

**Family reunification support to inpatient parents
in Western Cape substance abuse treatment
centres: An explorative study**

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Declaration of the Researcher

I, Brandon Lebuso, hereby declare that the manuscript with the title, “*Family reunification support to inpatient parents in Western Cape substance abuse treatment centres: An explorative study*” is my own work. All references used or quoted were acknowledged by citing in text and referencing in the bibliography. I further declare, that I have not previously in its entirety, or in part, submitted the said manuscript at any other university to obtain a degree.

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May 2019

Declaration of Text Editor

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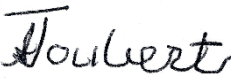
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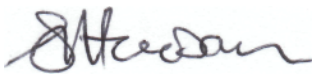
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Preface

The dissertation is presented in article format as indicated in Rule A.5.4.2.7 of the North-West University Potchefstroom Campus Yearbook

- The dissertation consists of Section A, Part 1 : Is the introduction , Part 2 : Literature Review.
- The articles are presented in Section B. The articles are intended to be submitted to the Southern African Journal of Social Work and Social Development (Article 1) and Biomed Central Journal for Substance Abuse (Article 2). The researcher followed the Chicago Manual Style referencing style and guidelines for authors of the journal in Article 1. The BioMed Journal reference style and guidelines for authors of the journal in Article 2.
- Section C consists of summary of research study, methodology, recommendation and implication of findings. Section D consist out of list of 15 Annexures.
- In Section A and C the researcher used the Harvard reference guide according to the North-West University's referencing manual.

Dr. S. Hoosain



Abstract

Parental substance abuse is a pervasive problem in South Africa and the Western Cape and places children at risk. These parents need inpatient treatment as they are dependent on drugs and alcohol, and it affects their ability to parent. Parents at substance abuse treatment centre are separated from their children and need family reunification support. According to the White Paper on Families (2013) and Guidelines on Reunification Services for Families (2012), family's needs to be preserved and this can be done through promoting family reunification services within substance abuse treatment centre. The Guidelines on Reunification Services for Families (2012) provides a framework for social workers in substance abuse treatment centres to restore the well-being of families to regain self-reliance and optimal social functioning. The removal of the parent from their children may be traumatic for both parent and child. However, through engaging both parent and child through the process of family reunification may rebuild the relationship and address the parental substance abuse. Parents in treatment centres that are not being reunified with their children, may face the risk of relapse and children being at risk to abuse and neglect.

Findings of the study indicate that parents want to improve their relationship with their children by having them part of the inpatient treatment programme. Inpatient social workers are providing parenting skills and family therapy to aid family reunification. However, inpatient social workers have experience challenges with family reunification, explaining that they do not experience the designated social workers as available and accessible and as a result affected family reunification of inpatient parents.

The aim of the study is to explore and describe family reunification support available for inpatient parents at substance abuse treatment centres in order to promote family reunification. A qualitative approach was implemented utilizing a descriptive design. Data collection was done through semi-structured interviews and collages with 15 inpatient parents and three focus groups with 13 social workers at Western Cape substance abuse treatment centres. Section B consisted out of Article 1 and Article 2, that reflected the experiences and recommendation of inpatient parents and social workers on family reunification within substance abuse treatment centres.

Key words: family reunification, inpatient parent, inpatient social worker, designated social worker, substance abuse

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SECTION A

PART 1: ORIENTATION TO THE RESEARCH

1. Introduction and discussion of the problem statement

Family Reunification

The primary aim of family reunification is to keep families together. Family reunification is based on the assumptions that people need a family in which to develop optimally, and that the best way of achieving this is to allow them to be with their families (Ziehl, 2003; Kaakinen *et al.*, 2018; Masten, 2018). Family reunification can be defined as an “*approach that offers services to families who have been separated and/or alienated in order to reconstitute them as a family with the resources and skills to address their problems as a family*” (Garthwait, 2012:23). Family reunification, therefore, forms an important aspect of promoting functional and integrated families (Strydom, 2014; Wong, 2016, Griffiths *et al.*, 2017; Hoosain & Potgieter, 2018). Family reunification exists as an intricate interface between social workers and family members who have been separated. This may involve complex negotiation and intervention strategies. Successful reunification relies on the availability, willingness and capacity of families and communities to receive and support those being integrated (Worton *et al.*, 2014; Sauls, & Esau, 2015; Balsells *et al.*, 2017).

The South African Guidelines on Reunification Services for Families (2012) describe family reunification as a phase that seeks to facilitate reintegration into family and community after separation. The guideline comes from the White Paper on Families (2013) policy that advocates for families to be persevered. These guidelines state that successful reunification requires extensive collaboration such as the involvement of family members, social workers, children and community base support services, and substance abuse treatment centres. Roles and responsibilities of services providers, families, children and inpatient should be clearly communicated within a family reunification plan (Department of Social Development, 2012). The guidelines are applicable to social welfare programmes such as an adult family member that have been separated due to mental health issues, children that needs to be reunified with their biological parents and includes individual receiving inpatient treatment for their alcohol and drug abuse (Department of Social Development, 2012; 6). The Guidelines on Reunification Services for Families (2012), also encourages children and families to be involved in pre and post-treatment of the inpatient parent substance abuse treatment, and to assist with the transition of reunification once treatment has been completed. Substance abuse is defined by the Substance Abuse Health Services Administration (SAMHSA, 2015) as; The consumption of alcohol and drugs by an individual in which the regular use of substances result in

clinical impairment, such as health-related problems, failure to meet responsibilities at work, school, or home.

Family reunification may not be a priority in substance abuse treatment centres as writers such as Geyer and Mahlangu (2018) and Groenewald and Bhana (2018) confirmed that inpatients have described the lack of support in contacting families and reconnecting with children after completing treatment. Groenewald and Bhana (2018) and Kalam and Mthembu (2018) also suggest that substance abuse treatment centres may also not have structured processes for family reunification. Literature proposes that family reunification is failing parents who want to reunify with their family, and as a result may cause further family disintegration (Lloyd, 2018; Iusmen, 2019). In addition, research also indicates that parents who are substance abusers are less likely to reunify with their children who have been within inpatient treatment (Brook *et al.*, 2015:119; Balsells *et al.*, 2016:118).

Social workers are usually the point of entry for most individual and families that are affected and affected by alcohol and drug abuse in South Africa and the Western Cape (Burnhams *et al.*, 2012; Ederies, 2017; Vuza, 2018). These social workers refer clients for inpatient treatment services, and becomes the designated social worker, to whom the social worker at the substance abuse treatment centre need to coordinate aftercare and reunification services, once the inpatient has completed their treatment programme (Alpaslan & van der Westhuizen, 2013; Magidson *et al.*, 2017; Mhangwa, *et al.*, 2018). In South Africa social workers at substance abuse inpatient treatment centres are mandated by the Minimum Norms and Standards for Inpatient Treatment (2005) and Guidelines Family Reunification services (2012) to provide family reunification services.

According to Kalam and Mthembu (2018) and Groenewald and Bhana (2018), more literature is required focusing on supporting parents to reconnect with the children and families. Research with parents who are inpatients at substance abuse treatment centres also suggests how, during the reunification phase of aftercare planning, parents may report resentment at being ignored, judged and stigmatize (Karam, 2014:68; Potgieter, 2016:2; Wong, 2016:2). Research by Alpaslan and van der Westhuizen, (2013), Bhana and Groenewald, (2018), Geyer and Mahlangu, (2018); Mhangwa, *et al.* (2018), indicated that lack of support hindered the inpatients from reconnecting with family and community after leaving the inpatient treatment centre. However, there is limited literature on the family reunification support available to inpatient parents in substance abuse treatment centres in the Western Cape and, there is also a lack of empirical studies on South Africa Guidelines on Reunification Services for Families (2012) for inpatients in substance abuse treatment centres is being implemented.

The researcher is employed as a family's policy developer in the Provincial office of Western Cape Department of Social Development. The core of the researcher's work is facilitating policy education on South Africa's White Paper on Families (2012). The White Paper policy document is guided by the family systems approach. Figley and McCubbin (2016), and Becvar and Becvar (2017) defined family system theory as, whereby each member is interdependent and any change in the behaviour of one member will affect the behaviour of others. The study shifts the focus from sobriety of the inpatient to their parenting role as suggested by Siqveland *et al.* (2014) and Neger and Prinz (2015), Hakansson *et al.* (2018).

Inpatient Parents

Social workers at substance abuse treatment centres in the Western Cape have confirmed that on average between 60 - 80% of inpatients that have been admitted were parents (Oberholzer, Rossouw & Van Der Merwe, personal communication 2017, 16 August 2017). South Africa do not have statistics on parents that have been admitted to substance abuse treatment centres. Empirical literature by Myers *et al.* (2014) indicated that, the South African Community Epidemiology Network on Drug Use (SACENDU) only collects demographic and drug use data on inpatients within substance abuse treatment centres. Literature provides evidence that inpatient parents may have made arrangements for someone else such as their maternal or paternal grandparents to care for their children, while they receive inpatient treatment (Taylor *et al.*, 2016; Gordon, 2018). However, researchers have also illustrated that those parents that are abusing drugs and alcohol, children are often placed in alternative care such as foster care while the parent is receiving inpatient treatment (Blackie, 2015; Darsamo, 2016:66). Inpatients who are parents want to be reunified with their children and therefore regular contact and visitation comprise an essential part of the family reunification (Wong, 2006:119; Panchanadeswaran & Jayasundara, 2012:972).

Research has indicated that children between 0-5 years of age are most vulnerable when separated from their parents as well as vulnerable to abuse, neglect and often twice as likely to abuse alcohol and drugs later in life (Fewell & Straussner, 2011: 1-2; Matzopoulos *et al.*, 2014:127; Prinz & Neger, 2015:2). Importantly it's the stage for social, emotional, intellectual, physical and spiritual development (Lillard *et al.*, 2013:2-3; Milteer *et al.*, 2012:205; Cameron & McClelland, 2012:136). Successful reunification for this age group is therefore essential as parental substance abuse places these children at risk (Mariscal & McDonald, 2016; Albert, 2017; Risholm Mothander *et al.*, 2018) . Furthermore, parents need to have a connected relationship with their children in order to meet their developmental needs (Lambert & Andipatin, 2014:44). Inpatient parents with children under the age of 5 years old were therefore the target population of the current study.

Literature available indicates that parents at inpatient treatment centres feel that they do not spend sufficient time with their children during visitation. In addition, parenting programmes are secondary to the substance abuse treatment programme and inpatient parents' voices are not being heard as they want to connect and be with their children (Wong, 2006:126; Panchanadeswaran & Jayasundara, 2012:982; DeGarmo *et al.*, 2013:10-11).

Inpatient Treatment

In the Western Cape, the admission to substance abuse treatment centres rose significantly from 0.3% in 2002 to 33% in 2013 (Hobkirk *et al.*, 2016:2). Inpatient duration in South Africa is between 3 to 6 months (Department of Social Development, 2005). Substance abuse treatment centres practice and procedures are guided by the South African Norms and Standards for Inpatient Treatment Centres (2005). One of the guiding principles of the norms and standard is based on the family centred approach. This approach advocates for support and capacity building through programmes that strengthen family development. Inpatient substance treatment usually involves addressing psychosocial, behavioral and medical intervention (Myers *et al.*, 2012:2; Dwommoh, 2014:7). The average period for inpatient treatment may be 3 weeks to 6 months (Department of Social Development, 2005:33). For patients who are parents, this means being absent from their children for up to 6 months while they undergo treatment (Darsamo, 2016:66). During treatment, an aftercare plan is compiled by the social worker in order to reunify the inpatient parent with their children and family (Department of Social Development, 2005:35; Carelse, 2018; Magidson *et al.*, 2018).

Aftercare planning

While the South African Norms and Standards for Inpatient Treatment Centres (2005), does not refer to family reunification it does refer to “aftercare planning and discharge planning”. Aftercare and discharge planning are terms used when preparing the inpatient to be released as treatment has been completed. International literature uses the term discharge planning in the field of substance abuse (Englander *et al.*, 2017; Humensky *et al.*, 2017). Within treatment an inpatient social worker assists the inpatient to compile an aftercare plan (Carelse, 2018; Magidson *et al.*, 2018). This plan usually involves the transition of the inpatient back into the family after completing their inpatient treatment programme (Elias, 2017; Carelse, 2018). The literature on aftercare planning indicates that the patient needs to be supported with skills to cope with their cravings, job placements, parenting skills and family therapy support (Mhangwa *et al.*, 2018, Groenewald & Bhana, 2018; Geyer & Mahlangu, 2018).

Research confirms that support can prevent relapse. Support can be defined as assistance that is available to one person from another and can be the key to emotional or informational resources emerging from different social relations between individuals or groups (Spilsbury & Korbin, 2013:9; Balsells *et al.*, 2016:813;). Informal support includes visitation from friends, neighbors, relatives and engaging in spiritual activities or religious practices that are facilitated within the substance abuse treatment centre in order to create a safety network once treatment has been completed (Balsells *et al.*, 2016:4; Manual *et al.*, 2016:17). Simultaneously it can strengthen the capacity of families as there is lack of support for inpatient parents at substance abuse treatment centres (Lewandowski & Hill, 2009:2019; Balsells *et al.*, 2016:1). Family reunification support may therefore be a cornerstone to recovery, but there is a gap in literature for family reunification support. While there is literature available on aftercare services current research illustrates that there is a lack of family reunification support for inpatient parents and gap in literature within substance abuse treatment centres, that may result in failed reunification with their children once treatment has been completed (Wong, 2006:126; Panchanadeswaran & Jayasundara, 2012; DeGarmo *et al.*, 2013; Manual *et al.*, 2017).

Family reunification within the context of substance abuse is the transition of the inpatient back into the family after completing their inpatient treatment programme and forms part of aftercare planning. According to Balsells *et al.* (2016) and Bosk *et al.* (2017) the reunification phase of the inpatient parent by the inpatient social worker at the substance abuse treatment centre is facilitated as a collaboration with the designated social worker. It is then expected by the inpatient parent to assume the role of a parent, spouse, significant other and member of the family after they are being reunified (Balsells *et al.*, 2016:812).

Problem Statement and Rationale

Parents who are referred for inpatient treatment for their substance abuse will need family reunification support in order to reunify with their children and family, once their treatment has been completed. For families who have been separated due to a parent's admission to a substance abuse treatment centre, family reunification becomes more complicated as their abuse of substance such as alcohol and drugs, have resulted in family resentment and being reunified with their children may place their children at risk (Choi *et al.*, 2012; Henry *et al.*, 2018). As a result, parents may feel isolated and stigmatized by their family members (DeGarmo *et al.*, 2013; Brook *et al.*, 2015). Furthermore, literature on family reunification support is predominantly within the Child Welfare sector, with the focus on children being reunified with their biological parent after removal (Carnochan & Austin, 2013, Balsells *et al.*, 2015; Stephens, 2017). There is limited research on family reunification in the substance abuse field. This may also result in family breakdown and compounds relapse rates among inpatient parents (Brook *et al.*, 2015:216; Balsells *et al.*, 2016:4). International and local literature on

family reunification support reveals that the process of family reunification is failing, as there is a lack of commitment and support for parents during the period of being separated from their children (Makofane and Nhedzi 2015, Miller, 2018; Mitchell, 2019). Writers such as Groenewald and Bhana (2018) and Kalam and Mthembu (2018) believe that family reunification has not been adequately explored within the substance abuse field.

Aftercare planning focuses on linking the inpatient with support groups, community-based and family support in order to remain sober (Elias, 2016; Mhangwa, Kasiram & Zibane, 2018). Support is, therefore, a key to family reunification as a protective measure that can prevent further family breakdown, once parents have completed their treatment programme (Balsells *et al.*, 2016:4; Manuel *et al.*, 2017). However, there is a lack of focus on family reunification within aftercare services at substance abuse treatment centres (Graham & Grant, 2015; Radel *et al.*, 2018). In addition, there is a gap in current research as most of the South African literature in the field of substance abuse focuses on the pathology of substance abuse on families and individuals (Pasche & Stein, 2012; Myers *et al.*, 2014; Hobkrik *et al.*, 2015; Gibbs *et al.*, 2018). The limited research on reunification within the context of substance written by Lewandowski and Hill (2009), Panchanadeswaran and Jayasundara (2012) and Manuel *et al.* (2017) focusing on inpatient parents, recommend that research in the field of substance abuse goes beyond the sobriety of the inpatient and recognize the diversity of inpatients, especially with regard to those who are parents. The proposed study, therefore, aims to address the gap in the literature by exploring family reunification support at substance abuse treatment centres by interviewing both inpatient parents and inpatient social workers.

International literature confirms that when the inpatient parent is in the process of family reunification within substance abuse treatment centres, the benefits of having regular contact with their children may include: Helping the family to maintain their relationship, providing an opportunity to improve and repair their relationships with the child, creating an opportunity for inpatient parents to learn new parenting skills (e.g. dealing with the child who displays challenging behaviour), (Triseliotis, 2010:60; Van Schalkwyk, 2012:89; Karam, 2014:2; Sauls, & Esau, 2015:9; Child protection best practices bulletin, s.a.:2). Findings from this study may inform family reunification for inpatient parents and provide family reunification guidelines for inpatient social workers. By providing guidelines for family reunification within substance abuse treatment centres, inpatient social workers may be able to help inpatient parents reunify with their children. Despite the lack of literature on family reunification at substance abuse treatment centers, writers such as Makofane and Nhedzi (2015), Sauls and Esau (2015), Potgieter and Hoosain 2018, confirm that family reunification is challenged by the lack of commitment of parents during and post family

reunification, social workers not being equipped and well-resourced to provide family reunification services.

The study will be able to contribute to the field of substance abuse as the topic is aligned with the objectives of the South Africa's National Drug Master Plan 2013-2017 which encourages applying research and development to meet the predicted needs and future changes in the field of substance abuse. Authors such as Paris *et al.* (2015) and Bosk *et al.* (2017), believe substance abuse cannot be treated in isolation, as the inpatient parent and their family need to be taken into consideration during family reunification. Bronfenbrenner's Ecological Systems Theory (EST), was therefore used to guide the study.

Bronfenbrenner's Ecological Systems Theory

Bronfenbrenner's Ecological Systems Theory (EST) (1979) emphasizes that substance abuse cannot be dealt in isolation and that inpatient social workers need to collaborate on a micro level to provide family reunification support to inpatient parents (Tse *et al.*, 2016; Galvani, 2017). Informal and formal support is embedded within the scope of EST. According to Mudavanhu and Schench (2014:371), EST maintains that the environment and its immediate settings actively shape the outcome of an individual's life on a micro level. The support available for inpatient parents at substance abuse treatment centres during family reunification phase will, therefore, be influenced by their environment such as interaction with other inpatient parents or individuals who are not parents, their immediate setting such as therapy sessions provided by a therapist and by their families through family counseling on a macro level. In addition, inpatient parents receiving treatment will also, in turn, shape and influence those around them, which include their own children when they have completed their treatment programme. Inpatient social workers, while working with inpatient parents on family patient parents, children and the community can create a responsive environment for family reunification support of inpatient parents and their children. Family reunification may not be possible during and post inpatient treatment, however through the process of family reunification the family and children of the inpatient parent can still be supported.

2. Research aim and objectives

Aim

To explore formal and informal support available to inpatient parents during family reunification phase at substance abuse treatment centres, using semi-structured interviews with inpatient parents and focus groups with inpatient social workers.

Objectives

1. To explore formal and informal support available to inpatient parents during family reunification phase in Western Cape substance abuse treatment centres.
2. To explore and recommend guidelines for family reunification within substance abuse treatment centres with inpatient parents and social workers.

The researcher explored family reunification support within Western Cape substance abuse treatment centres and have therefore chosen a qualitative research approach.

3. Research Methodology

3.1 Research Approach

A qualitative research approach was utilized in this research. The purpose of this approach was to gather information about a specific phenomenon and to generate deeper meaning of human experiences (Babbie & Mouton, 2011:437). In this case, the phenomenon that the researcher had explored was family reunification support to inpatient parents in substance abuse treatment centres.

3.2 Research Design

A qualitative descriptive research design (Sandelowski, 2000:335) was used as the aim of the study was to explore family reunification support to inpatient parents in substance abuse treatment centres. Writers such as Colorafi and Evans (2016:17), believe that qualitative description is most suitable to health environments research as it provides factual responses to questions on how people feel about the living space and factors that hinder the usage of their space. The qualitative descriptive design was chosen as the researcher seek to describe the support available for inpatient parents at substance abuse treatment centres during the family reunification phase. The research design is the most cost-effective manner in which data can be collected in order to investigate the research hypotheses (De Vos *et al.*, 2011). Descriptions can be in the form of summaries of interviews or descriptions of data that was observed. The design is also referred to as an “explorative-descriptive design and is often implemented when researchers want to study a specific population to understand the needs of a specific population or views regarding appropriate interventions...” (Grove *et al.*, 2013:64). This method assisted the researcher to gain in-depth knowledge from inpatient social workers’ point of view and create awareness for the inpatient parents about family reunification support at substance abuse treatment centres. The design can be used when descriptions and clarification of phenomena are required (Sandelowski, 2000:339, Elahi & Dehdashti, 2011:2). The aim in qualitative descriptive studies is to discover who, what, where and how (Sandelowski, 2000:338). This study had two research objectives and the participants were able to describe who supported them, what reunification support was available, how the support was available and how family reunification can be improved

within substance abuse treatment centres. This assisted the researcher to provide guidelines to social workers for family reunification within substance abuse treatment centres.

3.3 Population

For this study, the population consisted of inpatient parents with children between 0-5 years of age and social workers from five substance abuse treatment centres in the Western Cape. One treatment centre being a government treatment facility, and the rest were partially funded by the government and registered as a Non-Profit Organisation (NPO) were selected to be part of the research study.

The first population that was of interest to the researcher were inpatient parents who live in Western Cape. Inpatient parents reside within Western Cape substance abuse treatment centres between 3 and 7 weeks. The researcher in a telephonic conversation with the psychiatric nurse at treatment centres indicated that inpatients within their first two weeks of being admitted may experience withdrawal symptoms from their alcohol and drug abuse. During the third week of inpatient treatment, the patients are sober and would be able to have a meaningful discussion on the topic of interest. They are also parents and for purposes of this study were referred to as inpatient parents. Nine males and six female inpatient parents were interviewed.

The second population group in this study were social workers at substance abuse treatment centres situated in the Western Cape. Thirteen social workers have been recruited from the five treatment centres. Substance abuse treatment centres appoint on average five inpatient social workers if the occupancy rate of the inpatient treatment centre has an average of 60 clients as the total maximum population receiving treatment. The researcher, through the gatekeeper, recruited a minimum of three social workers each from the five-selected substance abuse treatment centres. For the purpose of this study social workers at substance abuse treatment were referred to as inpatient social workers.

3.5 Sampling Method

Purposive sampling was applied to the study as the results needs to be generalised to a specific population such as inpatient parents and inpatient social workers at Western Cape substance abuse treatment centres (Edmonds & Kennedy, 2013; Babbie & Maxfield, 2014). The goal of purposive sampling is to sample participants in a strategic way so that those sampled are suitable for the research question (Bryman, 2008:418). Literature confirms that a minimum of fifteen participants should be included in studies with a qualitative descriptive design (Mason, 2010). The researcher recruited 28 participants and conducted semi-structured interviews with 15 inpatient parents and three focus groups with 13 social workers.

The inclusion criteria for inpatient parents were as follows:

1. Inpatient parents who were admitted to substance abuse treatment centres and receiving treatment for their abuse of alcohol and drugs at the five-selected substance abuse treatment centres in the Western Cape.
2. Inpatient parents who have children between 0-5 years of age who were separated from their children due to their substance abuse and receiving inpatient treatment.
3. Inpatient parents were both biological mothers and fathers.
4. Inpatient parents were at the treatment centre for a minimum of three weeks. The researcher in contact with the psychiatric nurse at the substance abuse treatment centres indicated that inpatients within their first two weeks of being admitted may experience withdrawal symptoms from their alcohol and drug abuse. Substance abuse treatment centres identified have an average of between four- and seven-week treatment programmes which made it suitable to recruit and select inpatient parents from the third week of treatment.

The inclusion criteria for inpatient social workers were as follows:

1. Participants were registered social workers at the South African Council for Social Service Professions (SACSSP) working at treatment centres.
2. Social workers were both male or female.
3. Social workers were employed at a treatment centre for a minimum of 6 months to ensure enough experience in working at a substance abuse inpatient treatment centre

During this research study, the researcher attained data saturation as similar themes emerged during data collection; (1) the researcher selected an appropriate study design, which is the qualitative descriptive design, (2) then implemented the appropriate data collection method such as semi-structured interviews and focus group and (3) the researcher has documented the process of evidence. Interviews with inpatient parents were one method by which the study results reach data saturation.

The interview questions have been structured to facilitate asking multiple participants the same questions and rephrasing questions (Fusch & Lawrence, 2015:1410). The study consisted of 28 participants, 15 inpatient parents and 13 social workers who gave consent to participate in this study. This was sufficient for the study as data saturation was reached. Depending on the study, data saturation can be reached by conducting six interviews (Fusch & Ness, 2015:1408)

Three focus group discussions with thirteen inpatient social workers at Western Cape substance abuse treatment centres were facilitated. Research suggests that a minimum of three focus groups is sufficient for data saturation to have been reached (Hancock *et al.*, 2016; Geust *et al.*, 2017). Qualitative research is about understanding the meaning behind participants' experiences and therefore more data does not necessarily mean more information (Mason, 2010:3).

4. Data Collection

The researcher collected data through semi-structured interviews and collages that were completed by inpatient parents receiving treatment for their alcohol and drug abuse. The researcher collected data through focused group discussions with social workers.

4.1 Method of data collection

Semi-structured interviews were used during this research. According to Fetters *et al.* (2013), a semi-structured interview is useful when the researcher wants to gain a thorough representation of participant opinion about, or insights into, or explanations of a certain topic such as what family reunification support is available for inpatient parents in substance abuse treatment centres. The researcher developed an interview schedule with 6 main questions and 5 demographic questions that include the age of inpatient parent, marital status, and number of children, where the children are currently placed with and ages of children. In addition, a collage was used to facilitate the discussion as it assisted in generating information on what support inpatient parents need within substance abuse treatment centres with family reunification. Interviews were audio recorded with the consent of the inpatient parent. The researcher made use of additional descriptive field notes with a pen and A4 paper. Information gathered assisted the researcher to provide recommendations on family reunification within substance abuse treatment centres.

4.2 Developing the Interview schedule for inpatient parents and focus group

Questions were based on the title of this research study and included questions about family reunification support for inpatient parents. Literature was gathered by the researcher on the topic of interest in order to formulate the questions. The researcher divided the literature into themes and also divided the questions in the semi-structured interview and focus group schedules such as what support is needed within inpatient treatment and barriers thereof. The order of the questions was funneled starting with a broad theme of family reunification support at inpatient treatment to more specific questions related to how the social workers provide family reunification support. Semi-structured interviews and focus groups were guided by the questions outlined in the interview schedule (Greeff, 2009). Focus group and semi-structured interview schedules were tested on colleagues in the social work field.

4.3 Semi-structured interviews

The researcher interviewed all the male clients while a female fieldworker interviewed the women. The concern was that female clients may feel uncomfortable to engage with a male researcher during semi-structured interview because of conflict with males or a history of abuse by men. In order to prevent this, the researcher appointed and trained a female social worker (field worker) to conduct the semi-structured interviews in order to avoid any feelings of discomfort during the interviews. The field worker was a social worker who attended Ethics Training from North West University at Wellington satellite office. A confidentiality agreement was signed by the field worker. Furthermore, the researcher made use of a collage in addition to the semi-structured interview schedule. A collage is a visual data collection method used to gain insight into factors underlying human behavior (Simmons & Daley, 2013:2). It is beneficial to make use of collages in research as participants reflect more deeply on what they have created and their engagement with the substance abuse treatment programme (Simmons & Daley, 2013:2). A collage also provided visual prompts that free the participants thinking, helping them to conceptualize their ideas (Simmons & Daley, 2013:2). A collage was a suitable data collection method in this study, as the aim is to explore family reunification support and to develop reunification guidelines for inpatient parents at substance abuse treatment centres. The process was facilitated by the researcher and female field worker as follows with inpatient parents:

1. Inpatient parents' interviews lasted between 60 and 90 minutes. Interviews were conducted at the five-selected substance abuse treatment centres in the Western Cape.
2. On arrival at the treatment therapy room, the researcher introduced himself and explained the purpose of this research project.
3. Tea, coffee and snacks were provided before and during the interview. The researcher provided clarity to the participants on how confidentiality and anonymity will be applied when data are published. Consent was given by the inpatient parents' as the interviews will be audio recorded.
4. The researcher reminded the inpatient parent that he or she can withdraw from the study at any given time.
5. Information with regards to the debriefing session and the possibility of counseling were provided by the researcher.
6. The inpatient parent could ask any questions needing clarification. The researcher started with the interview schedules which included the demographic details of participants and collage once all questions were addressed. Demographic details helped the researcher to identify

participants and added to the richness of the data. The demographic details for inpatient parents included age, marital status, ages of children and where the children were placed.

7. The researcher explained to the inpatient parent what a collage is and asked them to make a collage on what support they need on an A3 paper. The collage was done at the beginning of the interview and it was used as a tool to generate a discussion. Inpatient parents were given the opportunity to explain their collages as it relates to what support is available for family reunification during the interview.
8. A semi-structured interview guide with 6 main questions was used by the researcher to gather detailed information.
9. Once all the interview questions were addressed, inpatient parents had the opportunity to ask questions. Information gathered from the semi-structured interviews and collages were transcribed then analyzed once all the interviews have been concluded.

4.4 Focus group with social workers

Focus groups are often seen as group interviewing and it is based on semi-structured interviews (Rubin & Babbie, 2011;468-469). A focus group is a goal-directed discussion (Sarantakos, 2005), while De Vos *et al.* (2011:469) noted that a semi-structured interview is a useful method of data collection which assists the researcher in developing an understanding about a specific phenomenon. Data are collected through interaction between group participants and as the discussion progress, the individual response becomes sharpened and refined (Ritchie *et al.*, 2003:171). The group discussion was audio recorded with the consent of social workers. The audio recording was immediately downloaded and recorded on a password-protected laptop. The researcher has facilitated 3 focus groups with a social worker in the following manner;

1. The focus group discussions were facilitated at Kensington and Hesketh King treatment centres who have a suitable conference facility to host at least between seven and eight social workers.
2. Social workers were notified via email two weeks in advance who all will be participating in the focus group discussion. When social workers arrived at the venue, the researcher introduced himself and explained the purpose of this research project. On arrival tea, coffee and snacks were served.
3. When the group was completed the researcher formally initiated the session, with a personal introduction, outlined the research topic, and background information on the purpose of the study and its funder. Confidentiality was stressed, and anonymity will be limited, and an

explanation was given of what will happen to the data and of proposals for reporting. Focus groups were audio recorded, and consent obtained from the social workers.

4. The researcher made use of a focus group interview schedule with social workers that comprised out of five questions, including main questions, probing questions and follow up questions. In addition, demographic details such as age, gender, years of experience and qualifications were collected from inpatient social work participants.
5. Once all the interview questions were addressed, social workers had the opportunity to ask questions.
6. At the end of the interview, the researcher conducted member checking by summarising the session to ensure that the information that was shared by social workers correlates with the information documented by the researcher.

4.5 Data analysis

Once data collection and scrutiny have been completed, the researcher should start the process of analyzing the data (Bless *et al.*, 2006:99). Analysis of data needs to be done in order to detect co-variance of two or more variables. Data from the semi-structured interviews, collages and group discussions were analyzed thematically following Braun and Clarke (2013:4). Thematic analysis is a method for identifying, analysing, and reporting patterns (themes) within data. The following steps were followed based on the guidelines provided by Braun and Clarke (2013:4):

1. The data was transcribed by both the researcher and an independent transcriber. A confidentiality agreement was signed by the transcriber once the ethics committee had approved the study. The interviews and focus group transcriptions have been organized into files and text units that were explicable. Organizing data provided the researcher with a glimpse of the information gathered from the interviews. Audio recordings were transferred to a password protected laptop, after which it was deleted from the audio recording device. Descriptive field notes were written during and after each interview with inpatient parents and social workers and reviewing of audio recordings. The data was then studied by the researcher by reading data collected and compiling lists if important ideas or themes emerge (Braun & Clarke, 2013). An inductive approach was applied through the data analysis allowing the themes to emerge from the data itself. Braun and Clark (2006) view this as coding the data without trying to fit it into pre-existing coding frame.
2. To ensure that all audio recordings are fully protected, the researcher placed a password on the digital device. The audio device was stored within a locked cupboard to which only the researcher had access to.

3. All data recorded from the interviews were transcribed by both the researcher and an independent transcriber appointed by the researcher.
4. The researcher has organized the data collected into meaningful groups and a list of ideas has been drawn up (Braun & Clarke, 2013:4). The essence of qualitative data analysis is category formation and the researcher appointed a co-coder to assist with this process (See Annexure 12). This next step required a great mindfulness of the data, a focused attention to data and an open mind. Themes were identified during this process, together with patterns and persistent ideas in the collected data (De Vos *et al.*, 2011:411). The researcher has identified two main themes for inpatient parents; inpatient parents benefiting from parenting programmes and children and families of inpatient parents having minimal participation within the treatment programme. Three themes were identified for social workers who recommended guidelines for reunification such as 1) guidelines for the improvement of reunification services to inpatient parents, 2) guidelines to improve the relationship with the designated social worker in order to improve family reunification services and 3) guidelines to involve the children and families within the treatment programme. The coding of data can take numerous forms which include; abbreviations, key words and colour coding. The researcher made use of key words and colour coding when themes were identified. The same themes were highlighted in the same colour. There was also a co-coder who assisted the researcher in the coding process (See Annexure 11).
5. Once codes were identified, the researcher has analyzed and organized codes into themes (Braun & Clarke, 2013). The researcher has restructured and analyzed the candidate themes until the main candidate themes are clear to the researcher.
6. The main themes, subthemes and codes are presented below focusing on the aim of the study exploring family reunification support within substance abuse treatment centres in the Western Cape and the objectives which was 1) explore formal and informal support available to inpatient parents and 2) explore and recommend guidelines for family reunification with inpatient parents and inpatient social workers. The themes and results of the study are presented in detail in article format in Section B.

Table of Themes

Theme	Subtheme	Codes
1. Support available	1.1 Formal Support	Positive relationship with children
		Social work support
	1.2 Informal support	Support received from family
		Visitation from children
		Support groups
2. Kinship Care		Maternal support
Theme	Subtheme	Codes
1. Guidelines for Family reunification planning	1.1 Improved reunification	Structural changes
		Admission criteria
		Structured plan with families
		Alternative accommodation: Halfway House
		Policy change
2. Guidelines for the designated social worker	2.1 Improved communication	Participation of designated social worker
		Role confusion
		Planning session with designated social worker
3.Guidelines for Family Participation.	3.1 Barriers	Program to involve families
		Family barriers
		Inpatient social work barriers

A few findings became very clear. Firstly, there was a positive response from inpatient parents on parenting programs. Secondly inpatient parents do receive visitation from their children and families. They experience the visitation is positive although there is minimal involvement of their children and families in the treatment program. Findings with inpatient social workers indicate that they are going the extra mile in assisting the inpatient parent with family reunification. Two treatment centres indicated that they are able to provide accommodation to inpatient parents, although it is not a formal institutional arrangement within their treatment programme. Inpatient social workers have a misconception on who is responsible for family reunification within substance abuse treatment centres. This creates role confusion between inpatient social workers and designated social workers. Inpatient social workers provided guideless for family reunification to create a conducive environment that support reunification within substance abuse treatment centres.

Findings of the study are discussed in detail in two articles in Section B i.e. 'Family reunification support to inpatient parents in Western Cape substance abuse treatment centres. This article will be submitted to the Southern African Journal of Social Work and Social Development and can be found in Section B. The second article entitled, 'Guidelines for family reunification in Western Cape substance abuse treatment centres with inpatient parents. This article will be submitted to the Biomed Central Journal for Substance Abuse. This article can be found in Section B

5. Ethical Aspects

The researcher was aware that qualitative research may trigger relational and professional boundaries when engaging with the inpatient parents and social workers, and this is where the researcher had to manage his role as a researcher (Kendall & Halliday, 2014:306). The researcher has maintained neutrality and respected the autonomy and dignity of the inpatient parent and social workers within a substance abuse treatment centre and his role was one of a researcher during the interview and not a social worker. This was done by the researcher by respecting the privacy of individuals and ensure that they are not personally identifiable (Gibson *et al.*, 2013:19). The researcher has also focused on attributes such as approachability, warmth, interest, trustworthiness, and concern (Kendall & Halliday, 2014:306).

5.1 Legal authorization

Ethical clearance for the specific research study was granted by the North-West University (Ethics Number: NWU-00078-18-S1). Once authorization was received, the researcher obtained legal authorization from The Department of Social Development Research and Population unit to recruit inpatient parents and social workers from Kensington treatment centre as this is a government-funded substance abuse treatment centre.

Legal authorization was obtained by completing and submitting a research proposal to the Research and Population unit for approval. The researcher has sent the approval letter and overview of the research study to the Facility Manager at Kensington treatment centre once legal authorization had been obtained. The Facility Manager was given time to study the proposal. Once the proposal was reviewed by the Facility Manager, the researcher made an appointment with the manager to address any questions and explain the study in-depth and the research process. The project commenced when permission was granted.

5.2 Goodwill consent

Goodwill permission was not needed from the government-funded treatment facility as the rest of the substance abuse treatment centres were registered as non-profit organisations. Goodwill permission was sought from the Board of Directors and Management from these five organisations. The researcher forwarded the final version of the proposal to the Board of Directors and Management of the five substance abuse treatment centres once ethical clearance was received from the HREC. The Directors and Management were given time to study the proposal. When they have reviewed the proposal, the researcher made an appointment with the manager to address any questions and explain the study in-depth and the research process. Once permission was granted, the research project commenced.

5.3 Process of sample recruitment and informed consent

The following process was followed in obtaining consent and recruitment of inpatient parents and social workers at the five substance abuse treatment centres in the Western Cape;

1. The researcher requested the Directors from five substance abuse treatment centres to act as the five gatekeepers for the study. The gatekeepers were informed about the aim of the study, the inclusion and exclusion criteria for the selections of the two participant groups and also about the possible ethical implications of the study.
2. Each of the gatekeepers were requested to appoint a mediator at each of the participating substance abuse treatment centres and to bring the researcher in contact with the mediators. The mediators were the chief social workers at each of the substance abuse treatment centres. The mediators were informed and trained for their role in this research project by the researcher. The training involved sharing the aim of the study, the different inclusion criteria, the ethical implications of the study and what will be expected of them when approaching potential participants for the study. The mediators then identify potential participants from their case files. Mediators informed the independent person with regards to the inpatient parents that were selected who met the inclusion criteria.

3. The researcher appointed and trained an independent person, who was not employed by the substance abuse treatment centre or Department of Social Development. The independent person has liaised with the mediator to meet individually with each prospective inpatient parent and social worker participant to inform them of the study and to obtain their informed consent for voluntary participation in the study. Informed consent was obtained for interviews to be audio recorded from both social workers and inpatient parents. Participants were informed that they are free to withdraw from the study at any point without any disadvantage to themselves. Prospective participants had the opportunity to ask any questions and to clarify any uncertainties about the research on the day the participants meet with the independent person.
4. Participants who showed interest in participating in the study were given informed consent documents. The documents contained all the necessary information about the study that will help the participants to make an informed decision regarding their participation. Prospective participants were given 1 week to think about their participation. After 1 week those participants who are willing to participate were asked to sign the informed consent forms in the presence of the independent person and a witness. Participants were asked to give informed consent to be audio recorded as well.
5. The independent person handed the signed documents to the researcher after which the researcher made personal contact with each participant to make further arrangements with regards to their participation in either the one-on-one interviews or the focus group discussions. Participants were informed two weeks in advance of their scheduled interviews and focus groups.
6. Inpatient parents and social workers were given the opportunity to ask the researcher questions about the study before the semi-structured interviews and focus groups were conducted.

5.4 Confidentiality and Anonymity

Inpatient Parents

The researcher made use of a unique number to replace participant names, which ensured that data and identities remained anonymous. No one other than the researcher, field worker, mediators, and gatekeepers were able to identify inpatient parents by name. They have signed a confidentiality agreement. The researcher explained to the participants that only he will have access to their biographical information and when the results are being reported. When the interview ended, recordings were transferred to a password protected laptop, after which it was deleted from the audio

recording device. The data was transcribed by an assistant that was appointed by the researcher. The assistant signed a confidentiality agreement.

Social Workers

Focus groups discussion has taken place in a conference room of the substance abuse treatment centres. The researcher informed participants that he could not ensure anonymity and no internal confidentiality as a violation of privacy can be a result of others in the group. The groups had the responsibility of managing confidentiality. Pseudonyms names were assigned to participants and they have received a code e.g. SW001 or SW003, in order to identify them. The researcher made notes and audio recorded the focus groups discussion. Audio recordings were immediately transferred to a password protected laptop once focus group has been completed. Transcripts was transcribed by an assistant that was appointed by the researcher. A confidential agreement was signed by the assistant and data during transcriptions were in a safe place for storage on a laptop that is password protected.

5.5 Publishing and storing results

The researcher will submit the article to the South African Journal of Social Work and Social Development and Biomed Central Journal for Substance Abuse for possible publication. The guidelines of the journal publication can be viewed at Annexure 14. Hard copies will be stored in lock-up cabinets at the offices of CCYF and COMPRES. See CCYF SOP guidelines on data storage attached (Annexure 13). The CCYF is an office of NWU based off campus. The CCYF SOP is based on and is in accordance with the NWU guidelines and regulations of data storage. Data will be stored for five years and will then be destroyed as stipulated in the CCYF guidelines for record keeping.

5.6 Research expertise

The researcher has been a registered and qualified social worker for 10 years and is being supervised by a qualified social worker. The supervisor, Dr. Hoosain, has a Ph.D. in Social Work and has 20 years of social work experience that is inclusive of training and lecturing at the North-West University of Potchefstroom. She also has experience in working with substance abuse inpatient treatment centres and inpatient parents who are addicted to drugs and alcohol. Dr. Hoosain has successfully provided supervision to several students who used semi-structured interviews. As a study leader, Dr. Hoosain has successfully completed ethics training in Introduction to Research Ethics in Health Research: Principles, Process, and Structures: the new NHREC AND DoH guidelines 2015 and one-day training on ethics of post-research obligations of public health ethics in 2018. Dr. Hoosain has also completed the TRREE online training certification.

The researcher has completed a post-graduate degree in Clinical Social work at UCT and was exposed to research including conducting semi-structured interviews. In order to ensure that the researcher adheres to the guiding principles for conducting interviews, the researcher has role-played his interview with his peers and supervisor. In addition, the researcher has completed a two-day workshop on 3 and 4 May 2018 on the basics of health research ethics.

5.7 Trustworthiness

According to Ritchie et al. (2003) the researcher needs to be ethically engaged throughout the research process to ensure trustworthiness of the study. There are four criteria for establishing trustworthiness in qualitative research, namely: credibility, dependability, confirmability, and transferability (Ritchie *et al.*, 2003; Rubin & Babbie 2011).

(1) Credibility

Credibility, in terms of truth and validity, was assured by means of prolonged engagement with the data. By gathering data from multiple sources (data triangulation) or using several analysts to review the data (observer triangulation), the researcher ensured the credibility of a study (Lietz & Zayas, 2010). Writers such as Toben and Begley (2004:388), confirms that triangulation is the process whereby multiple types of data of collections methods are used.

The data was transcribed by an independent transcriber which ensured the quality control of the data and who signed a confidentiality agreement. Once all the transcripts from the inpatient parents' interviews and social workers focus group was completed, the transcriber handed the transcripts to the researcher for coding. The researcher familiarised himself with the data through the reading and re-reading of the transcriptions. To ensure credibility and quality control the researcher appointed an independent co-coder for the study who has signed a confidentiality agreement. The co-coder highlighted certain common themes within the transcripts in a summarised version as well as point out any inconsistencies. Member checking was done to ensure that the information shared by participants correlates with information documented by the researcher. This was done by summarizing what was shared by the participants during focus groups and semi-structured interviews. Another means to enhance credibility, is that the results from the study were discussed with the participants for commentaries, clarifications, and acceptance.

To further enhance credibility the researcher allowed for frequent debriefing sessions between the researcher and research supervisor or the researcher with a colleague. This provided a sounding board for the researcher to test developing ideas and interpretations, and it helped the researcher to recognize his own biases and preferences.

(2) Dependability

It refers to the standard of consistency by leaving reliable documentation of the research process. The study was conducted step-by-step according to the research process. This was assured by describing what was planned by the researcher through the research design, how the implementation will be executed as well providing a detailed description of the data gathering process. To ensure quality control the researcher has followed the procedure for data collection and data analysis as stated in the proposal. The researcher has trained the fieldworker for the data collection process.

(3) Confirmability

Refers to the objectivity of the researcher towards the study. The researcher has conducted a literature study after the completion of the semi-structured interviews and focus group discussion. This was done to avoid any bias from the researcher, in order to do a literature study to guide the study.

(4) Transferability

Refers to data that were collected in a specific manner in order for the data to be beneficial to other settings as well. A detailed description has been provided by the researcher with regards to the researcher process and the methodology that was followed that will allow further research to be conducted in a similar study of interest.

6.Choice and structure of research report

The research report is in the format of an article and makes use of the following structure;

Section A

Part 1 Introduction, orientation to the research and problem statement. This part introduces the study by discussion the research problem as well as the research methodology

Part 2: Literature study (Harvard referencing style according to NWU guidelines).

Section B: Articles

This section contains two articles in which the research finding of the empirical study are written according to the guidelines of the Southern African Journal of Social Work and Social Development (article 1) and Development and Biomed Central Journal for Substance Abuse (article 2). The title for Article 1 is: Exploring family reunification support for inpatient parent within Western Cape Substance abuse treatment centres. Article 2: Guidelines for Family Reunification in Western Cape Substance Abuse Treatment Centres with inpatient parents.

Section C

This section includes the summary, reflection, conclusion, and recommendations of this study.

Section D

This section contains the appendixes and references.

7. Conclusion

Section A part 1 provides an overview of the research problem, the aim as well as the methodology that was followed when conducting a study around inpatient parents and social workers experiences of family reunification support with their children within substance abuse treatment centres. Parents need to be reunified with their children once inpatient treatment has been completed. In order for reunification to take place, children should be included in the treatment programme in order to smooth the transition back home once the parent has completed their programme. Section A part 2 consists of a literature review of the current literature available on family reunification support within substance abuse treatment centres and the theories which guided the study.

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PART 2

A LITERATURE REVIEW ON FAMILY REUNIFICATION FOR INPATIENT PARENTS IN SUBSTANCE ABUSE TREATMENT CENTRES

1. INTRODUCTION

The purpose of a literature review was to create the theoretical framework for the study, to indicate where it fits into the broader debates and to justify the importance of the study (Fouché & Delport, 2011:109). Section A, part 1, included a broad overview of the problem statement, as well as the rationale of the study. Section A, part 2, consists of a literature overview of the White Paper on Families, overview of family reunification internationally, failed reunification and on South Africa Guidelines on Reunification Services for Families (2012). The literature review provided an overview of the key concepts, including; substance abuse and parenting, substance abuse treatment centres and family reunification support and aftercare planning within substance abuse treatment centres. In addition, Bronfenbrenner Ecological Systems Theory (EST) will be discussed.

2. FAMILY REUNIFICATION SERVICES

2.1 OVERVIEW OF FAMILY REUNIFICATION SERVICES

Globally, family reunification is seen as the process whereby the child needs to be reunified with the family. Carnochan and Austin (2013:179) defined reunification as “services that are provided for the purpose of returning children who have been placed in out of home care to their families of origin”. Balsells *et al.* (2015:1) defined family reunification as the process through which children and adolescents under a measure of temporary separation (foster care or residential) return to live with their biological families”. In addition, Balsells *et al.* (2016:1) define family reunification “as the process by which a child returns to his or her biological family after a period of temporary foster-care resulting from abandonment, negligence, abuse or inadequate parenting”. According to South Africa’s Children’s Act 38 of 2005 as amended, a child should be reunified with the biological parent if reunification is in the best interests of the child. The focus should be first to stabilize the family household circumstances and then reunify the child with the biological parent. This is usually done through reunification services rendered by a designated social worker, as stated in Section 157, subsection 2 of the Children’s Act 38 of 2005.

Significant international literature on family reunification focuses on refugee’s families, whereby either the children are separated from their families, or the parents are separated from their children (Nygren, 2016; Miller *et al.*, 2018; Gambaro *et al.*, 2018; Groenendijk & Strik; 2018). The United Nations High Commissioner for Refugees (UNHCR:2017) defined a refugee as a displaced person

who has been forced to cross national boundaries and is not able to return home safely. By being separated from their families in a country that is not known to refugees, make them vulnerable to economic exploitation and children being placed at risk (Olsen *et al.*, 2016; Freccero *et al.*, 2017; Stark *et al.*, 2018). However, in South Africa most of the literature on family reunification focusses on child protection as children are at risk to abuse and neglect.

In South Africa, legislation and policy that guides family reunification are the Children's Act (38 of 2005) and South African Child Welfare Manual (2013). The designated social worker, in South Africa, is usually responsible for the removal of children when abuse and/ or neglect has been established through their safety and risk assessments (Meinck *et al.*, 2015; Spies *et al.*, 2017). The Child Welfare Manual (2013) provides designated social workers with a guideline to initiate the process of family reunification in the following manner: 1) designated social worker to outlines roles and responsibility with the biological parent and child by completing a written agreement, 2) designated social worker having regular contact with the family to assess the progress of the family, 3) designated social worker to prepare the biological family for reunification through family counselling and 4) children to be prepared by the designated social worker to go home and live with their biological parents.

Writers such as Potgieter (2016) and Delpont *et al.* (2017) confirm that it is also the designated social worker's responsibility to develop a family reunification plan, that involves the family and children and multidisciplinary team for the purpose of placing the child back with the family. Family reunification can take place any time within a two-year period (Fortune, 2016). However, literature confirms that family reunification can be challenging, as designated social workers are not equipped and have a lack of resources to provide family reunification services, families facing poverty, lack of commitment of parents and substance abuse within family households that hamper reunification (Sauls & Esau, 2015; Mosoma & Spies, 2016; Hoosain & Potgieter, 2018).

If the environment is not conducive for a child to be reunified with their biological parents', legislation (Childrens Act, 28 of 2005) recommends that the best interests of the child need to be taken into consideration (Fortune, 2016; Strydom & van Huyssteen, 2016). This would mean that the designated social worker needs to make alternative arrangements in placing the child with a family member or in foster care (Meinck *et al.*, 2015). Writers such as Makofane and Nhedzi (2015), Sauls and Esau (2015), and Hoosain and Potgieter (2018), proposed that designated social workers should restructure their case load to prioritize family reunification, improved collaboration amongst social services professionals, capacity building on family preservation services, keeping parents informed

about decisions regarding their children in care, designated social workers to involve parents in therapeutic interventions and to be available to parents during family reunification.

Furthermore, in the Western Cape, parental substance abuse is a pervasive problem and places children at risk and complicates family reunification (Chetty & Ramson, 2016; Kalam & Mthembu, 2018; Suchman *et al.*, 2019). These parents are often placed within inpatient treatment for their drugs and alcohol abuse and are separated from their children. In South Africa, district social services are often used as entry point to gain access to specialized substance abuse treatment and little is known about the profile of the people accessing these services (Burnhams *et al.*, 2012). This would mean that a social worker would do the intake, assessment and refer the client for inpatient treatment. The social worker who referred the client for inpatient treatment becomes the designated social worker. The designated social worker is mandated by the Children's Act and Guidelines on Reunification Services to Families (2012), to provide family reunification services.

Social workers within substance abuse treatment centres play a crucial role in the process of reunification of the inpatient parent with their child. This would mean that the inpatient social worker should have certain characteristics to increase a sense of positive experience by parents receiving family reunification within inpatient treatment. Limited literature is available regarding the skills and expertise of social workers working within the field of substance abuse in South Africa. A study done Sodano (2010) and Magidson *et al.* (2017) revealed that the educational achievement of social workers includes knowledge of some evidence-based techniques such as Cognitive Behaviour Therapy (CBT) and that there was a need for competency training such as screening, assessment, and intake and crisis intervention. CBT is person-centred and working with parents who abuse alcohol and drugs cannot happen in isolation. Research explains that the family holds important information on how the parent's alcohol and drug abuse has started and what can positively or negatively influence treatment (Lander *et al.*, 2013:194; DeGarmo *et al.*, 2013:10-11). Therefore, social workers play a crucial role when it comes to providing support to parents abusing alcohol and drugs, as parents must return to their family after receiving inpatient treatment or when children need to be reunified with their parent.

Parents play an important part when it comes to family reunification. According to Kaakinen *et al.*, (2018) and Masten (2018), people need a family in which to develop optimally, and that the best way of achieving this is to allow them to be with their families. Family reunification can only materialize if the circumstances of the parent are stable (Talbot, 2008:105; Sauls & Esau, 2015:6;). Characteristics such as availability, warmth, family cohesion, and stimulation, refer to stable families (Harden, 2004:1; Gould *et al.*, 2018:3).

2.2 WHEN REUNIFICATION FAILS

International and local literature on failed reunification, within the child welfare sector, refers to parent(s) not showing any improvement in their behaviour that led to the removal of their children during and post reunification, social workers not having the capacity to render family reunification services and not having the ability to assess the readiness of the parents to reunify their children (Sauls, & Esau, 2015; Hayes, 2016; Vischer *et al.*, 2017; Potgieter & Hoosain 2018; Mitchell, 2019). For this study, failed reunification may result in lack of parenting skills, poverty, family history of substance abuse and lack of support after the inpatient parents have completed their treatment programmes (Wessels, 2012; Watt *et al.*, 2014; Gould & Ward, 2015). Writers such as Lombard and Sibanda (2015) and Klaassen and Rodriques (2017) believe if the child is at risk, the best interests of the child need to be taken into consideration. This would mean that an alternative placement, such as a family member, needs to be arranged by the designated social worker. Family reunification appears to be intricate, and inpatient parents may need support.

2.3 FAMILY REUNIFICATION SUPPORT AT SUBSTANCE ABUSE TREATMENT CENTRES

Family reunification for this study refers to interventions provided to inpatient parents within substance abuse treatment centres, that would aid the process of reunification from treatment centre to their home and children, once treatment has been completed. Spilsbury and Korbin, (2013) and Balsells *et al.* (2016) define support as assistance that is available to one person from another and can be the key to emotional or informational resources emerging from different social relations between individuals or groups. For the purpose of this study, family reunification may include formal and informal support.

2.3.1 FORMAL SUPPORT

Below figure 1 provides an indication of what formal support is available within a substance abuse treatment centre. A discussion will follow on formal support within treatment.

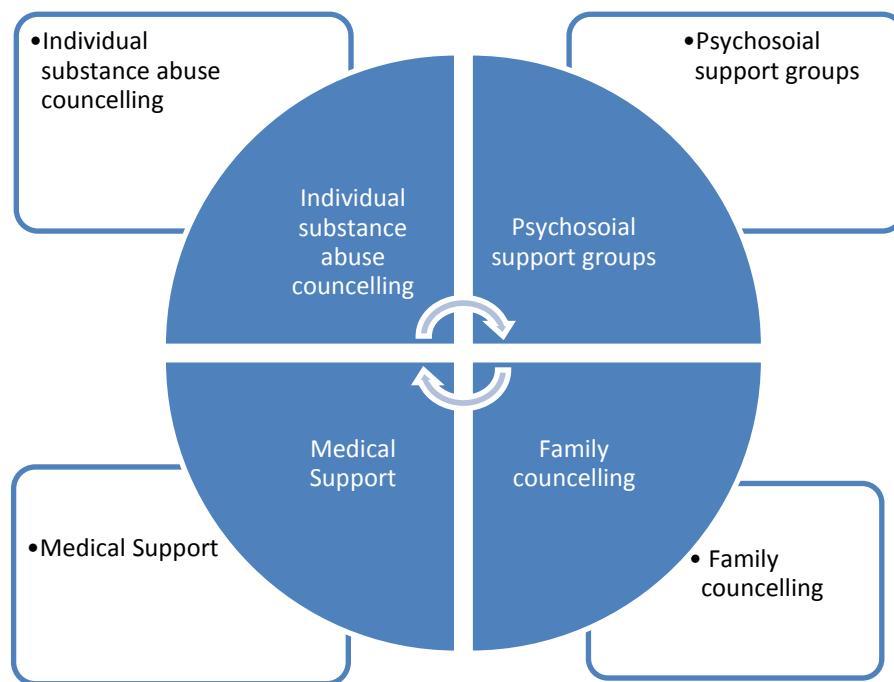


Figure 1: Formal support within Substance Abuse Treatment Centres.

Figure 1 illustrates formal support services being rendered within substance abuse treatment programmes, such as medical support and therapeutic services. The formal support services are usually rendered by professionals, such as social workers, psychiatric nurses, psychologists and doctors within the inpatient treatment programme (Department of Social Development, 2005; UNODC, 2017). This is known as formal support that is usually rendered by professionals such as social workers, psychiatric nurses, psychologists and doctors within the inpatient program (Department of Social Development, 2005; UNODC, 2017). This therapeutic service provides the inpatient parent with psychosocial and physical assistance to deal with difficult life events that may cause them to relapse after they have completed their program (Burnhams *et al.*, 2012; Balsells *et al.*, 2017). Parents are within inpatient treatments and have access to professionals that can assist with the process with family reunification on through formal support. This can be done through parenting programmes and involving the children within the inpatient treatment program.

The section on the edges of figure 1 illustrates the need to provide formal support to inpatient parents when they have completed their inpatient treatment programme. A study conducted by Jun *et al.* (2017) with 172 women who attended 1 inpatient treatment and 2 outpatient treatment programmes in Cleveland Ohio, has found that they respond significantly to formal support within an inpatient

treatment programme and treatment completion. However, the same report has highlighted poorer treatment completion for those who attended outpatient treatment and receiving formal support. In South Africa, empirical literature by Myers *et al.* (2019) confirms that patients within inpatient treatment have better treatment completion compared to those who completed outpatient treatment. Formal support of inpatient parents within substance abuse treatment centres will therefore be explored.

2.3.2 INFORMAL SUPPORT

Informal support within substance abuse treatment centres is displayed within figure 2. A discussion on informal support will follow within treatment.

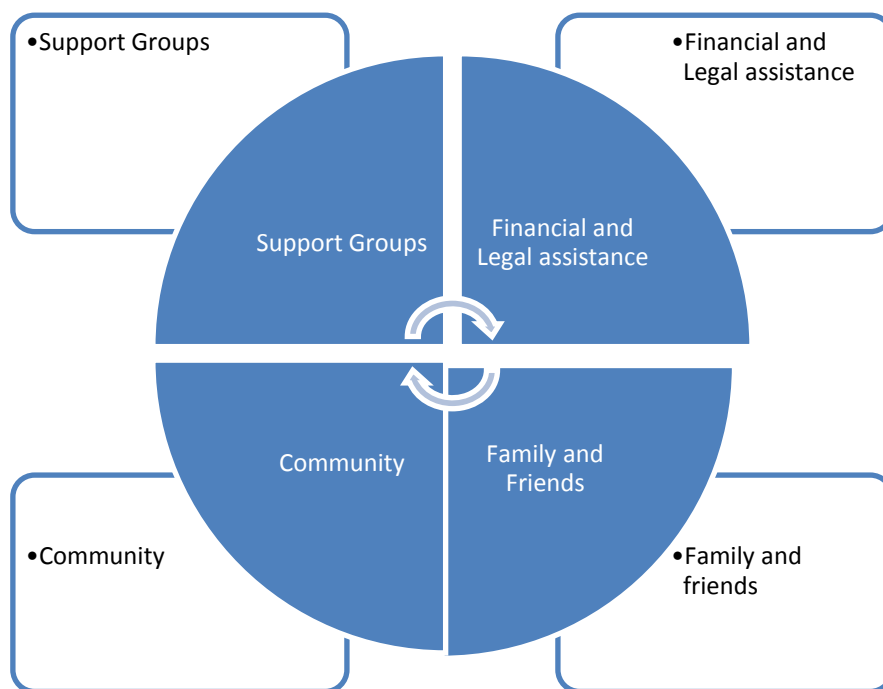


Figure 2: Informal support within Substance Abuse Treatment Centres

Informal support for inpatient parents within substance abuse treatment centres may include visitation from friends, family, extended relatives and engaging in spiritual activities or religious practices, that are facilitated to create a safety network once treatment has been completed (Balsells *et al.*, 2016:4; Manual *et al.*, 2016). Research conducted by Baldwin and Duffy (2013) has illustrated that financial aid and accommodation are often needed by inpatients' parents. This is often provided through informal networks, such as a financial institution or local business, once they have completed their inpatient treatment programme. Legal aid is generally needed, as the parental rights may have been terminated due to parental neglect and conflict with the law (Begun *et al.*, 2016; Barringer *et al.*, 2017). Literature indicates that informal support plays a prominent role in reunification (Akin *et al.*,

2015; Jun *et al.*, 2017). Family, friends, and community are viewed as a protective factor; however, they can also be a risk factor for inpatient parents. Studies conducted by Lewandowski and Hill (2009) and Manual *et al.* (2016) have illustrated that inpatients have strained or limited support because of their family or friends abusing substances. This does mean that prior to discharge, the quality of informal support of the inpatient parent needs to be assessed by the inpatient social worker as well as the designated social worker. Knowing what helps and hinders individuals' connections to informal support may provide important information.

In the following section, substance abuse will be defined and the impact it has on parents. In addition, the prevalence rate of parents being admitted to treatment, substance abuse treatment centres defined, programmes within substance abuse treatment centres and aftercare planning within inpatient treatment will be discussed.

3. SUBSTANCE ABUSE AND PARENTING

3.1 SUBSTANCE ABUSE DEFINED

According to The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM 5) (American Psychiatric Association [APA], 2013), substance use disorder are patterns of symptoms resulting from the use of a substance that you continue to take, despite experiencing problems as a result. The continued use of substances can result in substance-induced disorders. According to DMS 5, substance-induced disorder, including intoxication, withdrawal and other substance or medication-induced mental disorders, detail alongside substance use disorder. The DSM 5 defines a person dependent on a psychoactive substance if the person meets three of the following criteria 1) tolerance, 2) substance is taken in larger amounts over longer period of time than was intended, 4) unsuccessful efforts to stop using or control the use of substances, 5) considerable amount of time spent in activities to obtain substances, use it, or recover from its effects, 6) withdrawal or reduced interaction form social, occupational and recreational activities because of substance use, 7) continued use of substance, despite having a persistent or recurrent physical or psychological problem caused by the substance (APA, 2000: 197). Taking the above-mentioned clinical and theoretical definition of substance abuse, it appears that there is no universal agreement on how these terms should be used. Therefore, for the purpose of this study, substance abuse is defined as: “The misuse and abuse of legal or illicit substances such as nicotine, alcohol, over-the-counter and prescription medication, alcohol concoctions, indigenous plants, solvents and inhalants, as well as the use of illegal or illicit substances e.g. using drugs (such as sleeping tablets, pain medication or sedatives) for improper purposes, i.e. to get high” (National Drug Master Plan, 2013-2017). The term substance abuse is defined in South Africa’s Treatment and Prevention of Substance Act, 2008 and Minimum Norms Standards for

Inpatient Treatment Centres (2005) that regulates substance abuse service across four levels of intervention, such as awareness, prevention and early intervention, statutory and reintegration and aftercare services. The term substance abuse is also used in South African literature within substance abuse treatment centres (Burnhams *et al.*, 2012; Myers, *et al.*, 2014; Dada *et al.*, 2015).

3.2 SUBSTANCE ABUSE TREATMENT CENTRES DEFINED

Internationally, the National Institute for Drug Abuse [NIDA] (2008) defined treatment centres as providing direct intervention to individuals with a substance abuse. Treatment occurs in a non-hospital setting at a licensed treatment facility and treatment period varies. Treatment programmes may vary, while both medical assistance and therapeutic programmes are provided in a 24-hour recovery environment (Reif *et al.*, 2014:1; Lopez- Goni *et al.*, 2017).

Treatment centres in South Africa is defined by The Prevention and Treatment of Substance Abuse Act, 2008, section 35, *as the provision of specialised social, psychological and medical services to service users and to persons affected by substance abuse with a view to addressing the social and health consequences associated therewith; “treatment centre” means a private or public treatment centre registered.* In addition, substance abuse treatment centres in South Africa are guided by the Minimum Norms and Standards for Inpatient Treatment (2005). The norms and standards provide substance abuse treatment centres with policies, guidelines and minimum requirements of an inpatient treatment programme. The average period for inpatient treatment may be 3 weeks to 6 months (Department of Social Development, 2005:33). For patients who are parents, this means being absent from their children for up to six months while they undergo treatment.

3.3 PREVELANCE RATES OF PARENTS BEING ADMITTED TO SUBSTANCE ABUSE TREATMENT CENTRES

Although no record of the number of parents within an inpatient treatment for substance abuse such as alcohol and drugs are available in South Africa (Erasmus, personal communication 2017, 16 August). The researcher has established that, on average, between 60 - 80% of inpatients that have been admitted were parents with children between 0-5 years of age within the Western Cape substance abuse treatment centres (Oberholzer, Rossouw & Van Der Merwe, personal communication, 16 August 2017). Parents need to have a connected relationship with their children to meet their developmental needs (Lambert & Andipatin, 2014: 44). During the parents’ stay at the substance abuse treatment centre, it is important to maintain contact with the child during the family reunification process. According to Gewirtz and Nerenberg (2016), visitations and telephone contact can be emotional for the parents as well as for the child. It is during weekly visitation and family

counselling sessions that the reunification phase of inpatient parent with their child is initiated. To improve the likelihood of inpatients' parent's reunification with their children, parents within substance abuse treatment centres should be committed to working with their assigned caseworker (Sauls & Esau, 2015:21). The child can be viewed as the centre of reunification and plays an important role when family reunification is considered. However, this becomes difficult when inpatient parents are separated from their children while undergoing substance abuse treatment.

3.4 EFFECTS OF SUBSTANCE ABUSE ON PARENTING

Substance abuse has various effects on the human life cycle in terms of the individual's physical, emotional, social and cognitive abilities (Horgan, 2011:21; Musyoka, 2013:11; Kelley *et al.*, 2015:2). Based on the family systems model, substance abuse can negatively impact on parenting skills. Empirical literature by Rayn *et al.* (2015) have showed that parents who abuse substances such as alcohol and drugs, discipline skills are likely to suffer, and they monitor their children poorly. The harmful effects of parental substance abuse contribute to poorer family management practices than non-abusers which often leads to the neglect of children (Ryan *et al.*, 2016). In addition, parents who are receiving treatment for their substance abuse often not only deal with their alcohol and drug abuse, the possibility of relapse, and struggles with employment and living arrangements, but also with their role as parents and the influence of their substance abuse on their children (Gainey *et al.*, 2007, 185; Ebersole *et al.*, 2014; Neger & Prinz, 2015). Furthermore, parents that abuse substances such as alcohol and drugs are often in need of inpatient treatment services. As a result, children are often placed in alternative care such as foster care (Darsamo, 2016:66.)

Good parenting lays the foundation for attachment, cognitive stimulation and creates a conducive environment for parents and children to communicate effectively (Lander *et al.*, 2013; Gould & Ward, 2015). However, when parents abuse substances they fail to meet obligations at work, home or school. There are health implications and the increased amount of recovering from the substances (Baldwin & Duffy, 2013; Paris *et al.*, 2015; Barlow *et al.*, 2019). Research confirms that children between ages of 2-3 years of age are at risk for a wide variety of negative outcomes that include, emotional, social, behavioural adjustments, cognitive and academic difficulties (Solis *et al.*, 2012; Calhoun *et al.*, 2017; Risholm-Mothander *et al.*, 2018). Parents entering substance abuse treatment centres to be treated for their substance abuse such as alcohol and drugs, are impacting on the well-being of children and families (Horgan, 2011; Neger & Prinz, 2015). In South Africa, inpatient parents are forced to separate from their children as the majority of substance abuse treatment centres do not accommodate children. Inpatient parents are therefore obligated to make arrangements for someone to care for their young children while they are undergoing inpatient treatment.

In addition, abuse of alcohol and drugs effect the individual's cognitive, social, emotional and physical abilities (Thomas *et al.*, 2011:21; Musyoka, 2013:11; Kelley *et al.*, 2015:2). Based on the bio-psychosocial model of addiction, substance abuse can negatively impact the parenting skills in the following ways:

3.4.1 Physical

Substance abuse may lead to malnutrition, heart disease, neurological disorder, liver disease and physical weakness (Zschucke *et al.*, 2012:1; Hasler *et al.*, 2012:3; Krasikova *et al.* 2015:281). As a result, the inpatient parent may not be able to perform his or her daily task such as going to work and providing for their children and family. In addition, the abuse of substance while pregnant can have harmful effects on women's health and foetus (Horgan, 2011: xii; Oliver *et al.*, 2014:402-403). Consequences of alcohol abuse may result in foetal alcohol spectrum disorder because of alcohol use (Oliver *et al.*, 2014: 402) and impaired cognitive and emotional development as a result of drug abuse (Lander *et al.*, 2013:2; Akin *et al.*, 2015:120).

3.4.2 Emotional

Mental health such as anxiety, mood or personality disorder are some of the symptoms that parents experience when not able to maintain their substance abuse or still abuse substance (Colpaert *et al.*, 2012:1; Hersh *et al.*, 2014; Daley *et al.*, 2018). Research confirms, that women who abuse substances had more psychosocial difficulties, mental health problems and traumatic events as compared with male substance abusers (Tracy *et al.*, 2012; Barringer *et al.*, 2017:76). Parents suffering from mental health disorders may neglect their parenting responsibility.

3.4.3 Cognitive

Prolonged use of substance can result to impair the memory, damages to the orbitofrontal cortex that can lead to poor judgment and maladaptive decision, and dysfunction of dopaminergic neurotransmission in the mesolimbic-mesocortical reward system causing hypersensitivity to alcohol and alcohol-related stimuli (Colpaert *et al.*, 2012:1; Lucantonio *et al.*, 2012: 358; Czapla *et al.*, 2016:1). The impact of substance abuse cognitively may affect how the substance abuse interacts with his or her children and or result in financial problems for the family as the individual is not able to obtain or remain employed. As a result, children may be at risk to neglect.

3.4.4 Social

Parents tend to withdraw from their children and family because of their substance abuse. According to Lander *et al.* (2013:2), parents are pre-occupied with using substances or recover from it to spend quality time with their children to foster healthy attachment. Research by Boa *et al.* (2016) and Gordon (2018) have reported that maternal and or paternal grandparents are assuming the role of parent as a result of the parent's alcohol and drug abuse. Furthermore, parents abusing substance are prone to have impaired parenting skills and as a result puts their children at risk to neglect, maltreatment and physical abuse (Matzopoulos *et al.*, 2014; Darsamo, 2016).

In addition, parents abusing substances may result in children emotional needs not being met as the parent is under the influence of a substance and not emotionally available for their child (Kelly *et al.*, 2015). This may lead to children developing 'attachment disorders', due to parental substance abuse, that result in deficits in a cognitive and social-emotional function that lead to less resilience (Lander *et al.*, 2013:4). Writers such as Lander *et al.* (2013) and Darsamo (2016), confirms children born with Foetal Alcohol Syndrome (FAS) often have a broad range of cognitive and behavioural deficits that impacts on their development and often end up in alternative care. Furthermore, parents abusing alcohol and drugs effects can be both indirect (e.g., through a chaotic living environment) and direct (e.g., physical or sexual abuse) (DeGarmo *et al.*, 2013:2; Ebersole *et al.*, 2014:330).

In view of the above mentioned, inpatient parents are faced with a considerable number of hurdles such as dealing with their substance abuse and the impact it has physically, mentally and emotionally on themselves and their children. Furthermore, it is also expected that the inpatient parent to fulfill their role as a parent once inpatient treatment has been completed. The following section will discuss substance abuse treatment programmes and aftercare planning within inpatient treatment.

3.5 CURRENT PROGRAMMES OFFERD AT SUBSTANCE ABUSE TREATMENT CENTRES

There are different approaches to treatment based on the various models of addiction addressing the needs of the substance abuser. However, current trends indicate that there is a need to adopt an eclectic model (Bouffard & Taxman, 2003; Gifford *et al.*, 2006; Luoma *et al.*, 2013; Winters *et al.*, 2018) that combines different aspects of treatment models. The eclectic model adopts specific themes, such as teaching skills to resist the triggers associated with the individual's substance abuse pattern, address mental health and family concerns, that can contribute to the relapse and maintenance of substance abuse and build on the substance abuser's strengths (Horigian *et al.*, 2016:79; Rash *et al.*, 2016:2; Winters *et al.*, 2018: 143). In Europe (Pajulo *et al.*, 2011 & 2012; McRae-Clark & Moreland, 2018)

and United States of America (Wong, 2006; Gainey *et al.*, 2007; Paris *et al.*, 2015) there are several substance abuse inpatient treatment centres where young children stay with their parents. Writers such as Lewandowski and Hill (2009), Panchanadeswaran and Jayasundara (2012) and Manuel *et al.* (2017), focusing on inpatient parents, have therefore recommended that research in the field of substance abuse go beyond the sobriety of the inpatient and recognise the diversity of inpatients, especially those who are parents. Focusing on the parenting relationship while undergoing inpatient treatment may assist parents to play their expected roles in the upbringing of their children while receiving inpatient treatment.

In South Africa, limited literature is available with regards to treatment programmes within substance abuse treatment centres. In reviewing literature by Sodano *et al.* (2010), Saban *et al.* (2017), Parry *et al.* (2017), Magdison *et al.* (2017), Carelse (2018), and Magdison *et al.* (2018), the researcher has concluded that the following programmes are the prefer choice amongst substance abuse treatment centres in the Western Cape and South Africa;

- Matrix Model.
- Motivational Interviewing
- Twelve Step Programme

Empirical literature by Ederies (2017) and Carelse (2018) confirms that substance abuse treatment programs range from 8-18 months for both inpatient and outpatient, followed by aftercare services (van der Westhuizen, 2013; Swanepoel *et al.*, 2015; Geyer & Mahlangu, 2018). Outpatient treatment programme is less restrictive compare to inpatient and can be a good standalone option for someone with a mild substance abuse, or it can be part of a long-term treatment program (Friedrichs *et al.*, 2016; Nunes *et al.*, 2018). For the purpose of this study, the selection of above-mentioned programs was based on the current literature in the field of substance abuse within inpatient treatment.

3.5.1 INPATIENT TREATMENT MODELS

In view of the above mentioned, the following inpatient treatment models will be described that is used in South Africa and internationally.

3.5.1.1 MATRIX MODEL OF ADDICTION

The Matrix model emerged in the late 1980's to address the abuse of cocaine within substance abuse treatment centres and was developed in the United States by the Matrix Institute on Addiction (Shoptaw *et al.*, 1995; Rawson & McCann, 2005). This model is an intensive outpatient treatment

programme and assists the client to become drug-free and remain within the programme for 12 months. The 12-month programme is guided and supported by a trained therapist and consists of relapse prevention groups, education groups, social support groups, individual counselling, and urine and breath testing delivered in a structured manner (Ederies, 2017; Salimi *et al.*, 2018; Magidson *et al.*, 2018). According to the Matrix Institute in the US, organisation must be registered to offer the Matrix Model (Rawson & McCann, 2005). Although the Matrix model of addiction is used within outpatient treatment, local and international literature indicates that it has been used within inpatient substance abuse treatment centres as well (Magidson *et al.*, 2017; Carelse, 2018).

3.5.1.2 TWELVE STEP PROGRAMME

Empirical literature by Carelse (2018), indicates that the Twelve 12 Step Programme is a well-known model for programmes of substance abuse intervention in South Africa. The 12 -Step model (1938) was developed by the Alcoholics Anonymous (AA), through its founder Bill Wilson. He wrote about the positive effects experienced when people struggle with alcoholism shared their stories with each other. Although the model is used during post-treatment such as support groups, literature confirms that inpatient treatment centres have also adopted its principals within their treatment programme (Kelly *et al.*, 2013; Ranes *et al.*, 2017). The 12 Step Programme consist of the following six fundamentals; 1) Admitting one's inability to control substance abuse or compulsive behaviour, 2) Acknowledgement of a higher power that can provide strength to overcome, 3) Recognizing errors and mistakes from the past, 4) Amending past errors and mistakes, 5) Acceptance and learning new behaviour that governs life and 6) Assisting others undergoing recovery from substance abuse or compulsive behaviour (Musyoka, 2013; Zemore *et al.*, 2017; Kelley, 2017).

Inpatients attending 12 step inpatient treatment may also receive individual counselling, group counselling and family therapy (Magidson *et al.*, 2017; Carelse 2018). Furthermore, a parson within such programme is required to make list of all person they have harmed and be willing to make amends to such person if possible and if it is safe to do so.

3.5.1.3 MOTIVATIONAL INTERVIEWING

Motivational Interviewing (MI) was developed by William R. Miller in 1983 and have since been refined since its original publication. This technique is used for reluctant inpatients that are ambivalent about a change (Edwards *et al.*, 2003; Mantler *et al.*, 2015). MI is based on the principles of from client-centred therapy, CBT, systems theory and social psychology of persuasions (Miller & Rollnick, 1995 and 2002; Magill *et al.*, 2018). Basic principles of MI include working with resistance, establishing the conflicts, avoiding confrontation and enhancing self-efficacy (Miller & Rollnick

2002; Sayegh *et al.*, 2017). By applying these principals, the therapist may give advice, provide verbal feedback, clarifying goals and provide advice through individual therapy sessions. In addition, the therapist does not portray a confrontational or judgmental role while utilizing MI with inpatients (Madson *et al.*, 2016:1).

These are the models that are predominantly being used in South Africa as reported by Sodano *et al.* (2010), Saban *et al.* (2017) and Parry *et al.* (2017). However, these models mainly focus on the individual and its substance abuse within the treatment centres. The approach of these models is not being disputed. However, these treatment models are not prioritizing children and families within inpatient substance abuse treatment centres. This has implication for parents within substance abuse treatment centres that want to be reunified with their children. Research confirms that inpatient treatment centres are the ideal place where inpatients can play their expected role as parents (Gainey *et al.*, 2007:185; Lewandowski & Hill, 2009; Panchanadeswaran & Jayasundara, 2012; Manuel *et al.*, 2017). Writers such as Gainey *et al.* (2007) and Panchanadeswaran and Jayasundara (2012) on the implementation of parenting programmes within inpatient treatment centres, have shown that parents are able to communicate effectively with their children and increased parents relapse prevention skills.

Despite the benefits of having the children with their parents while receiving inpatient treatment, can be challenging as parents may experience substance withdrawal and need detoxification. Writers such as Britt *et al.* (2017) and Bezing and Levin (2018), confirm that inpatients having withdrawal, upon being admitted to inpatient treatment, may experience seizures or delirium tremens, which may be fatal. Parents experiencing withdrawal may not be able to care for their children while receiving inpatient treatment. Treatment for detoxification includes using psychosocial and/or pharmacological interventions (Bhatia *et al.*, 2017). Furthermore, authors such Stein (2016), Anderson *et al.* (2017) and Britt *et al.* (2017), have illustrated that inpatients transitioning from detoxification to substance abuse treatment, have shown to have improved sobriety outcomes and the transition to aftercare.

Furthermore, the treatment models are developed within a Western and European context and being implemented within the South African context. Families in South Africa are diverse culturally and by household structures, income, resources, education, and cultural identity (Department of Social Development, 2013; Naidoo & Rabe, 2015; World Bank Report, 2016; Statistics South Africa, 2017). International literature on treatment models appears not to take into consideration the diversity of individuals in South Africa accessing these services. Empirical literature by Ederies (2017) confirmed that in the Western Cape, beneficiaries are not able to attend and complete their outpatient treatment programme due to financial constraints and geographical location of the programme. Furthermore,

by focusing on the individual and its substance abuse within inpatient treatment, overlooks the challenges families are facing. The family will be able to provide valuable information and resources, physical, emotional and psychological support within inpatient treatment that can aid parents to be reunified with their children (Gainey *et al.*, 2017; Paris *et al.*, 2017; Manuel *et al.*, 2017). These parents may need family reunification support. Furthermore, aftercare planning is part of the support services that is being provided to inpatient within treatment centres.

3.6 AFTERCARE PLANNING

International literature uses the term discharge planning, and therapists place emphasis on the individual's sobriety and assisting with transition from treatment to their families and community (Calcaterra *et al.*, 2016; Wakeman *et al.*, 2017; Herschman, Proctor & Wainwright, 2017). Writers such as Hawkins *et al.* (2012:34) Humphreys and Laudet (2013:35), Bowen, Chawla and Witkiewitz (2014), and Best and Laudet (2015) confirm that activities within discharge planning include assistance with peer support networks, assisting in providing structured planning to those in recovery and follow up with medical care services such as mental health care. Discharge planning is based on the medical model of addiction (Wei *et al.*, 2015; Englander *et al.*, 2017; Matthews & Snoek, 2017), and views the individual in isolation and does not consider the family and children during discharge planning. International literature confirms that there is a lack of focus on family reunification services for inpatient parents within the discharge planning (Wong, 2006:119; Panchanadeswaran & Jayasundara, 2012:972, Balsells *et al.*, 2016; Miller, 2018).

In South Africa, the Minimum Norms and Standards for Inpatient Treatment (2005) provides a guide for social service professionals to develop an aftercare plan for inpatients. Treatment duration in South Africa is from three weeks to six months, and it's between this time period an aftercare plan is developed for the inpatient with the inpatient social workers (Department of Social Development, 2005). Once treatment is completed, inpatients are then referred to the designated social worker to receive community-based support services, family support and self-help groups in order to remain sober. However, literature in South-Africa and Western Cape indicates that the inpatient receives limited aftercare support from the designated social worker and that there is a lack of family support, support groups, and this contributes to relapse (Alpaslan & Van der Westhuizen, 2013; Swanepoel *et al.*, 2016; Geyer & Mahlangu, 2018). This would mean that the inpatient needs to deal with the lack of aftercare support, while needing family reunification services.

The study will be focussing on inpatient parents at substance abuse treatment centres who are separated from their children and needs to be reunified with their children. International empirical literature by Balsells *et al.* (2016), Bosk *et al.*, 2017, Manuel *et al.* (2017), and Radel *et al.* (2018)

confirms that substance abuse treatment centres are the ideal place to initiate that process of family reunification that includes children and family members. Results from these studies indicates improved parent and child relationship and better response to treatment outcomes.

In the following section, policy and legislation will be discussed that impacts family reunification of inpatients parents within substance abuse treatment centres. For the purpose of this study, the White Paper on Families (2013), Guidelines on Reunification Services for Families (2012), Prevention of and Treatment of Substance Abuse Act 70/2008 and Minimum Norms and Standards for Inpatient Treatment (2005), will form the legislative framework. The Children Act 38 of 2005 is also viewed as important legislation, however this was discussed under section 2.1 of the literature review study.

4. POLICY AND LEGISLATION REGARDING FAMILY REUNIFICATION SERVICES AND SUBSTANCE ABUSE

4.1 WHITE PAPER ON FAMILIES

Family preservation is one of the key strategic objectives of the White Paper on Families (2013) and seeks to strengthen families that face challenges or disintegration and reduce the likely-hood of a family member being removed (Department of Social Development, 2013). The White Paper on Families (2013) was largely a response to the concerns of the White Paper on Social Welfare Services (1997). This policy document outlined the countries' commitment to securing basic welfare. It focuses on the family and its life cycle, children, youth and aged. The White Paper on Social Welfare Services (1997) further outlined strategies to promote family preservation services. This comes in the implementation of pro-family policies and services in South Africa (Department of Social Development, 1997:4-5). Despite being pro-family, the White Paper has received wide criticism from feminists for not taking non-numerated work in consideration for caregivers in families seriously (Patel *et al.*, 2018:8). Rabe and Naidoo (2015:1) believed the White Paper on Families (2013) advocates for heteronormative family, middle class and nuclear in nature. However, the family holds key information on how to best assist the individual with their substance abuse. In addition, this study focuses on family reunification support for inpatient parents. The White Paper on Families (2013), in fact, advocates for families to be preserved. Providing family reunification to adults that are separated from their families are aligned with the objectives of the White Paper on Families (2013) that seeks to preserve families.

4.2 GUIDELINES ON REUNIFICATION SERVICES TO FAMILIES

Family reunification has traditionally referred to the physical reunification of children with their biological parents (Mfubu & Willie, 2016; Bennett & Eremenko, 2018; Aguilera & Korninek, 2018). However, this concept has been reconsidered by introducing the Guidelines on Reunification Services for Families (2012). The guidelines include all the family members who are separated from their families for various reasons. This may include incarceration, mental health issues and alcohol and drug abuse (Department of Social Development, 2012). The purpose of the guidelines is to provide standardization among social service professionals providing reunification services to families.

The aim of the Guidelines on Reunification Services for Families is as follows:

- To restore the well-being of families to regain self-reliance and optimal social functioning.
- To facilitate the reintegration of a family member into their families and community after separation.
- To promote the building of family relationship as support systems to their members.

(Department of Social Development, 2012)

Despite having these guidelines, there are minimal literature in the field of substance on family reunification within substance abuse treatment centres. The Guidelines on Reunification Services for Families (2012) may assist with successful reunification, improve the relationship between parents and children and improve the sobriety rate of inpatient parents' post treatment.

4.3 PREVENTION OF AND TREATMENT OF SUBSTANCE ACT 70/2008

The Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) is the guiding legislative document promulgated to address the substance abuse problem in the South African context. The Act makes provision for rendering of substance abuse treatment services that are inclusive, comprehensive and coordinated in addressing the needs of inpatients. This has led to the establishment of coordinated body known as the Central Drug Authority (CDA). The CDA is to provide an oversight function in the implementation of the Act and is responsible for the development of a National Drug Master Plan 2013-2018 (NDMP) to develop a holistic approach to address the substance abuse problem.

According to the National Drug Master Plan 2013-2018, interventions aimed at combating substance are coordinated at three levels:

- Supply reduction: Its objective is to prevent the manufacturing and supply of illicit substances and substance-related crime by means of law enforcement and legislative crime fighting strategies.
- Demand Reduction: These aim to prevent the inception of substance abuse. Its strategies consist out of prevention and early services aimed at raising awareness, enhancing life skills and creating opportunities for meaningful contribution to society.
- Harmful reduction: Aims to minimizing and mitigating the social, economic and health impact on individuals, groups and communities. This included the treatment, rehabilitation, re-integration and aftercare of person and and/or is substance dependent.

(Department of Social Development, 2013:28)

Treatment for substance abuse is aligned with the harm reduction, as identified in key policy documents. The Prevention of and Treatment for Substance Abuse Act (Act No. 70 of 2008), the NDMP (DSD, 2013), South African Guidelines on Reunification Services for Families (2012), and White Paper on Families (2013) are aligned with this study at a harm reduction level.

4.4 MINIMUM NORMS AND STANDARDS FOR INPATIENT TREATMENT

Inpatient treatment is aim at providing individuals with the necessary skills to stop his/her compulsive substance seeking and use. Substance abuse is usually characterized as a chronic disorder and its usually result in the occasional relapse and once off treatment is usually not sufficient (Burnhams *et al.*, 2012; NIDA, 2018). For most, inpatient treatment is long term that requires multiple intervention and monitoring. The International Standards for Treatment (UNODC, 2017) of Drug Use Disorder and Principles of Drug Addiction Treatment (NIDA, 2018) advocates for the following standard activities within an inpatient treatment centre;

1. A comprehensive psychosocial and medical assessment is conducted with each inpatient entering the programme to determine the individual's needs.
2. The individualized treatment plan should be developed by a multidisciplinary team of professionals with the inpatient being involved.
3. It may include a range of therapeutic intervention such as individual and group psychosocial intervention and life skills. In addition, an evidence-based intervention that is used in outpatient treatment can be adapted and implemented within inpatient treatment such as Cognitive Behaviour Therapy (CBT) and Motivational Interviewing (MI). Inpatient treatment

centres to provide a comprehensive service that includes vocational skills, employment training, and treatment for mental health disorders.

4. Assist in developing a social network (i.e. as significant other, family and friends) that can monitor recovery from substances and treatment compliances.
5. Encourage active involvement in self-help, religious or other support groups.
6. Assist with the securing of stable accommodation, legal and financial challenges.

South Africa's inpatient treatment programme is guided by the Minimum Norms and Standards for Inpatient Treatment Centres (2005). The following minimum standard activities are being implemented within treatment centres;

1. All inpatients should undergo a biopsychosocial and medical assessment upon entering the treatment centre.
2. Inpatient treatment centres to ensure that all treatment programmes are safe and evidence base and reflect internationally accepted standards.
3. Practical support is provided to families and caregivers to participate in the treatment programme. It included follow up a telephone call and financial aid to families to visit the inpatient at the treatment centre. In addition, if possible and requested, the treatment centre can provide family counselling to the inpatient within treatment.
4. Treatment centre to ensure prior to release, that inpatient refers to referral social worker, community services and self-help-groups

(Department of Social Development, 2005)

The International Minimum Norms and Standards for inpatient treatment were developed in 2017 and it was a third edition (UNODC, 2017), while South Africa's Norms and Standards were developed in 2005 (Department of Social Development, 2005). Furthermore, the acknowledgments within South Africa's Norms and Standards highlighted that the document was developed within 6 months to be presented and approved by the Cabinet (Department of Social Development, 2005:2). In addition, it appears it was not widely consulted and piloted within South Africa's within the field of substance abuse and within substance abuse treatment centres. The ramification of this has resulted in unequal access to treatment services (Meyers *et al.*, 2010;) lack of sustainability of substance abuse treatment centres (Mawoyo, 2011) and passable performance monitoring systems within substance abuse treatment centres (Govender *et al.*, 2014).

These challenges within substance treatment centre may have also impacted on the inpatient parents receiving lack of support to be reunified with their children and families. South Africa's Norms and Standards for Inpatient Treatment Centre is long overdue for a review. A revised Norms and Standards will enable substance abuse treatment centres to be able to preserve families through reunification support within treatment.

In the following section, a theoretical framework for substance abuse will be discussed. A variety of theoretical frameworks have emerged with the purpose of explaining the complexity of substance abuse. These frameworks fall within five different paradigms such as the 1) Disease Model Theory, 2) Social Learning Theory Model, 3) Psychoanalytic Model, 4) Family Systems Theory Model and 5) Bio-Psychosocial Model of Addiction.

5. THEORETICAL FRAMEWORKS OF SUBSTANCE ABUSE

5.1 THE DISEASE MODEL THEORY

The Disease Model Theory (Jellinek's, 1960) states that substance abuse involves pathological changes in the brain that result in overpowering urges. These oddities create an altered response to substance abuse. The inability to control amounts, cravings, and withdrawals are indicators of a biological component of substance abuse (Jang *et al.*, 2000:874; Volkow *et al.*, 2016:363). The disease theory of addiction identifies drug-seeking as an obsessive behaviour rather than a sensible choice due to biochemical changes in the brain that happen with regular substance abuse (Volkow *et al.*, 2016).

Despite viewing substance abuse as a disease which influences and changes brain functioning, the learning theory model demonstrates that the abuse of alcohol and drugs is a learned behaviour.

5.2 SOCIAL LEARNING THEORY MODEL

Social Learning theory was theorized by Albert Bandura (1977), and it hypothesizes that people learn from each other, through observation and modelling. The Learning Theory Model consist out of different schools of beliefs regarding cultured or conditioned behaviours. Individuals do not start life to abuse substances. The drug/alcohol abuser must a) be taught that substance use is tolerable, b) able to recognize the effects of the substances, and c) view them as desirable (Marlatt & Gordon, 1985; Doweiko, 2011). Writers such Akers and Jennings (2015), Coomber *et al.*, (2016), and Akers and Jensen (2017) confirms, that the substance abuse behaviour is often learned within a group such as amongst friends, families and community, and becomes the accepted norm within the specific group or culture.

In order to unlearn the alcohol and drug abuse behaviour, it may require the individual to undergo psychoanalytic therapy.

5.3 PSYCHOANALYTIC MODEL

Psychoanalytic theory is the theory of personality organisation and the dynamics of personality development that guides psychoanalysis (Auchnicloss, 2015; Litchenberg *et al.*, 2016). This theory views drug abuse as an adaptive mechanism by which an individual attempt to cope with self-regulatory deficits rising from childhood deprivation a maladaptive child-parent relationship (Capuzzi & Stauffer, 2016; Fonagy *et al.*, 2018).

Psychoanalytic theory looks at substance abuse as a problem in the balance between the id, superego, and ego. It's hypothesized that when the id overpowers the ego and superego, it can cause a person to take drugs and alcohol without thinking about the consequences (Litchenberg *et al.*, 2016; Culbreth & Lassiter, 2017). This is also known as pharmacological reward potentials (Doweiko, 2009:10). The individual chooses to make use of alcohol/drugs with the anticipation that the drug will have pleasurable effects.

Psychoanalytic theory mostly centred on the individual, however the individual cannot be viewed in isolation as there are multiple pathways how substance abuse effects an individual's functioning.

5.4 BIO- PSYCHOSOCIAL MODEL OF ADDICTION

In an effort to reflect the multivariate nature of substance abuse, many authors refer to the biopsychosocial model of addiction. Writers such as Engel (1977), Griffiths (2005), Boettiger, Garland and Howard (2011) and Cheng (2018) view the model, as the interaction of biological, cognitive, psychological, social development and environmental variables are considered to contextualize substance abuse, using the bio-psychosocial model of addiction. According to Kumpfer *et al.* (1990), the bio psychosocial model incorporates the other models into a single model and it's reasonably conceptualized. This would mean that important factors in the treatment with a client are not being ignored when all variables are being considered. In addition, the bio-psychosocial model is based on the premise that biochemical factors, disorders of self, learned or conditioned behaviours, family and social factors contribute to the initiation and maintenance of drug abuse. The theory stress that there are multiple pathways to use the substance and that the differential effect of these factors varies from individual to individual (Fisher & Harrison, 2005).

Despite the importance of abovementioned theoretical models, the family systems theory model on substance abuse will be appropriate for this research study.

5.4 FAMILY SYSTEMS THEORY

The Family Systems Theory model was developed from the biologically based general system theory (Von Bertalanffy, 1968) that focused on complex systems, sharing organizing principles, which can be discovered and modelled mathematically. Key concepts in both theories are feedback homeostasis and boundaries. This model views alcohol and drug abuse as a symptom of a dysfunctional family (Pears *et al.*, 2007; Lander *et al.*, 2013). In particular, the concepts of homeostasis, the rules and goals that govern the interactions between family members and ways in which the rules are applied, may all contribute to alcohol and drug abuse (Fisher & Harrison, 2005; 191; Lander *et al.*, 2013:3). This theory stresses the need to include family members in treatment and address family dynamics, so that the substance abuser has a healthier, stable, flexible and open family environment after treatment.

Families are considered to form the foundation of social units in communities around the world, and healthy individuals within families build strong families and communities (Chatters *et al.*, 2014; Aschenbeck *et al.*, 2017; Hamby *et al.*, 2018). Families have the responsibility to care and nurture for their children, and children depend on their family to protect them and provide for their needs (Weiss *et al.*, 2016; Hammer & Neal, 2017). However, this becomes challenging when a family member, such as a parent, abuse alcohol and drugs, and needs inpatient treatment which means that he/she or they have to be separated from their children. The abuse of alcohol and drugs often disrupt family routines and result in family disintegration (Lewis *et al.*, 2015; Smith & Wilson, 2016). The Family Stress Theory (FST) indicates that when families receive support and assign meaning to the stressful event, will determine whether a crisis will follow (Sullivan, 2015; Murry *et al.*, 2018). In addition, Boss and Mulligan (2003) and Bronfenbrenner's Ecological Systems Theory (1979) support FST, and believe that the culture, values, belief and family developmental life cycle influence how a family would respond to a challenge. Despite the family members' ability to remain resilient, the inpatient parent may find it difficult to amend their relationship with their children and family (Baldwin & Duffy, 2013; Paris *et al.* 2015; Barlow *et al.* 2019).

Substance abuse cannot be dealt with in isolation, therefore Bronfenbrenner Bio Ecological Systems Theory (EST) will be used as a theoretical framework for this study. The EST will be discussed in the following section.

6. THEORETICAL FRAMEWORK FOR THE STUDY

According to Mudavanhu and Schench (2014:371), the ecological systems theory maintains that the environment and its immediate settings actively shape the outcome of an individual's life. Family reunification should be viewed within the life space of the family and factors influencing their lives. This means that the social worker within the substance abuse treatment centres should look at the environment of the inpatient parents, their support groups and the context they live in, as those aspects play a vital role in family reunification.

6.1 Bio-Ecological System Theory Defined

According to Bronfenbrenner (1979:21) the Bio-Ecological Systems Theory can be described as; *The ecology of human development that involves the scientific study of the progressive, aggressive mutual progression between an active, growing human being and the changing properties of the immediate settings in which the developing persons live, as the process is affected by relations between these settings, and by the larger contexts in which the settings are embedded*". The Bio Ecological Systems theory views human development as a person-in-environment context as it uses different types of relationships and surroundings of an individual to help explain their development (Johnson, 2011; Miller, 2012) and Tudge (2013:244) is of the opinion that the model looked at development emerging through the interaction between individuals and their environment. Figure 3 is an illustration of the different levels of interactions within the ecological system that consist of the inpatient parents' context.

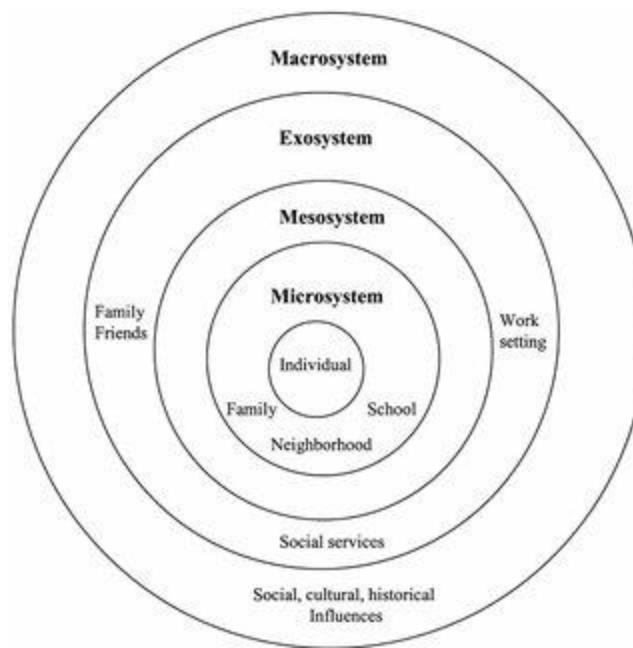


Figure 3: Bio-Ecological Systems Theory

All systems are connected to each other and can influence each other during family reunification. It also points out that while the relationship close to the individual have a direct impact; factors outside the close relationship have a powerful impact on an individual (Tudge *et al.*, 2017). External social factors all affect human development and behaviour (Bronfenbrenner, 1979), thus the environmental conditions an individual is exposed to whether positive or negative directly influences their development. Furthermore, Bronfenbrenner has described four ecological systems that conceptualize environmental contexts such as the micro, meso, exo and macrosystems.

6.1.1 Microsystem

This is the inner layer of Bronfenbrenner's model and thus refers to the relationships between the inpatient parent and their immediate surroundings while receiving inpatient treatment (Ryan, 2001; Walker *et al.*, 2018). The micro-system consists out of close interaction in which the inpatient parent has an interpersonal connection with family members, special events and critical events which often impacts on their life's (Cabrera *et al.*, 2014). Support within the micro system consists out of the family, school, childcare environments, caregivers, neighbourhoods, religious community that is needed for inpatient parents to be reunified with their children once treatment has been completed. (Johnson, 2011; Boxer *et al.*, 2013; Velez-Agosto *et al.*, 2017:902).

6.1.2 Mesosystem

The mesosystem is the next layer and it provides the connection between the support structures of the inpatient parent's microsystem (Bronfenbrenner, 1979). It provides the connection between two or more microsystems in which the inpatient parent are the active participants, such as the interaction between the child and social service professionals (Collins, Frels & Onwuegbuzie, 2013). The manner in which the two microsystems interacts with the mesosystem can jointly influence the outcome of the inpatient parent reunification with their child (Bronfenbrenner, 1979). The mesosystem may include, family, community, and support groups (Neal & Watling Neal, 2013; Velez-Agosto *et al.*, 2017).

6.1.3 Exosystem

The exosystem is nested within the mesosystem and it includes remote special settings that have an indirect effect on the inpatient parent such as support network, reunification services and the broader society (Bronfenbrenner, 1979; Neal & Watling Neal, 2013; Paat, 2013). The need for parenting programmes, in South Africa, has been recognised by the Children's Act (No. 38 of 2005), Integrated Parenting Framework (2012) and White Paper on Families (2013) (Department of Social Development, 2012; Department of Social Development, 2013). These policies and legislation give clear guidelines that Provincial Departments of Social Development must provide and fund substance abuse programmes (Budlender, Proudlock, & Giese, 2011:1). However, the National Drug Master Plan (NDMP) 2013-2018 plan does not include a focus on parenting needs, even though it supports research in the field of substance abuse and despite the identified need for parenting programmes in South Africa.

6.1.4 Macrosystem

The macrosystem is broadly defined as the large overarching set of culture, beliefs, social values, political ideologies, customs, laws and government, economy and wars that would include the microsystem, mesosystem and exosystem (Bronfenbrenner, 1979; Neal & Watling Neal, 2013; Anderson, Boyle & Deppeler, 2014; Velez-Agosto *et al.*, 2017). This would mean, for the context of this study, family reunification support within inpatient treatment are influenced by the historical period and current agendas within a country and globally (Anderson *et al.*, 2014). In addition, Taylor (1871) is of the opinion that cultures are complex, and it includes transferring of knowledge, belief, arts, morals and customs (sited in Wahab, Odunsi & Ajiboye, 2012:1). Research confirms that parents have credible sources of information about alcohol and drugs that may influence their children's alcohol and drug use, by speaking favourably or unfavourably about alcohol and drug use, this can

shape cognitive expectancies and establishing norms of behaviour (Ebersole *et al.*, 2014; Escario & Wilkinson, 2015).

7. CONCLUSION

Parents' need for family reunification support was previously excluded within substance abuse treatment centres, and as a result, parents felt unimportant as their voices were not heard. Role clarification within inpatient treatment centres and a designated social worker should be clear when rendering family reunification to inpatient parents. Providing family reunification cannot take place in isolation. It requests a collaborative partnership where the inpatient parent, child concerned, inpatient social worker within substance abuse treatment centres and designated social workers should work together. The collaborative partnership may increase parent's commitment and sense of accountability to be part of family reunification. To children, separated from their parents, it can be traumatic for both parent and child, therefore therapeutic intervention such as family reunification support within inpatient treatment is needed to strengthen families.

Section B will consist of Part 1 and 2 as the findings of this study will be presented in the form of articles. Article 1 was drafted using the guidelines of the South African Journal of Social Work and Social Development and article 2, was according to the Biomedical Journal for Substance Abuse

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SECTION B

Section B includes the following 2 articles:

Article 1: Family reunification support to inpatient parents in Western Cape substance abuse treatment centres.

Article 2: Guideline for family reunification in Western Cape substance abuse treatment centres with inpatient parents.

ARTICLE 1

FAMILY REUNIFICATION SUPPORT TO INPATIENT PARENTS IN WESTERN CAPE SUBSTANCE ABUSE TREATMENT CENTRES

This article will be submitted to the Southern African Journal of Social Work and Social Development academic journal for review and publication.

The Author Guidelines for publication in the journal will first be presented below, followed by the article as it will be submitted to the journal.

Instructions to Authors: Southern African Journal of Social Work and Social Development (SAJSWSD)

Please adhere strictly to these instructions to facilitate the publication process of articles.

STYLE GUIDELINES (CHICAGO MANUAL OF STYLE: AUTHOR-DATE)

This guide endeavours to achieve a standardised typographical style and consistent language choices. The main objective is to make it easier for authors, editors, copyeditors, layout editors and all those who publish to know what choices to make in the myriad of existing options. Unisa Press uses the Chicago Manual of Style (<http://www.chicagomanualofstyle.org/>).

Guidelines for Technical Preparation of Manuscript

Layout

Submit manuscripts electronically—MSWord file.

All graphic material has to be positioned at the correct place in the text and should be of a good quality. Do not add supplementary files with graphic content. Manuscripts must be presented as: A4 pages; normal margins; 12pt Times Roman; 1.5 line spacing. Proofing language must be set as UK English (colour—not color; travelled—not traveled; organise; organisation; organising—not -ize). Do not type double spaces anywhere; not between words, at the end of sentences or after colons. Articles should not exceed 6000 words from the first word in the title to the last word in the list of references. Make sure you follow the guidelines for ensuring a blind peer review. Then present an indented abstract of not more than 250 words. Abstracts should not contain any footnotes or citations. Do not type the abstract in italics.

Below the abstract, please provide 4–6 keywords for indexing (only proper nouns in capitals). Distinguish between keywords/phrases with semicolon, e.g. Pentecostal; hymnal records; migration;

southern regions of Africa. Authors should include their affiliation or ORCID below their name, after the title of the article. No numbers should be used in headings or in lists

Style

Do not use the ampersand (&) anywhere in the text or citations; use “and” instead. In text, only sparingly emphasise words by using italics. Italicisation should otherwise be reserved for book titles and words from a language other than that of the text. Italicized words/phrases in another language are glossed by an equivalent word/phrase in the language of the text in single inverted commas placed in brackets, e.g. ...*indoda* (“a man”). Words well-known in South African English are set as roman, for example, lobola, ubuntu, indaba. Words/terms that need to be singled out as being “borrowed” from another author/source may be placed in double inverted commas. Titles of publications must be in headline style (significant words are capitalised) and in italics when typed in the text. Titles of articles are placed between “double inverted commas.” Also see citation guidelines for examples.

Quotations

When quoting from a source, use “double inverted commas.” To quote within a quote, use ‘single inverted commas.’ When quoting more than five lines, indent. Do not print indented text in italics and do not use quotation marks. A citation after the indented quote follows after a full stop, e.g. According to the report the council will discuss the matter at the next council meeting to be held on 5 January. When quoting within an indented quotation, use “double inverted commas. “Final full stops and commas are placed inside the quotation marks. Colons and semicolons are placed outside of quotation marks. Question and exclamation marks are only placed inside quotation marks if they form part of the quoted material. E.g. Do you know if she is “accredited”? and He asked: “Are you accredited?” When adding notes to a quote or changing a quotation, use square brackets, e.g. [own translation/emphasis]/[t]oday.

Numbers

In text, numbers one to nine are in words; numbers 10 and above are in digits. At the start of a sentence all numbers are in words. In brackets all numbers are in digits, as for numbers of tables, figures and chapters. When in text, percentages (below 10) are in words—seven per cent; above 10 are digits—22 per cent/13.5 per cent. Decimals—7.5 per cent—are always in digits (also in text). Use the % sign in brackets and per cent in text.

Acronyms

Give the full name when first mentioned (with acronym in brackets), thereafter use the acronym uniformly and consistently: Unisa; CSIR; HSRC; Sabinet/SABINET

et al.

et al. (not italics) Never use in the reference list. When citing a text with four+ authors, use only the first author's name followed by et al. in text, but list all authors in the reference list.

Tables and Figures

Table headings appear above the tables and are numbered. **Table 1:** Our Table. Figure captions appear below the figures and are numbered. Captions should include, in the following order: Figure 1 Artist, *title* (date). Medium/support, metric dimensions. Name of collection, city of collection, other collection information such as “gift of ...”, accession number (copyright or credit-line information in parentheses). Credit lines should include all elements specified in the letter of permission from the rights holder, institution and/or photographer: Figure 1: Sandro Botticelli, *Primavera* (ca. 1482). Tempera on panel, 203 x 315 cm. Galleria degli Uffizi, Florence (photograph provided by Scala / Art Resource, New York). Figure 2: Roman sarcophagus, *Death of Meleager* (3rd century CE). Detail. Musée du Louvre, Paris (photograph © James Smith, Rome).

Figure 3: Alfred Stieglitz, *Equivalent* (1925-27). Gelatin silver print, 11.7 x 9.2 cm. The Museum of Modern Art, New York, anonymous gift (© 2009 Estate of Alfred Stieglitz / Artists Rights Society (ARS), New York). If using a scan from e.g. a catalogue, this must be indicated by means of an exact reference: Figure 4: Pieter Brueghel the Elder, *The Misanthrope* (1568). Tempura on canvas, 86 x 85 cm. Signed and dated: ‘BRVEGEL 1568’. Museo e Gallerie Nazionali di Capodimonte, Naples, catalogue number 585 (reproduced from Martin 1978, figure 37).

Citation Guidelines: Chicago Author-Date

In Text:

Within the body of your text, citations are indicated in parentheses with the author's surname, publication date, and page number (if needed, as when quoting direct words), e.g. (Smith 2012, 45). Citations are placed within the text where they offer the least resistance to the flow of thought, frequently just before a mark of punctuation. Single-author citations: If the author's name appears in the text it is not necessary to repeat it, but the date should follow immediately: Malan (2014, 4) refers to this ... Single author with two or more works in the same year: (Gray 2009a; 2009b). One publication with two+ authors: ... contested by Smith and Jones (2013, 16). Also (Smith and Jones 2013, 16). Multiple publications: ... venture failed (Bergin 2009; Chance 2008, 14–17).

When citing multiple publications/authors do so alphabetically (Louw 2010a, 3; Ncube 2008, 77; Zeiss 1993, 4). Multiple authors with the same initial surname and same year of publication shorten titles: (Coe et al., “Media diversity,” 2001) and (Coe et al., “Social media,” 2001). No page numbers

are needed if citing a text on the internet, e.g. academic freedom (Smith 2014), unless page numbers are available.

References

Authors

List authors alphabetically. Use surnames, first names (if known) and initials. The entries are additionally sorted by the work's date of publication (oldest to newest). Do not use a dash to replace author names. If no author or editor, order alphabetically by title (corresponding with text citation). A single-author entry precedes a multi-author entry beginning with the same surname. Successive entries by two+ authors, when the first author is the same, are alphabetised by co-authors' surnames.

Titles

Use headline-style capitalisation in titles and subtitles of works and parts of works such as articles or chapters (i.e., Biology in the Modern World: Science for Life in South Africa). Capitalize significant words and proper nouns. Use headline-style capitalization for titles of journals and periodicals (i.e., *Journal of Social Activism*). Titles of stand-alone publications are typed in italics when used in text: *Evangelism and the Growth of Pentecostalism in Africa*

Electronic references (NB: The text reference must correspond with the alphabetical reference list) Author's surname, name and initials (if available); title of article/publication. website address (URL). Macdonald, Fiona. 2017. "The Extraordinary Life of the 1920s Lady Gaga." BBC Culture, September 20. Accessed October 6, 2017. <http://www.bbc.com/culture/story/20170920-the-extraordinary-life-of-the-19th-century-lady-gaga>. Personal communications, letters, conversations, emails, interviews, recordings may be listed separately in the reference list. Omit: Inc., Co. Publishing Co. etc. from the name of the publisher.

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One Author

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**FAMILY REUNIFICATION SUPPORT TO INPATIENT PARENTS IN WESTERN CAPE
SUBSTANCE ABUSE TREATMENT CENTRES.**

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SECTION B PART 1: ARTICLE 1: FAMILY REUNIFICATION SUPPORT TO INPATIENT PARENTS IN WESTERN CAPE SUBSTANCE ABUSE TREATMENT CENTRES

Abstract:

The article focus on family reunification support for inpatient parents admitted to Western Cape substance abuse treatment centres. Parents at substance abuse treatment centres are separated from their children and may therefore need family reunification support. Research indicates that available support for inpatient parents during aftercare or discharge planning may not be sufficient at substance abuse treatment centres to assist inpatient parents with family reunification. While international and local literature on substance abuse focuses on the inpatient's sobriety, this article attempts to shift the focus from the sobriety of the inpatient to their parenting role. The aim of the study was therefore to explore formal and informal support available to inpatient parents during family reunification at Western Cape substance abuse treatment centres. A qualitative descriptive explorative design was implemented. Semi-structured interviews, focus groups and collages was used to collect data. The participants were inpatient parents and social workers at substance abuse treatment centres of the Western Cape. Results showed that parents want to improve their relationship with their children. Inpatient parents want to have their children part of the therapeutic programme. Inpatient social workers are providing inpatient parents with family therapy and parenting skills that would assist them to reunify with their children. Aftercare planning do not prioritize family reunification services within substance abuse treatment centres. The findings of the research suggest factors promoting reunification, alongside recommendations for including family reunification services for R parents

Key words: family reunification, inpatient parent, aftercare, substance abuse treatment centres, parental substance abuse

INTRODUCTION AND PROBLEM STATEMENT

Family reunification involves the transition of a family member back to his/her family after being separated for some period (Garthwait 2012, 23; Department of Social Development 2013; Lloyd 2018). Research confirms that family reunification can be complex, as it requires the participation of the family members in order for reunification to be successful (Balsells et al. 2016; Potgieter and Hoosain 2018). The child welfare sector is globally known for the reunification of children, who were removed due to physical, emotional abuse and/or inadequate parenting, then returned to their biological parents after temporary separations (Austin, Lee, and Sarah 2013; Balsells et al. 2016; Potgieter and Hoosain 2018). Literature on family reunification within the child welfare sector approves that parents are sometimes unwilling to care for children, parents find it difficult to adjust with their children post reunification, availability of designated social workers to provide reunification services is an issue and the same goes for lack of resources for family reunification services (Makofane and Nhedzi 2015; Lombard and Sibanda 2015; Mosoma and Spies 2016; Potgieter and Hoosain 2018).

In the substance abuse field, writers such as Wong (2006), Panchanadeswaran and Jayasundara, (2012), DeGarmo et al. (2013) and Akin, Brook, and Floyd (2015), indicated that inpatient parents at treatment centres do not spend sufficient time with their children during visitation, feeling isolated and stigmatized by their family members. Family reunification support may therefore be needed to assist with the transition of the parents back to the family home when their treatment is completed (Balsells et al. 2016; Radel et al. 2018). According to Lombard and Sibanda, (2015) and Danzy and Jackson (2018), support during family reunification may include information, psychosocial, emotional, community-based support services during and post reunification. Family reunification activities at a substance abuse treatment centre may include parenting programmes, structured supervision during children's visitation hours, providing accommodation for children within inpatient treatment and family therapy. Groenewald and Bhana (2018) and Kalam and Mthembu (2018) believe that family reunification has not been adequately explored within the substance abuse field.

The benefits of family reunification for the parent and child may include; 1) providing opportunity for the parent to improve their relationship and maintain contact with their children and 2) inpatient parent learning new parenting that will aid them in dealing with a child that displays challenging behaviour Karam, (2014), Sauls and Esau (2015, 9), Makofane and Nhedzi (2015) and Bosk, Van Alst, and Van Scoyoc, (2017). Despite the benefits of family reunification, Makofane and Nhedzi (2015), and Potgieter and Hoosain (2018), view family reunification as a multifaceted process, as it

involves willingness and the involvement of family members, taking into consideration the children's cognitive ability, meeting family needs, communication and flexibility amongst family members. Given its complexity, Chamber et al. (2018) postulates that support is significant during the process of family reunification. International and local literature on family reunification support reveals that the process of family reunification is failing, as there is a lack of commitment and support for parents during the period of being separated from their children (Makofane and Nhedzi 2015; Miller 2018; Mitchell 2019). According to Radel et al. (2018), Henry et al. (2018) and Mitchell (2019), parents who abuse alcohol and drugs are not receiving sufficient support during the reunification process with their children. Research also indicates that substance abusers have lower levels of reunification with their children after completing their inpatient treatment programme (Akin, Brook, and Lloyd 2015, 119; Balsells et al. 2016, 118). The problem that what the research therefore attempted to explore was family reunification support at substance abuse treatment centres.

SUBSTANCE ABUSE INPATIENT TREATMENT IN SOUTH AFRICA

Substance abuse is defined as; *A maladaptive pattern of uses indicated by continued use despite knowledge of having a persistent or recurrent social, occupations, psychological or physical problem that is caused or exacerbated by the use of alcohol and drugs* (World Health Organization 1994, 4). This often leads to dysfunctional behaviours, as well as legal and safety concerns. The abuse of alcohol and drugs often continues, despite causing social, occupational, physiological and physical harm (Fagan, Pinchevsky, and Wright 2015; Sussman et al. 2018). As a result of the continued use of alcohol and drugs, and losing control by the individual, is where the substance abuse occurs. Peele (2016) and Lewis (2017) view addiction as a chronic disease. Individuals are often in need of intense inpatient treatment services that would address psychosocial and behavioural treatment for their abuse of alcohol and drugs.

According to The South African Network for Epidemiology Network on Drug Use (SACENDU 2018), the country had an increase in people being admitted for treatment programmes, which raised from 8 787 in 2016 to 10 047 in 2018. In South Africa, inpatient parents are forced to separate from their children, as most substance abuse treatment centres do not accommodate children (Nagel 2017). Inpatient parents are obligated to make arrangements for someone to care for their young children while they are undergoing inpatient treatment. Inpatient treatment is to provide psychoeducational interventions, which assist with sobriety when treatment is completed (Parry et al. 2017; Meyers 2019).

According to the South African Minimum Norms and Standards for Inpatient Treatment, the duration for treatment is between three to six months (Department of Social Development 2005). During the inpatient stay within treatment, the first two weeks is dedicated to assessments, intakes, screenings, developing an individual development plan and detoxification (Scheibe et al. 2017; Andersson et al. 2018; Myers et al. 2019). Current support for patients at substance abuse treatment centres are facilitated by a multidisciplinary team that provided psychoeducational therapy through individual, group and family therapy (Engelbrecht and Gouws, 2017, Kalam and Mthembu 2018; Meyers, 2019). The multidisciplinary team within inpatient treatment consists of inpatient social workers, psychiatrist, doctors, psychologist and occupational therapist (Parry et al. 2017; Isobell, Kamaloodien, and Savahl 2018; Magidson et al. 2018).

Prior to the completion of the inpatient treatment programme an aftercare plan is developed by the inpatient social worker with the inpatient client. The researcher used the term aftercare, as this is the accepted term in South Africa. Aftercare services focuses on linking the inpatient with community-based support services, support groups and follow up sessions with designated social worker post treatment (Alpaslan and van der Westhuizen 2013, and 2015; Crafford, Geyer, and Swanepoel 2016). Inpatient social workers at the substance abuse treatment centres are the case managers for inpatients and are usually responsible for the individual plans (Carelse 2018; Magidson et al. 2018). They manage the aftercare planning. Inpatient social workers and inpatient parents were therefore the target population of the study. Inpatients who are parents may also need family reunification support (Murphy et al. 2017; Lloyd 2018; Miller 2018). The family reunification phase at substance abuse treatment centres are similar but different to aftercare planning. It may involve services, such as regular visitation, parenting programmes, contact between the inpatient parents and children during the treatment programme (Department of Social Development 2005, 33; Akin, Brook, and Lloyd 2015, 122). According to Graham and Grant (2015) and Radel et al. (2018) there is a lack of focus on family reunification within aftercare services at substance abuse treatment centres.

Paris et al. (2015) and Bosk, Van Alst, and Van Scoyoc (2017), believe substance abuse cannot be treated in isolation, as the inpatient parent and their family need to be taken into consideration during family reunification. Bronfenbrenner's Ecological Systems Theory (EST), was therefore used to guide the study. EST focuses on the person and its environment, as there is an equal relationship between the individual and their environment (McCormick et al. 2013; Greene 2017). The person within the environment refers to the inpatient parent, and fitting in the environment is linked to individual, groups and community needs, capabilities and resources within their physical environment, based on the unique cultural and socio-historical context (Bronfenbrenner 1979; Greene

2017). Bronfenbrenner (1979) viewed EST as a set of nested structures, each nested in the other. These sets of structures are known as microsystem, mesosystem, exosystem, and macrosystem. In the context of the current study, there is a mutual relationship between the inpatient parent and their children, family, peers, and neighbourhood on a micro level. The interaction between the inpatient parent and their children and family is viewed as the meso level, while the exosystem could be the inpatient parents' employer, inpatient and designated social workers, and support or social groups in the community. Policy and legislation refer to the macrosystems, such as the South Africa Norms and Standards for Inpatient Treatment Centres (2005) and Guidelines on Reunification Services for Families (2012) that provides a framework for service delivery in the field of substance abuse and family reunification.

Rationale

While there is a significant amount of literature on family reunification services within the child welfare sector (Sauls and Esau 2015; Seita et al. 2016; Hoosain and Potgieter 2018; Hope and Van Wyk 2018), there remains limited research on family reunification support for inpatient parents at substance abuse treatment centres in the Western Cape, South Africa. By providing effective family reunification support, inpatient parents may be able to reunite with their children after completing their treatment programme (Balsells et al. 2016; Radel et al. 2018). The results of the study may also be used to promote family reunification at substance abuse treatment centres. The study, therefore, aims to explore family reunification support at substance abuse treatment centres by interviewing inpatient parents with children between 0 and 5 years of age, and inpatient social workers. The research question, which the study therefore attempted to answer was "What family reunification support is available in Western Cape substance abuse treatment centres?" In order to answer the research questions, a qualitative descriptive research methodology was chosen.

METHODOLOGY

A qualitative research approach was implemented. Writers such as De Vos et al. (2011, 91) and Rubin and Babbie (2011), indicate that a qualitative research approach is ideal to obtaining in-depth information and to secure, through description, such aspects as inpatient experiences of family reunification within substance abuse treatment centres.

A qualitative descriptive design was chosen as the study described the available support for inpatient parents at substance abuse treatment centres during family reunification. Authors such as Sandelowski, (2000, 334) and Collorafi and Evans (2016, 16) believes that descriptive studies provides an overall synopsis of events using terms that are used by those involved in those events. According to Sandelowski (2000), qualitative descriptive study is used when the researcher aims at identifying descriptions of a specific phenomenon. For this research study, the research was able to obtain the perceptions of inpatient parents and social workers on family reunification support within substance abuse treatment centres.

Population for this study was inpatient parents and inpatient social workers at substance abuse treatment centres in the Western Cape. To ensure that participants were selected on the basis of relevance to the study, purposive sampling was used to provide the researcher with a sample to access contextually relevant insights into the phenomena of family reunification support for inpatient parents and inpatient social workers (Bayat and Fox 2008; Babbie and Mouton 2001). Inclusion criteria are that these inpatient parents have children between 0-5 years of age and are in their third week of treatment. Inclusion criteria for inpatient social workers, were social workers to be registered at the South African Council for Social Service Professions (SACSSP) working at the Western Cape substance abuse treatment centers, 2) male or female social workers and 3) a minimum of 6-months work experience within inpatient treatment centers. The sample size was determined by data saturation, which was identified after 15 semi-structured interviews with inpatient parents and three focus groups with 13 inpatient social workers. Inpatient parents consisted of eight males and six females with the youngest parent being 20 years old and the eldest 38 years of age. Twenty-one percent were married and 79 per cent of inpatient parents are in a relationship. Forty-three per cent indicated that their children are being taken care of by their maternal parents and 57 per cent indicated that their children are taken care of by their significant other. The ages of the children that have been recorded, range from 1 years old (the youngest) to 16 years old (the oldest). Inpatient parents that were interviewed had on average of 2 children with the youngest being between ages 0 and 5 years of age.

Inpatient social workers consisted of 11 females and two males. Forty-seven per cent ranged between the ages of 51-60, seven per cent 41-50, 23 per cent 31-40 and 23 per cent 21-30 years of age. Years of experience are recorded amongst inpatient social workers. Thirty-eight per cent 2-5, seven per cent 9-10 and 11-15, 30 per cent had more than 15 years' experience. All inpatient social worker participants had indicated that they have a BA degree in social work, while only 53 per cent indicated that they have obtained post-graduate degrees in social work at tertiary institutions.

Ethical considerations

Ethical approval was received from the North West Ethics Committee with ethics number **NWU-00078-18-S1**, and legal authorization received from the Western Cape Department of Social Development to conduct the study at Kensington Treatment Centre, as they are a government facility. Goodwill permission was obtained from Ixande Recovery, Toevlug, and Hesketh King substance abuse treatment centres. Voluntarily informed consent was obtained from all the participants. To ensure privacy and confidentiality, the researcher made use of codes, e.g. inpatient parent 001 or social worker 003, in order to identify them (Rubin and Babbie 2011). During the focus group discussion, the researcher assured privacy by allowing participants to introduce themselves by reiterating that the groups confidentiality needs to be respected and will clarify if the participants are uncertain about this. In addition, the researcher informed inpatient social workers that anonymity could not be ensured. The group had the responsibility in managing confidentiality.

Limitation of the Study

The study has limitations as inpatient parents and inpatient social workers were recruited from five substance abuse treatment centres in the Western Cape. The study excluded the rest of South Africa's substance abuse treatment centres. This study did not include the designated social worker that refers the client for inpatient treatment. Focus group discussion with the designated social worker may have added value to the recommendation for family reunification support for both professionals and inpatient parents.

Data Collection

The researcher and a female field worker (social worker) collected data. The female field worker conducted semi-structured interviews with female inpatient parents to avoid any feeling of discomfort by being interviewed by the male researcher. Data were collected through semi-structured interviews and collages that was completed by the inpatient parents. An interview schedule was used with 6 main questions and 5 demographic questions that include age of inpatient parent, marital status, number of children, where the children are currently placed with and ages of children. The collage helped generate information and to map ideas during data collection. Empirical literature by Simmons and Daley (2013, 2) were convinced that the use of collages is beneficial, as it will assist the participants to reflect more deeply, such as their experience of family reunification within substance abuse treatment centres. Through the pasting of pictures on an A3 paper, the inpatient parents managed to creatively discuss what family reunification support is available within substance abuse treatment centres. See figure 1 of an example of a collage made by a participant. Interviews took

between 60-90 minutes and participants gave consent to be interviewed. Interviews and focus groups took place at the 5 selected substance abuse treatment centres in the Western Cape.



Figure 1. Collage made by inpatient parent.

In addition, focus groups were facilitated with inpatient social workers. The focus groups were between 110 and 160 minutes per group. All interviews were audio recorded and stored on a password protected laptop. Transcripts and collages completed by inpatient parents and social workers is kept in safe storage in lock cupboard of the office of CCYF and COMPRES. Data will be kept for five years and will then be destroyed

Data Analysis

Braun and Clarke's (2013) thematic analysis was employed. It assisted the researcher in identifying, analyzing and reporting patterns (themes) within data. Firstly, the researcher familiarised himself with the data by listening to an audio recording and transcribing the data. Transcribing was done by an assistant that the researcher appointed. To ensure credibility and quality control the researcher appointed an independent co-coder for this study. The co-coder highlighted common themes within the transcripts in a summarised version and pointed out the inconsistencies. Information was sorted into broad categories, in order to identify possible themes and subthemes. To ensure further trustworthiness of the data verification, the researcher applied credibility (i.e. method of data

collection and independent coder), dependability (i.e. description of research methodology and data analysis), confirmability (i.e. method of interviewing and data recording, and transferability (i.e. literature control and method of sampling) throughout the research process (Ritchie et al. 2003; Babbie and Rubin 2011).

DISCUSSION OF FINDINGS

This discussion of the findings includes verbatim quotes of both inpatient parents and inpatient social workers on family reunification support available within substance abuse treatment centres.

Table of Themes

Theme	Subtheme
1. Support available	1.1 Formal Support
	1.2 Informal support
2. Kinship Care	

Themes:

Formal support:

According to the Department of Social Development (2005) formal support should consist of therapeutic sessions facilitated by professional staff, such as inpatient social workers, psychiatrist, medical staff and psychologist within inpatient treatment, as prescribed by the South African Norms and Standards for Inpatient Treatment. Formal support is available at Western Cape substance abuse treatment centre, as social workers stated

‘We will do sessions within a group session from a social point of view on relationships and parenting skills’ (SW:001).

‘So what we did which we never do, we took the child into the treatment centre to be with his mom and also to see how the mom would interact with her child and how we can work on the relationship between mother and child’ (SW:005)

‘I have a client now, who has 2 children in foster care. Each one with different foster mothers. She asked if I can find the foster mothers for her to make contact with the children. I asked external social worker to assist’ (SW:006)

Response from social workers indicate that they go beyond their core function, which is to provide psychoeducational therapy to address the individual's alcohol and drug abuse. By viewing the person within an Ecological System and being part of a family, social workers were able to adapt their programme to accommodate parents' needs, such as implementing parenting programmes to assist inpatient parents to connect with their children. Writers such as Burnhams et al. (2012), Balsells et al. (2016) and Manual et al. (2016) believe that psychosocial and physical assistance can aid inpatients to difficult life events that may cause them to relapse after they have completed their program. Simultaneously it can strengthen the capacity of families as there is lack of support for inpatient parents at substance abuse treatment centres (Lewandowski and Hill 2009, 2019; Balsells et al. 2016,1). Writers, such as Byrne, Howsare, and Lander (2013), Prinz and Neger (2015) and Barlow et al. (2018) confirm that parenting programs within substance abuse treatment centres improve relationships and sobriety outcomes post treatment. All the participants received support, which would help reunification with their children. Participants shared the following;

'I also learned to improve the relationship with your children and never had a relationship with my children. I have learned to communicate better' (IP:002).

'Yes, they provided information on how to be with your children and the activities that you can do, like playing games and to let them feel the fatherly love and care and also build a relationship with your children by asking them how their day was' (IP:001).

'What I learned here was to discipline my children and to have a better relationship with them' (IP:014).

By learning parenting skills, the inpatient parent will be able to take care of their children when treatment is completed, making the conditions for family reunification favourable. Family reunification is largely dependent on the inpatients ability to commit to the reunification process and the child's willingness to engage with the parent. Research states that parenting lays the foundation for attachment, cognitive stimulation and creates a conducive environment for parents and children to communicate effectively (Byrne, Howsare, and Lander 2013, 2; Gould and Ward 2015, 2). Two participants also shared that a commitment was made by their designated social worker, to provide aftercare and family support service post treatment. An inpatient parent indicated that;

'My social worker that referred me here and brought me to the treatment centres informed me that he will continue to provide counselling and family support once I have completed my programme. Social worker will be linking us with other families in our community that can act as a support system. This will include my wife and my children' (IP:001).

The aftercare services strengthen the family reunification, as they include activities such as family support service, linking the inpatient with community-based support services and support groups, in order to equip the family and inpatient with coping skills post treatment (Alpaslan and Van der Westhuizen 2013; Bhana and Groenewald 2018). Furthermore, while formal support assisted inpatient parents to rebuild the relationship with their children, literature confirms that informal support is needed during and post reunification within inpatient treatment centres (Lloyd 2015; Liddle et al. 2018; Barlow et al. 2019).

Informal support

Informal support is facilitated by non-professionals within substance abuse treatment centres and may include visitation or support from families, inpatient needed legal aid and linking the inpatient with support groups and employment (Lloyd 2015; Barringer et al., 2017). The results indicate that eight participants received support from their families through weekly visitation and telephonic contact sessions during treatment. Participants shared the following;

‘Yes, my child also came with my family to come visit me at the treatment centre. What was heartbreaking for me is when I had to ask my children for forgiveness. When you on drugs you don’t give a damn’ (IP:010).

‘Yes, my child also came with my family to come visit me at the treatment centre’ (IP:001)

‘I get visits from my mom and dad that support me, sometimes they bring my child along to come visit me’ (IP:006).

Responses indicate that inpatient parents have experienced visitation and regular contact from their children as positive. Writers such as Kiraly and Humphreys (2015), Andersson (2018), and Potgieter and Hoosain (2018), believe that in order for parents to reunify with their children they need to have regular contact in order for family reunification to take place. The involvement of families and children during family reunification, confirms that substance abuse treatment centres do not only focus on the individual alcohol and drug abuse, but view the family as a system that needs support (McCubbin 2016; Bhana and Groenewald 2018).

Furthermore, in order for family reunification to be successful within substance abuse treatment centres, requires well-coordinated services between social workers, families, children and inpatients.

Support groups are viewed as informal support within substance abuse treatment centres, such as Narcotics Anonymous (NA) and Alcohol Anonymous (AA). Research findings indicated that four inpatient parents are attending AA and NA within the substance abuse treatment centre. Participants shared that:

'Yes we do get attend NA/ AA meetings weekly and it helps me a lot to have that support' (IP:011).

'We have NA here coming to talk to us, its good to have it. It helps as we can relate with each other' (IP:013).

In addition, one participant shared that;

'It's not going to be easy to improve the relationship. I will be making use of NA and AA that will provide support to our family' (IP:006). The participant appears to be concerned about his relationship with his family. He indicated that the support will be needed once treatment is completed to aid family reunification. This confirms literature by Chatterjee, Jedwab, and Shaw (2017) and Deane et al. (2018), that family reunification process does require a significant amount of time in order for it to be successful.

Kinship Care

Kinship care refers to a permanent or provisional arrangement that is informal, in which a family member or non-family member has assumed the full-time care of a child whose parents are unable to do so (Halsa, Haugland, and Wigg 2017; Danzy and Jackson 2018). Fourteen participants placed their children in the care of their partners and maternal parents while receiving inpatient treatment. Six of the participants children were being cared for by the maternal grandmother. Participants shared that;

'My kids are with their mother and their grandparents in Lambarts Baai that is about 30km from where I live. My children receive financial support by my father-in-law mostly' (IP:002).

Another participant shared that her mother is the sole provider of her children; *'My mom is taking care of my children out of her own because I am here, and my children need to be taken care of by her' (IP:008).* Research by Taylor et al. (2016), Gordon et al. (2018) and Takahara et al. (2010), confirms that grandparents are finding it difficult to attend to the health, financial and trauma needs of children of inpatient parents.

Additional findings indicated that eight participants' children are taken care of by their spouse or partners while they are receiving inpatient treatment. One inpatient parent shared that;

'Two of my children live with my boyfriend and the youngest one live with my mother. My mother and boyfriend takes care of my children' (IP:014)

Despite having these potential benefits of providing residence to inpatient parent's children, maternal or paternal grandparents may need support, as they are providing for the inpatient parent's children. Literature illustrates that grandparents may find it difficult to take care of children's health concerns, finances and dealing with traumatized children (Solis et al. 2012; Klamman et al. 2017). Maternal

grandparents may need support as inpatient parents may relapse. That will place their children at risk. However, during focus group discussions, two social workers indicated that their substance abuse treatment centres provide accommodation to their inpatient family and children. One social worker shared that:

‘We took the child into the treatment centre to be with his mom and also to see how the mom would interact with her child and how we can work on the relationship between mother and child’ (SW:005).

By not separating the child from the parent may have benefits, that would include improved relationship with their children, parent learning new skills and parent being able to care for their children (Karam 2014, 2; Sauls and Esau 2015, 9; Makofane and Nhedzi 2015; Bosk, Van Alst, and Van Scoyoc 2017). This can be the corner stone to recovery for inpatient parents, as this could assist them to successfully reunify with their children post treatment. Empirical studies by Lander et al. (2013) and Prinz and Neger (2015), confirm that parenting intervention within substance abuse treatment centres have resulted in improved parenting, social skills and pro-social behaviour, and this may aid reunification of inpatient parents with their children. The results of the current study also contradict research by Sauls and Esau (2015), Darsamo (2016), Urban et al. (2016) Potgieter and Hoosain (2018), which indicates that children whose parents abuse alcohol are removed and placed into statutory care. None of the inpatient parents in this study’s children had been placed into statutory care, which makes the process of reunification easier, as there are no court procedures, but it may place children at risk if parents’ relapse.

CONCLUSION

The research findings suggest that social workers, within Western Cape substance abuse treatment centres, are providing formal and informal support to inpatient parents to assist with family reunification. The results of the study indicated support for family reunification to inpatient parents are parenting programmes that are being facilitated by social workers. In addition, substance abuse treatment centres can provide accommodation to family and children, and inpatient parents receive regular visitation from their children and families, that support family reunification. Research findings indicate that parents want to improve their relationship with their children. However, findings suggest that support is limited to children and families while the inpatient parents are receiving informal and formal support within inpatient treatment. Family reunification, in some instances, may not be always possible, as the best interest of the child always need to be taken into consideration during and post reunification. On a micro level, inpatient parents have wanted to be reunified with their children and take up their caregiving responsibilities. Although receiving support

within inpatient treatment, an inpatient parent is concerned that their children and families are not provided with psychosocial support. On meso level, inpatient parents and social workers need to assess informal and formal support systems while the inpatient parent is still in treatment. Inpatients parents need support, as aftercare planning do not prioritize family reunification services. Substance abuse treatment centres are the ideal place for social workers and inpatient parents to access their community-based resources and identify support service that will aid reunification services. In addition, it has also been established that grandparents are providing care to children, while parents are receiving inpatient treatment, and they may need support (Klaman et al. 2017).

RECOMMENDATIONS

The following recommendation could aid inpatient parents with after care planning and family reunification within substance abuse treatment:

- A reunification plan to be drafted with inpatient parents and social workers identifying community-based formal and informal support services.
- Referral social workers and inpatient social workers to map community-based support services for inpatient parents and develop a database.
- Social workers to compile a family developmental plan that will form part of the inpatient parent family reunification and aftercare plan.

Lastly, it is recommended that policy documents within the field of substance abuse, include an emphasis on providing family reunification support services within substance abuse treatment centres, along with structured parenting programmes. In doing so, parents will be empowered and equipped with skills that will assist them to rebuild the relationship with their children. This may prevent further disintegration of families during reunification.

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ARTICLE 2

GUIDELINES FOR FAMILY REUNIFICATION IN WESTERN CAPE SUBSTANCE ABUSE TREATMENT CENTRES WITH INPATIENT PARENTS

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5. Jones X: Zeolites and synthetic mechanisms. In *Proceedings of the First National Conference on Porous Sieves: 27-30 June 1996; Baltimore*. Edited by Smith Y. Stoneham: Butterworth-Heinemann; 1996:16-27.

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6. Schnepf E: From prey via endosymbiont to plastids: comparative studies in dinoflagellates. In *Origins of Plastids. Volume 2*. 2nd edition. Edited by Lewin RA. New York: Chapman and Hall; 1993:53-76.

Whole issue of journal

7. Ponder B, Johnston S, Chodosh L (Eds): Innovative oncology. In *Breast Cancer Res* 1998, 10:1-72.

Whole conference proceedings

8. Smith Y (Ed): *Proceedings of the First National Conference on Porous Sieves: 27-30 June 1996; Baltimore*. Stoneham: Butterworth-Heinemann; 1996.

Complete book

9. Margulis L: *Origin of Eukaryotic Cells*. New Haven: Yale University Press; 1970.

Monograph or book in a series

10. Hunninghake GW, Gadek JE: The alveolar macrophage. In *Cultured Human Cells and Tissues*. Edited by Harris TJR. New York: Academic Press; 1995:54-56. [Stoner G (Series Editor): *Methods and Perspectives in Cell Biology*, vol 1.] APPENDIX B E&OE March 2012 7

Book with institutional author

11. Advisory Committee on Genetic Modification: *Annual Report*. London; 1999.

PhD thesis

12. Kohavi R: Wrappers for performance enhancement and oblivious decision graphs. *PhD thesis*. Stanford University, Computer Science Department; 1995.

Link / URL

13. Mouse Tumor Biology Database [http://tumor.informatics.jax.org/cancer_links.html]

Dataset with persistent identifier

Zheng, L-Y; Guo, X-S; He, B; Sun, L-J; Peng, Y; Dong, S-S; Liu, T-F; Jiang, S; Ramachandran, S; Liu, C-M; Jing, H-C (2011): Genome data from sweet and grain sorghum (*Sorghum bicolor*). *GigaScience*. <http://dx.doi.org/10.5524/100012>.

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Table preparation

General

Tables should be sequentially referenced in the text. Each table should be numbered in sequence using Arabic numerals (i.e. Table 1, 2, 3 etc.). Tables should have a title that summarizes the whole table, maximum 15 words. Detailed legends may then follow, but should be concise.

Formatting

Small tables [less than one side of A4 (210mm x 297mm)] that are integral to the manuscript should be pasted into the end of the document text file in portrait form, and will be displayed in the final published form of the article. Tables may be subdivided into labelled parts, but each table should form a single unit. Such tables should be formatted using the ‘Table object’ in a word processing program to ensure that columns of data are kept aligned – do not use tabs to separate the columns. The title and legend should not be inside table cells, but appear outside the table.

Tables should not include shading or colour as this won’t be reproduced in the online version. Tables should not include vertical rules, and horizontal rules should only be used within the body of the table if essential for clarity (horizontal rules under main headings/subheadings and at the end of the table should be included). Full stops rather than commas should be used to indicate decimal points.

Larger tables should be submitted separately as additional files. Additional files will not be displayed in the final, published form of the article, but a link will be provided to the files as supplied by the author.

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GUIDELINES FOR FAMILY REUNIFICATION IN WESTERN CAPE SUBSTANCE ABUSE TREATMENT CENTRES WITH INPATIENT PARENTS

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Abstract

Objectives: To provide guidelines for family reunification within substance abuse treatment centers through focus groups discussions with social workers and semi-structured interviews with inpatient parents.

Methods: Thirteen social workers and 15 inpatient parents from Western Cape substance abuse treatment centers have participated in semi-structured interviews and qualitative focus group discussions. Thematic analysis was conducted, and an independent co-coder developed the themes.

Results: Participants suggested the following 1) Family reunification guidelines for social workers, 2) Guidelines for family participation to improve family reunification, 3) Communication between inpatient social worker and designated social workers and 4) Barriers towards providing family reunification support to inpatient parents.

Conclusion: Despite highlighting multiple challenges, social workers proposed: family reunification plans, pre-admission criteria and communication guidelines for the designated social worker. In addition, providing accommodation for inpatient parents and their children, and needing additional funding to create a conducive environment for family reunification within inpatient treatment. Inpatient parents recommended that substance abuse treatment centers should include children and families within treatment.

Key words: Inpatient treatment, aftercare, family reunification, inpatient parents, inpatient social workers

Introduction

Recent international trends in the substance abuse field indicates that substance abuse treatment centers are increasingly accommodating children of the parents who abuse alcohol and drugs, particularly the mothers [1-3]. Results from literature also indicated that accommodating children of patients at treatment centers improved sobriety outcomes post-treatment and improved relationships with their children. The parents were able to provide care for their children while receiving inpatient treatment. Further studies have shown that providing residency to the children of inpatient parents is effective, as parents are sober and committed to the treatment program [4-5]. The International Minimum Norms and Standards for inpatient treatment were developed in 2017 and it was a third edition [6], while South Africa's Norms and Standards were developed in 2005 [7]. These are policies, which prescribes standards of services and programs for inpatient treatment. Furthermore, the acknowledgments within South Africa's Norms and Standards indicated that the document was developed within six months to be presented and approved by the Cabinet [7]. In addition, it appears it was not widely consulted and piloted within South Africa within the field of substance abuse and within substance abuse treatment centers. The ramification of this has resulted in unequal access to treatment services, [8] lack of sustainability of substance abuse treatment centers [9] and passable performance monitoring systems within substance abuse treatment centers [10]. In South-Africa, accommodating children of patients at substance abuse treatment centers, is not usual practice and due to a lack of resources, substance abuse treatment centers may not be able to accommodate children with their parents in the foreseeable future. Family reunification services may, therefore, always be required at substance abuse inpatient treatment centers, to ensure the successful transition of inpatient parents back home with their children after treatment has been completed.

Inpatient Treatment

Inpatient treatment in South Africa can be described as residential treatment services aimed at promoting the quality of life of the individual who is abusing alcohol and drugs [7, 11-12]. The service also includes the patient family system, such as husband wife, children and other family members, with the help of a multi-disciplinary team. The multidisciplinary team usually consists of social workers, psychologists, doctors, psychiatric nurses and occupational therapists [12]. Literature confirms that the Motivational Interviewing, 12 Step Program, Cognitive Behavior Therapy are well-known substance abuse treatment models in South Africa and Western Cape [12-14]. Substance abuse treatment programs in South Africa and Western Cape is based on a medical model, with a focus on the individual and their substance abuse [12, 15-17].

Assessments usually happens within the first week and it is an ongoing process. Once satisfied with the outcome, the social worker and inpatient will decide on the treatment goals. This is done through the development of an Individual Development Plan, that is goal-directed. Inpatient treatment in South Africa is between three- six months [7], and, closer to the release date, an aftercare plan is drafted between inpatient and social worker. This would mean for patients who are parents being absent from their children for up to six months while they undergo treatment.

Aftercare

In literature, the term aftercare and discharge planning are used interchangeably, referring to a structured treatment plan, preparing the patient for life after treatment [18-19]. It includes services such as engaging with self-help groups, family support and meaningful activities that can help build peer networks. Furthermore, the Minimum Norms and Standards for Inpatient Treatment (2005) in South Africa provides a guide for social service professionals to develop an aftercare plan for inpatients. Treatment duration in South Africa is from three weeks to six months, and it's between this time period an aftercare plan is developed for the inpatient with the social workers [7]. Literature on aftercare, however, indicates that the inpatient receives limited aftercare support from the

designated social worker and that there is a lack of family support, support groups, which may contribute to relapse [18, 20-21]. International literature also confirms that there is a lack of focus on family reunification services for inpatient parents within the discharge planning [23-26]

Family Reunification Guidelines

Policies that guide family reunification in South Africa, is the Children's Act (38 of 2005) and South African Child Welfare Manual (2013). The Child Welfare Manual outlines steps for the designated social worker, to provide family reunification for children that have been removed from the care of the biological parents. Empirical literature on the Child Welfare Manual (2013) outlines steps for family reunification that includes; 1) designated social worker assessing regularly the progress of the parents by having regular contact with them, 2) a written agreement between the parent, child and designated social worker to outline their responsibility, 3) designated social worker to prepare the biological parent for reunification through family therapy and 4) the designated social worker to prepare the child to go home and return to their biological parents [27]. This study was conducted at the Child Youth Care Facilities with an emphasis on children needing reunification services and not parents who are undergoing substance abuse treatment. In addition, the aim of the Guidelines on Reunification Service for Families (2012) is to reunify adults who were separated from their families, owing to mental health issues, incarceration, and alcohol and drug abuse [28]. The Guidelines on Reunification Services for Families (2012) are an additional policy framework, which provides a standardized framework on how family reunification services within the substance abuse field should be facilitated in South Africa. It requires social workers to firstly do screening and family assessments, which are then followed up with a family developmental and reunification plan. This process requires social workers, inpatient parents, family members and children to provide input on the reunification plan and sign an agreement. Family reunification is a complex process [25,29] and it becomes even more complex when it involves vulnerable children, who may be at risk when their parents have to undergo inpatient treatment for substance abuse. However, little is known about how the South African Guidelines for Reunification services are implemented. Moreover, there is limited

empirical research on guidelines for family reunification services at substance abuse treatment centers. Anecdotal evidence suggests that social workers at substance abuse treatment centers may not be aware of the South African Guidelines on Reunification services (2012) and view family reunification as a separate process to aftercare or discharge planning at substance abuse treatment centers. Despite the lack of literature on family reunification at substance abuse treatment centers, writers such as Makofane and Nhedzi 2015, Sauls and Esau, 2015, Potgieter and Hoosain 2018, confirm that family reunification is challenged by the lack of commitment of parents during and post family reunification, social workers not being equipped and well-resourced to provide family reunification services. The existing literature also suggests that family reunification is a multifaceted process that requires a plan, which should include an inpatient parent, social workers, children and families [12-25]. The paper, therefore, attempts to address the gap in literature on guidelines for reunification at substance abuse treatment centers.

By exploring guidelines for family reunification, social workers may be better equipped to not only provide family reunification services for inpatients at substance abuse treatment centers, but also manage the risk of placing vulnerable children back with a parent who may relapse in the future. The South African White Paper on Families (2012) advocates for family to be preserved through the process of family reunification. The White Paper on Families (2012) is based on the family systems theory, that believes that families function as a system, and that when an individual experience a crisis, it affects the entire system [30-31]. In addition, the study was guided by Bronfenbrenner Ecological Systems Theory (EST), as a significant amount of literature on family reunification used it as a theoretical framework [32-33]. The Ecological Systems theory is considered appropriate for this study, as it can assist in providing family reunification guidelines for social works in substance abuse treatment centers that provide services to inpatient parents, by promoting a responsive environment in which parents can be supported and empowered through family reunification services.

Social workers are mandated to provide family reunification services according to the Children Act and Guidelines on Reunification Services to Families (2012). Although there is a significant amount

of literature in the Child Welfare sector, there is limited literature available in South Africa and the Western Cape on reunification guidelines within substance abuse treatment centers. Literature available in South Africa in the field of substance abuse focuses on the pathology of substance abuse on families and individuals [34-36]. To fill the gap, we conducted a qualitative study, exploring family reunification support at Western Cape substance abuse treatment centers. Reunification guidelines may assist social workers to provide family preservation services within substance abuse treatment centers. Benefits of implementing the reunification guidelines may contribute to an improved relationship between inpatient parent and children, better treatment outcomes and learning parenting skills. The main research question which the study therefore attempted to answer was “What family reunification support is available in the Western Cape substance abuse treatment centers?” The aim of the study was therefore to explore and describe family reunification support available at substance abuse treatment centers and the objective was to explore guidelines for family reunification at substance abuse treatment centers. The focus of this paper is the objective of the study exploring guidelines for family reunification at the Western Cape substance abuse treatment centers. The researcher made use of a qualitative descriptive research methodology.

Methods

The study was a qualitative research approach, as the researcher wanted to gather a deeper understanding of social workers and inpatient experiences within substance abuse treatment centers. The qualitative approach assisted the researchers to determine whether the goal was to obtain thorough in-depth understanding of inpatient parents’ experience of family reunification and family reunification support, provided by social workers within substance abuse treatment centers. A qualitative approach provides valuable narratives, as it assigns meaning on how people interpret the world. In addition, a qualitative descriptive research design was used to explore and recommend guidelines for social workers and inpatient parents in substance abuse treatment centers.

Recruitment procedures

There were 28 participants recruited, 13 social workers and 15 inpatient parents from five substance abuse treatment centers in the Western Cape. One substance abuse treatment center was a government-funded facility and the other four treatment centers were partially funded by the government and registered as a Non-Profit Organization (NPO). The inclusion criteria for social workers were as follows: 1) social workers to be registered at the South African Council for Social Service Professions (SACSSP) working at treatment centers, 2) male or female social workers and 3) a minimum of 6-months work experience within inpatient treatment centers. Inclusion criteria for inpatient parents were: 1) Inpatients who have children between 0-5 years of age and who have been separated from their children owing to their substance abuse and receiving inpatient treatment and 2) Inpatient parents must have been at a treatment center for a minimum of three weeks.

Authorization of the study

The study was approved by the North West University's ethics committee in order for the study to commence with ethics number **NWU-00078-18-S1** being allocated. Legal authorization was received from the Western Cape Department of Social Development Research and Population unit to recruit social workers and inpatient parents, as this is a government substance abuse treatment Centre. Goodwill permission was received from the Board of Directors and Management from the four partially funded substance abuse treatment centers with NPO registration.

Sample Characteristics

Inpatient parents

The age of inpatient parents that were selected, range from the youngest (20 years) to 38 years as the oldest. They consisted of eight males and six females, while 21% of participants indicated that they were married and 79% indicated that they are in a relationship. Inpatient parents are separated from their children while receiving inpatient treatment. Participants indicated that their children are currently staying with their maternal grandparents (43%), while 57% indicated that their children are

currently being cared for by their significant other. Children ages ranged from 1 to be the youngest and 16 years to be the eldest.. The parents who were recruited not only had children between 0-5 years of age but had children as old as 16 years as well.

Social Workers

The social workers that were recruited, consisted of two males and eleven females. The average age for social workers ranged between 51-60 (47%), 41-50 (7%), 31-40 (23%) and 21-30 (23%) years of age. Looking at the years of experience amongst participants, 38% reported having on average between 2-5 years, while 7% each between 9-10 and 11-15 years and 30% had 15 years and more experience working with inpatient treatment. Social work participants had completed their bachelor's degree in social work at tertiary institutions. However, only 53% of participants have completed a postgraduate degree in the field of substance abuse at a tertiary institution. Given the explorative nature of this study, the researcher chose to conduct focus groups with social workers and semi-structured interviews with inpatient parents.

Data Collection

Focus Groups with social workers

The researcher has conducted three focus groups with a total of 13 social workers through semi-structured interviews. Pseudonyms were allocated to social workers to protect their identity. Focus groups are a useful method of data collection, which assisted the researcher in gaining a better understanding of the topic of interest. Data were collected through interaction between social works. As the discussion progressed their responses became more sharpened and refined. The focus group was audio recorded with the consent of the social workers. Focus group discussion was facilitated by the researcher and scheduled between 110 and 160 minutes with social workers. The researcher allowed time for social workers to debrief post focus group discussion.

Semi-Structured interviews with inpatient parents

A semi-structured interview was conducted with 15 inpatient parents. Data was collected by the researcher and a field worker. The field worker, who is a social worker, interviewed female inpatient parents in order to avoid any discomfort from being interviewed by the male researcher. The researcher made use of a collage, in addition to the semi-structured interview schedule. A collage is a visual data collection method used to gain insight into factors underlying human behavior. The collage also provided visual prompts that freed the participants thinking and helping them to conceptualize their ideas. Participants were requested to paste pictures on an A3-paper that would represent their experiences of family reunification support received within substance abuse treatment centers. Participants were allocated codes e.g. 001 or 003, in order to identify them and protect their identity. Interviews with inpatient parents lasted between 60 and 90 minutes. In addition, participants gave consent to be audio recorded.

Data collected from inpatient parents and social workers were analyzed using a thematic approach.

Qualitative Analysis

The thematic approach by Braun and Clarke (2013) will be used to analyze focus group discussions of social workers and semi-structured interviews with inpatient parents. It is a method used for identifying, analyzing and reporting patterns (themes) within data. The following steps were used by the researcher, based on the guidelines provided by Braun and Clarke (2013):

1. The researcher appointed an assistant that transcribed the data. A confidentiality agreement was signed by the assistant. Transcriptions were organized into files and text units that were more explicable. Organizing the data, provided the researcher with a glimpse of the information gathered from the focus groups and semi-structured interviews. The data was then studied by the researcher by reading data collected and compiling lists of important themes. The researcher ensured that all audio recordings were protected by placing a password on the digital device.

2. Data collected, was organized by the researcher into meaningful groups, once a list of ideas has been drawn up.
3. Codes were identified, and the researcher had analyzed and organized codes into themes. The researcher made use of visual representation by developing a table of contents to render the process of selection of candidates and sub-themes clearer. The researcher then restructured and analyzed the candidate themes, until the main candidate themes are clear to the researcher.
4. A final report was then written by the researcher, whereby the data was presented in an analytic narrative by displaying the results found in a brief manner through the representation of the themes found.

In addition, the researcher ensured the trustworthiness of the study by having the data transcribed with the assistance of an independent transcriber who signed a confidentiality agreement. A co-coder, who signed a confidentiality agreement, was appointed and was responsible for highlighting themes in a summarized version. Dependability was ensured by conducting the research step-by-step, according to the research process. This was done by describing what was planned by the researcher through the research design, how the implementation was executed and a detailed description of the data gathering process was provided. To ensure confirmability, the researcher has conducted a literature study after the completion of focus group discussions with social workers. This was done to avoid any bias from the researcher, in order for the literature study to guide the study. Furthermore, the researcher has ensured transferability as detailed description was provided regarding the research process and the methodology. This was to ensure that research is to be conducted in a similar study. Three main key themes were identified to which recommendations were made for reunification guidelines. The following section presents the results of the study with inpatient parents and social workers.

Results

Table 1 contains a list of themes and sub-themes that has emerged through analyzing the data of both inpatient parents and inpatient social workers. Results are described below and take the form of themes.

Table of Themes

Table 1

Theme	Subtheme
1. Guidelines for Family reunification	1.1 Improved Reunification
2. Guidelines for social workers	2.1 Designated social worker
3. Guidelines for Family Participation.	3.1 Barriers

Guidelines for Family Reunification

Inpatient social workers and inpatient parents' participants provided valuable information, which may improve family reunification within inpatient treatment.

Improved Reunification

In order to improve the existing processes of family reunification at inpatient substance abuse treatment centers, eight social workers stated that structural changes were to be made to substance abuse treatment centers. They made these recommendations as they felt that children of the inpatient parent should be accommodated at the treatment center. Participants shared the following;

“I would think to make more accommodation so that if a mom has a child whether it be mother or father, to be admitted with the child. So that you don’t separate the child from the parent while you are treating the parent” (SW:004).

“If we had the money, I would build a school on the property so that the mothers can start interacting on a normal basis with the kids while they are in treatment. So that the mother can start learning that she is able to care for the child. I would think to make more accommodation so that if a mom has a child whether it be mother or father, to be admitted with the child. So that you don’t separate the child from the parent while you are treating the parent” (SW001).

“At our offices we have lots of space, I mentioned that why don’t we make use of the space and build a kitchen. We need to create more happy times for the family. So, when they come they can start practicing being a family again by start cooking a meal together. I think that will start the process or assist the process of reunification” (SW:13).

The participants provided an indication that substance abuse treatment centers may not be a family or child friendly environments. These results suggest that substance abuse treatment centers may not be structurally designed to accommodate families, but rather individuals. Empirical literature on inpatient treatment centers providing accommodation for children of inpatient parents, has shown improved relationships and sobriety outcomes [4-5].

In addition, six participants shared the need for a Halfway House that could be an option should family reunification not be possible. Halfway Houses could provide additional support towards family reunification of inpatient parents, once inpatient treatment has been completed. The Halfway House may provide temporary accommodation and equip inpatients with skills to deal with their sobriety [48]. A Halfway House is usually a residence where patients go after they completed their inpatient treatment. Participants shared their ideas:

“The first step is to get the person back in to the community where he comes from. The second step to go for the halfway house only for those who don’t have any other option. A halfway house then

also gives the opportunity to learn some other skills, basic maintenance skills that you need around your house” (SW:002).

“When you go to the halfway house it would be slightly less wild, not as safe as being in treatment but as long as we are bridging the bridge between in this facility and the wild west. Sometimes I feel that this person just needs that little more coaching before she goes out and attempt it, especially for those with the low self- esteem and I think with the females that is a major issue” (SW:003).

“I think the halfway house will be part of our ideal world) because that is something that I often miss, sometimes I would share with them, this person needs more guidance and I know sending her out to my colleague in the field she is not going to get to it, maybe once a month” (SW:006).

Recommendations from participants suggest that additional support for inpatients is required by referring clients to Halfway Houses. Writers such as Mutua (2017) and Proudfoot (2019) approve that Halfway Houses are a drug- and alcohol-free environment, that provides psychosocial support services, and the living situation provides a natural support network. While family reunification is ideal and encouraged through policies, it may not always be in the best interests of the child. Literature confirms that family reunification is not always possible [26-27]. One inpatient shared that: *“My ex-girlfriend does not want me to be a father for my child. Her family do not want me at their home, because of my drug use. It will be difficult” (IP:004).*

Writers such as Matzopoulos et al. (2014) and Cazpla et al. (2016) have illustrated that parental substance abuse often result in impaired family functioning, that is characterized by domestic violence, parents neglecting to care for their children and mistrust within the family. While family reunification may be difficult for some inpatient parents, as described by the participant, inpatient parents can potentially be referred to Halfway Houses in a situation whereby family reunification is not possible or additional support is needed. Unfortunately, there are only four registered Halfway Houses in the Western Cape.

Empirical literature indicates that successful family reunification requires the involvement of family members and children [3,56]. Responses from the social work participants reveal that family reunification is not being prioritized within substance abuse treatment centers. They do, however, need to involve family in the planning process, as substance abuse cannot be treated in isolation [2,26]. To formalize the process of family involvement, participants suggest that there is a need for a family reunification plan. Participants shared the following:

“There is a need for family reunification plan as well that will help the service user to connect with the family” (SW:011).

“A family reunification plan needs to be drawn up, as family reunification is the last focus. Often the referral social worker needs to change their focus to the family as this is not really my priority, my priority is the inpatient addiction” (SW:013).

Recommendations made by participants are aligned with the Guidelines on Reunification Services for Families (2012), that advocates for children and family members, with the assistances of social services professionals to develop a family reunification plan. Writers such as Parry et al. (2017) and Carelse (2018) confirmed that an aftercare plan needs to be developed with the inpatient by the social worker at the treatment center. This would mean, in addition to the aftercare plan, a family reunification plan needs to be developed within inpatient treatment [28].

Guidelines for social workers

Responses of social workers suggest that social workers should change their views on reunification policy and legislation, in order to prioritize family reunification of inpatient parents during and post treatment. This may result in inpatient social workers and substance abuse treatment centers to review their current inpatient treatment program, that is guided by the Minimum Norms and Standards for Inpatient Treatment (2005).

“It is important firstly for social workers to have a paradigm shift to apply family reunification. So, at a policy level and governance things needs to change we need to involve National and Provincial departments and have that discussion because finances is aligned to policies” (SW:012).

“There is a need for more family organization and not child protection, because everything is about child protection. Everybody don’t see family they see child protection and we see substance abuse. We need more family organization to assist with family reunification” (SW:013).

The comment of the participant indicates that the focus is on child protection, with minimal support on family. According to the South African Minimum Norms and Standards for Inpatient Treatment (2005), a psychosocial assessment and medical certificate are needed for a patient to be admitted, which excludes the family. Pre-admission criteria refer to the screening of family members and inpatients prior to admission for inpatient treatment. This would mean that the voices of the children and family of the inpatient parent are not being heard, which may impact on family reunification. The majority of the social work participants indicated that there are pre-admission criteria for inpatient parents.

“We would like to have a pre-admissions process, we would like the family to be involved in programs, but they are not realities because the family at home will still sit with all their caution and distrust. There hasn’t been anything for them while whoever was in. So that is an ideal world for me” (SW:003).

“Some social workers will say they already have a pre-program before they come to us. I think it’s a good thing to have” (SW:002).

Despite the Guidelines on Reunification Services for Families (2012), which mandates inpatient social workers to facilitate the process of family reunification at substance inpatient treatment centers, social work participants all agreed that family reunification is the responsibility of the designated social worker.

Designated Social Worker

The results suggest that the roles and the responsibilities of the social workers involved in family reunification may need to be clarified. The findings also give an indication that family reunification may not be a priority at substance abuse treatment centers, as indicated by the participants. Participants shared the following:

“The designated social worker need to develop a developmental plan with the child, within the treatment center I am only responsible to develop a discharge plan on the parent and what they need to do and how the social worker can assist him” (SW:008).

“What I am hearing is that a family reunification plan needs to be drawn up, as family reunification is the last focus. Often the referral social worker needs to change their focus to the family as this is not really my priority, my priority is the inpatient addiction. Family reunification is very low on the priority list” (SW:013).

“I think that can also be a challenge sometimes, it is ideal if you do have external social workers that are able to provide the family reunification service, and again like you said their caseload is quite high” (SW:005).

The comments by the social work participants reveal the confusion regarding their role in family reunification within inpatient treatment. The inpatient social work participants were frustrated with the limited commitment and response from the designated social workers, as important information needs to be shared with them with regard to the inpatient progress.

Guidelines for Family Participation

The participation of all family members is essential for the reunification process. In addition, literature indicates that family plays an important role in the recovery of the inpatient parents, as they provide emotional, material and physical support [44-45]. Currently, family members have minimal involvement in the treatment program of the inpatient parents. Inpatients stated the following:

“No social worker or any staff talked about reunification with my children” (IP:009).

“I would love it if there is some way where programs can incorporate the spouse or the girlfriend or the mother of your kids also getting help because you ruined, not ruined maybe as such but you had a huge negative impact on their lives because I can’t see any positives coming from me being in rehab” (IP:008).

‘No there were no program for the children it was just me and my kids chatting’ (IP:001). The quotes by participants indicate that support is only limited to the inpatient parent, with limited involvement of children and families. From an Ecological Systems Theory (EST), on a micro level, the social worker should involve the children and family during family reunification. Substance abuse cannot be dealt with in isolation [33,47,57]. The findings confirm research by Bhana and Groenwald (2018), Carelse (2018), and Kalam and Mthembu (2018), that families may not receive enough support at substance abuse treatment centers. Six social work participants indicated the need for a planning session, which includes family members. Inpatient social work participants shared the following:

“What we can do is have them all together from the start and discuss what going to happen within treatment and that helps” (SW:009).

“Starting to build a relationship there already instead of when they go out and have to wait for the after-care facilities to start, maybe sometimes it’s delayed or maybe it does not happen. To have the kids and the parents to interacting here where we can work with them and to see how we can facilitate reunification” (SW:006).

Responses from inpatient social workers indicates that there is lack of preparation and planning of children and families within inpatient treatment. Recommendations from inpatient social workers are aligned with the Guidelines on Reunification Services for Families (2012) and Minimum Norms and Standards for Inpatient Treatment (2005) that require children and families to be involved during the family reunification process within the inpatient treatment family.

To involve families and children in the inpatient treatment program, may require inpatient social workers to shift their focus away from the inpatient parent alcohol and drug abuse, to a more family orientated focus, as one participant explained: *“We involve the family from the first day, so they are aware of where we at. Sometimes we do weekly updates, sometimes we do family meetings, so the family is on par. Because remember the family has been damaged as well by the behavior of the client, if the need be, you refer those children to the children services, either support or counselling”* (SW:004). The comment by the participant illustrates that it is possible for families to be involved in substance abuse inpatient treatment from the start, which would help the reunification process, because reunification requires inclusion and participation of all members of the family, including children. Importantly, the family must address the damage that parental substance abuse has caused, as well as the risk to the children [34-36] Therefore, family reunification for inpatient parents requires the commitment of not only the family, but all professionals, particularly social workers at substance abuse treatment centres and the designated social workers. Social work participants agreed that involving the children and families can assist the inpatient parent with family reunification. However barriers, which hampered the reunification process, emerged from the data.

Barriers

The results revealed that transportation costs prevented families from access to services at inpatient treatment centers. Communication among the social workers and then between the social workers and family were also barriers which hindered the process of reunification at substance abuse treatment centers. Twelve of the social work participants experienced communication challenges with the designated social workers:

“It would be good if there was some kind of responsiveness or maybe some interest on their part because I find it very seldom that whoever has done the referral would actually call and ask how the client is and when will we have the family session. Some of them do it but very seldom ” (SW:003).

“One of our challenges is we try to communicate more often with them via telephone or email, sometimes we really struggle” (SW:001).

As the majority of inpatient social workers experienced communication challenges, they agreed that there is a need to improve communication with the designated social worker. Improved communication between inpatient social workers and designated social workers, may improve family reunification, as the family and inpatient parent would be better supported [1,5,25]. Social work participants suggested the following:

“I actually quite liked your idea of the weekly contact with the externals whether they reply or not I supposed is their business. I think ultimately it could benefit the client in terms of the continuing of care and sustainability” (SW:009).

“We need to keep regular contact with the external social worker, it’s important to the social worker now on how the client has progress, feedback should go to the social worker and families” (SW:007).

Response from inpatient social work participants suggested that there should be guidelines on regular feedback on the client’s progress. Regular feedback on the client progress to the designated social worker, family and children could be beneficial. Empirical literature supports that regular contact during family reunification may improve the relationship between biological parent and child [23-24]

Response from the family and children may give an indication whether family reunification is possible after treatment. This will assist the inpatient social worker to better plan family reunification with the inpatient parent, family, children and designated social worker. A social work participant also expressed difficulty in communicating with both the designated social worker and families;

“There should be shared planning between internal and external social worker. We do not get full detail on the inpatients from the external social worker. So, the biggest thing is to get the information from both the family and external social family” (SW:013). However, other participants explained that families often do not have the money for transportation to substance abuse treatment centers, which are often located in isolated areas away from communities where the inpatients live.

“Families seldom have finances to get to the treatment center for family sessions. In the past we used to arrange with work transport to fetch the family at nearest train station, but now families cannot afford it” (SW:011).

“Our treatment center is not accessible via public transportation, which makes it difficult for families to attend family session and visit clients” (SW:010).

“In general, they [inpatient] struggle to get in contact with them and that stresses them out, so we try to work on that” (SW:005).

Comments from the participants suggest that lack of visitation and not attending family therapy sessions impacts on the inpatient progress. Substance abuse treatment centers in the Western Cape may not have the necessary resources to provide families with support. Therefore, participants have recommended the following that will aid children and families to be more involved in the inpatient treatment program. *“Having milestone events of recovery for those who stay sober. We have once a year having all those who completed the program and we invite them with their family, So we make arrangement for the family and children, So if we had money we could exactly do more and I recommend this to involve them more” (SW:008).*

Social work participants have stated that having family programs can be costly and that the treatment centers do not always have enough funding. One inpatient social worker shared that: *“We wanted to make our treatment centers more children friendly and it was good, but we do not always have the finance” (SW:008).* Lack of funding can be an additional barrier for substance abuse treatment centers to provide family reunification services to inpatient parents. The comments by the participants illustrate how communication and resources are important to ensure that families are included in the process of not only inpatient treatment, but also for family reunification. The barriers highlighted by social worker participants may delay family reunification if they are not addressed.

Discussion

To our knowledge, this is the first study to explore family reunification support and guidelines for reunification within Western Cape substance abuse treatment centers. The study was guided by Bronfenbrenner Ecological Systems Theory (EST). A few major themes emerged from our study, which may contribute towards developing future guidelines.

To improve family reunification within substance abuse treatment centers, social workers have proposed structural changes to their treatment centers. The majority of participants thought that accommodation for the inpatient parents' children and families needed to be provided within inpatient treatment. The social workers believed that this will allow families to stay together, and parents to still care for their children while receiving inpatient treatment. Empirical literature maintains families need to stay together, as they are the primary source of attachment, nurturing and socialization [29, 30]. There is international empirical literature that agrees that, providing residency to children of inpatient parents, result in improved relationship and sobriety outcomes [4-5]. This may require awareness raising on an exosystem level, in order to influence policy and legislation to avail the necessary funding for structural changes to the treatment center. In this case, the exosystem refers to the policy makers and implementers of the Guidelines on Reunification Services for Families (2012) and Children's Act (38 of 2005). However, the inpatient social workers appeared to be eager that treatment centers provide accommodation to children of inpatient parents. As a result, future research should explore substance abuse treatment centers providing residency to children and parents within inpatient treatment.

In addition, social work participants have proposed that Halfway Houses could be an alternative for inpatient parents, should family reunification not be possible after completing their inpatient treatment program. Participants shared that inpatient parents may not be ready to go back to their children and families as they may relapse. Writers such as Leon (2015) and Komasi et al. (2017) view addiction as relapse disease, and reunification may not be possible as literature support that a parent

abusing alcohol and drugs are often characterized by child neglect, showing lack of warmth and emotional response to children and domestic violence [1,5,35]. As a result, the inpatient parent may not be accepted back home. One participant indicated that they will not be allowed to see their children, as the family is concerned that relapse may occur. The child may be at risk, therefore, in the best interest of the child, family reunification cannot take place. Empirical literature approves that individual abusing alcohol and drugs are often isolated and stigmatized by family members [2]. Therefore, a Halfway House may provide therapeutic services to inpatient parents to provide them with the necessary skills to reintegrate into society, and better support and care for themselves [53-54]. A Halfway House may also be ideal to render reunification services by focusing on the parenting skills and encourage regular contact with children and encourage the parent to take small steps to become more stable and more responsible. This can all be managed well, because the children are not at risk, given that reunification has not taken place. A halfway house can also provide stability to the parent. Internationally, Halfway Houses are well researched within the field of substance abuse, but not in South Africa [48-49]. We have established that within the Western Cape, four Halfway Houses are registered with the Department of Social Development.

Social work participants suggested a change in policy to create a suitable environment that encourage family reunification for inpatient parents. Therefore, it may be necessary to create an awareness on an exosystem level, to inform policy implementers and funders on the importance of family reunification. The lack of funding and focus on policy could contribute to failed reunification, relapse of inpatient parent and placing the children at risk [26,38]. By creating awareness amongst policy developers and implementers, may mandate social workers to provide and policy implementers to avail funds for family reunification services. Future research should include the practical implementation of family reunification that is guided by the Guidelines on Reunification Services for Families (2012) and Children Act (38 of 2005).

In addition, a pre-admission criterion has been recommended as a guideline to encourage family involvement. Participants shared that families are often excluded in the program, and the family do

not always trust the inpatient parent. This confirms empirical literature, stating that family receives minimal support within inpatient treatment with aftercare planning [41]. Inpatient social workers involving the families during pre-admission, suggest that they view the individual within a family system and not in isolation [28,30]. Therefore, inpatient social workers are viewing family reunification on a meso level, whereby they are taking into consideration the life space of the inpatient parent and factors influencing their lives [33]. As the pre-admission appears not to be common practice amongst inpatient social workers, the future research on pre-admission is proposed. The result of this research may identify barriers, training opportunities for inpatient social workers, and recommendations for policy.

The Guidelines on Reunification Services for Families (2012) was written for social service professionals, and it does not specify whether the designated social worker or inpatient social worker is responsible for family reunification. The role confusion may result in family reunification not being prioritized within inpatient treatment. To avoid role confusion, guidelines for the specific roles and responsibilities for the designated social worker and inpatient social worker should be developed. This may contribute better coordination of services amongst social workers to improve family reunification. Coordination of services may include referral to parenting groups and family therapy service that is facilitated amongst social workers on a meso level of the EST. The roles and responsibility of inpatient and designated social worker could be explored in future research.

There was a positive response from social work participants to involve families in the planning process of family reunification. Participants have proposed that a family reunification plan needs to be developed with the inpatient parent and their families. By involving the family within the planning, may provide the opportunity for the family to take ownership and create a conducive environment for family reunification to take place once the inpatient parent has completed their inpatient program. The family reunification plan is based on the family system theory that indicates that each family member has capabilities and strengths to address any crises with the family system [28,30]. Family reunification planning within inpatient treatment may require further exploration between inpatient

social workers, inpatient parents and families within substance abuse treatment centers. Participants suggestion cuts across three levels on Bronfenbrenner Ecological Systems Theory (EST). Substance abuse cannot be dealt in isolation, as it requires a collaborative approach on a micro, meso and exosystem level amongst professionals, communities, social networks, in order for inpatient parents to be supported with family reunification [30-33].

Majority of inpatient parents indicated that their families and children have received minimal support, while they receive inpatient treatment. Despite receiving support from the inpatient social workers, parents suggested that more should be done to include their families within the inpatient treatment program. One inpatient parent indicated that no staff member spoke about being able to reunify with their children post treatment. This may be that the focus of the inpatient treatment program is mainly focused on the alcohol and drug abuse of the inpatient, as stated within literature [12,15,17]. As a result, it may place the inpatient parent at a disadvantage as reunification might fail post treatment. Literature agrees that successful reunification need the willingness and commitment from children, families and biological parent with the support of social workers [26-28].

Despite these challenges, social work participants have indicated that their program could do more to include the children of the inpatient parent in order to strengthen parent and child relationship. Family reunification requires the involvement of family members and children [26,56], responses from inpatient social workers and inpatient parents reveal that family reunification is not being prioritize within substance abuse treatment centers. The findings suggest that the family should be involved during the admission of the inpatient parent, and that they needed to be updated on the clients progress. In addition, it was pointed out that the family has been traumatized because of the inpatient parents' alcohol and drug abuse, and children need support services. Literature by Rastam, Tedgard and Wirtberg (2018) stated that the separation of children from their parents may be experienced as traumatic. Literature supports that children having regular contact with the biological parent may improve their relationship. Therefore, a family reunification plan has been proposed by the social

work participants. This plan should include the input of the designated and inpatient social worker, inpatient parent, family members and children.

In addition, the reunification plan should be regularly monitored by family members, inpatient social workers and designated social workers. Literature support the idea that families have valuable information to contribute to the patient recovery [30-31]. Families are able to identify additional strengths and challenges that may have been overlooked by the inpatient parent and could assist with family reunification post treatment. Furthermore, literature on aftercare planning supports that patient are receiving minimal support and designated social workers are challenged with resources [20,43].

The social work participants have expressed their frustration during focus group discussion on the lack of response from the designated social worker in their attempt to make contact and follow up on their client's progress. This may have implication for inpatient parents that need family reunification support once inpatient treatment has been completed. Family reunification support included activities such as ongoing individual and family therapy provided by the designated social worker, referral to parenting programs and family support services [25-26]. In order to improve their communication with the designated social worker, inpatient social workers have recommended 1) regular stakeholder engagement meetings with designated social workers and 2) provide designated social weekly feedback on the inpatient parent's progress.

Furthermore, social work participants have indicated that families are struggling financially and that hampers their availability to visit the inpatient parent and attend family therapy sessions at treatment centers. In addition, families do not always contact the inpatient parent and the substance abuse treatment center is not always accessible via public transport for family members. Despite these challenges, inpatient social workers emphasized that more needed to be done in order to get the families involved with the treatment program :1) arrangement to be made for transporting families to the treatment center, 2) to celebrate milestones of recovery at substance abuse treatment centers and having families to attend these occasion, 3) shared planning between inpatient social worker and

designated social work and 4) funds to create a conducive environment for family reunification within inpatient treatment. Not only do the participants want to make structural changes in order to provide accommodation for the children of inpatient parents, but they would like the treatment center to be a child-friendly environment as well. Research by Balsells et al., (2016), Bosk, Van Alst and Van Scoyoc, 2017, Manuel et al. (2017), and Radcl et al. (2018) confirms that inpatient treatment is the ideal place to initiate family reunification, as the parents are sober and want to reunify with their children.

Conclusion

The study helped fill a gap in the literature surrounding guidelines on family reunification as a different approach to support inpatient parents, and their willingness to engage with their inpatient parents on family reunification, and the challenges that they anticipate in implementing family reunification within substance abuse treatment centers. Despite many challenges, including role confusion, misconception about family reunification, and lack of funding to provide family reunification, inpatient social workers were committed to helping their inpatient parents to reunify with their children and family. Given enough resources to make structural changes to treatment centers, training and supervision on family reunification, inpatient social workers may improve family reunification outcome of inpatient parents post treatment. Finally, the results give an indication that social workers are willing to go beyond the scope of addressing the inpatient parents' alcohol and drug abuse. Findings of this research may aid substance abuse treatment centers to be more creative to include families within inpatient treatment. The suggestions and positive responses from inpatient parents give an indication that they are willing to make shift in approach by including family reunification within substance abuse treatment centers. Therefore, opportunities exist to enhance inpatient social workers' understanding of family reunification by targeted education.

The guidelines may equip inpatient social workers to provide family reunification services within inpatient treatment. By doing so, social workers will be able to identify children that are at risk with

a parent who may relapse once treatment is completed. Inpatient social workers will also be able to equip inpatient parents with skills and therapeutic services, aimed at family reunification. In doing so, families may be preserved, as mandated by the White Paper on Families (2013).

List of abbreviations

Not applicable

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Availability of data and materials

Data sharing is not applicable for this study. All the transcripts and life histories hard copies that is completed by inpatient parents and social workers will be kept in safe storage in a locked cupboard of the office of CCYF and COMPRES. According to the strategy for record keeping, data will be kept for five years and will then be destroyed.

Ethics and consent to participate

This study was approved by the North-West University Research and Ethics Committee in South Africa. Approval was also given by the research and ethics committee of the Western Cape Department of Social Development. All participants provided verbal and written consent prior to participation in focus groups and semi-structured interviews.

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Competing interest

The authors declare that they have no competing interest.

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SECTION C

SUMMARY, CONCLUSION AND RECOMMENDATIONS

1 Introduction

Section A gave an orientation of the research and discussion of the problem statement as well as a literature review. In Section B, the results of this study were discussed. This section consisted out of two articles. The first article Part 1 focussed on Family reunification support to inpatient parents in Western Cape Substance Abuse Treatment Centres. The second article Part 2 focused on, Guidelines for family reunification within the Western Cape substance abuse treatment centres with inpatient parents. In section C, a summarised overview of the research problem, the methodology that was used during this study, a conclusion and recommendation based of section B of this study, are provided. In conclusion, the limitations as well as the implication of the study are discussed.

2. Summary of Research Problem and achievement of the aims and objectives

Writers such as Sauls and Esua (2015) and Balsells *et al.* (2016) agree that successful reunification relies on the willingness and commitment from the children, families and biological parent. In South Africa, there is limited empirical literature available on family reunification within inpatient treatment. However, in the child welfare sector there are enough literature. However, the findings indicate that family reunification services are minimal, designated social workers not being equipped and not having the resources to provide reunification services (Potgieter, 2016; Delport, Le Roux & Spies, 2017; Vischer *et al.*, 2017). Empirical literature by Baldwin and Duffy (2013) and Balsells *et al.* (2017) approve that both informal and formal support is needed to rebuild relationships with children and family, in order to assist with family reunification post treatment. Therefore, the aim of this study was to explore formal and informal support available to inpatient parents during family reunification support at Western Cape substance abuse treatment centre. The research question that the empirical study answered was the following: What family reunification support is available for inpatient parents in the Western Cape substance abuse treatment centres? The study had two objectives such as:

1. To explore formal and informal support available to inpatient parents during the family reunification phase in Western Cape substance abuse treatment centres.
2. To explore and recommend guidelines for family reunification within substance abuse treatment centres with inpatient parents and social workers using focus groups with social workers.

Findings indicated that inpatient parents are receiving formal support through therapy from inpatient social workers. Parents shared that they never had a relationship with their children, as a result of their alcohol and drug abuse. However, receiving support from the social worker they have started rebuilding their relationship with the children. Parents have experience of parenting programmes facilitated by the inpatient social worker as positive. Findings also indicated that parents received informal support by regular visitation from their families and children. In addition, they attended Narcotics Anonymous (NA) and Alcohol Anonymous (AA) while receiving inpatient treatment. Furthermore, current findings indicated that the majority of the children were not being removed from their biological parents. These children may be at risk, as they may not be monitored by any social workers. Maternal grandparents may not be able to provide for the children's health-related needs and have to deal with children left traumatized as they are separated from their parent (Solis *et al.*, 2012; Klamman *et al.*, 2017). Moreover, despite experiencing positive support with family reunification, inpatient parents shared that their children and family's involvement in the treatment programme is limited, as the focus appears to be mainly on the inpatient. However, inpatient social workers have indicated that much needed to be done to involve families within the treatment programme.

Social workers at substance abuse treatment centres are mandated by the Guidelines on Reunification Services for Families (2012) to provide family reunification services within inpatient treatment. However, they believe the designated social worker is responsible to provide family reunification services. The Guidelines on Reunification Services for Families (2012) are not clear on who should provide family reunification services. This resulted in role confusion, and family reunification not being part of the inpatient treatment programme. There are significant international empirical literature illustrating that substance abuse treatment centres are the ideal place to rebuild parent and child relationship, in order to assist with family reunification post treatment (Murray & Horton, 2015; Carlson, Patel & Stover, 2017; Seay *et al.*, 2017). This places the inpatient parent at a disadvantage. He or she wants to reunify with their children post treatment. In addition, inpatient social workers affirmed inpatient parents by indicating that there is limited involvement of family members and children within the inpatient treatment program. Inpatient social workers also shared that inpatient parents' families are challenged financially, as they are not able to attend family therapy sessions or visit the inpatient parent within inpatient treatment. Despite these challenges, inpatient social workers appear to be willing to shift their approach in providing family reunification to inpatient parents within inpatient treatment.

After the completion of the study, it appears that the research question has been answered and objectives achieved. Findings reflect participants' thoughts on informal and formal support available for family reunification within substance abuse treatment centres, such as parenting programmes, visitation from children and families, and NA and AA attendance. In addition, findings also reflect participants' suggestions on guidelines for family reunification, which included social work guidelines, guidelines for family participation and guidelines for reunification.

The context of the study was substance abuse treatment centres in the Western Cape. In the next section an overview of the research methodology will be provided.

3. Summary of Research Methodology

The researcher has undertaken a literature review (Section A: Part 2) and achieved the aim of the qualitative descriptive study.

A qualitative approach followed by a descriptive design was utilised. This study had two research objectives and the inpatient parents were able to describe who supported them, what reunification support was available, how the support was available and how social workers can improve family reunification within substance abuse treatment centres. This assisted the researcher to achieve his objective, by exploring informal and formal support for inpatient parents and provide guidelines for family reunification to social workers within substance abuse treatment centres.

Inpatients parents and social workers were identified by purposive sampling, as described by Babbie and Rubin (2013). The participants included inpatients parents with children between 0-5 years of age and social workers at five substance abuse treatment centres in the Western Cape. Inpatient parents were requested to complete a collage on their experience of family reunification support within inpatient treatment, followed by a semi-structured interview. Social workers were requested to engage in focus group discussion. Participants agreed, the semi structured interviews and focus group were recorded and data was transcribed by an assistant appointed by the researcher. The assistant signed a confidentiality agreement. The researcher made field notes of semi-structured interviews and focus groups of participants. Member checking was done by the researcher after each interview and focus groups. Clarke and Braun's (2013) thematic analyses were used to analyse the semi-structured and focus group discussions. These data were analysed into two main themes for inpatient parents; positive experience of inpatient parents attending parenting programmes and kinship care from family members while receiving inpatient treatment. For social workers three main themes were identified, such as; 1) guidelines for family reunification, 2) guidelines for social workers and 3) guidelines for family participation.

The Ecological Systems Theory of Bronfenbrenner (1979) provided insight of the influence other systems such as families, social workers and policy had on inpatient parents that needed family reunification support. There should be a collaborative approach between the parent, inpatient social work, designated social worker, children, family and substance treatment centres. Thus, the inpatient parent cannot be worked with in isolation, but environmental influences should also be considered.

4 Conclusions

The focus of this study was to explore family reunification support for inpatient parents in Western Cape substance abuse treatment centres. The information provided an understanding of family reunification support within substance abuse treatment centres. Inpatient social workers were able to share their thoughts on how to improve family reunification within treatment. It was established that social workers do provide family reunification support, and this was confirmed by inpatient parents. But understanding inpatient parent's recommendations on family reunification, social workers can render effective reunification services if they are able to get the commitment of families and children to work with them (Smith, 2016; Danzy & Jackson, 2018). Parents felt that social workers could have done more to include the children and families within the inpatient treatment programme. Social workers, however, indicated that they have a lack of financial resources to provide sufficient family reunification support. In addition, support from the designated social worker responsible for family reunification post treatment, was viewed as minimal by inpatient social workers.

Despite the lack of commitment from designated social worker, the social workers at substance abuse treatment centres is willing to provide additional support to assist inpatient parents with family reunification. They have recommended that families needed to be included in planning of family reunification during pre-admission, family reunification plan to be drafted with the inpatient parent, family and children, and communication guideline for the designated social worker to coordinate services. In addition, inpatient social workers also recommended that inpatient parents should make use of Halfway house as an option should reunification not be possible. Suggestion by participant can be beneficial to the inpatient parent as reunification planning can build on the parent-child relationship as well as their attachment and persevere families.

5. Recommendations

In view of the above-mentioned conclusion, the following recommendation and guidelines with regard to the designated social worker, inpatient social worker, inpatient parent, policy makers and for further research can be made.

5.1 Recommendation for inpatient parents

- A reunification plan to be drafted with inpatient parents and social workers identifying community-based formal and informal support services.
- Referral social workers and inpatient social workers to map community-based support services for inpatient parents and develop a database for referral.
- Social workers to compile a family developmental plan that will form part of the inpatient parent family reunification and aftercare plan.

5.2 Recommendation for guidelines for inpatient social workers

- A pre-admission assessment that would involve all family members, inclusive of children, designated social worker, and inpatient social worker.
- Family reunification plan to be developed with the inpatient parent that would involve the inputs of children, family members and the designated social worker.
- Substance abuse treatment centres to provide accommodation for inpatient parents and children and facilitate family-based intervention that would aid family reunification.
- To develop a communication guideline between the designated and inpatient social worker, in order to enhance the coordination of service for family reunification support for the inpatient parent

5.3 Recommendation for guidelines for designated social workers

- To provide input on the reviews of inpatient parent's progress at the substance abuse treatment centres.
- To provide the family of the inpatient with support, such as linking them with community-based support groups, provide ongoing family therapy and attend to the developmental needs of children.
- The designated social worker to provide input to the family reunification plan and monitor the progress of the plan, once treatment has been completed.

5.4 Recommendation for policy makers

To review policies on family reunification, such as the Guidelines on Reunification Services for Families (2012) and Children's Act, 38 of 2005, in order to provide structural support for family reunification within inpatient treatment.

5.5 Recommendations for further research

- To include more substance abuse treatment centres in South Africa in order to broaden the sample of the study.
- To include children and family members who receive family reunification support. This study only included inpatient parents and it is important to explore children's and families' experience on family reunification.
- To combine social work experience on family reunification, with a study of designated social workers' experience of family reunification to inpatient parents and to compare the results.
- To explore family reunification within a Halfway House for inpatient parents and compare the results to those of substance abuse treatment centres.

6. Limitation of the study

The sample consisted only of inpatient parents and social workers at substance abuse treatment centres. It did not include the children of the inpatient parents and the designated social worker or any other professional within the multidisciplinary team providing family reunification.

This study was conducted in the Western Cape and excluded the rest of South Africa. In addition, the participants were only parents with children between the ages of 0-5 years. The study has also not included the views of the designated social workers, only inpatient social workers.

7. Implication of the findings

Parents play an important role in the lives of children. Therefore, parents' relapsing post treatment may have an impact on children's well-being and their development. Therefore, it is important to provide family reunification support to inpatient parents while they are within treatment. This would be an ideal opportunity to rebuild their relationship, as they are sober and want to reunify with their children.

This is the first study of such nature in South Africa, and information gathered can be utilized to 1) create awareness amongst inpatient social workers to shift their approach and create an environment that support family reunification within treatment; and 2) awareness amongst policy makers and funders to review current legislation that could make funds available and provide structural support for family reunification within inpatient treatment. When inpatient parents are provided with family reunification support, within inpatient treatment, their children's well-being may improve as well, since the inpatient parent now has the ability to remain sober post treatment. In addition, should the inpatient parent relapse post treatment while in the process of family reunification, the children and

families may still have access to support services from the designated social worker, in order to mitigate from being at risk.

8. Reflections

The researcher is a social worker who is currently employed as a Policy Developer and conducts regular policy education on the White Paper on Families (2012) with social workers. The White Paper on Families (2012) advocates for families to be together, as strong families build strong communities. Parents abusing alcohol and drugs often lead to child abuse and neglect and family disintegration. The effects of alcohol and drug abuse are faced with stigma and distrust from children and families, which makes it difficult for the parent to reunify with them after completing their inpatient treatment. This makes reunification intricate, as children and families still need to rebuild trust with the inpatient parent, with the assistance of the social worker. Therefore, the researcher had to guard against biasness, and personal feelings regarding the dynamics against family reunification of the participants. In addition, participants were from different social classes and it was difficult to generate a deeper meaning, while others understood the questions very well.

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SECTION D

ANNEXURES

ANNEXURE 1: ETHICAL APPROVAL



Private Bag X1290, Potchefstroom
South Africa 2520

Tel: 018 299-1111/2222

Fax: 018 299-4910

Web: <http://www.nwu.ac.za>

Research Ethics Regulatory Committee

Tel: 018 299-4849

Email: nkosinathi.machine@nwu.ac.za

ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North West University Health Research Ethics Committee (NWU-HREC) on 12/11/2018, the NWU Health Research Ethics Committee hereby approves your study as indicated below. This implies that the North-West University Research Ethics Regulatory Committee (NWU-RERC) grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: Family reunification support to inpatients parents in Western Cape substance abuse treatment centres: An explorative study.																																
Study Leader/Supervisor (Principal Investigator)/Researcher: Dr S Hoosain																																
Student: B Lebuso																																
Ethics number:	<table border="1"><tr><td>N</td><td>W</td><td>U</td><td>-</td><td>0</td><td>0</td><td>0</td><td>7</td><td>8</td><td>-</td><td>1</td><td>8</td><td>-</td><td>A</td><td>1</td></tr><tr><td colspan="3">Institution</td><td></td><td colspan="4">Study Number</td><td colspan="3">Year</td><td colspan="3">Status</td></tr></table>			N	W	U	-	0	0	0	7	8	-	1	8	-	A	1	Institution				Study Number				Year			Status		
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Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation																																
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Commencement date: 2018/11/12		Risk:	<table border="1"><tr><td>Medium</td></tr></table>	Medium																												
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Expiry date: 2019/11/30																																
Approval of the study is initially provided for a year, after which continuation of the study is dependent on receipt and review of a six-monthly (or as otherwise stipulated) monitoring report and the concomitant issuing of a letter of continuation.																																

Special in process conditions of the research for approval (if applicable):

- Please provide the HREC with copies of the goodwill permission letters from all the entities to be included in this study, indicating access to potential participants in the study.
- Please provide the HREC with copies of the signed confidentiality agreements with the co-coder, the mediators and the independent person when they become available.

General conditions: <i>While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:</i> • The study leader/supervisor (principle investigator)/researcher must report in the prescribed format to the NWU-HREC: – annually (or as otherwise requested) on the monitoring of the study, whereby a letter of continuation will be provided, and upon completion of the study; and
--

- without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.
- The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the study leader/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.
- Annually a number of studies may be randomly selected for an external audit.
- The date of approval indicates the first date that the study may be started.
- In the interest of ethical responsibility the NWU-RERC and NWU-HREC reserves the right to:
 - request access to any information or data at any time during the course or after completion of the study;
 - to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;
 - withdraw or postpone approval if:
 - any unethical principles or practices of the study are revealed or suspected;
 - it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;
 - submission of the annual (or otherwise stipulated) monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and / or
 - new institutional rules, national legislation or international conventions deem it necessary.
- NWU-HREC can be contacted for further information or any report templates via Ethics-HRECApply@nwu.ac.za or 018 299 1206.

The NWU-HREC would like to remain at your service as scientist and researcher, and wishes you well with your study. Please do not hesitate to contact the NWU-HREC or the NWU-RERC for any further enquiries or requests for assistance.

Yours sincerely



Digitally signed by Wayne
Towers
Date: 2018.12.04
22:29:11 +02'00'

Prof Wayne Towers
Chair NWU Health Research Ethics Committee

Current details: (22351930) M:\DSS1\8533\Monitoring and Reporting Cluster\Ethics\Certificates\Templates\Research Ethics Approval Letters\9.1.5.4.2 HREC Ethical Approval Letter.docm
3 December 2018
File reference: 9.1.5.4.2

ANNEXURE 2:

Signed approval form from Department of Social Development approving research study.



Research, Population and Knowledge Management

tel: +27 21 483 4512 fax: +27 21 483 5602

48 Queen Victoria Street, Cape Town, 8000

Reference: 12/1/2/4

Enquiries: Clinton Daniels

Tel: 021 483 8658/483 4512

B. Lebuso

33 Van Eyssen Road

Glen Lily

Parow West

7500

Dear Mr Lebuso

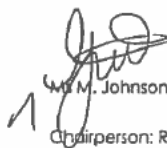
RE: APPROVAL TO UNDERTAKE RESEARCH IN THE WESTERN CAPE DEPARTMENT OF SOCIAL DEVELOPMENT

1. Your request for ethical approval to undertake research in respect of *'Family reunification support to inpatient parents in substance abuse treatment centres: An explorative study'* refers.
2. It is a pleasure to inform you that your request has been approved by the Research Ethics Committee (REC) of the Department, subject to the following conditions:
 - That the Secretariat of the Research Ethics Committee be informed in writing of any changes made to your proposal after approval has been granted and be given the opportunity to respond to these changes.
 - That ethical standards and practices as contained in the Department's Research Ethics Policy be maintained throughout the research study, in particular that written informed consent be obtained from participants.
 - The confidentiality and anonymity of participants, who agree to participate in the research, should be maintained throughout the research process and should not be named in your research dissertation or any other publications that may emanate from your research.
 - The Department should have the opportunity to respond to the findings of the research. In view of this, the final draft of your research dissertation should be sent to the Secretariat of the REC for comment before further dissemination.

- That the Department be informed of any publications and presentations (at conferences and otherwise) of the research findings. This should be done in writing to the Secretariat of the REC.
- Please note that the Department supports the undertaking of research in order to contribute to the development of the body of knowledge as well as the publication and dissemination of the results of research. However, the manner in which research is undertaken and the findings of research reported should not result in the stigmatisation, labelling and/or victimisation of beneficiaries of its services.
- The Department should receive a copy of the final research dissertation and any subsequent publications resulting from the research.
- The Department should be acknowledged in all research reports and products that result from the data collected in the Department.
- Logistical arrangements for the research must be made through the office of the Director: Facility Management and Quality Monitoring, subject to the operational requirements and service delivery priorities of the Department.
- Please note that the Department cannot guarantee that the intended sample size as described in your proposal will be realised.
- Failure to comply with these conditions can result in this approval being revoked.
- Please provide written acceptance of these conditions and recommendations within 5 working days of the receipt of this letter.

receipt of this letter.

Yours sincerely


 GD Miller
 Chairperson: Research Ethics Committee

Date: 20 NOV 2018

I hereby acknowledge receipt and accept the conditions set out in this letter of approval.

Name:	Brandon Helusor
Signature:	
Date:	22/11/2018
Place:	D.S.D Head Office, Cape Town

ANNEXURE 3:

Signed approval form from substance abuse treatment centre.



NORTH-WEST UNIVERSITY
YUNIBESITHI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT
POTCHEFSTROOMKAMPUS

Centre for Child, Youth and Family Studies
3rd East Street
Wellington
7655

Tel: 021 8643593
Fax: 021 8642654

05/06/2018

Brandon Lebuso
33 Van Eyssen
Parow West
7500

Tel: 076 5334254

I would like to request your goodwill permission to do research at your organisation – Hesketh King. I am in the process of obtaining ethical approval from the North-West University's Health Sciences Research Committee.

The research is about exploring family reunification support of inpatient parents at substance abuse treatment centres. I would like to provide inpatients parents with children between 0-5 years of age and social workers the opportunity to share their views on family reunification support within substance abuse treatment centres.

I plan to do semi-structured interviews and collages with inpatient parents that meet the research study criteria at your treatment centre. The interviews will take place at your organisation. I will also be having focus group discussion with your social workers. Venue for the focus groups will be identified within Cape Metro district. Social Workers traveling more than 60km from their home or workplace to the venue will be reimbursed. I will provide refreshments for the participants before their interviews and focus groups.

I am planning to start with the interviews and focus groups in June 2018. Participation will be voluntary and participants will give written consent before the interviews and focus group take place. What will be expected of you:

- Director/CEO to get permission from board members in order for the study to be conducted at the organisation.
- It will be the Director/CEO responsibility to appoint a staff member (mediator) that will identify 2 social workers and 3 inpatient parents with children between 0-5 years of age.
- The mediator's will also approach those individuals and thereon it will be an independent person (social worker) responsibility to explain the process to the participants. The independent person will be appointed by the researcher.

Furthermore, the researcher will be in contact with the Director/CEO to explain the research study. The mediator will be trained on the research project that will include both inclusion and exclusion

criteria for identifying social workers and inpatient parents. I would appreciate it if you would give your goodwill permission.

If you agree to the above will you, please be so kind as to sign below. Individual consent will also be obtained from the participants after the independent person have explained the process with them. Once document has been signed, the researcher will setup an appointment with the Director/CEO of the substance abuse treatment centre. Please contact me if you need more information on 076 5334254

Thank you
Researcher
Centre For Child Youth and Family Studies
North-West University
Potchefstroom campus

A. Oberholzer
Manager

10-07-2018.
Date

ANNEXURE 4:

Consent form of inpatient parents



Private Bag X1290, Potchefstroom
South Africa 2520
Tel: +2718 299-1111/2222
Fax: +2718 299-4910
Web: <http://www.nwu.ac.za>



INFORMED CONSENT DOCUMENTATION FOR INPATIENT PARENTS AT SUBSTANCE ABUSE TREATMENT CENTRES.

TITLE OF THE RESEARCH STUDY: FAMILY REUNIFICATION SUPPORT TO INPATIENT PARENTS IN WESTERN CAPE SUBSTANCE ABUSE TREATMENT CENTRES. AN EXPLORATIVE STUDY.

ETHICS REFERENCE NUMBERS: NWU-00078-18-S1

PRINCIPAL INVESTIGATOR: DR SHANAAZ HOOSAIN

POST GRADUATE STUDENT: MR. BRANDON LEBUSO

ADDRESS: 33 VAN EYSEN PAROW WEST, CAPE TOWN, 7500

CONTACT NUMBER: 076 5334254

You are being invited to take part in a **research study** that forms part of a Masters study with the topic; **Family reunification support to inpatient parents in Western Cape substance abuse treatment centres. An explorative study.** Family reunification is an approach that equip individuals, who are separated from their families, with skills and support in order to reunite with them. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You

are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00078-18-S1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- We plan to explore support available to you so that you reunite with your children as you are now separated from them and may want to go back to your family and children when you complete your treatment. Social workers call this family reunification or reuniting with your children after being separated from them for a period of time while you have been at the substance abuse treatment centre. This study may help to develop family reunification guidelines for social workers working with inpatient parents at substance abuse treatment centres.
- This study will be conducted within a therapy room provided by the treatment centre during the month of September 2018. It will involve inpatient parents from Kensington, False Bay Therapeutic Community Centre, Ixande Recovery, Toevlug and Hesketh King treatment centres. A minimum of 15 participants will be included in the study.

Why have you been invited to participate?

- You have been invited to be part of this research because you are part of the population group that can best respond to the research question and it can benefit social workers within the field of substance abuse.
- You also fit the research because you are; (1) a parent at a treatment centre (2) parent of child that is under 5 years of age (3) in your third week of treatment and (4) able to speak Afrikaans or English.

What will be expected of you?

- You will be expected to participate in a semi-structured interview with the researcher. You will be asked to make a collage which is a form of art where you cut pictures out of magazine which you have chosen to represent what support is available for you at the treatment centre to help you re-unite with your child after you have completed your treatment at the centre. You will then paste these pictures on an A3 sheet of paper. The researcher will guide you if you are not sure of what to do. You will then be expected to tell the researcher about your collage. The collage and discussion will take more or less 30 minutes. After completing the collage and telling the researcher about the collage, you will be expected to respond to 6 questions regarding the support available to you at the substance abuse treatment centre which may help you reunite with your child after being separated while undergoing treatment at the centre. This discussion will be 1 hour exploring reunification support to parents within substance abuse treatment centres.

Will you gain anything from taking part in this research?

- There are no direct gains from participating in the study, however only indirect gains to society. You will be able to indirectly contribute towards helping social workers develop guidelines to support inpatients parents return to their children when they have completed their treatment as inpatient parents are separated from their children while they are receiving treatment at substance abuse treatment centres.

Are there risks involved in you taking part in this research and what will be done to prevent them?

- The risks to you in this study are high. The questions may cause some discomfort, but the researcher is equipped to contain any distress with support with confidentiality. If you need to be referred for additional support, or if you feel your participation in the research process has caused you any distress the researchers will refer you to the multidisciplinary team at your centre.
- You may still experience some anxiety at the start of the interview, however the researcher will ease you into the interview by requesting you to complete a collage. This activity will serve as an ice breaker. The collage will be done in the beginning of the interview and it will be used as a conversation started.
- If you are a female participant, you will be interviewed by a trained female field worker who is like someone who collects data on behalf of the researcher. The field worker has undergone ethics training and has been trained by the researcher to conduct interviews with female participants in this study. The field worker can deal with any discomfort that you may experience.

How will we protect your confidentiality and who will see your findings?

- Anonymity of your findings will be protected by the researcher and the University of North West by keeping all data within a locked cabinet. Your privacy will be respected by using codes to identify participants such as 001. Your results will be kept confidential by storing all data and voice recordings on a laptop that is password protected. Only the researchers and Dr Hoosain (study leader) will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. Data will be stored for 5 years.

What will happen with the findings or samples?

- The findings and data of this study will only be used for this study and will not be used in future.

How will you know about the results of this research?

- We will give you the results of this research when the study is completed and results been received by March 2019.

- You will be informed of any new relevant findings by written correspondence or email.

Will you be paid to take part in this study and are there any costs for you?

- This study is funded by the researcher.
- No, you will not be paid to take part in the study because you're voluntarily participating.
- Refreshments will be served before the focused group discussion takes place.
- There will thus be no costs involved for you, if you take part in this study.

Is there anything else that you should know or do?

- You can contact Mr. Brandon Lebuso at 076 533 4254 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: Family reunification support to inpatient parents in Western Cape substance abuse treatment centres. An explorative study

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I clearly and in detail explained the information in this document to
.....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

Declaration by researcher

I (*name*) declare that:

- I had it explained by who I trained for this purpose.
- I did/did not use an interpreter
- I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.

- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

.....
Signature of researcher

Current details: (23239522) G:\My Drive\9. Research and Postgraduate Education\9.1.5.6 Forms\9.1.5.6_HREC_ICF_Template_Apr2018.docm
 28 April 2018 File reference: 9.1.5.6

ANNEXURE 5:

Consent forms for Social Workers



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South Africa 2520
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Fax: +2718 299-4910
Web: <http://www.nwu.ac.za>



INFORMED CONSENT DOCUMENTATION FOR SOCIAL WORKERS AT SUBSTANCE ABUSE TREATMENT CENTRES.

TITLE OF THE RESEARCH STUDY: FAMILY REUNIFICATION SUPPORT TO INPATIENT PARENTS IN WESTERN CAPE SUBSTANCE ABUSE TREATMENT CENTRES. AN EXPLORATIVE STUDY.

ETHICS REFERENCE NUMBERS: NWU-00078-18-S1

PRINCIPAL INVESTIGATOR: DR SHANAAZ HOOSAIN

POST GRADUATE STUDENT: MR. BRANDON LEBUSO

ADDRESS: 33 VAN EYSEN PAROW WEST, CAPE TOWN, 7500

CONTACT NUMBER: 076 5334254

You are being invited to take part in a **research study** that forms part of a Masters study with the topic; **Family reunification support to inpatient parents in Western Cape substance abuse treatment centres. An explorative study.** Family reunification is an approach that equip individuals, who are separated from their families, with skills and support in order to reunite with them. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You

are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00078-18-S1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

What is this research study all about?

- We plan to explore family reunification support to inpatient parents in substance abuse treatment centre. This study may help develop family reunification guidelines for social workers working with inpatient parents at substance abuse treatment centres.
- This study will be conducted within a conference room provided by the treatment centre during the month of September 2018. It will involve social workers from Kensington, Claro Clinic (Goodwood), False Bay Therapeutic Community Centre, Ixande Recovery, Toevlug and Hesketh King treatment centres working with parents. A minimum of 15 participants will be included in the study.

Why have you been invited to participate?

- You have been invited to be part of this research because you are part of the population group that can best respond to the research question and it can benefit other social workers within the field of substance abuse.
- You also fit the research because you are; (1) a registered social worker working in an treatment centre (2) employed as a social worker more than 6 months at an treatment centre and (3) able to speak Afrikaans or English.
- You will not be able to take part in this research if you have less than 6 months working experience within a substance abuse treatment centre.

What will be expected of you?

- You will be expected to participate in a semi-structured interview that will be facilitated through a focused group discussion. The researcher will be asking 5 main questions with several probing questions. Focus group discussion will be scheduled between 110 and 160 minutes with social workers. The researcher will be facilitating 2 focus groups with a minimum of 7 to 8 social workers. You will be requested to attend only 1 out of the two focus group discussions. A total of 15 social workers will partake in the focus group.

Will you gain anything from taking part in this research?

- There are no direct gains for you if you partake in this study, only indirect gains to society.
- Indirect gains may include (1) social workers transferring knowledge amongst fellow social workers (2) social workers can contribute toward the social work and substance abuse field (3) encouraging social workers to review their current treatment programme or social work approach within substance abuse treatment centres.
- Knowledge shared by social workers may contribute to the development of reunification guidelines for inpatient parents within substance abuse treatment centres.

Are there risks involved in you taking part in this research and what will be done to prevent them?

- The risks to you in this study are minimal and there is no physical harm as well. You will have the opportunity to share knowledge with other social workers and can be listened to by their peers. You may feel self-conscious due to lack of intervention and/ or resources within their treatment centres during this group sharing stage. To account for this, the researcher will refer you to an external social worker or employee's wellness programme for debriefing.
- The researcher will not be able to ensure your anonymity and no internal confidentiality as violation of privacy can be as result of others in the group. Each group member will have the responsibility in managing confidentiality. You will be requested to sign group rules in order to affirm your confidentiality amongst colleagues.
- You may feel overwhelmed due to certain participants being dominant in the group discussion. To counter this, the researcher will set ground rules that would encourage to give each participant an equal opportunity to share their views and opinions.
- There are more gains for you in joining this study than there are risks.

How will we protect your confidentiality and who will see your findings?

- Anonymity of your findings will be protected by the researcher and the University of North West by keeping all data within a locked cabinet. Your privacy will be respected by using codes to identify participants such as 001. Your results will be kept confidential by storing all data and voice recordings on a laptop that is password protected. Only the researchers and Dr Hoosain (study leader) will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. Data will be stored for 5 years.
- The researcher will not be able to assure anonymity and no internal confidentiality as violation of privacy can be as result of others in the group. The groups will have the responsibility in managing confidentiality. The researcher and

participants will agree on the group rules, including confidentiality. Group rules will be written down on a A3 paper emphasising confidentiality and respect amongst social workers. Social workers will be each requested to put down their initial on the A3 page to affirm their confidentiality amongst themselves.

What will happen with the findings or samples?

- The findings of this study will only be used for this study and will not be used in the future. If data is to be used for further studies, it needs still to be approved by the Research Ethics Committee on your behalf.

How will you know about the results of this research?

- We will give you the results of this research when the study is completed and results been received by March 2019.
- You will be informed of any new relevant findings by written correspondence or email.

Will you be paid to take part in this study and are there any costs for you?

- This study is funded by the researcher.
- No, you will not be paid to take part in the study because you're voluntarily participating.
- Travel expenses will reimbursed if you use your private vehicle
- Refreshments will be served before the focused group discussion takes place.
- There will thus be no costs involved for you, if you do take part in this study.

Is there anything else that you should know or do?

- You can contact Mr. Brandon Lebuso at 076 533 4254 if you have any further questions or have any problems.
- You can also contact the Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or carolien.vanzyl@nwu.ac.za if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

Declaration by participant

By signing below, I agree to take part in the research study titled: Family reunification support to inpatient parents in Western Cape substance abuse treatment centres. An explorative study

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) on (*date*) 20....

.....
Signature of participant

.....
Signature of witness

Declaration by person obtaining consent

I (*name*) declare that:

- I clearly and in detail explained the information in this document to
.....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

.....
Signature of person obtaining consent

Declaration by researcher

I (*name*) declare that:

- I had it explained by who I trained for this purpose.
- I did/did not use an interpreter
- I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) on (*date*) 20....

.....
Signature of researcher

ANNEXURE 6:

Inpatient Parent interview schedule.

BIOGRAPHICAL INFORMATION	
Number Assigned:	
Age:	
Marital status:	
Number of children:	
Where is your child/children currently placed?	
Ages of children:	
Make a collage on the support that is available during your stay at the substance abuse treatment centre that can aid family reunification, once your treatment has been completed. Family reunification is the process which helps parents and children live together after they have been separated. (After the parent has made the collage, the researcher will ask the participant to tell the researcher about the collage)	
1. What are your plans after discharge from the substance abuse treatment centre? 2. Can you describe the support available at the substance abuse treatment centre that can assist you to be reunified with your child for example from social workers and other staff? 3. What support are you currently receiving from family, friends or partner to take care of your children? 4. Can you tell me more about your children? 5. Is any kind of financial or legal support needed for you to be together and live with your child/children when you have completed your treatment at the centre. 6. Can you describe any support you receive from the community and what additional support is needed that can assist you to be reunified with your child? Reunified means to be together again with your child/children after being separated from them.	

ANNEXURE 7:

Social worker focus group interview schedule.

BIOGRAPHICAL INFORMATION					
Number Assigned:					
Age:	21-30 years	31- 40 years	41-50 years	51 -60 years	
Gender:	Male			Female	
Years of experience:	6month-1 year	2-5 years	6-10 years	11-15 years	15 years and more
Undergraduate Qualification:					
Post graduate Qualification:					
1.1 Can you describe your family reunification support towards inpatient parents within your substance abuse treatment programme? 1.2 How would you describe the formal and informal support for inpatient parents regarding family reunification? 1.3 If your organisation had enough funding, what informal and formal support systems would you implement in your treatment centres for parents to be reunified with their children? 1.4 Can you describe the communication between yourself and the external social worker or referral agency to assist the parent to be reunified with their child? 1.5 Can you describe the challenges that you may experience when it comes to providing support to inpatient parents with family reunification?					

ANNEXURE 8: EXAMPLE OF COLLAGE WITH INPATIENT PARENTS



ANNEXURE 9: EXAMPLE OF INTERVIEW TRANSCRIPT

Inpatient Parent 001 (IP:001)

R	Good Morning (001) how is it going with you today
001	001) It is going well with me today thank you Sir.
R	The study is looking at family reunification support for inpatient parents and you have characteristics fit the description for my study as you are an inpatient parent and have a child between 0-5 years of age. I understand that my colleague Jessica Payne came to you to discuss the consent forms to which you agree to partake in the study. I also need to go over the consent form again with you in case you have any answers before proceeding with the interview. So the interview will be recorded on my cell phone and will store your information on my laptop that is password protected. I will not be using your name while I am transcribing your discussion. You will get a pseudo name 001 and when i present my findings i will use the pseudo name as well and not your real name. I am still in process of collecting data and you are the first participant and i am hoping to complete my study and have result available in March 2019. You are also being free to withdraw from the study at any given time and your decision won't influenced your stay at the treatment centre. So, what will I be expecting of you (001) is that you need to make a collage firstly on your experience of support within the substance abuse treatment centre. This activity will take at least 30 minutes and provide feedback to me on your activity and then I will ask you 6 questions after you give feedback on your collage. I brought magazine, A3 paper, pritt and scissors in order for you to complete the task. So, everything you paste on the A3 page you need to give me feedback. I just want to confirm are you clear on the activity.
001	I am ok sir I understand.
R	Well if you struggle with the activity please do not hesitate to ask for assistance.
001	Sir sorry, can you kindly explain again how I need to compile this collage.
R	There is no right or wrong way how you compile the college. You may use random picture that can explain what type of support you received within the treatment centre. If you think back, who were the people that supported you while you were at the treatment centres and what type of support was it. Ok so you have completed the collage. Are you able to give feedback on your collage and talk about the support that you receive while you are the substance abuse treatment centre?

001	This picture represents my therapist. We had one on one session with our therapist who assisted us with the different phases of our addiction. Here I have my family, I have received lots of support from them. I also received support from my wife and sisters. Here we are spiritual. We have church and I see this as a support. We have a lot of group work session within the treatment centre that I also see as support.
R	So what I am hearing is that you have your therapist that provides one on one sessions, group work session, religion, your family and wife that you see as the support that you receive within the treatment centre. Tell who is the therapist or what type of profession is this.
001	Is therapist that provides one on one session, who helps you to deal with your anger and she explains how got this behaviour as a result of the drugs and how it affected your life.
R	Early on you spoke about family members that provided support to you. Can you perhaps elaborate on the family members that provided you with support?
001	That will be my wife, mother, sisters and brother .. those are the persons that usually comes to come visit me at the treatment centre. And I am really thankful for that for them coming to visit me. We were also told not to expect for family to come visit all the time because it can easily upset us. If they don't come, you may think that they do not care for you and will just do anything here just to be released from treatment. Likely I did not experience it myself since I receive regular support from my family. Their will also will come a time that I need to go home and ask for forgiveness to my family for all those things that I have done to them.
R	May I ask when you had an opportunity to go ask forgiveness.
001	Yes we did go home within the 6 weeks of treatment we are allow to go home for a weekend it is called a 'Home Pass' . This actual in your step 8 and 9 while receiving treatment.
R	So who did ask for forgiveness when you went home.
001	I went to ask forgiveness for my mom, wife, father, sisters and brother for everything that I have put them through.
R	What I heard so far is only about your family, do you still have contact with your child.
001	Yes my child also came with my family to come visit me at the treatment centre. What was heartbroken for me is when I had to ask my children for forgiveness. When you on drugs you don't give a damn. The younger child would not understand as she is only 1 years of age, however for the older children and to ask for forgiveness and they

	also know that I am at a treatment centre. I also learn to improve relationship with your children and never had a relationship with my children. I have learned to communicate better and I told them that they can talk to me any time if they have a problem. When I used to smoke drugs I was never at home, and this have affected my children.
R	What would you so the effects was on your children?
001	My children are on school, and it effected them during exam times. When I argue in the house it does affect them with their studies. I am not the one that is very aggressive but at times when I was under the influences I used to argue with my wife in front of my children.
R	What I hear is that your drug abuse mainly effected your older children. How would you think if would have affected your younger child?
001	My eldest mostly grew up with my wife grandparents. However, the younger one, we have a good relationship. My wife and I have our own home and we raised our younger one in this home. And its also an indication for me to commit for the sake of my child and it's a good feeling.
R	I just want to confirm if the 3 children were conceived with your wife.
001	Yes sir all 3 is from my wife, we have been together for more than 15 years and we are 3 years married. My wife and I went through ups and downs . She the one that have always supported me and I hurt her very much.
R	Your collage reflect the support and the skills that you received within the treatment centre. Would you say the skills gained will assist to be with your family and children again?
001	We still receive guidelines in the treatment centre to see how we can cope outside so that we do not relapse. So if you have craving what should I do ? I may need to eat sweet to get over the craving. Here in the treatment centre is no drugs and when you go out in the community the drugs available everywhere. And it's the reality that I need to face. These other programmes that I need to make use of such as sport in my community to assist with my recovery. I also have weekly programmes at home that is in place when I get release from treatment.

ANNEXURE 10: EXAMPLE OF FOCUS GROUP TRANSCRIPTS

Social work participants (SW)

R	Okay, good morning, everyone. I am Brandon Lebsuo and welcome to this focus group . I do believe everyone have received communication with regards to day's session and that prior to this Mrs Jessica Payne have engage with each of you on the consent forms. The title of this study is Exploring family reunification support for inpatient parents at substance abuse treatment centres in the Western Cape. You meet the criteria for this study as you are social workers working within substance abuse treatment centres, have more than six months experience working within a substance abuse treatment centre and register as a social worker at the Social Service Council for Social Worker Professionals. A little background of the study, the study will be exploring family reunification support within substance abuse treatment centres. Family Reunification is a term usually used within the child protection sector as it focuses on the need for the child to be reunified with the family. However, few literatures is available with regards to family reunification and support for inpatient parents at substance abuse treatment centres that needs to be reunified with their children. But I think before we get started we need to lay down a few group rules. I have put down a few ground rules in advance, but everyone can add. The following ground rules I have put down such as participation, respect and confidentiality. But is there any other group rules that you want to put down.
SW:004	Can we please put our cell phone on silent.
R	Yes, we can do so. We can put it on silent or vibrate. I would just request that when you have a call just to leave the room quickly to take the call and return after the call in order for the discussion to continue. Is everyone comfortable with the rules? For the study we wont be using names when information is been recorded. I will give each of you pseudo number to use such as 001 a think that is important. The consent form was also discussed two weeks ago with the Independent person Mrs Jessica Payne to which discussed the confidentiality and the focus of the study. I assume everybody is comfortale with the ground rules and consent form. <i>(Everyone nodes in agreement). Ok just to kick of proceedings I gave each of you a coin. On the back of the coin is a date such as 1997 or 2004. You need to indicate what is significant about that date. You then first have to introduce you, share the name of organisation and programme and what is significant about that date. I</i>

	<i>think I will start it off, I got the year 2008 on my coin. Well I was still at ABC Treatment Centre in 2008, but in 2011 I moved to the Metro East Regional office as programme coordinator. In 2013 I went to go work for an NGO for almost 3 years and in 2015 I joined DSD head office in the Families programme as a policy developer.</i>
SW:001	Mine is also 2008 and strangely enough it's the year I decided I wanted to be a social worker. Currently I am working at FGH Treatment Centre and we work with adult females.
SW:002	I also have 2008 , it was a time where the economy of the country was very bad and I had a business where I had to import certain products from America. But due to the poor economy at that stage my business went down. It is also the same year where I was appointed as a Principal at a child and youth care centre in Wellington. I worked there for 6 years and currently I am working at DEFG treatment centre.
SW:003	Mine is 2017, for me was celebrating the first year at ZZZ treatment centre I have been at ABC for long as 26 years then I move to DEFG treatment centre.
SW:004	Ok mine is 2015, I was working at 1B3 Counselling Centre it was my second year. I worked there until 2017 and now I am at 893 Recovery inpatient working with adults and youth.
SW:005	Mine is 2004.It the time where we still lived in the Netherlands I am currently at 1234 treatment centres and working with adult male and females.
SW:006	I am also from 1234 treatment centre, I have 2011, Its also the year when I study social work. I work at 1234 treatment centre with adults males and females as well.
R	Wow it looks like we have a wealth of experience here today in the room. I think the introduction just help setting the tone for the group discussion. So handed each of you a questionnaire. Can you kindly start filling it in? Starting with the assigned number. As indicated I working with pseudo names. So for you HHH your assigned number will be 001 and BBB you will be 002, CCC you will be 003, and DDD 004, EEE 005 and FFF 006.
SW:006	What if I am between 6 month and a 1 year of experience. How do I complete it?
R	Its fine just mark it with an x. It should be good. (Brandon) Ok so everyone have completed the forms. I think before we get stuck into the questionnaire, I wish to

	give you again the title of the focus for title that speaks about exploring family unification support with inpatient parents within substance abuse treatment centres. The study is focusing on parents with children between 0-5 year of age and we are looking at parents that need to be reunified with their children while receiving treatment. First Questions: So can you describe the reunification support that you provide your inpatient parents within your substance abuse treatment centres. So think about a time where you had a parent that had a child and what was the process working with the parent.
SW:004	Ummmm...I have a client (pause) female, two kids between 9 and 5 years old, the challenges is the female is from UK an her children are in UK. Daily contact is made telephonically and via skype, face time so that they can see what is happening with mom.
R	Oh ok so there is some kind of contact between the children and the mom. Would anyone else like to share?
SW:005	) I have a patient who is a single mom rooming the streets, and also had a 2 year old son that was removed due to substance abuse, lack of support and care taking. The external social worker had difficulty in placing the child as the family members were also abusing substances and was not safe for the child. So what we did which we never do, we took the child into the treatment centre to be with his mom and also to see how the mom would interact with her child and how we can work on the relationship between mother and child. So the son stayed with her at the treatment centre for a few weeks. (Paused) Very interesting the one day the mom would interact with the child and the next day she would have nothing to do with the child. When the mom goes for group sessions he often would cry because he knew that was his mom. It was interesting for us as staff to see the interaction between the mom and child. That was just on specific case that when we accommodate a mom with her child.
SW:003	May I ask a question, just out of curiosity in terms of mother and mood swings towards the child, was their psychological underlining problem with the mom.
SW:005	Yes we did refer her to the psychologist and it was found that there were underlying psychological problems with the mom, but I could have been also at the early stage of treatment for the mom that she have detoxed period that was at its worse so we look at different diagnose issues such comorbidity and or dual diagnosis.

ANNEXURE 11: INPATIENT CO-CODING

Question	Responses	Category
1. Can you describe the support available at the substance abuse treatment centre that can assist you to be reunified with your child for example from social workers and other staff?	- We will do sessions within a group session from a social point of view on relationships and parenting skills. - I have a client now, who has 2 children in foster care. Each one with different foster mothers. She asked if I can find the foster mothers for her to make contact with the children. I asked external social worker to assist? - I also learned to improve the relationship with your children and never had a relationship with my children. I have learned to communicate better. - My social worker that referred me here and brought me to the treatment centres informed me that he will continue to provide counselling and family support once I have completed my programme. - Yes, my child also came with my family to come visit me at the treatment centre.	Postive response to parenting / rebuilding relationship Formal support/Social workers providing parenting programs. Designated social workers support of reunifcaiton Formal support/ family reunification with designated social worker Improved communication Formal support/ improved communication/relationship with children Aftercare support from designated social worker/ Informal support Informal support: Visitation from children Informal support: Attending support group within substance abuse treatment centres .

	What was heartbreaking for me is when I had to ask my children for forgiveness. When you on drugs you don't give a damn. • Yes we do get to attend NA/AA meetings weekly and it helps me a lot to have that support. • 'No social worker or any staff talked about reunification with my children. • I would love it if there is some way where programs can incorporate the spouse or the girlfriend or the mother of your kids also getting help because you ruined, not ruined maybe as such but you had a huge negative impact on their lives because I can't see any positives coming from me being in rehab. • No there were no programme for the children it was just me and my kids chatting. • So what we did which we never do, we took the child into the treatment centre to be with his mom and also to see how the mom would	Limited involvement of family. Reunification not taking place within treatment. Inpatient parents need to get family involved in the treatment program. Informal support: Accommodation provided by treatment centres
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	<i>interact with her child and how we can work on the relationship between mother and child'</i>	
--	--	--

ANNEXURE 12

Consent form for co-coder.



CONFIDENTIALITY UNDERTAKING

entered into between:

I, the undersigned

Prof / Dr / Mr / Ms Piershuin Ederies

Identity Number: 8101315137081

Address: 9 Monowatt Rd. Ottery, Cape Town

hereby undertake in favor of the **NORTH-WEST UNIVERSITY**, a public higher education institution established in terms of the Higher Education Act No. 101 of 1997

Address: Office of the Institutional Registrar, Building C1, 53 Borchard Street, Potchefstroom, 2520 (hereinafter the "NWU")

1 Interpretation and definitions

1.1 In this undertaking, unless inconsistent with, or otherwise indicated by the context:

1.1.1 "Confidential Information" shall include all information that is confidential in its nature or marked as confidential and shall include any existing and new information obtained by me after the Commencement Date, including but not be limited in its interpretation to, research data, information concerning research participants, all secret knowledge, technical information and specifications, manufacturing techniques, designs, diagrams, instruction manuals, blueprints, electronic artwork, samples, devices, demonstrations, formulae, know-how, intellectual property, information concerning materials, marketing and business information generally, financial information that may include remuneration detail, pay slips, information relating to human capital and employment contract, employment conditions, ledgers, income and expenditures and other materials of whatever description in which the NWU has an interest in being kept confidential; and

1.1.2 "Commencement Date" means the date of signature of this undertaking by myself.

1.2 The headings of clauses are intended for convenience only and shall not affect the interpretation of this undertaking.

7 Jurisdiction

This undertaking shall be governed by South African law be subject to the jurisdiction of South African courts in respect of any dispute flowing from this undertaking.

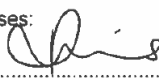
8 Whole agreement

8.1 This document constitutes the whole of this undertaking to the exclusion of all else.

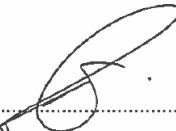
8.2 No amendment, alteration, addition, variation or consensual cancellation of this undertaking will be valid unless in writing and signed by me and the NWU.

Dated at ^{Cape Town} ~~Potchefstroom~~ this September 7, 2018

Witnesses:

1 

2
(Signatures of witnesses)


(Signature)

ANNEXTURE 13: STANDING OPERATING PROCEDURE (SOP) STORAGE GUIDELINES

PURPOSE OF SOP

The purpose of this SOP is to clearly describe how data of students and staff should be treated upon completion of their studies and research projects. It will be described how data will be stored at the office of the Centre for Child, Youth and Family studies (CCYF) in Wellington, who will accept responsibility therefor, and how and when the data will be destroyed.

The storage and destroying of files after completion of studies form part of the wider task of data management. Mrs. Melanie Hanekom (administrative officer) will distribute this SOP to all new students to enable them to adhere to the system of data submission after completion of studies.

DEFINITION OF TERMINOLOGY

Data: Data is collected by students and staff during the research process and is captured in various manners:

- Audio tapes
- Videos on CD/DVD
- Field notes
- Transcriptions of interviews
- Drawings
- Photos
- Other visual data

Destruction of data: Hard copies of visual data, transcriptions, field notes, drawings and photos will be shredded. Electronic data on CD/DVD and audio tapes will be destroyed by scratching and breaking the CD/DVD and by breaking audio tapes.

REASON FOR PRESERVATION

- Legally compelled by legislation (NHREC, 2014), as well as professional Boards.
- Examiners may, during and after the examination, have questions about the data and request to peruse the data.
- There may be negative consequences for participants resulting from their involvement in the research which may necessitate re-evaluation of the data.
- It serves as proof that research findings have not been fabricated or manipulated.

- There may be legal and/or disciplinary procedures by statutory boards which may necessitate the re-evaluation of data.

PROCESS FOR HANDLING OF RESEARCH DATA.

Study supervisors are responsible to collect all data, described above, from students after completion of examinations and up until ten days before the graduation ceremony. Students can forward data via registered mail or personally deliver it to the supervisor.

- Study supervisors will hand over the data to the relevant administrative officer.
- Staff will hand over all data to the administrative officer upon completion of research projects.
- The administrative officer will document details of the data in a record-book and store the data in a safe.

PLACE AND MANNER OF PRESERVATION.

- Safe in Annex of CCYF in Malherbe Street, Wellington. The walk-in safe is spacious. The office is secured by safety gates and an alarm system.
- The data will be stored in large envelopes.
- The data will be filed alphabetically, according to year and the name of the student or staff member. A sticker on the envelope will indicate the student's name, graduation date, title of study and name of supervisor.
- The receptionist of CCYF will keep the key to the safe and only she and the administrative officer will have access to the safe. The receptionist will not hand over the key to any staff member.

DESTRUCTION

- Mrs. Melanie Hanekom (administrative officer) will keep a record book with the dates for destruction of data. This will be a date five year after a student's graduation ceremony.
- Possibilities will be explored for implementation of electronic reminders relating to destruction by e.g. Groupwise.
- Written data will be shredded by the technical officer under supervision of the line manager.
- CD's/DVD's and audio tapes will be destroyed by the technical officer under supervision of the line manager. These CD's/DVD's will be scratched and broken.
- A note will be added to the record book reflecting the exact date of destruction and the name of the person who destroyed it.

RESPONSIBILITY

Administrative

Line Manager	Mrs. Melanie Hanekom (Administrative officer)
Technical Officer	Mrs. Marie Janse van Vuuren
Receptionist	Mrs. Louise van Wyk

Academic

Academic staff responsible for supervision of studies	Dr. Shanaaz Hoosain
All post-graduate students of CCYF	

ANNEXTURE 14: AUTHOR GUIDELINE FOR ARTICLE 1

Author Guidelines

Instructions to Authors: Southern African Journal of Social Work and Social Development (SAJSWSD)

STYLE GUIDELINES (CHICAGO MANUAL OF STYLE: AUTHOR-DATE)

This guide endeavours to achieve a standardised typographical style and consistent language choices. The main objective is to make it easier for authors, editors, copyeditors, layout editors and all those who publish to know what choices to make in the myriad of existing options. Unisa Press uses the Chicago Manual of Style (<http://www.chicagomanualofstyle.org/>).

1. Guidelines for Technical Preparation of Manuscript

Layout

- Submit manuscripts electronically—MSWord file.
- All graphic material has to be positioned at the correct place in the text and should be of a good quality. Do not add supplementary files with graphic content.
- Manuscripts must be presented as: A4 pages; normal margins; 12pt Times Roman; 1.5 line spacing.
- Proofing language must be set as UK English (colour—not color; travelled—not traveled; organise; organisation; organising—not -ize).
- Do not type double spaces anywhere; not between words, at the end of sentences or after colons.
- Type hard spaces (shift + control + space bar) when phrases are preferred to be presented as a unit, e.g. 10_000; Vol. 1 (2):_22–21.
- Articles should not exceed 6000 words from the first word in the title to the last word in the list of references.
- Make sure you follow the guidelines for ensuring a blind peer review.
- Then present an indented abstract of not more than 250 words. Abstracts should not contain any footnotes or citations. Do not type the abstract in italics.

- Below the abstract, please provide 4–6 keywords for indexing (only proper nouns in capitals). Distinguish between keywords/phrases with semicolon, e.g. Pentecostal; hymnal records; migration; southern regions of Africa.
- Authors should include their affiliation or ORCID below their name, after the title of the article.
- No numbers should be used in headings or in lists
- Please note the format and order of information required for the presentation of **book reviews**:
- *Oxford Dictionary of Journalism* <Book title in italics>
- Tony Harcup <Book author name(s) and surname>
- Oxford University Press. 2014. xiv + pp. 368 <Publisher, date and number of pages>
- ISBN: 978-0-0000000-1 <ISBN>
- **Reviewed by Rod Amner** <Reviewer details>
- Department of Languages <Affiliation: Department>
- University of Limpopo (Turfloop), South Africa <Affiliation: Institution>naominkealah@ul.ac.za <email address>

Style

- Do not use the ampersand (&) anywhere in the text or citations; use “and” instead.
- In text, only sparingly emphasise words by using italics. Italicisation should otherwise be reserved for book titles and words from a language other than that of the text.
- Italicised words/phrases in another language are glossed by an equivalent word/phrase in the language of the text in single inverted commas placed in brackets, e.g. ...*indoda* (“a man”). Words well-known in South African English are set as roman, for example, lobola, ubuntu, indaba.
- Words/terms that need to be singled out as being “borrowed” from another author/source may be placed in double inverted commas.
- Titles of publications must be in headline style (significant words are capitalised) and in italics when typed in the text. Titles of articles are placed between “double inverted commas.” Also see citation guidelines for examples.

Acknowledgements

- Acknowledgements appear at the end of the article, should be brief, and recognise sources of financial and logistical support and permission to reproduce materials from other sources. Save a copy of documentation granting such permission. Adherence to copyright rules remains each author's sole responsibility.

Footnotes

- Footnotes with references in Arabic numbers (1, 2, 3—do not use i, ii, iii) are allowed on condition that these are limited to essential notes that enhance the content without impeding the fluent reading of the article. Footnotes are typed in 10pt. font and single spacing; hanging indent.

Endnotes are not allowed.

- Footnotes do not replace the alphabetical list of references at the end of the text. References in notes are regarded as text references and not bibliographic information.

Quotations

- When quoting from a source, use “double inverted commas.”
- To quote within a quote, use ‘single inverted commas.’
- When quoting more than five lines, indent. Do not print indented text in italics and do not use quotation marks. A citation after the indented quote follows after a full stop, e.g.

According to the report the council will discuss the matter at the next council meeting to be held on 5 January 2017. (Smit 2002, 1)
- When quoting within an indented quotation, use “double inverted commas.”
- Final full stops and commas are placed inside the quotation marks.
- Colons and semicolons are placed outside of quotation marks.
- Question and exclamation marks are only placed inside quotation marks if they form part of the quoted material.
- E.g. Do you know if she is “accredited”? He asked: “Are you accredited?”
- When adding notes to a quote or changing a quotation, use square brackets, e.g. [own translation/emphasis]/[t]oday.

Numbers

- In text, numbers one to nine are in words; numbers 10 and above are in digits.
- At the start of a sentence all numbers are in words.
- In brackets all numbers are in digits, as for numbers of tables, figures and chapters.
- When in text, percentages (below 10) are in words—seven per cent; above 10 are digits—22 per cent/13.5 per cent.
- Decimals—7.5 per cent—are always in digits (also in text).
- Use the % sign in brackets and per cent in text.

Equations

- Use Mathtype for display and inline equations, but not for single variables. Single variables should be inserted into the text as Unicode characters.

Abbreviations

- Abbreviations that begin and end on the same letter as the word, do not get a full stop (Mr/Dr/Eds) but Ed.
- Academic degrees: (Preferably without any punctuation) BA; DPhil; MSc

TYPES OF ARTICLES PUBLISHED

As SAJSWSD is an accredited academic journal, it needs to adhere to the minimum requirements of the Department of Higher Education and Training of South Africa. This means that mostly empirical peer reviewed research articles should be published, but a limited number of pages can contain book reviews or conference reports. In exceptional cases one article per issue might address research issues per se. The decisions of the reviewers and the editors are final.

GENERAL

No more than two articles will be published about any specific research project in SAJSWSD. No articles will be published as part 1 and part 2. In every SAJSWSD issue, no person may author more than one sole authored or more than two co-authored articles.

Copyright of an article will be assigned to the University of Johannesburg and Unisa Press if the article is published. Copyright covers the exclusive right to reproduce and distribute the article in any medium.

Submitting any article to SAJSWSD implies that it presents original, unpublished work, and is not considered for publication elsewhere.

It remains the right of the University of Johannesburg and Unisa Press to submit any article for originality checking to determine its extent of non-original information.

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

- The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
- The submission file is in OpenOffice, Microsoft Word, RTF, or WordPerfect document file format.
- Where available, URLs for the references have been provided.
- The text is 1,5 spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses); and all illustrations, figures, and tables are placed within the text at the appropriate points, rather than at the end.
- The text adheres to the stylistic and bibliographic requirements outlined in the Author Guidelines, which is found in About the Journal.
- If submitting to a peer-reviewed section of the journal, the instructions in Ensuring a Blind Review have been followed.

ANNEXTURE 15: AUTHOR GUIDELINES FOR ARTICLE 2

Author pre-submission checklist for manuscripts for publication in supplements to BioMed Central journals

Before submitting the manuscript to your supplement organizer, please go through the list of points below, and refer back to the main instructions if necessary. You should be aware that we are not charging for access to your article and therefore require you to submit your files in the correct format to allow for efficient production. If we have to make any changes in proof due to incorrect formatting of the original files, these will be at the discretion of the Editors, and may incur a charge.

When you have checked each of the points, please make the required changes to your files.

Wrongly formatted manuscripts cause problems and delays during the production process.

Title page of manuscript

- Authors' affiliations should be in the following format: Department, Institute, City, Post/Zip code, Country.
- Each affiliation must be linked to an author.
- All authors must be linked to their corresponding affiliation(s) using superscript numerals.
- Authors should not list their qualifications on the title page.
- One corresponding author should be indicated.
- A contact email address should be listed for each author.
- The title should be in bold, sentence case with no full stop at the end and no underlining.

Manuscript sections

- 8. Abstracts should be no longer than 350 words.
- 9. Abstracts should not cite references, figures or tables, and the use of abbreviations should be minimized.
- 10. Abstracts must be structured into sections for research articles.
- 11. All articles should include the following sections (in order): Abstract; Background; Main text with appropriate subheadings (for research articles these should include Methods, Results, Discussion, Conclusions); List of abbreviations used (if any); Competing interests;

Acknowledgements; References; Figure legends (if any); Tables (if any); Additional data files (if any). Do not number the sections. For more information, see [Manuscript preparation](#).

- 12. Please use sentence case for titles, headings and subheadings, with no unnecessary initial capital letters.
- 13. Figures must be supplied as separate files (see below).
- 14. Do not include footnotes or text boxes.
- 15. Avoid including long URLs in the main body of the text, put them in the reference section with the name of the website

(see [Manuscript preparation](#)).

References

- 16. References must be cited in the text using consecutive numbers in square brackets.
- 17. References to other articles from within the same Supplement as your article must be highlighted in red.
- 18.
- The reference list should be provided in the correct format so that the links to the article's abstract on PubMed (and/or [References](#) section in the full text on the publisher's website if applicable) can be created (see [Manuscript preparation](#)).
- Figures
- 19. Each figure must be provided as a separate file, not embedded in the main manuscript file.
- 20. If a figure consists of separate parts e.g. A and B, it is important that these parts are submitted in a single figure file and [References](#) section in
- not as individual figure files.
- 21. The image file should not include the figure number, title or legend; these should be included in the manuscript file after the references.
- Sub-labelling (e.g. A, B, C) may be included in the figure file.
- 22. Figures must be closely cropped so that only a small white border appears around the image.

- 23. Figures should be of adequate resolution to ensure good reproduction online (see Scaling/resolution).
- 24. Please name figure files so it is easy to identify which manuscript they belong to and which figure number they are.

Tables

- 25. Tables smaller than one side of A4 (210mm x 297mm) can appear within the main article and should be included at the end of the manuscript file, in the order that they are referred to in the text.
- 26. Tables must be divided into cells/fields - tables generated with tabbed text are not acceptable.
- 27. Tables should not include colour or shading
- 28. Horizontal rules should only be used under main headings and the end of the table and not between rows, unless
- essential for clarity.

Additional files

- 29. These may consist of larger tables or other files, such as movies, PDF files, etc, that are not intended to appear within
- the body of the article.
- 30. If authors have included additional files, they must include a separate section in the manuscript that lists: file name(s),
- file format(s), title(s) of data and short description(s) of data.
- 31. Additional files must have the appropriate three-letter file extension for the programme you have used to generate them (e.g. .xls for Excel; .pdf for Acrobat files etc). Additional files must be cited in the text in the following way, eg: "see Additional file 1"