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SOCIAL WORKERS' EXPERIENCES OF THE TRANSTHEORETICAL MODEL OF CHANGE IN INVOLUNTARY TREATMENT OF SUBSTANCE USE DISORDERS

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ABSTRACT

Substance use disorders (SUDs) lead to changes to the brain, withdrawal symptoms and cravings that contribute to persons with an SUD being unmotivated to enter treatment. This discussion explored how social workers view and experience the use of the transtheoretical model of change as a framework to support the development of internal motivation, and consequently voluntary participation in treatment options. A qualitative approach was followed, guided by a combination of the explorative and descriptive research designs. Non-probability purposive sampling was used to select social work participants. Data were collected through individual semi-structured interviews and subjected to thematic data analysis. Ethical considerations included voluntary participation, informed consent, privacy, anonymity, confidentiality and the management of research data. The findings highlighted the participants' perceptions and experiences of those aspects within the different stages of the transtheoretical model of change that may support social workers to guide involuntary clients towards a motivation for change.

Keywords: involuntary treatment; substance use disorder; transtheoretical model of change; treatment services

INTRODUCTION AND BACKGROUND

The World Health Organization (WHO, 2020) describes 'substance abuse' as the harmful use of psychoactive substances that may lead to a substance use disorder (SUD) consisting of a cluster of cognitive, behavioural and physiological symptoms. This results in continued use despite significant substance-related problems (American Psychiatric Association [APA], 2013), an increased tolerance of the substance, and withdrawal symptoms when use is discontinued (Stoke et al., 2018). Deepmala (2014) describes the progression of SUD as beginning with experimentation, transitioning to casual use of substances, progressing to regular use, and ultimately leading to a disorder where the individual requires treatment to support the cessation of substance use.

Symptoms of SUD, which are utilised in the diagnosis of SUD, include hazardous use; social, interpersonal, physical or psychological problems; neglect of major family, employment and societal roles; withdrawal symptoms and cravings; tolerance of the substance and increased use; repeated unsuccessful attempts to quit or control use; much time spent using substances; and giving up healthy activities (APA, 2013; Rehm et al., 2013). Once symptoms of SUD are present, short- and long-term physical, social and psychological effects that impact on the individual, family, community and society at large can be observed (Deepmala, 2014). Short-term effects include intoxication and overdoses, which can potentially result in death. Long-term use of the substance leads to changes in the brain, impacting on mood, thoughts and behaviour, and giving rise to specific symptoms associated with SUD (Rehm et al., 2013). SUD is further characterised by a compelling physical, psychological and emotional compulsion to use substances that alter the mind and mood, and "an underlying change in brain circuits that may persist beyond detoxification" (APA, 2013, p. 483).

Factors contributing to SUDs and their prevalence

The World Drug Report (United Nations Office on Drugs and Crime [UNODC], 2020) indicates that the prevalence of the harmful use of substances has been on an increase globally, with an estimated 35.6 million people suffering from SUDs. While SUDs are more prevalent in developed countries, the harmful use of substances is increasing more rapidly in developing countries (UNODC, 2020). In Africa, the production and trafficking of illicit substances are emerging at an alarming rate and result in health, crime and development-related challenges (Armiya'u, 2015).

South Africa has been affected particularly severely in that the harmful use of substances is twice the global norm, and SUDs have been observed in 15% of the population (Department of Social Development [DSD], 2017; Monyakane, 2018). Importantly, those who experience poverty in South Africa are more likely to have SUD than those who are not (UNODC, 2020). As such, the harmful use of substances in South Africa is considered a central threat to development and there are specific concerns regarding the harmful use of substances among the youth (Monyakane, 2018). Erasmus et al. (2023) report that cannabis was the most common substance of choice reported among persons who received treatment for SUD in South Africa during the first half of 2022. This was followed by methamphetamine, where the highest use was reported in the Western Cape. Alcohol and heroin were the third highest substances of

choice. Alarmingly, 24% of all admissions to treatment facilities consisted of persons younger than 20. It is necessary to explore why older persons in the Western Cape, where this study was conducted, are reluctant to access treatment options.

Factors contributing to SUDs include unemployment, poverty, lack of good parenting, peer pressure, lack of appropriate knowledge of substances and SUDs, genetics, availability of substances, and mental illness (DSD, 2017). The latter aspect in particular is confirmed by Erasmus et al. (2023), who indicate mental health as a primary component of dual diagnoses. In the Western Cape a higher proportion of persons in treatment programmes suffer from mental health problems than in the rest of the country (Dada et al., 2019).

Consequences of SUD

The increase in global drug supply and demand poses a variety of challenges for systems aimed at preventing and treating SUD such as law enforcement, and health and social services (UNODC, 2020). As an example, the South African Police Services (2023) report that, between July and September 2023, 227 instances of possession of illegal substances and 6 184 alcohol-related cases of attempted murder, murder, rape and assault with the intent to inflict grievous bodily harm were recorded. In addition, Monyakane (2018) warns that SUDs are a major contributor to poverty, reduced productivity, unemployment, dysfunctional family life, political instability, the escalation of chronic diseases, injury and premature death.

Moyana et al. (2019) distinguish between the physical, psychological and social consequences of SUD. Physical consequences include malnutrition, heart disease, neurological disorders, liver disease, and physical weakness. Psychological consequences encompass withdrawal symptoms such as anxiety, stress, depression and personality changes, including aggression and compulsiveness. Social consequences are reported to include isolation from close relationships with family and friends, and greater association with other substance users. These consequences, among others, serve as the Central Drug Authority's (CDA) motivation to make South Africa a country free of the harmful use of substances (CDA, 2019). Involuntary committals for SUD are a form of intervention that speaks directly to that goal. This entails that a person who presents SUD symptoms can be pressured to receive treatment, which may include statutory actions.

Continued concern about the prevalence of SUD and the lack of progress to address substance use to limit consequences, and the need for research to "ensure effective and efficient services for the combating of substance abuse and to strengthen mechanisms for implementing cost-effective interventions to empower vulnerable groups" is reported by the Department of Planning, Monitoring and Evaluation (2019, p. 3).

Treatment

The challenges facing individuals with SUDs in making informed decisions as a result of changes in the brain may lead to resistance or reluctance to seek treatment (APA, 2013; Hall et al., 2014). Farhoudian et al. (2022) explain that some factors that underlie the lack of motivation to enter treatment are not understanding why treatment is needed, a fear of stigma and a fear of withdrawal symptoms. Brenner et al. (2020) draw a link between depression and

SUDs (cf. Dada et al., 2019) and assert that there is a prevalence of SUDs among persons with depression of up to 40%. They report on findings from clinical studies indicating that 30% of patients with a dual diagnosis of depression and SUDs do not respond to treatment, with approximately 50% not responding adequately, resulting in a high probability of relapses. These findings confirm the view of Bach et al. (2023) that there is an urgent need to find effective ways of addressing treatment resistance.

The Prevention of and Treatment for Substance Abuse Act, No. 70 of 2008 (Republic of South Africa [RSA], 2008) describes treatment as a specialised interdisciplinary service rendered by health practitioners, mental health practitioners and social workers, focusing on social, psychological and medical services. According to the CDA (2019), treatment involves a structured process to refer individuals with SUD to a service provider, who can present to them a range of intervention choices tailored to their specific requirements. Treatment is referred to as recovery management (CDA, 2019), and includes prevention, early intervention, treatment, aftercare and reintegration as interventions on a continuum of care (DSD, 2013). The treatment journey concludes when health and wellbeing have been restored to the greatest possible extent (CDA, 2019).

Kaloiya and Sonkar (2018) identify five focus areas for treatment: 1) The development of a therapeutic relationship between the service provider and service user;2) the assessment and monitoring of the SUD and the individual's personal context; 3) management of intoxication and withdrawal states; 4) developing a treatment plan based on the assessment outcomes; and 5) preventing relapses. The CDA (2019) refers to two concepts related to treatment. The first concept is the continuum of care, which has to do with a variety of intervention options. Moyana et al. (2019) concur that this continuum is based on the individual needs of service users, and that it includes a spectrum of services that will support a person towards recovery from SUD. The second concept has to do with recovery management, which is aimed at a long-term client-directed way of providing services along the continuum of care. Elements of treatment in terms of recovery management include client empowerment, assessment, recovery resource development, recovery education and training, ongoing monitoring and support, recovery advocacy, and evidence-based treatment and support services (CDA, 2019).

Resistance to treatment may lead to involuntary treatment that results from pressure from the workplace or family members, and statutory interventions (Werb et al., 2017). While internal motivation and self-determination are identified as key to successful treatment outcomes (Scheibe et al., 2020), Kaloiya and Sonkar (2018) emphasise that service providers must be careful not to exclude unmotivated persons in service delivery and make provision for assisting them to move towards motivation to enter treatment voluntarily. The focus of this study was on the way in which social workers approach involuntary treatment, which can be viewed as the first element of client empowerment (cf. CDA, 2019).

Involuntary treatment

The Prevention and Treatment of Substance Abuse Act, No. 70 of 2008 (RSA, 2008) does not explicitly define involuntary treatment. However, it does outline the characteristics of an involuntary service user, which include being a danger to themselves or to the immediate

environment, causing a major public health risk, doing harm to their own welfare or the welfare of others, and/or committing a criminal act to sustain their dependence on substances. Opsal et al. (2019) expand on the above description, explaining that one of the primary reasons for involuntary treatment is to protect an individual from self-destructive behaviour and/or behaviours that can cause harm to others or the environment.

During involuntary treatment, an individual may be compelled to participate in a treatment programme because of various factors such as statutory stipulations, family influence, or workplace pressure. Despite this pressure, the person may express their lack of willingness to actively engage in the treatment process (Werb et al., 2017). On the one hand, Scheibe et al. (2020) argue that treatment should be based on self-determination. On the other hand, Opsal et al. (2019), while also agreeing that self-determination is being impacted on through involuntary treatment, describe the reason behind involuntary treatment as a short-term intervention aimed at saving the life of the person or protecting others from harm caused by the SUD-related consequences. A long-term goal of involuntary treatment is to encourage a movement towards a motivation to participate voluntarily. Kaloiya and Sonkar (2018) also argue that treatment outcomes are dependent on the level of motivation of the client to engage with treatment interventions. However, the authors postulate that this does not mean that unmotivated persons who are at risk of harming themselves or others are being left behind. On the contrary, these authors concur that client-centred treatment should make provision for interventions aimed at motivating persons with SUD to participate voluntarily in treatment.

Ndou and Khosa (2023) refer to the South African Community Epidemiology Network on Drug Use (SACENDU), 2017), which raised a concern regarding the steady rise in relapse rates after treatment. The authors highlight the importance of ongoing participation in treatment to promote long-term change and recommend that social workers explore effective ways to enhance motivation to change. Responding to this recommendation, this study considered the transtheoretical model of change (TTM) and focused on social workers' experiences of the use of the TTM in involuntary treatment of SUD. This theoretical framework is presented next, followed by a summary of the research methodology and the findings of the study. The article concludes with recommendations for social work practice.

THEORETICAL FRAMEWORK

The TTM aims to support the development of internal motivation and thereby voluntary participation in treatment of SUD (Scheibe et al., 2020; Velasquez et al., 2005). This model provides social workers with a framework to facilitate and encourage behavioural changes (Hoy et al., 2016; Ndou & Khosa, 2023). However, behavioural change requires an internal motivation to change, which is associated with satisfying experiences. Contrary to internal motivation, external motivation is associated with change in response to external stimuli, such as pressure from an employer. The TTM focuses on ways to support involuntary clients to actively engage in treatment by focusing on their personal motivation to pursue recovery rather than relying on external pressures that may push them involuntarily into treatment services (Legault, 2016). According to Serafini et al. (2016), understanding motivational factors contributing to the SUD that also impact participation in treatment, can provide valuable insights for social workers to support involuntary clients to develop the motivation necessary

to actively engage in treatment. By recognising and addressing motivational factors, social workers can effectively guide individuals towards embracing a genuine desire to participate in treatment. Furthermore, Hachtel et al. (2019) explain that the TTM suggests that service users' engagement with treatment and recovery tasks is not a linear process. Instead, it involves movement back and forth between stages to support changes in their perceptions. Velasquez et al. (2005) refer to a process of change that involves stage-based interventions, with specific strategies to be utilised within each stage. The TTM consists of five stages of change to produce behavioural change (Robinson & Vail, 2012).

Stage 1 - Precontemplation: In this initial stage, there is little or no consideration of changing risk-behaviour because of a lack of insight or recognition of the consequences of the SUD (Opsal et al., 2019). The social worker creates opportunities to become aware of the consequences of the harmful use of substances.

Stage 2 - Contemplation: In this stage, the person begins to assess the risks associated with their behaviour and considers the option of change. They may seek and evaluate information, but they are not fully committed to engaging in bringing about change (Opsal et al., 2019). The social worker encourages reflection on the reasons behind the motivation to continue using substances, and the possible reasons why treatment should be considered.

Stage 3 - Preparation: The considerations raised during the previous stage leads to readiness for change. The person starts planning how and when to change behaviour (Hoy et al., 2016). During this stage, the social worker encourages the person and provides support to access resources and support.

Stage 4 - Action: The plan developed in the previous stage is put into action. Active steps are taken to change risky behaviour, and the person becomes able to enter and engage in treatment interventions. As a result, a new behavioural pattern is established and new skills are developed to prevent a return to the risky behaviour (Opsal et al., 2019).

Stage 5 - Maintenance: This stage involves strengthening and sustaining the behavioural changes made during the action stage. Self-efficacy plays an important role during this stage (Hoy et al., 2016).

The first three stages are particularly relevant to assist persons to move from external to internal motivation to change, and hence to promote voluntary treatment. Social work focuses on helping those who cannot readily help themselves, including treatment-resistant clients (Osborne-Leute et al., 2019). Bukhari et al. (2021) acknowledge that working with involuntary clients may impact on social worker's professional and personal wellbeing. Therefore, they recommend that a framework be adopted to empower social workers to assist clients to move towards internal motivation to engage with services offered. Bell (2019), exploring how the use of motivational interviewing as a technique of TTM, can assist social workers to support individuals who resist treatment, identified both social worker-related and client-related factors that pose challenges for the effective implementation of the TTM. Challenges for social workers include making a paradigm shift from experiencing resistance as only a challenge in service delivery to an understanding that motivation for change forms part of the intervention process, a lack of training and confidence to implement the TMM, and the fact that the move

between the different stages can be time consuming, which is not appreciated by their employer organisations. Challenges experienced with treatment-resistant clients include lack of support for them and cognitive impairment. Bell (2019) recommends that social workers receive training and supervision to capacitate them to effectively implement the TTM, and that they should be supported by the management of their organisations to utilise this framework in their work environments. The challenges mentioned underscore the importance of further exploration to discover innovative solutions that facilitate the effective implementation of the TTM in practical settings. Therefore, the research presented in this article aimed to explore and describe the experiences of social workers to make recommendations for the effective utilisation of the TTM for involuntary treatment of SUD.

METHODOLOGY

To explore the perceptions and realities experienced by social workers regarding the use of the TTM in involuntary treatment of SUD, this study was positioned as a qualitative research project. Through this approach, the meanings attached to the research question of this study were fully explored through in-depth narrative descriptions (Tuffour, 2017). A combination of exploratory and descriptive research designs was used to inform the choice of research methodology. The exploratory research design was used to discover new information (Swedberg, 2018), influencing the identification of the research population and sampling method as well as the technique to ensure that data were obtained from social workers who had experience in the field of SUD treatment, and also to identify a method for data collection that would ensure a full exploration of the topic. The descriptive research design was included to support the explorative research design, as it was used to describe details and characteristics that could be used to construct recommendations for practice (Nassaji, 2015). This design influenced the choice of methods for data collection and analysis.

To purposefully select participants who could share perceptions and experiences of the use of the TTM in SUD treatment, non-probability purposive sampling was used to draw a sample from registered social workers within the Western Cape province. The location was chosen as it facilitated accessibility. The inclusion criteria were social workers registered with the South African Council of Social Services Professions, who had more than two years of experience in working with individuals with SUD, and employed in in- and outpatient treatment facilities.

Data were collected through the use of individual semi-structured interviews. The semi-structured questions focused on the participants' experience and understanding of the TTM, their perceptions of how services can be delivered during the stages of the TTM, and the challenges they experienced during each of the stages. Thematic content analysis, employing the eight steps for qualitative data analysis proposed by Tesch (in Creswell, 2014) was used to analyse the data.

An interview guide, transcripts of the interviews, verbatim quotes, a literature control, an independent coder, non-probability purposive sampling, a comprehensive description of the research methods and techniques, and reflexivity were all elements to enhance the credibility, dependability and confirmability of the study's findings (Anney, 2014; Lietz & Zayas, 2010). The limitations of the study included that its scope was limited to the Western Cape region.

Although the findings were context related, they did contribute to a better understanding of how the reported challenges experienced by social workers in the use of the TTM can be addressed. The study also focused exclusively on social workers, and the perspectives of clients with SUD were not addressed, potentially limiting the understanding of the topic.

Ethical practice included avoidance of harm by conducting interviews at times and venues chosen by the participants, voluntary participation based on informed consent, anonymity, confidentiality and privacy through the use of pseudonyms and the storage and confidential management of data. The study was ethically cleared by the University of the Western Cape (Reference HS21/8/11).

DISCUSSION OF THE FINDINGS

Eight participants took part in the study. Data saturation was reached after six interviews, and was confirmed after the eight interviews. The geographical areas in the Western Cape represented by the participants were Paarl, Worcester, Ceres, Hermanus, Plettenberg Bay, Cape Town and Bellville. The participants worked in prevention, early intervention, treatment, statutory and aftercare services to their respective client systems. Their years of experience ranged from 2 to 20 years in the field of SUD.

The themes emerging from the data revealed perceptions regarding the difference between voluntary and involuntary treatment, descriptions of experiences related to what works well, challenges, requirements regarding the use of the TTM, and descriptions of experiences and perceptions related to intervention in the five stages of the TTM.

Theme 1: Perceptions regarding the difference between voluntary and involuntary treatment

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

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

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

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

When comparing voluntary with involuntary treatment, the participants in this study highlighted that involuntary service users typically exhibit a lack of desire to be in the treatment programme, an inability to recognise the problem, and/or limited awareness of the problem because of poor insight. Pasareanu et al. (2017), confirming this viewpoint, note that successful

treatment outcomes are primarily dependent on a service user's ability to develop insight and judgement regarding their own substance use. Therefore, a willingness to undergo treatment voluntarily is crucial. Consequently, the principle of autonomy serves as the foundation for service users accessing treatment voluntarily. Cousins (2020) adds that the unwillingness to participate in the treatment programme may have implications that have to do with power dynamics, coercion and control in the provision of services, which then affects the relationship between the service user and the service provider.

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

> *OK, 'voluntary', I would say, is your client who is aware of his problem or addiction and wants to be helped and is motivated to some level to be help[ed].*
>
> *So, in my opinion, voluntary clients have the motivation to be treated. They are basically accepted that they have substance use disorder or a substance use problem. There is a desire to enter the process of change, and they are willing, and there is to some degree an understanding of the problem and what the process of rehabilitation or change will entail.*
>
> *A voluntary client is a person [who] understands that there is a problem and that made a decision that they have a problem, and they're seeking help towards [treating] their addiction.*

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

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

> *To my knowledge, there are two types of involuntary clients. The first one is referred from the court who is a mandated client. Then there are involuntary clients that have been sent by their families or employers to come for help.*
>
> *With involuntary clients, they did not give consent per se.*
>
> *And then involuntary is for me like a forced situation. Where the client is doing it for some reason to please people, or the court is sending him. It's a must and not a want.*

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

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

> *And that makes change very difficult, because if you force me to go somewhere, I will not change at all. I've seen it so many times. They will relapse because they are not ready for change*.

> *They* [involuntary clients] *don't have insight with regards to the substance use disorder, which basically makes them reluctant. They are not at the point yet where they are motivated and that they have insight with regards to what it is that is happening in their lives*.

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

Theme 2: Descriptions of experiences related to what works well, challenges and requirements regarding the use of the TTM

Referring to the previously mentioned issue of insufficient insight that leads to the lack of motivation to change, a participant added that an advantage of the TTM is that the person is guided to understand the impact of the SUD: "*Advantages for me is that a client himself can start to see where is the problem and when it is the problem*". Other participants indicated that interventions are based on where the person is at in their understanding of their situation, and that the focus is on what is needed for this person to engage actively with treatment to become able to move towards recovery.

> *The advantages of this theory are that you get to understand where the client is, and you get to treat the client actually where the client is.*

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

Motivation for various stages within the TTM dictate the necessary interventions that are needed to ensure motivation for change and the movement to recovery and maintaining it. Acknowledgement is given of the stage of change in which the client is in order for treatment to be responsive to the client's readiness for change. As such, the TTM considers a decisional balance where the client is being guided to decide to engage in treatment aimed at changing their situation (Jimenez-Zazo et al., 2020). However, according to the participants, the TTM is not without challenges:

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

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

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

Another participant added that the context of client systems needs to be considered:

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

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

In terms of requirements for the effective use of the TTM, some participants referred to the setting of realistic and attainable goals in the contemplation and preparation stages, so that the clients can benefit from experiences of achievements they were able to make.

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

> *Finding realistic changes that they can make. Finding realistic goals. It's during the preparation phase because sometimes clients can get really pie in the sky* [referring to guiding clients towards realistic steps that they could carry through].

Similarly, Pennington (2021) posits that the TTM constructs stages of change, which is a representation of movement from a lower stage to a higher stage of change. The importance of assisting clients to move from the precontemplation phase is highlighted by Hall et al. (2014). They advise that the emphasis should be on highlighting risks and consequences to raise doubts about the continuation of substance use. Next, the contemplation stage can be used to explore

ambivalence, alternatives and reasons for change, as well as to increase the confidence to change.

Theme 3: Descriptions of experiences and perceptions related to intervention in the precontemplation stage

This stage entails working with a person who does not show insight into the consequences of substance use or the SUD, and who is not ready to engage with treatment interventions. The aim is to create an awareness of the risks and consequences of the continued use of substances (Hall et al., 2014). One participant summarised the precontemplation stage as follows:

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

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

> *If the client is in a precontemplation stage then I would look at what is the advantages and disadvantages of using drugs*.

Similar to the above descriptions, Opsal et al. (2019) advise that this stage should focus on creating awareness, so that the person becomes able to recognise the consequences of substance use on them and their families. Hall et al. (2014) explain that the focus of intervention in the precontemplation phase is on creating awareness of the impact of the SUD on the person, the family, the workplace and the community. For this reason, the inclusion of families can be a vital way to provide the person with facts and descriptions of what happens during substance use, as well as the consequences. In this study, the participants acknowledged that families are often not included in their services, while the involvement of families is viewed as an advantage of the TTM:

> *Many times, we do neglect to involve the family within the precontemplation stages. The family can play a very pivotal or important role in the stage as well as in the motivation of the client*.
>
> *And then also having the family support to go forward with changing*.

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

According to Jimenez-Zazo et al. (2020), the precontemplation stage is characterised by the absence of any observed intention to engage. Therefore, the focus in this stage should be on creating awareness and providing education about the benefits of harm reduction. Hall et al. (2014) state that education during the precontemplation stage is intended to cultivate awareness, with the goal of reducing substance use and modifying behaviours that impact detrimentally on both personal wellbeing and the wellbeing of others. Therefore, the inclusion

of awareness through education can be a highly effective strategy to assist involuntary clients to start considering change. In this study, the participating social workers acknowledged that awareness through education is mostly included in services to address misperceptions:

> *For me, the focus of intervention would be to, first of all, educate the client about, or creating awareness, what the substance is about... how different substances have negatives. And the positives, because some persons could see positives in substance use*.

> *I think the focus there should be on education to give the client information about what is substance abuse, what are the negative consequences of it, and what are available resources out there that can assist them.*

The above strategy to assist clients to explore advantages and disadvantages to create an awareness among involuntary clients is supported by Hall et al. (2014), who explain that highlighting the risks and consequences may raise doubts about their current behaviour.

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

> *Usually we do motivational interviewing where you ask the client how his or her substance use problem has affected the person's life. To show the client this and that is what happened when you were using substances*.

> *We implement motivational interviewing just for them* [the clients] *to realise where they are at but also for them to create their own internal or external motivation. What I like about motivational interviewing is that working with resistance is kind of working at their pace*.

Confirming the above, Bischof et al. (2021) note that motivational interviewing focusing on creating awareness may strengthen motivation to change behaviour, which may in turn promote adherence to treatment in later stages. Jimenez-Zazo et al. (2020) explain that the goal of the precontemplation stage is to enhance awareness of the benefits of change. This increased knowledge can potentially serve as a motivation to move towards contemplating participation in treatment options.

Theme 4: Descriptions of experiences and perceptions related to intervention in the contemplation stage

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

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

One participant added that, apart from becoming aware of the consequences of substance use, the person also starts to consider changing behaviour. This participant again emphasised the inclusion of family members in this stage:

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

The inclusion of support systems to assist clients in the contemplation phase is highlighted by Mahlangu and Geyer (2018), who conclude that those with SUD have a need for family members to be included and educated about how to support them. One participant added the importance of the inclusion of the church and support groups:

To involve the family, to involve the church. Not friends. Support groups, to have sessions on a weekly basis to get them into a routine.

According to Zebrowski et al. (2021), it is crucial to acknowledge that the contemplation stage involves individuals considering taking action in the near future, although they are not yet committed to making plans and taking concrete steps. Pennington (2021) refers to a decisional balance where the advantages for changing outweigh the disadvantages for clients contemplating to make changes. Confirming this line of thought, a participant described experiences in the contemplation stage in terms of exploring with the client why behavioural change would be beneficial:

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

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

Theme 5: Descriptions of experiences and perceptions related to intervention in the preparation stage

In the preparation stage, the client is preparing to embark on making changes in their lives that will show readiness for change. Zebrowski et al. (2021) describe the preparation stage in terms of where clients are taking the initial steps to embark on the process of change – for example, scheduling an appointment with a social service professional for intervention. One participant added that the intervention focuses on preparing the client to enter treatment:

I believe that the focus in the preparation stage is preparing the client now to go to therapy.

As in the descriptions of the previous two stages, another participant stressed the importance of including the family:

I think it is really important that you include the family in the preparation stage; starting to make certain changes in the family will help the client.

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

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

So, in the preparation stage, I say it is always the easiest when clients come to us and say they are ready to either reduce their use or they are two weeks clean. Some say, "You know what, I was using three substances, and I only use one substance now since implementing lifestyle changes.

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

Finding a realistic change that they can make. Finding realistic goals.

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

In line with the above descriptions, Williams et al. (2019) comment that goal setting, small successes and the achievements of goals is one way of motivating clients to move to the action stage.

Theme 6: Descriptions of experiences and perceptions related to intervention in the action stage

The action stage entails working with someone who is willing to make the necessary changes to address the SUD. In terms of this study, it would mean that the client has moved from being an involuntary to a voluntary client. This stage is characterised by the intention and active engagement of changing the environment and/or behaviour of the client (Zebrowski et al., 2021). Further clarifying this stage, one participant summarised the action stage as follows: "*The action stage is where the client actually is in and busy with the treatment*". Furthermore, another participant referred to self-efficacy and indicated that the client becomes more independent during this stage: "*In this stage, the client can keep on working for themselves to succeed in recovery*". Despite this statement, other participants highlighted that the use of support groups and regular contact with the client and the family are still required.

So, we refer those who are in the action stage to NA [Narcotics Anonymous]. *Here we try to encourage them to find sober peer support, because that will help them maintain sobriety and to stick to the new healthy behaviours that they have implemented*.

It is important that you, as the practitioner, are visible, accessible, and are there and not forgetting about the client; and always monitoring. It is important that you, the practitioner, is involved, as well as the family. So that they don't feel that they are now alone and that you forgot them.

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

Theme 7: Descriptions of experience and perceptions related to intervention in the maintenance stage

This stage may be viewed as an extension of the action stage, with a focus on maintaining sobriety to prevent relapse. Underscoring the significance of this stage, Azmi et al. (2018) point out that relapse remains a long-term risk and challenge, and that this stage assists clients to develop strategies to prevent relapses. This viewpoint is further reinforced by the participants in this study.

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

Once the client is out of rehabilitation, determining how to support the client will be helpful to stay in the maintenance stage, otherwise the client will relapse.

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

One participant concurred that relapse prevention strategies should be included in the action stage already so as to prepare the client for the maintenance stage.

So, in the maintenance stage, we focus on primarily relapse prevention even though it is also implemented in the action stage. The main focus is on the relapse prevention, especially in the earlier stages of recovery.

The findings confirm that the maintenance stage is characterised by sustaining the changes made during the action stage and actively preventing relapse (Zebrowski et al., 2021). According to Ritonga et al. (2022), aftercare services provide programmes to respond to high cases of relapse. Mahlangu and Geyer (2018) advise that these programmes must include therapeutic interventions to assist clients to deal with life challenges without reverting back to the use of substances. The participants in this study explained that their understanding of this stage is that the client is assisted with services that ensure that support is available in times of need. Additionally, this stage helps with implementing further changes necessary to maintain sobriety.

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

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

In support of the above descriptions, Ritonga et al. (2022) describe the purpose of aftercare services as strengthening behavioural changes and social changes in the family environment. As mentioned, the focus is on preventing relapses. However, one participant also described the focus of this stage as management of relapses:

> *Clients can easily have a relapse, because they do not attend sessions anymore. They do not come to an individual session, and they feel like they are now a recovering addict, so they don't need our services anymore*.

This is confirmed by Wangithi and Ndurumo (2020, p. 153), who advise that "relapse is a key area that requires further investigation", because younger adults have a higher relapse tendency. Kabisa et al. (2021) argue against confining the management of relapse to detoxification alone. Instead, they advocate for a stronger focus on providing extended follow-up services. These authors base their viewpoint on research that has shown that "more that 50% of persons with a SUD relapse after treatment" (Kabisa et al., 2021, p. 10).

Wangithi and Ndurumo (2020) assert that the employment status of clients is significantly linked to relapse. This line of thought supports Mahlangu and Geyer's (2018) report that unemployment contributes extensively to social issues like substance use. These authors explain that unemployment can become a risk factor in the maintenance stage, while employment opportunities can serve as a protective factor that may prevent relapses. As a final description of the participants' perceptions and experiences, the role of the social worker in the maintenance stage was also described in terms of assistance to find employment.

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

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

The findings described in this section were aimed at describing social workers' perceptions and experiences of the use of TTM in involuntary treatment of SUD. The article concludes with recommendations aimed at the effective implementation of this model in practical settings.

RECOMMENDATIONS

To further contribute to the discovery of innovative solutions that facilitate the effective implementation of the TTM in treatment settings, further research is recommended as follows: 1) Exploration of the application of the TTM in the field of substance use from a multidisciplinary perspective, involving various disciplines to promote an interprofessional approach; 2) an investigation into the experiences and perceptions of clients and their families regarding the use of the TTM; and 3) research focusing on individuals with SUDs who transitioned from being involuntary to voluntary clients, aiming to identify successful strategies and factors that facilitated positive outcomes to contribute to the effective use of the TTM.

The following recommendations are proposed for social work practice. Concerning social inclusion to combat discrimination and marginalisation in social work practice (Lee, 2021), it is recommended that social workers use the TTM as an intervention strategy and motivational interviewing as a technique to use with involuntary clients referred for interventions in terms of Section 33 of the Prevention and Treatment of Substance Abuse Act (RSA, 2008). Furthermore, organisations in the field of substance should develop policies and practices to ensure services are rendered to involuntary clients, considering that resistance to change is a characteristic of SUD. It is recommended that networking takes place to ensure collaboration with other stakeholders in the support of clients' recovery journey, such as churches, support groups and organisations that could support the creation of, or networking with, employment opportunities. Recognising that reluctance to enter treatment is a characteristic of SUD, continuous professional development opportunities should be made available for social workers in the field of substance use to develop the knowledge, understanding and skills to use the TTM and motivational interviewing effectively. In addition, it is recommended that specialised training and education be viewed as a requirement for social workers rendering services in the field of substance use. Consideration of clients' contexts should receive attention when providing services using the TTM to guide macro services that address contextual needs and challenges. Families should also be included and motivated to participate in services throughout the interventions in the stages of the TTM. Importantly, the maintenance stage should be considered as an integral and not an optional part of the intervention process.

This article has provided an account of social workers' experiences in using the TTM in the treatment of involuntary clients with SUD. The findings of this study demonstrate the significant role the TTM can play in enhancing treatment accessibility for involuntary clients and facilitating a transition towards voluntary participation in interventions.

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