the data analysis phase. Both the employment sector and the out-patient treatment centres were involved in the orientation and data collection phases. Permission was granted by the SANCA Mpumalanga Management Board and the Mpumalanga Employers' Organisation Management Board to gain entry to the demarcated areas. The orientation phase, data collection phase and data analysis phase are discussed next.

4.4.1 Orientation phase

During the orientation phase the research study was introduced to and discussed with the four out-patient treatment centres; action plans for the implementation of the study were jointly developed and agreements regarding participation in the study were reached. A staff member from each out-patient treatment centre was recruited to assist the researcher in coordinating the study in his/her specific site. These staff members, called site coordinators, were

individually orientated on their roles and responsibilities. The site coordinators were consistently involved in the planning of the study and implementation of the situation analysis process.

Key informants from two Employers' Organisations in Mpumalanga also assisted in the preliminary planning of the study, formulation of the criteria for the selection of employer participants, the identification of potential employer participants, as well as initiating contact with employers.

Orientation discussions were conducted individually with 47 participants (40 employers and/or management staff members and 7 employees) from the employment sector to introduce and discuss the action plans for the implementation of the study and to ensure participation in the study. On completion of the orientation phase 29 participants from the employment sector (22 employers and/or management staff members and 7 employees) indicated their willingness to participate in the data collection phase. Informed written consent was obtained from participants from the employment sector, as well as the staff members from the four out-patient treatment centres concerned after completion of the orientation phase.

SANCA Polokwane experienced problems in identifying employer organisations and employers in their area for involvement in the study.

4.4.2 Data collection phase

During the data collection phase, qualitative interviews (Babbie, 2011:318-326; Boyce & Neale, 2006:3; Greeff, 2011:351-352,360-361; Welman, Kruger & Mitchell, 2010:197-202) were conducted – face to face interviews with the 29 representatives from the employment sector and focus group interviews with the staff members concerned from each of the three out-patient treatment centres in Mpumalanga. Although SANCA Polokwane from Limpopo province was involved in the group orientation discussions, they experienced serious financial constraints at the time and were compelled to withdraw from the research study. This treatment centre was therefore not involved in the data collection phase. The interviews were conducted by means of semi-structured interview schedules (Greeff, 2011:351-353,369-370) and the problems, needs and the resources to deal with substance abuse and dependency in the workplace were assessed, as well as the extent of collaboration between employers and out-patient treatment centres to address the problem in the workplace.

4.4.3 Data analysis

In accordance with the grounded theory approach, the data was systematically analysed (Braun & Clarke, 2006; Creswell, 2013; Fouché & Schurink, 2011; Monette *et al.,* 2011) in three stages of coding, i.e. open, axial and selective coding. During the open coding stage,

the data from the audio recordings, field notes and transcripts from the individual and focus group interviews were examined and re-examined in search of the major themes. The data collected from the individual interviews and focus groups were first broken down into codes and sub-codes. The different codes were then sorted into potential themes and sub-themes. The data from the employment sector and out-patient treatment centres were separately analysed into two sets of data with themes and sub-themes - data set 1 derived from individual interviews and data set 2 from the focus groups. These two sets of data were then consolidated to present the main themes and sub-themes. Although 29 individual interviews were conducted, data saturation (Creswell, 2013:89; Fouché & Schurink, 2011:319) was reached after the data of 20 participants were analysed which negated the need for inclusion of the remaining nine. Data analysis and the data saturation were verified by an independent analyst (co-coder).

A member-checking meeting (Botma, Greeff, Mulaudzi & Wright, 2010:231-232; Creswell, 2005:252; Ellingson, 2009:42) was conducted with participants from both populations with the purpose to share information on the research findings and to engage the participants in feedback. Feedback from the member-checking meeting is integrated in the research findings on the related themes. The aim of the member-checking process was to enhance the credibility of the data analysis (Botma *et al.,* 2010:231,232; Creswell, 2005:252; Ellingson, 2009:42).

4.5 Trustworthiness

Trustworthiness was established through consistency by creating a transparent step-by-step audit trial and by using a co-coder; truth value (regular peer discussions with site coordinators and research mentors for reflexivity purposes) and member checking; applicability (different categories of sampling groups and data saturation); neutrality as the experiences of the participants were considered and authenticity through the ample use of direct quotations (Babbie, 2010:307-308; Botma *et al.,* 2010: 232-234; Creswell, 2005:252; Ellingson, 2009:42).

4.6 Ethical considerations

Ethical approval for conducting the research study was obtained from the North-West University (No. NWU-00125-11-51). The researcher strived to adhere to the Code of Ethics outlined in Kirst-Ashman and Hull (2009:406-4210), Long *et al. (*2006:252-253,258-271), Poulin and Contributors (2000:21-23), Segal *et al.* (2007:464-483), South African Council for Social Service Professions (2012) and Strydom (2011:115-129). Ethical responsibilities such as responsibilities to clients, colleagues, the social work profession, the employment sector (representing the broader community), as well as those responsibilities pertaining to professional conduct, were taken into consideration. These ethical responsibilities were based

on the following core values: service; social justice; dignity and worth of each person; confidentiality; the importance of human relationships and collaboration; competence and integrity.

Permission was obtained from the SANCA Mpumalanga Management Board and the Mpumalanga Employers' Organisation Management Board to gain entry to the demarcated areas. Written informed consent was obtained from all the participants and their right to withdraw from the study at any time was explained to them.

Measures were implemented to ensure the confidentiality of the information provided by the participants. Participants were assured of the ethical conduct with regards to confidentiality. This was also stipulated in the written consent. One of the macro-businesses required an additional formal written confidentiality agreement signed by the Director of the School of Psychosocial Behavioural Sciences from the NWU (Potchefstroom) and all relevant participants, including the researcher. Coordinators from the out-patient treatment centres were also orientated on confidentiality matters during their induction programme.

The interviewing protocol was thoroughly explained to all participants and the role of the participants and the researcher was discussed. Permission was obtained from participants to use audio tape recordings during the individual and focus group interviews.

Time was allowed after the individual and focus groups interview for debriefing sessions to clarify any misunderstandings. The participants were, however, often not available for these sessions due to their extreme time constraints. The researcher arranged regular electronic follow-up with the participants to promote open communication channels and to provide feedback to the researcher as alternative to the debriefing sessions.

Interviews (individual and focus groups) were recorded on Dictaphone and transcribed verbatim. All transcripts and records will be stored in the archive allocated for the School of Social Work at the NWU (Potchefstroom) for a period of 5 years.

5. RESULTS

The data analysis process produced three main themes regarding the concerns, needs and resources of the employment sector and out-patient treatment centres in addressing substance abuse in the workplace. The following main themes were identified: limiting factors experienced in addressing the problem of substance abuse in the workplace, which at the same time indicated problem areas; needs identified in dealing with the problem of substance abuse in the workplace; and strengths identified in support of the process of combating the

problem of substance abuse in the workplace. Each theme is discussed separately here in relation to the identified sub-themes. The relationship between the data that emerged from the empirical study and existing theoretical knowledge is also indicated. The themes and related sub-themes are shown in Table 1.

5.1 Themes and sub-themes

Table 1: Situation analysis - Themes and sub-themes

THEMES	SUB-THEMES
1. Limiting factors - substance abuse in the workplace	**1.1 Ignorance of substance abuse problems** *Ignorance of substance abuse prevalence in the workplace *Ignorance of the consequences of the link between HIV/AIDS and substance abuse *Ignorance of treatment benefits as an alternative to dismissal *Ignorance of workplace policies **1.2 Unsupportive workplace environment** * Negative attitudes of employers and colleagues towards employees with substance abuse problems * Insensitivity towards substance abuse problems * Dysfunctional support structures in the workplace **1.3 Underutilisation of out-patient treatment centres**
2. Needs - substance abuse problems in the workplace	**2.1 Clear workplace policies on substance abuse** **2.2 Supportive workplace environment** **2.3 Mobilisation of specialist treatment services** ***** Prevention of substance abuse in the workplace * Assessment of the needs in the workplace regarding substance abuse problems * Treatment services for dealing with substance abuse in the workplace * Networking between employers and out-patient treatment centres * Professional conduct from out-patient treatment centres
3. Strengths - to deal with substance abuse in the workplace	**3.1 Employers complying with legislative requirements** **3.2 Existing substance abuse workplace policies and procedures** **3.3 Supportive workplace environment** **3.4 Existing external resources for dealing with substance abuse** **3.5 Positive treatment outcomes**

5.1.1 Theme 1: Limiting factors - substance abuse in the workplace

The following sub-themes with regard to the limiting factors were identified: ignorance of substance abuse problems, an unsupportive workplace environment regarding substance

abuse problems and underutilisation of out-patient treatment centres in dealing with the problem.

Sub-theme 1.1: Ignorance of substance abuse problems

❖ **Ignorance of substance abuse prevalence in the workplace**

Most of the participants reported that substance abuse problems existed in the workplace, that members of management seemed to consume the most alcohol and that some employers themselves experienced substance abuse or dependency problems. However, the extent of the problem was unknown, and most of the employers stated their unawareness of needs regarding the combating of substance abuse in their businesses. Only a few substance abuse cases were identified annually and referred for treatment.

The employers expressed their views as follows:

> *"There is definitely a problem. I just don't know how big the problem is."*

> *"There are one or two substance abuse cases every year in the business."*

> *"My senior management are drinking the most! I don't want to fire all my top management!"*

The viewpoint of a treatment centre on the reasons for the infrequent referrals:

> *"Employers don't refer. Employees don't come, they don't seek help from the employers. They scared to tell the employers 'I'm having a problem with alcohol' because they are scared to lose their jobs. I guess it's a lack of knowledge, all around from the employee to the employer. So we need to educate our employers what is the right thing to do."*

These findings are in line with current literature regarding the discrepancy between the prevalence and referral rates of substance abuse cases. An estimated 5-35% of employees are dependent drinkers and approximately 7-20% probably have drug problems (Eberlein, 2010:32; Grobler *et al*., 2006:401; Hitzeroth & Kramer, 2010:37-38; McCann *et al.,* 2011:45). Yet, lower referral rates of employees with substance abuse problems for treatment have been reported nationwide, as well as in the Limpopo and Mpumalanga provinces (SACENDU, 2012a:2; 2012b:28). A low identification rate of employees with substance abuse problems has also been identified (McCann *et al*., 2011:289). For instance, the South African Chamber of Mines revealed an estimated identification rate of 1% of substance abuse which occurs mainly at hospitals where employees have been referred for reasons other than substance

abuse problems. Also, according to the UNODC (2013:10), a limited number of people who needs treatment for substance dependency actually receive it.

- **Ignorance of the consequences of the link between HIV and AIDS and substance abuse**

Although many companies implement HIV awareness programmes, most of the employers in the study were unaware of the negative consequences of the link between substance use and HIV and AIDS. Participants from the employment sector were also unaware of resources that can show the interrelatedness between HIV and AIDS and substance abuse.

The following statement from an employee reflects the limited focus on substance abuse:

> *"Very little is done to promote substance abuse awareness in our company…the company mainly focuses on HIV awareness campaigns."*

Literature sources consistently highlight the negative consequences of the link between substance use and HIV and AIDS (Department of Social Development, 2013a:37,44; McCann *et al.,* 2011:172; Rose & Zweben, 2002:148-149; UNODC, 2012:97; UNODC, 2013:ix; Van Dyk, 2005:298). Given that businesses are already contending with increased labour costs due to 37% HIV-related absenteeism (Barnett & Whiteside, 2006:264), it is evident that the link between substance use and HIV and AIDS is placing huge additional pressure on the business sector.

- **Ignorance of treatment benefits as an alternative to dismissal**

Some of the employers reported that legal requirements and demands on employers to consider rehabilitation in the event of substance abuse behaviour placed considerable additional pressure on them. Dealing with substance abuse problems was considered time consuming and not a priority by most of the employers in the study. Production and profits were regarded as the main priority. Limited awareness of the benefits of treatment and counselling as alternatives to dismissal was also evident. Some employers were misinformed about the legal requirements regarding substance abuse incidents in the workplace:

> *"The law says...fire them...fire them if they are drinking."*

> *"The employer carries the most risks if employees are drinking! I haven't got time to deal with the problems. Money is the business."*

A comment from a treatment centre:

> *"By retrenching the employee with substance abuse problems, or having vague reasons to get rid of him, that will not help. We can rather network ways of how you can keep the employee so that you don't need to*

constantly re-employ and train new employees…this is the way how you can keep the employee and still get help for his problem."

A particularly vulnerable group seemed to be the unskilled labour workers. Most of the employers reported that replacing skilled workers was more difficult due to their scarce skills and expertise than replacing unskilled labour workers due to the wide availability of unemployed labour workers. Some of the employers expressed a greater willingness to refer skilled workers for substance abuse treatment in order to retain them.

Some of the interpretations of the legal requirements to manage substance abuse in the workplace are in conflict with requirements from The Labour Relations Act 66 of 1995 (Acts see South Africa). The said Act stipulates that the employer has to provide opportunities for counselling and rehabilitation for substance abusers before dismissal is considered. The South African Labour Guide (South Africa, 2011:1-3) also states that alcoholism and drug dependency are considered kinds of incapacities and not misconduct and that dismissal for unsatisfactory performance due to incapacity should be considered only after appropriate counselling and rehabilitation steps for employees have been implemented.

❖ **Ignorance of workplace policies**

Some of the employees stated that policies on substance abuse in the workplace were unclear while others reported that there were no workplace policies at all in this regard in their businesses. In some cases workplace policies are masking the problem such as a policy of zero tolerance. A comment from a treatment centre in this regard:

"So the employee will rather be absent from work than going to work and get caught and be fired. They stay away on the pretext that they're sick."

Grobler *et al.* (2006:403-404) and McCann *et al.* (2011:211) reiterate the importance of clear policies and procedures for dealing with substance abuse and dependency in the workplace. The negative impact of substance abuse on the workplace and the legal obligations imposed on them have forced employers to develop workplace policies and practices to deal with the problem. Grobler *et al.* (2006:403-404) and McCann *et al.* (2011:211) refer specifically to the importance of clear policies and procedures for dealing with substance abuse and dependency in the workplace. Various policies have been implemented in SA to deal with substance abuse, especially with regard to alcohol problems and, to a lesser extent, to the problem of illicit substances. However, according to the NDMP (Department of Social Development, 2013a:59-60) few drug-related policies have been implemented effectively in SA.

Sub-theme 1.2: Unsupportive workplace environment

- **Negative attitudes of employers and colleagues towards employees with substance abuse problems**

Negative attitudes identified in the workplace included resistance to and a lack of interest in the problem of substance abuse, as well as in finding a solution to the problem, or disregarding or condoning the problem. The stigma attached to substance dependence was identified as a problem resulting in colleagues covering for or protecting each other, and/or problem employees concealing their own substance abuse problems. Conversely, some of the participants mentioned reversed stigmatisation and the social endorsement of drinking:

"*You are excluded if you do not drink."*

The following comments illustrate some of the negative attitudes. An employer said:

"The workplace is not a Rehab Centre. I need to make money."

An employee in treatment said:

"Others take the opportunity they have, the information they have to laugh at you and degrade you."

The following study (McCann *et al.*, 2011:22) exemplifies the indifference towards substance use in the workplace. The study, an American study of 1 300 railroad workers, revealed a collective awareness of alcohol problems among the employees, yet few workers were willing to report cases of alcohol abuse. Over a period of a year, 36% of the employees had seen co-workers drunk on duty; 15% had experienced co-workers who were too drunk or had too severe a hangover to work; and 60% said they had worked harder to cover for drunken co-workers. Only 14% of the co-workers were willing to report alcohol-abusing colleagues if they caused serious damage, and 7% of the co-workers said that they would not report a colleague at all, even if someone were killed as a result.

- **Insensitivity towards substance abuse problems**

A lack of sensitivity regarding high-risk situations was identified, for example employees involved in rehabilitation programmes were often expected to manage work functions where alcohol was served, and they were actually expected to serve the alcoholic drinks. The employee participants perceived this as a sign of either ignorance or insensitivity. Encouraging substance use was also identified as a problem, for example providing free alcoholic drinks at work functions and annual events, and holding regular Friday after-work social functions where

liquor was available. A lack of encouragement for and acknowledgement of employees' successes in treatment was reported, leading to feelings of discouragement and demotivation.

Employees said:

> *"The session when we were acknowledged for completing the treatment programme – I was so proud...my employer did not even know about the ceremony. I don't think they realise the importance of such an event in our lives."*

> *"The employer should not expect of employees in rehab to arrange work functions where drinks are served, or expect us to actually serve the drinks."*

> *"They say: 'He's going to fail in the programme. He's going to go back and drink again.' Some are still encouraging me to join them in their drinking activities. You have to fight this thing alone."*

The viewpoint of a staff member from a treatment centre**:**

> *"Big damage is done at work-parties where alcohol is provided for free. I see a big preventative role for us…to make the employers aware of the negatives of such a culture. I saw something in the paper the end of last year…an employer said he wanted to give a year-end function without alcoholic drinks. He did…and it was successful."*

❖ **Dysfunctional support structures in the workplace**

Limited confidence was expressed in the ability of employers to deal with the problem of substance abuse in the workplace. Also, some wellness assistance programmes in the workplace were not experienced as functional or supportive of employees in treatment. Employee Assistance Programmes (EAPs) were acknowledged as support structures, yet they were not perceived as professional treatment sources.

The significance of sound workplace substance abuse management programmes is highlighted in the NDMP (Department of Social Development, 2013a:129). The importance of awareness among employers and employees about the benefits of a drug-free workplace, i.e., superior customer service, higher employee morale, increased productivity, reduced staffing costs and reduction in employee theft is emphasised. An appeal is made in the NDMP (2013-2017) for partnerships between the government and the public sector to implement comprehensive, ethical and sound workplace substance abuse programmes (Department of

Social Development, 2013a:129). However, according to the NDMP, South Africa lags behind international standards to manage employee substance abuse as part of occupational health, safety and risk management programmes.

Moreover, few businesses in the study had EAPs with the exception of some of the macro-businesses. Substance abuse problems were dealt with mainly by the employer or staff members responsible for human resource management. Participants from the employment sector mentioned that some of these staff members were not capable of dealing with substance abuse in the workplace or motivating employees to join treatment programmes when necessary. An unwillingness on the part of employees to acknowledge substance abuse problems or become involved in treatment programmes was observed.

Another impediment mentioned by staff at the treatment centres was that corporate time frames for treatment often did not correlate with actual and realistic time frames. It was also mentioned that employers were not always prepared to accept relapses, which then frequently resulted in immediate dismissal.

An employer said:

> *"I want value for my money…so the employee needs to be rehabilitated as soon as possible...and sometimes the rehabilitation process is continuing time after time…and still the person has not been rehabilitated."*

A comment from an employee in treatment:

> *"Unfortunately now, for now, there is no one really who has an understanding of what this programme entails. I normally keep to myself, because you know, you don't trust them, except a very few. There are very few of those who might seem to understand you, but then later on it becomes negative too… it has a negative impact, for the person cannot keep confidential issues if you have that kind of a problem."*

Although EAPs are regarded as key in dealing with substance abuse and dependency in the workplace (Dalton *et al.,* 2006; Grobler *et al.,* 2006; McCann *et al*., 2011; Roman, 2002; Services SETA, 2003a) limiting factors in EAPs have also been identified. An inherent inability of EAPs to identify employees with drinking problems has been pointed out. McCann *et al. (*2011: 289) refer to possible reasons for this limitation namely that most problem drinkers are not easily detected, reduced work performance often develops gradually and is not easily

measurable, and the signs and symptoms of substance abuse problems are less visible among low-to-moderate drinkers than those of dependent drinkers.

According to Roman (2002:207-208), successfully addressing the problem of substance abuse in the workplace requires attention to the following measures: training needs to be provided to EAP staff in the basics of substance abuse intervention; workplace personnel need to refrain from endeavouring to bring about behaviour change in substance abuse employees; and such employees need to be referred to appropriate specialists for treatment.

Grobler *et al*. (2006:403) maintain that training of EAP staff in the early identification of substance abuse problems, as well as in referrals to an appropriate treatment facility at the earliest possible stage, will deliver better end results.

Sub-theme 1.3: Underutilisation of out-patient treatment centres

Most of the employers in the study were unaware of the external resources that could be utilised to deal with substance abuse in the workplace. The limited visibility of out-patient treatment centres and the lack of feedback to employers on treatment progress were identified as possible reasons for the few referrals of employees for treatment. The unsupportive workplace culture and negative attitudes were also perceived as possible reasons for the underutilisation of specialist treatment resources.

The participants from the employment sector expressed the following views in respect of this sub-theme.

> *"Our (employer's) knowledge of SANCA is extremely limited."*

> *"We're bluffing ourselves if we think that everybody knows about SANCA."*

Staff members from the treatment centres said:

> *"The business people need our services, there's no doubt about that, for the sake of their productivity. But we haven't taken initiative. Our marketing strategies are not vigorous enough. They won't come to SANCA… they haven't got time for that. What is key to them, is their productivity. We need to go out and market ourselves."*

5.1.2 Theme 2: Needs - substance abuse problems in the workplace

Most needs regarding combating substance abuse in the workplace were also identified as limiting factors and were related to workplace policies, workplace environment in respect of substance abuse and mobilisation of specialist resources to assist employers in dealing with the problem. The interrelatedness between the identified needs and the limiting factors was evident.

Sub-theme 2.1: Clear workplace policies on substance abuse

A need was expressed for clear workplace policies and procedures on treatment issues such as payment of treatment fees, time-off allowed from work for treatment sessions, support structures in the workplace to assist problem employees in the reintegration process, and constant monitoring and evaluation of treatment progress. Limiting factors with regard to workplace policies in this respect have already been discussed under Sub-theme 1.1. Participants considered benchmarking with different employers as an ideal opportunity to enhance workplace policies on substance abuse in the workplace.

An employer's comments on benchmarking:

> *"It will be interesting to benchmark with other companies on the empathy level – how far will your company support somebody with dependency problems? We need to share with each other best practices of how we are dealing with the problem. What about time off, or special leave, or maybe sick leave. In this way we can compare our own policies and procedures…and maybe we are not so far behind, or maybe we need a change. We need to think out of the box."*

Sub-theme 2.2: Supportive workplace environment

An unsupportive workplace environment was earlier expressed as a major limiting factor. Questions were asked as to whether employers were truly concerned about the problem in the workplace:

> *"Is the problem really considered to be serious enough – or do we wait until it's a crisis and then we want to run to SANCA?"*

The employees expressed a strong need for a caring and sensitive environment for employees with substance abuse or dependency problems. A concerned workplace, consistent dissemination of information from management on the seriousness of the problem of substance abuse and information on alternative solutions to the problem were considered evidence of a supportive workplace environment. As part of a supportive workplace culture, the employees in the study expected the management team in a business to be trustworthy and appropriately equipped to deal with the problem. A need was also expressed for encouragement for employees during the rehabilitation process, as well as for acknowledgement of successes.

McCann *et al*. (2011:228-237) discuss at length the need to change the workplace environment if it in any way condones or encourages alcohol abuse. These authors recommend 'treating the company' before attending to the problems of employees.

'Treatment' of a company involves changing possible resistance to a substance abuse workplace policy; education of the entire workforce including management, employees and shop stewards; assessment of the problem as well as its causes; implementation of different solutions including disciplinary measures; and the involvement of external service providers such as social workers.

Sub-theme 2.3: Mobilisation of specialist treatment services

- **Prevention of substance abuse in the workplace**

  Throughout the situation analysis, prevention was identified as a key priority requiring attention, and this was reiterated at a member-checking meeting. The key role of the employer has also been emphasised by a treatment centre:

> *"If the employer can understand his role in the whole rehab process that would be fantastic. I see the role of the employer as very crucial in the patient's awakening that alcohol and drugs are bringing problems."*

The call for prevention measures is strongly supported by literature. Prevention is regarded as a priority measure to combat substance abuse and a key change in the new NDMP (Department of Social Development, 2013a:86-87). The NDMP (Department of Social Development, 2013a:50-51) indicates a significant shift from a supply reduction approach to one of primary prevention. Substance abuse prevention is described by McCann *et al*. (2011:278) as activities aimed at preventing or delaying the onset of substance abuse problems and subsequently increasing the treatment success rate. The workplace is regarded as the ideal environment to disseminate prevention messages on substance abuse (McCann *et al.*, 2011:276). Raising awareness among employees of the impact of substance abuse on the workplace performance has been indicated as a successful measure to improve worker safety and to increase productivity (ASBTDC, 2011:2). Estimates indicate that 60% of workplace problems are caused by moderate to occasional substance abusers (Dalton *et al.*, 2006; McCann *et al.,* 2011:289; Segal *et al.,* 2007), which further stresses the unqualified importance of preventative measures in the workplace.

- **Assessment of the needs in the workplace regarding substance abuse problems**

Assessment of needs on different levels was requested, that is, assessment of the extent of the problem of substance abuse in the workplace; assessment of employees' needs with regard to the problem and assessment of the capacities of employers to deal with the problem. The importance of individualised services to meet the needs of employers, as well as of employees, was consistently mentioned.

One employer reported:

> *"You know, 90% of my workers are illiterate. You cannot just walk into the workplace and try to tell them about the negative consequences of substance abuse! You need to meet them in the field. You need to use visuals. They need to understand the message and how they could benefit. And they need to provide feedback on how they experienced your services."*

A member from a treatment centre on assessment:

> *"Sometimes the businesses are not even aware of their own needs. We can come and say 'guys, we went through your profile, your history, this is what we think we can offer."*

Literature sources support the importance of assessment and point out that assessment is key to effectively determine the nature of client needs in order to individualise treatment services and provide essential information on resources and support systems (Kirst-Ashman & Hull, 2009:29,31; Parker & Bradley, 2006:13,17; Segal *et al.,* 2007:67). With regard to the individualisation of needs, the needs, wants, perceptions, preferences and satisfaction of clients should be studied systematically so that organisations can act on this information. Andreasen and Kotler (2008:38-41) refer in this regard to organisations (out-patient treatment centres) that should make every effort to identify and meet the needs of their clients within the constraints of their budgets.

❖ **Treatment services for dealing with substance abuse in the workplace**

A need for information and awareness programmes on the nature of treatment was expressed. Employers asked questions in terms of treatment issues such as:

> *"What does treatment mean? What will it cost the employer? Why not mobilise sponsors for the implementation of the treatment programme?"*

Out-patient treatment centres expressed the importance of early identification and early intervention before the development of substance dependency. The identification of substance abuse trends in the workplace was considered very important to enable employers to respond proactively and refer problem cases quickly. Train-the-trainer programmes to deal with the issue of substance abuse in the workplace were suggested – these programmes could form part of skills development in the Broad Based Black Economic Empowerment (BB BEE) social programmes. Involvement in such programmes could have mutual financial benefits for the employment sector, as well as out-patient treatment centres. The out-patient treatment centres also stressed the need for the development and implementation of relapse prevention

programmes. Employers preferred an outcome-based method of treatment and, of course, positive treatment results. Most of the employers expressed a need for positive out-comes:

> *"I want success stories."*
> *"We need a clear before and after picture."*
> *"I want to see a difference…results."*

The supportive role of out-patient treatment centres was also expressed by an employer:

> *"SANCA will be my refuge…I will know that there's a plan B…a friend for the employer to phone."*

An out-patient treatment centre's views on the identification of trends:

> *"As an organisation, we must go out as part of the networking to research in terms of the services and the needs. But through our research, you know, we could alter the programme which could address those needs that even the business wasn't aware of."*

Literature sources substantiate the findings that services should include empowerment of the workforce by means of education programmes including information on early identification and early intervention to better results. Grobler *et al*. (2006:403) argue that the treatment success depends heavily on early diagnosis, as well as early intervention. McCann *et al.* (2011:231-235) discuss at length the importance of education of key role players, as well as the whole workforce on substance abuse in general. Eberlein (2010:208-215) refers to the 95% solution in the treatment process depending heavily on proper aftercare, as well as the involvement of significant role players such as employers during this phase. Hitzeroth and Kramer (2010:114-115) and McCann *et al. (*2011:256-257) reiterate the importance of regular visits to treatment counsellors and regard aftercare as an essential component of substance abuse treatment.

Remaining sober and being reintegrated in the community are extremely difficult (Eberlein, 2010:212). Service users require reintegration services, including relapse prevention, to enable them to maintain sobriety; these services play a major role in their lives after completion of the treatment programme (Department of Social Development, 2013b:8). To maintain sobriety and prevent relapse, the following services and measures are suggested: a recovery plan; reintegration plan; life style changes, including improvements in health, social and legal status, stable marital relationships and support groups (Department of Social Development, 2013b; Eberlein, 2010:215-220; Fisher & Harrison, 2009; Hitzeroth & Kramer, 2010:190-191; Van Wormer & Davis, 2008:30-31). An individual reintegration plan should be developed for each service user and should include the activities, services and resources necessary for continued sobriety, including the support of the employment sector.

❖ **Networking between employers and out-patient treatment centres**

Participants from the employment sector considered networking between the employment sector and treatment centres, awareness raising and the increased visibility of out-patient treatment centres essential to increase the utilisation of such centres. A team approach was also highlighted. Participants identified different core components of a networking programme which included a clear purpose to establish the programme, clarity on the characteristics of such a programme and the procedures to follow in order to establish the programme. Foreseeably, increased corporate involvement due to the marketing of treatment centres will lead to a proportional increase in referrals. Participants from the out-patient treatment centres stressed that whether out-patient treatment centres will be able to deal with an increase in traffic, or not, will depend on their infrastructure and capacity.

A comment from an employer on networking included the following:

> *"I think our company's knowledge about SANCA is extremely limited…I'm looking forward to meet with them and find out what they can offer and what their capacities are."*

One of the employers described the importance of teamwork in the networking process:

> *"We are working in a circle…the circle must be a circle… we must be on the same line, otherwise the line will break…the circle will not be a circle anymore."*

Pierson and Thomas (2010:360) describe networking as "the process of linking together individuals, groups and/or communities with common interests in order to spread information, knowledge, resource sharing, and mutual support". The assumption is that networking would increase capacities to solve social problems, meet organisational or individual challenges and promote a general aim. Dalton *et al.* (2006:407) refer to networking as a process by which moral support is gained and important information is gathered in areas outside of one's own expertise through the development of external and internal contacts.

The purpose of networking is described by Kirst-Ashman and Hull (2009:85-86) as attempts by social workers to "strengthen or develop linkages among people, groups, or other organizations" in order to connect clients to resources. In other words, with regards to the linkages between employers and out-patient treatment centres, networking is considered a means to connect the employees experiencing substance abuse problems to the treatment resource which in return holds benefits for the employer. Weyers (2011:143) stresses the importance of effective communication between the people in the network and the cultivation of meaningful relationships to ensure successful networks.

❖ **Professional conduct expected from out-patient treatment centres**

The employers stressed the importance of professional conduct from out-patient treatment centres without mentioning, though, reciprocal commitments on their part. They expected out-patient treatment centres to respect employers' time, deliver quality services, honour commitments, focus on service delivery, provide regular feedback on the progress of treatments and ensure sustainable relationships between themselves and employers.

Expectations from one of the employers in terms of professional conduct:

> *"You must know your boundaries. Don't be prescriptive. And don't manipulate the employer to accept your ideas and services…don't impose a guilt trip."*

Participants from the treatment centres on professional conduct:

> *"The employer must also be consistent for what they're expecting. If they say our workshop starts at 10:00…sometimes half past eleven there's still nobody. When they want our services, they must be there. It must go both ways…from us and from our partners. It's a two-way street."*

With regards to professional conduct, social workers are directed by the Code of Ethics of the South African Council for Social Service Professions (SACSSP) regarding the ethos of the profession, professional conduct and quality service delivery (SACSSP, 2012). Reference is also consistently made in literature sources to the core values of service, dignity and respect for the worth of the individual, importance of human relationships, and integrity and competence (Greenfield, 2001; Long *et al.,* 2006; Poulin & Contributors, 2000; Strydom, 2011). Considering the importance of team work mentioned earlier, reciprocal professional conduct, respect and honouring of commitments are essential to ensure successful networking.

5.1.3 Theme 3: Strengths to deal with substance abuse in the workplace

During the situation analysis, various strengths for dealing with the problem of substance abuse in the workplace were acknowledged, although by only a few of the participants. These strengths included compliance with legal requirements for counselling and treatment of substance abusers, the existence of workplace policies and procedures for addressing substance abuse, the existence of a supportive workplace environment to deal with substance abuse problems, the existence of external resources to support the process of combating the problem more effectively, and the existence of positive treatment outcomes. These strengths were aligned with a strengths-based approach that built on the strengths and resources of clients (Poulin & Contributors, 2000:4-7,25; Van Wormer & Davis, 2008:17). The above-

mentioned strengths, ironically, were also identified by most of the participants as limiting factors and needs.

Sub-theme 3.1: Employers complying with legislation requirement

Testimonies of employees indicated that few employers considered treatment before dismissal. Some of the employers were willing to support problem employees, especially those who had credible and longstanding work records, as well as those who were willing to cooperate with the treatment process. Such employees were more readily trusted and successfully reintegrated into the workplace.

The following comments from some of the employees indicated tolerance on the part of the employer:

> *"Management has been generous with me – this is my second treatment attempt – I should have been fired."*
> *"When management sees that you have a substance abuse problem, they speak to you about being referred for help. They assist you to get help like they did for me; it's like a second chance before they consider dismissal. I feel what they are doing now is enough."*

Several South African Acts stipulate labour requirements for dealing with substance abuse and dependency in the workplace and emphasise the obligations of employers, as well as employees in this regard. The legal obligations of employees and employers are stipulated in the Occupational Health and Safety Act (85 of 1993), the Compensation for Occupational Injuries and Diseases Act (130 of 1993), Labour Relations Act (66 of 1995), and the Employment Equity Act (55 of 1998). Employers are legally obligated to allow for treatment and rehabilitation of employees with substance abuse and dependency problems resulting in poor work performance before dismissal is considered.

Carroll and Buchholtz (2006:545) support the treatment of employees with substance abuse problems and state that it is "better to help the troubled employees than to discipline or discharge them…recovered employees are better employees".

Sub-theme 3.2: Existing substance abuse workplace policies and procedures

Some of the participants mentioned the existence of protocols and policies for problem identification, referral procedures, measures to assist employees with substance abuse problems, and monitoring of treatment progress.

A comment from an employee in treatment:

> *"Our Employee Wellness officer is situated in Johannesburg, which is almost 400 km from my local workplace. My case was promptly dealt with in the system, but I preferred to approach the local out-patient treatment centre because of private and practical reasons. And I was 'so out of it' that I never thought of any other alternative. My employer respected my request. The procedures were clear."*

This viewpoint from the employee is supported by literature resources. Guidelines on substance abuse workplace policies are available and the supportive role of such policies are clearly indicated by Albertyn and Bhoola (2011:292-324), Grobler *et al. (*2006:403-404) and Services SETA (2003b:41-42).

Sub-theme 3.3: Supportive workplace environment

Internal support structures such as EAPs and health and safety divisions to assist employees with substance abuse problems were regarded as strengths in the workplace as was collaboration between employers and employees on problem identification and solutions. Other essential strengths were the encouragement for employees to sign up for treatment, support for them during the rehabilitation process, prompt follow-up of problem cases by management, an open and non-judgemental attitude to employees with substance abuse problems, and support from colleagues in the reintegration process after treatment.

Some comments from employees:

> *"My immediate supervisor was exceptionally supportive and I had an intensive and in-depth 'fact-finding discussion' with him. The strong support from some of my colleagues and managers was maybe because I'm employed for 17 years with this company. And I have a credible work track record."*

> *"Strict monitoring by management from the onset is extremely valuable and helps me not to relapse."*

Sub-theme 3.4: Existing external resources for dealing with substance abuse

External resources such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and SANCA were acknowledged as valuable external support structures for employees with substance abuse problems. The out-patient treatment centres involved in the study reported that they provided holistic, structured and evidence-based treatment programmes. This was substantiated by participants from businesses in the employment sector that had relationships

with out-patient treatment centres. Where applicable, treatment centres were given due credit for their cultivation of positive relationships with employers. According to one of the employees:

> *"SANCA is the main source in the community to help with substance abuse problems."*

Some viewpoints from treatment centres on the services that they can offer:

> *"The employment sector will get value for their money because we are experts…and we are reliable…we are available…and we've got knowledge…and something that's critically important is, we offer services to different cultural and language groups."*

The importance of specialist substance abuse treatment and the utilisation of in- and out-patient treatment are acknowledged in various literature sources (Department of Social Development, 2013a:128; Goodman, 2007:6-7; Grobler *et al.,* 2006:403; Roman, 2002:208). The use of specialist social workers in treating substance abuse and dependency in the workplace is supported by Goodman (2007:6-7,93) due to these people's ability to engage effectively with clients with substance abuse problems. SANCA is considered one of the expert bodies that advises the Central Drug Authority (CDA) on strategies and interventions to combat substance abuse in SA (Department of Social Development, 2013a:128).

Sub-theme 3.5: Positive treatment outcomes

The credibility of out-patient treatment centres was further acknowledged in employees' testimonies of success stories. Some of the employee participants reported that the treatment services were valuable and the counsellors knowledgeable and experienced. The following are some of the comments in respect of this sub-theme.

> *"I'm living proof that SANCA is working."*

> *"SANCA changed so many aspects in my life – the end results, the success stories are all evidence of the advantages of the treatment programmes – and that will sell the programmes."*

Goodman (2007:82,89), Miller and Weisner (2002), Slaymaker and Owen (2006) and Stevens and Smith (2005) refer to various treatment benefits for the employment sector, namely reduced crime rates, an increase in employee efficiency, fewer incidents of disciplinary action on the job, and an increase in retaining employees in treatment. Goodman (2007:89) refers to a major research study on drug treatment in Britain, namely the National Treatment Outcome

Research Study that also revealed significant treatment benefits such as a reduction in crime rates and reconvictions. Eberlein (2010), Hitzeroth and Kramer (2010) and McCann *et al.*(2011) state that chances of relapse are reduced when strong support systems such as the workplace, and sustainable aftercare programmes, including continuous contacts with treatment counsellors exist, and when clients personally implement major lifestyle changes.

To summarise

The interrelation between the substance abuse problems, the impact of the problem on the workplace, the responses of colleagues and utilisation of resources were evident. This included an interdependence on each other and the environment to deal with the problem, and aligns with the ecosystems perspective. The following section on the interpretation of the data further supports the interrelation between the themes.

5.2 Interpretation of the data

In accordance with the grounded theory approach, the data was systematically analysed through a process of open coding, axial coding and selective coding (Braun & Clarke, 2006:86-93; Creswell, 2013:86-86,89,195-196; Fouché & Schurink, 2011:319-320).

Failure to address substance abuse in the workplace was extensively discussed by the participants and eventually identified as the central phenomenon or code of interest (axial coding).

Three themes (sub-categories) relating to the central phenomenon were identified, namely limiting factors, needs, and strengths of dealing with the problem. Causal conditions influencing the central phenomenon, approaches (strategies) in response to the phenomenon and, also, consequences as a result of the approaches were identified with regards to the limiting factors. In the final stage of selective coding the interrelationship between the themes was drawn and portrayed in Table 2.

Regarding the first theme – limiting factors to the successful resolution of substance abuse problems in the workplace - it became evident that the ignorance of the problem of substance abuse in the workplace, an unsupportive workplace environment and the underutilisation of out-patient treatment centres were causal conditions influencing the core phenomenon. Ignorance, one of the major causal conditions, was especially pertinent in the following respects: the prevalence of substance abuse in the workplace; the negative link between HIV/AIDS and substance abuse; and treatment benefits as an alternative to dismissal and other expedient workplace policies. Other major causal conditions included unsupportive workplace environments, negative attitudes of employers and colleagues and an insensitivity

towards employees with substance abuse problems. The gap in service delivery was further exacerbated by dysfunctional support structures and ill-equipped personnel. The underutilisation of treatment centres was a further cause for the gap in service delivery.

Approaches (strategies) in response to the gap in service delivery included the following: ignoring the problem; over-protection of colleagues; stigmatisation of the employees with substance abuse problems; concealing the problem; utilising unfeasible measures to address the problem; and preference to dismissal as opposed to treatment.

Consequences resulting from the causal conditions and approaches (strategies) were the following: limited or late identification of substance abuse problems; infrequent referrals for treatment; an increase in relapse risks; and production losses due to increase in absenteeism, substance abuse related accidents, sick leave, medical expenses and even theft. Underutilisation of out-patient treatment centres was also identified as a consequence of the causal conditions and the approaches aimed at dealing with the problem. It was therefore clear that the causal conditions, approaches and consequences all served to sustain the gap in service delivery.

The second theme revealed a close relationship between the limiting factors and the needs to deal with substance abuse in the workplace, i.e., the need for clear substance abuse workplace policies, a need for a supportive workplace environment, a need for specialist treatment services such as awareness, preventative and training programmes and, lastly, a need for networking between the employment sector and out-patient treatment centres. The participants thus expressed a need to address the gap and solve the problem. Mitigating the losses felt by both the employer and employee, therefore, required a rework of approach.

The third theme revealed strengths and available resources to deal with the problem. Some employees reported positive experiences and identified strengths in the workplace such as adherence to legal requirements for treatment of employees with substance abuse problems; existing and functional workplace policies and procedures; a supportive workplace environment, utilisation of specialist treatment services and positive treatment outcomes. Furthermore, specialists and credible programmes, aiming at providing services to the employment sector, were available.

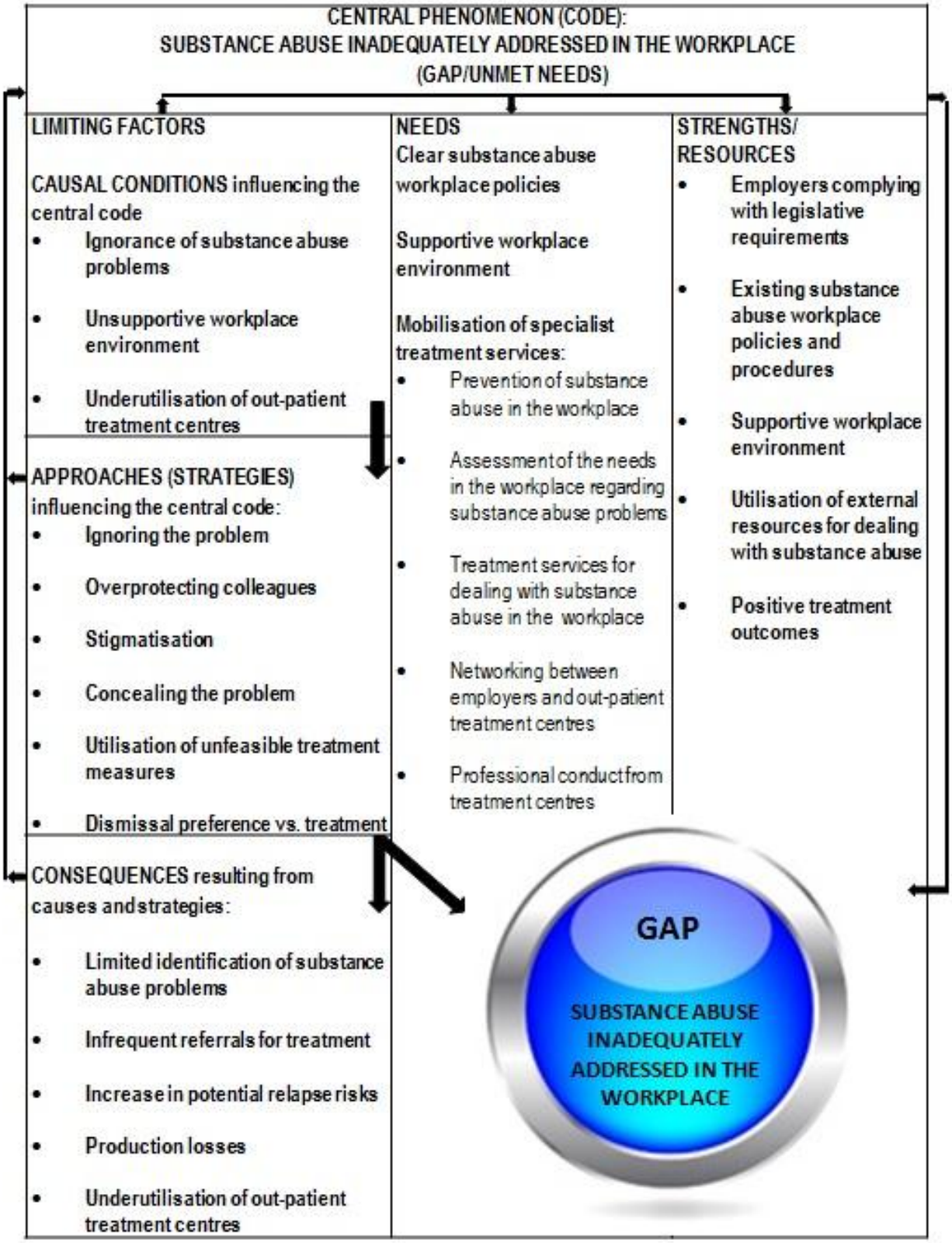
The interrelatedness between the substance abuse problems and the responses of colleagues, as well as the negative impact of the problem on the employment sector, was evident. Due to these responses the gap in service delivery was sustained. Interdependence on each other to deal with the problem was further highlighted.

The role of the social worker was to focus on the available strengths and resources in order to facilitate healthier connections between employers and employees, as well as to encourage collaboration between the employment sector and treatment centres and so address the problem and unmet needs. Such an approach is aligned with macro-level practice from a strengths perspective.

The ecological approach provided the framework for the researcher to assess both the problems and the needs, and identify the strengths within the macro environment. A need to develop networking relationships between employers and out-patient treatment centres was clearly voiced.

The interrelation between the themes is shown in Table 2.

Table 2: Selective coding: interrelationship between themes



6. CONCLUSIONS

Ignorance of the scope of substance abuse in the workplace, indifference towards substance abuse problems, the stigma attached to substance dependence resulting in concealing the problem, and insensitivity regarding high-risk situations that may cause relapses, all result in numerous employees with substance abuse problems either not detected or attended to.

Although legal requirements stipulate that employers have to provide opportunities for counselling for substance abusers before dismissal, employers either experience these requirements as additional demands or they are misinformed about the requirements. Limited knowledge regarding the benefits of treatment as an alternative to disciplinary action was displayed.

Furthermore, many companies implement HIV awareness programmes but the enormous negative consequences of the link between substance use and HIV and AIDS are not addressed. This all points to a lack in knowledge and foresight to combat the problem of substance abuse in the workplace to counter the huge economic losses for the employer

Despite the availability of specialist out-patient treatment centres to assist employers in dealing with the problem, these centres remain underutilised. Limited visibility of out-patient treatment centres and lack of feedback to employers on treatment progress were identified as possible reasons for the lack in collaboration.

Therefore, not only were limiting factors within the workplace ascribed to the underutilisation of treatment centres, but limited marketing and communication on the part of the out-patient treatment centres as well.

In order to attend to the problem of substance abuse in the workplace, ‘treating’ an unsupportive workplace environment first needs attention. Considering that treatment success depends heavily on early diagnosis as well as early intervention, employers can contribute to better treatment results if prevention messages on substance abuse and problem solutions are continuously disseminated to employees. Education of key role players in the workplace on early identification, early intervention and treatment as disciplinary measure, as well as relapse prevention programmes are means to empower the workforce in combating substance abuse in the workplace.

The development of clear substance abuse workplace policies has been recommended by both the employer and employee. However, workplace policies should be a support structure in the workplace and not mask problems of substance abuse as mentioned earlier. Benchmarking between different employers to share best practices regarding workplace

policies is a viable means to not only develop workplace polices but also to streamline existing policies.

The importance of a team approach between the employers and out-patient treatment centres to deal with the problem in the workplace was consistently highlighted. Such a team approach though, requires professional conduct and collaboration from both the employer and the out-patient treatment centre.

The ecosystems approach provided the framework to indicate the interrelation between the problems, needs, strengths and resources, and the gap in service delivery. In combination, the needs and strengths motivated the further exploration of collaborative approaches aimed at dealing with the gap in service delivery on a macro-level. The development of a networking process, in other words a networking programme (Dalton *et al.,* 2006; Kirst-Ashman & Hull, 2009; Pierson & Thomas, 2010), could serve as a new approach (strategy) to counter the gap in services and needed further exploration. Components central to such a programme also needed to be unpacked.

7. RECOMMENDATION

To develop a networking programme for employers and out-patient treatment centres with specific reference to the findings of the situation analysis on the needs and the core components of such a programme to address substance abuse in the workplace.

REFERENCES

Acts see South Africa

Albertyn, C. & Bhoola, U. 2011. Proposed substance abuse policy and procedural agreement. (*In* McCann, M., Harker Burnhams, N.H., Albertyn, C. & Bhoola, U., *eds*. 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta. p. 292-324).

Andreasen, A.R. & Kotler, P. 2008. Strategic marketing for non-profit organizations. 7th ed. Upper Saddle River: Merrill Prentice Hall.

Anon. 2009. The naked truth - statistics (SA & Global). http://www.tnt.org.za/index.php/ption=com_content&view=article&id=21&Itemid=51 Date of access: 15 March 2011.

Arkansas Small Business and Technology Development Centre (ASBTDC). 2011. Arkansas drug free workplace: facts and figures about drugs and alcohol in the workplace. http://asbtdc.ualr.edu/drugfree/facts.asp Date of access: 24 February 2011.

Babbie, E. 2010. The practice of social research. 12th ed. Belmont: Wadsworth Cengage Learning.

Barnett, T. & Whiteside, A. 2006. Aids in the twenty-first century: disease and globalization. 2nd ed. New York: Palgrave Macmillan.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Pearson Education South Africa.

Boyce, C. & Neale, P. 2006. Conducting in-depth interviews: a guide for designing and conducting in-depth interviews for evaluation input. m_e_tool_series_indepth_interviews.pdf Date of access: 14 February 2012.

Braun, V. & Clarke, V. 2006. Using thematic analysis in Psychology. *Qualitative research in Psychology,* 3:77-101. www.QualResearchPsych.com Date of access: 30 May 2012.

Carroll, A.B. & Buchholtz, A.K. 2006. Business & society: ethics and stakeholders management. 6th ed. Mason: Thomson South-Western.

Creswell, J.W. 2005. Educational research: planning, conducting, and evaluating quantitative and qualitative research. 2nd ed. Upper Saddle River: Merrill Prentice Hall.

Creswell, J.W. 2013. Qualitative inquiry & research design: choosing among five approaches. 3rd ed. London: Sage Publications.

Dalton, M., Hoyle, D.G. & Watts, M.W. 2006. Human relations. 3rd ed. Mason: Thomson South-Western.

Delport, C.S.L., Fouché, C.B. & Schurink, W. 2011. Theory and literature in qualitative research. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 297-306).

Department of Social Development. ***see*** South Africa. Department of Social Development.

Eberlein, R. 2010. Lifestyle changes to beat addiction. Randburg: Knowres.

Ellingson, L.L. 2009. Engaging crystallization in qualitative research: an introduction. London: Sage.

Falkena, H., Abedian, I., Von Blottnitz, M., Coovadia, C., Davel, G., Madungandaba, J., Masilela, E & Rees, S. 2011. SMEs' access to finance in South Africa: a supply-side regulatory review. www.treasury.gov.za/publications/other Date of access: 21 June 2011.

Fisher, G.L. & Harrison, T.C. 2009. Substance abuse: information for school counselors, social workers, therapists, and counselors. 4th ed. Boston: Pearson Education.

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 89-100).

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 307-327).

Goodman, A. 2007. Social work with drug and substance misusers: transforming social work practice. Wiltshire: Learning Matters.

Greeff, M. 2011. Information collection: interviewing. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 341-375).

Greenfield, J.M. 2001. The non-profit handbook: fundraising. 3rd ed. New York: John Wiley & Sons.

Grobler, P., Wärnich, S., Carrell, M.R., Elbert, N.F. & Hatfield, R.D. 2006. Human resource management in South Africa. 3rd ed. London: Thomson Learning.

Hitzeroth, V. & Kramer, L. 2010. The end of addiction: a comprehensive South African guide. Cape Town: Human & Rousseau.

International Centre for Alcohol Policies (ICAP). 2013. Alcohol and the workplace. The ICAP Blue book: practical guides for alcohol policy and prevention approaches. Module 22. http://www.icap.org Date of access: 10 January 2013.

Kirst-Ashman, K.K. & Hull, G.H. 2009. Generalist practice with organisations and communities. 4th ed. Belmont: Brooks/Cole.

Long, D.D., Tice, C.J. & Morrison, J.D. 2006. Macro social work practice: a strengths perspective. Belmont: Thomson Brooks/Cole.

McCann, M., Harker Burnhams, N.H., Albertyn, C. & Bhoola, U., *eds*. 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta.

Miller, W.R. & Weisner, C.M. 2002. Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum.

Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2011. Applied social research: a tool for the human services. 8th ed. Belmont: Thomson Brooks/Cole.

Neuman, W.L. 2006. Social research methods: qualitative and quantitative approaches. 6th ed. Boston: Pearson Education.

Parker, J. & Bradley, G. 2007. Social work practice: assessment, planning, intervention and review. 2nd ed. Glasgow: Bell & Bain.

Parry, C.D.H. & Bennetts, A.L. 1998. Alcohol policy and public health in South Africa. Cape Town: Oxford University.

Pelser, I. 2011. ETTEx Network: the future of drug testing (e-mail). 11 February 2011.

Pierson, J. & Thomas, M. 2010. Dictionary of Social Work. Berkshire: Open University Press.

Poulin J. & Contributors. 2000. Collaborative social work: strengths-based generalist practice. Belmont: Thomson Brooks/Cole.

Roman, P.M. 2002. Missing work: the decline in infrastructure and support for workplace alcohol intervention in the United States, with implications for developments in other nations. (*In* Miller, W.R. & Weisner, C.M., *eds.* Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum. p. 210).

Rose, S.J. & Zweben, A. 2002. Interrelationship of substance abuse and social problems. (*In* Miller, W.R. & Weisner, C.M., *eds.* Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum. p. 145-156).

SACENDU (South African Community Epidemiology Network of Drug Use). 2012a. Monitoring alcohol and drug abuse trends in South Africa (July 1996-June 2012). SACENDU research brief, 15(2). Tygerberg.

SACENDU (South African Community Epidemiology Network on Drug Use). 2012b. SACENDU report back meetings –November 2012. Monitoring alcohol and drug trends: January-June 2012. Tygerberg.

Segal, E.A., Gerdes, K.E. & Steiner, S. 2007. An introduction to the profession of social work: becoming a change agent. 2nd ed. Belmont: Thomson Brooks/Cole.

Services SETA. 2003a. Toolkit: employee assistance programmes and the law in South Africa. Parktown: s.n.

Services SETA. 2003b. Toolkit: managing substance abuse in the workplace. Parktown: s.n.

Slaymaker, V.J. & Owen, P.L. 2006. Employed men and women substance abusers: job troubles and treatment outcomes. *Journal of substance abuse treatment*, 31:347-354, May.

South Africa. 1993. Occupational Health and Safety Act 85 of 1993.

South Africa. 1993. The Compensation for Occupational Injuries and Diseases Act 130 of 1993.

South Africa. 1995. The Labour Relations Act 66 of 1995.

South Africa. 1998. The Employment Equity Act 55 of 1998.

South Africa. 2011. The South African Labour Guide. http://www.labourguide.co.za/workplace-discipline/code-of-good-practice-dismissal-general-461 Date of access: 24 February 2011.

South Africa. Department of Social Development. 2013a. National Drug Master Plan (NDMP) 2013-2017. Pretoria.

South Africa. Department of Social Development. 2013b. Reintegration and aftercare model for substance abuse services. Pretoria:

South African Council for Social Service Professions (SACSSP). 2012. Policy guidelines for course of conduct, code of ethics and the rules for social workers. 4th ed. Pretoria.

Stevens, P. & Smith, R.L. 2005. Substance abuse counselling: theory and practice. 3rd. ed. Upper Saddle River: Merrill Prentice Hall.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 113-129).

Strydom, H. & Delport, C.S.L. 2011. Sampling and pilot study in qualitative research. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 390-396).

UNODC (United Nations Office on Drugs and Crime). 2012. World drug report. Vienna: United Nations Publication, Sales No. E. 12.XI. 1. http//www.unodc.org/documents/data-and-analysis/WDR2012/WDR 2012 web_small.pdf Date of access: 12 January 2013.

UNODC (United Nations Office on Drugs and Crime). 2013. World drug report. Vienna: United Nations Publication, Sales No. E.13.XI.6. http:www.unodc.org/secured/wdr/wdr2013/World_Drug_Report_2013.pdf Date of access: 8 March 2013.

Van Dyk, A. 2005. HIV/AIDS care & counselling: a multidisciplinary approach. 3rd ed. Cape Town: Pearson Education.

Van Wormer, K. & Davis, D.R. 2008. Addiction Treatment: a strengths perspective. 2nd ed. Belmont: Brooks/Cole, Cengage Learning.

Welman, C., Kruger, F. & Mitchell, B. 2010. Research methodology. 3rd ed. Cape Town: Oxford University.

Weyers, M.L. 2011. The theory and practice of community work: a Southern African perspective. 2nd ed. Potchefstroom: KEURKOPIE.

ARTICLE 3: SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

ABSTRACT

The increase in substance abuse among the employed in recent years in South Africa (SA) has enormous cost implications for employers. A situation analysis revealed an inability of support structures in the workplace to deal with the problem. Although specialist resources are available to assist employers in addressing the problem, these resources remain underutilised. During the situation analysis, a need was identified for a networking programme between employers and out-patient treatment centres to deal with the problem. The essential components for such a programme were also determined. The purpose of this article is firstly to report on the findings regarding the identified components and secondly to present guidelines to develop a networking programme between employers and out-patient treatment centres to address, collaboratively, substance abuse in the workplace.

Key words

Substance abuse, workplace, networking programme, employers, out-patient treatment centres, collaboration

1. INTRODUCTION

Employers are confronted with enormous challenges to combat substance abuse in the workplace. The increase in substance abuse among the employed (Grobler, Wärnich, Carrell, Elbert & Hatfield, 2006:404; McCann, Harker Burnhams, Albertyn & Bhoola, 2011:45) has huge cost implications for employers. Legal demands are specified for employers in order to effectively manage substance abuse and dependency in the workplace (South Africa, 2011:1-3). Although support structures in the workplace are available to deal with the problem such as Employee Assistance Programmes (EAP) and substance abuse workplace policies, the problem remains largely unattended to. Employees with substance abuse problems receive scant attention and the negative economic consequences for the employers are therefore exacerbated. External specialist treatment services (Eberlein, 2010:53-54; McCann *et al.,* 2011:247-250) are available to assist the employers in combating substance abuse in the workplace, yet, these services remain underutilised and a huge gap to combat substance abuse in the workplace was pointed out in a situation analysis.

The situation analysis was implemented to gain knowledge about the problem of substance abuse in the employment sector and to understand the nature of interactions between individuals (employees) and various systems in the environment (employment sector and out-patient treatment sectors) (Kirst-Ashman & Hull, 2009:9,280; Long, Tice & Morrison, 2006:35,41-42; Poulin & Contributors, 2000:4-5; Segal, Gerdes & Steiner, 2007:13-14,152-153). Findings revealed a need for networking between the employment sector and out-patient treatment centres to deal with the problem of substance abuse collaboratively.

Macro-level interventions in the study focused on adjusting the gap between the needs of employees and substance related issues in the employment environment, and social service delivery. The research study on a macro-level focused on a large number of participants from the employment sector with similar characteristics who could benefit from social services (Kirst-Ashman & Hull, 2009:9-10). This approach was followed with a strengths based perspective in mind and with the focus on the strengths, resources and capacities of the employers, employees and out-patient treatment centres (Poulin & Contributors, 2000:5-9; Van Wormer & Davis, 2008:17-21).

Macro practice, from a strengths perspective, required collaboration, the empowerment of clients and the establishment of healthier connections between people (Poulin & Contributors, 2000:4). The research study was conducted with a practical outcome in mind and with the assumption that the relevant role players would gain specific benefits from it (Monette, Sullivan & DeJong, 2011:4-5).

A networking programme was regarded a viable option to collaboratively manage the problem (see Article 2). The core components of a networking programme for employers and out-patient treatment centres to address substance abuse in the workplace were also determined in the situation analysis. The purpose of this article is two-fold: firstly to report the viewpoints on the core components for a networking programme and secondly to present guidelines to develop a networking programme.

2. PROBLEM STATEMENT

Employers find themselves in an extremely vulnerable position due to the major economic consequences because of the increase in substance abuse among the employed, as well as the negative link between substance use and HIV and AIDS (Department of Social Development, 2013:37,44; McCann *et al.,* 2011:172;). Businesses involved in high-risk and safety-sensitive occupations (McCann *et al*., 2011:70; Pelser, 2011:10) are even at greater risk when employees are on duty whilst under the influence of a substance. In addition to that, employers are legally obligated to effectively manage substance abuse in the workplace by

providing counselling and treatment for employees with substance abuse dependency before dismissal is considered (South Africa, 2011:1-3). Amidst all of these factors, an unsupportive workplace environment towards substance abuse problems in the workplace, limited identification of problem cases, infrequent referrals of employees for treatment and limited or lack of expertise to deal with the problem in the workplace had been identified (see Article 2).

The above problems prevail in spite of the fact that substance abuse treatment centres are available to provide specialist assistance to employers in combating the problem in the workplace. The mission of substance abuse treatment centres supports the above, i.e., to provide specialist services for clients with substance abuse problems and to act as a support system for the employment sector, including the employers. Furthermore, social work has always been involved in service coordination, in interagency networks and in collaboration as "no single agency has the resources to address the many demands of consumers" (Long *et al.*, 2006:136). The scenario described earlier presents a dire need for collaboration between employers and treatment centres to address the problem of substance abuse in the workplace. This need for collaboration, the research findings on positive treatment outcomes, resources and strengths in the workplace and testimonies of treatment successes served as motivation for the development of a networking programme (see Article 2).

Backer (2003), however, voices some serious concerns about deficiencies in any collaboration process. Backer (2003:2,8-9) states that many collaborations fail and, according to some reviewers, are often inefficient mechanisms for bringing about change, especially if not properly planned and if sufficient resources are not available to ensure that interventions provide sustainable long-term outcomes. Also, some collaborations are entered into without first assessing whether collaboration is appropriate to address the particular problem. Furthermore, groups sometimes come to the collaboration table only to achieve their personal objectives without any serious intent to engage in a genuine partnership. Another reason for failure is that the participants may have unrealistic expectations regarding collaboration deliverables. Moreover, collaborations are often created without proper attention to the establishment process and sustainability requirements thereof.

The overarching research question covered in this article is:
What are the essential components of a sustainable networking programme to guide employers and out-patient treatment centres to collaboratively combat substance abuse in the workplace?

3. AIM AND OBJECTIVES

3.1 Aim

The aim of the study is to develop a networking programme for employers and out-patient treatment centres to address substance abuse collaboratively in the workplace.

3.2 Objectives

To determine the core components to establish a networking programme for employers and out-patient treatment centres

To develop a framework for a networking programme for employers and out-patient treatment centres to address substance abuse in the workplace.

4. RESEARCH METHODOLOGY

4.1 Literature study

The literature review served mainly to indicate the relationship between the theories which emerged from the empirical study and existing theoretical knowledge (Delport, Fouché & Schurink, 2011:305). The literature review was narrowed down to the process of developing a networking programme for employers and out-patient treatment centres and literature sources from the social work and business field were consulted. A grounded theory approach was followed and guidelines from Babbie (2010), Creswell (2013), Fouché and Schurink (2011) and Neuman (2006) were followed and adapted to implement the grounded theory process.

4.2 Research design

The systematic grounded theory approach of Strauss & Corbin (Babbie, 2010:307-308; Creswell, 2013**:**83-90; Fouché & Schurink, 2011:318-320; Monette *et al.,* 2011:225-226) was followed to generate theory based on the viewpoints of participants on how to establish a networking programme. This approach involved several visits to the field to conduct interviews with a large number of participants. The aim was to constantly compare and analyse the data in search of new sampling cases or contexts of interest (Neuman, 2006:406). Through the systematic collection of data and almost simultaneous analysis of the data, the grounded theory was discovered (Fouché & Schurink, 2011:319). Monette *et al. (*2011:225) refer to the continual interplay of data collection, data analysis and theory development.

Grounded theory was used to firstly determine the concerns and capacities of the employers and out-patient treatment centres to address substance abuse in the workplace. These

findings were reported in article 2 of the study. Secondly, the core components to develop a networking programme were identified and are reported in this article.

4.3 Sampling and research context

Qualitative exploratory and descriptive research (Babbie, 2010:92-93; Fouché & De Vos, 2011:95-96; Neuman, 2006:33-34) was conducted to gain insight into the needs, strengths and viewpoints of participants in establishing a networking programme.

The non-probability theoretical sampling technique used in grounded theory was applied to select the participants in the employment sector and out-patient treatment centres. Participants shared a common denominator, namely dealing with substance abuse problems in the workplace in some way (Creswell, 2013:83; Weyers, 2011:309). Participants were theoretically chosen (Creswell, 2013:86; Fouché & Schurink, 2011:319; Strydom & Delport, 2011:392) to assist the researcher in developing a framework for a networking programme and in searching for pertinent data to develop a theory.

The two main populations involved in the situation analysis were the employment sector and out-patient treatment centres in the Limpopo and Mpumalanga provinces. Limpopo and Mpumalanga are clustered into one region for research and statistical purposes (SACENDU, 2012a:1) and both were therefore included in the research study. The main focus was on out-patient treatment centres as recent statistics (SACENDU, 2012b) revealed that most clients in SA and in the said provinces received such out-patient treatment. The four SANCA treatment centres were involved as they are the only registered centres that provide substance abuse out-patient treatment in the said provinces.

Participants from the employment sector included employers because of their role in managing the problem of substance abuse in the workplace. Employers from the small, medium and macro businesses were selected according to the National Small Business Act 102 of 1996 (Falkena, Abedian, Von Blottnitz, Coovadia, Davel, Madungandaba, Masilela & Rees, 2011:26). Businesses engaging in high-risk and safety-sensitive occupations (McCann *et al*., 2011:70; Pelser, 2011:10), such as public transport and security institutions and construction industries were selected due to the significant life-threatening danger to employees in the workplace and/or the public. The National Drug Master Plan (Department of Social Development, 2013:76) also refers to ‘occupational groups at risk’ as being priority target groups. Businesses within the proximity of out-patient treatment centres were included due to cost-effective considerations. Employees who were involved either as clients in substance abuse treatment or in aftercare were involved. Staff members from the four out-patient treatment centres concerned participated in the study on the basis of their specialist

knowledge and experience in the field of substance abuse and their treatment service delivery to the employment sector.

4.4 Method

Approval from the SANCA Mpumalanga Management Board was obtained to conduct the research study in all SANCA centres in the Limpopo and Mpumalanga provinces. Likewise, official approval from the Management Board of the Mpumalanga Employers' Organization was obtained to participate in the research study. Written informed consent was obtained from all the participants and their right to withdraw from the study at any time was explained to them.

A situation analysis was implemented between March 2011 and June 2012 comprising three phases, namely the orientation phase, the data collection phase and the data analysis phase and are discussed next. Both the employment sector and the out-patient treatment centres were involved in the orientation and data collection phases.

4.4.1 Orientation phase

The research study was introduced to and discussed with the four out-patient treatment centres; action plans to implement the study were jointly developed and agreements regarding selection of relevant staff members to participate in the study were reached. A staff member from each out-patient treatment centre was recruited to assist the researcher in coordinating the study in his/her specific site. These staff members, referred to as site coordinators, were individually briefed on their roles and responsibilities. The situation analysis was collectively implemented by the site coordinators and the researcher in all the sites.

During the orientation phase key informants from two Employers' Organisations in Mpumalanga assisted in the preliminary planning of the study, formulation of the criteria for the selection of employer participants, the identification of potential employer participants and initiating contact with the employers.

Orientation discussions were individually conducted with 47 participants from the employment sector (40 employers and 7 employees) to introduce and discuss the action plans for the implementation of the study and to encourage participation in the study. A total number of 29 participants from the employment sector (22 employers and 7 employees) indicated their willingness to participate in the subsequent data collection phase and written consent was obtained from them.

4.4.2 Data collection

During the data collection phase, qualitative interviews (Babbie, 2011:318-326; Boyce & Neale, 2006:3; Greeff, 2011:351-352,360-361; Welman, Kruger & Mitchell, 2010:197-202) were conducted. Individual interviews with 29 representatives from the employment sector and focus group interviews with the staff members concerned from each of the three out-patient treatment centres in Mpumalanga were held. SANCA Polokwane treatment centre from Limpopo province was involved in the group orientation discussions, however, the centre experienced dire financial difficulties at the time and was compelled to withdraw from the research study. SANCA Polokwane was therefore not involved in the data collection phase.

The interviews were conducted utilising semi-structured interview schedules (Greeff, 2011:351-353,369-370). Data was constantly compared with those of the new subjects, their recommendations and emerging theories. New participants were selected and information gathered until data saturation was reached (Creswell, 2013:85-86,89; Fouché & Schurink, 2011:318). This grounded theory method of 'thinking comparatively' and gathering multiple viewpoints was implemented to avoid biases which could arise from the initial interpretations (Babbie, 2010:307-308).

The core components of and procedures to establish a networking programme between employers and out-patient treatment centres to address substance abuse in the workplace were determined.

4.4.3 Data analysis

The data collected from the individual interviews and focus groups were systematically analysed (Braun & Clarke, 2006:86-94; Creswell, 2013:85-86,89,195-196,208-209; Fouché & Schurink, 2011:319-320) by generating codes, searching for themes, reviewing the themes and defining the main themes. Two sets of data with themes and sub-themes emerged from the interviews - data set 1 from the individual interviews and data set 2 from the focus group interviews. These two sets of data were then consolidated to present the main themes and sub-themes.

Although 29 individual interviews were conducted, data saturation was reached after the data of 20 participants were analysed. This resulted in the remaining nine becoming superfluous. The data analysis and the data saturation were verified by an independent analyst/co-coder (Creswell, 2013:89; Fouché & Schurink, 2011:319) to enhance trustworthiness of the data analysis.

A member-checking meeting (Botma, Greeff, Mulaudzi & Wright, 2010:231,232; Creswell, 2005:252; Ellingson, 2009:42) was conducted with participants from both populations with the

purpose of sharing information on the research findings and to engage the participants in feedback. Feedback from the member-checking meeting was integrated as part of the related themes in the research findings. The member-checking process enhanced the credibility of the findings.

4.5 Trustworthiness

Trustworthiness (Babbie, 2010:307-308; Botma *et al.,* 2010:232-234; Creswell, 2005:252; Ellingson, 2009) was established through:

- ✓ Obtaining truth value by means of reflexivity and member checking.
- ✓ Applicability by using different sampling groups, data saturation and dense description.
- ✓ Consistency due to a step-by-step audit trail and using a co-coder.
- ✓ Neutrality because of regular sessions with supervisors as well as the consistent involvement of site coordinators in the research for feedback and reflexion purposes.
- ✓ Authenticity through the ample use of direct quotations and consideration of the feelings and experiences conveyed by the participants. All the interviews were documented and submitted to the co-coder for analytical verification.

4.6 Ethical considerations

Ethical approval for conducting the research study was obtained from the North-West University (No. NWU-00125-11-51). The Code of Ethics described in Kirst-Ashman and Hull (2009:406-4210), Long *et al. (*2006:252-253,258-271), Poulin and Contributors (2000:21-23), Segal *et al.* (2007:464-483), South African Council for Social Service Professions (2012) and Strydom (2011:115-129) were guiding the researcher. Ethical responsibilities towards clients, colleagues, the social work profession and the employment sector were taken into consideration. The following social work core values were also taken into account:

The primary ethical principle was to serve the employers and employees in addressing the problem of substance abuse in the workplace (core value of service.) The researcher strived to enhance the accessibility of information, services and resources in dealing with substance abuse in the workplace (core value of social justice).

Permission to gain entry to the demarcated areas was granted by the SANCA Mpumalanga Management Board and the Mpumalanga Employers' Organisation Management Board. The researcher obtained permission from participants to use audio tape recordings during the individual and focus group interviews. Written informed consent was obtained from all the participants and their right to withdraw from the study at any time was explained to them (core value of dignity and worth of each person).

Measures were implemented to ensure the confidentiality of the information provided by the participants. Participants were assured of the ethical conduct with regard to confidentiality. This was also stipulated in the written consent. Interviews were recorded on Dictaphone and transcribed verbatim. All transcripts and records will be stored in the archive allocated for the School of Social Work at the NWU (Potchefstroom) for a period of 5 years. Coordinators from the out-patient treatment centres were orientated on confidentiality matters during their induction programme (core value of confidentiality).

In accordance with macro-level practice, the importance of collaboration was demonstrated through the engagement of members from the employment sector and treatment centres. The role of the participants and the researcher was discussed with all the participants as part of the interviewing protocol. Debriefing sessions were held, where possible, to clarify any misunderstandings after the individual and focus group interviews (core value of the importance of human relationships and collaboration).

The researcher has extended practical experience in social work and has been practising as counsellor in the field of substance abuse treatment since 2009 (core value of competence). The researcher strived to behave in a responsible and honest manner towards the employment sector, out-patient treatment centres and the profession. Credit was also given to the contributions of literature sources and findings were reported unambiguously (core value of integrity).

5. RESULTS

Results from the situation analysis are reported in this section followed by an interpretation of the results.

5.1 Situation analysis: networking programme - themes and subthemes

The viewpoints of participants on the core components of a networking programme are reported in this section. Various themes were identified during the data analysis process. Constant refinement of these themes eventually culminated in the final themes, namely the purpose of networking, the characteristics of a networking programme and the process of developing a networking programme.

Most of the participants had difficulty in separating networking and treatment services. For instance, in nearly all the questions related to a networking programme, most of the participants referred to treatment services and service delivery. The latter was continually interwoven, thus indicating that service delivery could not be divorced from the networking programme. An outline of the themes and sub-themes is given in Table 1.

Table 1: Situation analysis: - themes and sub-themes

THEMES	SUB-THEMES
1. Purpose of networking	1.1 Collaboration between employers and out-patient treatment centres 1.2 Marketing 1.3 Mutual benefits for employers and out-patient treatment centres
2. Characteristics of a networking programme	2.1 Collaboration between employers and out-patient treatment centres 2.2 Marketing 2.3 Mutual benefits for employers and out-patient treatment centres 2.4 Competent out-patient treatment centres
3. Process to develop a networking programme	3.1 Collaboration 3.2 Marketing 3.3 Assessment of the out-patient treatment centres and the needs of the employment sector 3.4 Planning 3.5 Implementation 3.6 Monitoring and Evaluation

5.1.1 Theme 1: Purpose of networking

The first theme focused on the purpose of networking, comprising collaboration, marketing and the benefits of such a programme for employers and out-patient treatment centres.

Sub-theme 1.1: Collaboration between employers and out-patient treatment centres

Most of the participants said that the purpose of networking between employers and out-patient treatment centres was to establish collaboration, cultivate sound relationships and support each other.

Employers commented as follows on collaboration:

> *"In the networking sessions we have a platform to voice our needs and to position ourselves."*
>
> *"I won't feel alone anymore...I will know there is somebody, a friend…I have somebody… a refuge to turn to…to help me deal with the problem in my workplace."*

A participant from an out-patient treatment centre on collaboration:

> *"It's about working together, partnerships…about walking together."*

Sub-theme 1.2: Marketing

Networking was regarded as a marketing opportunity and an ideal platform to promote the services of the treatment centres, as well as the potential benefits of a networking programme. Participants described the purpose of networking as a vehicle to ensure that both the employer and out-patient treatment centre remain knowledgeable and the centres remain relevant. Testimonies of success stories related to the treatment programme were regarded as an integral part of the marketing message.

Comments from participants from the employment sector on marketing:

> *"Marketing is fundamentally about creating an awareness…building an image, generating an enquiry."*

> *"The purpose of marketing is to remain relevant…and that is only possible if you are informed and you keep others informed about your business. You need to market to create interest in your core business."*

The views of members from treatment centres on marketing:

> *"Our core business is providing the most effective services for our clients in combating the struggle against substance abuse. We always need to balance the delivery of quality services and marketing especially considering our limited manpower capacity. Marketing is not our first priority."*

Sub-theme 1.3: Mutual benefits for employers and out-patient treatment centres

Empowerment of the employment sector and capacity building of treatment centres were identified as mutual benefits resulting from collaboration and marketing. Employers in general emphasised the principle of 'givers gain', that is, people gain by giving. This principle was considered applicable to the employment sector as well as the out-patient treatment centres when dealing with substance abuse in the workplace. In other words, through education of role players in the workplace and awareness programmes on substance abuse in general, assistance of specialists from the treatment centres, financial support from the employment sector, as well as through collaboration, both sectors could be empowered and capacitated.

Participants believed that these benefits could eventually result in a healthier workforce and a stronger out-patient treatment sector, in other words sharing and collaborating with long-term benefits in mind.

An employer commented as follows on the value of mutual gains:

> *"It's about givers gain…If I give, I will get. It does not mean if I give to you, you will give to me. It means if I give to you, somebody will give to me and if not today, one day."*

The viewpoints from an out-patient treatment centre on the benefits of marketing:

> *"I think recognition… that we are a trustworthy organisation and that we can render the service that we promote… and obviously some employees will then benefit and stop using or abusing substances so the productivity will go up."*

Most of the participants regarded collaboration, marketing and mutual benefits as the main reasons for entering into a networking programme. Collaboration in this regard could create opportunities to develop or strengthen linkages between members of the network to connect clients (employees) with resources (treatment centres) (Kirst-Ashman & Hull, 2009:85). In terms of the ecosystems perspective, the role of the social worker would therefore be the "person in the middle" to reach employees with problems and to assist the employers in dealing with the problem of substance abuse in the workplace (Poulin & Contributors, 2000:5). Mutual benefits imply that the network will likely be functioning on a quid pro quo basis – something for something (Kirst-Ashman & Hull, 2009:85,90). Treatment centres, however, were reluctant to actively market their services due to the possible increase in the demand for services without sufficient human resources to deal with the demand.

5.1.2 Theme 2: Characteristics of a networking programme

Collaboration, marketing, mutual benefits and competent out-patient treatment centres were identified as important characteristics of a networking programme. The competency of the organisation was highlighted as the bonding component in linking all the characteristics of a networking programme. These characteristics were identified through research questions such as:

When would employers consider establishing a networking programme with out-patient treatment centres?

What are the most important pre-requisites to establish a networking programme?

How could sustainability of a network be ensured?

What should be avoided when establishing a networking programme?

Sub-theme 2.1: Collaboration between employers and out-patient treatment centres.

Continuous nurturing of relationships and regular communication between employers and out-patient treatment centres were regarded as essential qualities of a collaborative relationship. Such a relationship was described as 'working together', 'walking together', 'knowing each other' and 'sharing experiences and services'. Role clarity, and shared responsibilities and decision-making powers were considered important in sustaining collaboration.

An employer expressed the need for support and expertise from out-patient treatment centres:

> *"You asking me when the employer will consider to network with SANCA…I'm telling you…as soon as possible, because we have no knowledge of how to deal with the problem of substance abuse in the workplace. I need them to help me."*

An employer referred to the importance of teamwork and coordination:

> *"Network is about a circle….If we don't understand each other somewhere along the line, the line is going to break. You are going to pull your way and I am going to pull my way. The circle must remain a circle."*

Sub-theme 2.2: Marketing

The participants from the employment sector regarded consistent marketing of out-patient treatment centres and their services as an important feature of a networking programme. Knowledge of the principles and processes of marketing and the application of marketing skills were considered essential. The importance of marketing the benefits of a networking programme was consistently raised. The employers insisted that the marketing of treatment centres had to be supported by quality service delivery from the centres. Most out-patient treatment centre staff members revealed limited knowledge of marketing principles and processes. Some participants from the out-patient treatment centres questioned whether the centres had the human resources and capacity to meet the needs of the employment sector. They emphasised that the core business of out-patient treatment centres is to deliver quality treatment services. By the same token, it is of paramount importance to maintain a balance between marketing and service delivery.

Comments from staff members from a treatment centre regarding the reasons why the community is unaware of SANCA included the following:

"We don't have a strategy how to go about of making sure we market ourselves."

"Our name is the problem…it's very similar to CANSA ....people are confused!"

A participant from the employment sector referred to the need for the creative utilisation of existing structures in the workplace to disseminate information on substance abuse problems:

"We need quick information groups on sites…almost similar to quick cash machines where you can draw money…information on substance abuse problems and solutions need to be available immediately… peer groups, union members need to be the quick machines spreading the message on site how to get help."

Sub-theme 2.3: Mutual benefits for employers and out-patient treatment centres

Benefits for both the employment sector and the out-patient treatment centres to join the programme were considered essential for sustainability of the networking programme. Participants listed several significant benefits for employers, such as a support system or so called "refuge" to deal with substance abuse problems, empowerment of employers to address the problem and benchmarking with other employers regarding best practices. Benefits for out-patient treatment centres included, inter alia, the availability of a platform to voice the needs of treatment centres, developing a database of employer supporters and create opportunities for fundraising.

A staff member from a treatment centre's perception on mutual benefits:

"Through our interventions in areas where we are working, there are sometimes gaps that we identify, sometimes our own programmes are not working. We can come up with a new model to assist the employers to address issues in the workplace. It also helps us to grow and develop new programmes and projects for the employers."

Sub-theme 2.4: Competent out-patient treatment centres

Most of the employers expected high levels of competency from out-patient treatment centres, including ethical behaviour, professional conduct and quality service delivery.

Ethical behaviour

Members of a treatment centre emphasised mutual ethical conduct:

> *"There must be trust…on both sides there need to be trustworthiness. There should be loyalty and there should be commitment. A person should not be there one time and not there the next time in your networking relationship. And we need to be open and honest about what we can deliver. We must know what the staff members are able to deliver."*

Ethical behaviour was viewed by the participants as the foundation of a competent organisation, such as an out-patient treatment centre and included trustworthiness, honesty, sincerity and integrity. The employers stressed the importance of respecting confidential matters and not to be judgemental.

Professional conduct

An employer on the professional conduct that is expected of treatment centres:

> *"Don't shut the door with your opening request for money. People don't like to feel guilty because they are not giving money. First build your relationships before you come down on the employer. And another thing is …don't be aggressive on people's time. The information that you give must be relevant and that is only possible if you get experience how the corporate world works."*

The employers expected out-patient treatment centres to be knowledgeable about substance abuse in general, ways of combating it, treatment services and supplementary services if further referrals were necessary. Out-patient treatment centres should also know how to facilitate the planning, establishing and sustaining of a networking programme. Sufficient human resources were expected to be available to meet the expectations and needs of employers. Respecting the employers' priorities, time frames and working conditions were emphasised. In short, an out-patient treatment centre was expected to deliver specialised services, display expertise and achieve positive results.

Quality services

A medical sister from the health and safety division at a macro business on service quality:

> *"When we need to refer the employee for services, it is always an urgent matter. We don't want to phone and reach a voice mail. We don't want to leave a message and nobody returns our calls. We also need to stay*

informed on personnel changes. Keep us informed who is taking over the cases. Keep your organogram up to date and inform us on the changes. And there is something else that is very important...we need to see progress. I don't want to send the worker back for continued rehab efforts."

The participants stated that quality service delivery required effective governance and proper coordination of services by treatment centres. Out-patient treatment centres were also expected to be approachable, punctual, project a positive image and remain focused on the tasks at hand.

The expectations regarding the networking relationship included clear and consistent communication, as well as regular feedback on the process and progress of the treatment services. The employers stated that the employment sectors' recommendations on the improvement of services and their feedback on treatment should also be considered.

An employer spoke as follows on expected treatment outcomes:

"I want value for my money…so the employee needs to be rehabilitated as soon as possible…and sometimes the rehabilitation process is continuing time after time…and still the person has not been rehabilitated!?"

A comment from a staff member from a treatment centre on employers' expectations:

"Employers don't understand the disease and if they do understand they really don't want to work with the fact. They don't know how the treatment programme works. They send clients for treatment to be rehabilitated so that no more time is spent on the problem. They don't know the importance of aftercare. They don't know."

To summarise: The themes mentioned earlier related to the purpose of a networking programme also emerged as important characteristics of such a programme. In other words, these factors were not only regarded as the purpose for entering into a networking programme but also as important qualities in the sustainability thereof. The participants considered the competency of an organisation as a core characteristic underlying all other characteristics. Challenges for the out-patient treatment centres included the unrealistic expectations of employers regarding the time frame for and the success rate of the treatment of employees with dependency, as well as their expectations of adequate human resources in out-patient treatment centres. Furthermore, the responsibility for establishing the required collaboration was deemed to primarily reside with the treatment centres.

5.1.3 Theme 3: Process to develop a networking programme

The participants did not identify the sequence of activities to establish a networking programme in the same order. However, collaboration, marketing, assessment, planning, implementation, monitoring and evaluation were pointed out as pivotal in the process and are discussed below as sub-themes. This is recorded in no particular order of priority.

Sub-theme 3.1: Collaboration between employers and out-patient treatment centres

The cultivation of sound relations between employers and out-patient treatment centres was accorded high priority. The participants from both populations perceived collaboration as involving all the main role players, sharing common goals, developing sound relations and being of benefit to both parties.

An employer referred to the shared goal between the employer, employee and the out-patient treatment centre:

> *"Remember, the end product is the rehab of the employee…so your services and my operational needs as an employer create a safety net for the employee. And when he falls, we will catch him. My biggest asset is my workers. So the biggest benefit of the networking relationship for me will be to retain my workers."*

Sub-theme 3.2: Marketing

Employers expected the out-patient treatment centres to take responsibility for the marketing of the networking programme. Personal contacts were regarded as the most important marketing tool. Employers proposed that the contact details of the treatment centres be distributed by the centres as a marketing tool for their services. An employer stated that out-patient treatment centres should promote their services to companies by being more visible and robustly seeking networking opportunities.

An employer commented as follows on marketing products:

> *"I'm saying…your products need to be nice, neat, up-to-date, well presented, marketable and maintained."*

The viewpoint of an employer on the importance of marketing in the process:

> *"You need to start with marketing. First you need to do research…who is your market? Then market a tailor-made service. Build your client base…build your relationships. You need to involve the union members in*

your networking programme…they represent the employees and they have a lot of power and influence to ensure treatment for their members who are involved in a disciplinary hearing because of substance abuse affecting his work and the safety of colleagues and the public."

Sub-theme 3.3: Assessment

The participants from both populations recommended assessment of out-patient treatment centres and the employment sector.

Assessment of the out-patient treatment centres

The participants recommmended in-depth assessment by out-patient treatment centres of their strengths, competencies and capacity to deliver services. Possible weaknesses, such as limited visibility of out-patient treatment centres, poor marketing strategies and a shortage of human resources should also be investigated. Staff members reiterated that the core business of a treatment centre is the delivery of quality treatment services to clients with substance abuse problems:

"This is why we are here…this is our mission and if we neglect our core business we might as well close our doors."

Out-patient treatment centres indicated that they have to consistently reflect on their mission and assess whether the focus is still supporting their core business. A staff member from a treatment centre raised the question:

"How many clients can we deal with and still ensure an effective service? We have this open door policy that we don't show anybody away but with how many clients can we physically deal with? We must assess our work and plan strategically. And we must be realistic. That is where the networking is going to be very important…once we've built a proper relationship, we can address our weaknesses."

The threats that confront the centres revealed aspects such as the acceptability of social drinking and financial constraints for the treatment centres.

Assessment of the needs of the employment sector

The employers recommended that once a collaboration relationship had been established, the scope and impact of substance abuse problems in the workplace and what employers needed to do to combat these problems should be thoroughly investigated. The distribution of anonymous self-evaluation questionnaires among employees to identify substance abuse

problems or dependency as a way of assessing the extent of the problem in the workplace, was suggested. Assessing the needs of particular employees was also suggested as a way of individualising service delivery. The assistance of treatment centres in the assessment process was recommended by employers.

An employer commented as follows on the assessment of employees' needs:

> *"You need to do a survey to find out what my employees need. Do they need help with alcohol abuse or do they want HIV counselling. And then we must decide where we should start. But first you need to build a relationship with them. The workers must know how they will benefit from the relationship. I as employer want to decide if I'm going to waste my time or is this networking relationship going to be beneficial for my business."*

A comment from a treatment centre on measures to assist the employers in assessing the problem of substance abuse in the workplace:

> *"We can help them to observe the problem…through our eyes and our ears and our nose and our mouth. We can gather information so that they can address the problem. We can offer a tailor-made service."*

Sub-theme 3.4: Planning

The formulation of strategic and operational plans, the development of a networking agreement between employers and treatment centres and the collective defining of reciprocal roles and responsibilities were considered crucial in the planning process. Several roles and responsibilities were identified for employers, as well as for out-patient treatment centres, such as establishing the networking programme, involvement in the overall networking process, disseminating information on substance abuse in general, as well as treatment services and evaluating the programme.

The comment of an employer on planning:

> *"I need a type of a roadmap to deal with the problem in my business."*

A staff member from a treatment centre shared an African idiom with the group as example of teamwork and planning:

> *"If you want to walk fast, walk alone. If you want to walk far, walk together."*

Sub-theme 3.5: Implementation

- ✓ The participants stated that all relevant role players should be included in the implementation of the proposed networking programme
- ✓ That the programme should be implemented on a trial basis
- ✓ That awareness and training programmes on substance abuse in general should be offered in the workplace
- ✓ That there should be regular follow-up on referrals from the health and safety divisions of companies and
- ✓ That feedback should be given to employers on the progress of employees in treatment.

A comment from one of the staff members from a treatment centre:

> *"When we network, we always have to think that networking is a twin sister of implementation."*

Sub-theme 3.6: Monitoring and Evaluation

Most of the employees distinctly highlighted the importance of monitoring and evaluation in their reintegration process. One of the employees mentioned that monitoring is important from the onset of the rehabilitation process and needs to continue indefinitely and added:

> *"Monitoring is not a check list …monitoring is a communication process between the employee and the employer on the progress and the obstacles. What do we need to avoid? What do we need to repeat? Monitoring needs to be done in partnerships."*

The purpose of evaluation was regarded by some employers as identifying alternatives when adjustments were necessary and dealing with failures by considering new approaches to meet the individualised needs of employers. The employees considered acknowledgement from employers for treatment successes as part of the evaluation process – they experienced such feedback as important and encouraging.

Regular feedback sessions between employers and out-patient treatment centres on the outcomes of the proposed networking programme, as well as on the progress of employees' treatment, were recommended as a way of reflecting on successes and identifying problem areas. Insufficient feedback from out-patient treatment centres on treatment progress was mentioned as a major shortcoming. The employers said that they needed a *"before and after picture"* and required evidence of treatment successes.

A staff member from a treatment centre on the interrelation between planning, implementation and evaluation:

> *"It's good to network, but if there's not a plan and action following it that you can evaluate the plan, it actually has stopped with networking and you've made no progress."*

Interdependence and mutual reliance on members of the network to commit themselves, to serve and to work as a team were clearly voiced and aligned with the ecosystems perspective (Long *et al.,* 2006:35; Poulin & Contributors, 2000:4-5). In accordance with macro-level practice, collaboration was consistently identified as a core component (Kirst-Ashman & Hull, 2009:10; Long *et al.,* 2006:3,42-43) to establish a networking programme. However, it was specifically recommended by the employment sector that the treatment centres accept responsibility for marketing of the networking programme as well as initiating the establishment of such a programme.

5.2 Interpretation of the data: interrelationship between themes

The situation analysis provided elaborate themes in terms of the components deemed necessary by the participants to develop a framework for a networking programme. Constant refinement of the themes eventually culminated in the final themes. In accordance with the grounded theory approach, the data was systematically analysed (Braun & Clarke, 2006; Creswell, 2013; Fouché & Schurink, 2011; Monette *et al*., 2011) by means of open, axial and selective coding. During the open coding stage, the data from the audio recordings, field notes and transcripts from the individual and focus group interviews, were examined and re-examined in search of the major categories. The need for a networking relationship, between employers and out-patient treatment centres, aimed at addressing substance abuse in the workplace was identified as the core phenomenon or code of interest (axial coding).

Three themes (sub-categories) relating to the central phenomenon were identified, namely that the programme needs to comprise a specific purpose, distinguishable characteristics and specific procedures (see Table 1). The importance of collaboration, mutual benefits and, also, professional and competent service delivery was evident in all the themes. The importance of marketing was consistently highlighted by the participants, especially regarding the purpose of networking (theme 1), the essential characteristics of a networking programme (theme 2) and the process of establishing a networking programme (theme 3). Considering that marketing was identified as one of the weaknesses of the treatment centres, this is a huge challenge for the centres in the process of developing a networking programme.

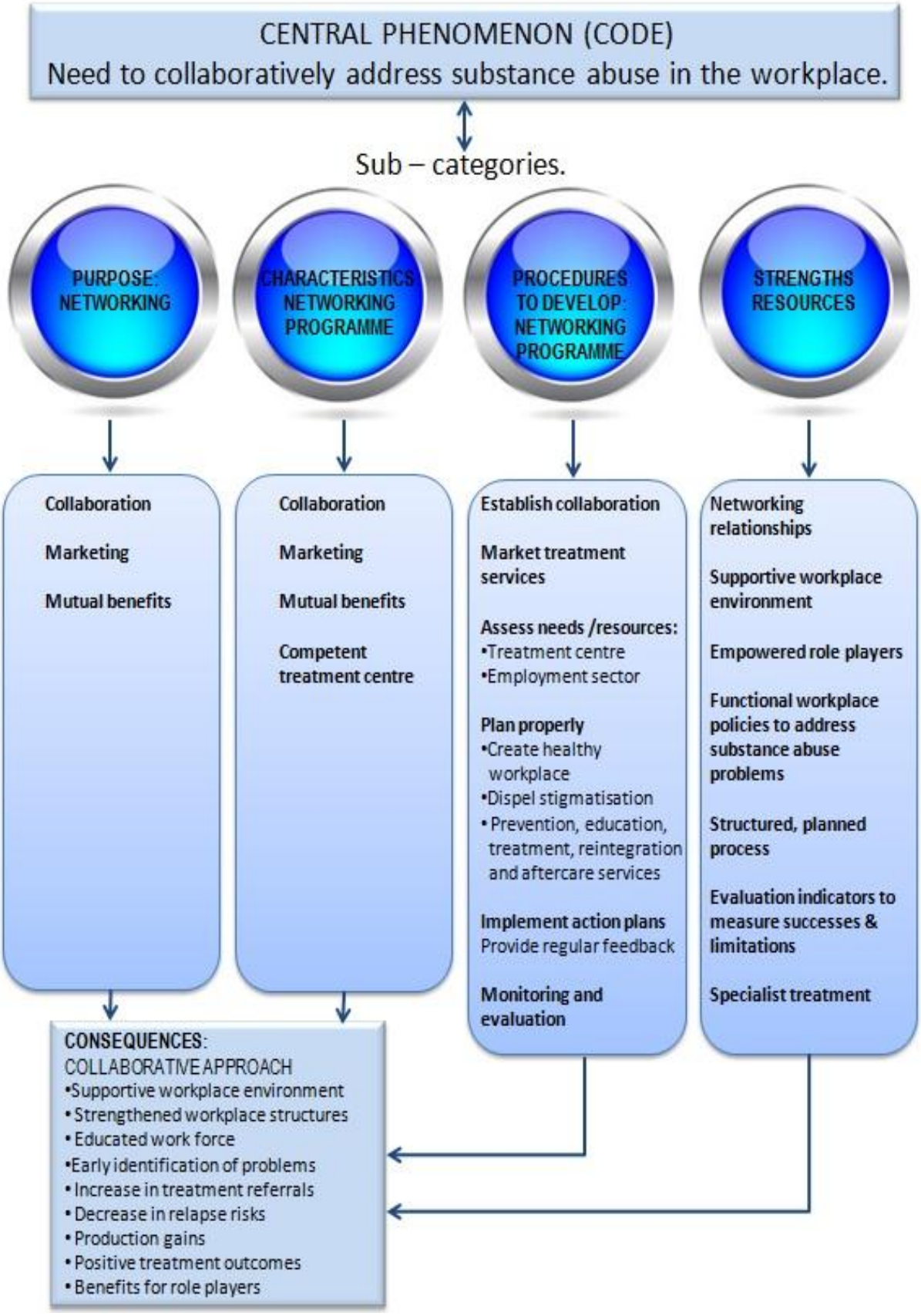
Procedures important to the development of the programme were identified: assessing the needs and resources of both the employment sector and the treatment centre; planning properly; implementing and monitoring action plans; providing regular feedback and evaluating the progress of the programme. A collaborative approach to the execution of the procedures was consistently emphasised. Strengths and resources identified in both populations aligned with the strengths-based approach (Poulin & Contributors, 2000:5-9; Van Wormer & Davis, 2008:17-21).

The macro-level role and function of the social worker, within a networking relationship, required attention to the individualised needs of employees, as well as assisting the employment sector in creating a healthier workplace environment with regard to substance use and abuse (Long *et al.,* 2006:40). A networking programme comprising collaboration, mutual benefits and specialist service delivery provided opportunities for mutual support and personal growth for all parties involved. The ecosystems approach, therefore, created a framework for a higher degree of employee functionality through the betterment of the employment sector with subsequent positive consequences (Segal *et al.,* 2007:153). Such consequences include, inter alia, a supportive workplace environment, empowered workforce, early identification of problems, increase in referrals for treatment, decrease in relapse risks, a positive effect on production and subsequent financial gains, and eventually a healthier workplace culture (see Figure 1 for consequences).

Collaboration and the focus on the strengths perspective aligned with the macro-level practice to improve the social functioning of the macro employment environment (Kirst-Ashman & Hull, 2009:10; Long *et al*., 2006:3).

The interrelationship of the themes are further depicted in Figure 1.

Figure 1: Selective coding - interrelationship between themes



6. PROPOSED NETWORKING PROGRAMME

The networking programme (Dalton, Hoyle & Watts, 2006; Kirst-Ashman & Hull, 2009; Pierson & Thomas, 2010) is expected to serve as a new approach (strategy) to deal with the gap in service delivery. The purpose of the networking programme was to, inter alia, address substance abuse in the workplace through collaboration between employers and out-patient treatment centres. The aim of the programme was to provide a plan to establish a networking programme for employers and out-patient treatment centres. Although the data derived from the grounded theory provided the framework, procedures which were lacking, were added to guide role players in developing and implementing the programme. The proposed networking programme was eventually based on the data collected from the situation analysis in this study, the researcher's experience as a counsellor in substance abuse treatment and her exposure to different networking programmes, as well as supportive theoretical knowledge.

Kirst-Ashman and Hull (2009:180,244) describe a programme, in the context of social services, as an "ongoing configuration of services and service provision procedures intended to meet a designated group of clients' needs." These authors state that the programme should have clear goals with specific deliverables to muster support. They further describe the purpose of a programme as encompassing three important aspects, namely, defining the needs through an assessment procedure (situation analysis), identifying the recipients of the services (employment sector) and specifying the deliverables of the programme (out-patient treatment services). Networking, networks and a networking programme have been discussed comprehensively in Section A of this study with specific references to Dalton *et al.* (2006), Kirst-Ashman and Hull (2009), Long *et al.* (2006), Pierson and Thomas (2010), Poulin and Contributors (2000) and Weyers (2011).

The themes discussed in Paragraph 5 were utilised as the framework for the proposed networking programme. In some instances, detailed viewpoints from participants were integrated as a whole in the programme. In other instances, the essential concepts in the themes were summarised and reflected as part of the programme. Theoretical knowledge aided to support, confirm and guide the researcher to ensure a comprehensive programme.

The different components of the proposed networking programme and related procedures are depicted in Table 2 followed by a detailed discussion on the different components, i.e., the purpose of a networking programme, characteristics of a networking programme and the process to develop a networking programme.

Table 2: Proposed networking programme

COMPONENTS	PROCEDURES
6.1 Purpose of a networking programme	6.1.1 Collaboration 6.1.2 Marketing
6.2 Characteristics of a networking programme	6.2.1 Competency of the out-patient treatment centre 6.2.2 Mutual benefits for the employment sector
6.3 Process to develop a networking programme	6.3.1 Assessment of the out-patient treatment centres • Reflect on the mission of the treatment centre • Assess the professional conduct • Assess the quality of services • Assess the strengths of the treatment centre • Assess the weaknesses within the treatment centre • Identify opportunities in the employment sector • Identify external threats 6.3.2 Collaboration between employers and out-patient treatment centres • Establish an employer data-base • Establish collaborations with employers • Establish a networking agreement • Define roles and responsibilities • Assess the needs of employers and employees 6.3.3 Marketing of the networking programme • Marketing mind-set • Market the benefits of the networking programme • Utilise marketing tools 6.3.4 Planning • Develop action plans 6.3.5 Implementation • Implement the action plans • Select appropriate programmes • Feedback 6.3.6 Monitoring and evaluation • Monitoring • Evaluating

6.1 Purpose of a networking programme

The purpose of the programme is to establish collaborations and to market the programme and the services provided by out-patient treatment centres.

6.1.1 Collaboration

The purpose of the networking programme for employers and out-patient treatment centres is to establish collaborations, to cultivate relationships and to support each other. Continuous nurturing of relationships such as regular feedback on the progress of the networking programme, follow up visits from the out-patient treatment centres and regular communication between employers and out-patient treatment centres are essential to sustain the collaboration relationship.

Collaboration is regarded as a sharing relationship: a shared commitment to the collaborative relationship and mutual goals; a jointly developed structure; shared responsibilities and mutual authority; and sharing of resources and accountability (Backer, 2003; Hepworth, Rooney, Rooney, Strom-Gottfried & Larsen, 2010; Long *et al.,* 2006). Collaboration is further regarded as an "honest exchange of ideas, plans and resources" Long *et al. (*2006:169).

6.1.2 Marketing

The networking programme also provides an ideal opportunity and platform to promote the programme and the services of the treatment centres, as well as to generate funds for the treatment centres. Marketing further provides opportunities to influence behaviour through cultivating attention, interest and preference toward the out-patient treatment centres (Andreasen & Kotler, 2008:36; Jobber, 2004:826; Kurtz & Boone, 2006:16-17). Sustaining close contact with various employer target groups in the community and uncovering their needs and their expectations of the out-patient treatment centre are not only important marketing opportunities but also an important way to cultivate relationships (Greenfield, 2001:33).

6.2 Characteristics of a networking programme

Competency of the out-patient treatment centres and mutual benefits are important characteristics for the establishment and sustainability of the networking programme.

6.2.1 Competency

Competency of the out-patient treatment centre with specific reference to ethical behaviour, professional conduct and quality services are important pre-requisites for sustaining the programme.

The Code of Ethics of the South African Council for Social Service Professions (SACSSP) regarding the ethos of the profession, professional conduct and quality service delivery (SACSSP, 2012) set the standards required from social workers. Social workers employed by out-patient treatment centres are registered with the SACSSP and must adhere to these standards of professional conduct and service delivery. Out-patient treatment centres are further regulated by a number of Acts and the treatment programmes are based on minimum service standards as well as the National Department of Social Development's norms and standards.

6.2.2 Mutual benefits for employers and out-patient treatment centres

The programme provides opportunities to respond to the needs of the role players involved in the programme and therefore holds mutual benefits for employers and out-patient treatment centres. These aspects are essential to attract role players to enter the networking programme (Andreasen & Kotler, 2008; Backer, 2003; Greenfield, 2001; Jobber, 2004; Kurtz & Boone, 2006; Lancaster & Massingham; 2011; Long *et al.,* 2006; Weyers, 2011).

The mutual benefits of the networking programme serve to encourage the continuous involvement of role players in the programme. A detailed list on the benefits of a networking programme for the employment sector and out-patient treatment centres include the following:

6.2.2.1 Benefits for the employment sector

- ✓ Availability of the out-patient treatment centres as support systems or 'refuges' to assist employers in dealing with substance abuse problems in the workplace
- ✓ Empowerment of employers in addressing substance abuse in the workplace
- ✓ An increased knowledge of specialised resources available, such as the out-patient treatment centre to assist employers in dealing with substance abuse problems in the workplace
- ✓ Positive treatment outcomes, such as a healthier working environment due to improved safety in the workplace, reduced triggers for employees in recovery, retention of employees, decreased absenteeism and increased productivity with ultimate financial gains for employers
- ✓ Empowering of employees in recovery
- ✓ Improvement of employee morale due to less workforce absenteeism; opportunities for advantages such as marketing and sales benefits; volunteering opportunities for interested employees and opportunities for personal growth (Andreasen & Kotler, 2008:10,415)
- ✓ Creation of networking opportunities to benchmark with different employers on best practices for dealing with substance abuse in the workplace and streamline own workplace policies and

- ✓ Creation of favourable behaviour change towards the programme and treatment services if the benefits of the programme outweigh the costs involved (Weyers, 2011:316).

6.2.2.2 Benefits for out-patient treatment centres

- ✓ Continuous exposure to networking opportunities
- ✓ Developing and expanding of a data-base of supporters
- ✓ Availability of a platform to voice the needs of treatment centres and employees
- ✓ Enhanced visibility and positioning in the community as primary resource for substance abuse treatment
- ✓ Feedback opportunities to make necessary adjustments to the programme
- ✓ Promotion of professional growth in staff members
- ✓ Fundraising opportunities to enable expansion of services and an increase of human resources
- ✓ Partnering with prestigious corporations to ensure support from other employers, increased revenue, positive impact on the organisation's mission, access to new audiences and exposure to expertise in the corporate sector to enhance growth in the organisation (Andreasen & Kotler, 2008:416) and
- ✓ Enabling the treatment centres to achieve their mission and goals.

6.3 Process to develop a networking programme

6.3.1 Assessment of the out-patient treatment centres

Kirst-Ashman and Hull (2009:29,31) and Segal *et al.* (2007:67) state that assessment is key to individualise the needs of the client and to collect information on clients' resources and support structures. Kirst-Ashman and Hull (2009:31-32) add that the results of assessment activities can serve as the foundation for the development, implementation and adjustment of intervention plans. Andreasen and Kotler (2008:68-75) refer to the necessity of reflecting on the organisation's mission, strengths and weaknesses and the external opportunities and threats during the assessment process.

An in-depth assessment of the treatment centres is therefore essential and comprises an assessment of the mission, professional conduct, quality of services, strengths and weaknesses and the potential external opportunities and threats confronting the centre.

6.3.1.1 Reflect on the mission of the treatment centre

The mission of the out-patient treatment centre is its core business and basic purpose – what the organisation is trying to accomplish and what value the organisation can offer to customers (Andreasen & Kotler, 2008:67-68; Hollensen, 2010:3; Kotler & Armstrong, 2010:51-52; Kurtz & Boone, 2006:66). Reflection on the mission and core business and an assessment whether

the networking programme aligns with the organisation's core business is therefore critically important.

6.3.1.2 Assess the professional conduct

It is important for out-patient treatment centres to assess whether they adhere to the general ethical standards and responsibilities of the social work profession towards the employment sector, and with regard to professional conduct and performance as required by the SACSSP (2012). The Code of Ethics is further discussed in Kirst-Ashman and Hull (2009:406-4210), Long *et al.* (2006:252-253,258-271), Poulin and Contributors (2000:21-23), Segal *et al.* (2007:464-483) and Strydom (2011:115-129).

The employment sector also needs to become aware that social workers are regulated by the requirements of the SACSSP and that treatment centres are obligated to adhere to legal requirements and minimum standards to govern the centres.

6.3.1.3 Assess the quality services

Out-patient treatment centres need to assess the quality of their services and the SERVQUAL model (Lancaster & Massingham, 2011:513) is recommended. The SERVQUAL model developed by Parasuraman, Zeithaml and Berry (Lancaster & Massingham, 2011:513-514), proposes the following five criteria for assessing service quality:

- ✓ Reliability – the extent to which services is delivered to the standards expected and promised.
- ✓ Assurance – the degree of trust and confidence the customer has in the service provider.
- ✓ Tangibles – physical signs which may be used as indicators of quality service provision such as exhibition material and office facilities.
- ✓ Empathy – customers' expectations of service providers to understand their individual needs and wants.
- ✓ Responsiveness – the willingness and ability of the service provider to meet and adapt to customers' needs.

The SERVQUAL model further points out that service quality problems usually occur where a gap exists between what consumers expect and what they perceive they receive (Lancaster & Massingham, 2011:514). Assessment of possible gaps of what the employers expected in terms of the networking programme and service delivery and what they perceive they received is therefore important.

6.3.1.4 Assess the strengths of the treatment centre

According to Kurtz and Boone (2006:47), the strengths of an organisation reflects its core competencies – what it does well – and the capabilities valued by customers but competitors find difficult to duplicate. Hollensen (2010:241) and Jobber (2004:45) particularly state that the capabilities and resources likely to be valued by customers should be listed by the treatment centres, for example what the employment sector thinks of a centre's service quality and the overall value of the service. Therefore, in order for treatment centres to assess the strengths of the centre, it is important to obtain feedback from the employment sector on aspects such as the following:

- ✓ Trustworthiness, credibility and financial reliability
- ✓ Specialist knowledge, expertise, core competencies and service delivery
- ✓ Treatment outcomes and testimonies of success
- ✓ Relevance of the treatment centre and
- ✓ Loyalty of the employment sector toward the treatment centre.

6.3.1.5 Assess the weaknesses within the treatment centre

Andreasen and Kotler (2008:74), Jobber (2004:44-45), Kotler and Armstrong (2010:67-68) and Kurtz and Boone (2006:47-48) describe weaknesses as internal limitations that may interfere with the organisation's performance and cause vulnerabilities. Inadequate financial resources, a weak market image, inadequate knowledge on marketing, shortage of human resources and limited capacity are examples of such weaknesses. Identification of the weaknesses within the treatment centre is therefore essential as the weaknesses could interfere with the centres' performance to establish and sustain a networking programme.

6.3.1.6 Identify the opportunities in the employment sector

Opportunities are described as favourable factors in the external environment that may be utilised to the benefit of the business and/or organisation (Kotler & Armstrong, 2010:68). Although limiting factors (weaknesses) were identified within the workplace (See Article 2 theme 1), these factors are also possible opportunities. For instance, facilitating change in an unsupportive workplace to develop a more supportive culture towards substance abuse problems; presenting awareness and education programmes regarding the negative consequences of the link between substance abuse and HIV and AIDS; providing treatment for employees facing a disciplinary hearing due to substance abuse behaviour as an alternative for dismissal, and empowering inadequate support structures in the workplace such as human resource management and/or EAPs to deal more effectively with substance abuse in the workplace. The above weaknesses should be regarded as challenges and

converted into opportunities by out-patient treatment centres to make a difference (Hollensen, 2010:243).

6.3.1.7 Identify external threats

Threats are described as unfavorable external factors that negatively impact an organisation and attack the organisation's weaknesses (Kotler & Armstrong, 2010:68; Kurtz & Boone, 2006:47-48). The acceptability of social drinking is one of out-patient treatment centres' greatest threats (competitors). The highly competitive market for fund raising, unsecured government subsidies and funding from donors can also be regarded as threats for the centres, impacting directly on their financial and human resource capacity and service delivery. Andreasen and Kotler (2008:12) and Jobber (2004:826) emphasise that government subsidies are needed to maintain services but add that non-profit organisations can no longer depend on automatic continuation of traditional sources of support. It is therefore important for out-patient treatment centres to identify the threats and either convert them into opportunities or develop strategies to avoid the threats or minimise their impact (Hollensen, 2010:243). Addressing these threats requires treatment centres to further explore opportunities for fundraising, and initiate informative campaigns highlighting the dangers of substance abuse.

6.3.2 Collaboration between employers and out-patient treatment centres

Establishing of collaboration is regarded as an important part of the procedures to develop a networking programme. Hepworth *et al*. (2010:451) refer to collaboration as a "mutually beneficial and well defined relationship entered into by two or more organisations to achieve common goals". Such a relationship includes a commitment to the relationship, mutual goals and sharing of resources. In order to establish collaborations with employers, the following steps need to be performed: the development of an employer data base, development of the criteria in order to select the employers, the actual process to establish the collaboration, establishing a networking agreement between the employer and the out-patient treatment centre, defining the reciprocal roles and responsibilities and assessing the needs of the employers and employees.

6.3.2.1 Establish an employer data-base

The first step in establishing an employer data-base is to categorise the broad employment sector into specific groups according to particular criteria. As it is not possible to reach all relevant role players in a demarcated area due to practical and cost-effective reasons, market segmentation (Andreasen & Kotler, 2008; Hollensen, 2010; Kurtz & Boone, 2006; Lancaster & Massingham, 2011; Weyers, 2011) is performed. The broad employer population is categorised into specific groups according to particular criteria with at least one important

common factor (Weyers, 2011:309). In terms of the networking programme the common factor is a collaborative approach to deal with substance abuse in the workplace.

The processes adopted by the researcher to establish a database are recorded below. The three main sources of business contacts of the SANCA Lowveld treatment centre utilised were:

- ✓ Employers' Organisations
- ✓ Existing employer database consisting of sponsors and consumers of services and
- ✓ The Management Board of the treatment centre who are key role players from the community.

Access to these sources created opportunities to develop a database consisting of small, medium and macro businesses (Falkena *et al.,*2011), the chamber of commerce, an international business network and other role players in the community with business affiliates. Specific high-risk and safety-sensitive occupational groups were also considered for inclusion, such as transport, mining and timber companies involving heavy machinery and equipment, as well as security businesses (Department of Social Development, 2013:76; McCann *et al.,* 2011:70; Pelser, 2011:10). Employers located within the proximity of the out-patient treatment centres were considered for inclusion in the data-base.

A data-base therefore may include

- ✓ Employers' Organisations
- ✓ Management Board representatives of the out-patient treatment centre
- ✓ Existing database of the treatment centre
- ✓ Small, medium or macro-businesses
- ✓ Specific occupation groups including high risk and/or safety sensitive groups
- ✓ Businesses selected according to rural and/or urban areas
- ✓ Businesses selected according to the individualised needs and priority areas of the employment sector, as well as the treatment centres and
- ✓ Businesses selected according to the mission, goals, capacity and infrastructure of the treatment centres.

6.3.2.2 Establish collaborations with employers

The next step is to establish collaborations with the selected employers. Ways to motivate role players to buy in to a collaborative relationship are closely linked to the stages of and approaches to behavioural change (Andreasen & Kotler, 2008:97-100; McCann *et al*., 2011: 228-230; Poulin & Contributors, 2000:14). These different stages and approaches are the pre-

contemplation stage, the contemplation stage, the preparation stage, the action stage and the maintenance stage. It is during the contemplation stage that out-patient treatment centres need to effectively communicate the individualised benefits for employers (Andreasen & Kotler, 2008; McCann *et al*., 2011; Poulin & Contributors, 2000). Because collaboration is regarded as such an important characteristic of a networking programme, out-patient treatment centres should carefully consider these stages.

Backer's (2003:2,8-9) concerns about the deficiencies in the collaboration process underline the need to pay close attention to the aforementioned stages of (and approaches to) the best ways of establishing and sustaining successful collaborations. Backer further recommends proper assessment whether collaboration is indeed the appropriate step to address the particular problem. This author further states that proper planning of such collaboration is essential.

6.3.2.3 Establish a networking agreement

Attend to the development of a networking agreement between the employers and treatment centres, as well as the definition of reciprocal roles and responsibilities, once collaboration has been established. The agreement, also referred to as a memorandum of collaboration (Backer, 2003:122), needs to cover aspects such as the following:

- ✓ Agreement regarding reciprocal ethical and professional conduct
- ✓ Agreement regarding the establishment and sustainment of the networking programme
- ✓ Agreement on the reciprocal roles and responsibilities
- ✓ Agreement on the outcomes of services such as prevention and awareness programmes, training programmes, referral procedures, treatment policies and procedures and arrangements regarding reintegration and aftercare of the employee in recovery
- ✓ Agreement on treatment procedures for employees facing disciplinary action due to substance abuse behaviour in the workplace and
- ✓ Agreement on dealing with EAP related issues.

6.3.2.4 Define the roles and responsibilities

Clarity on the reciprocal roles, responsibilities and decision making powers of the employment sector and the out-treatment centre is required to sustain the collaboration relationship. These roles and responsibilities should be collaboratively defined and need to be included as part of the networking agreement. A list of possible roles and responsibilities of the employers and out-patient treatment centres includes the following:

The roles and responsibilities of employers

- ✓ Involvement in the overall planning process of establishing the networking programme
- ✓ Involvement to sustain the networking programme
- ✓ Disseminating information on the benefits of the programme
- ✓ Commitment as team members to the collaboration process
- ✓ Disseminating information on the dangers of substance abuse to the workforce in general
- ✓ Initiating opportunities to assess the needs regarding substance abuse in the workplace, as well as capacities and resources in the employment sector to address the problem
- ✓ Involvement in the development of solutions to address substance abuse in the workplace
- ✓ Supporting the reintegration of recovering employees in the workplace as part of an aftercare programme
- ✓ Supporting the networking programme financially, as well as services rendered by the out-patient treatment centre
- ✓ Evaluating the progress and outcomes of the networking programme and
- ✓ Evaluating the service quality of the out-patient treatment centre.

The roles and responsibilities of the out-patient treatment centres

- ✓ Acting as educators, facilitators, team or group leaders and programme developers (Long *et al.,* 2006:56-58)
- ✓ Initiating the establishment of the networking programme
- ✓ Facilitating the planning process to establish the programme
- ✓ Involvement in the sustainability of the programme
- ✓ Assessing the needs and resources in the workplace regarding combating substance abuse in the workplace
- ✓ Identifying areas for new initiatives related to combating substance abuse in the workplace and facilitating problem solving processes (Hepworth *et al.,* 2010:452)
- ✓ Providing treatment and support services regarding substance dependency according to the individualised needs of the employment sector
- ✓ Capacitating members of the employment sector to deal with substance abuse in the workplace
- ✓ Evaluating and providing feedback to employers on the progress of the programme and
- ✓ Assessing own professional conduct and quality service delivery.

In accordance with these roles, both the employer and out-patient treatment centre are involved as initiators of the programme, in the development and establishment of the programme, and in marketing and disseminating the networking messages and the information on substance abuse. Both are acting as support structures for employees during the reintegration process and aftercare phase and both are involved in evaluating the programme outcomes and service delivery. The employers' unique contribution would be financial support and the out-patient treatment centres' would be to contribute expertise and knowledge as substance abuse treatment specialists. Such an approach will most likely enhance collaboration and networking between the employers and out-patient treatment centres.

6.3.2.5 Assess the needs of employers and employees

- ✓ Once a networking agreement has been established, conduct an assessment of the scope and impact of substance abuse problems on the workplace and specific needs of employers to deal with the problem.
- ✓ Distribute anonymous self-evaluation questionnaires among employees to identify substance abuse and/or dependency as a possible tool to assess the extent of the problem in the workplace. Assessment of the needs of employees is conducted to individualise service delivery.
- ✓ Involve the treatment centres and the employers and/or other support structures in the workplace (EAPs, staff members from the employee wellness programmes, the human resource manager and staff members involved in the health and safety division of the company) in the assessment process.

6.3.3 Marketing of the networking programme

The initiative to market the programme is vested in the out-patient treatment centre. A good marketing mind-set, marketing of the benefits of the proposed networking programme and using different marketing tools to promote the message of networking are essential in the marketing process.

6.3.3.1 Develop a marketing mind-set

Andreasen and Kotler (2008:35-46) state that a good marketing mind-set is a pre-requisite to and a central principle of successful marketing. This includes a clear appreciation of what marketing comprises and the benefits for the organisation. These authors identify different orientations or mind-sets regarding marketing, namely the product mind-set, the sales mind-set, the organisation-centred mind-set and the target audience mind-set. A target audience mind-set requires the organisation to "systematically study the target audience's needs, wants, perceptions, preferences and satisfaction" (Andreasen & Kotler, 2008:39). A target audience

mind-set is one that endeavours to “sense, serve and satisfy the needs and wants of its multiple publics within the constraints of its budget” (Andreasen & Kotler, 2008:41). Out-patient treatment centres therefore need to study and adopt a ‘target audience mind-set’ in order to establish a sound networking relationship with employers.

6.3.3.2 Market the benefits of the networking programme

Marketing the benefits of a networking programme for both the employment sector and out-patient treatment centres is a key part of the marketing message. Mutual benefits were discussed in detail in Paragraphs 6.1 and 6.2 as one of the key components of the proposed networking programme. Discussing the benefits of the treatment programme with employers ought to be done in a composed manner so as to avoid creation of unrealistic expectations.

6.3.3.3 Utilise marketing tools

Lancaster and Massingham (2011:242-243) refer to various promotional tools collectively known as the communications or marketing mix, namely advertising, sales promotions, public relations, sponsorships, direct sales and events marketing. According to Andreasen and Kotler (2008:52-54), marketers should use the full marketing mix, as effective marketing is the right services “in the right place at the right time and at the right price”. Out-patient treatment centres need to consider the most appropriate marketing tools to promote the networking programme, such as the following:

- ✓ Establish good public relations, as this is a very important marketing tool in promoting the proposed networking programme. Revisit the previous discussions on collaboration and the cultivation of relationships, and continuously cultivate collaborations
- ✓ Prepare promotional material with information about the treatment centre, such as contact details, the scope and cost structure of treatment services and referral procedures, and arrange for the distribution of such material in the workplace. Alternatively, negotiate with the employer the inclusion of such material in the workplace policies on substance abuse and
- ✓ Promote new service products, especially as a means to meet the individualised needs of the employment sector on an ongoing basis.

6.3.4 Planning

Effective planning and an appropriate planning strategy require the following action plans:

- ✓ Obtain support from senior management within the treatment centre from the onset of the networking process; match the planning to the mission and culture of the organisation; communicate the plans and expectations clearly to those charged with the implementation of the process and train the personnel in the necessary marketing skills and knowledge to perform the tasks (Jobber, 2004:54-57)

- ✓ Ensure the support of the management structures from the employment sector
- ✓ Liaise with employers before any plans are developed and executed
- ✓ Involve the management structures from the employment sector in the planning process
- ✓ Develop strategic, as well as detailed operational plans for the establishment of the networking programme in collaboration with the employer and out-patient treatment centre
- ✓ Formulate appropriate planning strategies consisting of what should happen and why (Jobber, 2004:753)
- ✓ Submit plans that are visual; practical with specific goals, timelines and responsibilities; and individualised according to the employer's needs
- ✓ Present the plans to the employer for evaluation purposes and final approval (Andreasen & Kotler, 2008:86; Weyers, 2011:128). According to Andreasen and Kotler (2008:86), one of the biggest mistakes in project planning and implementation is neglecting to pre-test the plans with the target audience (employers) which often has the final decision to accept or reject the plans
- ✓ Legitimise the plans by getting the "employer's final approval of the plans, their permission to start with its implementation and their commitment to support the process" (Weyers, 2011:128)
- ✓ Weigh up the cost-effectiveness of establishing and sustaining a networking programme against the capacity of the treatment centre. Out-patient treatment centres need to align marketing of the programme and delivery of quality services
- ✓ Submit a costing structure for the implementation of the plans to the employer for approval
- ✓ Negotiate the funding of the programme and/or services with the employer
- ✓ Develop and regularly update an organogram indicating the relevant contact persons and details of the employment sector and out-patient treatment centre. Provide this organogram to both sectors to ensure continuity in contacts and sustainability of the networking programme and
- ✓ Develop monitoring systems and indicators to evaluate the progress of the programme and treatment services.

6.3.5 Implementation

Effective implementation depends on proper planning, an appropriate planning strategy consisting of what should happen and why, and regular feedback to relevant role players on the progress of the networking programme and treatment services.

6.3.5.1 Implement the action plans

Ensure that tasks such as the following are performed during the implementation phase (Andreasen & Kotler, 2008:86-87; Jobber, 2004:753; Weyers, 2011:129):

- ✓ Involve role players from both populations in a team effort to implement the networking programme in order to ensure sustainability of the programme
- ✓ Negotiate the assignment of a 'coordinator' in the business to assist in maintaining the networking programme to further enhance sustainability
- ✓ Train the people responsible to execute the necessary tasks
- ✓ Mobilise resources needed to perform the implementation tasks
- ✓ Coordinate and monitor the action plans
- ✓ Motivate the role players continuously to remain committed to the programme
- ✓ Implement the networking programme on a trial basis and evaluate the progress of the programme, as well as outcomes of the treatment services to revise the plans and address obstacles and
- ✓ Utilise the regular health and safety talk sessions in the company as opportunities and a platform to disseminate information.

6.3.5.2 Select appropriate programmes and services

Implement programmes and services according to the individualised needs of the employment sector as determined during the assessment phase of the programme. Compile a list of possible programmes and services for implementation such as:

- ✓ Information on the content of the treatment programmes
- ✓ Awareness and prevention programmes on substance abuse in general including the early signs and symptoms of substance dependency
- ✓ Information on solutions to deal with substance abuse problems
- ✓ Awareness programmes on the negative consequences of the link between substance abuse and HIV and AIDS and
- ✓ Training programmes on how to deal with employees' resistance regarding substance abuse problems; how to motivate employees for treatment; referral procedures; the importance of relapse prevention; and reintegration and aftercare services.

6.3.5.3 Feedback

- ✓ Arrange regular feedback discussions between the employer and out-patient treatment centre on the outcomes of the networking programme, as well as on the progress of employees' treatment to reflect on the successes and problem areas

- ✓ Follow up on the feedback with employers and/or relevant staff members to discuss possible obstacles in the workplace and/or the treatment services
- ✓ Involve employers, as well as employees in feedback sessions on the effectiveness of the services and obstacles and successes in order to evaluate the quality and value of services provided by the treatment centre and
- ✓ Ensure prompt follow-up on referrals from the health and safety division in the company and provide feedback on the progress of employees in treatment.

Jobber (2004:758) states that people who accept the value of the programme and a willingness to commit themselves to ensure its success, are ultimately needed to ensure successful implementation.

6.3.6 Monitoring and evaluation

According to Kirst-Ashman and Hull (2009:340) the purpose of programme evaluation includes opportunities to revise the programme in order to enhance efficacy, to ensure that the intended services are provided, to identify limitations and possible side effects, to identify successes and to build support for sustaining the programme.

Backer (2006:140) identifies three common purposes of evaluation namely monitoring, learning and impact assessment. Monitoring requires record keeping of activities, events, and participation; learning requires feedback on processes, effectiveness of activities, possible changes and best practices, and impact assessment requires specification of outcomes and how they will be achieved and measured. Rubin and Rubin *(in* Kirst-Ashman & Hull, 2009:256) emphasise the importance of monitoring both *effort* - measuring the energy, time, or money spent by the organisation to accomplish its goals, and *outcome* – measuring the changes brought about by the programme. Andreasen and Kotler (2008:464) state that evaluation is focused on the final outcomes – what worked and what did not work?

Backer (2006:113-121) discusses at length the interrelatedness between planning and evaluation, and provides general evaluation guidelines, evaluation questions and methods of evaluation. Evaluation starts at the outset of a programme and continues throughout the programme, says Weyers (2011:143).

In preparation of monitoring and evaluation, the following tasks should be executed:

- ✓ Discuss the purpose and value of the monitoring and evaluation process with the employee, as well as the employer
- ✓ Plan the monitoring process in collaboration with the employee

- ✓ Involve the employer or direct supervisor in the monitoring process (depending on the willingness of the employee due to confidentiality reasons) and
- ✓ Develop and apply monitoring and evaluation indicators, i.e., pre- and post-evaluation questionnaires to measure training and awareness programmes; evaluation and feedback reports to evaluate service delivery and quality services; indicators to monitor drug test results; indicators to measure referrals for treatment; work performance indicators; and indicators to measure the link between HIV and AIDS and substance abuse.

6.3.6.1 Monitoring

- ✓ Monitor and measure the networking programme in terms of the costs and the benefits. Are the benefits sufficient to justify the costs?
- ✓ Monitor the energy, time and resources invested by the out-patient centres to achieve the networking programme goals
- ✓ Measure the competency, performance, quality services and job descriptions of the out-patient treatment centre
- ✓ Measure the employers' time, human resource involvement and funds invested in establishing and maintaining the programme
- ✓ Measure the employer's efforts and costs in actually addressing substance abuse in the workplace and
- ✓ Measure the frequency of follow-up visits to specialists at the centres, attendance at aftercare sessions and outcomes of random testing for substance use.

6.3.6.2 Evaluation

- ✓ Evaluate factual outcomes (Kirst-Ashman & Hull, 2009:256) such as the employee's work performance, frequency of absenteeism, punctuality, involvement in incidents such as accidents, injuries, conflict encounters and misconduct
- ✓ Evaluate outcomes regarding the networking programme, i.e., did the programme serve the purpose that was expected; did the programme comply with the characteristics of a networking programme as initially identified and were the different procedures considered and implemented to establish the programme?
- ✓ Conduct a collective progress evaluation session with the employee and all relevant role players to assess the treatment progress and to plan strategies for the way forward
- ✓ Evaluate attitudes, perceptions and viewpoints regarding the programme's effectiveness, quality services and service delivery (Kirst-Ashman & Hull, 2009:257) and

- ✓ Evaluate the outcomes with regards to the expected benefits (see Paragraph 6.2.2) collaboratively by the employment sector and the out-patient treatment centres.

Ultimately, one of the purposes of programme evaluation is to enhance sustainability of the programme, as well as service delivery. Kirst-Ashman and Hull (2009:257) suggest the following tasks to establish sustainability:

- Define standardised procedures for continued implementation and integrate these procedures into the agency's policies
- Link the programme with other aspects in the agency's structure
- Establish the programme within the context of other programmes and services in the agency and
- Develop a feedback system to evaluate the programme's continuing effectiveness internally and externally.

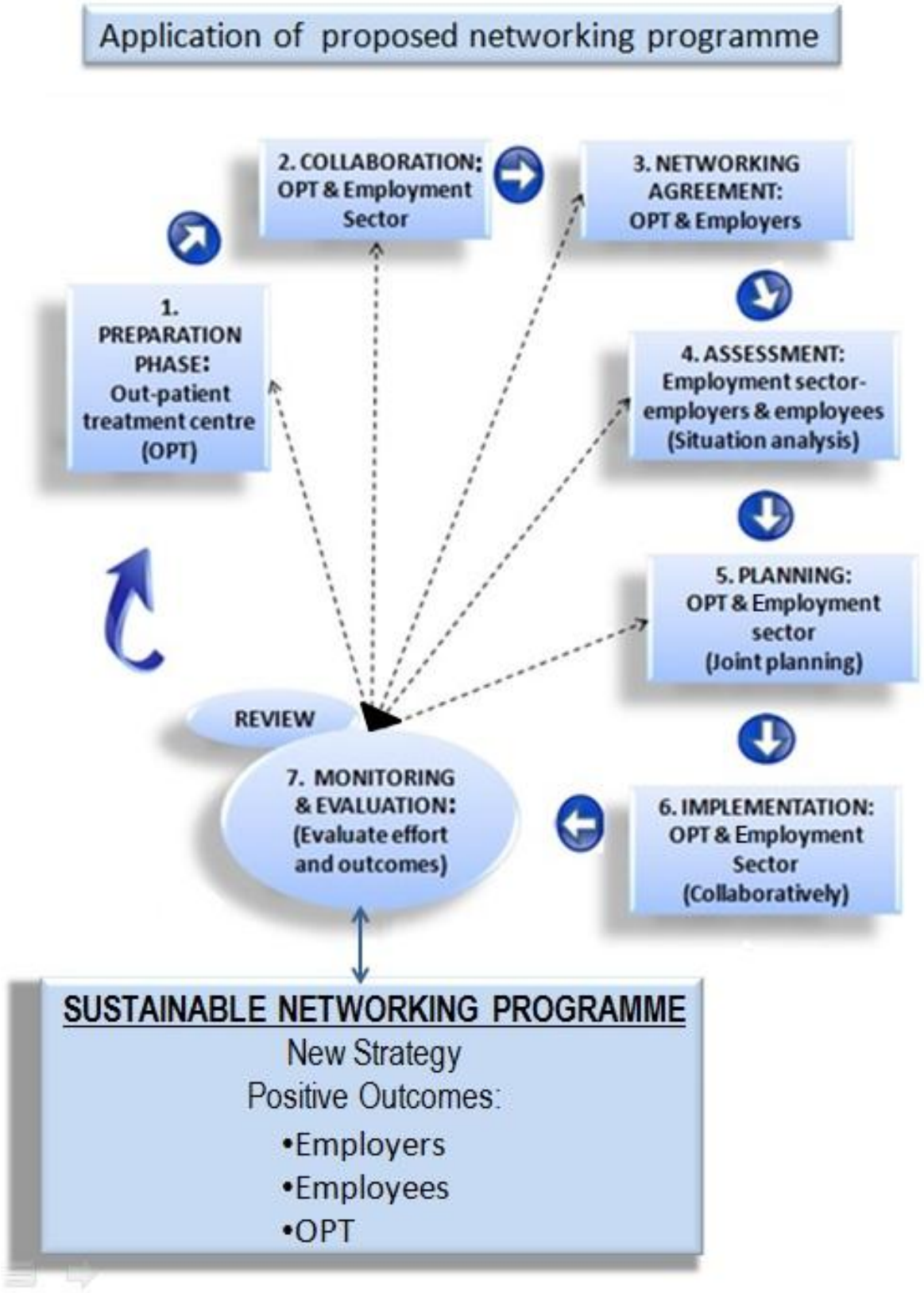
Although literature sources are available on the process and methods of evaluation (Andreasen & Kotler, 2008; Backer, 2006; Jobber, 2004; Kirst-Ashman & Hull, 2009; Weyers, 2011) specific indicators for evaluating a networking programme involving employers and out-patient treatment centres aimed at dealing with substance abuse in the workplace, could not be traced.

As this programme has not been applied and tested yet, it is not cast in stone and allows for improvements and adjustments to ensure its efficacy. A discussion on the application of the programme in practice follows next. Detailed information on the procedures to establish a networking programme was offered in Paragraph 6, and is therefore not repeated.

7. PRACTICAL APPLICATION OF THE PROPOSED NETWORKING PROGRAMME

The steps to apply the programme in practice are schematically presented in Figure 2, followed by a brief description on the different steps, as well as examples of a few projects in Appendix 20. Although the steps are presented in a specific sequence, in practice these steps need not be implemented in the same order. It may be necessary to revisit some of the steps or additional steps may spontaneously emerge.

Figure 2: **Practical application of the networking programme**



Steps to apply the networking programme in practice are the following:

Step 1: Preparation phase

The main purposes of the preparation phase is for the out-patient treatment centre to

- Become familiar with the proposed networking programme
- Identify unmet needs in the employment sector regarding delivery of social services
- Develop an innovative idea to address the need(s)
- Assess the strengths, weaknesses and basket of services of the treatment centre, as well as external opportunities and threats
- Bolster the success of the centre by means of empowering and training relevant staff members responsible for implementation of the programme and
- Prepare a proposal, for presentation to the decision makers, including facts on the problems and unmet needs, purpose of the networking programme, potential recipients of services, possible services and potential benefits. Benefits may include the following:

Benefits for the employment sector

- ✓ **Empowered employers**

  Out-patient treatment centres are utilised as support systems to assist with substance abuse problems

  An increase of knowledge regarding specialised resources to address substance abuse and

  Knowledgeable and skilled employers in dealing with substance abuse in the workplace.

- ✓ **Empowered employees**

  Employees in need of social services are reached and served

  Early identification of employees with substance abuse problems

  Strengthened support structures in the workplace

  Clear workplace policies and procedures

  Adherence to legal obligations for treatment of substance abuse and dependence

  Sustainment of employees in recovery

  Reduced triggers for employees in recovery and

  Retention of employees.

- ✓ **Healthier working environment**

  Improved safety in the workplace and a decrease in substance related accidents

  Decreased absenteeism, sick leave and theft

  Decrease in positive drug test results and

Increased productivity and corresponding financial gains.

Benefits for out-patient treatment centres

Continuous exposure to networking opportunities

Access to new audiences

Expanding data-base of supporters

Enhanced visibility in the community as primary treatment resource for substance abuse

Partnering with prestigious corporations to muster support

Platform to voice the needs of treatment centres

Platform to voice the needs of employees

Platform to voice needs of employers and

Feedback opportunities to make necessary adjustments to the programme.

Step 2: Establishing collaboration

Ensuring the sustainability of the programme requires the cultivation of a collaborative relationships with key role players in the employment sector and should thus consistently receive attention. Efforts to establish sustainability need to be applied from the onset, in other words, from the collaboration phase in the programme. In fact, each step should be executed with great care to enhance sustainability. Consistent nurturing of collaboration remains key to sustaining the networking programme. Additional actions should be taken to ensure sustainability and include the following:

- Establishing an employer data base
- Selecting people from the data base who are decision makers, influential people and people who are interested and motivated in addressing the need
- Mustering support and establishing close collaboration with the selected people for the proposed networking programme
- Presenting documentation on the facts of the unmet need(s), purpose of the proposed networking programme, available services to address the need, potential benefits for the parties involved and intended outcomes
- Negotiating, with the employment sector, the establishment of a task team to assist in the application of the networking programme. Ideally, the task team should be representative of the employment sector and could include role players from the Human Resource (HR) department, Employee Assistance Programme (EAP), Employee Wellness Programme (EWB), risks department who administer the zero

tolerance drug testing process, the department responsible for disciplinary actions, the health and safety department and the unions

- Encouraging role players to accept ownership of and contribute towards sustainable collaboration
- Linking the services with other structures in the business, i.e., HR department, EWP, EAP, health and safety department, risks department and unions and
- Establishing the programme within the context of other programmes and services in the employment sector including HIV campaigns, Employee Wellness campaigns, health and safety training programmes, random drug testing programmes and disciplinary action programmes.

Step 3: Establishing a networking agreement

The task team should establish a networking agreement with attention to

- Agree on a mutual code of ethics
- Formulate the goals and objectives of the programme
- Identify the roles and responsibilities of the parties involved
- Consider the time frame of the programme
- Identify possible services to address the unmet needs
- Prepare a preliminary itemised budget and means to source funding
- Define standardised procedures to ensure sustainability of the programme and integrate these procedures into the agency's policies and
- Develop a feedback system to evaluate the programme's continued efficacy internally and externally.

Step 4: Assessment of the employment sector

- Conduct a situation analysis and identify the strengths, limitations and needs of the employment sector, as well as opportunities for networking
- Involve employers and employees consistently in the process and
- Identify the priority needs and appropriate services to meet them.

Step 5: Planning

- Develop strategic and operational plans to address the individualised needs
- Obtain managerial support and approval from the treatment centre and the employers and

- Develop indicators to measure progress of the programme and impact of the services. These indicators could include pre- and post-evaluation questionnaires for training and awareness programmes, feedback reports on effectiveness of service delivery, drug test results, frequency of referrals for treatment and work performance. Performance indicators of employees could include the following: absenteeism records; results of random drug testing; response of management regarding drug test results; substance abuse related accidents at work; substance abuse related sick leave; knowledge and skills on dealing with substance abuse problems; increase/decrease in treatment referrals; and the frequency and extent of employer's and employees' involvement in the reintegration and aftercare process.

Step 6: Implementation of service delivery

- Continue nurturing support from the employment sector and treatment centre
- Implement services according to individualised needs on a trial run basis
- Initially involve a small group to showcase the programme with lower costs and less risks
- Monitor action plans and motivation levels and
- Provide regular feedback to the task team.

Step 7: Monitor and evaluate the programme and service delivery

Monitoring and evaluation are consistently needed and should be applied to all the steps during the application of the programme. Feedback to the task team and relevant role players in the employment sector, as well as the out-patient treatment centre on the progress of the implementation process is essential for continued support and sustainability. After evaluating the progress and impact of the networking programme, quality services and service delivery, it might be necessary to revisit some prior steps in the programme and adjust actions where necessary. Positive outcomes may perpetuate continued support of the programme; efforts to sustain the programme, as such, therefore need to be continued.

Effort and outcomes should be monitored and evaluated.

- ✓ Monitor *effort* –
  - Time and resources spent by employers and treatment centres to accomplish the goals
  - Competency, quality services and job descriptions of the treatment centre and
  - Reflect on the benefits initially identified during the preparation phase and evaluate the costs against the benefits.

- ✓ Evaluate *impact* –
  - Evaluate factual outcomes, i.e., the performance of employees before and after intervention of the treatment centre and
  - Evaluate attitudes, perceptions and viewpoints regarding the programme's efficacy, quality of services and service delivery.

8. THEORETICAL MODEL

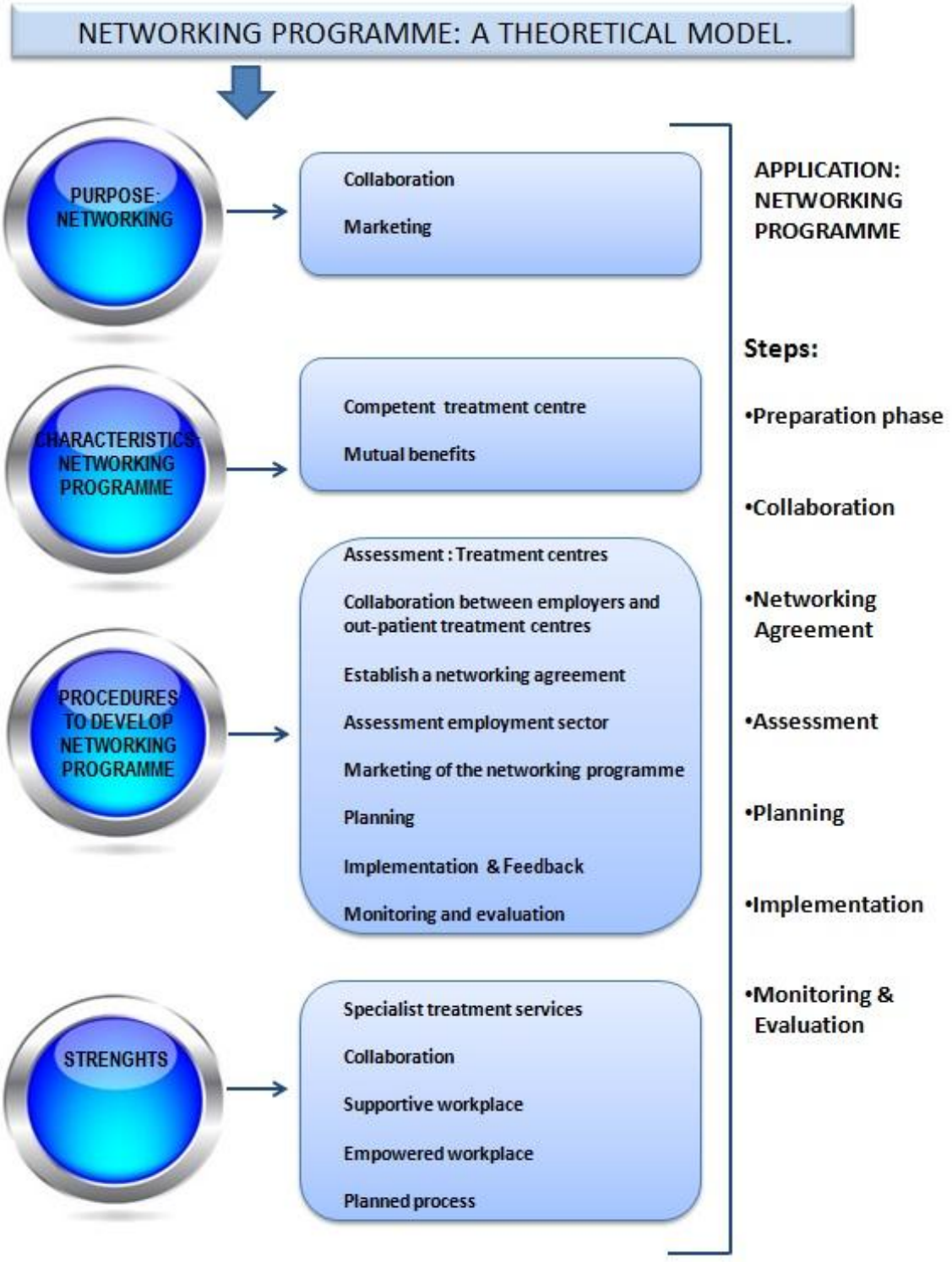
The proposed networking programme is regarded as a new strategy to both address the gap in service delivery and meet the needs of employers and employees in dealing with substance abuse in the workplace. The steps suggested by Kirst-Ashman and Hull (2009) and Weyers (2011) in the development of a programme support the framework of the proposed networking programme. Furthermore, some of the serious concerns by Backer (2003) about deficiencies regarding collaboration are addressed in this programme.

Findings from the situation analysis regarding the concerns, needs and resources of employers and out-patient treatment centres provided the motivation for developing the networking programme (Article 2). Findings from the situation analysis regarding the core components of developing a networking programme served as framework for the proposed programme (Paragraph 5, Table 1 of this Article). These findings were grounded in the knowledge and experiences of the participants.

The proposed networking programme and suggested steps to apply the programme in practice eventually culminated in a theoretical model with the aim to adjust social welfare resources and needs to combat substance abuse in the workplace. The aim is further to connect role players and combine their efforts with appropriate social welfare services. The interrelation between the needs of employees and employers, and resources to address the needs aligns with the ecosystems perspective. The social worker's role as being the "person in the middle" is to adjust the social welfare resources and the needs of the employment sector within the framework of the macro level environment. Collaboration and the establishing of connections between the employment sector and out-patient treatment centres are aligned with the strengths-based approach.

The relationship between the entire set of findings, as well as the steps to apply the programme in practice is depicted in Figure 3 and presented as a theoretical model of a networking programme.

Figure 3: Networking programme – A theoretical model



9. SUMMARY

The study brought to the fore such major issues as the huge impact of substance abuse on employers, legal demands to effectively manage the problem in the workplace and an inability of support structures to deal with the problem. The ecosystems approach provided the framework for assessing and understanding the needs of employers, employees and out-patient treatment centres.

The interrelatedness between the needs and support structures, as well as resources meant to deal with the needs in a collaborative way, was acknowledged. Strengths and resources which align with the strengths- based approach, were simultaneously identified. A need for networking and collaboration between the employment sector and out-patient treatment centres was clearly voiced. Serious concerns about the sustainability of collaboration were addressed through careful consideration of counteractive measures. A discussion on these measures was included in the proposed networking programme.

The aim was also to determine the procedures required to develop a sustainable networking programme. Findings from a grounded theory approach provided a framework highlighting the main components and procedures needed to develop such a programme. These findings included information on the purpose of networking and emphasised the characteristics and procedures to develop the programme. The importance of collaboration was highlighted as the cornerstone in the process to develop a networking programme.

This framework, however, did not provide sufficient information to direct the process. Theoretical knowledge from the business management field on networking, as well as from the social work field, was added to support, confirm and/or guide the empirical findings. The researcher integrated the empirical findings, theoretical knowledge and her experience in the field of substance abuse treatment and networking to develop a networking programme. The proposed networking programme highlights, amongst others, the purpose and distinctive features of such a programme, as well as those procedures and plans needed to address the issues that emerged from the findings. These procedures included the following:

- ✓ Awareness
- ✓ Prevention
- ✓ Education and treatment programmes to counter the major negative impact of substance abuse on the employment sector
- ✓ Empowering EAPs as support structures in the workplace and

- ✓ Assisting the employers to deal more effectively with the legal demands regarding substance abuse in the workplace.

The importance of awareness and comprehensive programmes aimed at combating substance abuse, as stated in the NDMP (2013-2017), are catered for in the networking programme. Furthermore, the networking programme is in alignment with both the appeal made by the NDMP for partnerships that militate against substance abuse in SA and the focus on sound workplace substance abuse management programmes.

Not only does the programme attempt to address the major issues derived from the findings, but it also provides significant potential benefits for both the employer and out-patient treatment centre. The programme attempts to meet the needs of employees and thus doing enable out-patient treatment centres to remain true to its mission and core business of "providing the most effective services for our clients in combating the struggle against substance abuse". The proposed networking programme was therefore developed on a macro-level, within the ecosystems approach with a strengths-based perspective in mind. Furthermore, the core values of social work - to serve and acknowledge the importance of human relations and collaboration - were adhered to.

It was obvious, though, that the main responsibility – that of establishing and sustaining the networking programme - is vested with the out-patient treatment centres. However, in order to successfully establish and sustain the programme, coordination between resources in the workplace and collaboration between employers and out-patient treatment centres are needed. Accompanied by quality service delivery by the treatment centres, the establishment of a networking programme is possible. Such a programme not only engages all key role-players in the network, namely employers, employees and out-patient treatment centres, but also provides ample opportunities for collaboration, as well as benefits for all role players.

Finally, the proposed networking programme requires a lot of patience, perseverance and teamwork if it is to be sustainable; in other words

'If we want to walk fast, walk alone. If we want to walk far, walk together'.

10. RECOMMENDATIONS

- ✓ As a means of collaboratively addressing the problem of substance abuse in the workplace, the networking programme is recommended for employers and out-patient treatment centres.

- ✓ It is recommended that the networking programme be implemented and tested within both the employment sector and out-patient treatment centres to evaluate its efficacy.

- ✓ It is further recommended that out-patient treatment centres take initiative to implement and establish such networking programmes.

- ✓ It is recommended that out-patient treatment centres become familiar with the proposed networking programme before engaging in the developmental process. Treatment centres need to assess whether the implementation of a networking programme is indeed the most suitable way to deal with substance abuse problems in the employment environment. Attention to the preparation phase in the application process is therefore critically important.

- ✓ It is recommended that the treatment centres assess their professional conduct and competency levels on a frequent basis as these principles are critically important in sustaining collaboration and the networking programme.

- ✓ As it is crucial to the longevity of the programme, it is recommended that role players who will be responsible for the implementation, be empowered and evaluated throughout.

- ✓ The benefits of the programme for all relevant role-players need to be weighed up against the costs on a frequent basis.

- ✓ Finally, a collaborative approach between employers, management, employees and out-patient treatment centres is recommended as this would maximise the success rate and positive outcomes and the networking programme.

REFERENCES

Acts **see** South Africa.

Andreasen, A.R. & Kotler, P. 2008. Strategic marketing for non-profit organizations. 7th ed. Upper Saddle River: Merrill Prentice Hall.

Babbie, E. 2010. The practice of social research. 12th ed. Belmont: Wadsworth Cengage Learning.

Backer, T.E. 2003. Evaluating community collaborations. New York: Springer.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Pearson Education.

Boyce, C. & Neale, P. 2011. Conducting in-depth interviews: a guide for designing and conducting in-depth interviews for evaluation input. m_e_tool_series_indepth_interviews.pdf Date of access: 1 March 2011.

Braun, V. & Clarke, V. 2006. Using thematic analysis in Psychology. *Qualitative research in Psychology,* 3:77-101. www.QualResearchPsych.com Date of access: 30 May 2012.

Creswell, J.W. 2005. Educational research: planning, conducting, and evaluating quantitative and qualitative research. 2nd ed. Upper Saddle River: Merrill Prentice Hall.

Creswell, J.W. 2013. Qualitative inquiry & research design: choosing among five approaches. 3rd ed. London: Sage.

Dalton, M., Hoyle, D.G. & Watts, M.W. 2006. Human relations. 3rd ed. Mason: Thomson South-Western.

Department of Social Development. ***see*** South Africa. Department of Social Development.

Delport, C.S.L., Fouché, C.B. & Schurink, W. 2011. Theory and literature in qualitative research. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 297-306).

Eberlein, R. 2010. Lifestyle changes to beat addiction: a guide to drug-free living. Randburg: Knowres.

Ellingson, L.L. 2009. Engaging crystallization in qualitative research: an introduction. London: Sage.

Falkena, H., Abedian, I., Von Blottnitz, M., Coovadia, C., Davel, G., Madungandaba, J., Masilela, E & Rees, S. 2011. SMEs' access to finance in South Africa: a supply-side regulatory review. www.treasury.gov.za/publications/other Date of access: 21 June 2011.

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 89-100).

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. *(In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 307-327).

Greeff, M. 2011. Information collection: interviewing. *(In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 341-375).

Greenfield, J.M. 2001. The non-profit handbook: fundraising. 3rd ed. New York: John Wiley & Sons.

Grobler, P., Wärnich, S., Carrell, M.R., Elbert, N. F. & Hatfield, R.D. 2006. Human resource management in South Africa. 3rd ed. London: Thomson Learning.

Hepworth, D.H., Rooney, R.H., Rooney, G.D., Strom-Gottfried, K. & Larsen, J. 2010. Direct social work practice: theory and skills. 8th ed. Belmont: Brooks/Cole.

Hollensen, S. 2010. Marketing management: a relationship approach. 2nd ed. New York: Pearson Education.

Jobber, D. 2004. Principles and practice of marketing. 4th ed. Berkshire: McGraw-Hill International.

Kirst-Ashman, K.K. & Hull, G.H. 2009. Generalist practice with organisations and communities. 4th ed. Belmont: Brooks/Cole Cengage Learning.

Kotler, P. & Armstrong, G. 2010. Principles of marketing: global and Southern African perspectives. Cape Town: Pearson Education.

Kurtz, D.L. & Boone, L.E. 2006. Principles of marketing. Mason: Thomson South-Western.

Lancaster, G. & Massingham, L. 2011. Essentials of marketing management. New York: Routledge.

Long, D.D., Tice, C.J. & Morrison, J.D. 2006. Macro social work practice: a strengths perspective. Belmont: Thomson Brooks/Cole.

McCann, M., Harker Burnhams, N.H., Albertyn, C. & Bhoola, U., *eds.* 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta.

Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2011. Applied social research: a tool for the human services. 8th ed. Belmont: Thomson Brooks/Cole.

Neuman, W.L. 2006. Social research methods: qualitative and quantitative approaches. 6th ed. Boston: Pearson Education.

Pelser, I. 2011. ETTEx Network: the future of drug testing (e-mail). 11 February 2011.

Pierson, J. & Thomas, M. 2010. Dictionary of Social Work. Berkshire: Open University Press.

Poulin, J. & Contributors. 2000. Collaborative social work: strengths-based generalist practice. Belmont: Thomson Brooks/Cole.

SACENDU (South African Community Epidemiology Network of Drug Use). 2012a. Monitoring alcohol & drug abuse trends in South Africa (July 1996-June 2012). SACENDU research brief, 15 (2). Tygerberg.

SACENDU (South African Community Epidemiology Network on Drug Use). 2012b. SACENDU report back meetings – November 2012: monitoring alcohol and drug trends: January-June 2012 Phase 32. Tygerberg.

Segal, E.A., Gerdes, K.E. & Steiner, S. 2007. An introduction to the profession of social work: becoming a change agent. 2nd ed. Belmont: Thomson Brooks/Cole.

South Africa. 1996. The National Small Business Act 102 of 1996.

South Africa. 2011. The South African Labour Guide. http://www.labourguide.co.za/workplace-discipline/code-of-good-practice-dismissal-general-461 Date of access: 24 February 2011.

South Africa. Department of Social Development. 2013. National Drug Master Plan (NDMP) 2013-2017. Pretoria.

South African Council for Social Service Professions (SACSSP). 2012. Policy guidelines for course of conduct, code of ethics and the rules for social workers. 4th ed. Pretoria.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 113-129).

Strydom, H. & Delport, C.S.L. 2011. Sampling and pilot study in qualitative research. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. Publishers. p. 390-396).

Van Wormer, K. & Davis, D.R. 2008. Addiction treatment: a strengths perspective. 2nd ed. Belmont: Thomas Brooks/Cole.

Welman, C., Kruger, F. & Mitchell, B. 2010. Research methodology. 3rd ed. Cape Town: Oxford University.

Weyers, M.L. 2011. The theory and practice of community work: a Southern African perspective. 2nd ed. Potchefstroom: KEURKOPIE.

SECTION C: SUMMARY, EVALUATION, CONCLUSIONS AND RECOMMENDATIONS

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1. INTRODUCTION

The research study explored the possibilities of establishing a networking programme between employers and out-patient treatment centres to address substance abuse problems in the workplace. The study set out to answer the following questions.

- ✓ What is the context in terms of substance abuse in the workplace?
- ✓ What are the experiences, concerns and resources of employers and out-patient treatment centres in dealing with the problem?
- ✓ What are the components of a successful programme that will enable employers and out-patient treatment centres to combat the problem collaboratively?

Little theoretical knowledge on the research topic could be found, and a grounded theory approach was followed to answer these questions. The empirical findings are reported and summarised in the respective articles of the research, namely on:

- ✓ Substance abuse, dependency and the workplace: A literature overview
- ✓ Substance abuse and the workplace: A situation analysis
- ✓ Substance abuse and the workplace: A networking programme for the employers and out-patient treatment centres

Section C summarises the research, evaluates the research by reflecting on its limitations and strengths, draws conclusions about the research, and makes recommendations with regard to further research.

2. SUMMARY OF THE RESEARCH

Employers invest a great amount of time, effort and resources to increase a company's production and profit levels, yet little is done to deal with the problem of substance abuse in the workplace, which has a major negative impact on production and company costs. Employers are legally obligated to provide counselling and rehabilitation for employees with substance abuse problems before dismissal is considered in cases of misconduct.

Intervention measures are needed to combat the problem, yet support structures in the workplace for dealing with substance abuse have been found to be inherently inadequate. Employers consequently have three main courses of action:

- ✓ To ignore the problem.
- ✓ To attempt to remedy the problem using their own resources.
- ✓ To use the services of specialist out-patient treatment centres to deal with the problem.

The first option of ignoring the problem is obviously not the answer.

The second option of using their own resources was found by this study, which included a theoretical component, to be unfeasible.

The third option formed the core of the study based on the fact that the empirical study and the literature review recognised this option as the most beneficial for all stakeholders. The core business of out-patient treatment centres is to 'treat clients with substance abuse problems', and the dual function, in the case of social workers, is to attend to employees with substance abuse problems and at the same time to interact with their workplace in order to connect them with treatment specialists where necessary. The interrelatedness between employees with substance abuse problems and the impact of these problems on the resources of employers provided the context for the study.

Collaboration between employers and out-patient treatment centres is considered a viable option for combating substance abuse in the workplace. A networking relationship between employers and out-patient treatment centres cannot only help with the treatment of employees but can also lead to a healthier workplace environment with subsequent economic benefits for employers. A networking programme for employers and out-patient treatment centres was developed as a new strategy to both address the gap in service delivery, and meet the needs of employers and employees in dealing with substance abuse problems in the workplace.

3. EVALUATION OF THE RESEARCH

The aim of the study was to develop a networking programme for employers and out-patient treatment centres to help them combat the problem of substance abuse in the workplace collaboratively. The intention was not to implement and test the validity of such a programme but to provide a 'roadmap' and guide for employers and out-patient treatment centres on how to establish a programme of this nature. Objectives to achieve this aim were the following:

- ✓ To contextualise substance abuse in the workplace in terms of national directives, legislative requirements for managing substance abuse and intervention measures to combat the problem.
- ✓ To explore the current concerns, needs and resources of employers and out-patient treatment centres in addressing substance abuse in the workplace.

- ✓ To develop a networking programme for employers and out-patient treatment centres to address substance abuse collaboratively in the workplace.

The following section will unpack the limitations and strengths of the study.

3.1 Limitations

- ✓ The empirical investigation focused only on out-patient treatment centres, and consequently no claim is made that the same results would have been achieved had in-patient treatment centres also been involved. Statistics indicate that most clients receive out-patient treatment nationwide and thus also in the Limpopo and Mpumalanga provinces – hence the decision to focus mainly on out-patient treatment centres.
- ✓ The research sample initially included an out-patient treatment centre in Limpopo province; however, financial constraints compelled this centre to withdraw from the study before data gathering could commence. The data gathering was as a result limited to three out-patient treatment centres located in different areas in Mpumalanga province. Data saturation was nevertheless reached and verified by an independent analyst.
- ✓ Employers in the rural areas were not included in the sample for logistical and financial reasons. The intention during the initial selection of employers was to include businesses in these areas, but outreach programmes in the areas were not sustainable due to financial constraints in the employment sector as well as in the out-patient treatment centres. This does not gainsay the fact that a dire need exists for assistance in combating substance abuse in rural workplace areas.
- ✓ Although the potentially important role of union members was highlighted, they were not involved in the study. The study was aimed primarily at entering the employment sector and establishing rapport with employers first before involving union members. The sensitive situation regarding employers, employees and unions was taken into consideration, and calls for the involvement of union members in the study were therefore not pursued.
- ✓ The contexts of the corporate world and the non-profit world are not always reconcilable. Limited knowledge of business principles and procedures often created insecurity and reluctance on the part of the out-patient treatment centres in the study to initiate contact with employers. At the same time, the not-for-profit goals of the out-patient treatment centres were often not reconcilable with the profit-driven goals of the business sector. These differences inevitably created a distance between the two parties and encumbered collaboration.
- ✓ The perception of the out-patient treatment staff in the study was often that marketing of their services would undermine the delivery of quality services to clients because of a likely

increase in the demand for services that could not be met owing to a shortage of treatment personnel.

- ✓ The researcher applied macro-level practice principles of engaging the social worker by using the "professional self" to form relationships and understand the unique experiences of the community; and utilising relationships and community collaboration to drive the process. Although the credibility of data collection and objectivity might be in question due to this approach, means to enhance trustworthiness and objectivity were applied such as the grounded theory method of comparative thinking; gathering of multiple viewpoints from several sampling groups; continued involvement of coordinators in the field and regular debriefing sessions; involvement of an independent co-coder in the verification of data collection, development of themes and data analysis; and consistent supervision discussions with the researcher's supervisors and co-coder.
- ✓ Article 3 functions as a unit and, as it is accordingly presented in this study, may be considered too long for publication.

3.2 Strengths

- ✓ The research study focused on the combating of substance abuse in the workplace. The relevancy of this focus is confirmed by literature findings that indicate that the majority of workplace problems are caused by low to moderate drinkers and substance abusers and not so much dependency. Prevention and awareness programmes therefore received ample attention in the networking programme.
- ✓ The proposed networking programme endeavours both to promote collaboration and maximise resources in the workplace. It hopes also positively to influence other systems in the community, such as social and family systems. The interdependence of workplace and community systems was recognised as crucial in the study.
- ✓ The study supported a 'strengths-based approach' that focused on partnerships and highlighted the strengths of employers and employees. The result was a balanced approach where strengths formed the foundation on which weaknesses and needs were addressed. In short, this was an integrated strengths/weaknesses approach.
- ✓ The initial theoretical frameworks, i.e., the ecosystems perspective and macro-level practice, provided an ideal framework for the application of the grounded theory approach, as well as the tenets of social work to serve; to enhance the accessibility of services; to value the inputs of each person and to focus on the importance of human relationships and collaboration.
- ✓ Although the study was initially planned to generate theory as its end goal, the theoretical model highlights opportunities in the workplace which could be utilised to apply the

programme and test its empirical verification. Steps to apply the networking programme in practice have therefore been included in the theoretical model presented in the study.

4. CONCLUSIONS

The following conclusions relate to each of the three articles and the aim and objectives of the study.

4.1 Conclusions regarding the articles

4.1.1 Conclusions regarding the context of substance abuse and dependency in the workplace

The first objective of the research, discussed in Article 1, was to contextualise substance abuse and dependency in the workplace. A literature review covered national directives, legislation requirements for employers regarding managing substance abuse in the workplace, intervention measures for dealing with substance abuse and findings on treatment outcomes.

The literature findings revealed clear national directives, legislation requirements and workplace policies that provide a well-defined context for employers to manage substance abuse in the workplace. The findings also revealed the availability of treatment specialists to assist employers in combating the problem with positive treatment outcomes supporting the involvement of such specialists.

The national directives advocate a shift towards comprehensive prevention programmes and campaigns to educate people. These measures are crucial for early identification and early intervention for employees with substance abuse problems to ensure better treatment results.

The literature findings also indicated that support structures are available in the workplace to deal with the problem of substance abuse, yet these structures are not properly equipped and referrals of employees for treatment are infrequent. Literature has further identified a need for addressing substance abuse in the workplace utilising specialists as a resource.

The need to reach and empower the entire workforce through awareness and prevention programmes is emphasised in literature sources. ‘Treatment of the workplace’ is considered just as important as treatment of employees with substance abuse problems. Education of support personnel in the workplace on the early signs and symptoms of substance abuse, prompt referrals for treatment, and knowledge of relapse prevention are regarded as essential

measures to promote a healthier workplace environment. Hence the term, ‘treatment of the workplace’.

Article 1 concludes with a recommendation to further explore the current concerns, needs and resources of employers, as well as of out-patient treatment centres in addressing the problem of substance abuse in the workplace.

Article 1 has been accepted for publication in *Maatskaplike Werk/Social Work (*March, 2014).

4.1.2 Conclusions regarding substance abuse in the workplace and the situation analysis

The second objective of the research study, discussed in Article 2, was to determine the concerns, needs and resources of employers and out-patient treatment centres in combating substance abuse in the workplace. A situation analysis revealed the limiting factors in the employment sector, what was needed to deal with the problem and the strengths available to do so.

The main priority of the employers in the study was production with profit-driven goals, yet, their limited knowledge of the scope of substance abuse in the workplace and of the link between HIV/AIDS and substance abuse was evident. Both these factors can have major negative economic consequences for employers. The benefits of treatment vs. dismissal of employees with substance abuse problems were also not appreciated, and the employers tended to regard the legal obligations to provide for counselling as additional demands on them. They also lacked information on the implementation of these obligations. Dismissal was often viewed as the first and only option. The empirical findings also revealed inadequate identification of employees with substance abuse problems, as well as limited referrals for treatment resulting in the underutilisation of the treatment centres. All this indicates limited insight among the employers regarding the importance of combating substance abuse in the workplace with the result that the major economic losses suffered by them continued largely unabated.

The workplace environment is, generally speaking, often not conducive to combating substance abuse mainly because employers and colleagues respond indifferently, insensitively or condone the problem and also because of the growing acceptability of social drinking. ‘Treatment of the workplace’ is therefore as important as treatment of the employee.

Despite the underutilisation of the treatment centres, some of the employers in the study expressed a need for assistance. The employer participation in the research process in itself led to increased employer awareness of and even interest in the services rendered by the

treatment centres. Employer participation is, in fact, the first step towards establishing a mutually beneficial networking system. The out-patient treatment centres, through their participation in the research project, have also experienced a heightened awareness with regards to networking and marketing.

The needs and strengths identified, the research findings on treatment benefits and the testimonies of success stories testified to the desirability of developing a networking programme for employers and out-patient treatment centres. The core components of such a programme were identified in the study and served as the framework for the proposed networking programme.

4.1.3 Conclusions regarding a networking programme for employers and out-patient treatment centres to combat substance abuse in the workplace

The third objective of the study, discussed in Article 3, was to develop a networking programme for employers and out-patient treatment centres to deal with substance abuse in the workplace.

The essential requirements and procedures for such a programme (identified during the situation analysis) served as the framework for the proposed networking programme. These were that the programme should serve a specific purpose and exhibit specific characteristics, and that certain procedures should be followed to establish the programme such as proper assessment, planning and actual implementation, as well as regular monitoring and evaluation of the programme. Although grounded theory provided the framework and set out the essential components of the programme, theoretical knowledge was added to make the programme more comprehensive.

The proposed networking programme is in line with

- ✓ the national focus on the implementation of comprehensive prevention measures, the increase in rehabilitative services and the strengthening of aftercare services and
- ✓ the theoretical requirements of generic programme development.

Substance abuse and its negative consequences on the workplace may be offset by aligning the programme's components with projects in the workplace. The success of such integration would depend on a high level of collaboration between all stakeholders, which is the purpose of the proposed networking programme. Serious concerns expressed in the literature regarding the effectiveness of collaboration are addressed in the programme by, for example, stressing the importance of sharing common goals, effective communication and the realisation of mutual benefits.

Major challenges are for employers to realise the potential value of the proposed networking programme and for out-patient treatment centres to recognise the value of marketing their services.

> *"Network is about a circle….If we don't understand each other somewhere along the line, the line is going to break. You are going to pull your way and I'm going to pull my way. The circle must remain a circle."*

4.2 Conclusions regarding the objectives of the study

The research questions guided the formulation of the objectives and are therefore also covered in this section.

- ✓ To contextualise substance abuse in the workplace in terms of national directives, legislative requirements for managing substance abuse and intervention measures to combat the problem.

  The literature review indicated the current situation regarding national directives, legislation requirements, available intervention measures and the findings on treatment outcomes in respect of substance abuse in the workplace. The main areas of concern, guidelines for managing the problem of substance abuse in the workplace, the resources and strengths available to support intervention measures, and the findings on positive treatment outcomes guided the literature search.

- ✓ To explore the current concerns, needs and resources of employers and out-patient treatment centres in addressing substance abuse in the workplace.

  The concerns, needs and strengths of the employers and out-patient treatment centres in the study regarding substance abuse in the workplace were determined as were the limiting factors regarding managing the problem and what was required to deal with the problem successfully. A need for collaboration and networking between the employers and out-patient treatment centres to combat substance abuse in the workplace was also identified together with the essential components of an effective networking programme. These components constituted the framework for developing the proposed networking programme for the employers and out-patient treatment centres.

- ✓ To develop a networking programme to enable out-patient treatment centres and employers to combat substance abuse collaboratively in the workplace.

  The components and procedures that developed from the grounded theory served as the framework for the proposed networking programme, and theoretical knowledge was added

to ensure a more comprehensive programme. The programme thus arose from grounded theory findings, theoretical knowledge and the researcher's experience in substance abuse treatment and networking.

All three objectives were thus achieved.

4.3 Conclusions regarding the main aim of the research study

The main aim of the study was to develop a networking programme for employers and out-patient treatment centres to combat substance abuse in the workplace collaboratively. This aim was realised through the achievement of the three objectives of the study.

5. RECOMMENDATIONS

Recommendations for the practical application of the networking programme:

- ✓ It is recommended that the networking programme be implemented and tested within both the employment sector and out-patient treatment centres to evaluate its efficacy.

- ✓ It is further recommended that out-patient treatment centres take initiative to implement and establish such networking programmes.

- ✓ It is recommended, however, that out-patient treatment centres become familiar with the content of the proposed networking programme before engaging in the developmental process.

- ✓ It is recommended that the treatment centres assess their professional conduct and competency levels on a frequent basis as these principles are critically important in sustaining collaboration and the networking programme.

- ✓ As it is crucial to the longevity of the programme, it is recommended that role players who will be responsible for the implementation, be empowered and evaluated throughout.

- ✓ The benefits of the programme for all relevant role-players need to be weighed up against the costs on a frequent basis.

- ✓ A collaborative approach between employers, management, employees and out-patient treatment centres is recommended as this will maximise the success rate and positive outcomes and the networking programme.

Recommendation with regards to article 3:

- ✓ Although article 3 functions as a unit and is presented accordingly in the study, it is recommended that the article be divided into sections for the sake of publication.

Areas for further research revealed by the study

- ✓ Research is needed on a networking programme between employers and in-patient treatment centres to combat substance abuse in the workplace in order to compare the findings with the findings of the present study.

- ✓ Research is needed on intervention measures to combat substance abuse in workplaces in rural areas, which are often extremely marginalised.

- ✓ Ways should be explored to include unions as partners in networking programmes aimed at dealing with substance abuse in the workplace.

- ✓ Research is needed on the possible inclusion of a module on networking between the corporate sector and substance abuse treatment centres in the curriculum of undergraduate social work students.

- ✓ Research is needed on the possible inclusion of a module on employee assistance programmes (EAPs) in the curriculum of undergraduate social work students with specific reference to the role of social workers.

- ✓ Research is needed on collaboration between substance abuse treatment centres and employee wellness programmes and EAPs.

- ✓ Research is needed on the implementation of Broad Based Black Economic Empowerment (BB BEE) social programmes by substance abuse treatment centres.

- ✓ Research is needed on developing a marketing programme for substance abuse treatment centres to promote effective marketing of treatment services

- ✓ Research is needed on collaboration between the occupational health and safety divisions in the corporate sector and substance abuse treatment centres in dealing with substance abuse in the workplace.

- ✓ Research is needed on collaboration between the corporate sector and substance abuse treatment centres to develop an intervention programme aimed at addressing the negative impact of HIV/AIDS and substance abuse in the workplace.

- ✓ Research is needed to determine which category of substance users/abusers respond best to treatment and where employers and out-patient treatment centres should focus collaborative intervention measures.

6. SUMMARY STATEMENT

The establishment of a networking programme that is beneficial to employers, employees and treatment centres is a viable option to address the gap in service delivery if it is accompanied by quality service delivery by the centres. Furthermore, in order to combat the problem of substance abuse and dependency in the workplace, coordination between resources in the workplace and collaboration with out-patient treatment centres are crucial.

The proposed networking programme as a theoretical model provides an opportunity to adjust social welfare resources and needs to combat substance abuse on a macro-level. The social worker's role as being the "person in the middle" is to adjust the social welfare resources and the needs of the employment sector within the framework of the macro level environment. The interrelatedness between the needs of employees and employers, and resources to address the needs aligns with the ecosystems perspective. The focus on collaboration and the establishing of connections between the employment sector and out-patient treatment centres are in line with the strengths-based approach. Lastly, the proposed networking programme is regarded as contributing to the knowledge base of social work within the ecosystems and macro level theoretical frameworks.

SECTION D: APPENDICES

SECTION D: APPENDICES

APPENDIX 1: SAMPLING CRITERIA FOR SELECTION OF PARTICIPANTS

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

TARGET GROUP	CRITERIA
OUT-PATIENT TREATMENT CETRES	✓ Staff members involved and functioning with employers, i.e., director / social workers / medical and other relevant staff members ✓ Staff members available and willing to attend the focus group sessions ✓ Staff members available and willing to assist in the research project ✓ Staff members engaged in services for employers & EAP tasks ✓ Coordinator to assist the researcher: • Staff member willing and available to act as co-facilitator at the focus group interviewing • Staff member available and willing to assist with liaising and arranging meetings with employers and follow up with the employers to maintain contacts • Staff member available and willing to assist with individual interviews with employers
EMPLOYERS: **Small businesses** **Medium businesses** **Macro businesses**	✓ Criteria categorised by the National Small Business Act : • Small businesses: very small/small enterprises: 10 - 50 employees • Medium business: fewer than 100-200 employees • Macro-enterprises: more than 200 employee ✓ Businesses engaging in high-risk and safety-sensitive occupations, i.e., transport, mining and timber companies (where heavy machinery and equipment are involved), as well as security businesses ✓ The following business were excluded: businesses in deep rural areas due to cost implications; employers using mainly shift workers due to logistical problems; and employers using seasonal labour due to the temporary nature of the contracts ✓ Businesses with /without employee assistance programmes ✓ Where informal relationships exist between employers and the out-patient treatment centre

	✓ Where “no relationships” exist between the employer and the out-patient treatment centre ✓ Businesses which need to get permission from their head-office should not be included in this research project in view of the time consuming process to be followed
EMPLOYEES: SANCA LOWVELD	✓ Involvement as clients either in treatment or in aftercare as part of an out-patient treatment programme ✓ Registration as clients with SANCA Lowveld due to accessibility. As an employee of SANCA Lowveld, the researcher could monitor the situation closely ✓ Willingness to participate in the research study

APPENDIX 2: SANCA PROVINCIAL MANAGEMENT: APPROVAL

8 HOPE STREET
P O BOX 1073
NELSPRUIT
1200

MEMBER OF SANCA

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

LOWVELD ALCOHOL AND DRUG HELP CENTRE

PRACTICE NO: 047 001 0107344

7 February 2011

FOR ATTENTION: MRS BREGGIE SMOOK

Mrs B. Smook
P.O. Box 19400
NELSPRUIT
1200

Dear Mrs Smook

RESEARCH WITHIN SANCA – MPUMULANGA PROVINCE

Your request to involve all the SANCA branches within Mpumulanga in your research project refers.

The SANCA's Provincial Management Board has approved your request to do research on ways to develop a partnership between specialized out-patient treatment centres and employers to provide an effective collaborative holistic treatment programme for employees with dependency problems.

It is requested that you inform the different SANCA branches of your planned activities before you make contact with employers in those areas.

We are looking forward to receive your research proposal.

Kind regards,

Mr Barry van Rensburg
Director – Provincial Coordinator

Funded By
NATIONAL LOTTERY NLDTF

PBO NO: 930010152
NPO ACT REG. NO: 001-938

APPENDIX 3: EMPLOYERS' ORGANISATION: APPROVAL

Werkgewers Organisasie / Employers' Organisation
MPUMALANGA
Reference number: **LR 2/6/3/335**
2818 Nelspruit 1200 ((013) 752 7337 Fax 086 594 5897
No. 3 Chereson Place, 36 Murray Street, Nelspruit
eom@netactive.co.za

02 March 2011

Ms Breggie Smook
PO Box 19400
Nelspruit
1200

RE: APPROVAL FOR CONDUCTING A RESEARCH PROJECT FOR PHD STUDIES WITHIN THE EMPLOYERS' ORGANISATION MZANZI

Your letter dated 28 February 2011 has reference.

Please note that the executive council during their monthly meeting on 01 March 2011, has approved your request for the following:

1. Information on the legal aspects about the roles and responsibilities of the Employer regarding substance use/abuse within the workplace;

2. Access to the contact list of our members;

3. Advice on selecting most suitable employment sectors;

4. Advice and recommendations on possible strategies to establish partnerships between SANCA and the Employers in Mpumalanga.

Hope you find this in order. We look forward in assisting you with any information necessary.

Yours sincerely,

TANIA PRETORIUS
(General Secretary

APPENDIX 4: CO-CODER CONFIRMATION OF INVOLVEMENT

PO Box 19714
Noordbrug
2522
Potchefstroom
E-mail: lelanie.kriek@gmail.com
Tel. 079 526 7382
MSc Research Psychology (NWU)

20 August 2013

Who it may concern

Involvement as Co-coder and Research Advisor

I was involved in the PhD study of Mrs Breggie Smook from 2012 till 2013.

My involvement included acting as a co-coder for the data that the student collected over a period of time. I coded all the data sets and verified my findings with the student.

I also assisted in constructing and refining themes with regard to presentation of the data and verified the final results as presented in the various articles of the study.

Furthermore, I advised the student with general research assistance which included the assurance of trustworthiness with regard to the data, as well as the reporting of the data.

We agreed that data saturation emerged from the data analysis process.

Kind regards

Lelanie Kriek

APPENDIX 5: ORIENTATION PHASE: DISCUSSIONS

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Target groups

- ✓ EMPLOYMENT SECTOR (individual discussions)
- ✓ REGISTERED OUT-PATIENT TREATMENT CENTRES in LIMPOPO and MPUMALANGA PROVINCES (group discussions)

1. Purpose of the orientation discussions

- ✓ To introduce the research study
- ✓ To provide the background and motivation for the study
- ✓ To discuss the roles of the participants
- ✓ To discuss the plan of action
- ✓ To obtain written consent

2. Background and problem statement

- ✓ According to numerous research findings the impact of substance abuse on the workplace is huge with enormous cost effects for the employer
- ✓ Specialised treatment for substance abuse is available at out-patient treatment centres. The focus of this research study will be on out-patient treatment centres in view of the fact that 80% of the clients in Mpumalanga and Limpopo provinces are registered for out-patient treatment
- ✓ Yet, according to the SACENDU statistics, the general referral rate from employers in SA amount to no more than 10 per cent. Thus, treatment centres in general are underutilised by the employment sector

3. Demarcation of the study

- ✓ Geographical area: Mpumalanga and Limpopo Provinces
- ✓ Population groups:
  Employment Sector (Employers, Employees)
  Out-patient treatment centres

4. Sampling and criteria for selection of participants

5. Plan of action: Individual and focus group interviews

Discuss logistical plans for the interviews (purpose of the interview, schedule date and time, confirm venue and general arrangements)

6. Written consent

Obtain written consent

Thank participants for their involvement and contribution.

APPENDIX 6: GROUP ORIENTATION DISCUSSIONS: AGENDA

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Target group: Registered out-patient treatment centres in Limpopo and Mpumalanga provinces

Agenda

1. Welcome
   - ✓ Attendance register
   - ✓ Purpose of orientation discussions
   - ✓ General arrangements
   - ✓ Time frame for the meeting
   - ✓ Arrange for a scribe
2. Background for research study
3. Demarcation and sampling criteria
4. Discussions
5. Roll out of the research project
   - ✓ Roles and responsibilities of coordinator
   - ✓ Roles and responsibilities of the treatment centres
   - ✓ Explain briefly the process of focus group interviewing
6. Questions, comments, feedback from the group
7. Finalise written consent
8. Plan of action
   - ✓ Recruitment of participants and coordinator
   - ✓ Planning logistics for induction of coordinator
   - ✓ Planning of logistics for focus group interview and schedule appointment for the interview
9. Closure

Thank group members for their participation.

APPENDIX 7: ORIENTATION PROGRAMME: SITE COORDINATOR

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Orientation sessions for the SANCA staff member (site coordinator) assisting in the roll out of the research project in his/her site comprises the following:

1. **Background information and problem statement**
   - ✓ According to numerous research findings the impact of substance abuse on the workplace is huge and results in enormous cost effects for the employer;
   - ✓ Specialised treatment for substance abuse is available at out-patient treatment centres. The focus of this research study will be on out-patient treatment centres in view of the fact that 80 per cent of the clients in Limpopo and Mpumalanga provinces are registered for out-patient treatment;
   - ✓ According to the SACENDU statistics the referral rate from employers in South Africa (SA) amount to no more than 10 per cent. Thus, treatment centres in general are underutilised by the employment sector.

2. **Demarcation of the study**
   - ✓ Geographical area: Limpopo and Mpumalanga provinces
   - ✓ Population groups: Employment sector (employers and employees)
   - ✓ Out-patient treatment centres

3. **Sampling criteria to select participants**

4. **Roles and responsibilities of the coordinator (SANCA staff member)**

4.1 Coordinator

- Keep SANCA director of own treatment centre informed on developments
- Communicate information to SANCA colleagues
- Assist with coordination of contacts with businesses/employers
- Feedback to the researcher on the progress of the project

4.2 Liaison and networking with employers

- Assist in identifying and compiling a list of participants from the employment sector (employers, human resource department, employee assistance managers, staff from the health and safety department, medical staff and peer educators)
- Assist with the sampling process according to set criteria

- Assist in recruiting employer participants
- Assist in introducing the research project to employers and other role players
- Assist in negotiating for the involvement of participants in the study
- Assist in arranging appointments with participants for orientation discussions
- Assist in arranging appointments for individual interviews with employers
- Assist in interviewing employers to participate in the study
- Arrange for feedback sessions with employer participants

4.3 Interviewing:

4.3.1 Data collection methods

In-depth individual and focus group interviews will be conducted as predominant methods of data collection in the study (Babbie, 2011:318-326; Boyce & Neale, 2006:3; Greeff, 2011:351-352,360-361; Welman, Kruger & Mitchell, 2010:197-202).

In-depth interviews will be conducted with participants from the employment sector representing the employers from small, medium and macro businesses; employers who are experts on networking, and employees who have been involved in out-patient treatment.

Focus group interviews will be conducted with relevant staff members from the out-patient treatment centres concerned.

Multiple viewpoints from different sampling groups will therefore be explored. In this way the researcher will strive to provide as complete a picture as possible (Boyce & Neale, 2006:4,7). A conscious attempt will be made to include participant representing different categories, for example gender, education and culture.

4.3.2 Interview protocol: individual and focus groups

An interview protocol comprising guidelines for both population groups will be followed to ensure consistency and reliability of the findings. Information which explains the purpose of the interview, why the participant has been chosen, issues of confidentiality, the process of the interview, permission to tape-record the interview, expected duration of the interview and informed consent to participate in the interview are included in the protocol. Permission will also be obtained to use quotes from interviewees with the assurance that their identity will be kept confidential (Babbie, 2011:266-267,318-324; Boyce & Neale, 2006:5-9; Greeff, 2011:343-353,360-372; Welman *et al.,* 2010:199-202).

4.3.3 Interview schedules

The research questions and objectives of the research study guided the development of the interview schedules. Interview schedules were developed for each population group, namely the employment sector (employers and employees) and the out-patient treatment centres (Boyce & Neale, 2006:5-7). Semi-structured interviews need to be conducted in order to allow much more flexibility for both the interviewees and the researcher (Greeff, 2011:351-352). A set of predetermined open-ended questions was formulated to guide the interviewees. Theoretical principles in both the individual and focus groups interview schedules were applied in the development of the interview schedules (Babbie, 2011:318-321; Boyce & Neale, 2006:5,1-12; Greeff, 2011:343-352,369-370; Welman *et al.,* 2010:202-203).

4.3.4 Interviewing techniques

The following research interviewing techniques (Greeff, 2011:343-346; Welman *et al.,* 2010:199-200) need to be considered during the interviews:

- ✓ Minimal verbal response
- ✓ Paraphrasing aimed at enhancing meaning through the reformulation of ideas
- ✓ Clarification of unclear statements, i.e., “could you tell me more...”
- ✓ Reflection on important aspects and further encouragement, i.e., “so you believe....”
- ✓ Encouragement to pursue a line of thought, i.e., “tell me more – I find that fascinating”
- ✓ Comments aimed at stimulating further responses, i.e., “I always thought that...”
- ✓ Spurring on and challenging participants to say more, i.e., “isn’t it true...”
- ✓ Reflectively summarising ideas, feelings and thoughts to ensure understanding, i.e., “so what you are saying is...”
- ✓ Listening
- ✓ Probing in order to deepen a response to a question/increase richness of data /hint at level of response desired/persuade participant to give more information
- ✓ Contradicting – giving opinion opposite to participant’s to arouse further comments
- ✓ Linking – relating participants’ comments to information the interviewer wants to know
- ✓ Feigning puzzlement / confusion – indicating that elaboration is needed
- ✓ Challenging – demanding more information
- ✓ Encouraging – compliments to encourage further participation
- ✓ Showing understanding and allowing time for elaboration
- ✓ Acknowledging – repeat participants’ answers to show attention

- ✓ Direct questions – to get more information
- ✓ Procuring details – asking further questions to get more information

4.3.5 Interviewing pitfalls

The following pitfalls (Greeff, 2011:346-347) need to be avoided during interviews

- ✓ Interruptions
- ✓ Competing distractions
- ✓ Stage fright
- ✓ Awkward questions
- ✓ Jumping – avoid erratic questioning
- ✓ Avoid "off the record" information
- ✓ Teaching and preaching
- ✓ Counselling
- ✓ Premature use of reflecting and summarising
- ✓ Revealing one's own response
- ✓ Superficial interviews – researcher moves the participant along too quickly
- ✓ Confidential information – when participant gives information that is threatening/dangerous – when researcher needs to reveal the info – inform participant
- ✓ Use of translators

4.4 Co-facilitator of focus group interviews

The tasks which need to be carried out before, during and after the focus group interviews comprise the following (Babbie, 2010:277; Greeff, 2011:359,372; Welman *et al*., 2010:198-199).

- ✓ Logistical arrangements
  - Arrange for venue and assist with preparation of venue
  - Flip chart board, name tags
  - Deal with possible distractions during the focus group interview

- ✓ Field notes (Greeff, 2011:359,372) - written account of what was observed and record of own thoughts and feelings experienced during the interview
  - Assist with taking field notes during the focus group interview
  - Record comments in order to capture information to serve as back-up for the interviews on the Dictaphone
  - Make notes on the chronology of events
  - Record spontaneous and passive attitudes

- Record non-verbal behaviour
- Record group dynamics, group interaction and interaction with facilitator
- Communication – what has not been said, what themes have been repeated
- Note the 'big idea'

✓ Post-meeting feedback session (debriefing session)

The purpose of the post-meeting:

- To reflect on the process and outcomes of the focus group interview
- To share experiences and noteworthy observations
- To discuss further planning and roll-out of the research project in the site

Key members of the out-patient treatment centre attending the focus group interview will be invited to join a post-meeting session. The co-facilitator has a key role during this meeting in providing feedback and sharing observations made during the focus group interview. Ideally the director of the treatment centre should also attend this meeting to ensure consensus on further action plans.

4.5 Administration

✓ Keep record of contacts with employers

✓ Establish employers' database with contact details

✓ Record discussions and submit to researcher for storage

REFERENCES

Babbie, E. 2010. The practice of social research. 12th ed. Belmont: Wadsworth Cengage Learning.

Boyce, C. & Neale, P. 2006. Conducting in-depth interviews: a guide for designing and conducting in-depth interviews for evaluation input. m*_e_tool_series_indepth_interviews.pdf* Date of access: 14 February 2014.

Greeff, M. 2011. Information collection: interviewing. (*In D*e Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 341-375).

Welman, C., Kruger, F. & Mitchell, B. 2010. Research methodology. 3rd ed. Cape Town: Oxford University Press.

APPENDIX 8: INTRODUCTION LETTER: EMPLOYERS

Breggie Smook
P.O. Box 19400
Nelspruit
1200

28 February 2011

The Coordinator
Employee Assistance Programme
Mpumalanga

To whom it may concern

Approval: To conduct a research study for PhD. studies (Social Work) within the company in Limpopo and Mpumalanga provinces

During the past year I have become particularly aware of the employer's vital role in the treatment of substance abuse within the workplace.

I have enrolled for PhD. studies (Social Work) at the North West University of Potchefstroom with the main aim of:
Investigating ways to develop a collaborative treatment programme for employees with substance abuse problems through fostering a partnership between specialised out-patient treatment centres and employers

Background
The South African Community Epidemiology Network on Drug Use (SACENDU) reports that alcohol is the most commonly abused substance, with cannabis next in line. Compared to other countries worldwide, findings also revealed that South Africa (SA) has one of the most alarming patterns of alcohol consumption. Substance abuse is a major contributor to many of society's problems including family problems, crime, violence, poor school performance and dropping out of school and universities. Likewise, negative effects manifest in the business community through absenteeism, increased use of medical benefits and workers'

compensation claims. Further consequences include poor productivity, high job turnover, interpersonal conflict, work-place injuries and damage to workplace property.

The employer is often the first tier of contact with the troubled employee and is therefore in an ideal position to assess the circumstances *and* advise the employee on the most suitable treatment programme. The employer plays a vital role in referring the employee for treatment, if necessary. Furthermore, the employer is a valuable resource of assistance and support to the employee in the recovering process.

Out-patient treatment is regarded as the most suitable treatment programme for clients unable to interrupt their employment and family life; for clients who have positive support structures; and for those who are able to continue the treatment in a more flexible environment. Out-patient treatment is also less costly.

This research study will focus mainly on programmes within the out-patient treatment setting in the geographical area of Limpopo and Mpumalanga provinces.

Research methodology

A qualitative research study will be conducted with a combination of exploratory and descriptive objectives.

Research methods will include

- ✓ Personal interviews (approximately 1 hour)
- ✓ Telephonic and/or e-mail contacts
- ✓ Focus group sessions (approximately 2 hours)

Participants

Participants from the Employee Assistance Programmes (EAPs), human relations and employers' organisations, as well as employees in rehabilitation, will be recruited to participate in the study. Registered out-patient treatment centres will also be involved in the study.

Role of the company

The employment sector is regarded as a valuable source of information on the following matters:

- ✓ The needs and problems of the employer in addressing substance abuse in the workplace

- ✓ Treatment measures currently utilised by employers in addressing substance abuse in the workplace
- ✓ The extent to which out-patient treatment centres are being utilised by the employers
- ✓ Recommendations regarding the developmental guidelines/strategies required to establish a collaborative approach between employers and out-patient treatment

In addition, the establishment of a long term partnership between the company and out-patient treatment centres is also envisaged where

- ✓ Employees could continuously be referred to the out-patient treatment centres when necessary
- ✓ Collaborative aftercare services between the company and out-patient treatment centres could be provided to the employee in the recovery process

The outcome of this research study will hopefully benefit the employer, the clients/employees as well as the out-patient treatment centres.

Your favourable consideration of this request will enable me to involve one of the major employment sectors in Mpumalanga province. Written approval to participate in this study will be highly appreciated.

Thank you kindly

Breggie Smook
Cell. 079 4951547
bsmook@absamail.co.za

APPENDIX 9: WRITTEN INFORMED CONSENT

Written consent to Gerbregda Smook to conduct a research study within out-patient treatment centres and the employment sector with the aim of completing the Doctorate degree in Social Work at the North West University, Potchefstroom campus.

Informed consent is hereby given to obtain relevant information from management, staff, volunteers as well as clients regarding the establishment and maintenance of a collaborative networking programme between employers and out-patient treatment centres to address substance abuse in the workplace.

1. **The researcher undertakes to:**
   - ✓ Make available adequate information on the goal of the investigation; the procedures which will be followed during the investigation; as well as possible advantages and disadvantages to which participants may be exposed to
   - ✓ Ensure that all possible means will be applied to protect the privacy of all participants
   - ✓ Ensure that the participation of all participants will be negotiated in all cases, that their co-operation will be respectfully requested and its importance carefully explained
   - ✓ Under no circumstances use concealed media such as video cameras, one-way mirrors or microphones without the knowledge and approval of the research participants
   - ✓ Adhere to ethically correct and transparent actions and attitudes
   - ✓ Refrain from making value-judgments
   - ✓ Respect the cultural customs of participants in all actions
   - ✓ Give recognition to sources consulted and the organisations which collaborated
   - ✓ Ensure that research findings will be formulated and conveyed in an unambiguous manner
   - ✓ Make available a concise final written report on the findings and recommendations of the research study

2. **The participants undertake to:**
   - ✓ Make relevant information available and accessible to the researcher
   - ✓ Fully collaborate in the research study and honour commitments regarding logistical matters and appointments
   - ✓ Adhere to copyright requirements on the content and findings of the research study material. The research study material remains the intellectual property of the North West University and copyright permission must be obtained from this institution

- ✓ Participants are free to withdraw from the research process at any stage on condition that the researcher will be informed in advance

Employer/Employee/Organisation: ……..….

Name of participant: ……

Signature:……

Date :……at.……

Researcher: ……

Signature: ……

Date: ……

APPENDIX 10: PROTOCOL: INDIVIDUAL INTERVIEWS

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

PARTICIPANTS: EMPLOYERS / EMPLOYEES

1. **Introduction**

   I want to thank you for taking the time to meet with me today. As I have explained, I am busy with a research study on the joint role of the employer and out-patient treatment centres aimed at addressing substance abuse in the workplace.

   Purpose of the interview:

   I would like to talk to you about networking in general between the employer and out-patient treatment centres. I would like to focus more specifically on a partnership programme between the employer and the out-patient treatment centre to deal with substance abuse in the workplace. Your viewpoint on the possible roles of the employer and out-patient treatment centres in addressing the problem of substance abuse in the workplace will be of great help.

   You have been selected to participate in this study due to your first-hand knowledge on and experience of the problem (either as an employer, or an employee involved in a treatment programme).

2. **Process of the interview:**

The interview should not take longer than an hour. To ensure that no times is wasted, nor thoughts lost, I request that we limit interruptions such as phone call interruptions. I also request that we avoid “off the record” information.

3. **Roles**

   My role as interviewer will be to ask questions and facilitate the interview process. The interview is not a counselling or education session. I am very interested to hear your story and will therefore mostly be listening. When I do not understand I will ask questions.

   Your role will be to share your views and feelings freely and therefore you will be doing most of the talking. You don’t have to talk about anything you don’t want to and you may end the interview at any time.

4. **Confidentiality:**

   All information will be kept confidential. You will not be identified; nor will any of the information included in my report compromise your identity. With your permission I would like to include some of your quotes in the report as this will add credibility to the information. I will take special care that you will not be identified through the quotes.

   I will be taping the session because I do not want to miss any of your comments. A Dictaphone will be used – with your permission. Because we are tape recording, I would appreciate it if you could speak up so that we do not miss any of your comments. I will also be taking some notes during the session to ensure that all information is recorded. All information will be transcribed and stored in a safe place.

   ** Are there any questions about what I have just explained?

   ** Are you willing to participate in this interview?

Signature: Participant

Signature: Researcher

Date:

APPENDIX 11: INDIVIDUAL INTERVIEW SCHEDULE – EMPLOYERS

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Participants: Employers

Purpose of interview

- ✓ To explore your viewpoints on a networking relationship between the employer and out-patient treatment centres to address substance abuse in the workplace
- ✓ To explore your ideas on the process of establishing a network relationship between the employer and out-patient treatment centres

Interview schedules

1. What is your viewpoint on the purpose of networking/liaising in general? Please explain.

2. What, in your experience, are the most important characteristics of a networking programme? Please elaborate.

3. When would an employer consider establishing a networking relationship with an out-patient treatment centre? Please explain.

4. What steps are necessary to establish a networking relationship between the employer and the out-patient treatment centre? Please explain.

5. How could a networking relationship between the employer and the out-patient treatment centre be sustained? Please explain.

6. What advantages could a networking relationship with out-patient treatment centres have for the employer? Please elaborate.

7. What would be the role of the employer in the networking relationship with out-patient treatment centres? Please list.

8. What would be the role of the out-patient treatment centre in the networking relationship? Please list.

9. What in your opinion should be avoided when establishing networking relations with employers? Why?

10. What should be included in a networking plan between the employer and the out-patient treatment centre? Please list.

- ✓ Is there anything more that you would like to add? Recommendations?
- ✓ What is your experience of the interview, i.e., questions/misperceptions/feelings?

Forward plan of action:

I will be analysing and consolidating all the information collected from you and other participants. I will provide you with feedback if you are interested.

Thank you for your time and cooperation.

APPENDIX 12: INDIVIDUAL INTERVIEW SCHEDULE - EMPLOYEES

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Participants: Employees involved in out-patient treatment

Purpose of interview

- ✓ To explore viewpoints on the role of the employer and the out-patient treatment centre in the treatment of employees experiencing substance abuse problems
- ✓ To explore perspectives on a joint treatment programme between the employer and the out-patient treatment centre to deal with substance abuse in the workplace
- ✓ To discuss possible effects of a collaborative relationship between employers and out-patient treatment centres on the rehabilitation process

Interview schedule

1. What measures are in place to deal with substance abuse in your workplace? Please list.

2. What role could the employer play to address substance abuse in the workplace? Please explain.

3. What are the responses of your employment sector towards employees with substance abuse problems? Please elaborate.

4. What is the response of your employer regarding substance abuse treatment / time off / funding / aftercare services? Please elaborate.

5. With whom at the workplace would you be willing to discuss your problem of dependency? Why?

6. How should the employer support you during the treatment process to be reintegrated in the work situation? Please elaborate.

7. What resources are available in the community to assist the employer in dealing with substance abuse in the workplace? Please list and elaborate.

8. What role could the out-patient treatment centre play in assisting the employer in addressing substance abuse? Please explain.

9. What effects could a networking relationship between the employer and out-patient treatment centres have on the rehabilitation process? Please elaborate.

10. What recommendations do you have to develop a networking programme for employers and out-patient treatment centres to address substance abuse in the workplace?

- ✓ What is your experience of the interview: questions/discussions with reference to your employer/misperceptions/feelings?
- ✓ Is there anything more that you would like to add?

Further action plans

I will analyse and consolidate all the information collected from you and other participants. I will provide you with feedback if you are interested.

Thank you for your time and cooperation.

APPENDIX 13: PROTOCOL FOCUS GROUP INTERVIEWS

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Participants: Registered out-patient treatment centre in Mpumalanga

1. **Introduction**

   I want to thank you for taking the time to meet with me today. As I have explained during the orientation session, I am busy with a research study on the joint role of the employer and out-patient treatment centres in addressing substance abuse in the workplace.

2. **Purpose of the focus group interview**

   - ✓ To explore the reasons why treatment centres are underutilised
   - ✓ To examine the possibilities of closer networking between employers and out-patient treatment centres to address the problem
   - ✓ To identify the capacities of out-patient treatment centres to address the problem in the workplace, and what the treatment centres can offer the employment sector
   - ✓ Lastly, to share ideas of the plan forward and ideas on how to go about establishing closer relations with the employment sector

3. **Process of the interview**

   The researcher explains the process of the focus group interview:

   - ✓ The interview should not take longer than an hour
   - ✓ To ensure that no time is wasted or thoughts lost, interruptions such as taking phone calls and moving in and out of the venue should be limited to the minimum
   - ✓ Group members are allowed to express themselves without fear of being criticised
   - ✓ Open and honest comments on the topic are welcomed
   - ✓ There are no “right” or “wrong” answers
   - ✓ The interview is not a counselling or education session

4. **Roles of participants in the focus group interview**

   Briefly explain the role of the facilitator, co-facilitator and participants

   Facilitator (the researcher)

   - ✓ To encourage participants to share their viewpoints by asking questions relevant to the topic, seeking for a range of ideas

- ✓ To uncover factors that may influence opinions, behaviour or motivation
- ✓ To assist group members to be more specific in their responses
- ✓ To direct the discussions in order to remain focused and achieve the purpose of the exercise
- ✓ To ensure open communication and interaction between group members
- ✓ To ensure participation from all group members
- ✓ Most importantly, to listen to the viewpoints and ideas of group members

Co-facilitator (SANCA staff member)

- ✓ To assist with logistics (preparation of venue, attendance register, refreshments, name tags, tape recorder, deal with possible distractions)
- ✓ To assist with taking field notes

Group members

- ✓ To generate large amounts of information in a short period of time
- ✓ To share multiple viewpoints and ideas in general on networking
- ✓ To share multiple ideas and opinions specifically on collaboration between the employer and the out-patient treatment centre to deal with substance abuse in the workplace

5. Confidentiality

Researcher explains the following:

"All information will be kept confidential. I will ensure that any information I include in my report does not identify you as participants. With your permission, I would like to include some of your quotes in the report as this will add credibility to the information. I will take special care that you will not be identified through the quotes.

With your permission a Dictaphone will be used because I do not want to miss any of your comments. Because we are tape recording, I would appreciate it if you could speak up so that it can be recorded clearly. I will also be taking some notes during the session - to ensure that all information is recorded - and will be assisted by the co-facilitator. All information will be transcribed and stored in a safe place."

- ✓ Are there any questions about what I have just explained?
- ✓ Are you willing to participate in this focus group interview?

The attendance register is circulated with a column to sign and indicate the willingness of the group members to participate in the interview

The focus group interview commences

APPENDIX 14: INTERVIEW SCHEDULE - FOCUS GROUPS

SUBSTANCE ABUSE AND THE WORKPLACE: A NETWORKING PROGRAMME FOR EMPLOYERS AND OUT-PATIENT TREATMENT CENTRES

Participants: Registered out-patient treatment centres in Limpopo and Mpumalanga provinces (**selected staff members according to set criteria**)

Interview schedule

1. 'Anonym' question (Wellman, Kruger & Mitchell, 2010:203)

   Opening statement from each participant: What are your first thoughts on networking in general? (Facilitator does not disrupt the silence – wait for participants to respond).

2. Introductory question**:** What do you regard as the most important characteristics of networking? Please explain.

3. What would be the purpose of a networking relationship/partnership between the employer and out-patient treatment centre? Please explain.

4. What advantages / disadvantages could a networking relationship have for out-patient treatment centres / the employer? Please elaborate.

5. Transition question

   What can you as a treatment centre offer the employer in a networking relationship to deal with substance abuse in the workplace? (*VIGNETTE* – facilitator uses sketch to provoke thinking and generate ideas regarding the capacity of the out-patient treatment centre and attitudes).

6. Key questions

   What in your opinion are the reasons for the low referral rate for treatment from employers? Please list.

   Most key role players in the community mention that they are unaware of the services of your out-patient treatment centres. How would you respond to that?

7. Ending question
   Do we need to collaborate with employers in our work? Why?

Any advice on your side how to go about to establish a networking relationship between employers and out-patient treatment centres.

8. Closure

   Final question: Have we missed anything? Is there anything more that you would like to add? Any final statements or recommendations?

   Facilitator summarises briefly the main points and verifies information.

9. Debriefing: What is your experience of the interview:

   - ✓ Were the questions clear?
   - ✓ What relevance do these questions have?
   - ✓ Were there any aspects that you did not understand?
   - ✓ Were there any questions that caused any uncomfortable feelings?

10. Way forward:

    The researcher explains the way forward.

    Individual interviews will also be conducted with employers and employees to explore their viewpoints on the topic.

    The information from all participants will then be consolidated and analysed.

    Feedback on the final results will be given at a SANCA provincial meeting. Background on networking principles and guidelines will also form part of this meeting. Orientation on networking could prompt SANCA staff members to apply networking skills and principles in order to promote future Gold Rush projects in the employment sector in celebration of the annual international day against substance abuse in June.

    The ultimate aim of this research study is to develop a networking programme for employers and out-patient treatment centres so that we can address substance abuse in the workplace collaboratively.

Thank you for your time and cooperation.

APPENDIX 15: SANCA POLOKWANE COMMUNIQUE

SANCA

Limpopo Alcohol and Drug Centre

Limpopo Alkohol en Dwelmsentrum

33Kerk St/-str 33 Polokwane

Tel: 015 295 3700 Fax: 015 291 2709

National Call Centre: 0861472622

SOUTH AFRICAN NATIONAL COUNCIL ON ALCOHOLISM AND DRUG DEPENDENCE
SUID-AFRIKAANSE NASIONALE RAAD INSAKE ALKOHOLISME EN AFHANKLIKHEID VAN VERDOWINGSMIDDELS

21/02/2012

Dear Breggie

Our telephone conversation has reference.

I am so sorry to have to withdraw from this programme. I think that this Networking programme can be of great value to any NPO (non-profit organization).

As you are aware we have not received any subsidy or Lottery funding for the past financial year and we have been fighting for survival. We appointed a fundraiser, on commission basis, and I thought that this will be the ideal situation to have someone dedicated to the networking programme. However, our financial situation changed to such an extent that our main focus is on raising funds to keep the office open. We had to reduce all our staffs working hours to save on costs and therefore also reduced some of our services that we used to deliver.

I understand that you will not be able to manage this process, due to the distance from Nelspruit to Polokwane and it would have been ideal to have a person here that can focus on the networking programme in Polokwane. I also understand that this programme will be able to raise funds in the long run, but we are doing crisis management at the moment with our focus on raising funds immediately in the short term.

I do hope that you will be able to share your knowledge on networking with us as soon as we are through this crisis.

I wish you well with the wonderful work that you are doing and hope that this programme will be a great success.

Kind Regards

Riette van der Linde
DIRECTOR

NPO 028-263

APPENDIX 16: THEMATIC ANALYSIS - PROBLEMS

QUALITATIVE INTERVIEWS: EMPLOYERS / EMPLOYEES / FOCUS GROUPS

ATTITUDE / CULTURE: WORKPLACE

Negative attitude towards person with problem

Stigmatisation

Threatened – possible job joss

Finances & production: highest priority

Incorrect interpretation of legal requirements re substance problems: dismissal only option

Employees – no confidence in employer's ability to address problem

Employees - no support system to confide in

Employers' inconsistent behaviour towards organisation

SUBSTANCE ABUSE PROBLEMS: WORKPLACE

Prevalence: Problem does exist

Few cases identified annually

Management biggest problems - some employers have problems themselves

Impact: Injuries /danger to workforce

HIV/AIDS & STD link with substance abuse

Production & financial losses

Dismissals create feelings of insecurity

Substance abuse in community impacts workplace

Demands on employer: Time-consuming to deal with substance abuse problems

Legal demands

Employees do not accept responsibility to take ownership of their problems

LIMITATIONS: EMPLOYMENT SECTOR

Employers unaware of substance abuse problems in their business

Lack of knowledge on substance abuse

Lack of proactive approach

Lack of communication

Incorrect interpretation of legal requirements to deal with substance problems in workplace

Lack of support for employees

Lack of policies & procedures

Employees - lack of opportunities to apply treatment knowledge in workplace

Employers focus mainly on HIV/AIDS issues

Treatment services
Lack of knowledge of specialised services

Employers - unaware of benefits of specialised intervention for business

APPENDIX 17: THEMATIC ANALYSIS - NEEDS

QUALITATIVE INTERVIEWS: EMPLOYERS / EMPLOYEES / FOCUS GROUP

INTERNAL NEEDS: WORKPLACE

Caring culture
Support & understanding of rehabilitation process

Considerate / sensitive not to expose employees to high risk situations in the workplace – serving drinks at functions

Support groups to assist employee with problem
Motivating & assisting employee for treatment

Encourage employee /acknowledge successes

Information / awareness
Knowledge on substance abuse problem /addressing problem

Communicate seriousness of message to employees

Information needed on alternatives for dismissal

Collaboration

Management, Employee Wellness Programme and employees to collect and share info on substance abuse, identification & addressing problem – prevention

Clear expectations

Financial assistance & funding / time off for treatment sessions

Monitoring & evaluation

Monitoring from onset of treatment

Monitoring measures need to be in place

Regular feedback on employee's progress - evaluate & adjust plans if necessary

EXTERNAL NEEDS OF EMPLOYER

(INTERVENTION BY ORGANISATION)

Support for employer / relief for employer

Assessment
Extent & impact of substance abuse on the workplace

Employees' needs regarding substance abuse

Organisation's capacity to deliver services

Outreach programme
Prevention / awareness

Information on treatment programmes

Planning
Alternative plans for service provision

Role clarification

Plan & source for funding

Planning for implementation of intervention

Cost-effective services

Treatment – accessible, specialised & individualised to meet needs of employer / employee

Feedback & evaluation
Mutual feedback from employer & organisation

Clarity on requirements for feedback

Professional conduct expected from organisation
Knowledgeable

Strong infrastructure

Ethical conduct

APPENDIX 18: THEMATIC ANALYSIS - STRENGTHS

QUALITATIVE INTERVIEWS: EMPLOYERS / EMPLOYEES / FOCUS GROUPS

INTERNALLY: WORKPLACE

Support from employers

Employer-support for treatment especially for employees with longstanding credible work records / trusted / willing to cooperate in treatment

Employers accommodate employees
- allows time off for treatment sessions
- reschedule employee's work-roster
- support-structures exist in workplace
- open, non-judgemental spirit exist
- financial support for employees for treatment
- rapid follow up from HR located elsewhere
- supportive attitude from employers provides peace of mind for employees
- collaboration between employer & employee
- fact-finding phase regarded as a support phase
- joint action-planning phase

Support from colleagues

Colleagues accept & support employee with problem

Protocol to deal with substance abuse in place -
management identifies problem
- disciplinary hearing – not immediate dismissal
- employee involved in choice of action plan
- assistance from management to implement action plan
- referral to treatment centre
- monitoring progress

Networking with SANCA

Existing relationships with SANCA

SANCA recommended as service provider

EXTERNALLY: TREATMENT CENTRE / SERVICES

Success stories:

"I'm living proof that SANCA is working"

"SANCA changed so many aspects in my life – the end results, the success stories are all evidence of the advantages of the programme – and that will sell the programme"

Credibility of the organisation

Existing sustainable relationships between organisation and some employers
Treatment programmes are structured & evidence-based Positive results
SANCA on resource list of some companies

When SANCA is personal choice of employee, it is accepted by company

Resources available in community

SANCA – main source
AA / NA / Internet
Multi-media
Government social workers
Government in-patient treatment centres
Private in- and out-patient treatment centres

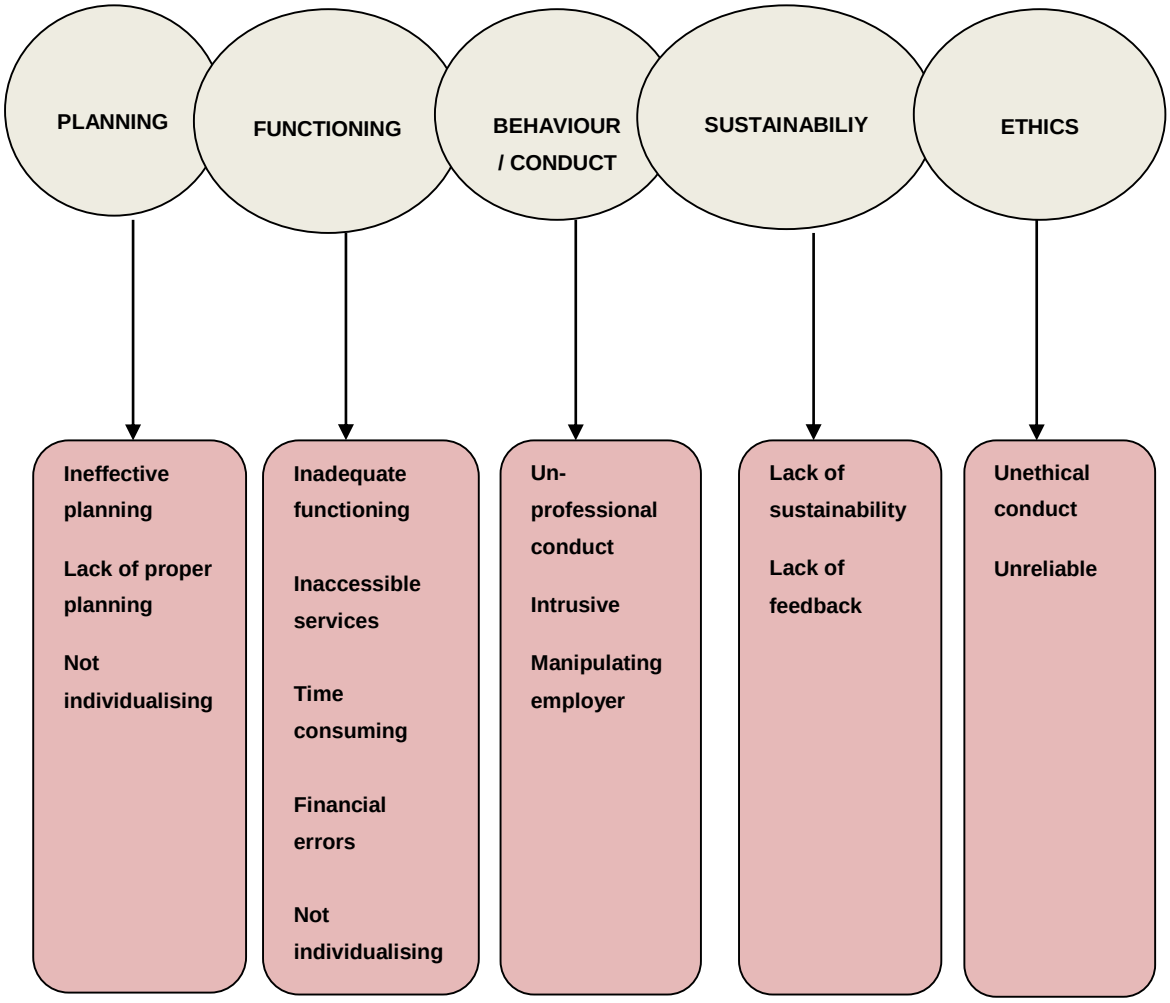
Unions – strong support structure for employee

Own family support group

(Some rural local communities – no resources)

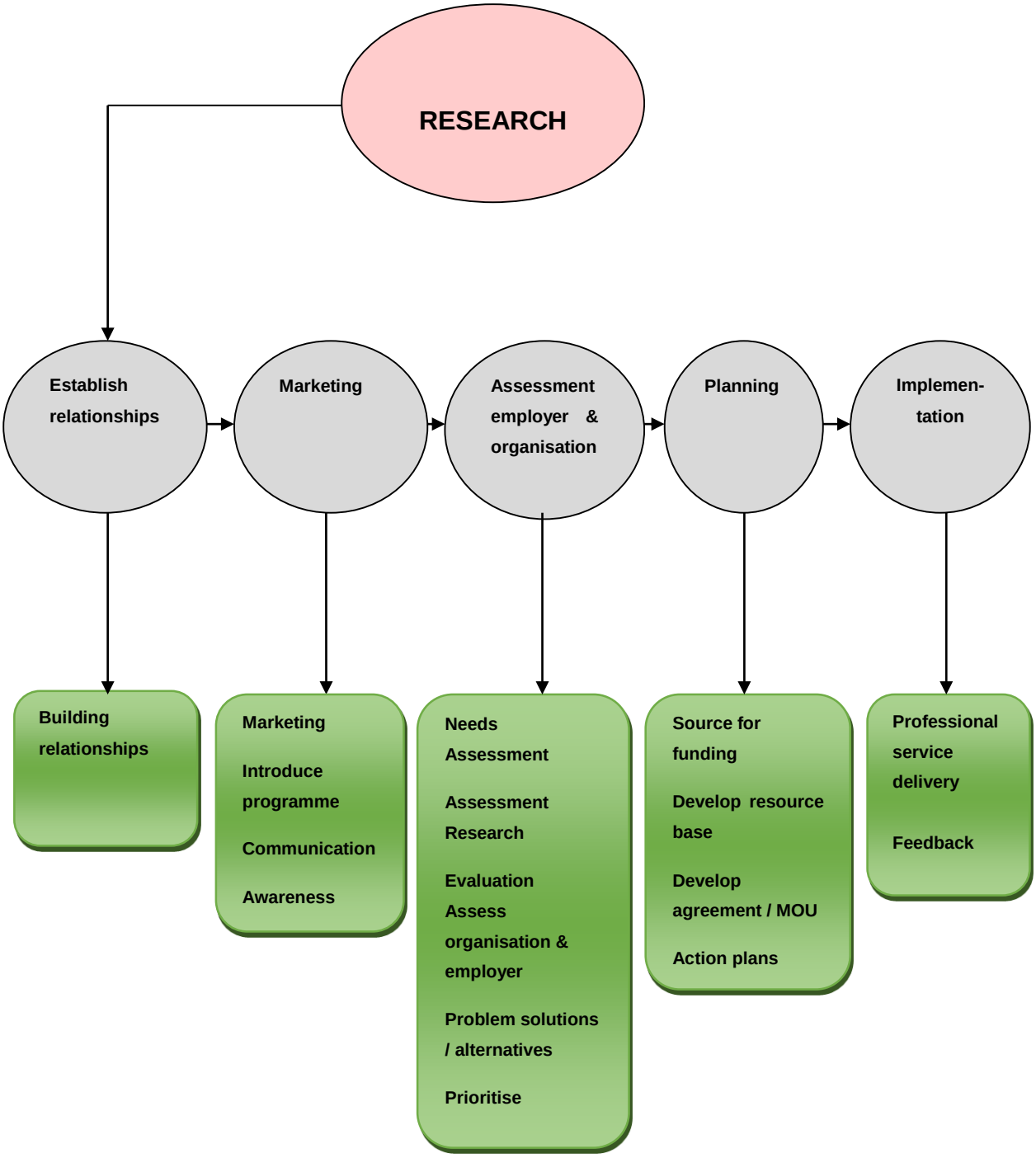
APPENDIX 19: THEMATIC MAPPING – EXAMPLES

Q 9: WHAT SHOULD OUT-PATIENT TREATMENT CENTRES AVOID WHEN ESTABLISHING A NETWORKING RELATIONSHIP?



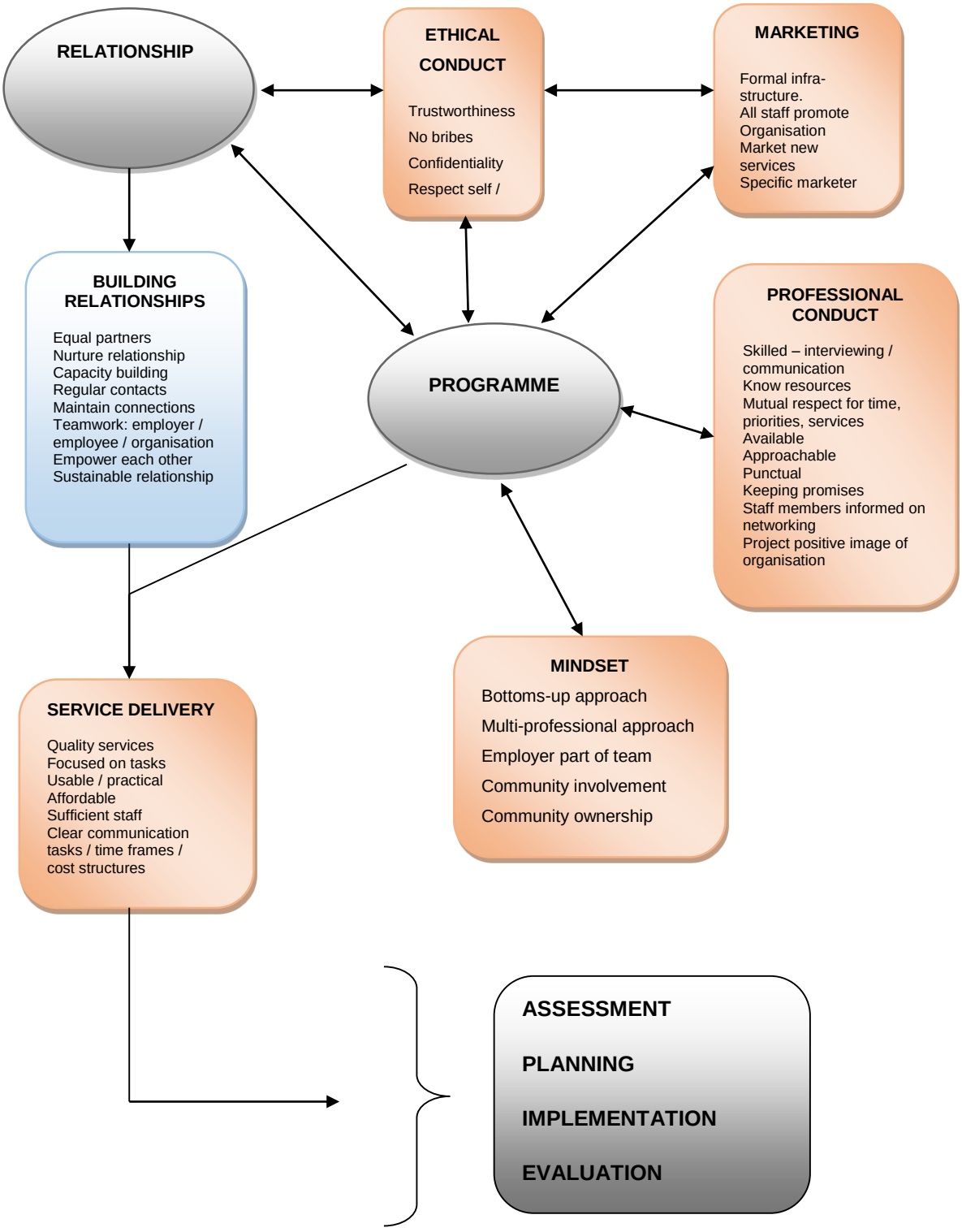
THEMATIC ANALYSIS: CONSOLIDATION - EMPLOYMENT SECTOR

Q4: STEPS IN A NETWORKING PROGRAMME



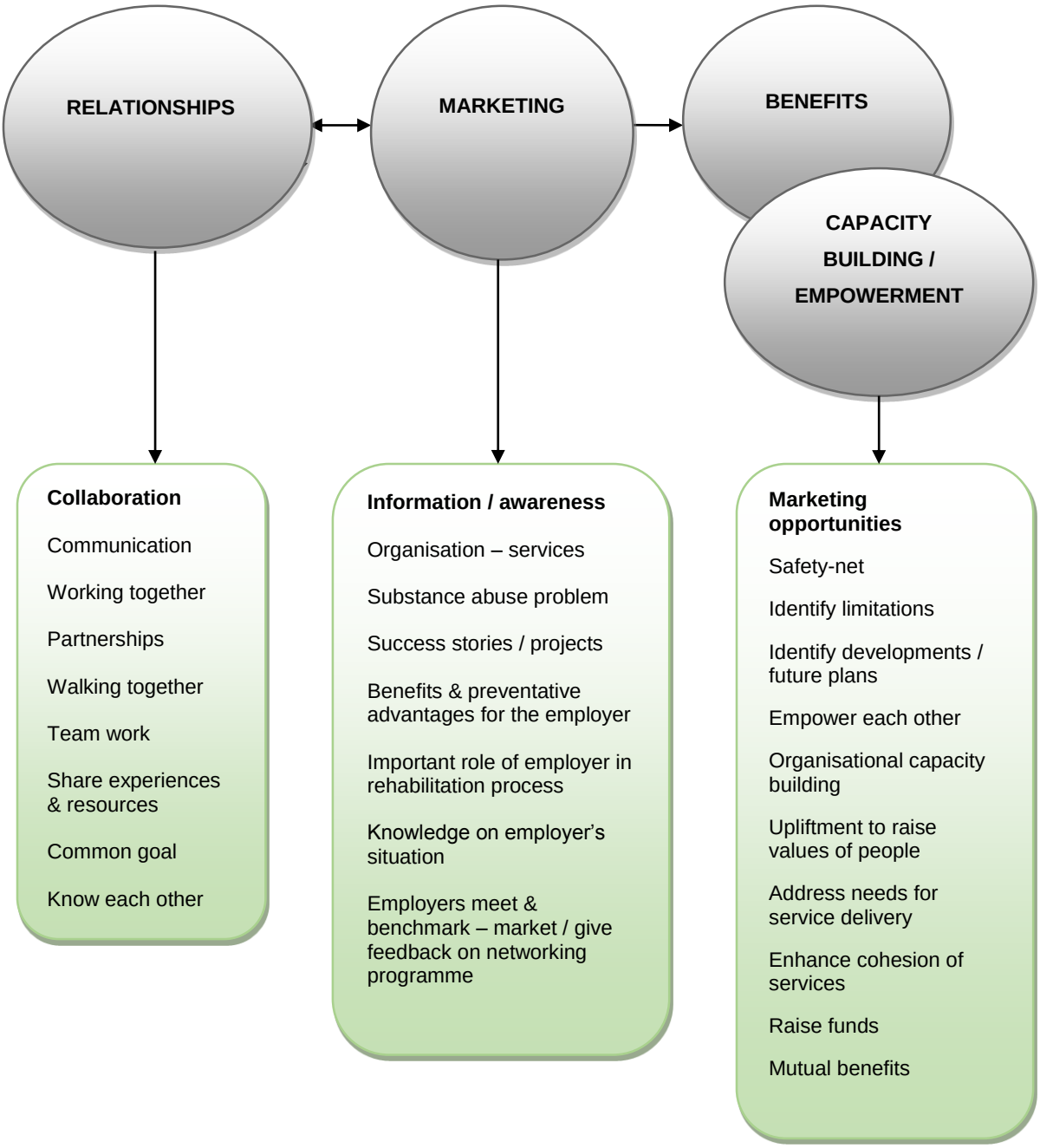
THEMATIC ANALYSIS: CONSOLIDATION - FOCUS GROUP INTERVIEWS

Q 2: MOST IMPORTANT CHARACTERISTICS OF A NETWORKING PROGRAMME



THEMATIC ANALYSIS: CONSOLIDATION - FOCUS GROUP INTERVIEWS WITH OUT-PATIENT TREATMENT CENTRES

Q1 & 3 COMBINED: PURPOSE OF NETWORKING PROGRAMME



APPENDIX 20: EXAMPLES - APPLYING THE PROGRAMME

Projects in applying the networking programme

1. **Practical application of the programme in a macro business on a trial-run basis**
   SANCA Lowveld out-patient treatment centre is initiating the process. The preparation phase has been completed. The collaboration phase has commenced. The EWP manager is an asset to the programme and has identified role players key to the proposed programme, i.e. HR manager from head office, members from the Health and Safety division, Risks department involved in random drug testing, Disciplinary actions department, staff involved in EAP issues and the unions. A brain-storming session with these role players has been scheduled and will introduce the programme, present general facts on substance abuse and its impact on the workplace, and discuss approaches to address the problem collaboratively. The establishment of both a task team and a networking agreement will be negotiated. The time frame of the programme, roles and responsibilities of relevant parties and funding will be discussed. Opportunities identified by the EWP manager include, amongst others, linking the programme with existing HIV and random drug testing campaigns and training the role players selected for the brain storming session. Action plans to apply the programme will be formulated after the brain- storming session has been conducted. Introduction of the networking programme to the corporate group on national level was also requested by the EWP manager. Envisaged time line: March 2014 – March 2015

2. **SANCA National – Feedback on the results of the networking programme**. Directors of SANCA out-patient treatment centres in SA are represented on the SANCA National management board. Feedback will be provided during a management meeting on the research results and the steps to apply the programme will be introduced. Training of relevant SANCA staff members for the networking programme, as well as the practical application of the programme in the different SANCA centres, will be negotiated
   Time line: SANCA National general management meeting – 2014

3. **Seminar for participants who were involved in the research study**.
   The purpose of an envisaged seminar is to provide feedback on the research results, introduce the programme application process, provide feedback on the results of the aforementioned trial run programme in the macro business and create opportunities for employers to benchmark best practices in dealing with the problem.
   Time line: June 2015 to coincide with the International World Day against Substance Abuse and the Gold Rush programme of SANCA National with the same theme.

4. **Electronic contact with all participants** involved in the study to provide brief feedback on the research results and information on preliminary action plans indicated above.
   Time line: April 2014

APPENDIX 21: SOCIAL WORK / MAATSKAPLIKE WERK

REQUIREMENTS FOR PUBLICATION IN A FEW JOURNALS SOCIAL WORK. A PROFESSIONAL JOURNAL FOR THE SOCIAL WORKER / MAATSKAPLIKE WERK. 'N VAKTYDSKRIF VIR DIE MAATSKAPLLKE WERKER

EDITORIAL POLICY/REDAKSIONELE BELEID

The Journal publishes articles, book reviews and commentary on articles already published from any field of social work. Contributions may be written in English or Afrikaans. All articles should include an abstract in English of not more than 100 words. All contributions will be critically reviewed by at least two referees on whose advice contributions will be accepted or rejected by the editorial committee. All refereeing is strictly confidential. Manuscripts may be returned to the authors if extensive revision is required or if the style or presentation does not conform to the Journal practice. Articles of fewer than 2,000 words or more than 10,000 words are normally not considered for publication. Two copies of the manuscript as well as a diskette with the text, preferably in MS Windows should be submitted. Manuscripts should be typed in 12 point Times Roman double-spaced on one side of A4 paper only. If possible the manuscript should be sent electronically to hsu@sun.ac.za. Use the Harvard system for references. Short references in the text: When word-for-word quotations, facts or arguments from other sources are cited, the surname(s) of the author(s), year of publication and page number(s) must appear in parenthesis in the text, e.g. "..." Berger, 1967: 12). More details about sources referred to in the text should appear the end of the manuscript under the caption "References". The sources must be arranged alphabetically according to the surnames of the authors. Note the use of capitals and punctuation marks in the following examples.	Die Tydskrif publiseer artikels, boek-besprekings en kommentaar op reeds gepubliseerde artikels uit enige gebied van die maatskaplike werk. Bydraes mag in Afrikaans of Engels geskryf word. Alle artikels moet vergesel wees van 'n Engelse opsomming van nie meer as 100 woorde nie. Alle bydraes moet krities deur ten minste twee keurders beoordeel word. Beoordeling is streng vertroulik. Manuskripte sal na outeurs teruggestuur word indien ingrypende hersiening vereis word, of indien die styl nie ooreenstem met die tydskrif se standaard nie. Artikels van minder as 2,000 woorde of meer as 10,000 woorde sal normaalweg nie oorweeg word vir publikasie. 'n Disket met die teks, verkieslik in MS Windows, moet twee kopieë van die manuskrip vergesel. Manuskripte moet in 12 pt "Times Roman" dubbelspasiëring slegs op een kant van 'n A4 bladsy getik word. Indien enigsins moontlik moet die manuskrip ook per e-pos versend word aan hsu@sun.ac.za. Verwysings moet volgens die Harvard-stelsel geskied. Verwysings in die teks: Wanneer woordelikse sitate, feite of argumente uit ander bronne gesiteer word, moet die van(ne) van die outeur(s), jaar van publikasie, en bladsynommers tussen hakies in die teks verskyn, bv. "(Berger, 1967:12). Meer besonderhede omtrent bronne moet alfabeties volgens die vanne van die outeurs aan die einde van die manuskrip onder die opskrif "Bibliografie" verskyn. Let op die gebruik van hoofletters en leestekens by die volgende voorbeelde.

TWO AUTHORS/TWEE OUTEURS: SHEAFOR, B.W. & JENKINS, L.E. 1982. Quality field instruction in social work: programme development and Maintenance. New York: Longman.

COLLECTION/BUN DEL ARTIKELS: MIDDLEMAN, R.R. & RHODES, G.B., *eds.* 1985. Competent supervision, making imaginative judgements. New Jersey: Prentice-Hall.

ARTICLE IN COLLECTION/ARTIKEL IN BUNDEL: DURKHEIM, E. 1977. On education and society. In: KARARABEL, J. & KALSEY, A.H., *eds.* Power and ideology in education. New York: Oxford University Press.

JOURNAL ARTICLE/ARTIKEL IN TYDSKRIF: BERN STEIN, A. 1991. Social work and a new South Africa: Can social workers meet the challenge? *Social Work/Maatskaplike werk*, 27(3/4):222-231.

THESISITESIS: EHLERS, D.M.M. 1987. Die gebruik van statistiese tegnieke vir die ontleding van gegewens in maatskaplikewerk-navorsing. Pretoria: Universiteit van Pretoria. (M tesis).

MINISTRY FOR WELFARE AND POPULATION DEVELOPMENT 1995. Draft White paper for Social Welfare. Government Gazette, Vol. 368. No. 16943 (2 February). Pretoria: Government Printer.

NEWSPAPER REPORT/KOERANTBERIG: MBEKI, T. 1998. Fiddling while the AIDS crisis gets out of control. Sunday Times, 8 March, 18.

INTERNET REFERENCESNERWYSINGS: MCKIERNAN, G. 1998. Beyond bookmarks: schemes for organizing the Web. Available:http://public.iastate.edulCYBER-STACKS/CTW.htm. [Accessed: *18/06/1998].*

APPENDIX 22: SOUTH AFRICAN JOURNAL OF BUSINESS MANAGEMENT

Instructions to Authors

Editorial policy: *The South African Journal of Business Management* publishes articles that have real significance for management theory and practice. Original theory and unique application plus readability and good writing style are important criteria for publication. No articles which have been published elsewhere or are under consideration elsewhere will be considered. Nor will any articles considered that are not written in perfect English or that do not adhere to the instructions to authors.

Copyright for all published material is vested in the Association for Professional Managers in South Africa.

All opinions expressed in papers appearing in the *South African Journal of Business Management* are those of the authors, and are not necessarily subscribed to by the editorial staff or by the Association for Professional Managers in South Africa.

Contributions must be written in English (to facilitate accessibility internationally).

The content of the Journal falls into two categories:

Managerial theory is devoted to the reporting of new methodological developments, whether analytical or philosophical. In general, papers are considered most appropriate if, in addition to developing new theory, some discussion of **applications**, either historical or potential, is included. Both state-of-the-art surveys and papers discussing new developments are appropriate in this category. The orientation is to the development of the theory of management.

Management practice is concerned with the methodology involved in applying scientific knowledge. Attention is focused on the problems of developing and converting management theory to practice, bearing in mind behavioural and economic realities. Papers should reflect the mutuality of interest of managers and management scientists in the exercise of the management function. Appropriate papers may include: examples of implementations that generalize experience rather than specific incidents and facts, or principles of model development and adaptation that underlie successful application of particular facets of management theory. The relevance of the paper to the professional manager should be highlighted as far as possible.

Correspondence from readers is encouraged on all matters pertinent to management. Especially welcome are academic replies to articles published in the Journal.

Lay-out of manuscripts: Articles should be submitted electronically. The following details should be provided: author's surname; type of word processing document and the file name. Use A4-size formatting, 1.5 spacing and margins of 30mm. The first page should contain the title with the name and complete address of the author to whom correspondence is to be sent. The title, which should be concise but sufficiently informative for information retrieval purposes, should appear on the second page without the names of the authors. Articles should not exceed 20 pages.
The text of the manuscript must be preceded by an English abstract of about 200 words.

Tables should be numbered consecutively in Arabic numerals (Table 1) and should bear a short yet adequate descriptive title. Footnotes to tables should be designated by lower-case letters appearing as superscript to the appropriate entries. Tables should be presented on separate sheets, grouped together at the end of the manuscript. Their approximate positions in the text should be indicated.

Mathematical notations should be selected so as to simplify the typesetting process. Authors should attempt to make mathematical expressions in the body of the text as simple as possible. Greek letters and unusual symbols (if handwritten) must be labelled when they first appear in the manuscript, as well as the subscript 'oh' (as distinguished from the number 'zero').

Illustrations should be prepared on separate A4 pages. Authors should use dedicated graphical software giving uniform lines and lettering of a size which will be clearly legible after reduction. Freehand or typewritten lettering and lines are not acceptable. Authors are requested to pay particular attention to the proportions of illustrations so that they can be accommodated in single (86 mm) or double (179 mm) columns after reduction, without wastage of space. Figures should be numbered consecutively in Arabic numerals (Figure 1), and descriptive captions should be listed on a separate page. All illustrations should be grouped together at the end of the manuscript, and their approximate positions in the text indicated.

References: the Harvard method should be used, namely short references in the text and more detailed references arranged in alphabetical order at the end of the manuscript.
References in the text. Cited information must be identified accurately. The surname(s) of the author(s), year of publication and page number(s) appear in parentheses after the quotation, for example (Coetzee, 1986:2-5), (Brown & Jones, 1986:2-5). Omit the page number(s) if the entire publication is referred to, for example (Berger, 1994). In works by three or more authors the surnames of all the authors should be given in the first reference to such a work, for

example ‘A recent study (Jones, Smith, Boren & White, 1993) shows …’ In later references to this work only the first author’s name is given, and the abbreviation *et al.,* a comma and the year of publication. For example: (Jones *et al.,* 1993).

References at the end of the manuscript. More details about sources referred to in the text must appear at the end of the manuscript under the caption ‘References’. Sources must be arranged alphabetically according to the surnames of the first author. If more than one publication by the same author(s) appear in one year they must be distinguished by an a, b, etc., for example 1981a, 1981b.

References from books. After the year of publication, follows the *title*. The Edition. Place of publication: publisher.
Bayliss, W.M. & Glass, B. 1991. *Principles of general psychology*. 4th Edition. London: Longmans.

References from chapters in a book. Tonne, E. 1980. Helping the poor. **In** Schoon, A. (Ed.). *Poverty in the 3rd World.* Harare: Omega Books.

References from journals. After the year of publication, follows the title of the article, *title of the journal*, volume, number, page(s).

Langmuir, 1. 1956. ‘Isomorphism, isoterism and covalence’, *Journal of Business*, **23**(3): 46-7.

References from the Internet. Hollard, P.J. 1999. *Food consumption and production*. [online] URL:http://www/wri.org/critcons/food.pdf.

Additional reprints can be ordered directly from the *printers* (see address in inside front cover).
The Scientific Editor is **Professor Eon Smit**, *South African Journal of Business Management*, Stellenbosch Business School, PO Box 610, Bellville 7535, South Africa. Please submit manuscripts to Marion Leurs (E-mail address: mjl@usb.ac.za)
No articles will be published without first undergoing an anonymous but rigorous refereeing procedure. The editor reserves the right to make the final decision with respect to publication.

APPENDIX 23: HEALTH SA GESONDHEID

Original Research (Empirical Research)

Structure adherence

Please ensure that you keep to this structure when formulating your article to the journal

HOUSE STYLE

Abbreviations

Abbreviations should be used as sparingly as possible. They can be defined when first used or a list of abbreviations can be provided preceding the acknowledgements and references.

Typography

• Please use 1.5 line spacing.
• Font size in 12pt
• Type the text unjustified, without hyphenating words at line breaks.
• Insert line numbers
• Use hard returns only to end headings and paragraphs, not to rearrange lines.
• Capitalise only the first word, and proper nouns, in the title.
• All pages should be numbered.
• First heading: FIRST HEADING (upper case, bold, and 14pt) ; Second heading: Second heading (normal case, bold, 14pt); Third heading: Third heading (normal case, bold, 12pt); Fourth heading: Fourth heading (normal case, bold, running in-text and separated by a colon).
• Use the Health SA Gesondheid reference format.
• Footnotes to text should not be used.
• Greek and other special characters may be included. If you are unable to reproduce a particular special character, please type out the name of the symbol in full.
• Place headings in bold caps; separated by space; no numbering. If additional levels of headings are used: secondary heading in bold no caps; third heading as normal.
• For quotations use single quote marks. For quotes within quotes use double marks. Quotations of more than 30 words are to be indented. Do not use quotation marks for indented quotes unless direct speech e.g. interviewee response.
• In the text (but not the references) titles of books should be in italics and titles of articles in quotation marks.
• Foreign language words should be given in italics unless they are part of normal usage, example et al.
• Use en dashes (or two hyphens) in text and single hyphens in ranges of numbers, dates etc.

• Format dates as follows: '20th century,' except at the beginning of sentences; hyphenate when used adjectivally; '1960s'; '10 October 2006.'
• Spell out 'per cent/ percentage' except in cases of exact statistical usage.
• Spell out the numbers one to nine, from 10 on use numerals, except at the beginning of a sentence – which should be avoided.
• Use a space for thousands (10 000 and above).
• Use decimal points (not decimal commas).
• Units should follow the SI standard.
• Avoid Americanisms (use ‘s’ not ‘z’).

Please ensure that all special characters used are embedded in the text, otherwise they will be lost during conversion to PDF.

Tables: Tables should be self-explanatory, clearly organised and supplemental to the text of the manuscript. Each table should include a clear descriptive title on top and should be numbered in Arabic numerals (1, 2, etc.) in order of its appearance as called out in text. Tables must be inserted in the correct position in the text, and uploaded separately as supplementary files each in their own excel sheet. Authors should place explanatory matter in footnotes, not in the heading. Explain all nonstandard abbreviations in table footnotes. For footnotes use the following symbols, in sequence: *,†,‡,§,||,,**,††,‡‡.

Figures: All figures must be inserted in the appropriate position of the electronic document, or uploaded separately as supplementary files.

Symbols, lettering and numbering (in Arabic numerals e.g. 1, 2, etc. in order of appearance in the text) should be placed below the figure, clear and large enough to remain legible after the figure has been reduced. Figures must have clear descriptive titles. Figure legends: The legends should be included in the main manuscript text file immediately following the references, rather than being a part of the figure file. For each figure, the following information should be provided: Figure number (in sequence); short title of figure (maximum 15 words); detailed legend, up to 50 words.

Photographs and images: If photographs of patients are used, the human subject should not be identifiable and use of the picture should be authorised by an enclosed written permission from the subject. The position of photographs and images should be clearly indicated in the text.

Electronic images should be saved as either .jpeg or .gif files. All photographs should be scanned at a high resolution (300dpi, print optimised).

Provision is made to upload individual images on the website as supplementary files. Please number the images appropriately.

Permission: Permission should be obtained from the author and publisher for the use of quotes, illustrations, tables, and other materials taken from previously published works which are not in the public domain. The author is responsible for the payment of any copyright fee(s) if these have not been waived. Letters of permission should accompany the manuscript. The original source(s) should be mentioned in the figure legend or as a footnote to a table.

COVER PAGE – first page.

Title (fourth-level heading).

The articles full title should contain a maximum of 95 characters.

Short title (fourth-level heading).

Derived from the title of the article, provide a short title of 50 characters or less.

Research significance (fourth-level heading).

Indicate the significance of the work being reported.

Author(s) details (fourth-level heading).

State the full name(s) and title(s) of all participating author(s) including their positions, affiliations and contact details, which includes postal address, email, telephone and cell number) of each author.

Corresponding author (fourth-level heading).

Indicate the author to whom all correspondence should be made. This author will liaise with the journal and take the responsibility to responding to all queries related to the article.

Author contribution (fourth-level heading).

Include a paragraph briefly summarising the nature of the contribution made by each of the authors listed using initials, along the lines of the following:

J.K. was the project leader, L.M.N. and A.B. were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. made conceptual contributions and S.T., U.V. and C.D. performed some of the experiments. S.M. and V.C. prepared the samples and calculations were performed by C.S., J.K. and U.V. wrote the manuscript.

Reviewers (fourth-level heading).

Provide three names and full contact details (including email) of potential reviewers to evaluate the work. These reviewers should not be people with whom the researcher(s) has recently collaborated or published.

Keywords (fourth-level heading).

Provide five keywords to the article, in alphabetical order and separated by a semi-colon. Avoid general and plural terms and multiple concepts (avoid, for example, "and", "of"). Be sparing with abbreviations: only abbreviations firmly established in the field may be used. These keywords will be used for indexing purposes.

ARTICLE STRUCTURE – second page and onwards.

Abstract (first-level heading).

In English, not more than 300 words. All original and review articles should include an abstract. The abstract for an Original Research article should consist of five paragraphs focusing on the Background, Objectives, Method, Results and Conclusion. All articles must contain an abstract translated into Afrikaans called ‘Opsomming’, not more than 300 words which forms part of the article Abstract.

Introduction (first-level heading).

The introduction contains two subsections; namely the background section and the literature review.

Setting (second-level heading).

The setting section should be written from the standpoint of readers that is without specialist knowledge in that area and must clearly state - and, if helpful, illustrate - the setting to the research and its aims in the context of previous work bearing directly on the subject. The setting section to the article normally contains the following five elements:

Key focus (third-level heading).

A thought-provoking introductory statement on the broad theme or topic of the research.

Background (third-level heading).

Providing the background or the context to the study (explaining the role of other relevant key variables in this study);

Trends third-level heading).

Cite the most important published studies previously conducted on this topic or that has any relevance to this study (provide a high-level synopsis of the research literature on this topic).

Objectives (third-level heading).

Indicate the most important controversies, gaps and inconsistencies in the literature that will be addressed by this study. In view of the above trends, state the core research problem and specific research objectives that will be addressed in this study and provide the reader with an outline of what to expect in the rest of the article.

Contribution to field (third-level heading).

Explanation of the study's academic (theoretical & methodological) or practical merit and/or importance (provide the value-add and/or rationale for the study).

Research Method and Design (first-level heading).

The methods should include:

Materials (second-level heading).

Describe the type of organism(s) or material(s) involved in the study.

Setting (second-level heading).

Describe the site and setting where your field study was conducted.

Design (second-level heading).

Describe your experimental design clearly, including a power calculation if appropriate. Note: Additional details can be placed in the online supplementary location.

Procedure (second-level heading).

Describe the protocol for your study in sufficient detail (clear description of all interventions and comparisons) that other scientists could repeat your work to verify your findings.

Analysing (second-level heading).

Describe how the data were summarised and analysed, additional details can be placed in the online supplementary information.

Results (first-level heading).

This section provides a synthesis of the obtained literature grouped or categorised according to some organising or analysis principle.

Tables may be used or models may be drafted to indicate key components of the results of the study.

• Organise the results based on the sequence of Tables and Figures you will include in the manuscript.
• The body of the Results section is a text presentation of the key findings which includes references to each of the Tables and Figures.
• Statistical test summaries (test name, p-value) are usually reported parenthetically in conjunction with the biological results they support, use SI units.
• Present the results of your experiment(s)/research data in a sequence that will logically support (or provide evidence against) the hypothesis, or answer the question, stated in the Introduction.

Note: All units should conform to the SI convention and be abbreviated accordingly. Metric units and their international symbols are used throughout, as is the decimal point (not the decimal comma).

Ethical considerations (first-level heading).

Papers based on original research must adhere to the Declaration of Helsinki on "Ethical Principles for Medical Research Involving Human Subjects" and must specify the recognised ethics committee from which approval for the research was obtained. Case studies must have the consent of the patient(s) or waiver of consent approved by an ethics committee.

Potential benefits and hazards (second-level heading).

What risks to the subject are entailed in involvement in the research? Are there any potential physical, psychological or disclosure dangers that can be anticipated? What is the possible benefit or harm to the subject or society from their participation or from the project as a whole? What procedures have been established for the care and protection of subjects (e.g. insurance, medical cover) and the control of any information gained from them or about them?

Recruitment procedures (second-level heading).

Is there any sense in which subjects might be ‘obliged’ to participate – as in the case of students, prisoners, or patients – or are volunteers being recruited? If participation is compulsory, the potential consequences of non-compliance must be indicated to subjects; if voluntary, entitlement to withdraw consent must be indicated and when that entitlement lapses.

Informed consent (second-level heading).

Where appropriate, consent of participants MUST be requested and put in terms easily comprehensible to lay persons. This should ideally be both ORALLY and in WRITING. An information sheet setting out factors relevant to the interests of participants in the study must

be written in like terms and handed to them in advance of seeking consent. They must be allowed to retain this sheet.

Data protection (second-level heading).

The project should comply with the requirements of current data protection legislation and how this is accomplished should be disclosed to participating subjects and those monitoring the research procedure. This should include proposed data storage arrangements, degree of security etc. And whether material facts have been withheld (and when, or if, such facts will be disclosed).

Trustworthiness (first-level heading).

This refers to the findings of the study being based on the discovery of human experience as it was experienced and observed by the participants.

Reliability (second-level heading).

Reliability is the extent to which an experiment, test, or any measuring procedure yields the same result on repeated trials.

Without the agreement of independent observers able to replicate research procedures, or the ability to use research tools and procedures that yield consistent measurements, researchers would be unable to satisfactorily draw conclusions, formulate theories, or make claims about the generalisability of their research.

Validity (second-level heading).

Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. While reliability is concerned with the accuracy of the actual measuring instrument or procedure, validity is concerned with the study's success at measuring what the researchers set out to measure. Researchers should be concerned with both external and internal validity. External validity refers to the extent to which the results of a study are generalisable or transferable. Internal validity refers to (1) the rigor with which the study was conducted (e.g. the study's design, the care taken to conduct measurements, and decisions concerning what was and wasn't measured) and (2) the extent to which the designers of a study have taken into account alternative explanations for any causal relationships they explore. In studies that do not explore causal relationships, only the first of these definitions should be considered when assessing internal validity.

Discussion (first-level heading).

This section normally contains the following four elements. It is suggested that sub-headings are used in this section.

Outline of the results (second-level heading).

Restate the main objective of the study and reaffirm the importance of the study by restating its main contributions;

Summarise the results in relation to each stated research objective or research hypothesis; link the findings back to the literature and to the results reported by other researchers; provide explanations for unexpected results.

Practical implications (second-level heading).

Reaffirm the importance of the study by restating its main contributions and provide the implications for the practical implementation your research.

Limitations of the study (first-level heading).

Point out the possible limitations of the study and provide suggestions for future research.

Recommendations (second-level heading).

Provide the recommendations emerging out of the current research.

Conclusion (first-level heading).

This should state clearly the main conclusions of the research and give a clear explanation of their importance and relevance, with a recommendation for future research (implications for practice). Provide a brief conclusion that restates the objectives; the research design; the results and their meaning.

Acknowledgements (first-level heading).

If, through your study, you received any significant help in thinking up, designing, or carrying out the work, or received materials from someone who did you a favour by supplying them, you must acknowledge their assistance and the service or material provided. Authors always acknowledge outside reviewers of their drafts and any sources of funding that supported the research.

Please list the source(s) of funding for the study, for each author, and for the manuscript preparation in the acknowledgements section.

Competing Interests (second-level heading).

A competing interest exists when your interpretation of data or presentation of information may be influenced by your personal or financial relationship with other people or organisations that can potentially prevent you from executing and publishing unbiased research. Authors should disclose any financial competing interests but also any non-financial competing interests that may cause them embarrassment were they to become public after the publication of the manuscript. Where an author gives no competing interests, the listing will read ‘The authors declare that they have no financial or personal relationship(s) which may have inappropriately influenced them in writing this paper.’ Authors' contributions (second-level heading).

In order to give appropriate credit to each author of a paper, the individual contributions of authors to the manuscript should be specified in this section. An ‘author’ is generally considered to be someone who has made substantive intellectual contributions to a published study.

Contributions made by each of the authors listed, along the lines of the following (author initials):

J.K. was the project leader, L.M.N. and A.B. were responsible for experimental and project design. L.M.N. performed most of the experiments. P.R. made conceptual contributions and S.T., U.V. and C.D. performed some of the experiments. S.M. and V.C. prepared the samples and calculations were performed by C.S., J.K. and U.V. wrote the manuscript.

References (first-level heading)

• Please avoid excessive referencing. References begin on a separate page. References cited in the text should all be included in the list at the end of the paper. Your reference list should appear at the end of your assignment/report with the entries listed in the same order that they were cited in the text

• Please see the journals full House Style Guide for Harvard Referencing

• It is very important that you use the right punctuation and that the order of details in the reference is also correct

• Only first words of the article title and words that normally begin with a capital letter are capitalised

• Authors are responsible for the accuracy of all references

SECTION E: CONSOLIDATED LIST OF REFERENCES

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Abadinsky, H. 2011. Drug use and abuse: a comprehensive introduction. 7th ed. Belmont: Wadsworth, Cengage Learning.

Acts **see** South Africa

Albertyn, C. & Bhoola, U. 2011. Proposed substance abuse policy and procedural agreement. *(In* McCann, M., Harker Burnhams, N., Albertyn, C. & Bhoola, U., *eds*. 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta. p. 292-324).

Andreasen, A.R. & Kotler, P. 2008. Strategic marketing for non-profit organizations. 7th ed. Upper Saddle River: Merrill Prentice Hall.

Anon. 2009. The naked truth – statistics (SA & Global). http://www.tnt.org.za/index.php/ption=com_content&view=article&id=21&Itemid=51 Date of access: 15 March 2011.

Arkansas Small Business and Technology Development Center (ASBTDC). 2011. Arkansas drug free workplace: facts and figures about drugs and alcohol in the workplace. http://asbtdc.ualr.edu/drugfree/facts.asp Date of access:: 24 February 2011.

Babbie, E. 2010. The practice of social research. 12th ed. Belmont: Wadsworth Cengage Learning.

Backer, T.E. 2003. Evaluating community collaborations. New York: Springer.

Barnett, T. & Whiteside, A. 2006. AIDS in the twenty-first century: disease and globalization. 2nd ed. New York: Palgrave Macmillan.

Botma, Y., Greeff, M., Mulaudzi, F.M. & Wright, S.C.D. 2010. Research in health sciences. Cape Town: Pearson Education South Africa.

Boyce, C. & Neale, P. 2011. Conducting in-depth interviews: a guide for designing and conducting in-depth interviews for evaluation input. m_e_tool_series_indepth_interviews.pdf Date of access: 1 March 2011.

Braun, V. & Clarke, V. 2006. Using thematic analysis in Psychology. *Qualitative research in Psychology,* 3:77-101. www.QualResearchPsych.com. Date of access: 30 May 2012.

Carroll, A.B. & Buchholtz, A.K. 2006. Business & society: ethics and stakeholders management. 6th ed. Mason: Thomson South-Western.

Creswell, J.W. 2003. Research design: qualitative, quantitative, and mixed methods approaches. 2nd ed. Thousand Oaks: Sage Publications.

Creswell, J.W. 2005. Educational research: planning, conducting, and evaluating quantitative and qualitative research. 2nd ed. Upper Saddle River: Merrill Prentice Hall.

Creswell, J.W. 2013. Qualitative inquiry & research design: choosing among five approaches. 3rd ed. London: Sage Publications.

Dalton, M., Hoyle, D.G. & Watts, M.W. 2006. Human relations. 3rd ed. Mason: Thomson South-Western.

Delport, C.S.L. & De Vos, A.S. 2011. Professional research and professional practice. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 45-60).

Delport, C.S.L., Fouché, C.B. & Schurink, W. 2011. Theory and literature in qualitative research. *(In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 297-306).

Department of Social Development. ***see*** South Africa. Department of Social Development.

Doweiko, H.E. 2006. Concepts of chemical dependency. 6th ed. Belmont: Thomson Brooks/Cole.

Eberlein, R. 2010. Lifestyle changes to beat addiction: a guide to drug-free living. Randburg: Knowres.

Ellingson, L.L. 2009. Engaging crystallization in qualitative research: an introduction. London: Sage.

Employee Assistance Professionals Association (EAPA). 2010. EAPA standards and professional guidelines for employee assistance programs. http://www.eapassn.org/files/public/EAPAstandards10.pdf Date of access: 8 March 2014.

Falkena, H., Abedian, I., Von Blottnitz, M., Coovadia, C., Davel, G., Madungandaba, J., Masilela, E & Rees, S. 2011. SME's access to finance in South Africa: a supply-side regulatory review. www.treasury.gov.za/publications/other. Date of access: 21 June 2011.

Fisher, G.L. & Harrison, T.C. 2009. Substance abuse: information for school counselors, social workers, therapists, and counselors. 4th ed. Boston: Pearson Education.

Fouché, C.B. & De Vos, A.S. 2011. Formal formulations. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 89-100).

Fouché, C.B. & Schurink, W. 2011. Qualitative research designs. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 307-327).

Goodman, A. 2007. Social work with drug and substance misusers: transforming social work practice. Wiltshire: Learning Matters.

Greeff, M. 2011. Information collection: interviewing. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 341-375).

Greenfield, J.M. 2001. The non-profit handbook: fundraising. 3rd ed. New York: John Wiley & Sons.

Grobler, P., Wärnich, S., Carrell, M.R., Elbert, N.F. & Hatfield, R.D. 2006. Human resource management in South Africa. 3rd ed. London: Thomson Learning.

Hanson, G.R., Venturelli, P.J. & Fleckenstein, A.E. 2009. Drugs and society. 10th ed. London: Jones and Bartlett.

Hepworth, D.H., Rooney, R.H., Rooney, G.D., Strom-Gottfried, K. & Larsen, J. 2010. Direct social work practice: theory and skills. 8th ed. Belmont: Brooks/Cole.

Hitzeroth, V. & Kramer, L. 2010. The end of addiction: a comprehensive South African guide. Cape Town: Human & Rousseau.

Hollensen, S. 2010. Marketing management: a relationship approach. 2nd ed. New York: Pearson Education.

International centre for alcohol policies (ICAP). 2013. Alcohol and the workplace. The ICAP BLUE BOOK: practical guides for alcohol policy and prevention approaches. Module 22. http://www.icap.org. Date of access: 10 January 2013.

Jobber, D. 2004. Principles and practice of marketing. 4th ed. Berkshire: McGraw-Hill International.

Kirst-Ashman, K.K. & Hull, G.H. 2009. Generalist practice with organisations and communities. 4th ed. Belmont: Brooks/Cole.

Kotler, P. & Armstrong, G. 2010. Principles of marketing: global and Southern African perspectives. Cape Town: Pearson Education South Africa.

Kurtz, D.L. & Boone, L.E. 2006. Principles of marketing. Mason Thomson South-Western.

Lancaster, G. & Massingham, L. 2011. Essentials of marketing management. New York: Routledge.

Long, D.D., Tice, C.J. & Morrison, J.D. 2006. Macro social work practice: a strengths perspective. Belmont: Thomson Brooks/Cole.

McCann, M., Harker Burnhams, N.H., Albertyn, C. & Bhoola, U., *eds*. 2011. Alcohol, drugs and employment. 2nd ed. Claremont: Juta.

Miller, W.R. & Rollnick, S. 2002. Motivational interviewing: preparing people for change. 2nd ed. New York: Guilford Press.

Miller, W.R. & Weisner, C.M. 2002. Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum.

Monette, D.R., Sullivan, T.J. & DeJong, C.R. 2011. Applied social research: a tool for the human services. 8th ed. Belmont: Thomson Brooks/Cole.

Neuman, W.L. 2006. Social research methods: qualitative and quantitative approaches. 6th ed. Boston: Pearson Education.

Parker, J. & Bradley, G. 2007. Social work practice: assessment, planning, intervention and review. 2nd ed. Glasgow: Bell & Bain.

Parry, C.D.H. & Bennetts, A.L. 1998. Alcohol policy and public health in South Africa. Cape Town: Oxford University.

Pelser, I. 2011. ETTEx Network: the future of drug testing (e-mail). 11 February 2011.

Pierson, J. & Thomas, M. 2010. Dictionary of Social Work. Berkshire: Open University Press.

Poulin, J. & Contributors. 2000. Collaborative social work: strengths-based generalist practice. Belmont: Thomson Brooks/Cole.

Roman, P.M. 2002. Missing work: the decline in infrastructure and support for workplace alcohol intervention in the United States, with implications for developments in other nations. *(In* Miller, W.R. & Weisner, C.M., *eds.* Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum. p. 197-210).

Rose, S.J. & Zweben, A. 2002. Interrelationship of substance abuse and social problems. (*In* Miller, W.R. & Weisner, C.M., *eds.* Changing substance abuse through health and social systems. New York: Kluwer Academic/Plenum. p.145-156).

SACENDU (South African Community Epidemiology Network on Drug Use). 2012. Monitoring alcohol and drug abuse trends in South Africa (July 1996-June 2012). Phase 32. SACENDU Research Brief, 15(2), 2012. Tygerberg.

SACENDU (South African Community Epidemiology Network on Drug Use). 2012. SACENDU report back meetings – November 2012. Monitoring alcohol and drug trends: January-June 2012. Phase 32. Tygerberg.

SANCA (South African National Council on Alcoholism and Drug Dependence). 2011. Out-patient treatment manual. SA [s.l.]: SANCA.

SANCA (South African National Council on Alcoholism and Drug Dependence). 2011. In-patient treatment model manual for substance abuse: Draft 5. SA [s.l.]: SANCA National.

Schurink, W., Fouché C.B. & De Vos, A.S. 2011. Qualitative data analysis and interpretation. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 397-423).

Segal, E.A., Gerdes, K.E. & Steiner, S. 2007. An introduction to the profession of social work: becoming a change agent. 2nd ed. Belmont: Thomson Brooks/Cole.

Services SETA. 2003. Toolkit: managing substance abuse in the workplace. Parktown: s.n.

Services SETA. 2003. Toolkit: employee assistance programmes and the law in South Africa. Parktown: s.n.

Slaymaker, V.J. & Owen, P.L. 2006. Employed men and women substance abusers: job troubles and treatment outcomes. *Journal of substance abuse treatment*, 31:347-354, May.

Smith, R.L. & Capps, F. 2005. Research and contemporary issues. (*In* Stevens, P. & Smith, R.L. Substance abuse counselling: theory and practice. 3rd ed. Upper Saddle River: Merrill Prentice Hall).

South Africa. 1978. Social Service Professions Act 110 of 1978.

South Africa. 1993. Occupational Health and Safety Act 85 of 1993.

South Africa. 1993. The Compensation for Occupational Injuries and Diseases Act 130 of 1993.

South Africa. 1995. The Labour Relations Act 66 of 1995.

South Africa. 1996. The National Small Business Act 102 of 1996.

South Africa. 1996. Constitution of the Republic of South Africa Act 108 of 1996.

South Africa. 1997. Non-Profit Organisations Act 71 of 1997.

South Africa. 1998. The Employment Equity Act 55 of 1998.

South Africa. 2008. Prevention of and Treatment for Substance Abuse Act 70 of 2008.

South Africa. 2011. The South African Labour Guide. http://www.labourguide.co.za/workplace-discipline/code-of-good-practice-dismissal-general-461 Date of access: 24 February 2011.

South Africa. Department of Social Development. 2006. National Drug Master Plan (NDMP): Draft 2006-2011. Pretoria.

South Africa. Department of Social Development. 2010. Central Drug Authority (CDA) annual report 2010/11. Pretoria.

South Africa. Department of Social Development. 2013. National Drug Master Plan (NDMP) 2013-2017. Pretoria.

South Africa. Department of Social Development. 2013. Reintegration and aftercare model for substance abuse services. Pretoria:

South African Council for Social Service Professions (SACSSP). 2012. Policy guidelines for course of conduct, code of ethics and the rules for social workers. 4th ed. Pretoria.

Stevens, P. & Smith, R.L. 2005. Substance abuse counselling: theory and practice. 3rd. ed. Upper Saddle River: Merrill Prentice Hall.

Strydom, H. 2011. Ethical aspects of research in the social sciences and human service professions. (*In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 113-129).

Strydom, H. & Delport, C.S.L. 2011. Sampling and pilot study in qualitative research. *(In* De Vos, A.S., Strydom, H., Fouché, C.B. & Delport, C.S.L., *eds*. Research at grass roots for the social sciences and human service professions. 4th ed. Pretoria: Van Schaik. p. 390-396).

Substance Abuse and Mental Health Services Administration center for substance abuse treatment (SAMSHA). 2011. Counsellor's treatment manual: matrix intensive outpatient treatment for people with stimulant use disorders. http://www.kap.samsha.go/products/manuals/matrix/index.htm Date of access: 22 July 2011.

UNODC (United Nations Office on Drugs and Crime). 2010. World drug report. Vienna: United Nations Publication, Sales No.E10.XI.13. World_Drug_Report_2010_lo-res Date of access: 17 March 2011.

UNODC (United Nations Office on Drugs and Crime). 2012. World drug report. Vienna: United Nations publication, Sales No. E. 12.XI. 1. http:www.unodc.org/documents/data-and-analysis/WDR2012/WDR2012web_small.pdf Date of access: 12 January 2013.

UNODC (United Nations Office on Drugs and Crime). 2013. World drug report. Vienna: United Nations Publication, Sales No. E.13.XI.6. http:www.unodc.org/secured/wdr/wdr2013/World_Drug_Report_2013.pdf Date of access: 8 March 2013.

Van Dyk, A. 2005. HIV/AIDS care & counselling: a multidisciplinary approach. 3rd ed. Cape Town: Pearson Education.

Van Wormer, K. & Davis, D.R. 2008. Addiction treatment: a strengths perspective. 2nd ed. Belmont: Thomas Brooks/Cole.

Welman, C., Kruger, F. & Mitchell, B. 2010. Research methodology. 3rd ed. Cape Town: Oxford University.

Weyers, M.L. 2011. The theory and practice of community work: a Southern African perspective. 2nd ed. Potchefstroom: KEURKOPIE.

WHO (World Health Organization). 2011. Global status report on alcohol and health. Switzerland: WHO Library Cataloguing-in-Publication Data.