University of Botswana

Faculty of Social Sciences

Department of Social Work

Research Topic

Social Workers' Knowledge, Attitudes and Self-Efficacy in Working with Clients with Alcohol Problems in Kweneng and South East Districts of Botswana

A Research Dissertation Submitted in Partial Fulfillment of the Requirements for the Master's Degree in Clinical Social Work

Submitted By

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APPROVAL

This dissertation has been examined and approved as meeting the required standard for a partial fulfillment of the requirements for the Master Degree in Social Work (MSW).

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DECLARATION

I declare that this is my original work, except where I referenced other researchers. This dissertation has not been submitted for any degree award in any other university.

Signed …….

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ABSTRACT

This study is among the first, to used mixed method design in Botswana to explore social worker's knowledge, attitudes and self-efficacy in working with clients with alcohol problems in Kweneng and South East Districts Councils. Central assumptions guiding the study were derived from TRA& PB and Self-efficacy theory. Firstly, simple random sampling helped select 65 participants, and then qualitative judgemental sampling selected 12 participants.

The results revealed that social workers had low levels of knowledge, 66% scored less than half (0-48%) on the AKS scale. Outcomes supported that social workers (51%) attitudes are marginally negative. ACSES scale showed that more than half of the social workers 51% had low confidence in their skills and knowledge. Control variables regressions showed that level of education (beta=.25, *p*=.04) together with clinical supervision (beta=.30, *p*= .03) positively affected social workers knowledge, attitudes, and self-efficacy. Multiple regressions indicated that knowledge (beta=.24, *p*=.05) and attitude (b=.28, *p*=.02) positively affected social workers intentions to help clients with alcohol problems. The study had many research and practical implications but at the core councils should provide training and formulate a clear Standard Operating Procedure for social workers for helping clients with Alcohol and Alcohol Problems.

Keywords; Knowledge, attitude, self-efficacy, alcohol problems, social workers.

ACRONYMS AND ABBREVIATIONS

AAPPQ	Alcohol and Alcohol Problem Perceptions Questionnaire
AAS	Attitude about Alcoholism Scale
ACSES	Addiction and Counsellor Self-Efficacy Scale
AKS	Alcohol Knowledge Scale
ANOVA	One way Analysis of Variance
CSO	Central Statistics Office
DSS	Department of Social Services
GoB	Government of Botswana
KAS	Knowledge, Attitude, and Self-Efficacy
MoLGRD	Ministry of Local Government & Rural Development
MOH	Ministry of Health
NIAAA	National Institute on Alcohol Abuse and Alcoholism
RAC	Rural Administration Centres
S & CD	Social and Community Development Department
SRS	Simple Random Sampling
SRSWOR	Simple Random Sampling without replacement
TRA & PB	Theory of Reasoned Action & Planned Behaviours
UB	University of Botswana
UBIRB	University of Botswana Institutional Review Board
WHO	World Health Organization

LIST OF DEFINITIONS

Standard definitions for alcohol problems are mainly found in the Diagnostic and Statistical Manuals of Mental Disorders (DSM) of the American Psychiatric Association (APA), and the International Classification of Diseases (ICD-10) of the World Health Organization (WHO). This study chose to adopt the DSM definitions of universalism, validity, and reliability.

Alcohol: commonly known as "*Bojalwa or Nno Tagi*" in Botswana. The type of alcohol discussed in this study refers to ethyl-molecular formula (C_2H_5OH). Ethyl alcohol, or ethanol, is an intoxicating ingredient found in beer, wine, and liquor (APA, 2000).

Alcohol Problems: refer to the compulsive and uncontrolled consumption of alcoholic beverages, usually to the detriment of the drinker's health, personal relationships, and social standing (APA, 2000). Alcohol problems include alcohol abuse or alcohol dependence which may cause liver cirrhosis among other conditions.

Alcohol Abuse / Harmful Use: "A maladaptive pattern of drinking, leading to clinically significant impairment or distress as manifested by *at least one* of the following:

- Continued use despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by the use of the psychoactive substance.
- Recurrent use in situations in which use is physically hazardous (e.g., driving while intoxicated) occurring within a 12 month period" (APA, 2000).

Alcohol Dependence/alcohol addiction/alcoholism: is a "A maladaptive pattern of drinking, leading to clinically significant impairment or distress, as manifested by *three* of the following:

- Need for markedly increased amounts of alcohol to achieve intoxication or desired effect;
- or markedly diminished effect with continued use of the same amount of alcohol, the characteristic withdrawal syndrome for alcohol;
- or drinking to relieve or avoid withdrawal symptoms, Drinking in larger amounts or over a longer period than intended, Persistent desire or one or more unsuccessful efforts to cut down or control drinking occurring within a 12-month period" (APA, 2000).

Attitudes: Attitude is a learned predisposition to respond in a consistently favourable or unfavourable manner with respect to given object or event (Ajzen, 2005). Respective of Ajzen definition; attitudes in this study referred to social workers affective, behavioural and cognition components towards clients with alcohol problems. The characteristics attributes of attitude are its evaluative (pro-con, pleasant-unpleasant) nature

Clients: In this study a client referred to a person receiving social or medical services *for* alcohol problems in the social and community development.

Knowledge: Facts, information, and skills acquired through experience or education; the theoretical and practical understanding of a subject (Pearsall & Hanks, 2003). The more informed you are on the topic, the stronger your attitude typically predicts behaviour.

Self-efficacy: According to the psychology dictionary it is our self-assurance in trusting our abilities, capacities and judgment. The concept is variously called self-efficacy in the health belief model and social cognitive theory and perceived behavioural control, in the theory of planned behaviour.

> The concept of self-efficacy refers to "one's belief in one's ability to perform successfully in a particular situation" (Bandura, 1986). It is characterised by personal attributes such as assertiveness, optimism, enthusiasm, affection, pride, independence, trust, the ability to handle criticism and emotional maturity.

Social worker: In this study, a social worker is an individual that is trained and employed in the social work profession to help people with a broad range of issues, including psychological, financial, health, relationship, and alcohol problems in the case of Botswana through the Department of Social and Community Development.

CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

Introduction to the study

Alcohol problems are one of the major public health issues facing many countries today (Hall, Amodeo, Shaffer & Vander Bilt, 2000; BNYC, 2004; Straussner, 2001; King & Lorenson, 1989; Rehm, Mathers, Popova, Thavorncharoensap, Teerawattananon & Patra, 2009; WHO, 2008). Since the late 1900s, alcohol problems were among the fast emerging problems that required prompt attention in Botswana (Campbell & Ntsabene, 1997; Molamu & MacDonald, 1996; MacDonald, 1997; Molamu & Manyeneng, 1988). The Government of Botswana [GoB] has since tasked front-line health practitioners with the responsibility of working on alcohol problems (Global Status Report on Alcohol, 2004; WHO, 2008; MoH, 2010). The health practitioners among others include nurses, psychologists, counsellors, guidance and counselling teachers and social workers.

During the early 2000s, these practitioners established diverse programs and came up with campaigns such as Fokotsa Dino (2010), Youth Against Alcohol Abuse Campaign (2012) and the Alcohol Levy (2008). The core objective of these programs was to reduce alcohol prevalence and associated risk factors. Despite the efforts, alcohol problems have continued to be on the rise in Botswana (Campbell, 2003; Global Status Report on Alcohol, 2004; World Health Organization, 2004). The health problems related to excessive alcohol use, both regarding morbidity and mortality, are also considerable in most parts of the world (Clark & Foy, 2000; Galvani, 2006; Miller 2001; WHO, 2008). High alcohol intake is

associated with increased risk of cardiovascular diseases, suicides, road accidents, violence, HIV transmission and family break-ups (MOH 2010; Phorano, Nthomang & Ntseane, 2005; Rehm, Chisholm, Room & Lopez, 2006; WHO, 2008).

The adverse health and social consequences often result in people seeking and receiving social work intervention (Galvani & Forrester, 2008; National Institute on Alcohol Abuse and Alcoholism, 2005; Vaughn, Howard & Jenson, 2004). Evidence from the literature suggests that because of their prominence in varied health and social service settings, social workers are well-positioned to intervene with persons with alcohol problems (Amodeo, Shaffer & Vander Bilt, 2000; Straussner, 2001; Holder, Longabaugh, Miller, & Rubonis 1991; King & Lorenson, 1989). Extensive literature shows that social workers are well placed to play an active role in screening, assessment, treatment and referrals of clients with alcohol problems because of the profession's holistic and ecological approach (Galvani & Forrester, 2011; Rhodes & Johnson, 1996; Van Wormer, 1987).

Despite the need for intervention with clients with alcohol problems, existing literature suggests that social workers in many parts of the have yet to provide effective interventions to clients with alcohol problems (Amodeo, Fassler & Griffin, 2002; Faul & Hudson, 1997; Gregoire, 1994). This shortfall has been mainly due to lack of or inadequate knowledge, negative attitude and low self-efficacy (Bailey, 1963; Geissinger, Humphry, Hanft & Keyes, 1993; Peyton, Chaddick & Gorsuch, 1980; Sapir, 1957; Sterne & Pittman, 1965).

Mueser, Rosenberg, Drake, Miles, Wolford, Vidaver, & Carrieri (1999) indicated that most social workers fail to ask clients about alcohol and drug use because of lack of knowledge on alcohol issues. The lack of knowledge has been linked to inadequate alcohol

problems training and skills (Christensen et al., 2004; Ingraham, Kaplan, & Chan, 1992; Kiley et al., 1992). Gregoire (1994) found that social workers failed to identify and respond to clients alcohol problems in 83% of the cases examined. Faul & Hudson (1997) also found that social workers are increasingly challenged to provide effective interventions for alcohol-related problems.

Conversely, attitudes of the social workers providing treatment, contribute to the overall experience and outcomes (Amodeo & Fassler, 2000; Stein, 2003). Empirical research and clinical literature have suggested that social worker's attitudes are often somewhat negative towards clients with alcohol problems (Amodeo, 2000; Googins, 1984; Silverman, 1993; Strozier, 1995; Wechsler & Rohman, 1982). These negative attitudes are thought to result in social workers not recognizing alcohol problems issues, or inadequately treating and referring clients who have alcohol problems (Greer, Roberts, & Jenkins, 1990; Howard & Chung, 2000a; Ingraham, Kaplan, & Chan, 1992; Shipley, Taylor, & Falvo, 1990; Tober, 1993).

Additionally, self-efficacy has received support as a factor that predicts behaviour change (Burlington, Reilly, Moltzne, & Ziff, 1989; Fiorentine & Hillhouse, 2002; Maisto et al., 2000). Rose, Brondino & Barnack (2009) argued that social workers do not usually screen or assess clients due to lack of self-efficacy in utilizing alcohol treatment skills. Social workers tend to hesitate to raise the issue of alcohol problems with their clients because they would be uncertain about how best to proceed with treatment, once a problem was identified (Magura, 1994; Corse, McHugh & Gordon, 1995). It is also acknowledged that social workers lack confidence, and skills in working with people with alcohol problems (Harrison, 1992; Isaacs & Moon, 1985; Lawson, 1994; Leckie, 1990; Smith, 1988).

Justification of the study

This study therefore sought to explore the preceding literature challenges and gaps in Botswana. Firstly, research suggests that social workers knowledge, attitudes and self-efficacy influence their intentions to help clients with alcohol problems (Chappel & Veach, 1987; Howard & Chung, 2000a; Gregoire, 1994; Taricone & Janikowski, 1990). However, there is apparently no literature in Botswana that discusses the relationship between social workers knowledge, attitudes and self-efficacy and their intentions to help clients with alcohol problems. Secondly, there is comprehensive data on social workers' knowledge and attitude towards clients with alcohol problems worldwide, yet, little is known about the case of Botswana (Amodeo & Fassler, 2000; Kiley et al., 1992; Rogers, 2010; Wechsler & Rohman, 1982). This study was therefore, conducted with a view to establish social workers' knowledge, attitudes and self-efficacy in working with clients with alcohol problems in Botswana.

Background of the study: Consideration of key concepts

Alcohol use, problems, and effects

The total estimate of recorded and unrecorded adult per capita consumption of alcohol for Botswana is 8 litres of pure alcohol per inhabitant, well above the regional average of seven litres (WHO, 2002). In Botswana alcohol is commonly referred to as *"Bojalwa."* Traditionally people consume traditional alcohol termed "*Majalwa a Setswana*" such as "*Khadi, Tipi Ya Mokwatla, Setopoti and Chibuku.*" Commonly consumed alcohol comprises Black Label, Savanna, Autumn Harvest and a few more. Botswana was ranked nineth in Africa in terms of alcohol consumption while Nigeria tops the rankings with 12.28 litres per year, followed by Uganda and Rwanda (Global Status Report, 2004).

A population-based study found out that approximately 49% of adults in Botswana drink alcohol regularly, 30% of that figure were males and 19% females (Population-Based Survey, 2007). Health statistics in Botswana indicate that alcohol has been one of the major contributory factors of ill-health (Central Statistics Office, Gaborone, 2004). According to data collected by the Botswana Epidemiology Network on Drug Use, alcohol remains the most common primary substance of abuse reported by patients, accounting for 84% of the 72 patients (Global Status Report on Alcohol, 2004). In a study of adults aged 15-49, from 5 districts in Botswana, 31% of men and 17 % of women met the criteria for heavy alcohol consumption (Weise, et.al, 2006).

The health statistics report indicated that between 2001 and 2006, one out of 10 hospital admissions was related to accidents and injuries (MOH, 2007). Statistical data from Sbrana Psychiatric Referral Hospital in 2010 also revealed that 75% of psychiatric admissions were alcohol-related (MOH, 2010). In 2012, police recorded 3,748 drunken driving cases countrywide (Botswana Police, 2012). The police report also revealed that alcohol abuse has been linked to road accidents (Botswana Police, 2012). Alcohol was found to be a contributory factor in 200 recorded accidents in the first quarter of 2013 (January to March) that rose to 222 from April to June 2013 (Botswana Police, 2013). Furthermore, 3 % of all deaths in January to June 2013 were attributed to accidents and injuries encountered from drinking and driving cases (Botswana Police, 2013).

Nthomang, Ntseane & Phorano (2005) found that alcohol abuse by men led to gender-based violence, reduced women's ability to negotiate safe sex and increased the risk of both parties to contracting HIV. Mirkovic (2012) study in Botswana investigated whether imposed alcohol policies in Botswana were effective in alcohol reduction and Batswana perceptions

on the policies. The study findings revealed that 59 % of participants reported drinking in the same manner as before the alcohol levy was imposed, 27% reported drinking more while 14% reported less drinking (Mirkovic, 2012). These findings suggested that Batswana consume the same amount of alcohol regardless of the price and working hours of liquor stores (Mirkovic, 2012). Insignificant change in alcohol consumption was further linked to potentially harmful behaviour such as memory loss (43%), drinking and driving (33%) while 22% engaged in unprotected sex (Mirkovic, 2012).

Social workers' role and responsibilities

Social workers encounter clients with alcohol problems in a variety of settings, not limited to specifically alcohol prevention and treatment facilities (Abel, 1983; Davidson, 1992; Oliver, 1985; National Institute on Alcohol Abuse and Alcoholism, 2005; Walker, Baker & Bennett, 1996). However, in most instances alcohol and drug problems have not been placed on the social work agenda in the past (Adams, 1999; Forrester, 2000; Corby & Millar, 1998; Davies, Harwin & Forrester, 2002; Duncan & Coggans, 1995; Foster et al., 2003; Lawson, 1994; Kent, 1995; McCarthy & Galvani, 2004). McCarthy & Galvani (2010) recognised that core social work assessment, treatment and termination skills are ideal for working with clients with alcohol problems. Additionally, alcohol problems disorders such as alcohol abuse and dependence are explained in the DSM manual to promote universal knowledge in helping alcohol clients (APA, 2010).

Social workers' have the responsibility to ensure that clients with alcohol problems have access to affordable and efficient treatment (Fleming, 2005; McCarthy & Galvani, 2010; National Treatment Agency for Substance Misuse, 2009). While social workers routinely assess the variety of clients' needs, if they are less informed on alcohol and drug problems,

interventions for alcohol problems will be less effective (Alaszewski & Harrison,1992; Keene, 2001; NIAA, 2005; Rhodes & Johnson, 1996). It is, therefore, essential for social workers to identify clients who do not necessarily meet the criteria for alcohol disorders, yet drink at levels that place them at risk (Scottish Government, 2008).

Although social workers' are expected to exercise these roles, most studies acknowledged impediments in helping clients with alcohol problems (Best et.al, 2010; Galvani & Forrester, 2011; Scottish Government, 2008). The impediments suggest that social workers do not possess the necessary knowledge and attitudes, or skills to help clients with alcohol problems effectively (Siegfried et.al, 1999; Royal College of Psychiatrists 2002). Since attitudes can also impact on the extent to which knowledge is accepted and used in practice, staff attitudes towards individuals with alcohol problems are regarded as an important part in helping these clients (Scottish Executive Health Department, 2002).

The most valid and reliable tool used in studies is the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ). The tools could be used to aid in recruitment of staff that demonstrate therapeutic commitment and attitudinally suited to work with alcohol problems clients. It can also be used to determine social workers continuing professional development needs, and to evaluate the effectiveness of educational programmes. This study, therefore, adopted the AAPPQ (Appendix 3) scale to determine social workers professional needs regarding knowledge, attitudes, and self-efficacy in working with clients with alcohol problems.

Social workers' knowledge, attitudes, and self-efficacy

The subtopic discussed the major study variables to set a baseline and context of social workers' knowledge, attitudes and self-efficacy. Knowledge refers to facts, information, and skills acquired through experience or education subject (Pearsall & Hanks, 2003). Kagle (1987) reported that social workers need adequate recognition of alcohol disorders as a problem. According to Howard & Chung (2000a), social workers' and other helping professionals often failed to intervene with alcohol problems. Studies from other disciplines have similarly documented the lack of vital knowledge about educational training on alcohol problems among nurses (O'Neal, 1993) psychologists (Schlesinger, 1984) and social workers (Kerion, 1990; Levine & Mellor, 1988; Raffoul, 1986; Rodriguez, 1995). Giannetti, Sieppert & Holosko (2002) found that the education of health, mental health and social work professionals regarding alcohol abuse has been minimal.

Literature suggests that there is a correlation between knowledge and attitudes in predicting behaviour. Howard & Chung (2000b) found that some practitioners viewed alcohol and other drugs users as morally or genetically-defective and therefore not agreeable to treatment. Kagle (1987) also reported that social workers had negative attitudes about treatment success, and failed to intervene or make an appropriate referral where alcohol disorders were recognized as a problem. Amodeo (2000) examined the therapeutic attitudes and activities of two groups of practicing social workers (those with and those without explicit alcohol problems training). The results suggested that those without training scored significantly lower on an attitude scale (Amodeo, 2000).

Conversely, self-efficacy research focused more on beliefs about training, supervision and interventions targeting self-efficacy beliefs (Adams & Gallon, 1997; Amodeo & Fassler,

2001). Adams & Gallon (1997) studied the consistency between self-perceived capabilities and 'actual' competence for addiction counselling on social workers. Adams & Gallon (1997) found that new counsellors in the profession rated themselves more capable like their corresponding supervisors. Amodeo & Fassler (2001) evaluated the effect of professional development on patterns of practice and competency for working with addiction clients among social workers. The findings showed that social workers who completed intensive training had significantly diagnosed more clients with alcohol disorders and rated themselves as more competent in their intervention strategies when working with alcohol and substance abusing clients (Amodeo & Fassler 2001).

Globally, known factors that influence addressing alcohol problems include knowledge on alcohol problems (Amodeo & Fassler, 2001); attitude towards clients (Ritson, 1999) and supportive supervision on alcohol problems (Carrilio et al., 2002). Then, as noted, no evidence exists in Botswana to enlighten social workers on knowledge, attitudes, and self-efficacy. There is need to locally investigate the preliminary evidence that social workers knowledge, attitude, and self-efficacy predict behaviour. The study, explored social workers' knowledge level, attitudes, and self-efficacy in helping clients with alcohol problems in Botswana.

Statement of the problem

Alcohol is the most heavily used substance in Botswana and accounted for about 95% of all substance use (Campbell, 2003). Alcohol is recognized as a significant public health and social problem in Botswana (Molamu & MacDonald, 1996; Campbell & Ntsabene, 1997; Molamu & Manyeneng, 1988). The GoB has designed acts and policies to combat alcohol

problems such as the Liquor Act, 2003 (Act No. 9 of 2004), Substance Abuse and Drug Trafficking Strategic Plan (2003–07), Liquor Regulations (2008), Statutory Instrument No. 26 of 2008, Control of Goods and Intoxicating Liquor Levy Amendment Regulations (2008).

Despite GoB attempts, alcohol problems are growing in Botswana and so are the health and socio-economic consequences (Campbell, 2003). Alcohol is seen as a contributing factor to an increasing number of negative events, and injuries reported at health facilities (World Health Organization, 2004). The economic consequences of habitual alcohol use are devastating and act as various barriers to developments in Botswana (Global Status Report on Alcohol, 2004). In a WHO (2004) study, informants stated that since a significant proportion of household income was spent on liquor, less cash was available for food, clothing and other essential items.

Consequently, alcohol problems constitute one of the general issues encountered by social workers in most treatment populations (Hasin, Goodwin, Stinson & Grant, 2005; Kessler et.al, 1999; O'hare, Shen, & Sherrer, 2010; Shulenberg & Anthony, 1997). Social workers are often the first point of contact for individuals experiencing alcohol problems (Gassman, Demone & Albilal, 2001; Hall, Amodeo, Shaffer & Vander Bilt, 2000; Tam, Schmidt & Weisner, 1996). Social workers play vital roles in screening, assessment, case management, motivation to change, motivation to enter treatment, promoting treatment adherence, and intervention to prevent and treat alcohol use disorders (Fleming, 2005; McCarthy & Galvani, 2010; Straussner, 2001; van Wormer & Davis, 2008).

Additionally, social workers are in an ideal position to serve as addiction treatment personnel due to the clinical focus of their education (Amodeo, 2006). And yet, many who

work in social work settings still have difficulty with the identification and evaluation of clients with alcohol problems (Lundgren, Amodeo, Krull, Chassler, Weidenfeld, Zerden, Beltrame, 2011; Martino, Brigham, Higgins, Gallo, Frees, Albright, Condon, 2010; McCarty, Edmundson & Hartnett, 2007; Warren & Hewitt, 2010). This is probably because most social workers have little training in working with clients with alcohol problems (Straussner & Senreich, 2002). For social workers', inability to understand alcohol abuse as well as the role of addiction in a client's social, emotional, and medical problems leads to incorrect assessment and treatment (Schenk & Holosko, 1996).

In Botswana, the first Certificate in social work course, of the one-year duration, begun at the Botswana Agriculture College (BCA). BCA remained the only centre for training of social workers within Botswana until the programme was transferred to the University of Botswana in 1985, where a Certificate in Social Work and a Diploma in Social Work were offered (Ferguson-Brown, 1996). In 1986, a four-year degree programme was introduced. Lack of sufficient training and knowledge on alcohol problems could be associated with these slow beginnings of the profession in Botswana (Ferguson-Brown, 1996). It could also be concluded that oversight of curriculum specialization in problems factors such as Gender Based Violence, Substance Abuse, Poverty and HIV&AIDS has contributed to limited knowledge of these subject matters.

Another significant contributor to the anomaly is probably the small number of professionally educated and trained personnel, as shown in studies of the addiction treatment workforce (Campbell, Catlin & Melchert, 2003; Kerwin, Mulvey, Hubbard & Hayashi, 2003; Walker-Smith & Kirby, 2006). The training and education are currently still inadequate (Giannetti, Sieppert & Holosko, 2002). In consequence, limited training and education

usually result in negative attitudes, low levels of knowledge and self-efficacy in responding to the treatment needs of clients with alcohol problems. As such, Zastrow & Kirst-Ashman (1994) asserted that social workers require knowledge and skill in assessment, intervention and case management with alcohol clients because alcohol problems co-exist with many of the fundamental social and emotional problems that social workers' treat.

Literature has revealed that inadequate training and education for social workers' working in the addiction field has existed for a number of years across the globe (Petty, 1976; Logan, McRoy, & Freeman, 1987; van Wormer, 1987). Nonetheless, the researcher is not aware of any study in Botswana that distinctively looked at social workers knowledge, attitudes and self-efficacy in working with clients with alcohol problems. Recognition is made to a similar study that examined social workers' values in relation to drugs and alcohol programs (Kwakwa, 1992). That study was significant, in that it has contributed to identifying some of the gaps in the social work curriculum. However, no study has been done since then, which is not surprising because even in the western countries, little has been done to improve social workers training on issues of alcohol problems.

Additionally, over the years' research on alcohol in the social work profession in Botswana has focused mostly on alcohol prevalence, causes, consequences and the relationship with HIV & AIDS. Phorano, Ntseane & Nthomang (2005) conducted a study to determine a link between excessive alcohol consumption, gender-based violence and HIV & AIDS. Phorano et al. (2005) conducted in-depth interviews with agency coordinators, social workers', police commanders and police officers. Nzymi (2009) carried out a study to understand the root causes of alcohol use and abuse in the UB community.

Most of these studies used select study populations such as the Basarwa, police officers and UB students but not social workers. The majority of the researchers utilised qualitative designs except for Nzymi (2009) who used the quantitative method. It is apparent from the literature that qualitative methods have a limitation in respect of results validity and representativeness. As such the current study saw the need to focus on service providers as units of analysis and also add a quantitative aspect to collect data that are valid and representative of the whole community. The study, therefore, investigated social workers as units of analysis and used the mixed method (approach) methodology.

Main Goal

The goal of this study was to describe and explore social workers' knowledge, attitude, and self-efficacy in working with clients with alcohol problems in Kweneng and South East Districts of Botswana.

Specific objectives

1. To identify the level of social workers' knowledge of alcohol and alcohol problems.
2. To determine social workers' attitude towards clients with alcohol problems.
3. To assess social workers' self-efficacy in helping clients with alcohol problems.

Research questions

1. What is the level of social workers' knowledge of alcohol problems?
2. What are social workers' attitudes toward clients with alcohol problems?
3. What is the level of social workers' self-efficacy in helping clients with alcohol problems?

Theoretical Assumptions

1. The attitude of social workers' towards helping clients with alcohol problems positively affects behavioural intentions.
2. Subjective norms of colleague's knowledge and ability to deal with alcohol problems positively affect behavioural intentions.
3. Perceived behavioural control of social workers' in helping clients with alcohol problems positively affects behavioural intentions.
4. Behavioural intention to help clients with alcohol problems positively affects behaviour.

Significance of the study

Policy- The findings may also contribute by informing the Social and Community Development (S&CD) development and policy to ensure the highest quality of care for clients with alcohol problems. The outcomes of the study may play a substantial role in the review of Botswana's Alcohol Policy. Results may also help with the formulation and implementation of guidelines or policies that would direct practitioners on how to carry out alcohol problems interventions.

Professional practice: Findings from this study may help improve social workers' knowledge and skills, to anticipate consequences and design relevant interventions to address alcohol problems. Given the connection between perception and behaviour, the results may positively modify, or change social workers' attitudes in working with clients with alcohol problems in Botswana. The outcomes may also help social workers' to be aware of their self-

efficacy when helping clients with alcohol problems. Hence foster improvement on social workers with low self-efficacy and maintenance to those with high self-efficacy.

Research: The examination of social workers' knowledge, attitudes and self-efficacy in the field of alcohol is imperative to the education and development of future social work professionals in Botswana. The findings from the study will contribute to the existing knowledge of alcohol issues in social work and set a baseline of social workers' knowledge in Botswana. Significant attention is given to the prevalence, aetiology and outcomes of alcohol problems on clients but currently little knowledge exists about service providers. The study findings might help researchers to focus more on studying social workers' as units of analysis instead of unpacking clients' issues and neglecting service providers.

By inference, the background to the study assumes that knowledge, attitude and self-efficacy play a crucial role in social workers' intentions to help clients with alcohol problems worldwide. Tapping on studies of the forefathers of intention (Ajzen & Fishbein, 1980) and self-efficacy (Badura, 1977) , the theoretical rationale of this study is guided by the theory of Reasoned Action and Planned Behaviour and Self-Efficacy Theory. Both the theoretical philosophies and underpinnings are discussed thoroughly in the subsequent chapter.

CHAPTER TWO

THEORETICAL FRAMEWORK

Overview

Theories create the base of knowledge in everyday social work and influence the research. This chapter discusses the theories that guided the study to explain social workers' knowledge, attitudes and self-efficacy in working with clients with alcohol problems. Major assumptions guiding the study were derived from the Theory of Reasoned Action and Planned Behaviours (TRA-PB) currently the Integrative Model of Behavioural and Self-Efficacy Theory. Both theories are used to explain how knowledge, attitudes and self-efficacy and intention explain intention and behavioural action. This review provides a context for the present study and draws attention to theoretical proponents, tenets, and applicability.

The Theory of Reasoned Action and Planned Behaviour (TRA-PB)

The Theory of Reasoned Action and Planned Behaviour (TRA-PB) originated from the Health Belief Model which is now called Integrative Model of Behavioural Prediction. In this study, the researcher used the two names interchangeably where applicable. Social scientists and investigators from other disciplines have extensively referenced TRA to predict and understand motivational influences on behaviour (Ahern, Stuber & Galea, 2007; Lightfoot & Orford, 1986; Sheppard, Hartwick & Warshaw, 1988; Taylor & Todd, 1995; Wechsler & Rohman, 1982). TRA was developed in 1967 by Martin Fishbein and Icek Ajzen (1975, 1980). This theory originates from previous research in response to scholars who

doubted the usefulness of the attitude construct for predicting human Behaviour (Fishbein, 1966). The theory started out as the theory of attitude, which led to the study of relations between attitude and behaviours (Fishbein, 1967). The results of the study showed that the best predictor of behaviour is the intention. Intention is determined by three things: attitude toward the specific behaviour, subjective norms and perceived behavioural control (Fishbein & Ajzen, 1975). TRA focuses on theoretical constructs concerned with an individual's motivational factors as determinants of the likelihood of performing a specific behaviour (Fishbein & Ajzen, 1975).

Theory of Planned Behaviour (TpB) was added by Ajzen to improve the predictive power of the Theory of Reasoned Action by including perceived behavioural control (Ajzen, 1985). TpB states that attitude toward the behaviour, subjective norms, and perceived behavioural control, together shape an individual's behavioural intentions and Behaviours (Ajzen, 1985). With this addition, the theory was called the Theory of Reasoned Action and Planned Behaviour (TRApB). The main purpose of TRApB is to predict and understand motivational influences on behaviour that is not under the individual's volitional control (Ajzen, 1988).

Shifts on Origins of the TRA and TpB

The TRApB was first developed in the area of social psychology. The first psychologists to view attitude as individual mental processes that determine a person's actual and potential responses were Thomas and Znaniecki (1918). Many scientists viewed attitudes as the predictor of behaviour, until the early 1960s when some social scientists began to see attitudes and behaviour predictors. Contributions of scholars who were active in influencing the development of the theory are briefly discussed in the succeeding paragraph (Allport,

1935; Doob, 1947; Guttman, 1944; Rosenberg & Hovland, 1960; Thurston, 1929; Wicker, 1969).

Thurston (1929) developed methods for measuring attitudes using interval scales. Allport (1935) speculated that the attitude-behaviour relationship was not uni-dimensional as previously thought, but multi-dimensional. Attitudes were viewed as complex systems made up of the person's beliefs about the object, his/her feelings toward the object, and his/her action tendencies on the object. Guttman (1944) designed the scalogram analysis to measure beliefs about an object. Doob (1947) supported Thurston idea; that attitude is not directly related to behaviour, but it can tell us something about the overall pattern of behaviour. The view that attitude is multi-dimensional became universal in the 1950s. Rosenberg & Hovland (1960) posited that a person's attitude toward an object is filtered by his/her affect, cognition, and behaviour. In 1969, Wicker conducted an extensive survey and literature review on the subject, and he determined that "it is considerably more likely that attitudes would be unrelated or only slightly related to overt behaviours" (Ajzen & Fishbein, 1980: 25).

Core Assumptions or Tenets

As a result of these developments, Fishbein and Ajzen explored ways to predict behaviours and outcomes. They assumed that individuals are usually rational and make systematic use of information available to them. People consider the "implications of their actions before they decide to engage or not to engage in a given behaviour" (Ajzen & Fishbein, 1980). Thus, people are considered rational. People make predictable decisions in specific circumstances. People also examine the implications of their actions before they decide to engage or not to participate in certain behaviours. The Theory of Planned Behaviour contends that human action is guided by three kinds of considerations:

a) Beliefs about the likely consequences of the behaviour (behavioural beliefs),

b) Beliefs about the normative expectations of others (normative beliefs)

c) Beliefs about the presence of factors that may further or hinder the performance of the behaviour (control beliefs).

In their respective aggregates, behavioural beliefs produce a favourable or unfavourable attitude toward the behaviour; normative beliefs result in perceived social pressure or subjective norm; and control beliefs give rise to perceived behavioural control, the perceived ease or difficulty of performing the behaviour (Fishbein & Ajzen, 2010). Like attitudes, subjective norms and perceptions of behavioural control are assumed to emerge spontaneously and automatically from normative and control beliefs, respectively. In combination, attitude toward the behaviour, subjective norm, and perception of behavioural control lead to the formation of a behavioural intention (Ajzen & Fishbein, 1980). As a general rule, the more favourable the attitude and subjective norm, and the greater the perceived control, the stronger should be the person's intention to perform the behaviour in question.

Finally, given a sufficient degree of actual control over the behaviour, people are expected to carry out their intentions when the opportunity arises (Ajzen & Fishbein, 1980). Behavioural intention is the immediate antecedent of behaviour. Intention guides behaviour in a controlled and deliberate fashion (Ajzen & Fishbein, 1980). A person's attitudes toward behaviour are composed of two components:

a. His/her behavioural beliefs about the outcomes a behaviour is believed to yield and

b. His/her evaluation of these outcomes (whether the consequences of the outcomes are favourable or unfavourable).

Several investigators argue that the attitudinal and normative components are not conceptually distinct and that it is not possible to distinguish between personal and social influences on an individual's behavioural intention (O'Keefe, 1990). The argument is that the effect of a person's attitudes on his/her intention to undertake behaviour is contingent on subjective norms and vice-versa (Acock & DeFleur, 1972; Andrews & Kandel, 1979; Warner & DeFleur, 1969). Significant and large positive correlations between the attitudinal and normative components are not uncommon, ranging from .40 to .91 (Greene, Hale & Rubin, 1997; Miniard & Cohen, 1981; Shepherd & O'Keefe, 1984). Thus, the overlap between the attitudinal and normative components of the theory has been suggested, the two components are often highly correlated, and the influences of personal and social elements on behavioural intentions are not easily differentiated (Miniard & Cohen, 1981; O'Keefe, 1990).

Model strength

Well-designed measures of attitude towards a behaviour of interest, subjective norm, perceived behavioural control, intention and behaviour rarely show reliabilities of 0.75 or 0.80 (Hale, 2002). Thus, these scales mostly score a composite below 75% in reliability tests. Hence, attitudes, subjective norms and perceived behavioural control produced mean multiple correlations with intentions that ranged from 0.59 to 0.66 (Hale, 2002).

Equation: BI= (AB) W1 + (SN) W2

Where:

- BI = behavioural intention

- AB = one's attitude toward performing the behaviour
- W = empirically derived weights
- SN = one's subjective norm related to performing the behaviour (Hale, 2002).

Attitudes and subjective norms are highly predictive of intentions, and they correlated more strongly with the criterion than with each other (Fishbein & Ajzen, 1981). Findings further show that a manipulation designed to influence the attitudinal component has a strong effect on the attitudes measure and no significant impact on the normative measure, and vice versa (Ajzen & Fishbein, 1972). Theoretically, the attitudinal component of the theory is conceived as personal (i.e., internal) in nature while subjective norms reflect external social influence (Fishbein & Ajzen, 1975).

Application of TRA-PB to the study

Behavioural beliefs and Attitude

The TRA-PB applies to the present study because it will help to predict and understand motivational influences on behaviour that is not under the individual's volitional control. The theory proposes that behaviour is predicted by people's attitudes and beliefs. Social workers' knowledge and attitudes towards clients with alcohol problems such as alcohol abuse and dependence will determine their approval or disapproval of clients with alcohol problems. Beliefs of social workers on alcohol problems identify their attitudes to help clients with alcohol problems.

The researcher hypothesises that a social worker who has a belief that having knowledge of alcohol will result in a better understanding and helping clients with alcohol

problems is likely to accept and have a positive attitude towards clients with alcohol problems. Social work literature found that despite evidence that many clinicians and practitioners assist clients with alcohol problems, social workers lag behind other professions in embracing some aspects of the alcohol problems (Chappel, Jordan, Treadway & Miller, 1977; Lightfoot & Orford, 1986; Wechsler & Rohman, 1982). The findings show that social workers are uninterested in working with alcohol-abusing clients (Wechsler & Rohman, 1982) and in general, more negative regarding drug addiction treatment than other health care professionals, such as nurses (Lightfoot & Orford, 1986).

Chappel, Jordan, Treadway and Miller (1977) also found that clients benefited from working with clinicians whose expectations about outcomes were favourable, and conversely, that many substances abusing clients fulfilled the negative expectations of those treating them (Chappel et al., 1977). Social stigma and stigmatizing attitudes have been found to be impediments to effective care and primary practice interventions for individuals with alcohol problems (Ahern, Stuber & Galea, 2007). The opposite can also be true if the behaviour is believed to be positive. Behavioural beliefs and attitudes would be assessed by asking respondents about their beliefs, knowledge and attitude towards clients' alcohol problems.

Subjective Norm and Normative Beliefs

The more other social workers working in Social and Community Development know and assist clients with alcohol problems positively, the higher the individual is motivated to meet their exceptions. The social worker is expected to find out more about alcohol problems and help clients positively. Normative beliefs of significant others such as colleagues, friends and family would reflect social workers perception of whether their behaviour is encouraged and accepted within their circle of influence. If significant others

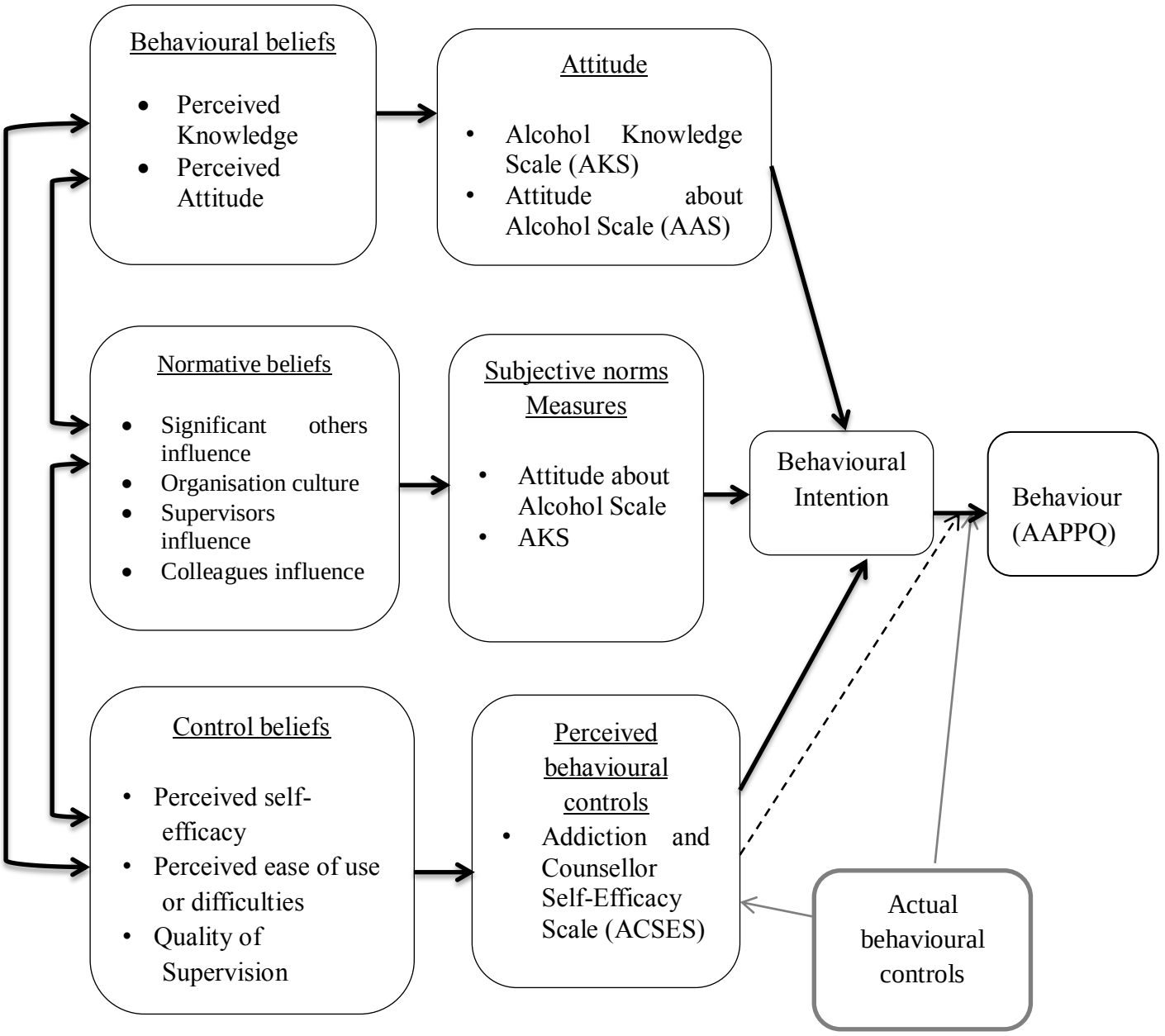
accordingly and positively help clients with alcohol problems the more a social worker would be motivated to meet their exceptions. Conversely, if significant others know less and help clients with alcohol problems negatively and the individual wants to meet their expectation, the experience is likely to less knowledge and help clients with alcohol problems negatively.

This study proposes, one's knowledge base of alcohol problems would reflect his/her attitude and affect the way in which he/she assists clients. The more knowledge one has on alcohol problems, the greater the positive intention towards helping clients and the higher the confidence in helping clients with such problems. Normative beliefs would be assessed by asking respondents to judge how likely it is that most people who are important to them especially supervisors and workmates would approve or disapprove of knowledge and treatment of alcohol problems.

Control Beliefs and Perceived behavioural control

Perceived behavioural control would reflect a social worker's beliefs regarding the resources and self-efficacy in their ability to perform the behaviour. People are not likely to form a strong intention to perform behaviour if they believe that they do not have any resources or opportunities to do so. This is even so if they hold positive attitudes toward the behaviour and believe that important others would approve of the behaviour (subjective norm). Social workers who believe that knowledge and attitudes are essential in helping clients with alcohol problems are likely to have greater perceived ease.

Model 1: TRA-PB variables and measures conceptual framework



Source: Adapted from the Theory of Reasoned Action Model

Model application

Attitude

Literature has shown that attitude influences behavioural intentions (Ajzen & Fishbein, 1980). Attitude's positive relationship to behavioural intention has received strong empirical support in previous research (Ajzen & Fishbein, 1980; Taylor & Todd, 1995). Therefore, *it is expected that social workers favourable attitudes towards alcohol problems would positively influence their intention to treat clients effectively and efficiently*.

Subjective norms

Subjective norms are concerned with how an individual's behaviour is influenced by the desire to act as other important referents think we should act or as they act themselves (Taylor & Todd, 1995). Subjective norms reflect the social worker's perception of whether their behaviour is encouraged and accepted within their circle of influence. *A positive correlation between subjective norms and intention to help clients with alcohol problems in practice is hypothesized.*

Perceived behavioural control

The individual's perception of how easy or difficult it is to carry out the behaviour is referred to as perceived behavioural control (Ajzen, 1991). Literature has demonstrated that perceived behavioural control is an important determinant of intention and ability to deal with alcohol problems (Taylor & Todd, 1995). Applied to social workers, perceived behavioural control reflects social workers beliefs regarding the resources and self-confidence in their ability to perform the behaviour. *A positive relationship is hypothesized between perceived behavioural control and intention to help clients with alcohol problems.*

Behavioural intention and Actual Behaviour performance

Behavioural intention is concerned with the motivational factors when a subject intends to take a particular action (Ajzen, 1991). The Theory of Planned Behaviour (Ajzen, 1991) suggests that behavioural intention is the most important determinant factor in predicting the decision to take a particular action or not. Past studies have used behavioural intention to forecast specific behaviour, given the close relationship between intention and behaviour (Ajzen, 1991). A meta-analysis showed that an average correlation of 0.53 has been reported for intentions and behaviour (Sheppard, Hartwick & Warshaw, 1988). *Hypothesis: A positive relationship between intention and actual behaviour when it comes to helping clients with alcohol problems is expected.*

Self-Efficacy Theory

This section examines self-efficacy theory, its origin and its application to the study. This construct originates from one of the giant propositions within the field of education and psychology. Self-efficacy is the current most frequently studied construct of social cognitive theory to Knowledge Attitude and Practice (KAP) studies. Bandura (1997: vii) asserted that "people's beliefs about their capabilities to produce desired effects are the most important determinants of the behaviours people choose to engage in and how much they persevere." The self-efficacy theory also maintains that these efficacy beliefs play a significant role in psychological adjustment, psychological problems, physical health, as well as professionally guided and self-guided behavioural change strategies (Bandura, 1977).

Self-efficacy is often used interchangeably in the literature with efficacy beliefs and perceived self-efficacy. The study adopted the term self-efficacy. According to Bandura (1986), Self-efficacy is an individual's assessment of their confidence in their ability to

perform specific skills in a particular set of circumstances and thereby achieve a successful outcome. Holden, Barker, Meenaghan & Rosenberg (1999) conceptualized social work self-efficacy as an individual's confidence in her/his ability to carry out a broad variety of professional tasks. According to this paradigm, behaviour change and maintenance are a function of: Expectations about the outcomes that will result from one's engaging in behaviour and; Expectations about one' ability to engage in or perform the behaviour.

That is, outcome expectations consist of beliefs about whether a given behaviour would lead to given outcomes whereas efficacy expectations consist of beliefs about how capable one is of performing the behaviour that leads to those outcomes. Bandura (1996: 391) articulated that "self-efficacy is concerned not with the skills one has but with judgments of what one can do with whatever skills one possesses."

Origins of Self-Efficacy Theory

Although the term self-efficacy is of recent origin, interest in beliefs about personal control has a long history of philosophy and psychology. According to Russel (1954) many social scientists tried to understand the role of "volition" and "the will" in human behaviour in the past decade. The theories of effectance motivation: (White, 1959), achievement motivation (McClelland, Atkinson, Clark & Lowell, 1953), social learning (Rotter, 1966), and helplessness (Abramson, Seligman & Teasdale, 1978) are just a few of the many theories that have sought to examine relationships of personal competence and human behaviour. In 1977, Bandura formalized the notion of perceived competence as self-efficacy and offered a theory of how it develops and how it influences human behaviour.

The four principal sources of efficacy beliefs Bandura (1977)

Enactive Mastery Experiences /Performance accomplishments

Include learning through a personal experience where one achieves mastery over a difficult or previously feared task and thereby enjoys an increase in self-efficacy (Bandura, 1977). Performance accomplishments attained through personal experience are the most potent source of efficacy expectations. Successive mastery over tasks needed to engage in behaviour helps the person to develop and refine skills. Also, it fosters the development of a repertoire of coping mechanisms to deal with problems encountered (Bandura, 1986).

Vicarious experience

This is learning that occurs through observation of events or other people, commonly referred to as models (Bandura, 1977). For modelling to affect an observer's self-efficacy positively, it is important that the model be viewed as overcoming difficulties through determined effort rather than with ease. The model also needs to be similar to the observer with other characteristics such as educational attainment, age and sex (Bandura, 1986).

Additionally, modelled behaviours presented with clear rewarding outcomes are more effective than modelling with unclear or unrewarded outcomes (Bandura, 1986). When the model possesses characteristics similar to those of the observer such as sex, ability level, and educational level, the observer thinks "If that person can do it so can I" and his/her efficacy strengthens. Conversely, if the same model is not successful, observers think "If that person cannot do it then how can I?" and their efficacy weakens (Bandura, 1977).

Verbal persuasive messages and feedback

Constitutes the third source of efficacy expectations. This method tends to transform efficacy expectations when someone who is respected and considered competent and knowledgeable about the behaviour expresses his/her belief in an individual's ability to be successful (Bandura, 1986). If the expert is optimistic, then efficacy should be strengthened. Conversely, if the expert expresses doubt, efficacy is likely to be weakened (Bandura, 1986).

Emotive experiences or affective States

Finally, one's physiological state, provides information that can influence efficacy expectations. People are more self-efficacious when they are calm than when they are aroused and distressed. Thus, strategies for controlling and reducing emotional arousal (specifically anxiety) while attempting new behaviours should increase self-efficacy and increase the likelihood of successful implementation. Bandura (1986) has noted that because high physiological arousal usually impairs performance, people are more likely to expect failure when they are very tense and viscerally agitated (Bandura, 1977).

Application of Self-efficacy theory

In the social work discipline, the theory has been applied within the context of hospital social work practice (Holden et al., 1996) and teaching research skills to social work students (Holden, Barker, Meenaghen & Rosenberg, 2002; Montcalm, 1999).The theory was also used to study the impact of service learning on perceived self-efficacy of social work students (Williams, King & Koob, 2002). These studies found that higher levels of professional experience and workplace support were associated with higher levels of perceived professional self-efficacy and, therefore, increased levels of knowledge.

Enactive Mastery Experiences- A social worker who has worked for a long time in casework with clients with alcohol problems is likely to have high self-efficacy in dealing with alcohol problems. This individual will develop mastery in skills, treatment, and knowledge on tackling alcohol problems. This can also be substantiated by Unrau & Grinnell (2002) study on self-efficacy on a sample of BSW and MSW students at a public university in the United States. From Week 1 to Week 6 the low confidence students showed an average gain of 11.7 points in research self-efficacy while the high confidence students showed a loss of 2.1 points. From Week 6 to Week 16 the low confidence students showed an average gain of 21.96 points in research self-efficacy while the high confidence students showed a gain of 4.7 points. Conversely, a social worker with less experience in working with clients with alcohol problems is likely to have lower self-efficacy.

Vicarious Experiences- A social worker who sees his/her colleagues using effective screening, assessment and treatments skills can be challenged to model his/her colleagues hence strengthening one's self-efficacy. The contrary can be applicable if the colleagues do not use effective screening, assessment, and treatment skills. In a similar assertion, Reeve (2009: 238) stipulates that many people with low self-efficacy become entrenched in self-doubt because they "never get a chance to prove themselves wrong and never give themselves opportunities to observe expert models or receive instruction or feedback."

Verbal Persuasion- The potency of verbal persuasion as a source of self-efficacy expectancies would be influenced by such factors as the expertise, trustworthiness, and attractiveness of the source (Eagly & Chaiken, 1993). An expert such as a clinical supervisor can give a social worker feedback that he/she can help clients with alcohol problems and reward him/her with a promotion or day off. That social worker's efficacy will grow stronger.

Equally, if the supervisor doubts the social worker's knowledge and skills in helping clients with alcohol problems, that social worker's self-efficacy will weaken.In a key experiment which addressed self-efficacy and goal setting on complex decision-making tasks in an organizational context, Wood & Bandura (1989) provided feedback to the student managers which indicated performance superiority or decline about other managers. Those who received negative feedback experienced a decrease in self-efficacy judgments and decremented performance. The performance of those receiving positive feedback varied according to the nature of the feedback. Those who were led to believe that they had easily achieved mastery tended to set lower goals for themselves compared with those who believed that they had achieved mastery through persistent effort.

Physiological and Affective States - A social worker who gets nervous or anxious when helping clients with alcohol problems is likely to think that he/she is not capable of helping such clients. As a result, success in eliminating that anxiety may improve the social workers' efficacy in helping clients with alcohol problems. Conversely, the opposite can also be experienced. People feel sensations from their body and how they perceive these emotional arousals influences their beliefs of efficacy (Redmond, 2010). Those who have been successful in similar situations interpret the arousal as energizing, whereas those without a history of such successes regard it as debilitating (Bandura, 1977).

Perceptions of self-efficacy influence what activities people attempt, how much effort they expend on those activities, and how long they persevere when obstacles are encountered (Bandura, 1986, 1997). Self-efficacy would be measured by asking social workers how confident they are to assist clients with alcohol problems. That is focusing more on the ability

to apply the knowledge acquired primarily in screening, assessment and treatment, and referral.

Further literature on application of the concepts of knowledge, attitudes and self-efficacy is further discussed in chapter three.

CHAPTER THREE

LITERATURE REVIEW

Overview

The study sought to examine social workers' knowledge, attitudes and self-efficacy in working with clients with alcohol problems in Kweneng and South East Districts of Botswana. Finally, this chapter explores empirical studies on 1) the scope of alcohol problems across the world; 2) history of alcohol problems studies in social work and lastly and lastly; 3) social workers knowledge, attitude and self-efficacy in helping clients with alcohol problems.

Scope of alcohol problems

Alcohol problems across the globe

The World Health Organisation has declared alcohol as a public health issue (WHO, 2006). Estimates show that about 2 billion people consume alcohol worldwide (WHO, 2004). In 2002, Substance Abuse and Mental Health Services Administration (SAMHSA) in the USA estimated that 22 million Americans either abused or were dependent on alcohol, illicit drugs, or both (U. S. Department of Health & Human Services, 2003). Of the estimated 7.7 million people aged 12 or above in need of treatment for an illicit drug problem in 2002, approximately 632,000 received specialty treatment while only 538,000 of the estimated 18.6 million who needed treatment for an alcohol problem received it (U. S. Department of Health and Human Services, 2004).

Approximately 22.3 million persons 12 years or older, or 9% of the US population, meet the diagnostic criteria for substance dependence or abuse (Substance Abuse and Mental Health Services Administration, 2006). In 2007, there were 863,300 alcohol-related admissions to hospital, of which 222 600 were alcohol specific and 640 700 alcohol attributable. While in 2008, there were 6769 deaths directly related to alcohol (Health and Social Care Information Centre, 2010). In 2010, an estimated 22.1 million adults and adolescents experienced substance abuse or dependence and 2.6 million received treatment for a problem related to substance use (SAMHSA, 2011). The cost of alcohol-related problems to the NHS was £2.7 billion in England (Department of Health, 2008), £405 million in Scotland (Scottish Government, 2008) and between £70 and £85 million in Wales (Welsh Assembly Government, 2008).

Alcohol problems in Africa

In traditional African society, the use of alcoholic beverages or *Bojalwa* in Botswana appears to have been well regulated (Willis, 2006). Somewhat, drinking served a communal and ceremonial purpose (Western Cape Department of Economic Affairs and Tourism, 2003). However, alcohol problems remain a pervasive problem facing Africa today with its long history dating as early as the late 1800s.

Statistics of alcohol and alcohol problems in Africa are also of no distinction as compared to world estimates. For most African countries, a pattern of increasing per capita consumption emerged in the 1960s, continued throughout the 70s and peaked around 1979 at about 4.5 litres (GAD, 2007). Sadly, Africa has the highest alcohol use and intoxication levels across the sphere, suggesting that alcohol consumption, abuse and dependence are at

the peak (WHO, 2005). Alcohol consumption in Africa is projected at about 16.6 litres per adult drinker per year, which is second only to consumption levels in Eastern European countries (Morejele et al., 2006). This was justified by the high incidence of unrecorded alcohol consumption which is hypothesized to be at 50% of all alcohol consumption. It was therefore estimated that 2% of the disease burden in Africa are attributable to alcohol (Rehm, Chisholm, Room & Lopez, 2006).

A study conducted on the global burden of the disease shows that the Sub-Saharan region of Africa was rated the 7th highest compared to other regions (WHO, 2002). The study indicated that an estimated 7.1litres of absolute alcohol are consumed per adult per year. The report showed that total unrecorded and recorded alcohol per capita (15+) consumption in 2010 was 8.4 litres for Botswana (WH0, 2014). The immediate effects of alcohol consumption included impairment of psychomotor coordination, slowed reflexes, increased blood pressure and reduced inhibitions (WHO, 2014). These effects lead to accidents, fighting, serious injuries, risky behaviour and a high proportion of emergency hospital admissions (WHO, 2014).

The prevalence of alcohol in Botswana is 37% (BIAS III, 2008).The Global Health Report notes that the prevalence of heavy episodic drinking for all sexes in 2010 was 17% (WHO, 2014). Alcohol remained the most heavily used substance in Botswana (95%), followed by marijuana (4%) with 1% being for ecstasy and glue (BIAS III, 2008).In Botswana, problems associated with alcohol noted in prior studies include aggressive behaviour, physical injury, risky sexual behaviours, poor academic performance (Alao, 2007; Malete, 2007; Peltzer, 2009; Phorano, Nthomang & Ntseane, 2005; Seloilwe, 2005; Weiser, et al. 2006).

A brief history of alcohol problems in Social work

The discussion on scope of alcohol problems has clearly demonstrated that alcohol problems have been significant since time immemorial worldwide. Social workers' played a significant role in treating alcohol problems clients and their families. Since then, the issue of social workers' engagement and the degree to which social workers' should be trained to intervene in alcohol problems has been rigorous debated (Adams, 1999; Billingham, 1999; Corby & Millar, 1998; Davies Duncan & Coggans, 1995; Harrison, 1992; Kent, 1995; Lawson, 1994; McCarthy & Galvani, 2004; Scottish Education Department Social Work Services Group 1988; Shaw et al. 1978).

First, we need to appreciate a brief history of alcohol problems interventions within the social work profession. In the United States, social workers' have assisted individuals with addictions and their families since the earliest days of the Charity Organization Societies and the Settlement House Movement of the late 1800s (Straussner & Senreich, 2002). Acknowledgements have to go to Mary Richmond's extensive contribution to social work knowledge and the addiction field within the profession. Richmond wrote a groundbreaking book, Social Diagnosis in 1917 that encouraged early identification and treatment, and also developed an alcoholism assessment tool which contains items that social workers now continue to use (Richmond, 1917).

The professional treatment of alcohol problems can be traced to the founding of the American Association for the Cure of Inebriates in 1870. Director of the Pennsylvania Sanitarium for Inebriates Dr. Joseph Parrish along with other leaders of the inebriate asylums developed a well-articulated disease concept of alcoholism (White, 1998: 26). However, the

professional treatment for clients with alcohol problems originated in the 19th century and re-emerged in the 20th century. In 1995, NASW found a practice specialty section for its members in the alcohol, tobacco, and other drug field and now offers a specialty clinical credential in this area. Social workers became increasingly involved in conducting alcohol research, primarily on prevention and treatment of alcohol problems; with initiatives like the National Institute on Drug Abuse that funded social work research development programs beginning 1999.

Likewise, the Yale University Laboratory of Applied Physiology and Biodynamics, directed by Dr. Howard Haggard, MD, launched the Yale Center for Alcohol Studies (1930). In 1955, Yale (currently Rutgers Summer School of Alcohol Studies) began its first formal training seminar for social workers. Subsequently, the centre published the Classified Abstract Archive of the Alcohol Literature (Kinney, 2009: 14) from 1940 to 1974, which then continued as The Quarterly Journal of Studies on Alcohol and is now titled the Journal of Studies on Alcohol and Drugs published by the Rutgers Center for Alcohol Studies. Moreover, the Yale Center also set in motion the National Council on Alcohol and Other Drug Dependence (NCADD) in 1944 (Brown & Brown, 2001; Center for Alcohol Studies; Kinney, 2009).

Notably, another impressive exertion is the works of Gladys Price, a social worker at the Washingtonian Center for Addictions in Boston during the 1940s. Price created the first alcoholism field placement for social work students and did pioneering work with wives of alcohol men with alcohol problems (Straussner & Senreich, 2002). At approximately the same time, Margaret Cork, a social worker at the Addiction Research Foundation in Toronto, Canada, established a treatment intervention for children of clients with alcohol problems.

Her book, The Forgotten Children, published in 1969, remains archetypal in the field. The first social work journal on addictions, the Journal of Social Work Practice in the Addictions, was founded in 2001.

In Africa scholars evidenced that alcohol problems emanated in the late 1900s with the urgent need of intervention (Molamu, 1986; Chitereka, 1999). The African Journals OnLine (AJOL) was initiated in May 1998 by the International Network for the Availability of Scientific Publication (INASP). It aimed to promote the awareness and use of African-published journals in the sciences by providing access to tables of contents (TOCs) on the Internet. By the end of 2003, the service provided TOCs and abstracts for over 175 journals, from 21 African countries.

Few social workers' and psychologists' works were featured in the African Journal of Drug & Alcohol Studies. The journal's primary aim is the publication of review and papers, aimed at both primary care practitioners and specialist mental health care professionals. The journals and abstracts indicate that social workers and other helping professionals in Africa have voiced their contributions in the alcohol field beginning in the early 2000s. Kalebka et al. (2013) explored emergency departments in South Africa to assess providers' attitudes and their level of exposure to substance-related and addictive disorders. The research concluded that more training in the field of drug dependence and treatment might be beneficial to HCPs (Kalebka et al., 2013).

In Botswana other helping professionals and a few social workers have been involved in the study of alcoholism and its dynamics. Selemogwe, Seloilwe & Manyanda (2014) examine patterns of drug use and socio-demographic profiles of clients who sought treatment

at a substance abuse treatment centre in Gaborone, Botswana. Findings revealed that alcohol was the most frequently reported drug (n= 236, 59 %). Morutwa & Plattner (2014) explored the relationship between self-control and alcohol consumption among students at the University of Botswana. The multiple regression analysis results revealed that self-control was a stronger predictor of the amount of alcohol consumed than age and gender.

Recognition is made of some social work scholars for the special attention they devoted in the wing of alcohol problems within the profession in Botswana and Africa (Matwetwe, 2007; Mupedziswa, 2005; Rwomire, 2014; Phorano, Nthomang & Maundeni, 1998). These social workers have contributed much to understanding the nature of alcohol; drinking patterns; consequences of alcohol; and transformation of alcohol problems.

Social workers knowledge of Alcohol problems

To ask informed questions and understand people's responses to alcohol problems, social workers require some knowledge of both the subject and evidence-based approaches to alcohol use assessment (Babor, Hofmann & Rousaville, 1992). However, there are numerous studies documenting the failures and successes of social service settings to identify and differentiate individuals who use, abuse, or are dependent on alcohol (Hack & Adger, 2002).

A quasi-experimental study was conducted in the United States of America with 38 undergraduate human services students including social work students to determine the effectiveness of a service-learning project in which students interacted with clients in a residential alcohol or substance abuse treatment exercise (Hogan & Bailey, 2010). The results indicated that experiential students demonstrated increased knowledge and improved

attitudes toward clients with alcohol or substance abuse issues from pretest to posttest, whereas the comparison sample did not. Another study of MSW students have shown that their levels of perceived preparedness, knowledge, and attitudes of students who participated in alcohol or substance abuse courses or internships and programs demonstrated higher learning in the addiction field (Bina et al., 2008; Lemieux & Schroeder, 2004; Richardson, 2008).

For over 25 years, social work academicians have been criticized for failing to integrate material on substance abuse into the curriculum in a coherent, comprehensive, and coordinated manner (Logan, McRoy & Freeman, 1987; Petty, 1976; Van Wormer, 1987). Straussner & Senreich (2002) found that most social workers had little training in working with clients with alcohol problems. Continually, the field of alcohol and drug abuse treatment has been criticized for its failure to use formal, validated assessment instruments as a basis for treatment of alcohol-related problems (Allen, 1991). Similarly, findings reveal that social workers who practice in the field of addictions believe that they need more training in the areas of assessment, advanced clinical techniques, and dual diagnosis (Hall et al., 2000).

Despite the evidence that social workers frequently encounter people with alcohol and other drug problems, and often report feeling ill-equipped to assess or respond effectively, not much has been done in this regard (Galvani & Forrester, 2011; Galvani & Hughes, 2010). Many practitioners report difficulties in identification of alcohol problems and rely most heavily on their observations of evidence of social harm resulting from alcohol problems and its impacts on a client live (Rodger, 2010). Social workers in New England Substance-use Disorders Treatment Centers reported significantly lower knowledge and skill levels in the area of assessment than their non-social work counterparts (Hall et al., 2000).Succinctly; the

data show that most social workers' are unable to pick alcohol problem issues, lack requisite knowledge. According to literature reviewed lack of knowledge is substantiated by incorrect assessments and screening of alcohol problems.

Attitudes towards clients with alcohol problems

The attitude of an individual consists of three components, namely cognitive, affective and behavioural (Bandura, 1977). Therefore, analysing attitude is essential for three primary reasons: firstly, attitudes guide our thoughts; secondly, attitudes influence our feelings (Baron & Byrne, 1977); and thirdly attitudes affect our behaviour (Myers, 1990). Much has been said about the attitudes of treatment professionals towards clients with alcohol problems. Clinical literature and research have suggested that attitudes are an essential element of alcohol treatment (Amodeo, 2000; Amodeo, Fassler & Griffin, 2002; Googins, 1984; Silverman, 1993; Strozier, 1995; Wechsler & Rohman, 1982).

Kagle (1987) discovered that social workers need adequate recognition of alcohol as a problem, hold negative attitudes about treatment success, and often fail to intervene or make an appropriate referral when substance abuse is recognized as a problem. In a similar vein, early researchers criticized beginning social workers for holding moralistic, blaming and negative attitudes toward clients with alcohol problems (Bailey, 1963; Sapir, 1957; Sterne & Pittman, 1965). These negative attitudes are believed to result in professionals not recognizing alcohol problems or inadequately treating and referring clients who have alcohol problems (Greer et al., 1990; Howard & Chung, 2000; Ingraham, Kaplan & Chan, 1992; Shipley et al., 1990; Tober, 1993).

Peyton, Chaddick, & Gorsuch (1980) found that graduate social work students were unwilling to treat clients with alcohol problems. Similarly, mental health professionals assigned negative characteristics to alcohol problems clients and rated them as "more foolish, dull, bad, and sick, slow, hopeless, weak and passive than average persons" (Rubin, 1996:74). As such, fuelling this quality of service is an indication of lack of knowledge and negative attitudes of social workers' concerning alcohol problems issues (Dunston-McLee, 2001; Stein, 2003; Stude, 1990; West & Miller, 1999; Richmond & Foster, 2003). Studies of MSW students in the USA have found that their levels of perceived preparedness, knowledge, and attitudes with respect to working with substance-abusing clients usually are low but that students who participated in alcohol and other substance courses or internships and projects demonstrated higher learning in this area (Bina et al., 2008; Lemieux & Schroeder, 2004; Richardson, 2008).

Hogan & Bailey (2010) performed a quasi-experimental study of 38 undergraduate human services students (including social work majors) to determine the effectiveness of a service-learning project in which students interacted with clients in a residential substance abuse treatment facility for women. Nineteen students were involved in the service learning project, and 19 were part of a comparison sample that did not participate in the project. The 19 students who did participate in this activity demonstrated increased knowledge and improved attitudes towards clients with alcohol and other substance abuse issues from pre-test to post-test, whereas the comparison sample of 19 did not (Hogan & Bailey, 2010).

Although most research suggests negative attitudes of social workers toward serving clients with alcohol problems, other studies show positive attitudes to individuals with sufficient skills and training on alcohol problems. Some research indicates high ratings of

optimism towards providing alcohol problems counselling after receiving training (Amodeo, 2000; Rerick, 1999; Richmond & Foster, 2003). Social workers who received alcohol training had low moralistic attitudes and more positive treatment intervention attitudes (West & Miller, 1999). Dunston-McLee (2001) found that social workers with high levels of co-occurring substance abuse training had more optimistic attitudes toward providing co-occurring counselling to clients with co-occurring problems slightly.

Self-efficacy in dealing with alcohol problems

Self-efficacy involves a person's judgements or beliefs about their ability to mobilise their motivation and cognitive resources to undertake actions to meet the demands made by organisational tasks (Bandura, 1995). It is an "action or judgment about the likelihood of successful task performance immediately before any effort is expended on the task" (Wood & Bandura, 1989: 408). It acts as "a powerful motivator of behaviour because efficacy expectation: determine the initial decision to perform a task, the effort expanded and the level of persistence that emerges in the face of adversity" (Rothmann & Cooper, 2008: 235).

Measuring a practitioner's self-efficacy in utilizing some skills is one feasible way to identify his or her level of confidence with clients with alcohol problems (Kranz, 2003). Firstly, social workers may be reluctant to treat alcohol problems because they believe it is beyond their remit or that they do not possess the necessary skills to do so. Mostly, clients are usually not screened, assessed, diagnosed, or treated when alcohol problems are present (Bliss & Pecukonis, 2009; Rose, Brondino & Barnack, 2009). That is due to lack of training and the perception that alcohol use screening is irrelevant in non-alcohol abuse treatment

settings. Secondly, it may also be due to lack of self-efficacy in utilizing alcohol use treatment skills (Magura, 1994; Rose et al., 2009).

Thirdly, practitioners may hesitate to raise the issue of alcohol problems with their clients because they are uncertain about how best to continue with treatment once a problem is identified (Corse, et-al., 1995). Counsellor self-efficacy in providing alcohol screenings and referrals was not related to the frequency of providing substance abuse screenings and referrals but was associated with counsellors' perceived confidence (Rodgers, 2010). In a meta-analysis of 114 studies, the concept of self-efficacy was more strongly related to job performance (Stajkovic & Luthans, 1998).

In summary, it was apparent in the literature review that for decades social workers received very little training or support to improve their skills, knowledge and attitude about alcohol problems. Literature further suggests that social workers knowledge and attitudes influence how they help clients with alcohol problems. This was substantiated by the frequency of referrals, incorrect assessments, and screening of alcohol problems cases. The literature also revealed that self-efficacy influenced social workers' intervening strategies regarding clients with alcohol problems. This implied that if social workers are to engage fully with clients' alcohol problems, then there is a need for more empirical data on social workers knowledge, attitude and self-efficacy in working with clients with alcohol problems.

Subsequently, chapter four discuss the methodology adopted by this study. It explicitly draws attention to the design, time dimension, sampling, data collection process, tools, analysis plan and ethical considerations.

CHAPTER FOUR

RESEARCH METHODOLOGY

Introduction

The goal of this study was to investigate social workers' knowledge, attitudes, and self-efficacy in working with clients with alcohol problems in Kweneng and South East Districts of Botswana. The chapter gives a detailed presentation of the study designs, methods, location, and procedures, data collection tools, sampling techniques, ethical consideration and limitations of the study. The study used a mixed methods approach to describe and explore variables.

Study methods and designs

The study adopted the mixed methods approach. Mixed methods research refers to a study in which investigators use "both qualitative and quantitative approaches or techniques in a single study or program of inquiry" (Tashakkori & Creswell, 2007). There is an increasing recognition of the importance of combining quantitative and qualitative research methods when conducting social work research (Cowger & Menon, 2001; Grinnell & Unrau, 2008; Padgett, 2008; Yegidis & Weinbach, 2009). Connelly (2009:31) emphasized that the goal of mixed methods research is to draw on the strengths and minimize the weaknesses of both types of research. This method is efficient because it allows the researcher to solve problems using both numbers and words, combine inductive and deductive reasoning. The study further utilised the descriptive and exploratory designs to describe social workers'

knowledge, attitudes, and self-efficacy. Triangulation of the designs improved validity and reliability of study findings.

*Phase 1***:** The study utilized the quantitative method. Quantitative research emphasizes collecting and analyzing numerical data; measuring scales and frequency of phenomena (Creswell, 2009). In this study, this approach used behavioural scales (through surveys) to measure knowledge, attitude, and self-efficacy of social workers. The researcher also utilized survey to collect demographic variables and quantitative data. A survey is a system for collecting information to describe, compare or explain knowledge, attitudes and behaviour (Fink, 1995:1). The researcher employed descriptive design to collect, analyse and interpret quantitative data. The main objective of descriptive research is to give an accurate portrayal of the characteristics of persons, situations or groups (Polit & Hungler, 1999). The focus was on identifying social workers knowledge level, attitudes and self-efficacy in working with clients with alcohol problems.

Phase 2: The researcher adopted the qualitative method. Qualitative methods can be defined as the techniques of "observing, documenting, analysing, and interpreting attributes, patterns, characteristics and meanings of specific contextual features of a phenomenon" (Leininger, 1985:5). Qualitative data are particularly useful when it comes to defining feelings and attitudes (Hakim, 1999). In this study, qualitative interviews were used to get in-depth data on social worker's knowledge, attitude and self-efficacy in helping clients with alcohol problems. The exploratory design was mainly adopted for the collection, analysis and interpretation of qualitative data. An exploratory design was deployed to gain insights on social workers knowledge, attitudes and self-efficacy on alcohol problems. That is, finding out why the knowledge level of social workers was high or low, why social workers have

positive or negative attitude and why social workers are confident or not in terms of their ability to assist clients with alcohol problems.

Time dimension

The study was a cross-sectional in nature and was conducted from August 2014 to April 2015. Cross-sectional or 'one-shot' studies gather data once, over a period of days, weeks or months (Neumann, 2000). It involves a close analysis of a situation at one particular point in time to give a 'snap-shot' result. Cross-sectional studies are usually exploratory or descriptive in nature. Cross-sectional studies look at how things are now, without any sense of whether there is a history or trend at work. This study used cross-sectional design because it is time efficient and profitable to study social workers at one particular point in time.

Sampling

This section provides an overview of the sampling procedures that were used in the study. The study site, population, units of analysis, sampling size and sampling procedures are discussed and justified. The term sample refers to a subset of the population selected to participate in a research study (Neumann, 2000). The sample is chosen from the study population that is commonly referred to as the "target population." Target population relates to the universe or collection of all elements being represented by a sample (Burns & Grove 1998; Polit & Hungler 1999). Sampling frame relates to an exhaustive list of all members of the population from which a sample can be drawn (Neumann, 2000).

Inclusion and exclusion criteria

The study included male and female social workers employed by the Social and Community Department (S & CD) under MoLGRD in Kweneng and South East Districts aged 18years old and above. The study was only open to practicing social workers with a Certificate, Diploma or Degree in Social Work. S & CD employees hired as social workers from Adult Education, Home Economics and any other related discipline without basic training in social work were not included. Social workers working under Ministry of Youth Sports and Culture, other ministries, churches and non-governmental organisation were excluded from the study as they have different work roles and responsibilities to S&CD.

Description of study site; Kweneng and South East Districts

The study was carried out in the South East and Kweneng Districts located in the southeastern part of Botswana. The geographical coordinates for Kweneng are 24°00′S 25°00′E. Kweneng District has a population of 304, 549, covering approximately 15 % of the country population. Based on its population size, Kweneng District is considered the second largest district in Botswana (CSO, 2011), and is made up of three sub district namely Letlhakeng, Molepolole/Lentsweletau and Mogoditshane/Thamaga.

The South East District is bound to the southwest by the Southern District, to the northwest by the Kweneng District and on the north by the Kgatleng District and its coordinates are 25.0000° S, 25.7500° E. South East District occupies an area of about 1492km2 in the southern region of Botswana. Only a little more than one-half of the total land is tribal land. The Batlokwa tribal area covers 215km2 while the Bamalete tribal area covers 670km2.The remaining land is divided into freehold farms and state land (CSO, 2011). The South-East District has a population of 316, 606, about 15, 6% of the national

population. The South East District development plan has indicated the need to keep its environment clean, to address the problems related to alcohol, drugs and cigarette smoking and to promote food hygiene (NDP-9, 2009).

Units of Analysis

The study focused on individual male and female social workers employed under Social and Community Development department under MoLGRD in Kweneng and South East Districts as units of analysis.

Sampling design

Phase 1**:** The researcher used simple random sampling technique without replacement (SRSWOR). SRSWOR is a sampling design that gives equal selection probability to every sampling unit of fixed sample size, and no sampling units can be selected twice or more. At any draw, the process for a simple random sample without replacement must provide an equal opportunity for inclusion to any member of the population not already drawn. The simple random sampling (SRS) procedure allowed the researcher to determine sampling errors and the accuracy of the estimates derived from statistical calculations. Costs of enumeration may be high because, by the luck of the draw, the sampled units may be widely spread across the population.

The researcher first prepared a sampling frame of all social workers in Kweneng and South East District on an Excel spreadsheet to determine their total number. Each row represented a random number assigned to each social worker. The researcher then printed the random numbers, cut them into small pieces and folded them. To draw a simple random sample without introducing researcher bias, a hat was used to select objectively the members of the population to be sampled. The researcher randomly selected a number each round from

the hat and placed it on the hat so that each social worker had an equal chance of being drawn each selection round. The researcher repeated selecting samples from the hat and placing them outside until the required sample size was drawn.

According to personal communications with Kweneng and South East Districts Council, Social and Community Development heads, there were approximately 77 eligible social workers. The researcher created a sampling frame for all eligible social workers and used simple random sampling to enumerate 65 social workers from the target population. The sampling frame comprised of social workers from both sexes and all sites in the two Districts. The statistic formula for the sample size was calculated as follows: n = N/ (1+N (e) 2). Where: n = sample size, N = population and e = allowance error (Neumann, 2000).

Therefore: n= 77/ (1+77 x (0.05)2)

=77/ (1+ 77 x 0.0025)

=77/ (1+ 0.1925)

=77/1.1925

= 64.57023 = 65

Phase 2: Judgmental non-probability sampling was employed. This is a technique whereby the researcher employs his or her expert judgment about whom to include in the sample frame (Babbie & Mouton, 2001). After conducting the survey, the researcher computed the summed composite score of the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ) for each participant. The researcher then ranked the AAPPQ scale scores from the highest to the lowest and then sampled participants who scored high (N=6) and low (N=6) scores. In this study, saturation was set at N=12 as far as qualitative interviewers are concerned. Zickmund (2010) also asserted that the minimum sample

saturation is approximated to be between 12-15 participants. As with all non-probability sampling methods, the degree and direction of error introduced by the researcher cannot be measured, and statistics that measure the accuracy of the estimates cannot be calculated.

Structured Questionnaire design

Firstly, a close-ended structured questionnaire with instructions and multiple choice questions was developed for the quantitative study. The questionnaire was divided into two sections: Section A was made up of socio-demographic questions while Section B was made of knowledge, attitude, and self-efficacy scales. Section B was in a table form so that respondents could circle their responses.

Pilot study and findings

The questionnaire was then piloted on fourth-year social work students at the University of Botswana to pre-test the questions before going to the field. The pilot revealed that the researcher needs to avoid using the word substance abuse and be consistent with the key study concept of alcohol problems for uniformity. Findings of the pilot test also assisted in changing the word counsellor to social workers' on the ACSES scale to improve specificity. After the pilot test, the researcher reviewed the questionnaire and made the two corrections respectively.

Data collection procedures

Data collection is the formal, systematic gathering of information relevant to the research sub-problems, using methods such as interviews and surveys (Burns & Grove

1998:744). This study was conducted in two folds through the use of survey and qualitative interview techniques.

Phase 1: Survey Data Collection

The researcher used the survey to collect data in phase one of the study design. As discussed the survey comprised the knowledge, attitude and self-efficacy scales. Following sampling, the researcher telephonically set appointments with the selected participants. The study purpose and procedures were discussed with each participant during the first agreed visit date. An informed consent form was read out and explained to each participant during the first visit. Each participant was asked to sign the consent form if he/she agreed to participate in the study. A self-administered questionnaire was then explained and distributed to each participant during the first visit. Questionnaires were administered to participants in offices and collected on the same day to avoid content error due to misplaced completed questionnaires.

The scales adapted from the study to measure knowledge, attitude and self-efficacy were as follows: Alcohol Knowledge Scale (AKS), Attitude about Alcoholism Scale (AAS), Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ) and Addiction Counsellor Self-Efficacy Scale (ACSES).

Behavioural beliefs, normative beliefs, and Attitudes

Knowledge-Alcohol Knowledge Scale (AKS)

Knowledge of alcohol and drugs was assessed by using a set of knowledge statements on the AKS designed by Gassman (1995). Respondents were asked to indicate whether they believed the 29 statements on the AKS were ‘‘true or false’’. Each correct answer to a question was assigned 1 point. The scale scores ranged from 0 to 29. The medium score was

14.5. Results above the medium score denoted more knowledge whereas results lower than the average score indicated limited knowledge (Gassman, 1995).

Attitude

Attitude about Alcoholism Scale (AAS).

The study also adapted a standardized questionnaire by Gassman (1995) to assess beliefs and knowledge concerning substance abuse. The instrument measured personal experiences and feelings; attitudes and beliefs; knowledge of legal issues and basic knowledge regarding the prevalence of alcohol, medical complications, research, and treatment issues. During the survey, the respondents were asked to note their agreement/disagreement with statements on the AAS by circling an answer on a 5 point Likert-type scale where "1 = Strongly Disagree to 5 = Strongly Agree." The scale reliability ranged from .87 to .90 (M=51). The total composite summed high scores indicated positive attitude while low scores indicated a negative attitude towards clients.

Actual Behaviour Performance

Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ).The scale was initially developed by Cartwright, Shaw and Spratley in 1975. In this study, AAPPQ was used to measure participants' intentions on actual behavioural beliefs and attitudes, normative beliefs and subjective norms. This scale was adapted as the dependent variable of the study. The six factors for the AAPPQ entail Role adequacy, Role legitimacy, Role support, Motivation, Task-specific self-esteem and Work Satisfaction. The AAPPQ was developed to test the hypotheses that three situational factors: role adequacy, role legitimacy, and role support, enhance motivation, satisfaction, and professional self-esteem of counselling individuals (Shaw et al., 1978).

The presence of these factors enhances motivation to work with alcohol problems clients, expectations of satisfaction, and professional self-esteem in therapeutic activity (Shaw et al., 1978). Role adequacy refers to practitioners feeling adequately prepared and viewing themselves as having appropriate knowledge. The term role legitimacy refers to the extent to which people regard particular aspects of their work as being their responsibility. Role support relates to the support which practitioners acknowledge receiving from colleagues to help them to perform their part effectively.

The instrument is comprised of 30 statements to which respondents indicate their levels of agreement or disagreement on a 5-point scale ranging from "strongly agree" to "strongly disagree". The reliability estimates of the instrument and subscales using Cronbach's alpha ranged from .70 to .90. A final score was calculated by summing up all ratings after reverse-coding negative items (15, 16, 17 and 18). Lastly, the AAPPQ scores were entered into SPSS and analysed to sample Phase 2 participants.

Control beliefs

The study collected socio-demographic and background data for each participant on: age, gender, ethnicity, religion, employment setting, position, years of counselling experience, whether the employment conducts alcohol problems screening and referrals and the extent to which participants receive clinical supervision on alcohol and alcohol problems.

Perceived behavioural control and self-efficacy

Self-Efficacy-Addiction Counsellor Self-Efficacy Scale (ACSES)

The scale was used to measure perceived self-efficacy. ACSES items are unique to the research questions and nature of the study. The purpose of ACSES was to measure social

workers' self-efficacy on their knowledge and skills of providing counselling on alcohol problems (Kranz & O'Hare, 2006:109). ACSES was designed by Murdock, Wendler, and Nilsson (2005) for practitioners to determine their level of confidence in employing key alcohol knowledge and intervention skills (Murock et al., 2005).

ACSES measured five components namely; Assessment, Treatment Planning, and Referral Skills (1-8), Co-Occurring Disorders Skills (9-17), Group Counselling Skills (18-23), Basic Counselling Skills (24-28) and Specific Addiction Counselling Skills (29-31). Responses to each item are coded on a Likert-type scale ranging from 1 = *very low confidence*, 2 = *low confidence*, 3 = *moderate confidence*, 4 = *high confidence*, and 5 = *very high confidence*. The composite score is calculated by summing the score on all of the 31-items. ACSES composite score range is 31 to 180, with higher scores above the median (M=97) indicating a greater degree of confidence. Test reliabilities range was .88 to .98 for the scale and subscales (Wendler, 2007).

Table 1: Study Variables

Variables	*Measure*	*Number of Items*	*Score range*	*Reliability*
Independent (IV):				
Knowledge	Alcohol Knowledge Scale (AKS)	29	0-29	Inventory
Attitudes	Attitude about Alcoholism scale (AAS)	20	0-100	.87 to .90
Self-efficacy	Addiction Counsellor Self-Efficacy Scale (ACSES)	32	0-160	.88 to .98
Dependent (DV):				
Helping Clients with Alcohol problems.	Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ)	30	0-150	.70 to .90

Quantitative Data Analysis Plan

The study utilised Statistical Package for Social Sciences (SPSS) to analyze quantitative data. SPSS 22.0 is a windows based program that can be used to perform data entry and analysis and to create tables and graphs. SPSS was first developed at Stanford University in the 1960s as a rigorous statistical package to analyze sociological data. The researcher used this tool because it can analyse large data sets from 1000+, analyze complex data interaction and give accurate statistical analysis. The tool is also time efficient and cost effective for data analysis. Questionnaires were assigned numerical codes ranging from 1-65. Data were then entered into SPSS 22.0 according to codes. Each row represented a client file while columns represented variables under study.

The researcher computed frequency distribution for all demographic variables. The reliability and validity of AKS, AAS, AAPPQ and ACSES were assessed using Cronbach's Alpha internal consistency estimate. The researcher conducted factor analysis on AAPPQ and ACSES factors. Factor analysis was measured using the Principal Component Analysis and rotated using Varimax rotation procedure. Descriptive analysis was used to summarize distributions of AKS, AAS, AAPPQ and ACSES scores by developing tabular presentations and computing descriptive statistical indices or percentiles.

Measures of central tendency included the mean, median, mode, variance and standard deviation, kurtosis, and skew. One Way Analysis of Variance (ANOVA) were used to assess whether the mean scores in knowledge, attitude, and self-efficacy of social workers' in helping clients with alcohol problems was different from the values of discrete variables with more than two categories. While the independent t- tests was used in values of variables

into two categories. These tests were done by age, sex, level of education and receiving regular supervision with AKS, AAPPQ, AAS and ACSES. Lastly, multiple regression analysis was conducted to identify significant predictors of intentions exhibited by the participants. Results were considered significant if the *p*-values were equal or smaller than 0.05 at reliability estimate of 95% confidence interval. Findings of the frequency distributions, factor analysis, descriptive analysis, and ANOVA and regression tests are objectively discussed in chapter five and six in-depth.

Phase 2: Qualitative Interviews Data collection

The researcher used the qualitative interview technique in the second phase of data collection. Qualitative research interviews attempt to understand the world from the participant's point of view, to unfold the meaning of peoples' experiences and to uncover their lived environment (Kvale, 1996). In simple terms qualitative interview is a process of finding out what people feel and think about their worlds. Interviews were conducted one on one in offices to ensure high standards of confidentiality and anonymity. Data were collected from a few cases or respondents so findings cannot be generalized to a larger population (N=12). The interviews were held two or more weeks after phase 1 data collection.

Based on Phase 1 survey data, the researcher computed a composite score for the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ) for each participant's response. Based on the AAPPQ scores, the researcher ranked participants survey results from highest to lowest scores. The researcher sampled the first top six and the last six participants. The researcher set up appointments through telephone calls to the 12 participants sampled for the interviews.

During the agreed visit date, the informed consent, voluntary participation and confidentiality form were again read and discussed with participants. Participants then signed the second informed consent form if they agreed to participate in the interviews. Then the researcher continued with the interview process on the same day and documented the responses. The researcher used an Interview Guide (see Appendix 6) for uniformity of the answers and easier data analysis to interview participants. In some cases, participants were encouraged to elaborate on a particular dimension of the topic of discussion by using probes. Probes were neutral to avoid biasing the participants' responses (Burns & Grove, 1998:307). The responses were documented using a pen and a notebook. After each interview session, the researcher safely filed the responses and put them in a carry bag.

Qualitative Data Analysis Plan

The study adapted Huberman & Miles (2004) method to analyze qualitative data. According to Huberman and Miles (2004), analysis consists of the concurrent flows of activity; data collection period, data reduction, data display, and conclusion drawing/ verification. Qualitative interview data were organized into themes, analyzed, and then compared against quantitative findings during interpretation. Firstly, the researcher coded all respondents' response sheets from 1-12. The response sheets were entered into a Microsoft document. Themes were derived from each question response and displayed in a table format. The researcher then analyzed and made interpretation of data themes to substantiate quantitative findings.

Ethical issues

Confidentiality protects participants in a study so that their individual identities cannot be linked to the information that they provide and will not be publicly disclosed (Lobiondo-Wood & Haber, 1997:45; Polit & Hungler, 1995:36). Confidentiality and anonymity were guaranteed by ensuring that the data obtained were used in such a way that no people other than the researcher knew the source. The responses were only identified by the numerical code.

Privacy refers to the right that all information collected in the course of the study would be kept in confidence (Poilt & Hungler, 1999:35). Privacy means that individuals can behave or think without interference as private behaviour will not be used to embarrass or demean them later. In this study, the researcher did not knowingly disclose any personal expression or Behaviour displayed by participants in the sessions that could demean them.

Informed consent and Right to withdraw- The participants were made aware of their involvement in the study when they signed a consent form requesting them to be interviewed about their knowledge, attitudes and self-efficacy in helping clients with alcohol problems. Participants were informed that they had a right to withdraw from participating in the study if they intended to do so without being prejudiced. Their rights were explained to them before engagement in the study. Participants were informed throughout the study about the voluntary nature of participation in research and about their freedom to withdraw at any stage. It must be noted that this research was done despite the fact that the participants were performing with knowledge of being researched.

Permission and authority- The researcher requested permission from the UBIRB office and MoLGRD to conduct the study. The researcher also solicited authority from the Rural Administration Centers (RAC) and heads of S & CD departments to give social workers time to participate in the study.

Study limitations

The strength of this study was the better sample size which provided sufficient statistical power for the hypothesis tests. Another plus for this study was the fact that participants were interested in a study so that they contribute in their program design. Being interviewed by a social work student gave practitioners the zeal to be in the study as they felt am one of their own. However, the study had limitations such as resources and time due to this large sample. The data were collected and completed using a cross-sectional study design hence unable to determine the prevalence and trends of study variables. This study had resource limitations as the large sample size had implication for printing, photocopying and other stationery costs. Moving from one village to another was also a limitation as it required sufficient transport budget.

The findings of social workers' views regarding their knowledge, attitudes and self-efficacy in regards to working with alcohol problems are explained in the chapter five.

CHAPTER FIVE

RESEARCH FINDINGS AND ANALYSIS

Overview

`The goal of this study was to explore and describe social workers' knowledge, attitude, and self-efficacy in working with clients with alcohol problems in Botswana'. The data analysis utilized the concurrent triangulation design. That is because; it allows for concurrent, but separate, collection and analysis of quantitative and qualitative data so that the researcher may best understand the research problem. This design allows the researcher to merge the two data sets, typically by bringing the separate results together during interpretation (Creswell, 2006). The objective is to enable the researcher to compare directly and contrast quantitative statistical results with qualitative findings or to validate, confirm, or expand quantitative results with qualitative data methods during the same timeframe and with equal weight analysis (Creswell, 2006).

With that, the researcher intentionally separated the quantitative and qualitative findings in this chapter while quantitative findings will be validated with qualitative findings in the succeeding chapter. This chapter first report Phase 1 key findings from central study variables and scales of age, sex, and clinical supervision, knowledge, attitude and self-efficacy. Scales used entail the Alcohol Knowledge scale (AKS), Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ), Attitudes about Alcoholism Scale (AAS) and Addiction and Counsellor Self-Efficacy Scale (ACSES).

Socio-demographics, descriptive statistics and reliability analysis are reported using numerical and tabular techniques to summarize data. A correlations matrix was used to extrapolate the relationship between central study variables. ANOVA and the Independent t-test were computed to identify differences in distribution and mean scores between knowledge, attitudes and self-efficacy and the socio-demographic characteristics (age, sex, and clinical supervision). Multiple regressions were used to identify predictors of social workers intentions in helping clients with alcohol problems as reported by participants. Results were considered significant at $p \leq 0.05$. Lastly, Phase two, qualitative interviews results are discussed using three broad themes of knowledge, attitude, and self-efficacy derived from participants' quotations.

Phase 1

Socio-demographic characteristics

Sixty-five respondents participated in the survey questionnaires. Most of the respondents were female (75%) N=49 while males accounted for 25% (N=16). Participants' ages ranged between 25 and 48 years old. Some 51% of the respondents' were from Kweneng District and 49% from South East. Most of the participants had a Bachelor's Degree (72%); followed by Diploma holders (20%) and the remaining a Master's Degree (8%). Most of the participants were interested in Gender Based Violence (14%) as their population problem while only 4% chose Substance abuse and treatment. The majority of participants answered "No" (97%) when asked if they ever received regular clinical supervisions on alcohol interventions while the remaining 3% said "Yes." About forty-nine (49%) percent of participants reported seeing 1-3 alcohol problems in an average week, 37% no clients at all, while 14% reported 4-6 clients. Socio-demographic characteristics of the study population are displayed in Table 2.

Nature of work

Most of the participants (80%) had more than five years' work experience while a few 20% had less than five years' work experience. The study only targeted social workers' employed as social welfares whose mandate is embedded in the specific services they offer. Social welfare officers focus on addressing the psychosocial needs of customers, serve as advocates and referral point for complex social cases such as adoption, marital cases, suicidal cases, child maintenance cases. They provide care and support to orphans and vulnerable children, coordination and support of welfare support to registered destitute persons. They are also responsible for the coordination and monitoring of the Community Home Based Programme (CHBC). Participants' characteristics and works experience data segregations are displayed on Table 2 in the next page.

Table 2: Frequencies and percentages of Socio-demographics

Variable	*Items*	*Frequency (N=65)*	*Valid Percent %*
Sex of Participants	Male	16	24.6
	Female	49	75.4
Age categories	25 to 29 years	27	41.5
	30 to 34 years	11	16.9
	35 to 39 years	15	23.1
	40 to 44 years	10	15.4
	45 to 49 years	2	3.1
Religion	None	7	10.8
	Mainline churches	20	30.8
	Pentecostal	36	55.4
	African Independent Churches	2	3.1
Marital status	Currently Married	17	26.2
	I lived with a partner but never married	1	1.5
	Single and never Married	46	70.8
	Widowed	1	1.5
District	Kweneng	33	50.8
	South East	32	49.2
Level of education	Diploma or equivalent	13	20.0
	Bachelor's degree	47	72.3
	Master’s degree	5	7.7
Area of interest in Social Work	Social welfare	42	64.6
	Community Development	11	16.9
Specific population problem of interest in Social Work	Substance abuse and treatment	3	4.6
	Gender Based Violence	9	13.8
Regular clinical supervision on alcohol interventions	Yes	2	3.1
	No	63	96.9
Alcohol problem clients would you see in an average week	No clients at all	24	36.9
	1-3	32	49.2
	4-6	9	13.8
Work Experience	0-2 years	11	17.0
	3-5 years	27	42.0
	6- 9 years	14	22.0
	10 years or more	13	20.0

Descriptive Statistics of Major study variables

This subsection involves summarizing distributions of scores by computing descriptive statistical indices on measures of central tendency and a tabular presentation. The most commonly used measures in this study comprised of the mean, variance, and standard deviation.

The Alcohol Knowledge Scale (AKS) mean total score was 12.4 (SD=2.43) and Attitude about Alcoholism Scale (AAS) mean was 52.3 (SD=10.3). Addiction Counsellor Self-Efficacy Scale (ACSES) scale mean was 96.7 (SD=32.8) while its Assessment, Treatment Planning, and Referral Skills subscale mean was 24.0 (SD=8.8). Co-Occurring Disorders Skills subscale mean was 27.9 (SD=9.6). Group Counselling Skills Subscale mean was 16.8 (SD=6.2). Basic Counselling Skill overall mean was 15.1 (SD=5.9) while the Specific Addiction Counseling Skills Subscale mean was 12.9 (SD=5.4). The AAPPQ scale mean was 79.9 (SD=15.8) whilst its Role adequacy subscale overall mean was 29.0 (SD=8.3). Role legitimacy subscale total mean was 10.8 (SD=3.7). Role support subscale mean was 7.9 (SD=3.0) while Motivation subscale mean was 9.4 (SD=2.9). Task-specific self-esteem subscale mean was 18.4 (SD=4.4) and lastly Work Satisfaction subscale mean was 10.9 (SD=3.5).

Factor Analysis-Factor analysis was conducted using the Principal Component Analysis and rotated using Varimax rotation procedure. Factor analysis carried out on AKS and AAS revealed that both measures were unidimensional.The 32 items from the ACSES scale were multi-dimensional. The rotated solution yielded five interpretable factors: Specific Addiction Counselling Skills (20.8%); Assessment, Treatment Planning, and Referral Skills

(17.7%); Co-Occurring Disorders Skills (16.5%); Group Counselling Skills (12.8%) and Basic Counselling Skills (11.1%). The scree plot indicated that the AAPPQ scale 30 items are multi-dimensional. The rotated solution yielded six interpretable factors. The Role adequacy factor accounted for 17.8%, Role legitimacy (16.8%) and Role support (9.6%), and Motivation (7.6%), Task-specific self-esteem (6.7%) and Work satisfaction factor accounted for 5.7% of the total variance explained. The preceding scales and subscale descriptive data are displayed in detail on Table 3.

Table 3: Descriptive statistics of major study variables

Subscales	*N of Items*	*Mean*	*Variance*	*Std. Deviation*
Alcohol Knowledge Scale (AKS)	29	13.4	5.90	2.43
Attitudes about Alcoholism Scale (AAS)	20	52.3	106.9	10.3
Addiction and Counsellor Self-Efficacy Scale (ACSES)	32	96.7	1073.2	32.8
Assessment, Treatment Planning. and Referral Skills ACSES Subscale	8	24.0	77.7	8.8
Co-Occurring Disorders Skills ACSES Subscale	9	27.9	92.4	9.6
Group Counselling Skills ACSES Subscale	6	16.8	37.9	6.2
Basic Counselling Skill ACSES Subscale	5	15.1	35.3	5.9
Specific Addiction Counselling Skills ACSES Subscale	4	12.9	28.9	5.4
Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ)	30	86.5	249.0	15.8
Role adequacy AAPPQ Subscale	10	29.0	69.4	8.3
Role legitimacy AAPPQ Subscale	4	10.8	13.7	3.7
Role support AAPPQ Subscale	3	7.88	8.83	2.9
Motivation AAPPQ Subscale	3	9.40	8.40	2.9
Task specific self-esteem AAPPQ Subscale	6	18.4	19.7	4.4
Work Satisfaction AAPPQ Subscale	4	10.9	12.2	3.5

Reliability Statistics and Validity of Scales

The reliability and validity of the measures AKS, AAS, ACSES and AAPPQ were assessed using the internal consistency estimate and Cronbach's Alpha and presented in Table 4. Item analysis was conducted on variables hypothesized to measure different factors on each scale. No reliability test was conducted on the Alcohol Knowledge Scale (AKS) as it is inventory. Attitude about Alcoholism scale item internal consistency estimate Cronbach's Coefficient Alpha was .75 indicating low reliability. Item analyses conducted on all the 20 items assumed to assess AAS correlations were more than .06.

Addiction Counsellor Self-Efficacy Scale Cronbach's Coefficient Alpha was .97, indicating high reliability. The 32 items hypothesized to assess ACSES were correlated with the total score for ACSES scale and all the correlations scored greater than .06. Item analysis conducted on all the five ACSES subscales also revealed a high reliability. Assessment, Treatment Planning, and Referral Skills Subscale Cronbach's Alpha was .94; Co-Occurring Disorders Skills Cronbach's Alpha was .94; Group Counselling Skills Subscale Cronbach's Alpha was .94; Basic Counselling Skills subscale Cronbach's Alpha was .93; and Specific Addiction Counselling Skills Subscale Cronbach's Alpha was .93.

Most of the 30 items of the AAPPQ construct correlations scored greater than .01 except for 2 items: Item 15 ($\underline{r}$ = -.148) and Item 21 ($\underline{r}$ = -. 001). Based on these results items 15 & 21 were eliminated. Item-total correlations for the revised scale 28 items yielded one correlation less than .01: item 16. This item was maintained because its content did not appear to differ markedly from the content of the other 27 items. The values for the Cronbach's Coefficient Alpha was .87, indicating high reliability.

Item analysis was also conducted on the six factors of the AAPPQ scale. Four factors of the AAPPQ scales correlation coefficients presented a high reliability with Role adequacy Cronbach's Alpha at .89; Role legitimacy Cronbach's Alpha was .81, Role support Cronbach's Alpha was .74 and Work Satisfaction Cronbach's Alpha was .79. Unlike the other factors, both Motivation Subscale Cronbach's Coefficient alpha .67 and Task specific self-esteem Subscale Cronbach's Alpha .60 indicated a low reliability. Subsequently, Table 4 presents précis reliability results.

Table 4: Reliability Statistics of Scales and Subscale

Subscales	*N of Items*	*Cronbach Alpha*
Alcohol Knowledge scale (AKS)	29	n.a
Attitudes about Alcoholism Scale (AAS)	20	.75
Addiction and Counsellor Self-Efficacy Scale (ACSES)	32	.98
Assessment, Treatment Planning. Referral Skills ACSES Subscale	8	.94
Co-Occurring Disorders Skills ACSES Subscale	9	.94
Group Counselling Skills ACSES Subscale	6	.94
Basic Counselling Skill ACSES Subscale	5	.93
Specific Addiction Counselling Skills ACSES Subscale	4	.93
Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ)	30	.86
Role adequacy AAPPQ Subscale	10	.89
Role legitimacy AAPPQ Subscale	4	.81
Role supports AAPPQ Subscale	3	.74
Motivation AAPPQ Subscale	3	.67
Task-specific self-esteem AAPPQ Subscale	6	.60
Work Satisfaction AAPPQ Subscale	4	.79

Correlations matrix and hypothesis tests of variables

The correlations were conducted to socio-demographics, knowledge, and attitude and self-efficacy scores to establish the direction and strength of relationships. First, correlations were done a) within socio-demographics then; b) between socio-demographics and central study variables (knowledge, attitude and self-efficacy) and; c) between predictors and the criterion.

Socio demographics, predictor and criterion

Correlations between socio-demographic variables indicated that there was no statistical significance among socio-demographics. The observations also revealed that age, sex, level of education and regular clinical supervision were not associated with any of the predictor variables (knowledge, attitude and self-efficacy).

A correlation of socio-demographics age and sex was not associated with the criterion variable Alcohol Problem Perceptions Questionnaire (AAPPQ). Level of education was significantly correlated with Alcohol and Alcohol Problem Perceptions Questionnaire at (r=.25, p=.04). Participants with high education tend to have high scores on AAPPQ composite scale.

There was a statistical association between regular clinical supervision and AAPPQ total score (r=.30, p=.02). This indicated that participants with high regular clinical supervision scores had high AAPPQ scores. The results suggested that social workers receiving education and regular supervision had strong intentions to help clients with alcohol problems.

Bivariate analysis of Criterion and predictor variables

Correlations between the predictors (knowledge, attitude and self-efficacy) and the criterion variable Alcohol Problem Perceptions Questionnaire (AAPPQ) were also observed. The results indicated that only attitude was significant (r=.27, p=.03). Table 5 shows that the higher the AAS scores (positive attitiude) , the higher the AAPPQ scores (intentions) which suggested that, social workers with a positive attitude had strong intentions to help clients with alcohol problems. The correlation matrix is clearly displayed in Table 5.

Table 5: Correlation Matrix of Socio-demographics, Predictors and Criterion Variables

Variables	1	2	3	4	5	6	7	8
1. Age	-							
2. Sex	-.22(ns)							
3. Education	.02(ns)	.21(ns)						
4. Clinical supervision	.10(ns)	-.10(ns)	-.04(ns)					
5. Alcohol Knowledge Scale	-.09(ns)	.01(ns)	-.03(ns)	.07(ns)				
6. Attitude about Alcoholism scale	.14(ns)	-.072(ns)	.08(ns)	.21(ns)	-.05(ns)			
7. Addiction and Counsellor Self-Efficacy Scale	-.14(ns)	-.06(ns)	-.05(ns)	.07(ns)	-.18(ns)	-.10(ns)		
8. Alcohol and Alcohol Problem Perceptions Questionnaire	.16(ns)	-.06(ns)	.25(.043*)	.30(.015*)	.22(ns)	.27(.032*)	-.01(ns)	-

* Correlation is significant at the 0.05 level (2-tailed).

One Way Analysis of Variance (ANOVA)

Difference of mean scores among central study variables

One Way Analysis of Variance (ANOVA) was used to test for mean differences between socio-demographics and central study variables with more than two categories. The socio-demographics age and education were entered as factors while the dependent list comprised of Alcohol Knowledge Scale-AKS; Attitude about Alcoholism scale-AAS; Addiction and Counsellor Self-Efficacy Scale-ACSES and; Alcohol and Alcohol Problem Perceptions Questionnaire-AAPPQ on SPSS22.0.

Differences in age and level of Education

One-way ANOVA was conducted to evaluate mean difference on age and level of education of participants across all the scale scores. The ANOVA conducted between the age categories and all scale mean scores was not significant except for Alcohol Knowledge Scale (AKS). Findings showed that knowledge was significant with age F (4, 60) =2.49, p=.053.

The findings suggest that age did not have any effect on social workers attitude and self-efficacy in helping clients with alcohol problems but affected knowledge. ANOVA results also showed that there was no statistical difference among the level of education across all scale scores. This indicates that education did not have an effect on social worker knowledge, attitude and self-efficacy in helping clients with alcohol problems and attitude. Variability was too small because most of the participants' had same level of education and age. The ANOVA results are subsequently presented in Table 6.

Table 6: Difference by age and level of education by scales- ANOVA

Scales by Age	*Sum of Squares*	*Df*	*Mean Square*	*F*	*Sig.*
Alcohol Knowledge Scale (AKS)	53.7	4	13.4	2.487	.053 *
	324.1	60	5.40		
Attitude about Alcoholism scale (AAS)	631.5	4	157.9	1.525	.206
	6211.1	60	103.5		
Addiction and Counsellor Self-Efficacy Scale (ACSES)	3202.1	4	800.5	.733	.573
	65483.7	60	1091.4		
Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ) Between Groups	880.0	4	220.0	.877	.483
Within Groups	15056.2	60	250.9		
Scales by Age					
Alcohol Knowledge Scale (AKS)	19.2	2	9.58	1.66	.199
	358.6	62	5.78		
Attitude about Alcoholism scale (AAS)	143.1	2	71.5	.662	.519
	6699.5	62	108.1		
Addiction and Counsellor Self-Efficacy Scale (ACSES)	222.565	2	111.2	.101	.904
	68463.3	62	1104.2		
Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ)	1062.7	2	531.4	2.22	.118
	14873.5	62	239.9		

Differences in sex and regular clinical Supervision

The Independent t-test was conducted to test mean difference for variables with two categories. Independent t-test was conducted to test mean differences on scale scores by sex and clinical supervision. Sex and clinical supervision were entered as factors while the dependent list comprised of Alcohol Knowledge Scale-AKS, Attitude about Alcoholism scale-AAS, Addiction and Counsellor Self-Efficacy Scale-ACSES and Alcohol and Alcohol Problem Perceptions Questionnaire-AAPPQ on SPSS 22.0.

No statistical difference was found between sex and all the scale scores. These outcomes suggest that sex did not have any effect or relationship with social workers knowledge, attitude and self-efficacy in helping clients with alcohol problems.

Knowledge, attitude and self-efficacy scales, by receiving clinical supervision t-test results, were not significant. AAPPQ ANOVA test was significant $\underline{F}$ (1, 63) = .041, p =.015. The results suggest that there was a positive relationship between clinical supervision and helping clients with alcohol problems. Table 7 on the next page shows the results.

Table 7: Difference in sex and receiving clinical supervision by Scales-Independent Sample Test

Scales by sex		*F*	*Sig.*	*T*	*Df*	*Sig. (2-tailed)*
Alcohol Knowledge Scale (AKS)	Equal variances assumed	2.48	.121	-.076	63	.940
Attitude about Alcoholism scale (AAS)	Equal variances assumed	.899	.347	.570	63	.571
Addiction and Counsellor Self-Efficacy Scale (ACSES)	Equal variances assumed	.002	.965	.471	63	.639
Alcohol and Alcohol Problem Perceptions Questionnaire	Equal variances assumed	.939	.336	.447	63	.657
Scales by Regular Clinical Supervision						
Alcohol Knowledge Scale (AKS)	Equal variances assumed	2.00	.162	-.538	63	.592
Attitude about Alcoholism scale (AAS)	Equal variances assumed	.595	.444	-1.74	63	.087
Addiction and Counsellor Self-Efficacy Scale (ACSES)	Equal variances assumed	4.37	.041	-.554	63	.582
Alcohol and Alcohol Problem Perceptions Questionnaire	Equal variances assumed	.041	.840	-2.51	63	.015 *

Multiple regression analysis of socio demographics, predictors and criterion variables

Multiple regressions were conducted to evaluate how much the socio demographics and predictor variables contribute to social workers intentions to help clients with alcohol problems (AAPPQ). The socio demographics tested included age, sex, level of education and regular clinical supervision. The independent variables were Alcohol Knowledge Scale (AKS), Attitude about Alcoholism Scale (AAS) and Addiction Counsellor Self-Efficacy Scale (ACSES). The criterion variable was helping clients with alcohol problems the Alcohol and Alcohol Problem Perceptions Questionnaire (AAPPQ).

Step 1

Socio demographics-The linear combination of socio-demographics and predictor variables were significantly related to social workers intentions to help clients with alcohol problems (AAPPQ), F (5, 59) = 3.80, *p*=.005. Level of education significantly accounted for 6% (beta =.25, p=.029). Receiving regular clinical supervision accounted for a significant 6% (beta=.25, *p*= .037). The squared multiple correlations (R^2) indicate that about 13% of the variances of AAPPQ scores in the sample can be accounted for by the linear combination of the two socio-demographic variables. *The findings suggest that level of education and clinical supervision positively affect social workers knowledge, attitude and self-efficacy in helping clients with alcohol problems.*

Socio demographics, knowledge, attitude and self-efficacy-Multiple regression was used to evaluate how well the criterion-helping the clients with alcohol problems (AAPPQ) is predicted by Knowledge (AKS), Attitude (AAS) and Self efficacy. Knowledge (AKS) was significantly related to AAPPQ, F (5, 59) =3.80, *p*=.05 and the correlation coefficient

(beta=.23) predicted 5% of the variance. Attitude and self-efficacy were not significantly related to AAPPQ but linear combination of the three independent variables predicted 6% of the variance in helping clients with alcohol problems (AAPPQ). *The results therefore indicate that knowledge and attitude together with self-efficacy positively affect social workers intention to help clients with alcohol problems.* The regression model findings are displayed on Table 8.

Table 8: Multiple regression model summary of socio demographics, predictor and criterion variables

Model	Predictors	Standardized Coefficients	T	Sig.
		Beta	B	Std. Error
1	What is your highest level of education completed?	.255	2.24	.029
	Do you receive regular clinical supervision on alcohol and alcohol problems interventions	.250	2.13	.037
	Alcohol Knowledge Scale (AKS)	.228	1.96	.054
	Attitude about Alcoholism scale (AAS)	.208	1.77	.082
	Addiction and Counsellor Self-Efficacy Scale (ACSES)	.042	.364	.717

a Dependent Variable: Alcohol and Alcohol Problem Perceptions Questionnaire

Knowledge, Attitudes and Self-Efficacy in working with clients with alcohol problems

Step 2

After running the controls, multiple regressions were used to evaluate how well the criterion-working with clients with alcohol problems (AAPPQ) is predicted by Knowledge (AKS), Attitude (AAS) and Self efficacy (ACSES and its subscales). Knowledge together with attitudes and self-efficacy were significantly related to social workers intentions in working clients with alcohol problems, F (3, 61) =2.98, p=.04. The three independent variables linear combination predicted 13% of the variance in helping clients with alcohol problems (AAPPQ).

AKS was significantly related to AAPPQ, F (3, 61) =2.98, p=.05 and the correlation coefficient beta=.24 predicted 5% of the variance. Helping clients with alcohol problems and attitude (AAS) was also statistically significant F (3, 61) =2.98, p=.02. AAS correlation coefficient b=.29 accounted for the remaining 8%. Both the regression coefficients were positive. Only knowledge and attitudes coefficients significantly contributed to the AAPPQ variance while self-efficacy (ACSES) did not. The findings in Table 9 indicate that knowledge and attitude positively affect social workers intention to help clients with alcohol problems.

Table 9: Knowledge, Attitudes, and Self-Efficacy *in working clients with alcohol problems (AAPPQ)*

	Criterion: helping clients with alcohol problems (AAPPQ)			
Model 2	Predictors	Standardized Coefficients Beta	t	Sig.
	Alcohol Knowledge Scale (AKS)	.243	1.99	.05
	Attitude About Alcoholism Scale	.285	2.37	.02
	Addiction Counsellor Self Efficacy Scale	.059	.479	.63

Phase 2: Qualitative Data Results

Findings from the qualitative interviews provide support for knowledge, attitude and self-efficacy as pertinent factors in predicting social workers intentions to help clients with alcohol problems in Botswana. The results are presented in textual themes as derived from participants' quotations and interpretations. Demographic characteristics of this data are presented first and then followed by responses deliberated in themes format.

Demographic characteristics of respondents

Based on the quantitative results, top six participants with high scores and bottom six participants with the least scores on the Alcohol and Alcohol Problems Perceptions Questionnaire (AAPPQ) were selected. Qualitative data comprised of 12 participants with ages between 27-48 years. There were more females 83% (N=10) than males 27% (N=2). The majority of the participants had a Bachelor's Degree 67% (N=8), followed by Diploma 25% (N=3) and Masters 8% (N=1). Participants were equally split across the Districts, Kweneng 50% (N=6) and South East 50% (N=6). These findings are further displayed in Table 10.

Table 10: Qualitative Data Socio-Demographics

Alcohol and Alcohol Problems Perceptions questionnaire Scores	Frequency	District	Age	Education	Sex
Top Six Participants					
119	1	South East	29	Bachelor's Degree	F
113	1	Kweneng	28	Diploma	F
112	1	South East	48	Bachelor's Degree	F
109	1	South East	35	Master's Degree	F
106	1	Kweneng	36	Bachelor's Degree	M
106	1	South East	38	Bachelor's Degree	F
Bottom Six Participants					
62	1	South East	27	Bachelor's Degree	M
60	1	Kweneng	32	Bachelor's Degree	F
58	1	Kweneng	29	Bachelor's Degree	F
50	1	Kweneng	34	Bachelor's Degree	F
46	1	South East	26	Diploma	F
39	1	Kweneng	35	Diploma	F

Thematic data presentations

The findings were deduced from three major themes namely; alcohol problems effects and social workers knowledge; attitude and; self-efficacy in helping clients with alcohol problems. Factors associated with knowledge emerged from themes such as the need for training alcohol; confusion and/or failure to clearly point out alcohol problems, and lastly quotes on how perceived knowledge influence attitude in predicting intentions.

Attitudinal factors were extrapolated from the negative and positive beliefs, consequences and outcomes associated with clients with alcohol problems. The self-efficacy theme was derived from grouping issues depicting performance accomplishments; persuasive verbal messages; feedback vicarious learning and; emotive experiences or affective states. The theme also gives exemplary quotes that explained how control beliefs influence perceived behavioural control and actual behavioural control to predict intentions.

Theme 1; Alcohol problems, effects, and social workers' knowledge

Confusion or difficulty in basic clinical counseling skills

During the interviews, participant social workers' were asked how they perceive alcohol and their perceived knowledge of alcohol issues (refer to Table 11 for verbatim results). Alcohol problems responses were extracted from Question 1 and 2; while perceived knowledge was retrieved from Question 4 and 7 of the qualitative interviews (See Appendix 6).

All the participants (n=12) viewed alcohol as a social problem triggering many socio-economic consequences in Botswana. Participants reported that alcohol is an issue affecting individuals, families and communities in Botswana. Alcohol was viewed as a precursor of

domestic violence, work unproductivity, relationship break-ups, justice-involved youth and "*bogoma*" or stubbornness (n=12). It was reported that many people drink and finish money on alcohol which leads to quarrels between partners (n=5).

Alcohol was seen as a cause of family abuse especially on women and children leading to child negligence, starvation, lack of parental support as men spent most of the time drinking alcohol (n=6). Participants are also linked child abuse, stubbornness, naughtiness, bad behaviour and poor performance at schools to children of clients with alcohol problems which latter infused criminal traits (n=2).

At the community level, alcohol was seen as a contributor to accidents, crime, and poverty as people waste money and have to do without food and shelter (n=6). Participants also ascribed alcohol to work unproductivity, increased intimate partner violence cases and family breakdowns in the society. Participants evidenced their assertions with examples from their day to day encounters as follows;

Respondent 1, "Yes, many people drink. Men spend their money on alcohol. It causes issues at homes between partners. One scenario is a situation where a drunken partner says he think the spouse is angry (o *ngadile*) with him when he gets home drunk and would start shouting at her." Respondent 3, "I see children referred by teachers from school due to bad behaviour and misconduct. Children of parents drinking alcohol come with problems of stubbornness (*bogoma*) and at times they just keep quiet during sessions or give the same response for all answers." Respondent 4, "I have seen about two clients. A woman complaining that her partner beats her and abuses her verbally when drunk. Another client was in financial debt due to alcohol. Respondent 6, "Abuse, a woman was beaten by her husband and came to seek help without her upper teeth."

Participants' perceived knowledge was assessed using question 4 and 7 of the interview guide. The majority of the participants (n=9) were unable to state the strategies or interventions they use to help clients with alcohol clients. For instance, Respondent 10 reported that,

> "No classified strategies, I just counsel them." Only three participants were able to state that they use cognitive restructuring, abstinence, and harm reduction to help clients with alcohol problems.

Participants supported the quantitative findings that more specific training on social issues like alcohol instead of generic counselling skills was needed in social work. Thus participants indicated that they did not mind helping clients with alcohol problems but thought that insufficient training on alcohol from the University lessens their skills and knowledge (n=11).

> Respondent 4 explained that "I believe that it would be helpful to be taught at UB level how to deal with a client with alcohol problems so that we do not just refer clients."

> Respondent 2, "I make a referral to psychologists as they are better placed to assist; they studied human behaviour more than social workers.

Collectively, theme 1 findings corroborate phase one results that social workers have low levels of knowledge on alcohol problems. Additional this lack of knowledge is associated with several factors such as education, experience and knowledge. Subsequently, theme 2 explains the relationship between participants' knowledge and attitudes in helping clients with alcohol problems.

Theme 2: Attitude

Participants were able to state clearly their emotions and views in response to alcohol problems and helping clients with alcohol problems as captured in the opening statement and question 3.

Negative beliefs about alcohol and alcohol clients

When asked about the first thing that comes to their mind about the word alcohol, participants said "*Matagwa"- drunkards,* alcohol abuse, bars, spending, violence, and fights, (n=10). This response highlighted that the majority of the participants had negative connotations to alcohol. For instance, Respondent 3 stated that "I picture drunkards (matagwa), bars, fights and all other bad things." Respondent 7, "I think of botagwa and irresponsibility."

In response to question 3, the majority of the participants (n=10) expressed that they did not like helping clients with alcohol problems. These participants' reported that clients with alcohol problems are in denial; playful; full of anger; difficult; forgetful and aggressive. Some participants very confidently to stated that they do not like people who drink (n=3). For example;

> Respondent, 3 stated that "I do not understand whether alcohol is addictive or what because no matter how I talk to them it is hard for them to quit drinking and I think that is being playful." Respondent 4, "These clients are in denial and infuriated (*ba tetle tshakgalo*)." Respondent 10 said, *"Ba a tena* (they are irritating), they act as if they are the only ones having problems."

Neutral regards towards alcohol and alcohol clients

Some participants indicated that they had a neutral reaction to hearing the word alcohol (n=2). The participants related issues of alcohol with their experiences of drinking,

passion for helping clients and viewed them as being in need of care and support. Some positive views were captured as follows:

> Respondent 1"Alcohol is alcohol, people drink, and it may be good, but some drink excessively."
>
> Respondent 12, People with alcohol problems are very sensitive they need to be treated with empathy and utmost confidentiality.

Similar to phase 1 results many of the participants had negative attitudes towards clients with alcohol problems. However, most participants gave neutral responses towards alcohol and clients with alcohol problems as compared to phase 1 findings. Theme 3 explains how knowledge, attitude and self-efficacy together influence participants' intentions.

Theme 3: Self-efficacy in helping clients with alcohol problems

Confidence

The qualitative interview assessed self-efficacy by asking participants "Question 5, what affects your confidence as a social worker to help clients with alcohol problems." Question 5(a-b) went further to ask how participants perceived the socio-demographics of age; sex experience and education in predicting their self-efficacy. The responses were similar to the quantitative regression findings that age and sex do not have any effect on social workers self-efficacy intentions. Both younger and older participants reported that they did not have problems with their age and sex because clients respect their professional status. In an affirming quote Respondent 5, reported that:

> "I am comfortable with my age and gender, but I realised clients prefer mature social workers unlike the younger colleagues joining us due to the age difference. They feel older ones understand them better."

Age, sex, education and self-efficacy

Unlike age and sex, all the participants (n=12) reported that education and experience influenced their self-efficacy intentions. Participants with more experience in practice expressed having the confidence to help clients with alcohol problems as they believed their skills improved and gained enactive mastery over the years (n=7).

> Respondent 7 "Looking at my experience, I am satisfied and confident enough to say that my skills in working with clients with alcohol problems have improved in the past years." Likewise, those with a few years of practice reported that with more years in the field they can do better through vicarious learning (n=2) and verbal persuasion (n=3). Illustratively, Respondent 2 stated that "experience-wise I am still learning the job, so I think I will get better with time."

The interviews also linked lack of education as a contributor to participants' low confidence regarding skills to help clients with alcohol problems.

> Respondent 4 noted that "I doubt my skills and knowledge in dealing with alcohol clients because I have had insufficient education on alcohol from school, and my experience is fine I just need more information on alcohol." Respondent 5 maintained that "I do not have confidence in my education of alcohol problems, and I feel my experience with alcohol is not too much that I do not see myself growing on issues of alcohol."

In summary, Table 11 presents participants' responses with corresponding figures that explain the relationship between knowledge, attitude, and self-efficacy with intentions. For clarity, the Master Codes are further divided into positive or negative response types while the frequencies of responses are provided next to each content area for objectivity. After table 11, is chapter six which integrate the phase 1 & 2 findings to identify any similarities and differences. The purpose of this integration is to end up with valid and well-substantiated conclusions and recommendations about the subject matter.

Table 11: Key qualitative findings with corresponding responses, theoretical themes, and figures

		Emerging Themes with Frequency of Respondents (N=12)			
Master Code	Identifier	Question	Commonly captured responses and quotes	Emerging theoretical themes	N
Knowledge	Alcohol problems interventions	4. What are some of the strategies or interventions that you use to help a client with alcohol problems?	Anger Management scales, cognitive restructuring, and counselling. Use of strength perspective.	Perceived Knowledge: adequate knowledge and ability to share alcohol problems strategies and intervention strategies.	3
	Basic counselling skills		Referral to psychologists as there a better placed to assist. Understand why the client is alcoholic. Educate clients about alcohol causes and consequences. Help clients participate in other activities such as playing football and keeping the right company of friends.	Confusion and difficulty in stating basic clinical counselling skills and interventions.	9
	Training	7. Have you ever received any training on Alcohol and alcohol problems?	Yes, but not in-depth. Remember a brief presentation from a course in mental health at UB.	Yes, received training or education on alcohol.	1
			No	No, training on alcohol.	11
Attitude	Views and beliefs on	Opening phrase; Can you please share with me the	See drinking as good although some drink excessively.	Thinking and displaying positive regards towards alcohol.	2

	alcohol	first thing that comes into your head when you hear the word "alcohol"?	Alcohol abuse; drunkards (matagwa); and irresponsibility. Sexual abuse, violence, rape, abuse and child negligence.	Negative beliefs about alcohol.	10
	Attitude towards clients with alcohol problems	3. Personally, what are your observations in working with people with alcohol problems?	They are generally good	Positive attitude towards clients with alcohol problems.	2
			Hard to deal and relate with Aggressive, playful and forgetful. Do not understand whether alcohol is addictive or what. Think clients are in denial and angry See clients as irritating and not taking responsibility.	Negative attitude towards clients with alcohol problems.	10
Self-efficacy	Confidence Age Gender	5.What affects your confidence as a social worker to help clients with alcohol problems; a) Do you think <u>age and gender</u> affect social workers perception of their self-efficacy when counselling clients with alcohol problems, how so?	General Confidence See client's problems similar to self and refer because I cannot handle it. The problem of confidence on alcohol issues because did not have much exposure to alcohol cases. Age Able to help clients although they think am small. Comfortable with age and gender but realised clients prefer mature social workers. Sex Stigmatising males because they refer to us as female social workers.	Confidence with age and sex. Not confidence with age and sex.	12 0

Self-efficacy	Use of experience Colleagues assistance Clinical supervision Physical state	b) Do you think <u>experience and education</u> affect social workers perception of their self-efficacy when counselling clients with alcohol problems, if yes how so?	Experience • Still learning the job and thinking they will be better with time. • Experience with alcohol is not too much that I do not see myself growing on issues of alcohol. • Satisfied and confident that their counselling skill has improved over the years. • Have grown overuse of past alcohol cases. • Supportive supervision helps on how to tackle alcohol problems cases	Experience affect confidence, how; Enactive mastery experiences Vicarious learning Verbal persuasion Emotive forces: anxiety	12 7 2 3 0
Education & Confidence			Education Do not have confidence in knowledge of alcohol problems. Do not have the necessary skills	Education affects confidence, how; Knowledge Skills	12 9 3
Other issues	What could be done to improve these?		Increase money Increase rehabilitation facilities. Access to computer and the internet Training on alcohol problems		1 1 8 12

CHAPTER SIX

DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

Overview

The goal for this study was to examine social workers knowledge, attitude and self-efficacy in working with clients with alcohol problems in Botswana. The guiding tenets of the study were derived from the Theory of Reasoned Action and Self Efficacy. The study used a mixed method involving quantitative and qualitative research approaches which analysed questionnaires and qualitative interviews respectively. A simple random sample of 65 participants was selected for the survey while judgemental sampling selected 12 interview participants.

Consistent with the TRA/PB and self-efficacy theories, it was expected that social workers attitudes (perceived knowledge/attitude); subjective norms (enactive mastery skills, vicarious learning and clinical supervision) and self-efficacy (ACSES) positively correlate with participants' intentions to help clients with alcohol problems (AAPPQ). Furthermore, it was assumed that comparing, confirming or corroborating quantitative results with qualitative results would describe the circumstantial details producing evidence of the established correlational relationships. Lastly, it was also expected that the mixed methods approach would provide detailed data that would help in guiding the present and future research problems. This chapter, therefore, interprets Phase 1 and Phase 2 study findings to answer the research objectives and draws conclusion and recommendations that can be implemented to address variables that significantly predict helping clients with alcohol problems.

Social workers knowledge on alcohol and alcohol problems

In corroboration with most studies, phase 1 and phase 2 findings also found out that social workers' have low knowledge on alcohol and alcohol problems. Frequency analysis of scores in Phase 1 survey findings indicates that social workers have less knowledge on alcohol and alcohol problems. In line with previous researches the results revealed that 66% of social workers scored less than half (0-48%) on the AKS (M=14.5) scale while 38% scored above the median (50-69%). Substantially, Phase 2 interview results also supported the assertion as the majority of the participants further acknowledged they lacked knowledge. In a similar confirmation, Hack & Adger (2002) also found that social service settings fail to identify and differentiate individuals who use, abuse, or are dependent on substances.

Like in other studies, it was also found out that participants alluded to not receive training on alcohol problems, limited access to computers and internet as major impediments to lack of knowledge. Consequently, the participants' were unable to state the strategies and skills they use to help clients with alcohol problems. Fairly, this response supports the evidence from past studies in chapter two who showed that indeed social workers have inadequate knowledge and are failing to diagnose alcohol problems (Gregoire, 1994; Hall et al., 2000; Straussner & Senreich, 2002.

In another contention, both the phase 1 and phase 2 results have proven that knowledge affects social workers intentions to help clients with alcohol problems like in previous research. The regression findings from Phase 1 revealed that helping clients with alcohol was significantly predicted by education and knowledge. The results showed that the more the education, the more the knowledge and the greater the motivation of intention to

help clients with alcohol problems. Phase 2 verbal responses were also consistent with the regression findings because most of the social workers pointed to education and training as a major impediment to knowledge.

Like in other studies, most of the participants' revealed that they do not understand clients with alcohol problems which were also evidenced by the inability to differentiate alcohol use, dependence, and abuse issues during interviews. Instead, participants viewed clients with alcohol problems as contributors to other social problems such as partner and child abuse, poverty, crime, and divorces. They did not view clients as encountering alcohol problems which clouded their judgement to the thorough screen, assess and plan interventions for clients with alcohol problems. Like in the past literature inability to identify alcohol problems was also associated with education on general practice as most of the participants had a degree as their highest level of education. The findings also corroborate the empirical evidence that most degree holders have less knowledge on specific issues such as alcohol and alcohol problems because of their generic training (Hall et al., 2000).

Social workers' attitudes towards helping clients with alcohol problems

This subtopic explains objective 2 and theoretical assumption one findings of the study. Objective 2 sought to identify social workers' attitudes towards clients with alcohol problems while Theoretical Assumption 1 projected that attitude of social workers towards helping clients with alcohol problems positively affects behavioural intentions. Like in past studies, the composite scores of Attitude about Alcoholism Scale (AAS) scale was divided into two subdivisions to explain whether social workers intentions to help clients with alcohol problems varied as a function of personal or professional attitudes. The assumption was assessed by multiple regression analyses to explicate the degree to which attitudes is related

to social workers' intention to help clients with alcohol problems (AAPPQ). Participants' were also asked to state what they think about alcohol and clients with alcohol problems.

Attitude towards clients

Both the phase 1 and phase 2 findings corroborate the previous research contention that social workers have negative attitudes towards clients with alcohol problems. The phase 1 results showed that more than 51% of the participants scored below the median (M=53), indicating negative views while 49% accounted for positive views on the AAS scale. These outcomes are in no way detached from other studies as they support that social workers attitudes are marginally negative towards helping clients with alcohol problems (Amodeo, 2000; Amodeo, Fassler, and Griffin, 2002; Googins, 1984; Silverman, 1993; Strozier, 1995). The professional attitudes (52%) and personal attitudes (55%) factors also revealed that participants had negative views. In agreement Rogers (2010) found out that segregating personal and professional attitudinal views discordantly proved that there were no differences in results.

Phase 2 findings also validated phase 1 and other results of research by revealing that participants' had a negative attitude towards clients with alcohol problems. Similar to other studies social workers pictured these clients as irresponsible, drunkards "*matagwa*", in denial, playful, angry and aggressive. For example Rubin (1996) also found out that mental health professionals rated clients with alcohol problems as "more foolish, dull, wrong, and sick, slow, hopeless, weak and passive than average persons." In a different contention to phase 1 finding, phase 2 findings also found out that social workers had neutral views instead of positive views towards clients with alcohol problems. This was mainly evidenced among social workers who reported using alcohol or having relatives and friend who use alcohol.

Attitude, motivation and intention to help

The study findings support the contention that social workers' attitudes positively affect their intentions to help clients with alcohol problems. In phase 1 the multiple regression analyses indicated that attitude as a result of knowledge *(p*=.05) and education (*p*=.03) evaluations independently predicted social workers intentions to help clients with alcohol problems (*see model 2*). The regression analysis further indicated that there is a positive correlational relationship between social workers knowledge, education, and attitudes. Similiary Chappel, Jordan, Treadway and Miller (1977) also found that clients benefited from working with clinicians whose expectations about outcomes were favorable, and conversely, that many substances abusing clients fulfilled the negative expectations of those treating them.

In agreement to the quantitative findings phase, 2 results indicated that having education and knowledge would help them understand alcohol problems issues and help clients' better. It was evident from the results that social workers had less knowledge, less education and negative attitudes hence less motivated to help clients with alcohol problems. The results support the view that social workers' attitudes motivate their intention them to help clients with an alcohol problem. In conformity, Kagle (1987) also reported that social workers' with negative attitudes about treatment success failed to intervene or make an appropriate referral where alcohol disorders were recognized as a problem.

Social workers self-efficacy

Discussions of self-efficacy centred on explaining social workers confidence, self-efficacy sources, and subjective norms. ACSES and its factors were used to explain

participants' level of confidence; higher scores indicate a greater degree of confidence and lower scores vice versa (M=97). The self-efficacy sources (enactive mastery skills, vicarious learning, and verbal persuasion) together with subjective norms explain the real predictors of social workers intentions in helping clients with alcohol problems (Bandura, 1977; Ajzein & Fishbein, 1980).

The quantitative and qualitative study findings wherein confirmation with the contention that social workers' have low confidence in their knowledge of alcohol problems. Phase 1 results revealed that social workers' had low confidence in their skills and knowledge to help a client with alcohol problems. The frequency analysis of the ACSES measure indicated that 51% of the participants' scored below the median (M=97) while 49% scored above. Participants also scored below the median on all the ACSES subscales which revealed that social workers lacked confidence on Specific Addiction Counselling Skills (55%) and Assessment, Treatment Planning, and Referral Skills (54%) as compared to other factors. The interviews responses supported Phase 1 findings as they reported poor education and experience on alcohol problems interventions as precursors of their low confidence. Both results support past results of research that clients have not assisted accordingly due to lack of training and lack of self-efficacy in utilizing alcohol use treatment skills (Schenk & Holosko, 1996; Rose et al., 2009).

Contrary to other study findings, the linear regression analysis to explore whether self-efficacy had an effect in helping clients with alcohol problems was not significant. However, the outcomes revealed that subjective norms (clinical supervision) significantly (p=.037) predicted social workers intentions. The results further indicated that 97% of social workers reported not receiving any regular clinical supervision on alcohol interventions.

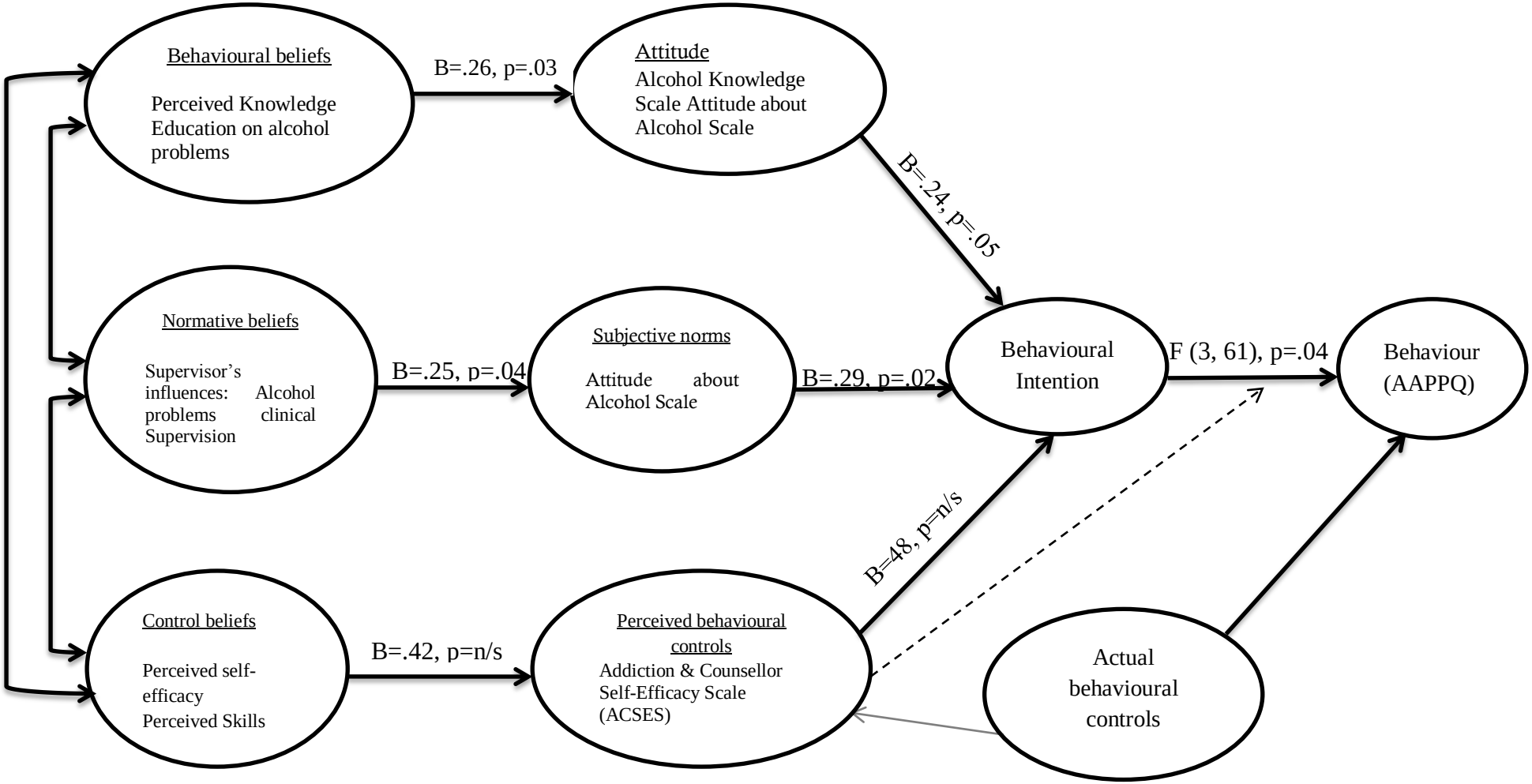
Comparably, interviews findings also documented that social workers receiving clinical supervision were able to grow from the experience and the feedback they received from their supervisor than those who did not receive supervision. Failure to receiving clinical supervision was associated with diminished knowledge, negative attitude and reduced efficacy in helping clients with alcohol and alcohol problems (Wood & Bandura, 1989).

Collectively, the results support theoretical assumption 2 that subjective *norm of colleague's knowledge and ability to deal with alcohol problems positively affect behavioural intentions.* The more a social worker received clinical supervision on alcohol intervention the more the knowledge level. It is therefore concluded that social workers with an enhanced level of education and regular clinical supervision tend to have more knowledge and motivation to help clients with alcohol problems.

Conclusion and recommendations

In conclusion, social workers had low levels of knowledge hence a negative attitude towards clients and low confidence on their skills to help clients with alcohol problems. The succeeding Model 2 linear regressions indicate that helping clients with alcohol problems (AAPPQ) was significantly related to level of education and receiving clinical supervision. The regressions further reveal that education, knowledge and attitude paired together predict social workers intentions to helping clients with alcohol problems. The model supports the theoretical findings of the study that subjective norms of others through receiving feedback from experts such as supervisors significantly predict social workers intentions and motivation to help clients with alcohol problems (Bandura, 1986).

Model 2: TRA-PB variables and measures results framework



Source: Adapted from the Theory of Reasoned Action Model

Based on the major findings of this study, the researcher recommends the succeeding professional, research and policy implications;

i) Policy

- S&CD should formulate a specific Standard Operating Procedure for social workers' on helping clients with Alcohol and Alcohol Problems.

i. Professional Practice

- There is a need to provide an in service specific training on alcohol screening, assessment and treatment planning to social workers employed by Social and Community Development (S&CD). Training can be requested from consultants, UB or NGOs like BOSASNET.
- University of Botswana need to provide short term or winter courses on addressing social problems such as alcohol problems and substance abuse.
- In response to the status quo UB social work department need to enhance their counselling courses to include training on alcohol problems.
- The government of Botswana can also request the Social Work Department at UB to attach student to alcohol and drug rehabilitation facilities in order to increase their knowledge on issues of alcohol and alcohol problems interventions. Practicing social workers should also be taken to rehabilitation facilities to model the alcohol and alcohol intervention process.
- S & CD should educate its social workers about alcohol referral facilities and groups available in their community such as Alcohol Anonymous, Narcotics Anonymous and

NGOs. All contacts details of alcohol and drug problems facilities should be availed at social workers' working station.

- The S&CD should at least create one counselling room where social workers are placed to provide a favourable professional counselling environment.
- A working computer with easy internet access is needed for continuous learning and research on cases that social workers encounter every day to enhance their knowledge base and confidence.
- Regular clinical supervision of social workers' at least once per week is recommended by a clinical supervisor. Expert knowledge and modelling has proven to be one of the core motivators to social workers intention to helping clients with alcohol problems. This assist in broadening the knowledge base, improved attitude and confidence of social workers in helping clients with alcohol problems. This would also help in reducing burnout and stress on the part of social workers.

ii. Research

- There is need to conduct an extensive empirical applied research to compare knowledge, attitude and self-efficacy of participants receiving specific education on alcohol problems and participants not receiving any alcohol education.
- Research exploring the effective elements of interventions is also needed. While this review identified some key elements that appeared to be consistent across the more successful interventions, more research is needed to explore how clinical supervision and education contribute to social workers intentions.

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APPENDIX 0

UNIVERSITY OF BOTSWANA

HUMAN INFORMED CONSENT FORM

Title of Project: *Social worker's knowledge, attitudes and self-efficacy in working with clients with alcohol problems in Kweneng and South East District, Botswana.*

Principal Researcher: *Keikanyemang Francis*

Dear Participant,

My name is Keikanyemang Ngande, a graduate student at the University of Botswana. I am asking for your voluntary participation in a study that I am doing on social worker's knowledge, attitudes, and self-efficacy in working with clients with alcohol problems in your District. I am conducting this study in partial fulfilment of the requirements for the Master's Degree in Social Work. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information, and I will take the time to explain. If you have questions later, you can ask my supervisor or me.

Purpose of the study
The study intends to find out the level of social workers' knowledge on alcohol and alcohol problems and social workers attitude in working with clients with alcohol problems. The study will also explore social workers self-efficacy in helping clients with alcohol problems.

Voluntary Participation
Participation in this study is completely voluntary. If you decide not to participate there will not be any negative consequences. Please be aware that if you decide to participate you may change your mind later and stop participating even if you agreed earlier. The choice that you make will have no bearing on your job or on any work-related evaluations or reports.

Procedures and duration
You are being invited to take part in this study because we feel that your experience as a social worker can contribute much to our understanding and knowledge of alcohol problems and practice issues. This study will be conducted in two stages: a survey that will involve your participation in a self-administered questionnaire that will take about 55 minutes and a tape recorded one-hour interview.

In the first stage the study will start with a survey covering almost all social workers in your district. Then the second stage will be interviews that will be conducted one week after the survey. The interviews will be scheduled with only few selected individuals. Therefore, if you accept, you will be asked to fill out surveys which will be provided and collected same

day upon completion by me or other research assistants. The survey has Section A and Section B. Section A comprises questions on socio demographic which requires filling in short answers and circling responses where applicable. Section B is a multiple choice questions which will require reading, understanding and circling the response. The information recorded is confidential, your name will not be included on the survey forms, only a number will identify you, and no one else except the researchers will have access to your survey.

During the interview, I or another interviewer will sit down with you in a comfortable place at the Council. No one else but the interviewer will be present unless you would like someone else to be there during the interview. The information recorded is confidential, and no one else except the researcher will have access to the information documented during your interview. The entire interview will be tape-recorded, but no-one will be identified by name on the tape. The tape will be kept safely by the researcher in a lockable drawer. The information recorded is confidential, and no one else except the researchers will have access to the tapes. The tapes will be destroyed after 6 weeks.

Potential Risks of Study
There are no anticipated risks in this study; only absolute personal views of respondents will be requested.

Benefits
There are no direct benefits to study participants. However, the study might help address some of the identified social workers crossing cutting needs on alcohol knowledge, attitude and self-efficacy in practice.

Confidentiality
Individuals will not be required to provide any information that will easily describe their identity when responding to the study questions. Names and biological descriptions collected would be stored in lockable shelves and destroyed upon completion of data analysis. Data will only be shared with the research team members. If you have any questions about this study, feel free to contact my supervisors:

Dr Tirelo Modie-Moroka Phone: (+267) 3552383/4/5
Prof Motshedisi Sabone Phone: (+267) 3552364

Authorization

By signing this form you are confirming that you have read and understood the foregoing information and freely give your consent to participate in this study.

Research Participant : _____
Signature : _____
Date : _____

APPENDIX 1

SOCIO-DEMOGRAPHIC FORM

INSTRUCTION: Please FILL in the correct answer and CIRCLE where appropriate. In this study a social worker will refer to an individual that is trained and employed to help people with a wide range of issues, including psychological, financial, health, relationship, and substance abuse problems through the Department of Social and Community Development.

SECTION A: DEMOGRAPHICS

1. What is your current age? (Please write age)_____

2. Sex:
    a. Female
    b. Male

3. What is your religion?
    a. None
    b. Mainline churches (Roman Catholic Church, Anglican, Seventh day Adventist, Methodist, etc)
    c. Pentecostal (Apostolic Faith Mission, Assemblies of God, Bible life, etc)
    d. African Independent Churches (ZCC, Head Mountain, etc)

4. What is your current marital status?
    a. Currently Married
    b. I lived with a partner, but never married
    c. Separated
    d. Divorced
    e. Single, and never Married
    f. Widowed
    g. Polygamous marriage
    h. Other (Specify):_____

5. What is your specific area of interest in Social Work?
    a. Social welfare
    b. Community Development
    c. Substance abuse and treatment
    d. Gender Based Violence

6. How long have you been a social worker in this District ?_____ Years ____Months

7. How many years have you worked in a clinical direct practice?_____ Years ____ Months
8. What is your highest level of education completed?

a. Secondary School
b. Certificate in _____
c. Diploma or equivalent _____
d. Bachelor's degree in _____
e. Master's degree in _____
f. Other (specify) _____

SECTION B: PRACTICE AND GEOGRAPHICAL QUESTIONS

9. In estimation how do you spend your time in a typical week on the following?

NOTE: 1=Never, 2=Little time, 3= Sometimes, 4=Most of times, 5=Every time

Task	Rate				
Alcohol problems screening and assessments	1	2	3	4	5
Alcohol problems individual counselling	1	2	3	4	5
Alcohol problems group counselling	1	2	3	4	5
Alcohol problems family counselling	1	2	3	4	5
Alcohol problems case management	1	2	3	4	5
Clinical supervision on Alcohol problems	1	2	3	4	5
Documentation	1	2	3	4	5
Administrative activities	1	2	3	4	5

10. Do you receive regular (e.g., monthly/weekly/daily) clinical supervision on alcohol and alcohol problems interventions, If yes, how often?

a. Yes, ____ times per _____
b. No

11. How many alcohol problem clients would you see in an average week?
a. No clients at all
b. 0-2
c. 3-4
d. 5-6
e. 7-8
f. $9\text{-}10^{+}$

12. How would you classify your practice setting?
a. Urban practice
b. Rural practice
c. Mixed Urban/Rural practice

APPENDIX 2

ALCOHOL KNOWLEDGE SCALE (AKS)

Please indicate whether the 29 statements on the AKS are true or false. CIRCLE one answer 1= True or 2= False.

ITEM	TRUE	FALSE
1. There are few prevention programs that address changes in alcohol and other drug use behaviour in Botswana.	1	2
2. Among Batswana over 37% have a significant alcohol problem.		2
3. People with alcohol problems generally consume 10 or more drinks a day.	1	2
4. Alcohol in Botswana is significantly related to the ethnic origin of an individual.	1	2
5. Children with Fetal Alcohol Syndrome (FAS) are jittery, hyperactive and irritable as new-borns.	1	2
6. Children with Fetal Alcohol Syndrome (FAS) are short for their age.	1	2
7. Daughters of male who consume excessive alcohol are much more likely than women of the general population to be victims of sexual abuse.	1	2
8. After the client has agreed that their drinking causes problems, you should negotiate with them to develop a treatment plan, making compromises to ensure their acceptance.	1	2
9. More than half of those with early age drinking problems continue to experience drinking problems 25 years later.	1	2
10. Retirement puts individuals at high risk for the development of alcohol or drug use problems.	1	2
11. During the 2000s, we saw a gradual but consistent downturn in per capital alcohol consumption in Botswana.	1	2
12. Over half of the Botswana population is either abstinent or drinks very little.	1	2
13. The presence of a disability puts individuals at high risk for the development of alcohol or drug use problems.	1	2
14. For most alcohol problems, alcohol serves as a necessary but not sufficient element.	1	2
15. A school-based substance prevention program aimed at alcohol and drug abstainers would fall under the "primary" stage of prevention.	1	2
16. A net result of the twin and adoption studies is to rule out the environment as an important explanation for alcohol dependence.	1	2

17. Daughters of males who take alcohol are much more likely than women of the general population to become alcoholics.	1	2
18. During competent alcohol detoxification, the treated individual in a potentially dangerous situation is given diazepam or another tranquilizer to control symptoms.	1	2
19. Chronic alcoholics have higher rates of damage to brain tissue, cardiovascular disease and various forms of cancer.	1	2
20. Ethyl alcohol is largely absorbed from the stomach and upper intestine and absorption is complete within 30-60 minutes on an empty stomach.	1	2
21. Ethyl alcohol is not addictive in the true pharmacologic sense.	1	2
22. Insurance covers outpatient alternatives more thoroughly than it covers inpatient treatment.	1	2
23. Alcohol withdrawal is rarely, if ever, life-threatening.	1	2
24. According to Alcoholics Anonymous, alcoholism is a progressive, incurable disease.	1	2
25. Clients with alcohol problems die from intoxication by other drugs than from alcohol intoxication.	1	2
26. After the client has agreed that their drinking causes problems, you should next solicit their explicit verbal agreement to start treatment.	1	2
27. Daughters of male alcoholics are much more likely than women of the general population to be victims of sexual abuse.	1	2
28. In chemical terms alcohol is described chemically as a stimulant.	1	2
29. It is quite clear that there is only one form of alcoholism.	1	2

Thank you please turns over to the next page.

APPENDIX 3

ALCOHOL AND ALCOHOL PROBLEM PERCEPTIONS QUESTIONNAIRE (AAPPQ)

Please indicate how much you agree or disagree with each of the following statements about working with clients with alcohol problems. Please circle one number for each question. Key: 1 = strongly agree, 2 = Agree, 3 = neither agree nor disagree, 4 =Disagree, 5 = strongly disagree.

ITEM	RATING				
1. I feel I have a working knowledge of alcohol and alcohol-related problems.	1	2	3	4	5
2. I feel I know enough about the causes of drinking problems to carry out my role when working with clients with alcohol problems.	1	2	3	4	5
3. I feel I know enough about the alcohol dependence syndrome to carry out my role when working with clients with alcohol problems.	1	2	3	4	5
4. I feel I know enough about the psychological effects of alcohol to carry out my role when working with clients with alcohol problems.	1	2	3	4	5
5. I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role when working clients with alcohol problems.	1	2	3	4	5
6. I feel I know how to counsel clients with alcohol problems over the long term.	1	2	3	4	5
7. I feel I can appropriately advise my clients about drinking and its effects.	1	2	3	4	5
8. I feel I have a clear idea of my responsibilities in helping clients with alcohol problems.	1	2	3	4	5
9. I feel I have the right to ask clients questions about their drinking when necessary.	1	2	3	4	5
10. I feel that my clients believe I have the right to ask them questions about drinking when necessary.	1	2	3	4	5
11. I feel I have the right to ask clients for any information that is relevant to their alcohol drinking problems.	1	2	3	4	5
12. If I felt the need when working with clients with alcohol problems, I could easily find someone with whom I could discuss any personal difficulties that I might encounter.	1	2	3	4	5
13. If I felt the need when working with clients with alcohol problems, I could easily find someone who would help me clarify my professional responsibilities.	1	2	3	4	5

14. If I felt the need I could easily find someone who would be able to help me formulate the best approach to a client with alcohol problems.	1	2	3	4	5
15. I am interested in the nature of alcohol-related problems and the responses that can be made to them.	1	2	3	4	5
16. I want to work with clients with alcohol problems.	1	2	3	4	5
17. I feel that the best I can personally offer clients with alcohol problems is referral to somebody else.	1	2	3	4	5
18. I feel that there is little I can do to help clients with alcohol problems.	1	2	3	4	5
19. Pessimism is the most realistic attitude to take toward clients with alcohol problems.	1	2	3	4	5
20. I feel I can work with clients with alcohol problems as well as others.	1	2	3	4	5
21. All in all, I am inclined to feel I am a failure with clients with alcohol problems.	1	2	3	4	5
22. I wish I could have more respect for the way I work with clients with alcohol problems.	1	2	3	4	5
23. I feel I do not have much to be proud of when working with clients with alcohol problems.	1	2	3	4	5
24. At times I feel I am no good at all with clients with alcohol problems.	1	2	3	4	5
25. On the whole, I am satisfied with the way I work with clients with alcohol problems	1	2	3	4	5
26. I often feel uncomfortable when working with clients with alcohol problems.	1	2	3	4	5
27. In general, one can get satisfaction from working with clients with alcohol problems.	1	2	3	4	5
28. In general, it is rewarding to work with clients with alcohol problems.	1	2	3	4	5
29. In general, I feel I can understand clients with alcohol problems.	1	2	3	4	5
30. In general, I like clients with alcohol problems.	1	2	3	4	5

Thank you please turns over to the next page

APPENDIX 4

ATTITUDES ABOUT ALCOHOLISM SCALE (AAS)

Please indicate your agreement/disagreement with statements on the AAS by CIRCLING an answer. Key: 1=Strongly Agree, 2=Agree, 3=Neutral/Not Applicable, 4=Disagree, 5=Strongly Disagree.

ITEM	RATING				
1. Clients with alcohol problems relapses into drinking can often provide a foundation on which to build successful treatment.	1	2	3	4	5
2. Recovery from alcoholism requires abstinence from alcohol.	1	2	3	4	5
3. There is nothing wrong with drinking moderate amounts of alcohol.	1	2	3	4	5
4. Paraprofessional counsellors can provide effective treatment for clients with alcohol problems.	1	2	3	4	5
5. Alcoholism is a disease.	1	2	3	4	5
6. Motivation of the client with alcohol problems for treatment is often effective when the client is brought under external pressure.	1	2	3	4	5
7. Before clients with alcohol problems are able to stop drinking, they need to gain some insight into the reasons for their drinking.	1	2	3	4	5
8. Casework with the spouse of a person with alcohol problems can often result in motivating the person to seek help.	1	2	3	4	5
9. Alcoholism has so many special features that its professional treatment should be referred to clinics, hospitals, and physicians that specialize in alcoholism.	1	2	3	4	5
10. Symptomatic treatment which succeeds in stopping the drinking is frequently enough to enable a client with alcohol problems to mobilize his/her resources and develop a satisfying life.	1	2	3	4	5
11. Alcoholism is best seen as a form of habit, not a disease.	1	2	3	4	5
12. Typically a client with alcohol problems does not see his/her condition as undesirable and does not really want to get well.	1	2	3	4	5
13. I feel I work better with clients with alcohol problems than with other clients.	1	2	3	4	5
14. It may be wrong of me, but in all honesty I am more likely to feel annoyed by a client with alcohol problems than to be sympathetic.	1	2	3	4	5
15. An alcohol or drug dependent person cannot be helped until he/she has hit "rock bottom."	1	2	3	4	5
16. Feelings of solidarity in Alcoholics Anonymous and Narcotics Anonymous are based on an unhealthy exclusion of the larger, non-alcoholic society.	1	2	3	4	5
17. Social workers should support legislation aimed at reducing the legal drinking age in order to promote responsible consumption.	1	2	3	4	5
18. Treatment of clients with alcohol problems is beyond the skills of social workers.	1	2	3	4	5

19. Alcoholism is best seen as a form of wrongdoing.	1	2	3	4	5
20. The best thing that can be done for a client with alcohol problems is to have the members of Alcoholics Anonymous take over the responsibility for helping him/her.	1	2	3	4	5

Thank you please turns over to the next page.

APPENDIX 5

ADDICTION AND COUNSELLOR SELF EFFICACY SCALE

Please indicate to what degree you feel confident employing the following knowledge and skills relevant to alcohol and alcohol problems interventions. Key: 1 = *very low confidence*, 2 = *low confidence*, 3 = *moderate confidence*, 4 = *high confidence*, and 5 = *very high confidence*.

ITEM	Rating				
1. Assess a client's previous experience with self-help groups such as AA, NA, CA, and so forth.	1	2	3	4	5
2. Help a client determine who is available to support her/his recovery	1	2	3	4	5
3. Help a client figure out what behaviours will support her/his recovery.	1	2	3	4	5
4. Teach a client about self-help support networks and related self-help literature.	1	2	3	4	5
5. Help a client develop realistic expectations about recovery.	1	2	3	4	5
6. Asses a client's readiness to change *alcohol* use.	1	2	3	4	5
7. Help a client recognize what triggers her/his *alcohol* use.	1	2	3	4	5
8. Challenge behaviours that interfere with a client's recovery.	1	2	3	4	5
9. Refer a client when I cannot treat her/his co-occurring mental illness.	1	2	3	4	5
10. Gather information about a client's employment history.	1	2	3	4	5
11. Assess a client's financial concerns.	1	2	3	4	5
12. Select high quality referral sources for a client if needed.	1	2	3	4	5
13. Gather information about a client's prior experience with substance abuse treatment.	1	2	3	4	5
14. Include a client in the referral and decision-making process.	1	2	3	4	5
15. Write accurate and concise assessment reports.	1	2	3	4	5
16. Use assessment data to develop a treatment plan.	1	2	3	4	5
17. Summarize a client's treatment and recovery information for other professionals.	1	2	3	4	5
18. Work effectively with a client who has both *alcohol* use and anxiety disorder.	1	2	3	4	5
19. Work effectively with a client who has both *alcohol* use and psychotic disorder.	1	2	3	4	5
20. Work effectively with a client who has both *alcohol* use and a mood disorder.	1	2	3	4	5
21. Work effectively with a client who has both *alcohol* use and a personality disorder.	1	2	3	4	5

22. Screen clients for co-occurring disorders.	1	2	3	4	5
23. Work effectively with a client who has both *alcohol* use and trauma-related issues.	1	2	3	4	5
24. Help members of a counselling group support each other.	1	2	3	4	5
25. Help members of a counselling group challenge each other responsibly.	1	2	3	4	5
26. Develop trust and cohesion among members of a counselling group.	1	2	3	4	5
27. Form a counselling group, including determining the type of group and selecting members.	1	2	3	4	5
28. React spontaneously and responsively in a group counselling situation.	1	2	3	4	5
29. Show empathy toward a client.	1	2	3	4	5
30. Convey an attitude of care and concern for all group members.	1	2	3	4	5
31. Create a therapeutic environment where a client will feel that I understand her/him.	1	2	3	4	5
32. Establish a warm, respectful relationship with a client	1	2	3	4	5

End of Survey

Thank you for your generous support and participation in this survey.

APPENDIX 6

QUALITATIVE INTERVIEW GUIDE

Opening statement

Today am here to talk to you about alcohol problems in Kweneng/South East District. Can you please share with me the first thing that comes in your head when you hear the word "alcohol"?

1. In your own view would you say alcohol is a problem in your District, how so?

2. In brief, can you share some of the alcohol problems that clients present to you in Kweneng/South East?

3. Personally what are your observations in working with people with alcohol problems?

4. What are some of the strategies or interventions that you use to help a client with alcohol problems?

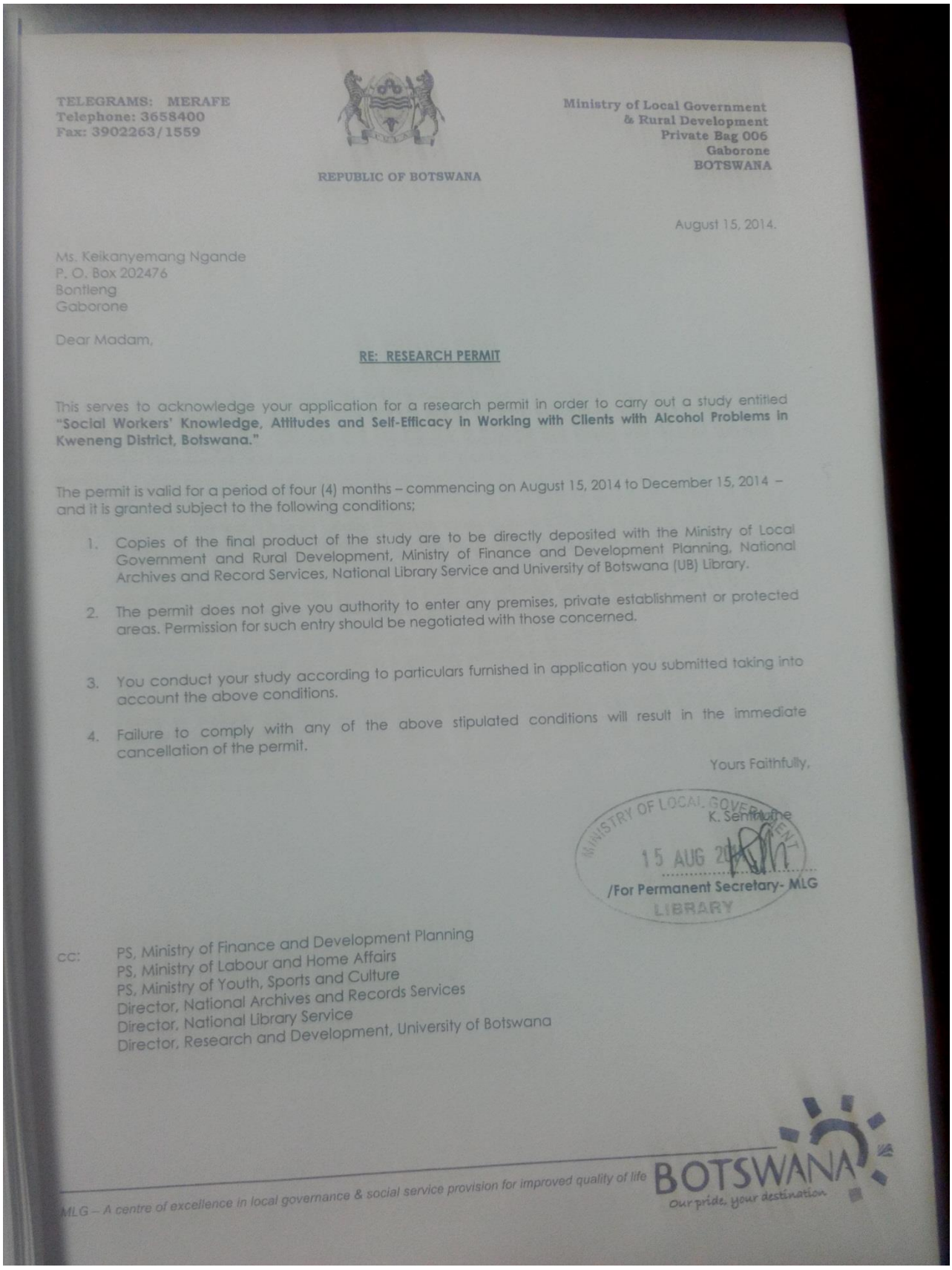
5. What affects your confidence as a social worker to help clients with alcohol problems? *Only ask the following questions if the respondent did not include a bolded variable in the response.*
   a. Do you think **age and gender** affect social workers perception of their self-efficacy when counselling clients with alcohol problems, how so?
   b. Do you think **experience and education** affect social workers perception of their self-efficacy when counselling clients with alcohol problems, how so?

6. What could be done to improve these?

7. Have you have ever received any training on Alcohol and alcohol problems?

That is all I have today, is there anything you would like to ask before we part? Thank you very much for your time again Sir/Madam.

RESEARCH PERMIT



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Telephone: 3658400
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REPUBLIC OF BOTSWANA

Ministry of Local Government
& Rural Development
Private Bag 006
Gaborone
BOTSWANA

August 15, 2014.

Ms. Keikanyemang Ngande
P. O. Box 202476
Bontleng
Gaborone

Dear Madam,

RE: RESEARCH PERMIT

This serves to acknowledge your application for a research permit in order to carry out a study entitled **"Social Workers' Knowledge, Attitudes and Self-Efficacy in Working with Clients with Alcohol Problems in Kweneng District, Botswana."**

The permit is valid for a period of four (4) months – commencing on August 15, 2014 to December 15, 2014 – and it is granted subject to the following conditions;

1. Copies of the final product of the study are to be directly deposited with the Ministry of Local Government and Rural Development, Ministry of Finance and Development Planning, National Archives and Record Services, National Library Service and University of Botswana (UB) Library.
2. The permit does not give you authority to enter any premises, private establishment or protected areas. Permission for such entry should be negotiated with those concerned.
3. You conduct your study according to particulars furnished in application you submitted taking into account the above conditions.
4. Failure to comply with any of the above stipulated conditions will result in the immediate cancellation of the permit.

Yours Faithfully,

K. Senkgodhe

MINISTRY OF LOCAL GOVERNMENT
15 AUG 2014
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/For Permanent Secretary- MLG

cc: PS, Ministry of Finance and Development Planning
PS, Ministry of Labour and Home Affairs
PS, Ministry of Youth, Sports and Culture
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