



Alcohol & Drug Abuse Research Unit

Medical Research Council

**Audit of Substance Abuse
Treatment Facilities in Gauteng
and KwaZulu -Natal (2006-2007):
Technical Report**

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EXECUTIVE SUMMARY

A cross-sectional audit of substance abuse treatment facilities in Gauteng and KwaZulu-Natal (KZN) was conducted from September 2006 to February 2007. A revised version of the Treatment Services Audit (TSA) Questionnaire was used to collect information from a number of domains including the organisational characteristics of the treatment facility (such as ownership status, intensity of care provided, and organisational resources); the type of services provided; the profile of clients served; the organisational environment of facilities, barriers to treatment entry for clients from under-served groups; the cultural, gender, and age appropriateness of services, and monitoring and evaluation activities.

Substance abuse treatment services in Gauteng and KZN are provided predominantly by private, non-profit facilities. Private non-profit facilities also serve the highest number of clients from under-served groups. Consequently, it is recommended that state funding to these facilities be increased. Furthermore, despite a high demand for substance abuse treatment services, treatment facilities are under-utilised. It is thus recommended that interventions which target the factors underpinning this under-utilisation of services are designed and implemented.

The range of treatment services provided by substance abuse treatment facilities in Gauteng and KZN is limited, with few facilities providing comprehensive services that integrate ancillary medical and mental health services with core addiction services. This audit found that organisational factors such as ownership status and intensity of care are associated with the demographic profile of clients served and the extent to which ancillary medical and mental health services are available. Ancillary medical and mental health services are significantly more accessible in inpatient facilities and with facilities with health and mental health professionals. Differences in the extent to which facilities ascribe to the goal of profit maximisation, differences in client profiles across facilities, and differences in organisational (particularly staffing-related) resources may account for these differences. Case management techniques may help facilitate the delivery of

integrated and comprehensive services so that clients at private non-profit outpatient facilities have access to ancillary medical and mental health services.

In addition, findings suggest that Black/African and female substance abusers remain under-represented in substance abuse treatment facilities. In terms of activities that target barriers to treatment entry for historically underserved population groups; while a significant proportion of few facilities perform outreach activities aimed at improving awareness of treatment options, there is still room for improvement. As few facilities employ dedicated outreach workers, the frequency with which outreach is conducted is highly questionable.

In terms of logistic and affordability barriers, while many facilities report providing financial assistance for the direct costs of treatment in terms of reduced fees, there are still relatively few free treatment slots available to indigent clients. This raises a concern about the availability of affordable treatment options to poorer communities. In addition, few facilities address the indirect costs associated with treatment entry, such as the costs of transport and childcare services. Several recommendations are made to address cost barriers. These include increasing the provision of state-funded outpatient services and shifting from facility-based outpatient service provision to the use of mobile clinics located in disadvantaged, high-need areas. This will also help address the costs of transport to facility-based services.

In terms of linguistic barriers to treatment entry, while several facilities report employing multilingual staff, a much smaller proportion of facilities employ African language-speaking therapists. This continues to be a barrier to treatment entry for Black/African persons. Recommendations for addressing this include training more African-language speaking health and social work professionals and providing these professionals with incentives to work in the substance abuse treatment field.

As with knowledge barriers and affordability barriers, private non-profit facilities are more likely to address cultural and linguistic barriers to treatment entry than facilities with another ownership status. The organisational goal of profit maximisation, historical factors in the provision of substance abuse treatment services in South Africa and the

overlap between race and socio-economic status in South Africa may help account for these findings.

In terms of the appropriateness of treatment services, findings point to the need for treatment facilities to receive ongoing training in order to ensure that their treatment programmes are culturally, gender and age appropriate. Facilities which did address the cultural and age appropriateness of their services were more likely to treat high proportions of Black/African and adolescent clients, respectively.

Findings point to the need for substance abuse treatment facilities in Gauteng and KZN to introduce routine, systematic client monitoring systems as well as the need for substance abuse treatment programmes to be comprehensively evaluated. In addition, as part of the monitoring of the quality of substance abuse treatment services and the extent to which these services have transformed to address historical inequities in service provision, a national treatment audit should be conducted on a regular basis. Findings from this national audit should be used to inform decision-making about the allocation of funding and other resources to existing facilities, based on the extent to which they provide services to historically under-served groups as well as the degree to which they provide comprehensive services of good quality.

PART 1: BACKGROUND

1.1. THE NEED FOR SUBSTANCE ABUSE TREATMENT

In South Africa, changes in the pattern of substance use over time highlight the need for accessible treatment services. During the apartheid era, the country's physical and economic isolation, strict monitoring of external borders, and stringent internal controls restricted access to and availability of most kinds of illicit drugs, with locally cultivated cannabis, Mandrax tablets, and prescription drugs being the only drugs widely available to South Africans. However, changes in global drug markets, such as improved drug supply- and demand-reduction strategies in Europe and the USA, have forced traffickers to seek alternative routes and markets. South Africa, due to its geographical location, is a convenient trans-shipment point for illicit drugs from drug-producing countries to drug markets. Socio-political changes that followed the collapse of apartheid, such as the reduction in internal and external border controls, the increase in land and air travel, increased trade, and the poorly resourced law enforcement agencies; together with the country's advanced banking, transport, and communication systems have also made the country an attractive new market for drug cartels. With these changes South Africans now have access to a broad range of illicit drugs (Parry et al., 2002a). Supply and demand indicators suggest that the domestic drug market is expanding, with drug prices decreasing, availability increasing, and treatment demand for substance-related problems on the rise (Parry et al., 2002a/b). This expansion of the domestic drug market has placed substance abuse treatment facilities under increased pressure to provide effective and accessible treatment services.

1.2. THE VALUE OF SUBSTANCE ABUSE TREATMENT

Yet, there is strong evidence that substance abuse treatment helps reduce the harms associated with substance abuse and benefits both the individual and broader society. Although few treatment outcome studies have been conducted in South Africa, international research, conducted across a variety of treatment settings and client populations, has provided considerable evidence of the benefits of substance abuse treatment (e.g. Gossop, Marsden, Stewart & Teacy, 2001; Simpson, Joe & Brown, 1997). In general, these studies reported positive outcomes, including reductions in substance

use, reductions in criminal activity, improvements in physical and psychological health, and improvements in social functioning.

In developing countries in general (Arif & Westermeyer, 1998), and South Africa in particular, few treatment outcome studies have been conducted. Despite methodological limitations (such as low follow-up rates), preliminary evidence points to the benefits of substance abuse treatment in these settings. For example, De Silva et al. (1992) reported that 36% of 234 patients attending a treatment centre in Sri Lanka were abstinent two years post-treatment. In addition, significant reductions in substance use were reported among patients in treatment centres in Thailand, with 50% of patients abstinent from amphetamine-type substances and 27% abstinent from opiates 6 months post treatment (Pengparn & Porncharoen, 2001). Only two substance abuse treatment outcome studies have been conducted in South Africa. Coetzee (2001) reported an abstinence rate of 55% among 58 patients attending an outpatient substance abuse treatment centre in 2000. In the second study of 89 patients attending a private inpatient facility, Coetzee (2004) reported an abstinence rate of 48% one year post-treatment. This emerging evidence points to the potential value of substance abuse treatment services in South Africa.

1.3. SUBSTANCE ABUSE TREATMENT SERVICES IN SOUTH AFRICA

Anecdotal reports from treatment service providers and communities point to an increased demand for substance abuse treatment services, with waiting lists for treatment slots increasing and communities mobilising around drug-related issues. This increased demand has placed treatment facilities under pressure to increase their coverage and provision of services to a greater number of users. Despite this pressure, little is known about the structure and functioning of the substance abuse treatment system in the country. This study attempts to address this gap in knowledge by examining substance abuse treatment services in two of the most densely populated provinces in the country: Gauteng and KwaZulu-Natal.

Gauteng is the smallest of the nine provinces in South Africa, but has the second largest population (Statistics South Africa, 2005). This largely urban province accounts for

19.4% of the population, of which 73.8% are Black¹, 19.9% are White, 3.8% are Coloured and 2.5% are Indian/Asian (Statistics South Africa, 2003). In contrast, KwaZulu-Natal has the largest share of the South African population (Statistics South Africa, 2005). This more rural province accounts for 20.5% of the population, of which 84.8% are Black, 5.2% are White, 1.5% are Coloured and 8.5% are Indian/Asian (Statistics South Africa, 2003).

1.3.1. Limited availability of services in relation to need

Access to substance abuse treatment remains limited in these provinces. This is partly due to the limited availability of treatment services, with existing resources in Gauteng and KZN are only able to serve approximately 3200 and 1200 people per year, respectively (Pluddemann et al., 2004). This is grossly inadequate, given that conservative estimates from the South African Demographic and Health Survey suggest that at least 10% of the population meet DSM-IV criteria for alcohol abuse and/or dependence (Parry et al., 2005). In regions that are home to more than 18 million people collectively (Statistics South Africa, 2005), this would translate to about 1 800 000 people requiring some treatment for alcohol-related problems, alone.

Despite high levels of substance abuse in Gauteng and KZN, substance abuse has been afforded relatively low priority. In general, provincial departments of social development have focused their resources on prevention, early intervention and statutory activities rather than the provision of treatment services. At present, there are only two state-run treatment facilities for substance abuse in Gauteng and KZN, respectively. Although there are other treatment facilities in these provinces that are subsidised by the state, funding to these facilities remains problematic. In addition, the number of beds available in state-funded general and psychiatric hospitals for patients with substance use disorders has decreased in these provinces. These factors have contributed to long waiting periods for affordable treatment slots at state-funded facilities. These waiting periods may have a negative impact on motivation to change, treatment retention and treatment outcomes (Mejita et al., 1997).

¹ The terms “White, Black, Asian/Indian, and Coloured” refer to demographic markers and do not signify inherent characteristics. These markers were chosen for their historical significance. These demographic characteristics are important as accurate user profiles assist in identifying vulnerable sections of the population and in planning effective prevention and intervention programmes.

1.3.2. Racial inequities in access to health and social services

While the limited availability of substance abuse treatment restricts access to treatment for all South Africans, substance abuse treatment seems to be relatively more difficult to access for poor Black/African and Coloured South Africans historically disadvantaged during the apartheid regime. For these racially-defined social groups, several socio-political factors restricted access to services (including substance abuse treatment services) under the apartheid system of governance. Firstly, funding to substance abuse treatment facilities was generally inadequate and treatment facilities were poorly distributed, with services being concentrated in urban areas that were historically reserved for Whites. Major disparities also existed between the racially-defined social groups in terms of the allocation of resources to and the quality of substance abuse treatment services, with treatment facilities serving White South Africans being relatively better resourced and providing more comprehensive services than those facilities serving black² South Africans (Myers et al., 2004; Myers & Parry, 2005).

Since South Africa's transition to democracy in 1994, the health and social service sector has worked hard to improve service delivery and reverse racial disparities in service provision (National Department of Health, 1997; National Department of Social Development, 1997; 2006). Despite this, concerns about disparities in health and social welfare service provision between the socially advantaged and the socially disadvantaged remain; with socio-economic disadvantage still associated with race in South Africa - despite a growing black middle class (Sanders & Chopra, 2006). Given these inequities, it is plausible that similar racial inequities exist in the substance abuse treatment sector.

To some extent, these concerns seem justified. According to recent findings from the South African Community Epidemiology Network on Alcohol and Drug Abuse (SACENDU) (Myers et al., 2004; Myers & Parry, 2005) and audits of specialist substance abuse treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004), the race profile of clients at specialist treatment facilities does not reflect the demographics of the general population. Throughout the country, there has been an

² The term "black South African" refers to all groups who were historically disadvantaged under the apartheid regime including ethnic Black/African, Coloureds of mixed race descent and Indian/Asians.

under-representation of Black and an over-representation of White South Africans in treatment facilities. This pattern of service utilization reflects the limited extent to which black South Africans have access to substance abuse treatment rather than lower levels of substance use by these racially-defined social groups (Myers et al., 2004; Myers & Parry, 2005) and highlights the importance of routinely examining service system factors associated with access to substance abuse treatment.

1.3.3. Factors associated with disparities in access to substance abuse treatment

- **Availability of public services**

Debate about the accessibility of services for historically disadvantaged groups has centred on **structural and environmental** factors that restrict access to services for black South Africans. More specifically, concerns have been raised about the **limited availability of affordable substance abuse treatment facilities**. In South Africa, the majority of the population (80%) are without medical insurance and rely heavily on the state sector to provide health and social welfare services (Goosen, Bowley, Degiannis & Plani, 2003) including substance abuse treatment. As with other services, the uninsured are disproportionately represented by poor, black South Africans (Goosen et al., 2003). For this sector of the population, there are few state-funded substance abuse treatment facilities and access to these facilities is hampered by lengthy waiting lists of up to six months (Myers, 2004; Myers & Parry, 2003).

Despite the apparent availability of substance abuse treatment services in each province, for the uninsured the availability of affordable substance abuse treatment has decreased in recent years, with the number of beds allocated for substance abuse in state hospitals decreasing. For the remaining state-subsidised treatment facilities, state funding has decreased in real terms, limiting their capacity to expand services to historically underserved areas (Myers & Parry, 2003; Myers & Parry, 2005). This has been partly due to the diversion of funds from tertiary level substance abuse treatment services to primary health (National Department of Health, 1997) and community-based social services (National Department of Social Development, 1997). While the policy of integrating substance abuse services into existing primary health care networks has been an attempt to improve the accessibility (and equitable distribution) of health and social services for historically underserved communities, in reality implementation has been slow with few

substance abuse treatment services being offered at a community level (Myers & Parry, 2005). **Poor infrastructure, limited capacity, and multiple demands** placed on PHC nurses and community-based social workers have been some of the reasons given for the slow pace of service delivery (Goosen et al., 2003; Sanders & Chopra, 2006). Whatever the reasons, an unintended consequence of these policy changes has been that access to substance abuse treatment has become even more restricted for poor South Africans.

- **Availability of private services**

The shortage of publicly-funded substance abuse treatment centres, together with the increased demand for substance abuse treatment, has given rise to a growing private treatment sector. Compared to the state treatment system, the private **for-profit** treatment sector has relatively more resources, shorter waiting lists, more evidence-based treatment programmes, more experienced staff, and provides relatively better treatment environments (Myers & Parry, 2003; Myers, 2004a; 2004b). Although these facilities fill an important gap in the market, they have been criticized for serving mostly White communities (given that they are largely unaffordable to the uninsured and that Whites may have wealthier social networks that can be drawn upon to co-fund treatment), having limited skills for dealing with the socio-cultural and language context of historically disadvantaged communities, and for being located in suburban areas and thus being inaccessible to the majority of the population (Myers & Parry, 2005).

There has also been a proliferation of private, **non-profit** treatment facilities. Although many of these are professionally-run accredited facilities with solid treatment programmes, in recent years several facilities have been started by well-meaning community members with little knowledge of how to treat substance abuse and few resources. Often these community-based facilities operate illegally and are unregulated by the state. Although private non-profit facilities are relatively more accessible to black South Africans than for-profit services, the quality of services provided by these facilities is often variable and waiting lists at the better resourced facilities are lengthy. In addition, many of the accredited non-profit facilities require clients to make some form of financial contribution towards their treatment (Myers, 2004b). Quality of services, waiting lists, and co-payment fees all restrict access to treatment for poor substance users.

1.4. SUBSTANCE ABUSE TREATMENT IN SOUTH AFRICA: PRIOR RESEARCH AND THE WAY FORWARD

In South Africa, national, provincial, and local governments control the allocation of resources for substance abuse services. For the state to plan and deliver substance abuse treatment services that ensure appropriate and adequate provision of services to the community (through addressing current and projected treatment needs, targeting high-risk groups, and improving accessibility for all sectors of the population), access to quality information about local treatment needs, existing treatment services, patterns of service utilisation, and service performance are required. This necessitates the development of a system for monitoring substance abuse treatment services (Grant & Petrie, 2001).

Yet, treatment service planning is hampered in South Africa by the lack of a monitoring system that routinely collects information on substance abuse treatment services. While the South African Community Epidemiology Network on Drug Use (SACENDU) project does collect descriptive information about the profile of clients served at treatment centres in five of the nine provinces in the country on a six-monthly basis and although this system provides essential information that should be collected as part of a national monitoring system; it does not collect information on the type, intensity or quality of treatment services provided. At present, only limited information is collected on the facilities that provide substance abuse treatment services. This information, typically contained in resource directories, generally consists of a brief description of the types of clients served and services provided.

Exceptions to this include two local-level audits of specialist substance abuse treatment facilities in Cape Town and Gauteng, conducted in 2002 and 2004, respectively (Myers & Parry, 2003; Myers, 2004). These audits reported on treatment facility characteristics, the profile of clients served, the type and range of treatment services provided, the accessibility of treatment services to clients from historically underserved groups, and treatment service monitoring and evaluation processes. In addition, these audits recommended that a national audit of substance abuse treatment facilities occur on a regular basis to facilitate the collection of quality information on substance abuse treatment services (Myers & Parry, 2003; Myers, 2005). By including all known substance abuse treatment facilities in Gauteng and KwaZulu-Natal provinces, the current

project represents a partial response to these recommendations and goes some way towards developing a national monitoring system of substance abuse treatment services.

In a context where there is an increasing demand for scarce health and social welfare resources due to the burden caused by poverty, TB, HIV/AIDS and other infectious diseases (Freeman, 2000), a study that describes the structure of the substance abuse treatment system, describes the extent to which this system adheres to norms and standards for treatment, and provides evidence as to whether barriers to accessing existing services exist within this system is useful. Through identifying gaps in current service delivery, this study could help guide the design of policies to improve service delivery and could also assist planning and decision-making around substance abuse treatment services by suggesting ways in which treatment service delivery can be improved (Thind & Andersen, 2003).

The nature of scientific inquiry also requires generalizability and applicability of research findings across widely diverse population groups. Although previous audits of treatment services have been conducted (Myers & Parry, 2003; Myers, 2004), these audits did not allow for comparisons to be made across provinces. For the first time, this study allows for comparisons to be made across two provinces in the country. This comparative research allows for similarities and differences across sites to be identified so that interventions can be targeted to specific sites (in this case: provincial treatment systems). This approach recognises that the structuring of substance abuse treatment systems will be influenced by contextual and environmental factors inherent to each province.

1.5. TERMINOLOGY

The following terms are used throughout this report:

- **Facility ownership** refers to the type of entity owning or responsible for the operation of the facility. In South Africa, private for-profit, private non-profit, and state (government) facilities comprise the main types of ownership. The state also provides funding for several private, non-profit facilities.
- **Treatment setting** refers to the environment in which a facility is located. In South Africa these include mental health settings such as psychiatric hospitals,

general health settings, stand alone substance abuse treatment facilities, correctional (criminal justice) settings, religious settings, and welfare settings.

- **Intensity of treatment** is defined as the amount of and level at which treatment services are provided. In South Africa, substance abuse treatment occurs at one of several intensity levels: primary care at an inpatient/residential level, outpatient, secondary inpatient care, and stepped down care that combines inpatient and outpatient services.
 - ◆ *Inpatient/Residential Treatment*: where clients reside temporarily or on a longer term basis in a facility that is not their home or usual place of residence. The treatment programme provides diagnosis, treatment and rehabilitation for clients with substance use disorders whose physical and emotional status does not allow them to function in their usual environments.
 - ◆ *Outpatient Treatment* refers to non-residential programmes that provide diagnosis, treatment and rehabilitation for clients with substance use disorders whose physical and emotional status allows them to function with support in their usual environments. Compared to inpatient programmes, services are provided at a lower level of intensity.
 - ◆ *Secondary inpatient treatment* refers to a residential treatment facility for alcohol and drug abuse clients who have received prior treatment in a primary care program. A treatment regimen of individual and group therapy as well as other activities aimed at the physical, psychological and social recovery of the addicted individual is continued. The programme offered at these facilities is of a lower intensity than that provided at the initial (primary) inpatient facility. Often these are referred to as halfway houses.
 - ◆ *Combined inpatient and outpatient services*: Also referred to as stepped-down care. All clients initially receive inpatient services. Having completed the residential programme, clients move to a lower level of care- outpatient services- to ensure that patient is smoothly reintegrated back into society and to provide aftercare support and follow-up.
- **Facility affiliation** refers to the type of state registration that a facility has obtained. In South Africa, substance abuse treatment facilities can be registered with either the

Department of Health or the Department of Social Development; with some facilities having dual registration. Each department has different requirements for registration, a discussion of which is beyond the scope of this report.

- **Retention** refers to the extent to which clients remain in treatment and complete the treatment programme.
- **Attrition** refers to the extent to which clients leave or drop out of treatment before the agreed upon date for treatment completion.

PART 2: METHOD

2.1. AIMS

- To gain an understanding of the characteristics of substance abuse treatment facilities in Gauteng and KwaZulu-Natal;
- To gain an understanding of the profile of clients served by substance abuse treatment facilities in Gauteng and KwaZulu-Natal;
- To increase knowledge about the nature of substance abuse treatment service delivery in Gauteng and KwaZulu-Natal;
- To increase knowledge about the accessibility of substance abuse treatment in Gauteng and KwaZulu-Natal;
- To compare two provincial substance abuse treatment systems: Gauteng and KwaZulu-Natal;
- To serve as a feasibility study for the development and implementation of an annual, national audit of substance abuse treatment services;
- To use this information to inform current substance abuse treatment service planning and delivery at the local, provincial and national level;
- To use this information to inform substance abuse treatment policy and at a provincial and national level

2.2. OBJECTIVES

- To describe and compare the characteristics of substance abuse treatment facilities in Gauteng and KwaZulu-Natal (e.g. intensity of care offered, type of facility ownership, treatment setting, and facility affiliation);
- To describe and compare the demographic profile of clients served at substance abuse treatment facilities in Gauteng and KwaZulu-Natal by facility characteristics (intensity of care and type of facility ownership);
- To describe and compare substance abuse treatment service delivery for treatment facilities in Gauteng and KwaZulu-Natal on a number of variables, namely: facility characteristics; treatment factors (number of clients served, treatment capacity, utilisation of treatment capacity, delay in service delivery, treatment retention, and treatment attrition), staffing characteristics, and treatment services offered;

- To describe and compare activities conducted by substance abuse treatment facilities in Gauteng and KwaZulu-Natal that target barriers to accessing treatment for clients from underserved groups by facility characteristics;
- To describe and compare activities conducted by substance abuse treatment facilities in Gauteng and KwaZulu-Natal to improve treatment retention for clients from underserved groups by facility characteristics;
- To describe and compare monitoring and evaluation activities conducted by substance abuse treatment facilities in Gauteng and KwaZulu-Natal by facility characteristics;
- Based on these findings, to describe the extent to which these facilities meet South African minimum norms and standards for treatment services as well as international best practice guidelines;
- To make recommendations that inform substance abuse treatment service policy, planning and delivery in Gauteng and KwaZulu-Natal;
- To disseminate the information collected, through a variety of mechanisms to local, provincial and national stakeholders.

2.3. DESIGN

A cross-sectional survey of substance abuse treatment facilities was conducted in the Gauteng and KwaZulu-Natal provinces, South Africa from September 2006 to February 2007.

2.4. SAMPLE

The sample consisted of the total population of substance abuse treatment facilities in Gauteng and KwaZulu-Natal. This study defined substance abuse treatment facilities as those facilities that deliver one or more *specialised* substance abuse treatment services to people with substance use disorders (Torres et al., 1995). These services include detoxification, rehabilitation programmes and psychological treatments. Using this definition, self-help groups and facilities that provide only information, education, crisis intervention and/or prevention services are not classified as substance abuse treatment facilities. In addition, solo practitioners and facilities that provide general health and social services, including substance abuse-related services (e.g. psychologists, social workers, and general hospitals) are not included in the sample. As Treatment Services

Audit Questionnaire (TSA) is designed to collect data from each physical location where treatment services are provided, a “facility” is defined as the point of delivery of substance abuse treatment services (i.e. the physical location). Several treatment services consisted of a central office from which satellite clinics operated. For the purpose of this study, these satellite clinics were not analysed as separate facilities.

The sample frame was constructed from the list of known treatment facilities made available by the Central Drug Authority (CDA) resource directory on alcohol and drug related services (CDA, 2003) and the SACENDU database of treatment facilities. Snowball sampling was used to expand upon these databases. In other words, these facilities were contacted telephonically and asked to identify other specialist substance abuse treatment facilities in Gauteng and KwaZulu-Natal that were not in the CDA’s resource directory. At the time of the audit, there were 30 facilities in Gauteng and 25 facilities in KwaZulu-Natal that satisfied the criteria used by this study for the definition of “substance abuse treatment facility”.

2.5. TREATMENT SERVICES AUDIT (TSA) QUESTIONNAIRE

The Treatment Services Audit (TSA) Questionnaire (revised version) was used to collect self-report information from substance abuse treatment facilities in Gauteng and KwaZulu-Natal. The TSA was designed for the purposes of auditing substance abuse treatment facilities in South Africa. The construction of the original TSA was based loosely on the Unified Facility Data Set Questionnaire (UFDS) (Carise et al., 2000) that has been used to collect one-day census information on the population of substance abuse treatment facilities in the USA. The questions contained in the original version of the TSA were discussed in focus groups of substance abuse treatment experts to ensure applicability to the South African context. A pilot version of the original TSA was then used at two treatment facilities in Cape Town and necessary changes were made to problematic items. The original TSA was used to audit substance abuse treatment facilities in Cape Town in 2002 (Myers & Parry, 2003). Subsequent to this, the TSA was revised to reflect South African minimum norms and standards for inpatient treatment centres. This revised version was used to audit treatment facilities in Gauteng in 2003. In order to minimise non-response and to include areas of emerging interest (such as questions about service delivery); several adjustments have been made to the revised

version of the TSA. These changes included additional questions about the organisation and work environment that relate to human resources and governing body procedures, additional questions about the types of treatment services offered (especially substance abuse counselling, medical and family services).

The TSA (revised version) is an eight page questionnaire with 45 questions, many of which require multiple responses. Information is collected from a number of domains including treatment facility characteristics, service delivery characteristics, types of treatment services offered, services to improve access to and retention in treatment, characteristics of clients served, staffing characteristics, organisational environment, and monitoring and evaluation activities. The TSA is directed at key informants from treatment programmes, such as clinical/treatment programme managers or treatment directors. The TSA collects self-report information in English and takes approximately 30 minutes to complete.

2.5. DATA COLLECTION

The field period ran from September 2006 to February 2007. Treatment programme managers and/or facility directors of all the treatment facilities in the sampling frame were contacted telephonically, informed about the study, and asked to participate. Data collection packets, including the TSA, a two-page guideline for completion of the TSA, and a covering letter explaining the purpose of the audit were sent via mail, fax, or email to the identified key informants at participating facilities in September 2006.

Questionnaire packs were mailed with self-addressed, stamped return envelopes. During the data collection phase, the principal investigator was available to answer facilities' questions about the audit. Telephone calls were made to all facilities to check whether they had received the TSA. Thereafter, reminder and follow-up telephone calls were made to all non-responding facilities. Non-responding facilities were sent reminder letters in December 2006. Some facilities indicated that they had lost or misplaced the TSA and were re-sent these. Follow-up calls to non-responding facilities and for correction of missing data continued through February 2007. Non-respondents were followed up telephonically on at least four occasions.

2.5.1. Challenges faced during data collection

The most challenging aspect of the data collection process was getting treatment service providers to complete and return the TSA questionnaire. More specifically the following challenges were experienced:

- Most centres expressed willingness to participate, but were busy and did not have the staff capacity to complete the questionnaire.
- Due to work demands, time constraints and staff shortages, many facilities misplaced questionnaires and had to be re-sent these.
- Difficulties were experienced when attempting to contact programme directors as they were not always available and often did not return telephone calls.
- Many facilities expressed that they had returned the questionnaires in the self-addressed postage-paid envelope provided with the TSA questionnaire, however, these questionnaires were never received. The reliability of the postal service thus presented a special challenge. Many facilities were kind enough to oblige and complete the questionnaire a second time, which was then faxed to us.

2.6. DATA ANALYSIS

Statistics for this study were computed using the Statistical Package for the Social Sciences (Norusis/SPSS Inc., 2005). Descriptive statistics were calculated for all treatment service-, service delivery-, client-, staff-, and access-oriented variables. Facilities were stratified by location (province), and separately by treatment intensity and ownership. For each of these strata, cross-tabulations were performed on all treatment service, service delivery, access-oriented, client and staffing variables. Chi-square tests of association were performed to determine whether there were any significant associations between the different types of facilities on these variables. Paired sample *t*-tests were conducted to identify significant differences between the mean number of facilities on service delivery and staff-oriented variables.

2.7. DATA CONSIDERATIONS

2.7.1. Response rates

Questionnaires were mailed to 61 facilities (35 in Gauteng and 26 in KwaZulu-Natal) believed to offer substance abuse treatment services. Of these facilities, 5% (3) were found to be ineligible for the survey as they did not meet the criteria for inclusion and a

further 5% (3) had closed down. Of the remaining 55 facilities, 84% returned the TSA questionnaire. Despite numerous requests to the facility, 1 questionnaire had to be excluded from analyses due to missing information. The final sample (N = 45) included 26 facilities in Gauteng and 19 in KwaZulu-Natal. Non-responding facilities tended to serve smaller numbers of clients and have fewer staff and other resources.

2.7.2. Quality assurance and item non-response

Careful editing and extensive follow-up greatly reduced item non-response. Where missing data occurred, facilities with missing values for a given variable were excluded from tabulations using that variable.

2.7.3. Further data considerations and limitations

Certain procedural considerations and data limitations must be taken into account when interpreting data from this audit:

- This audit attempted to obtain responses from all known treatment facilities in Gauteng and KwaZulu-Natal. It is, however, a voluntary survey and no adjustment was made for facilities that did not respond.
- This audit provides information on the substance abuse treatment system and its clients for the specified reference period only (i.e. the 12 months preceding the audit). Client counts reported here are estimated counts only and do not represent annual totals.
- The TSA collects data about treatment facilities and not about individual clients. Data on clients represent an aggregate of clients in treatment for each participating facility.
- Multiple responses were allowed for certain variables (e.g. type of services provided).
- The TSA collects self-report data from key informants at participating facilities. Social desirability processes and political concerns about ways in which findings will be used may have influenced facility responses on specific items. The TSA (revised version) incorporates a number of validity checks. For example, several differently worded questions are used to examine client retention rates.

PART 3: KEY RESULTS

3.1. CHARACTERISTICS OF SUBSTANCE ABUSE TREATMENT FACILITIES IN GAUTENG AND KWAZULU-NATAL

Treatment services research has shown that the organisational features of treatment facilities impact on the types of services available and the quality of services provided to clients (Lee et al., 2001). The following section describes a number of organisational features including intensity of treatment provided, ownership status, and facility affiliation.³

3.1.1. Treatment facility profile by intensity of care

Core findings:

- 28.0% of facilities in Gauteng and 50.0% of facilities in KwaZulu- Natal provide primarily inpatient treatment services
- 44.0% of facilities in Gauteng and 30.0% of facilities in KwaZulu-Natal offer mainly outpatient treatment services

Substance abuse treatment facilities in South Africa provide services at different levels of intensity. These include inpatient/residential treatment, secondary inpatient treatment and outpatient programmes. In Gauteng, the majority of facilities provide outpatient services (Figure 1) whereas in KwaZulu-Natal, the majority of facilities offer inpatient services (Figure 2). In both provinces, some treatment facilities provide stepped-down levels of care; in other words they offer outpatient services to clients who have completed an inpatient programme at the facility. In both provinces, only a small proportion of facilities offer stepped-down care services- as a consequence this report focuses on inpatient and outpatient care.

³ Denominators will change according to missing numbers.

Figure 1. Intensity of care provided in Gauteng (%).

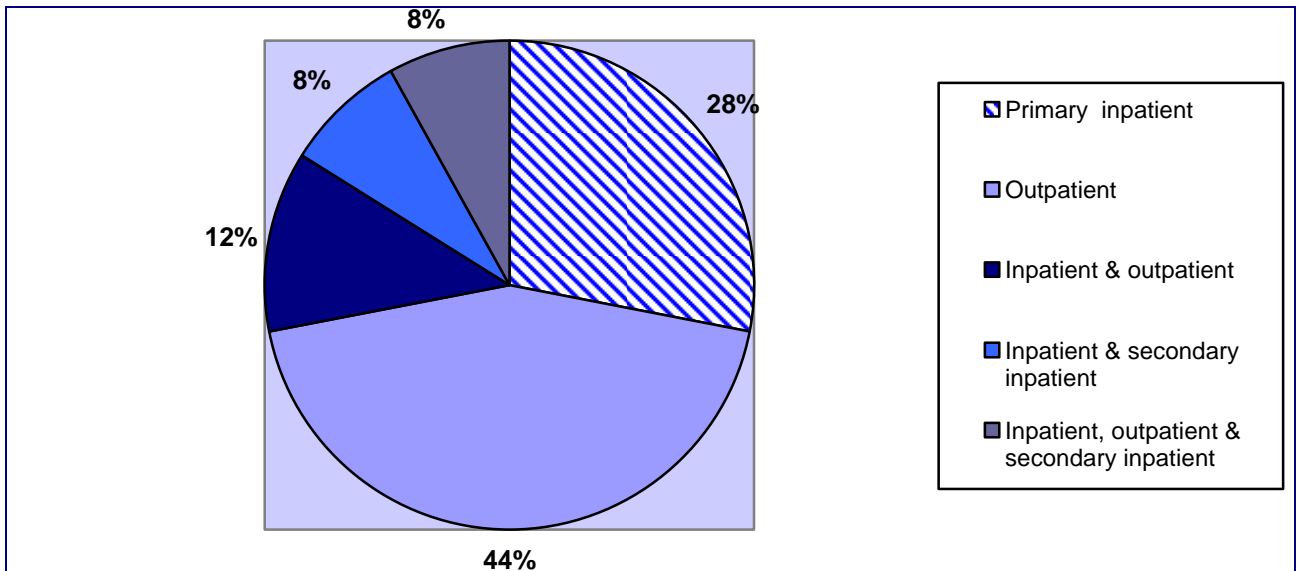
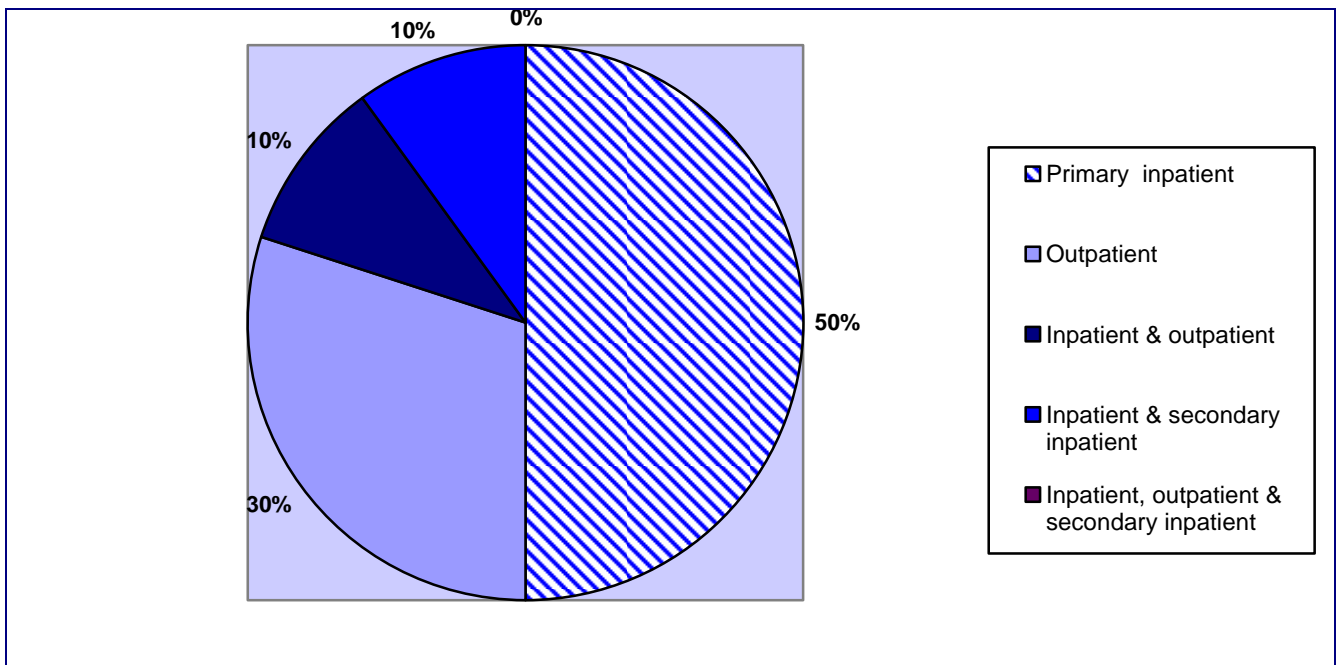


Figure 2. Intensity of care in KwaZulu- Natal (%).



3.1.2. Treatment facility profile by facility ownership

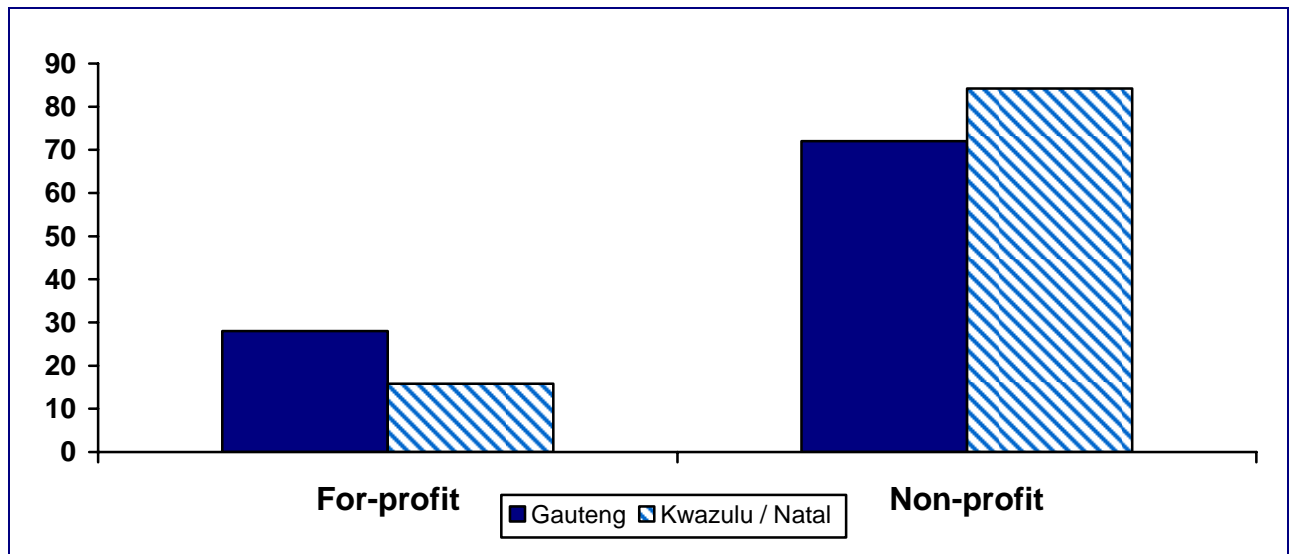
Core findings:

- 68.9% of facilities are privately owned
- Of the privately-owned facilities, 67.7% have non-profit and 32.3% have for-profit status
- Gauteng has a higher proportion of for-profit and a lower proportion of non-profit facilities than KwaZulu-Natal

Facility ownership (understood in terms of profit status and public/private orientation) has been shown to impact on access to substance abuse treatment (Lee et al., 2001). Most of the facilities (68.9%) that participated in this study are privately owned. Of the 31 privately-owned facilities, 21 (67.7%) have non-profit and 10 (32.3%) have for-profit ownership status. State-owned facilities account for 6.7% of the overall sample. The state does however provide funding to substance abuse treatment facilities, with a further 24.4% of the overall sample being state-subsidised.

When facility ownership is considered by province (Figure 3), the proportion of non-profit facilities significantly outweighs the proportion of for-profit facilities. However Gauteng has a higher proportion of for-profit facilities (28.0%) and a lower proportion of non-profit facilities (72.0%) compared to KwaZulu-Natal, where for-profit and non-profit facilities account for 15.8% and 84.2% of the total sample, respectively.

Figure 3. Profit status of privately-owned facilities by province (%).



3.1.3. Treatment facility profile by state affiliation

Core findings:

- The majority of facilities are registered with the Department of Social Development
- Overall, only 16.7% of facilities are not registered
- Similar proportions of facilities are registered in Gauteng and KwaZulu-Natal

Overall 83.3% (35) of the treatment facilities are registered with the Department of Social Development (DoSD) and 16.7% (7) are not registered. When facility affiliation is

compared across provinces, findings show that 83.3% (20) of facilities in Gauteng and in 83.3% (15) of those in KwaZulu-Natal 83.3% are registered.

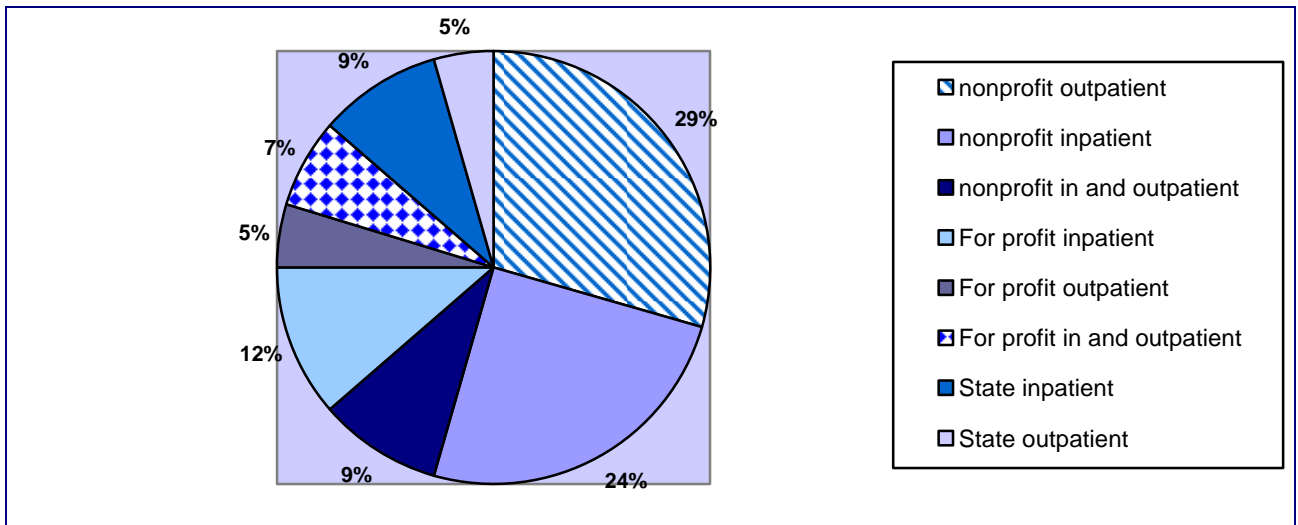
3.1.4. Treatment facility profile by intensity of care and facility ownership

Core findings:

- Overall, the majority of facilities are private non-profit facilities providing outpatient treatment.

As there is a large overlap between the intensity of care provided and ownership status, a new variable was created that combined these individual variables. Of the 44 facilities that responded to this question, the majority (29.5% (13)) are private, non-profit facilities offering outpatient services, 25.0% (11) are private, non-profit facilities providing inpatient treatment, 11.5% (5) are private for-profit facilities offering inpatient services, 4.5% (2) are private for-profit facilities providing outpatient treatment, 9.1% (4) are private non-profit facilities providing inpatient and outpatient services, 6.8% (3) are private for-profit facilities offering inpatient and outpatient treatment, 4.5% (2) are state outpatient facilities and 9.1% (4) are state inpatient facilities (Figure 4).

Figure 4. Intensity of care and ownership for the total sample (%)



Organisational characteristics (combined ownership and intensity of care) were compared across provinces (Table 1). In Gauteng, private non-profit outpatient services account for the highest proportion of facilities, whereas in KwaZulu-Natal, private non-profit inpatient facilities account for the largest proportion of facilities. Although Gauteng has

both inpatient and outpatient services in the private for-profit and state sectors, KwaZulu-Natal has no for-profit or state outpatient services. These differences are not significant.

Table 1. Facility ownership and intensity of care by province.

Facility ownership / Intensity of care	Gauteng		KwaZulu-Natal	
	N	%	N	%
Private non-profit outpatient	7	28.0	6	31.6
Private non-profit inpatient	4	16.0	7	36.8
Private for-profit outpatient	2	8.0	0	0.0
Private for-profit inpatient	3	12.0	2	10.5
Private non-profit inpatient & outpatient	3	12.0	1	5.3
Private for-profit inpatient & outpatient	2	8.0	1	5.3
State outpatient	2	8.0	0	0.0
State inpatient	2	8.0	2	10.5
Total	25	100	19	100

3.2. PROFILE OF CLIENTS SERVED BY SUBSTANCE ABUSE

TREATMENT FACILITIES IN GAUTENG AND KWAZULU-NATAL

This section describes the demographic profile of the clients served, in the 12 months prior to the audit, by substance abuse treatment facilities in Gauteng and KwaZulu-Natal.

3.2.1. Demographic profile of clients at treatment facilities in Gauteng and KwaZulu-Natal

<i>Core findings:</i>
<ul style="list-style-type: none"> • Treatment facilities provide services to significantly more males than females • Compared to other age cohorts, clients treated at substance abuse treatment facilities are most likely to be between 20 and 29 years of age • Black clients are underrepresented and White clients are overrepresented at substance abuse treatment facilities in both Gauteng and KwaZulu-Natal

For the overall sample, the estimated proportion of male clients ranges from 45.0% to 100.0% of the total client population ($\chi = 75.4$, $SD = 15.9$). In contrast, the estimated proportion of female clients ranges from 0.0% to 55.0% ($\chi = 25.1$, $SD = 15.9$) (Table 2). A paired sample *t*-test revealed that the mean proportion of male clients is significantly higher than the mean proportion of female clients ($t = 10.6$, $p < 0.000$). Similar findings

were found when cross-provincial comparisons were made (Table 2); with the mean estimated proportion of male clients being 72.7% in Gauteng and 78.7% in KwaZulu-Natal.

For the overall sample, independent sample *t*-tests revealed that the mean proportion of clients between 20 and 29 years of age is significantly greater than the mean proportion of clients between 30 and 39 years of age ($t = 2.7, p = 0.010$), between 40 and 49 years of age ($t = 4.6, p < 0.000$), and 50 years of age or older ($t = 7.7, p = 0.000$) (Table 2). The only non-significant relationship was between the mean proportion of clients between 20 and 29 years of age and the mean proportion of clients younger than 20 ($t = -1.7, p = 0.101$). When cross-provincial comparisons are made (Table 2); facilities in Gauteng appears to have a slightly older age cohort than in KwaZulu-Natal, where clients in the under 20 age group comprise the majority of the client population.

Table 2. Demographic profile of clients at substance abuse treatment facilities (N = 45).

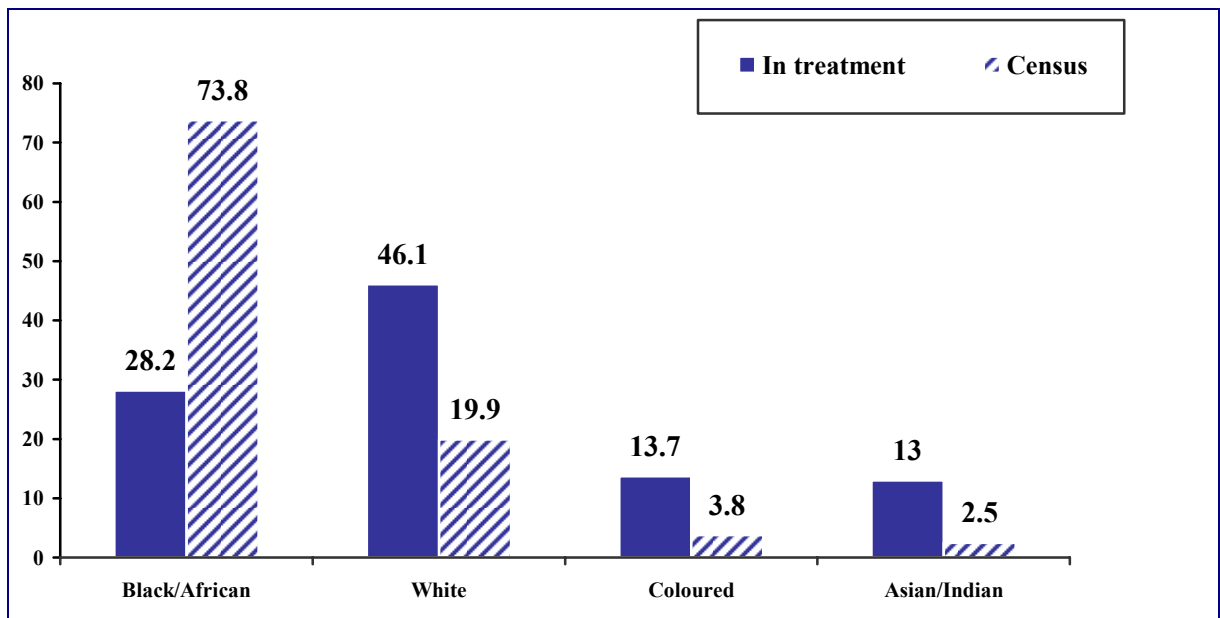
	Gauteng		Kwazulu / Natal		Total	
	M	SD	M	SD	M	SD
% of clients by gender						
Males	72.7	15.1	78.7	16.7	75.4	15.9
Females	27.7	15.1	21.8	16.8	25.1	15.9
% of clients by age						
<20	21.3	16.8	30.3	30.4	25.3	23.9
20-29 years of age	34.6	16.9	28.4	17.6	31.9	17.3
30-39 years of age	24.5	10.7	22.1	10.7	23.5	10.6
40-49 years of age	14.3	9.9	17.3	11.8	15.6	10.7
≥ 50 years of age	6.2	5.9	10.2	8.5	7.9	7.3
% of clients by race						
White clients	46.1	31.9	30.9	31.6	39.2	32.3
Black/African clients	28.2	23.2	41.1	27.9	33.9	25.9
Coloured clients	13.8	14.6	9.6	11.3	11.9	13.3
Asian/Indian clients	13.0	21.2	24.1	19.3	17.9	20.9

In terms of socially-defined race groups, when the overall sample is considered, the mean proportion of White clients in treatment is significantly greater than the mean proportion

of Coloured ($t = 4.7, p = 0.000$) and Asian/Indian clients ($t = 3.4, p = 0.002$). The mean proportion of White clients is not significantly different than the mean proportion of Black clients ($t = 0.56, p = 0.576$) (Table 2). When cross-provincial comparisons are made (Table 2); we found that the mean proportion of White clients is not significantly different from the mean proportion of Black clients in facilities in Gauteng ($t = 1.8, p = 0.07$) or KwaZulu-Natal ($t = 0.81, p = 0.426$).

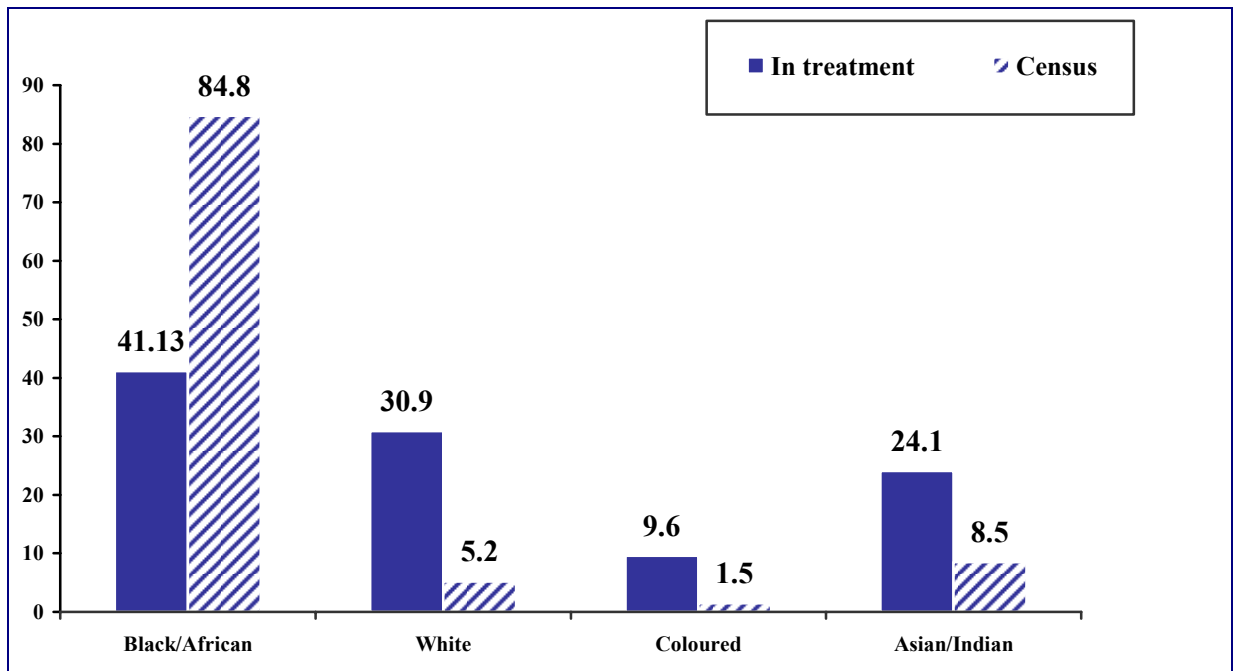
These findings are cause for concern when considered in the light of the demographic profile of the general population in these provinces. Compared to the demographic profile of the general population in Gauteng (Figure 5) and KwaZulu-Natal (Figure 6), respectively; Black/African clients are underrepresented and White clients are overrepresented in substance abuse treatment facilities.

Figure 5. Comparison of race profile of clients at treatment facilities with census data (2003⁴) for Gauteng (%)



⁴ Statistics South Africa (2003)

Figure 6. Comparison of race profile of clients at treatment facilities with census data (2003⁴) for KwaZulu- Natal (%)



3.2.2. Variations in the profile of clients served by organizational characteristics

Core findings:

- Compared to other facilities, private for-profit facilities are most likely to have high proportions of female clients
- Compared to other facilities, private non-profit outpatient facilities are more likely to have a client population comprised of large proportions of Black clients and clients less than 20 years of age

In terms of gender, high proportions of female clients are most likely to occur in private for profit inpatient and outpatient settings, were 40% and 50% of these facilities respectively, report that women comprise more than 41% of their total client population in the 12 months preceding the study (Table 3).

Compared to other types of treatment facilities, private non-profit outpatient and state outpatient treatment facilities are more likely to report that Black/African clients comprise more than 50% of the total client population (Table 3). Similarly, private non-profit outpatient and state outpatient treatment facilities are more likely to report that clients less than 20 years old comprise more than 40% of their total client population than other types of facilities (Table 3).

Table 3. Variations in demographic profile of clients at substance abuse treatment facilities by treatment intensity and ownership (N = 45)

	For-profit inpatient (N = 5)		Non-profit inpatient (N = 11)		For-profit outpatient (N = 2)		Non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Proportion of female clients												
0-10%	1	20.0	3	27.2	0	0.0	4	30.8	2	50.0	0	0.0
11-20%	0	0.0	1	9.1	0	0.0	7	53.8	1	25.0	0	0.0
21-30%	0	0.0	3	27.3	1	50.0	0	0.0	1	25.0	2	100.0
31-40%	2	40.0	3	27.3	0	0.0	2	15.4	0	0.0	0	0.0
≥41%	2	40.0	1	9.1	1	50.0	0	0.0	0	0.0	0	0.0
Proportion of clients less than 20 years of age												
0-20%	4	80.0	8	72.7	1	50.0	1	7.7	3	75.0	0	0.0
21-40%	0	0.0	1	9.1	1	50.0	8	61.5	1	25.0	0	0.0
41-60%	0	0.0	0	0.0	0	0.0	3	23.1	0	0.0	1	50.0
≥61%	0	0.0	2	18.2	0	0.0	1	7.7	0	0.0	0	0.0
Proportion of Black/African clients												
0-10%	3	60.0	5	45.4	2	100.0	1	7.7	0	0.0	0	0.0
11-30%	0	0.0	4	36.4	0	0.0	0	0.0	1	25.0	0	0.0
31-50%	1	20.0	1	9.1	0	0.0	3	23.1	2	50.0	1	50.0
≥51%	1	20.0	1	9.1	0	0.0	9	69.2	1	25.0	1	50.0

3.3. TREATMENT CAPACITY AND SERVICE UTILISATION

This section describes the number of clients treated in a typical month, treatment capacity, and the extent to which capacity is utilised. Variations in these factors are explored by treatment intensity and facility ownership.

Core findings:

- Facilities in KZN treat a significantly greater number of clients and have more treatment capacity than facilities in Gauteng
- Outpatient facilities treat significantly higher numbers of clients and have more treatment capacity than inpatient facilities
- No significant differences were found for treatment occupancy rates
- In patient facilities are more likely to have waiting lists than outpatient facilities
- Client retention rates are lowest at state outpatient followed by private non-profit outpatient facilities

3.3.1. Average number of clients treated per month in Gauteng and KwaZulu-Natal

Overall, the typical number of clients receiving substance abuse treatment per month ranges from 8 to 904 ($\chi = 120.4$, $SD = 211.7$). Of these facilities, the majority (41.5%) treat less than 20 clients per month, with only 36.6% of facilities treating more than 50 clients per month.

When provincial data are considered separately, the typical number of clients receiving substance abuse services per month in Gauteng ranges from 9 to 512 ($\chi = 87.0$, $SD = 117.2$). In KwaZulu-Natal, the typical number of clients receiving substance abuse treatment services per month ranges from 8 to 904 ($\chi = 163.1$, $SD = 290.3$). An independent samples *t*-test shows that facilities in KwaZulu-Natal treat a significantly higher mean number of clients than those in Gauteng ($F = 7.15$; $p = 0.01$)

Variations in the typical number of clients served by organisational characteristics

The typical number of clients at private for-profit inpatient facilities and private for-profit outpatient facilities ranges from 9 to 30 ($\chi = 17.6$, $SD = 7.9$) and 12 to 100 ($\chi = 56.0$, $SD = 62.2$), respectively. For private non-profit inpatient and outpatient facilities, the typical number of clients ranges from 8 to 512 ($\chi = 79.9$, $SD = 163.4$) and from 13 to 904 ($\chi = 266.3$, $SD = 337.4$), respectively. For state inpatient facilities, the typical number of clients served per month ranges from 8 to 150 ($\chi = 54.0$, $SD = 64.8$). A one-way analysis of variance procedure revealed that outpatient facilities treat a significantly higher mean number of clients than inpatient facilities ($F = 4.59$; $p = 0.04$). No significant differences were found for the mean number of clients treated by profit status.

3.3.2. Treatment capacity at substance abuse treatment facilities

In this study, treatment capacity refers to the number of treatment slots available to treat clients. For the overall sample, annual treatment capacity ranges from 12 to 1164 slots ($\chi = 133.4$, $SD = 255.4$). When provincial data are considered separately, annual treatment capacity ranges from 13 to 240 slots in Gauteng ($\chi = 63.2$, $SD = 66.9$) and from 12 to 1164 slots in KwaZulu-Natal ($\chi = 207.3$, $SD = 348.9$). An independent samples *t*-test revealed that facilities in KwaZulu-Natal have significantly greater treatment capacity than those in Gauteng ($F = 16.7$; $p < 0.000$).

Variations in treatment capacity by organisational characteristics

Treatment capacity at private for-profit inpatient and private for-profit outpatient facilities ranges from 13 to 32 slots ($\chi = 20.8$, $SD = 6.9$) and from 15 to 120 slots ($\chi = 67.5$, $SD = 74.3$), respectively. For private non-profit inpatient and private non-profit outpatient facilities, treatment capacity ranges from 12 to 72 slots ($\chi = 29.3$, $SD = 18.0$) and from 13 to 1164 slots ($\chi = 509.6$, $SD = 441.9$), respectively. At state inpatient and state outpatient facilities, treatment capacity ranges from 40 to 240 slots ($\chi = 107.0$, $SD = 92.6$) and from 30 to 150 slots ($\chi = 90.0$, $SD = 84.9$), respectively.

A one-way analysis of variance (ANOVA) procedure revealed significant differences in treatment capacity for different types of facilities ($F = 5.28$; $p < 0.001$); with private non-profit outpatient facilities having a significantly greater treatment capacity than private non-profit, private for-profit and state inpatient facilities. Treatment capacity did not differ significantly between private non-profit, state and private for-profit outpatient facilities. When treatment intensity and profit status were considered as separate variables, one-way ANOVAS revealed that outpatient facilities have a significantly greater annual treatment capacity than inpatient facilities ($F = 11.49$; $p < 0.000$). In contrast, treatment capacity did not differ significantly by profit/ownership status.

3.3.3. Substance abuse treatment occupancy rates

For the overall sample, the average proportion of occupied treatment slots ranges from 20.0% to 100.0% ($\chi = 75.5$, $SD = 18.5$). When provincial data are considered separately, the average proportion of occupied treatment slots ranges from 50.0% to 98.0% ($\chi = 77.2$, $SD = 15.1$) in Gauteng and 20.0% to 100.0% ($\chi = 74.0$, $SD = 21.4$) in KwaZulu-Natal. Independent samples *t*-tests found no significant differences on treatment occupancy rate between the provinces.

Variations in treatment service utilisation by organisational characteristics

Variations in the treatment occupancy rate by facility characteristics are reflected in Table 4. Although findings suggest that state facilities have the lowest treatment occupancy rates, followed by private non-profit facilities, and private for-profit facilities and that state facilities, one-way ANOVAS found no significant differences in treatment occupancy rates by ownership/profit status or by intensity of treatment provided.

Table 4. Proportion of treatment slots occupied by facility characteristics (%)

Facility ownership / Intensity of care	Min.	Max.	χ	SD
Private non-profit outpatient	20.0	90.0	64.8	23.4
Private non-profit inpatient	50.0	100.0	78.2	16.6
Private for-profit outpatient	80.0	80.0	80.0	0.0
Private for-profit inpatient	70.0	90.0	80.0	9.4
State outpatient	98.0	98.0	98.0	0.0
State inpatient	35.0	100.0	65.3	32.7

3.3.4. Waiting period for treatment services at substance abuse facilities in Gauteng and KwaZulu-Natal

For the overall sample, 59.1% (26) facilities use a waiting list when full to capacity. When waiting lists were examined by province, a Chi-square analysis showed that facilities in KwaZulu-Natal (KZN) were significantly more likely to place clients on waiting lists than facilities in Gauteng (Chi-square = 4.46, $p= 0.035$); with 70.0% of KZN facilities placing clients on a waiting list in comparison to 48.0% in Gauteng.

When waiting lists were considered by facility characteristics, a Chi-square analysis showed significant differences between the types of facilities (Chi-square =22.47, $p= 0.001$). Specifically, 100.0% of the private for-profit inpatient facilities, 90.9% of the private non-profit inpatient facilities, 50.0% of the state inpatient facilities, 50.0% of the private for-profit outpatient facilities, place clients on a waiting list when full to capacity. A smaller proportion of private non-profit outpatient facilities use waiting lists (16.7%) and no state outpatient facilities have waiting lists. We also examined the interaction between treatment intensity and the presence of waiting lists and found that inpatient facilities are significantly more likely to have waiting lists than outpatient facilities (Chi-square =18.40, $p= 0.001$).

3.3.5. Rates of client retention in treatment

For the overall sample, the estimated client retention rate ranges from 15.0% to 99.9% ($\chi = 73.7$, $SD = 22.7$). When provincial data are considered separately, the estimated client retention rate ranges from 15.0% to 99.9% ($\chi = 73.0$, $SD = 22.6$) in Gauteng and 25.0%

to 99.9% ($\chi = 74.6$, $SD = 23.3$) in KZN. Independent samples *t*-tests found no significant differences between the provincial client retention rates.

Variations in treatment retention by organisational characteristics

An independent samples *t*-test found that treatment retention rates were significantly higher for inpatient compared to outpatient facilities ($t = 3.20$; $p = 0.003$). No significant differences were found on ownership status. Variations in the treatment retention rate by both intensity and ownership status are reflected in Table 5. A one-way ANOVA revealed significant differences in retention rates ($F = 19.19$; $p < 0.000$); with state outpatient facilities having significantly lower retention rates than any other type of treatment facility, followed by private non-profit outpatient facilities which also had significantly lower retention rates than any other facility.

Table 5. *Client retention rates by facility characteristics (%)*

Facility ownership / Intensity of care	Min.	Max.	χ	SD
Private non-profit outpatient	40	80	57.1	10.8
Private non-profit inpatient	25	98	83.7	21.9
Private for-profit outpatient	75.0	90.0	82.5	10.6
Private for-profit inpatient	85.0	99.9	92.4	6.7
State outpatient	15.0	30.0	22.5	10.6
State inpatient	80.0	95.0	90.0	7.1

3.4. STAFF AND STAFF-RELATED ISSUES

This section describes the characteristics of staff employed by substance abuse treatment facilities in Gauteng and KZN. This includes a description of staff qualifications, professional development activities, and staff-related resources.

Core findings:

- No significant differences were found between the provinces on the number of type of staff employed
- State inpatient, followed by private non-profit inpatient facilities had the highest mean number of clinical staff compared to facilities with other types of characteristics
- Inpatient facilities were more likely to have access to and employ doctors and nurses than outpatient facilities

3.4.1. Characteristics of staff at substance abuse treatment facilities

Variations in the mean number of staff by staffing category for the overall sample and by province are presented in Table 6. For the overall sample, the number of full-time professional staff (i.e. staff responsible for treatment services) ranges from 0 to 42 people ($\chi = 7.0$, $SD = 7.3$) and the total number of non-professional full-time staff (such as support staff, administrators and cleaning staff) ranges from 0 to 7 ($\chi = 0.4$, $SD = 1.3$).

Table 6. *Mean number of staff per staffing category*

Staff category	Gauteng		KwaZulu-Natal		Overall	
	χ	SD	χ	SD	χ	SD
Professional (full-time)	6.2	4.8	8.1	9.8	7.0	7.3
Non-professional (full-time)	0.3	0.9	0.5	1.8	0.4	1.3
Part-time staff	2.3	1.9	2.2	1.9	2.2	1.9

The total number of full-time professional staff ranges from 0 to 19 in Gauteng and from 1 to 42 in KZN. Although findings suggest that facilities in Gauteng have fewer professional staff than facilities in KZN, *t*-tests do not support this hypothesis. In addition to full-time staff, many facilities employ sessional professionals on a part-time basis. For the overall sample, the number of part-time staff per facility ranges from 0 to 8. The number of part-time staff per facility ranges from 0 to 8 in Gauteng and from 0 to 6 in KZN. There were no significant differences between the provinces on this variable.

Table 7 presents the mean number of staff per staffing category for the overall sample and by province. Independent sample *t*-tests found no significant differences between facilities in Gauteng and KZN on the number and or/types of staff employed.

Table 7. Mean number of staff per staffing category (N = 45)

Staff category	Gauteng		KwaZulu-Natal		Overall	
	χ	SD	χ	SD	χ	SD
Psychiatrists	0.2	0.4	0.4	0.6	0.3	0.5
Doctors	0.8	0.9	0.9	0.7	0.8	0.8
Psychologists	0.8	1.2	0.6	1.0	0.7	1.1
Occupational therapists	0.2	0.4	0.4	0.8	0.3	0.6
Social workers	3.1	2.1	2.4	2.4	2.8	2.2
Support/addiction counsellors	0.7	0.9	1.9	5.1	1.2	3.5
Registered nurses	2.6	2.9	2.1	2.7	2.4	2.8
Auxillary nurses	0.0	0.0	0.9	3.1	0.4	2.1

Note. Numbers include full-time and part-time staff.

Variations in staff characteristics by organisational factors

Variations in the number of staff by organisational characteristics are reflected in Table 8.

A series of one-way ANOVAS found significant differences on the number of full-time professional staff ($F = 4.61$; $p < 0.001$); with state inpatient facilities having significantly higher numbers of full-time professional staff than any other type of facility.

Table 8. Proportion of staff by organisational characteristics (%)

Number of staff	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		state inpatient (N = 4)		State outpatient (N = 2)	
	χ	SD	χ	SD	χ	SD	χ	SD	χ	SD	χ	SD
Full-time professionals	3.8	1.5	8.7	5.8	1.5	2.1	4.4	2.6	20.3	16.2	2.5	0-7
Full-time nonprofessional	0.2	0.5	0.0	0.0	0.0	0.0	0.4	1.2	1.8	3.5	0.0	0.0
Part-time	4.6	2.5	3.2	1.9	1.5	2.1	1.2	1.3	2.0	1.2	1.5	0.7

Table 9 presents the mean number of staff per staffing category by organisational characteristics.

Table 9. Staffing categories by organisational characteristics

Staff categories	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	χ	SD	χ	SD	χ	SD	χ	SD	χ	SD	χ	SD
Psychologists	1.4	0.6	1.0	1.2	1.5	0.7	0.0	0.0	0.3	0.5	0.5	0.7
Social workers	1.2	0.8	2.7	2.3	1.5	0.7	3.7	2.5	3.8	2.1	2.5	0.7
Spprt Counsellors	1.4	1.3	1.0	2.0	0.0	0.0	0.5	0.8	5.8	10.8	0.0	0.0
Registered nurses	2.4	1.5	4.3	3.6	0.0	0.0	0.5	0.7	6.0	3.2	1.5	0.7
Auxillary Nurses	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	4.5	6.1	0.0	0.0
OTs	0.4	0.6	0.6	0.9	0.0	0.0	0.0	0.0	0.5	0.6	0.0	0.0
Doctors	1.8	1.1	1.2	0.7	0.0	0.0	0.4	0.7	1.0	0.0	0.0	0.0
Psychiatrists	0.4	0.6	0.6	0.5	0.0	0.0	0.0	0.0	0.5	1.0	0.0	0.0

One-way ANOVAs found significant differences on the number of doctors ($F = 3.28$; $p < 0.011$) by organisational characteristics and the number of nurses by organisational characteristics ($F = 5.40$; $p < 0.001$). For the former, private non-profit inpatient and for-profit inpatient facilities had significantly more doctors than state outpatient, private non-profit outpatient, and private for-profit outpatient facilities. In terms of nurses, state inpatient facilities employed significantly greater numbers of nurses than private non-profit inpatient facilities, which in turn employed more nurses than either for-profit or non-profit outpatient services.

3.4.2. Recent changes to the treatment team

We also explored changes that had been made to the treatment team in the 12 months preceding the study (Table 10). Independent sample t -tests comparing mean scores on each of these variables by province found that Gauteng and KZN did not differ significantly in terms of the number of treatment staff currently employed, the number of resignations, and the number of new appointments that occurred in the 12 months preceding the study.

Table 10. Changes to the treatment team in the last 12 months

Changes	Gauteng		KwaZulu-Natal		Overall	
	χ	SD	χ	SD	χ	SD
New appointments	2.4	3.2	2.2	2.1	2.3	2.8
Resignations/terminations among clinical staff	2.4	2.5	1.2	1.0	1.8	2.1
# Tx staff employed a year ago	12.9	20.2	7.9	10.7	10.7	16.7
# Tx staff currently employed	14.5	20.9	9.0	10.7	12.1	17.2

Variations in “treatment team changes” by organisational characteristics

Variations in “treatment team change” variables by organisational characteristics are reflected in Table 11. A series of one-way ANOVAS found significant differences on the number of staff who began work in the last 12 months ($F = 3.17; p = 0.013$) and the number of staff currently employed by organizational characteristics ($F = 6.24; p < 0.000$). For both variables, state inpatient facilities had significantly more new appointments and greater numbers of staff currently employed compared to other types of treatment facilities.

Table 11. Changes to the treatment team in the last 12 months by facility characteristics

Facility ownership & Intensity of care	New appointments		Resignations/terminations		Treatment staff employed a year ago		Treatment staff currently employed	
	χ	SD	χ	SD	χ	SD	χ	SD
non-profit outpatient	2.31	1.60	2.23	1.48	5.08	2.53	5.23	2.20
non-profit inpatient	1.78	1.72	2.20	3.23	13.75	19.00	14.89	16.24
for-profit outpatient	0.00	0.00	0.00	0.00	2.00	2.83	3.50	0.71
for-profit inpatient	1.60	1.34	1.40	2.07	10.20	10.85	12.75	9.54
State outpatient	0.50	0.71	0.00	0.00	1.50	0.71	3.50	2.12
State inpatient	7.00	6.63	2.00	2.65	49.67	35.01	53.33	39.11

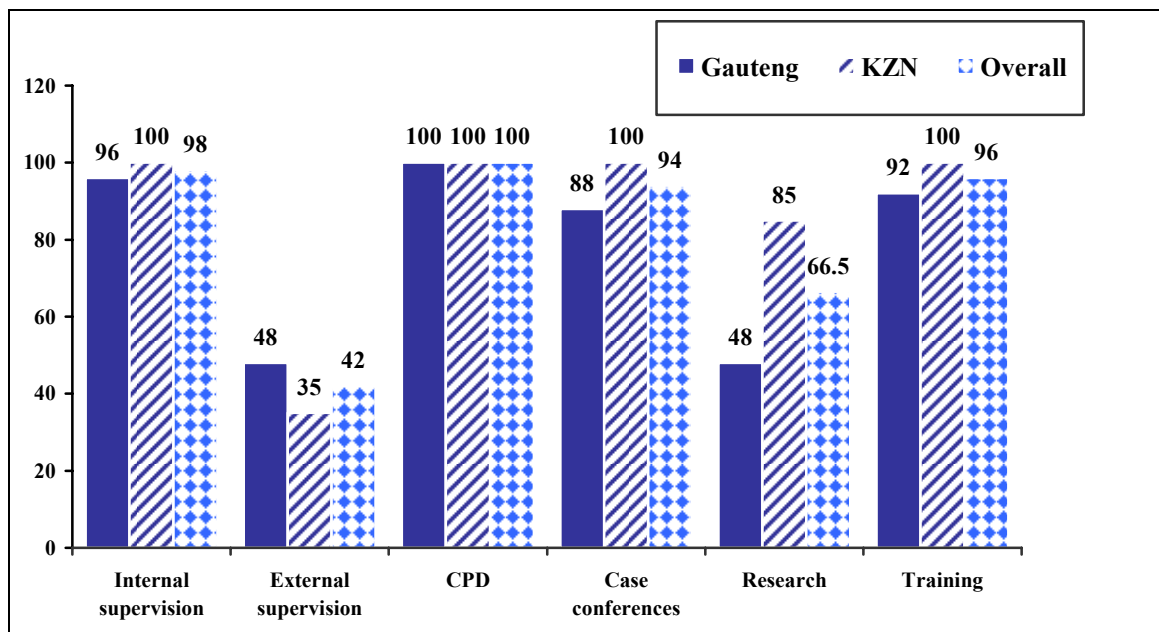
3.4.3. Staff participation in professional development activities

Core findings:

- Few facilities participate in research or provide staff with external supervision
- State outpatient and private for-profit outpatient facilities are least likely to participate in research
- Private for-profit outpatient and inpatient facilities are least likely to provide ongoing training to staff

Figure 7 reflects treatment facility staff participation in professional development activities for the overall sample, and separately by province. A high proportion of facilities reported that treatment staff participated in continuous professional development activities, received ongoing training in substance abuse, and received internal supervision- with no significant differences being observed across provinces on these variables. In contrast, a much smaller proportion of facilities participated in research-related activities and/or provided treatment staff with external supervision. Facilities in KZN were significantly more likely to participate in research-related activities than facilities in Gauteng (Chi-square = 5.95; $p = 0.015$).

Figure 7. *Extent to which facility staff participate in professional development activities*

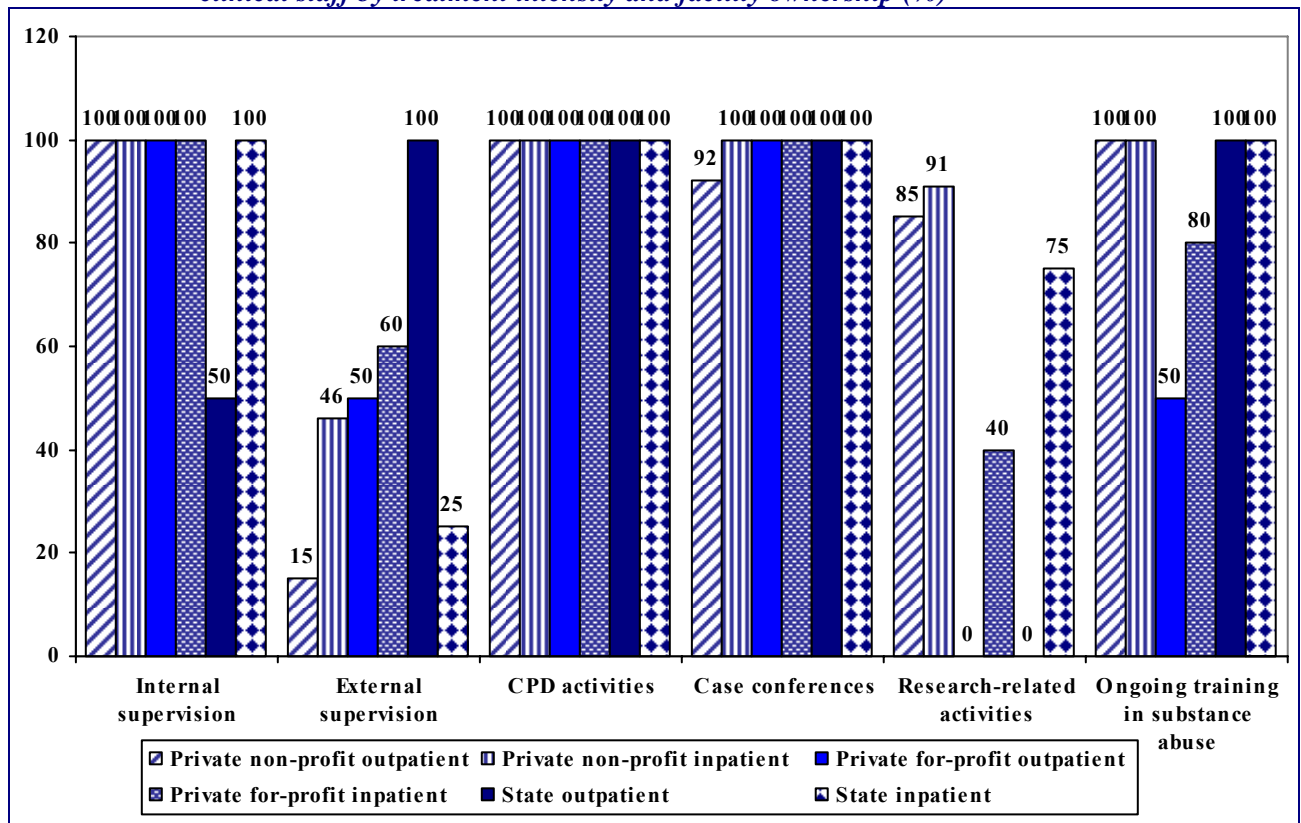


Variations in staff development activities by organisational features

Variations in the extent to which facility staff participate in professional development activities were explored by treatment intensity and type of ownership (Figure 8). Compared to the other types of facilities, staff at state outpatient facilities were significantly less likely to receive internal supervision (Chi-square = 21.99; $p < 0.0000$), with only 50% of facilities reporting providing this service to staff (Figure 8). In contrast, a higher proportion of these facilities provided staff with access to external supervisors, relative to other facilities.

Staff at state outpatient facilities and private for-profit outpatient facilities were significantly less likely to participate in research than staff at other facilities (Chi-square = 16.70; $p = 0.10$), with none of these facilities reporting participation in research. Finally, compared to other facilities, staff at private for-profit outpatient, followed by private for-profit inpatient facilities were the least likely to receive ongoing training in substance abuse (Chi-square = 13.04; $p = 0.042$).

Figure 8. *Proportion of treatment facilities requiring the professional development of clinical staff by treatment intensity and facility ownership (%)*



3.4.4. Resources to support staff development at treatment facilities

Core findings:

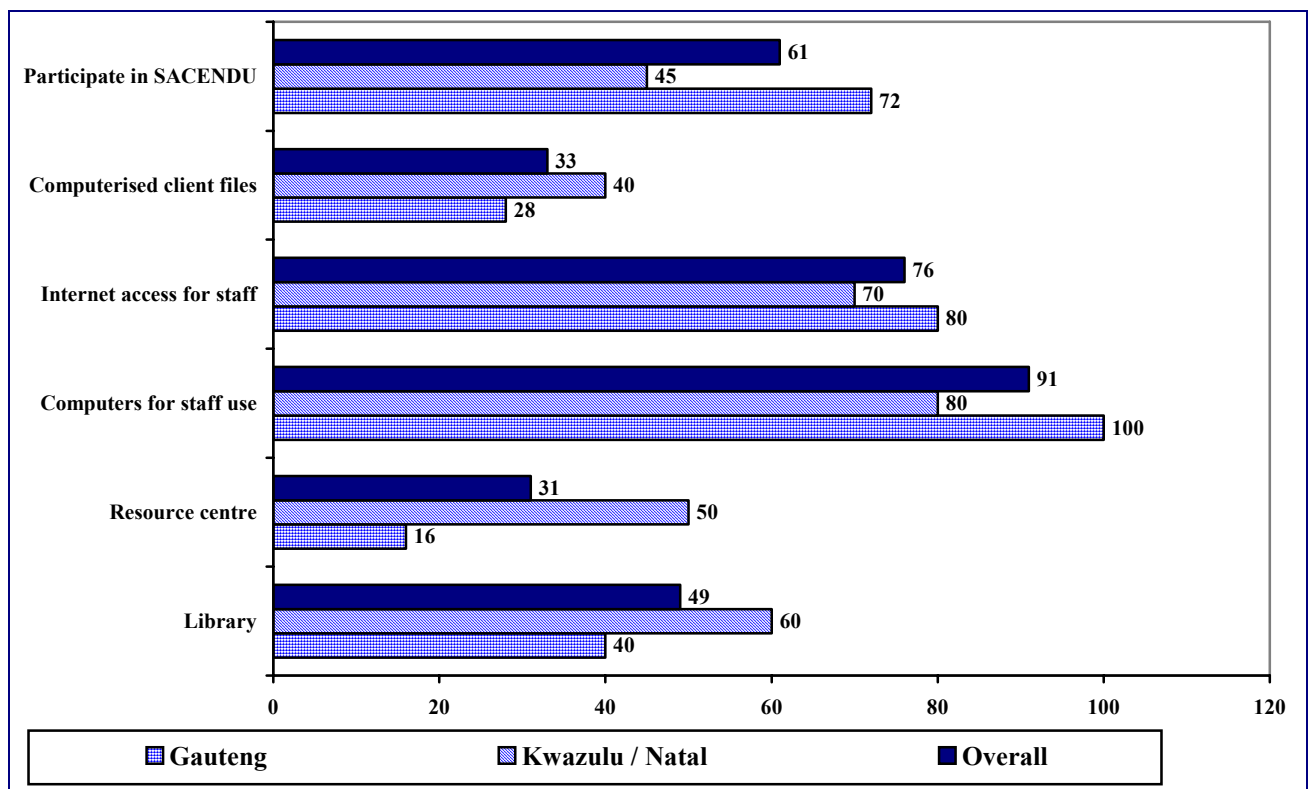
- Less than 50% of facilities provide staff with access to a substance abuse library or resource centre
- Less than a third of facilities maintain a computerised client information system
- State facilities are the least likely to maintain a computerised client information system
- State inpatient facilities are the least likely to provide staff with access to the internet

Figure 9 reflects the extent to which facilities provide resources to facilitate staff development for the overall sample, and separately by province. A high proportion of facilities report providing computers for staff use and internet access to staff (Figure 9). A

significantly higher proportion of facilities in Gauteng provided computers for staff use compared to facilities in KZN (Chi-square = 4.16; $p = 0.04$).

A smaller proportion of facilities participated in SACENDU, provided a substance abuse-related resource centre or library for staff. Compared to facilities in Gauteng, a smaller proportion of facilities in KZN participated in SACENDU. This difference approached significance (Chi-square = 3.38; $p = 0.066$). Compared to facilities in Gauteng, a significantly greater proportion of facilities in KZN provided a substance abuse-related resource centre for staff (Chi-square = 5.77; $p = 0.016$). A very small proportion of facilities maintained computerised client and case files (Figure 9). For this variable, no significant differences by province were observed.

Figure 9. *Proportion (%) of facilities that provide resources to support staff development*



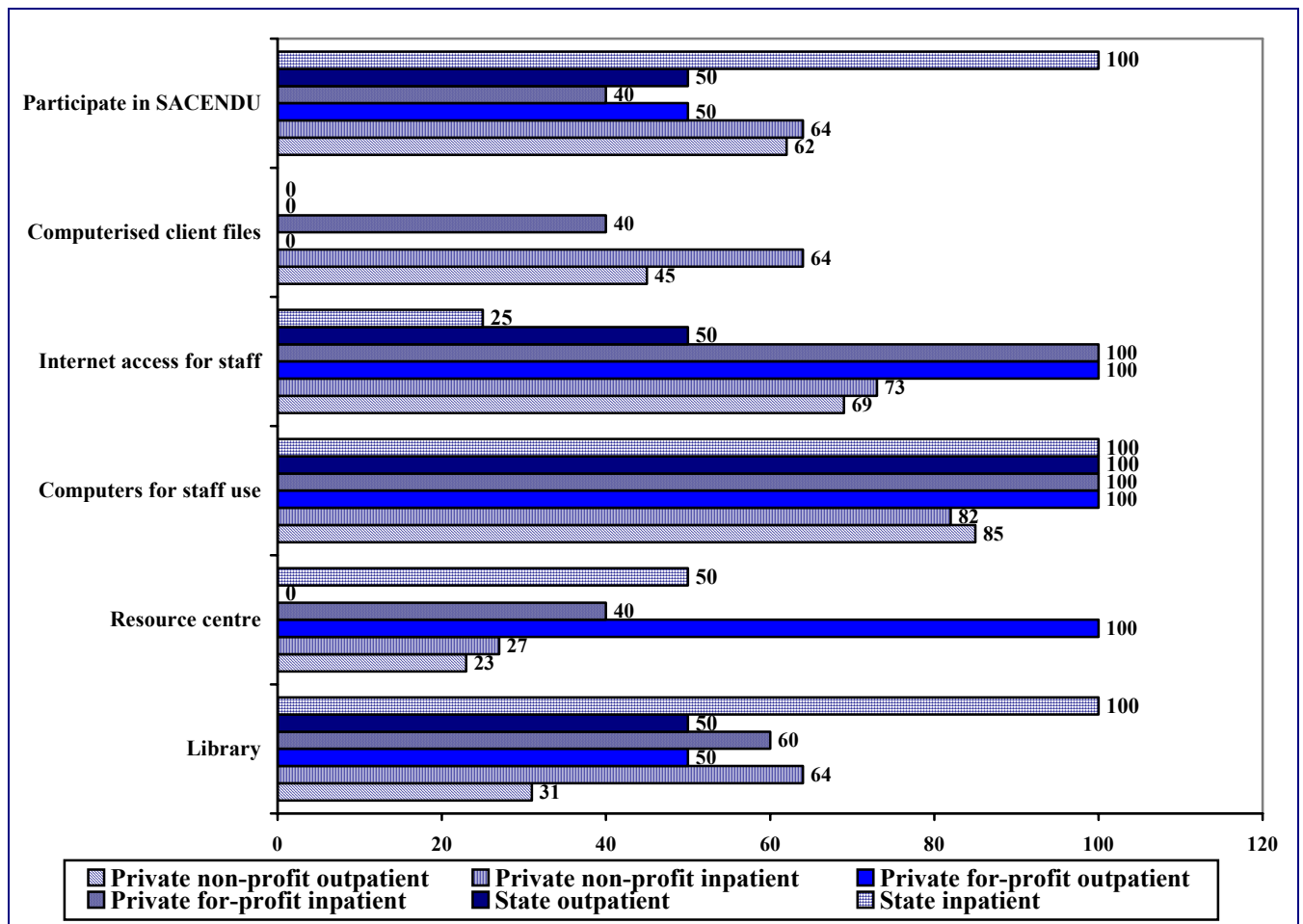
Variations in resources to support staff development by organisational features

The extent to which facilities provide resources to support staff and encourage professional development were explored by intensity of treatment and facility ownership (Figure 10). None of the state inpatient, state outpatient or private for-profit outpatient facilities maintained computerised client files (Figure 10). Other facilities were

significantly more likely to have a computerised client information system (Chi-square = 14.78; $p = 0.02$).

Compared to other facilities, a higher proportion of state inpatient facilities provided staff with access to a library and participated in SACENDU. This difference was not, however, statistically significant. In contrast, compared to other facilities, state inpatient facilities were significantly less likely to provide staff with internet access (Chi-square = 14.52; $p = 0.02$).

Figure 10. *Variations in proportion (%) of facilities that provide resources to support staff professional development by organisational features*



3.5. ORGANISATIONAL ENVIRONMENT & MANAGEMENT PRACTICES

Core findings:

- State and private for profit outpatient facilities were the least likely to practice good governance, such as holding regular management and staff meetings.
- A significantly greater proportion of facilities in KZN reported an increase in staff in the last 12 months than facilities in Gauteng
- Compared to other facilities, non-profit outpatient and state outpatient facilities were most likely to have decreases in staff in the 12 months preceding the study.

We also examined the proportion of facilities that implemented management practices prescribed by the minimum norms and standards for inpatient and outpatient treatment centres.

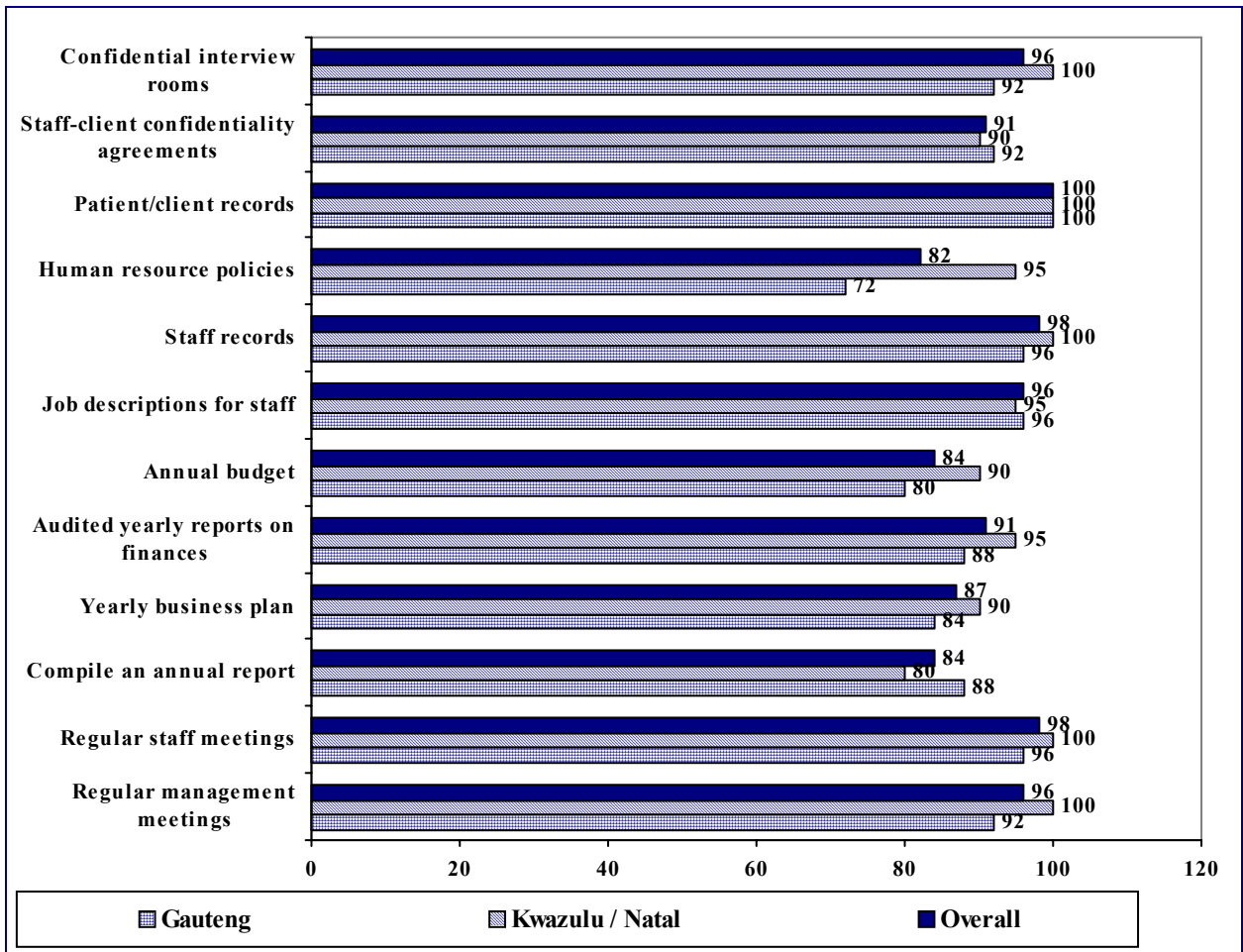
3.5.1. Management practices at treatment facilities

Overall, 72.7% of treatment facilities have a governing body or external management committee. Little difference was found across the provinces, with 72.0% and 73.7% of facilities in Gauteng and KZN, respectively following this practice. The extent to which facilities implement other good governance and management practices are displayed in Figure 11.

In terms of client record-keeping, while all facilities reported keeping client records, not all facilities had staff confidentiality agreements regarding client data. In addition, not all facilities had confidential interviewing rooms (Figure 11). This raises concerns about ethics. We observed no significant differences between the provinces on these variables.

In terms of good governance and management practices, almost all facilities reported keeping records on staff, providing staff with job descriptions, holding regular staff meetings, and holding regular management meetings. Despite the legal requirements of doing so, not all facilities reported the annual auditing of finances (only 91% of the overall sample), compiling an annual budget (only 84% of the sample), or developing a business plan for the facility (only 87% of the sample). We observed no significant differences between the provinces on these variables.

Figure 11. Proportion (%) of facilities reporting specific management practices

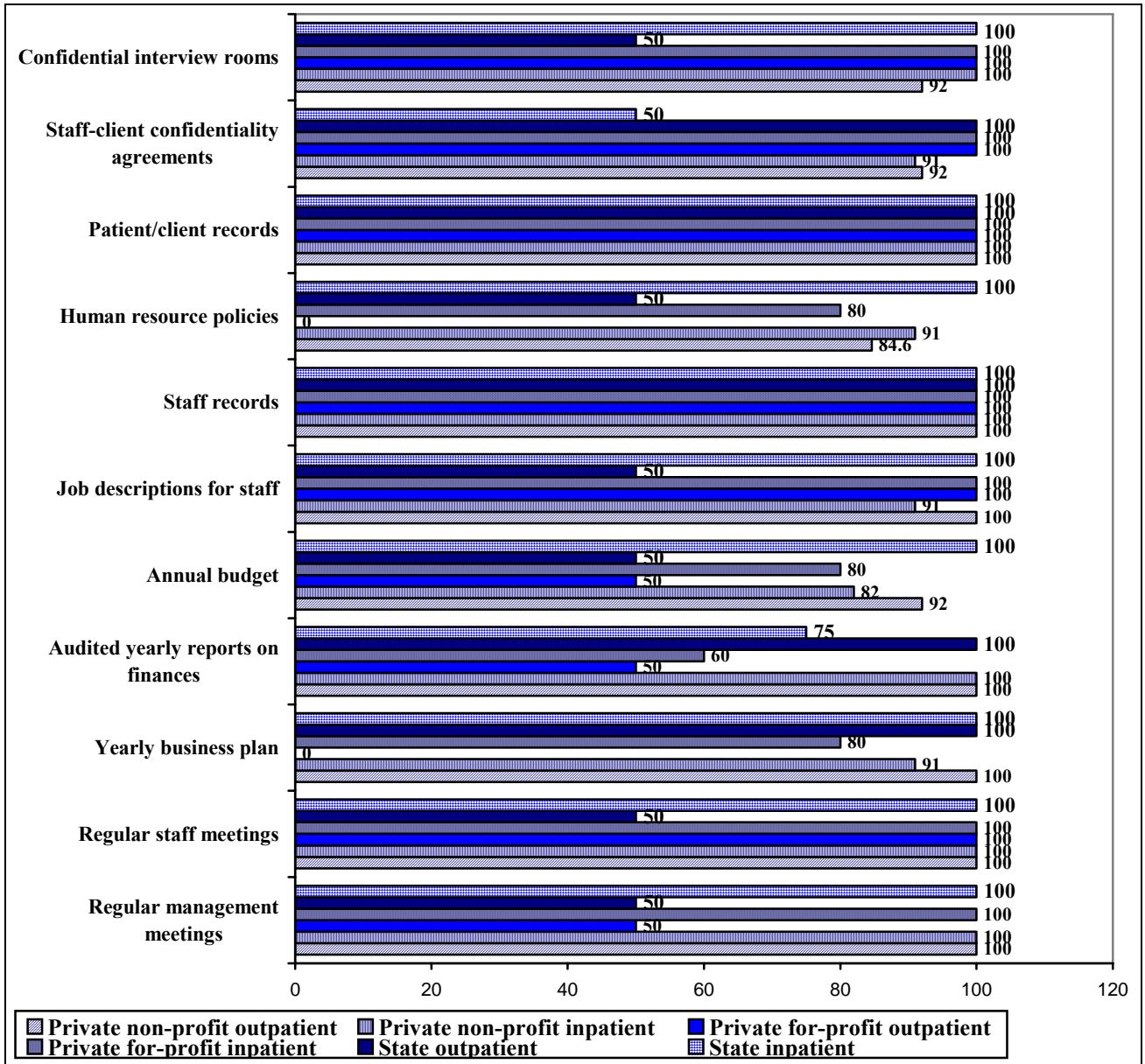


Variations in organisational environment and management practices

Variations in organisational environment, good governance and good management practices were explored by the organisational characteristics of treatment intensity and facility ownership (Figure 12).

Compared to other facilities, state and private for-profit outpatient facilities were significantly less likely to hold regular management meetings (Chi-square = 21.45; $p = 0.002$); with only 50% of these facilities responding “yes” to this variable. State outpatient facilities were also significantly less likely to hold regular staff meetings than other facilities (Chi-square = 21.99; $p = 0.001$); with only 50% of these facilities responding “yes” to this variable. State outpatient facilities were also significantly less likely to provide staff with job descriptions (Chi-square = 13.04; $p = 0.04$) and have human resource policies (Chi-square = 20.97; $p = 0.05$) than other facilities.

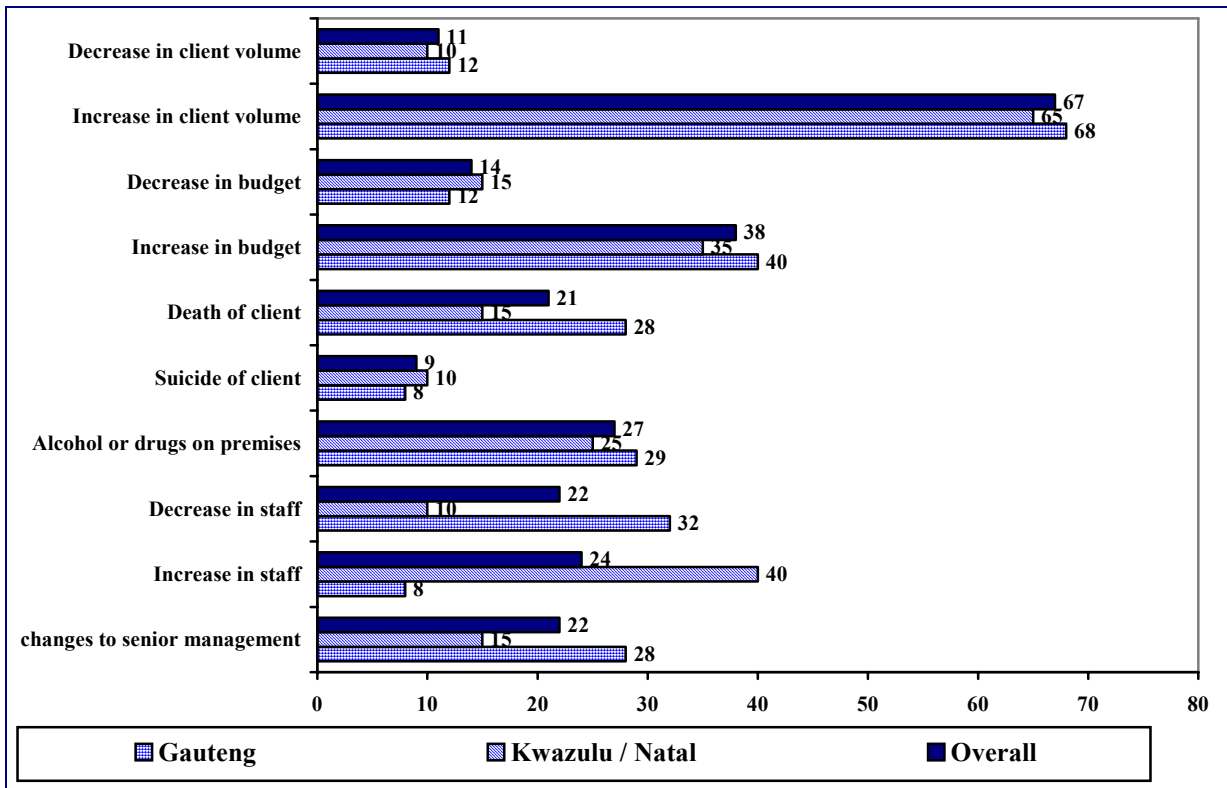
Figure 12. Proportion (%) of facilities reporting good management practices by organisational characteristics



3.5.2. Changes to organizational environment

We also examined significant event or changes that had occurred in the organisational environment of the facility in the 12 months preceding the study. The proportion of facilities reporting these events and changes is reflected in Figure 13.

Figure 13. Proportion of facilities reporting changes to organisational environment



More than two-thirds of facilities reported a significant increase in the volume of clients in the past year, while just over a third of facilities reported a significant increase in budget, and almost a quarter of facilities reported significant increases in staff. KZN had a significantly greater proportion of facilities reporting a significant increase in staff than facilities in Gauteng (Chi-square = 6.41; $p = 0.011$). In terms of client safety, almost a third of facilities reporting finding alcohol and drugs on the premises, 20% had experienced the death of a client and almost 10% reported a client suicide in the 12 months preceding the study. We found no other significant differences on organisational change variables between the provinces.

Variations in changes to organisational environment by facility characteristics

Facility characteristics were used to explore variations in significant events or organisational changes (Table 12). Non-profit outpatient and state outpatient facilities were significantly less likely to have significant increases in their staff component compared to other facilities (Chi-square= 14.91; $p = 0.02$). In contrast, these facilities were, relative to the other sites, most likely to have significant decreases in staff (Chi-

square = 19.35; $p = 0.004$). For example, 62% and 50% of non-profit and state outpatient facilities reported decreases in staff. Finally, compared to other facilities, state inpatient facilities were significantly more likely to have alcohol and illicit drugs on their premises, with all of these facilities reporting this occurrence (Chi-square = 22.28; $p = 0.035$).

Table 12. *Changes in the organisational environment in the last 12 months by facility characteristics*

	For-profit inpatient (N = 5)		Non-profit inpatient (N = 11)		For-profit outpatient (N = 2)		Non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Changes -senior management	1	20.0	3	27.3	0	0	2	15.4	1	25.0	0	0.0
Increase in staff	3	60.0	3	27.3	1	50.0	1	7.7	1	25.0	0	0.0
Decrease in staff	0	0.0	0	0.0	0	0.0	8	61.5	0	0.0	1	50.0
Alcohol/drugs found on site	2	40.0	4	36.4	0	0.0	0	0.0	4	100.0	0	0.0
Suicide of a client	0	0.0	1	9.1	0	0	2	15.4	0	0	0	0
Death of a client	0	0.0	1	9.1	1	50.0	5	38.5	1	25.0	0	0
Increase in budget	3	60.0	6	54.5	0	0.0	3	23.1	1	25.0	1	50.0
Decrease in budget	0	0.0	0	0.0	0	0.0	4	30.8	1	25.0	0	0.0
Increase in client volume	4	80.0	10	90.9	1	50.0	7	53.8	1	25.0	2	100.0
Decrease in client volume	0	0.0	0	0.0	0	0.0	1	7.7	2	50.0	0	0.0

3.6. PROFILE OF SERVICES PROVIDED BY SUBSTANCE ABUSE TREATMENT FACILITIES

This section describes the types of treatment services provided by facilities in Gauteng and KZN. We focus on both treatment services proper and ancillary health and welfare services. Ancillary services are those services directed towards problems that are associated with substance dependence (e.g. psychological dysfunction), whereas treatment services proper focus on eliminating or reducing the substance use disorder.

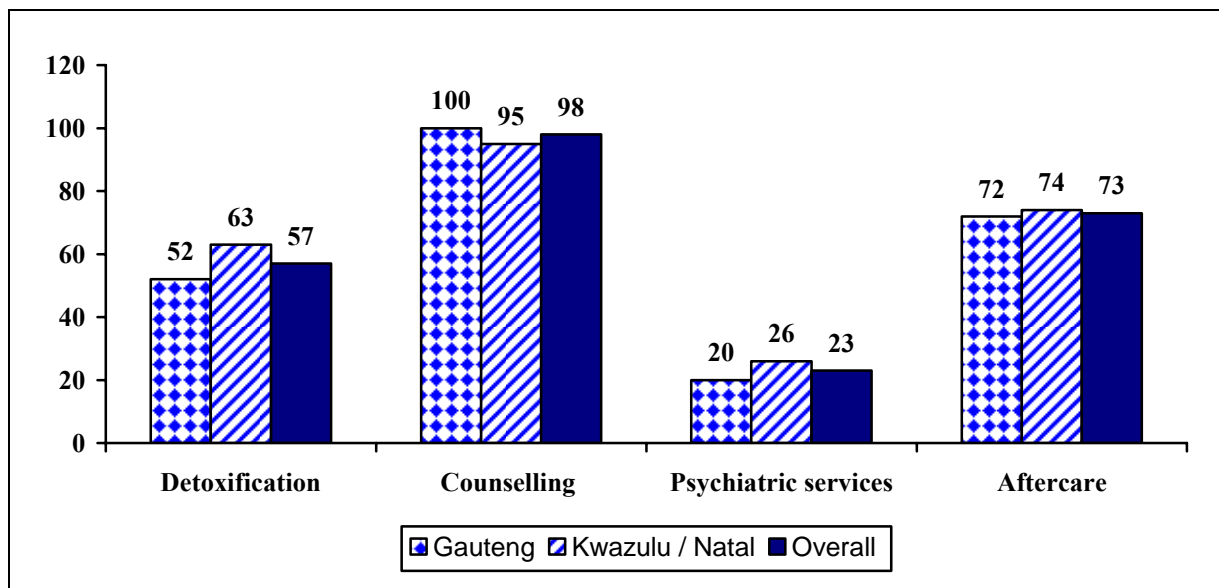
Core findings:

- Compared to the provision of core addiction services, a smaller proportion of facilities provide ancillary mental health or medical services
- Less than a third of facilities conduct psychological evaluations and less than two thirds conduct psychiatric assessments of clients
- Compared to other counselling services, a smaller proportion offer counselling directed at mental health problems
- Less than half the facilities provide harm reduction interventions to reduce the risk of HIV and other infectious diseases, and less than a third conduct harm reduction interventions targeting injection drug users.

3.6.1. Profile of treatment services offered

Almost all facilities offer some form of addiction counselling service, with a much smaller percentage (73%) some type of post-treatment aftercare service. In contrast, only 57% of facilities provide detoxification and other medical services. A very small proportion of facilities (23%) provided psychiatric services. This pattern of service provision was observed in both KZN and Gauteng, with no discernable differences emerging between the provinces.

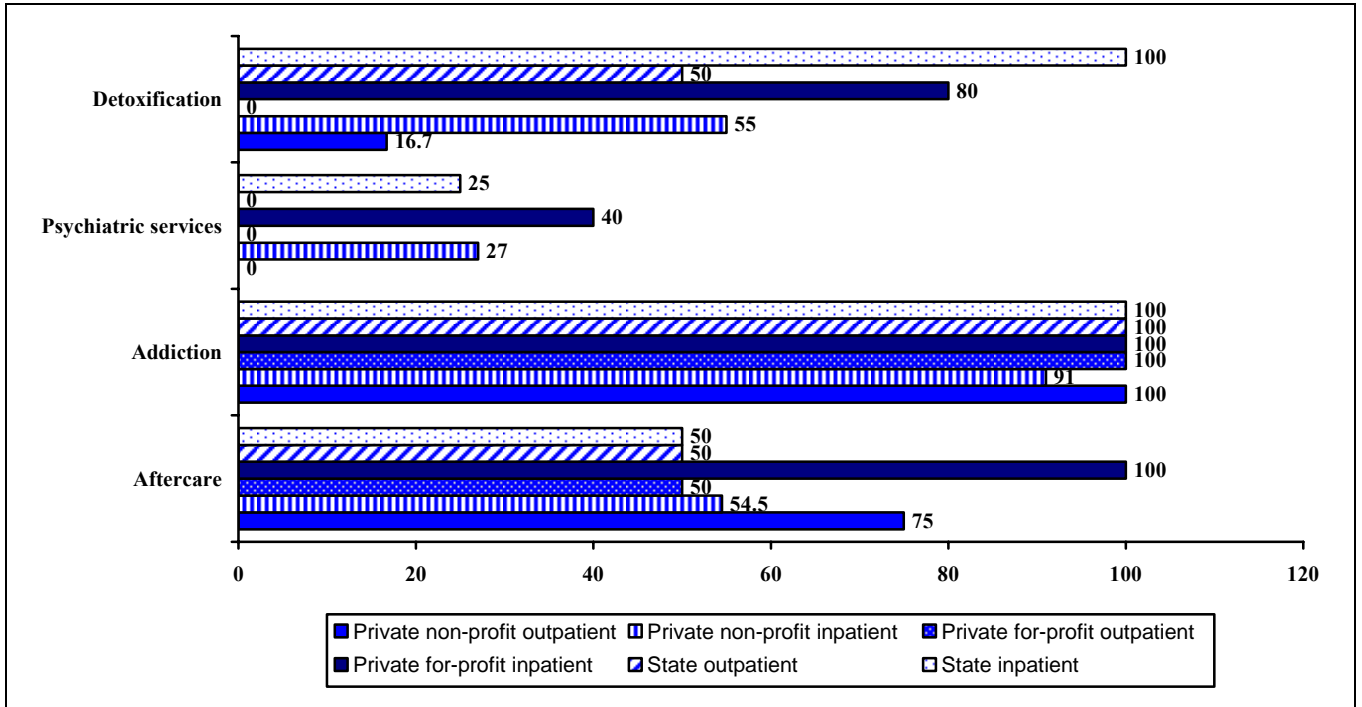
Figure 14. Proportion of treatment facilities providing treatment services (%)



Variations by treatment intensity and facility ownership

We examined the extent to which treatment facilities provide different services varied by organisational factors such as treatment intensity and facility ownership (Figure 15). A significantly higher proportion of state inpatient and private for-profit inpatient facilities provide ancillary medical services such as detoxification (Figure 15) relative to other sites (Chi-square = 20.04; $p = 0.003$). State inpatient and state outpatient facilities are the least likely to provide any form of aftercare service. State outpatient, private for-profit outpatient, and private non-profit outpatient facilities are the least likely to provide psychiatric services to clients.

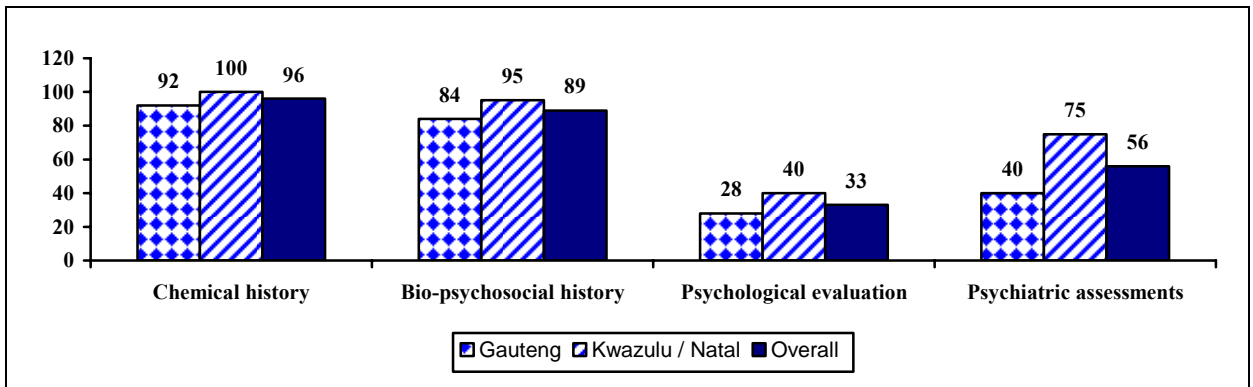
Figure 15. Proportion of facilities (%) providing treatment services by organisational factors



3.6.2. Provision of assessment services

When assessment services were considered, more than 90% of facilities complete a chemical history for each new client (Figure 16). More than 80% of facilities complete a biopsychosocial history for each client. In contrast, less than half of the facilities conduct psychological evaluations and less than two-thirds assess clients for psychiatric disorders (Figure 16). Compared to facilities in Gauteng, facilities in KZN are significantly more likely to offer psychiatric assessment services to clients (Chi-square = 3.89; $p = 0.050$)

Figure 16. Proportion of treatment facilities providing assessment services (%)



Provision of assessment services by treatment intensity and facility ownership

We examined how the provision of assessment services varied by treatment intensity and facility ownership (Table 13). State outpatient, followed by private non-profit outpatient facilities were significantly less likely to provide psychological evaluation services (Chi-square = 29.38; $p = 0.003$) and psychiatric assessments (Chi-square = 12.88; $p = 0.052$) relative to the other facilities. Compared to the other facilities, a higher proportion of for-profit inpatient facilities provided psychological evaluations and psychiatric assessments.

Table 13. *Proportion (%) of facilities providing assessment services by treatment intensity and ownership*

Types of Assessment services	For-profit inpatient (N = 5)		Non-profit inpatient (N = 11)		For-profit outpatient (N = 2)		Non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Biopsychosocial history	5	100.0	9	81.8	2	100.0	11	84.6	4	100.0	1	50.0
Chemical history	5	100.0	10	90.9	2	100.0	12	92.3	4	100.0	2	100.0
Psychological evaluation	3	60.0	4	36.4	1	50.0	3	23.1	2	50.0	0	0.0
Psychiatric assessment	5	100.0	8	72.7	1	50.0	5	38.5	2	50.0	0	0.0

Variations by speciality staffing resources

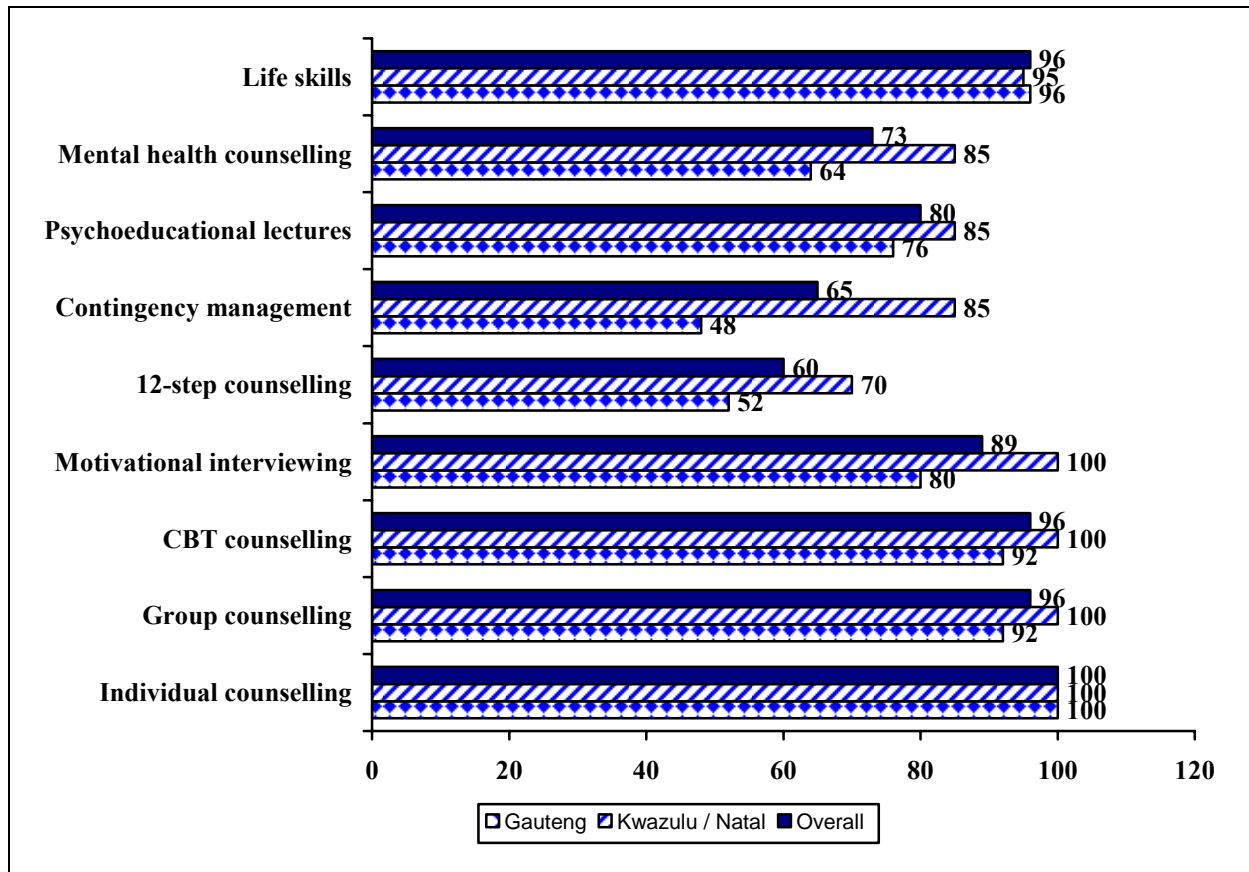
A greater proportion of facilities that employ mental health professionals (psychiatrists and psychologists) conduct psychiatric assessments than facilities without these speciality staff. Of the facilities employing psychiatrists, 70% conduct psychiatric assessments compared to 9.1% of facilities without psychiatrists (Chi-square = 10.78; $p = 0.001$). Similarly, of the facilities employing psychologists, 75% conduct psychiatric assessments compared to 35.7% of facilities without psychologists (Chi-square = 6.188; $p = 0.013$).

3.6.3. Substance abuse counselling services

All of the facilities (100.0%) provide one to one substance abuse counselling services, with more than 95% also providing substance abuse counselling services in a group format as well as life skills development services (Figure 17). A smaller proportion of facilities (73%) offer mental health-related counselling services. When specific substance abuse treatment modalities used by facilities during substance abuse counselling were considered, we found that 60% of facilities reported using 12-step

approaches, 65% reported using contingency management, 89% reported using motivational interviewing techniques, and 96% reported using cognitive behavioural therapy techniques (Figure 17). When cross-provincial comparisons were made, no significant differences were observed on any of these variables.

Figure 17. *Proportion of treatment facilities providing substance abuse counselling services (%)*



Provision of counselling services by treatment intensity and facility ownership

We examined how the provision of counselling services varied by treatment intensity and facility ownership (Table 14). In terms of treatment modalities, a significantly smaller proportion of private for-profit outpatient facilities (0%) reported using motivational interviewing techniques relative to the other facilities (Chi-square = 34.40; $p = 0.001$). Compared to other facilities, significantly smaller proportions of private for-profit outpatient facilities (0%) and state outpatient facilities (0%) reported using contingency management techniques (Chi-square = 33.41; $p = 0.001$).

In contrast, a significantly greater proportion of private for-profit inpatient facilities reported using 12-step models of treatment relative to the other facilities (Chi-square = 15.99; $p = 0.014$). Finally, compared to the other facilities, private non-profit outpatient and state outpatient facilities were the least likely to provide mental health-related counselling services (Chi-square = 19.85; $p = 0.003$). Inpatient facilities were significantly more likely to provide mental health counselling than outpatient ($F = 12.07$; $p = 0.001$)

Table 14. *Proportion of facilities providing counselling services by treatment intensity and ownership*

Types of counselling services: format and modalities	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Individual suds counselling	5	100.0	11	100.0	2	100.0	13	100.0	4	100.0	2	100.0
Group suds counselling	5	100.0	11	100.0	1	100.0	12	92.3	4	100.0	2	100.0
CBT counselling	5	100.0	11	100.0	2	100.0	12	92.3	3	75.0	2	100.0
Motivational interviewing	4	80.0	11	100.0	0	0.00	13	100.0	4	100.0	2	100.0
12-step counselling	5	100.0	7	63.6	1	50.0	4	30.8	3	75.0	0	0.0
Contingency management	5	100.0	7	63.6	0	0.0	8	61.5	3	75.0	0	0.0
Psychoeducation	5	100.0	8	72.7	2	100.0	9	69.2	3	75.0	2	100.0
Mental health counselling	5	100.0	11	100.0	2	100.0	4	30.8	3	75.0	1	50.0
Life skills	5	100.0	10	90.9	2	100.0	12	92.3	4	100.0	2	100.0

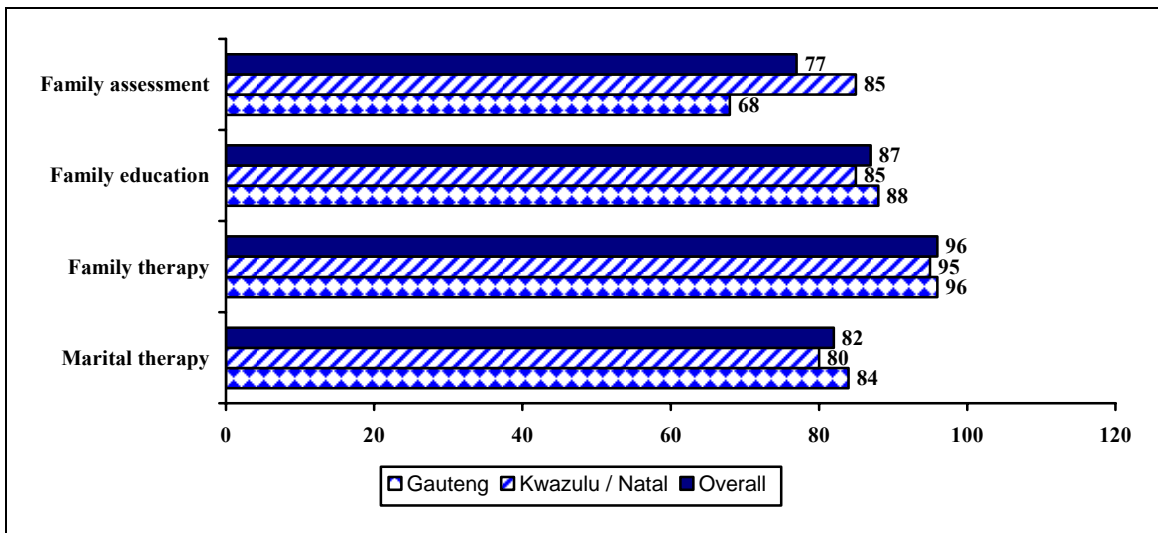
Variations by speciality staffing resources

A significantly greater proportion of facilities that employ mental health professionals (psychiatrists and psychologists) provide mental health counselling services. Of the facilities employing psychologists, 90% provide mental health counselling whereas only 54.2% of facilities without psychologists provide this service (Chi-square = 6.73; $p = 0.009$). Similarly, of the facilities employing psychiatrists, all (100%) provide mental health counselling compared to only 61.8% of facilities without psychiatrists (Chi-square = 5.43; $p = 0.020$).

3.6.4. Provision of family services

Almost all facilities (96%) offer family therapy to their clients (Figure 18). For the most part, this consists of one family session and is used to gather collateral on the presenting client or educate the family about addiction. These family interventions tend not to address family dysfunction. A smaller proportion of facilities also offer family assessment services (77%), family education services (87.0%), or marital and couple counselling services (82%). Facilities in Gauteng and KZN did not differ significantly from each other on any of these variables.

Figure 18. *Proportion of treatment facilities providing family services (%)*



Provision of family services by treatment intensity and facility ownership

We examined how the proportion of facilities providing family services varied by treatment intensity and facility ownership (Table 15). Compared to the other types of treatment facilities, a significantly smaller proportion of private for-profit outpatient facilities (50%) and state outpatient facilities (50%) reported providing family education services (Chi-square = 33.56; $p = 0.001$). The proportion of treatment facilities providing marital and/or family therapy did not differ significantly by treatment intensity and facility ownership.

Table 15. Proportion (%) of facilities providing family services by treatment intensity and ownership

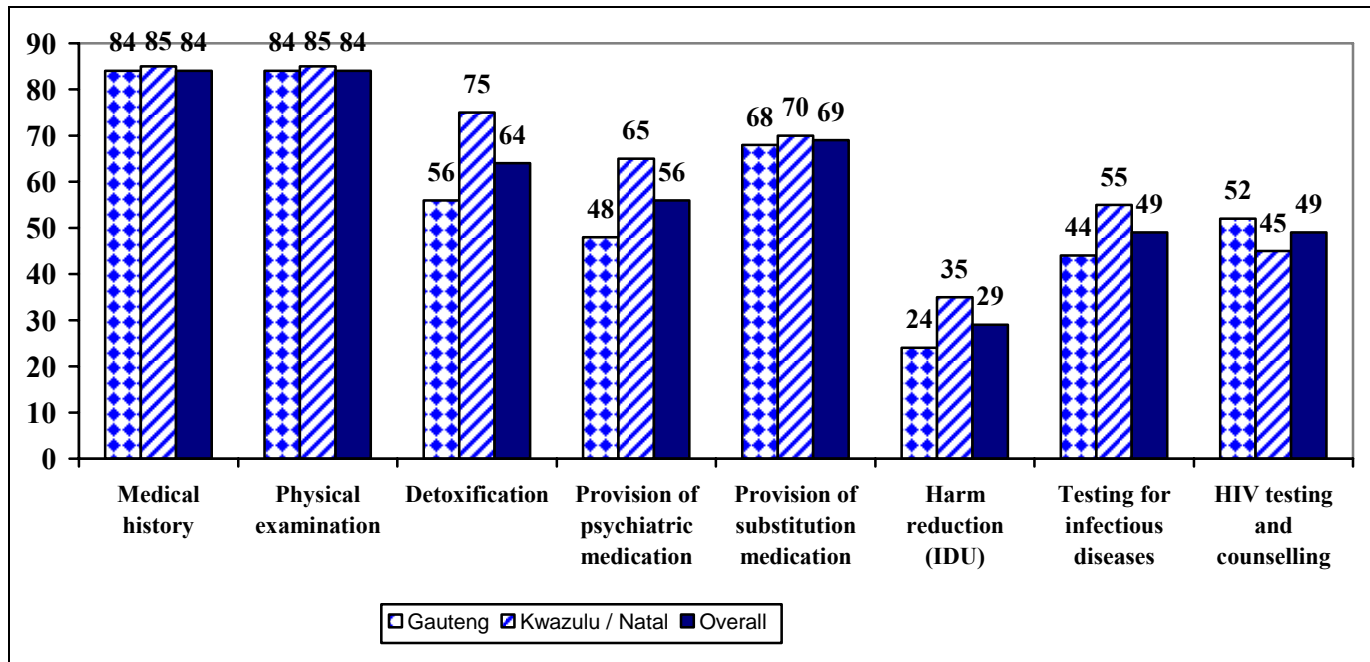
Types of family services	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Family assessment	4	80.0	8	72.7	2	100.0	10	76.9	2	50.0	2	100.0
Family education	5	100.0	9	81.8	1	50.0	12	92.3	3	75.0	1	50.0
Family therapy	5	100.0	9	81.8	2	100.0	13	100.0	4	100.0	2	100.0
Marital therapy	3	60.0	9	81.8	2	100.0	10	76.9	4	100.0	2	100.0

3.6.5. Provision of health and medical services

With regard to ancillary medical services, a large proportion of facilities conduct a full medical history of clients (84%) and physical examinations of clients (84%). A smaller proportion provide clients with psychiatric medication (56%); provide clients with substitution medications such as methadone, subutex and antabuse (69%); or offer detoxification services (64%)(Figure 19).

Regarding medical harm-reduction interventions, less than half of the facilities routinely test clients for hepatitis and other infectious diseases or provide HIV risk reduction interventions (such as testing and counselling). Less than a third of facilities conduct harm-reduction interventions among injection drug users (IDU). When we compared the extent to which these services were provided by province, we found no significant differences between facilities in Gauteng and facilities in KZN with regards to their provision of ancillary health services.

Figure 19. Proportion (%) of substance abuse treatment facilities providing health services



Provision of ancillary medical services by treatment intensity and facility ownership

We examined variations in the proportion of facilities providing ancillary medical services by treatment intensity. Compared to outpatient facilities, a significantly higher proportion of inpatient facilities conducted physical examinations (Chi-square = 7.88; $p = 0.007$), provided detoxification services (Chi-square = 15.86; $p < 0.000$), provided psychiatric medications (Chi-square = 26.17; $p < 0.000$), conducted interventions to reduce the risk of infectious disease (Chi-square = 7.46; $p = 0.009$), and conducted HIV risk reduction intervention (Chi-square = 8.94; $p = 0.005$). No significant differences emerged when we examined variations in the proportion of facilities providing ancillary medical services by ownership status.

We also examined variations in the proportion of facilities providing ancillary medical services by treatment intensity and facility ownership (Table 16). Compared to the other types of treatment facilities, a significantly greater proportion of private for-profit inpatient, private non-profit inpatient and state inpatient facilities reported providing detoxification services (Chi-square = 18.56; $p = 0.001$) and psychiatric medication (Chi-square = 20.96; $p = 0.002$). For medical intervention services, a significantly greater proportion of private for-profit and state inpatient facilities provided interventions to

reduce the risk of infectious disease (Chi-square = 39.99; $p < 0.000$) relative to other facilities.

Table 16. Proportion (%) of facilities providing medical services by treatment intensity and ownership

Types of ancillary health services provided	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Medical history	5	100.0	9	81.8	1	50.0	9	69.2	4	100.0	2	100.0
Physical examination	5	100.0	10	90.9	1	50.0	9	69.2	4	100.0	1	50.0
Detoxification services	4	80.0	8	72.7	0	0.0	4	30.8	4	100.0	1	50.0
psychiatric medication	5	100.0	8	72.7	1	50.0	1	7.7	3	75.0	0	0.0
substitution medication	4	80.0	9	81.8	1	50.0	8	61.5	1	25.0	1	50.0
Harm reduction (IDU)	3	60.0	4	36.4	0	0.0	0	0.0	2	50.0	1	50.0
Test for infectious diseases	4	80.0	6	54.5	0	0.0	1	7.7	4	100.0	1	50.0
HIV testing/counselling	4	80.0	6	54.5	1	50.0	2	15.4	3	75.0	0	0.0

Variations by speciality staffing resources

A significantly greater proportion of facilities that employ health professionals provide ancillary medical services compared to facilities without these staffing resources. Of the facilities employing doctors, 96.4% perform a full medical history and 100.0% conduct a physical examination compared to 68.8% and 62.5% of facilities without these staffing resources, respectively (for the former, Chi-square = 6.62; $p = 0.010$ and for the latter Chi-square = 12.16; $p < 0.000$). In addition, of the facilities employing doctors, 85.7% provide detoxification services whereas only 31.3% of facilities without doctors provide detoxification services (Chi-square = 13.44; $p < 0.000$).

A similar pattern is seen among facilities employing registered nurses. Of the facilities employing nurses, 96.8% perform a full medical history and conduct a physical examination compared to 61.5% of facilities without these staffing resources, respectively (for both variables, Chi-square = 9.66; $p = 0.002$). In addition, of the facilities employing nurses, 87.1% provide detoxification services whereas only 15.4% of facilities without nurses provide detoxification services (Chi-square = 20.96; $p < 0.000$).

Finally of the facilities with nurses, 64.5% provide HIV-related harm reduction interventions, in comparison with 15.4% of facilities without nurses (Chi-square = 8.84; $p = 0.003$).

3.7. ADDRESSING BARRIERS TO TREATMENT ENTRY FOR VULNERABLE GROUPS

This section describes the extent to which substance abuse treatment facilities target barriers to treatment entry for clients from historically underserved groups. These activities are grouped into (i) practices that improve awareness of substance abuse treatment options, (ii) practices that address logistical barriers such as finance or transport, and (iii) practices that address cultural and linguistic barriers to treatment entry.

Core findings:

- Outreach in disadvantaged areas is conducted by 71% of facilities
- Private for-profit facilities are the least likely to conduct any form of outreach
- In terms of logistic barriers, most treatment facilities do not provide child care or transport services
- In terms of affordability barriers, only 50% of facilities have free treatment slots available
- Private for-profit outpatient facilities are the least likely to offer reduced fees or free treatment slots to clients
- In terms of cultural and linguistic barriers, only 60% of facilities employ African language speaking counsellors
- Private for-profit facilities are the least likely to address cultural or linguistic barriers to treatment entry
- Few significant differences were found between facilities in KZNJ and facilities in Gauteng

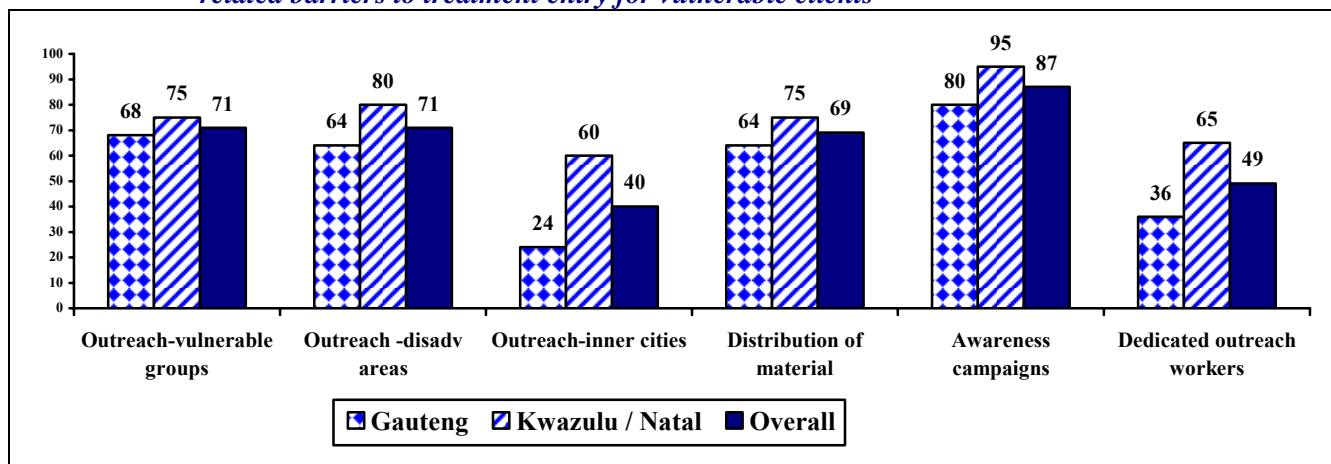
3.7.1. Practices that improve awareness of substance abuse treatment options

Overall, almost 90% of facilities report conducting awareness campaigns relating to substance abuse; however only 69% report distributing information and other materials relating to substance abuse treatment. Although just over 70% conduct substance abuse-related outreach among vulnerable groups and within disadvantaged areas, less than 50% had dedicated outreach workers to perform these activities, and the inner city areas were relatively neglected, with only 40% of facilities operating in these areas. No discernable differences were found between the provinces for these variables (Figure 20).

Independent samples t-tests revealed that the mean number of Black/African clients treated is significantly greater at facilities with dedicated outreach workers, compared to

facilities without these workers ($t= 3.98$; $p < 0.000$). Similarly the mean number of Black/African clients treated is significantly greater at facilities conducting outreach in disadvantaged areas, compared to facilities without these services ($t= 4.10$; $p < 0.000$).

Figure 20. *Proportion (%) of substance abuse treatment facilities that target awareness-related barriers to treatment entry for vulnerable clients*



Targeting awareness-related barriers by treatment intensity and facility ownership

We examined variations in the proportion of facilities addressing awareness-related barriers by ownership status. Compared to for-profit facilities, a significantly higher proportion of private non-profit and state non-profit facilities conduct awareness campaigns (Chi-square = 13.23; $p = 0.039$), conduct outreach in disadvantaged areas (Chi-square = 24.91; $p < 0.000$), employ dedicated outreach workers (Chi-square = 6.48; $p = 0.011$), and conduct outreach among vulnerable groups (Chi-square = 18.88; $p = 0.004$). No significant differences emerged when we examined variations in the proportion of facilities providing outreach services by intensity of care.

We also examined variations in the proportion of facilities targeting awareness-related barriers to treatment entry by treatment intensity and facility ownership (Table 17). Compared to the other types of treatment facilities, a significantly smaller proportion of private for-profit outpatient, followed by private for-profit inpatient facilities conducted outreach among vulnerable groups (Chi-square = 21.38; $p = 0.045$). In contrast all state and private non-profit outpatient facilities performed this activity (Table 17). Similarly, compared to the other types of treatment facilities, a significantly smaller proportion of private for-profit outpatient, followed by private for-profit inpatient facilities conducted

outreach within disadvantaged areas (Chi-square = 22.92; $p = 0.028$). In contrast all state inpatient and outpatient, and all private non-profit outpatient facilities performed this activity (Table 17). In summary, private for-profit outpatient facilities are the least likely to participate in any form of outreach activity, followed by private for-profit inpatient facilities. State outpatient and private non-profit outpatient treatment facilities are most likely to have dedicated outreach workers.

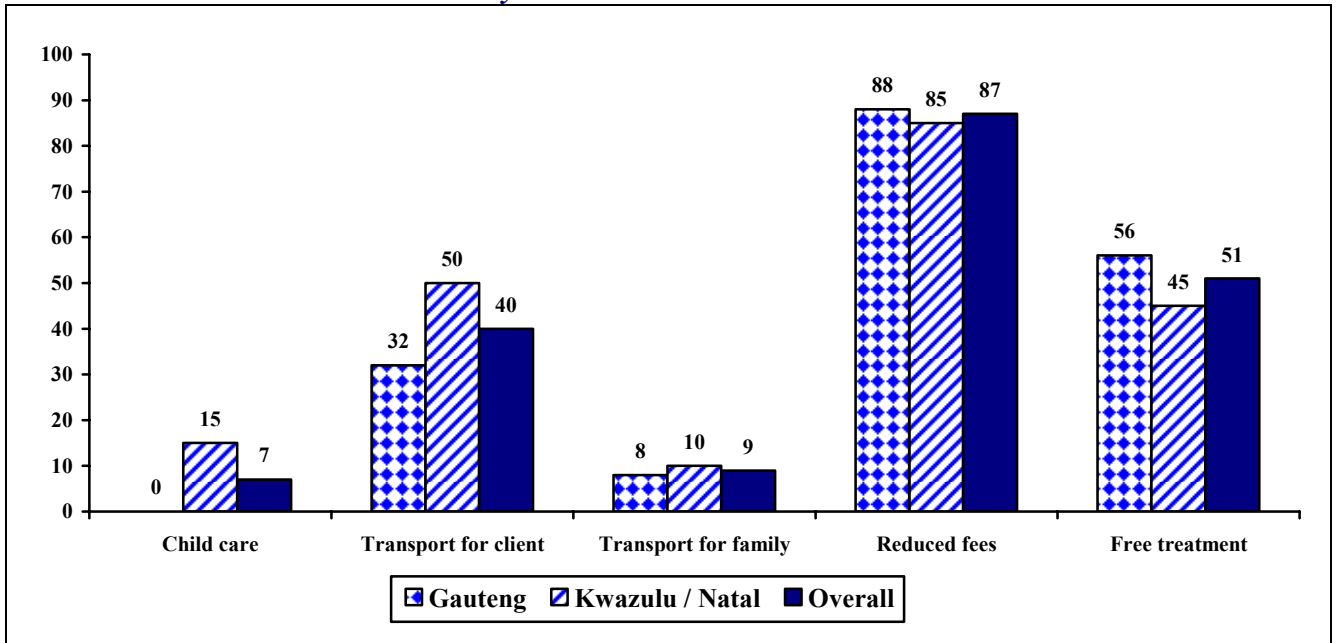
Table 17. *Proportion (%) of facilities that address lack of awareness of treatment options by treatment intensity and ownership*

Awareness raising activities	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Outreach: vulnerable groups	2	40.0	7	63.6	0	0.0	13	100.0	4	100.0	2	100.0
Outreach in disadv areas	1	20.0	8	72.7	0	0.0	13	100.0	4	100.0	2	100.0
Outreach in inner cities	1	20.0	5	45.5	0	0.0	9	69.2	1	25.0	0	0.0
Distribution of materials	2	40.0	8	72.7	1	50.0	12	92.3	2	50.0	2	100.0
Awareness campaigns	4	80.0	10	90.9	1	50.0	13	100.0	4	100.0	2	100.0
Dedicated outreach workers	1	20.0	4	36.4	0	0.0	10	76.9	2	50.0	2	100.0

3.7.2. Practices that address logistical and affordability barriers to treatment entry

In terms of costs barriers, while almost 90% of facilities offered reduced fees to indigent clients, only 50% of facilities had free treatment beds/slots available (Figure 21). For the overall sample, the average number of free treatment slots available per year is 114 (SD = 236.8), whereas on average 38 (SD = 39.6) and 229 (SD = 353.4) free treatment slots are available per year in Gauteng and KZN, respectively. Independent samples t-tests revealed that the mean number of Black/African clients treated is significantly greater at facilities with free treatment slots, compared to facilities without these slots ($t = 2.18$; $p = .035$).

Figure 21. Proportion (%) of substance abuse treatment facilities that target logistic barriers to treatment entry



In terms of transport barriers, only 40% provided the client with transport to the facility, and less than 10% provided transport to the client’s family so that they could participate in the treatment programme. Finally, in terms of child care barriers, less than 10% provided child care services to the client to enable them to participate in the programme. Facilities in KZN were significantly more likely to provide child care to clients than facilities in Gauteng (Chi-square = 3.82; $p = 0.050$). This was the only discernable difference between the provinces for these variables (Figure 21).

Practices that target logistic barriers by treatment intensity and facility ownership

We examined variations in the proportion of facilities addressing logistic and affordability barriers by intensity of care. Compared to outpatient facilities, a significantly higher proportion of inpatient facilities provide transport to clients (Chi-square = 10.85; $p = 0.001$), provide transport to clients’ families (Chi-square = 4.38; $p = 0.036$), and provide free treatment slots (Chi-square = 10.47; $p = 0.001$). No significant differences emerged when we examined variations in the proportion of facilities providing these services by ownership status. We also examined variations in the proportion of facilities targeting logistic barriers to treatment entry (costs, competing needs, transport) by treatment intensity and facility ownership (Table 18).

Table 18. Proportion (%) of facilities addressing logistical barriers to treatment entry by treatment intensity and facility ownership

Activities that address logistical barriers	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Child care	0	0.0	0	0.0	0	0.0	2	15.4	0	0.0	0	0.0
Transport for client	3	60.0	8	72.7	1	50.0	1	7.7	2	50.0	0	0.0
Transport for family	0	0.0	2	18.2	0	0.0	0	0.0	1	25.0	0	0.0
Reduced fees	5	100.0	9	81.8	0	0.0	12	92.3	4	100.0	2	100.0
Free treatment	3	60.0	9	81.8	0	0.0	1 ^a	8.3	4	100.0	1	50.0

Note. ^aMissing information N = 1.

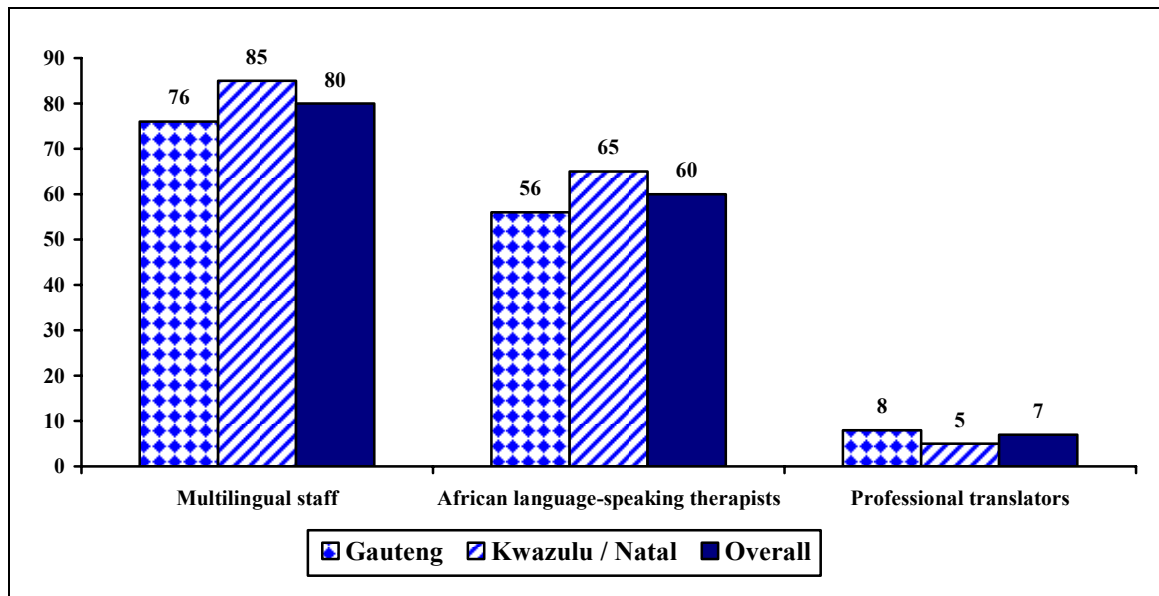
A significantly higher proportion of private non-profit inpatient facilities provide transport for clients while less than 10.0% of private non-profit outpatient and state outpatient facilities provide transport for clients (Chi-square = 14.25; $p = 0.027$) (Table 18). Only a small proportion of state inpatient and private non-profit inpatient facilities provide transport services to the client's family (Table 18). Private for-profit outpatient facilities are significantly less likely to offer reduced fees to clients compared to other facilities, with none of these facilities reducing the cost of treatment (Chi-square = 15.75; $p = 0.015$). Similarly, private for-profit outpatient facilities are significantly less likely to offer free treatment slots to indigent clients, with a significantly greater proportion of state inpatient and private non-profit inpatient facilities offering this service (Chi-square = 22.68; $p = 0.031$). Only a small proportion of private non-profit outpatient facilities (15.4%) make provision for child care services, with none of the other facilities providing this service (Table 18).

3.7.3. Practices that address cultural and linguistic barriers to treatment entry

In terms of cultural and linguistic barriers, while almost 80% of facilities reported employing multi-lingual staff, only 60 % of facilities employed African language-speaking counsellors (Figure 22). A much smaller proportion of facilities (7%) employed professional translators. No significant differences were found between the provinces for these variables (Figure 22). Independent samples t-tests revealed that the mean number

of Black/African clients treated is significantly greater at facilities with African language-speaking counsellors than at facilities without these counsellors ($t= 4.33; p < 0.000$).

Figure 22. *Proportion (%) of substance abuse treatment facilities that target cultural and linguistic barriers to treatment entry*



Practices that target cultural and linguistic barriers by treatment intensity and facility ownership

We examined variations in the proportion of facilities addressing cultural and linguistic barriers by ownership status. Compared to for-profit facilities, a significantly higher proportion of private non-profit and state non-profit facilities employ African language-speaking counsellors (Chi-square = 13.08; $p = 0.049$). No significant differences emerged when we examined variations in the proportion of facilities providing these services by intensity of care.

When the proportion of facilities targeting cultural and linguistic barriers to treatment entry was considered by treatment intensity and facility ownership, we found that the proportion of private for-profit outpatient and for-profit inpatient facilities employing African-language speaking counsellors was significantly lower than the other facilities (Chi-square = 15.21; $p = 0.019$). All of the state inpatient facilities and 85% of the private non-profit outpatient facilities employed African-language speaking counsellors (Table 19). Similarly, none of the private for-profit outpatient facilities employed multilingual

staff. Only a small proportion of private for-profit inpatient facilities (40.0%) employ professional translators (Table 19).

Table 19. *Proportion (%) of facilities addressing cultural and linguistic barriers to treatment entry by treatment intensity and facility ownership*

Activities that address cultural and linguistic barriers	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Multilingual staff	5	100.0	9	81.8	0	0.0	10	76.9	4	100.0	1	50.0
African language-speaking therapists	2	40.0	7	63.6	0	0.0	11	84.6	4	100.0	1	50.0
Professional translators	2	40.0	0	0	0	0.0	0	0.0	0	0.0	0	0.0

3.8 ADDRESSING BARRIERS TO ENGAGEMENT AND RETENTION IN TREATMENT FOR VULNERABLE GROUPS

This section describes the extent to which treatment facilities target barriers to engagement and retention in treatment for clients from historically under-served groups; particularly Black South Africans, women and young people. Retention activities are grouped into activities relating to (i) the cultural-sensitivity and appropriateness of treatment, (ii) the gender-sensitivity and appropriateness of treatment, and (iii) the age-sensitivity and appropriateness of treatment.

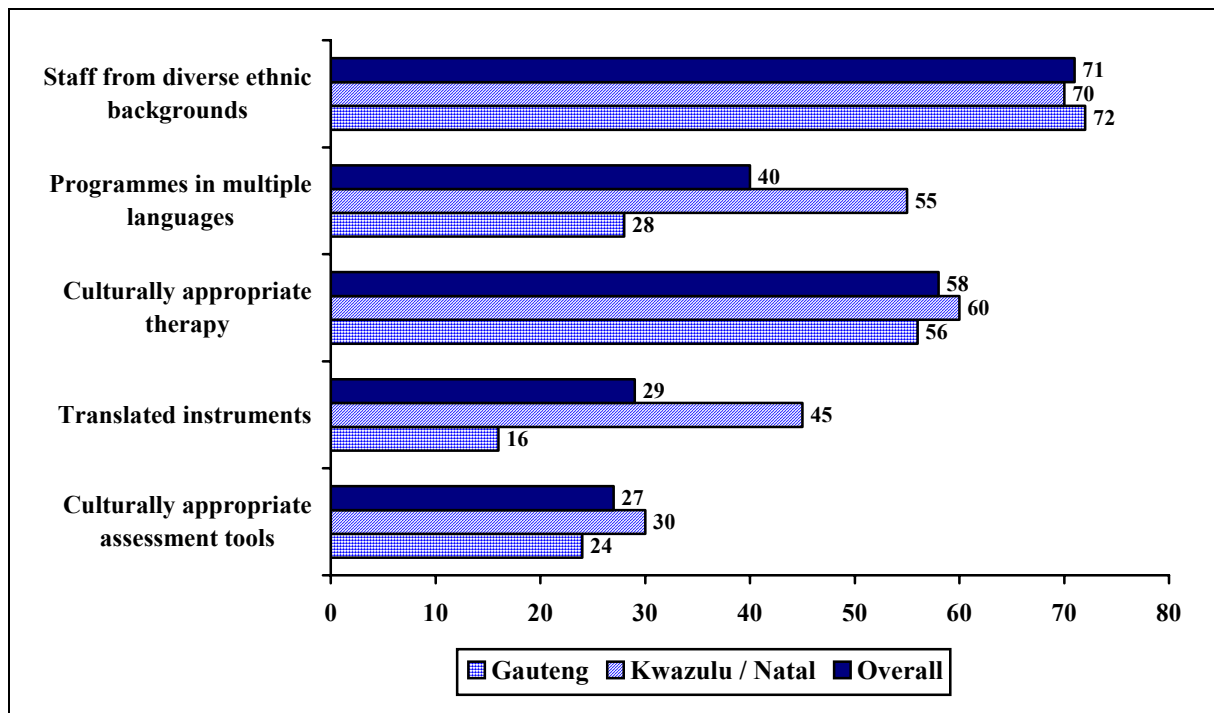
Core findings:

- Although 70% of facilities have staff from diverse ethnic backgrounds, only 40% offer treatment services in multiple languages
- State inpatient and private non profit outpatient facilities are the most likely to offer culturally appropriate services
- Facilities in KZN are more likely to use culturally appropriate assessment tools than facilities in Gauteng
- Facilities in KZN are more likely to provide gender-specific treatment services than facilities in Gauteng
- Only 50% of facilities train staff in gender-related treatment issues
- Only 60% of facilities employ staff trained to work with young people
- About half the facilities provide age appropriate treatment services

3.8.1. Cultural and linguistic sensitivity and appropriateness of treatment

Just over 70% of facilities report employing staff from diverse ethnic backgrounds (Figure 23). Despite this, only 40% provide treatment programmes in multiple languages, only 58% provide counselling that is culturally-appropriate, and only 29% report using culturally appropriate assessment tools (Figure 23). Less than a third of facilities have assessment instruments and programme materials translated into multiple languages, with a significantly greater proportion of facilities in KZN reporting the use of translated materials than facilities in Gauteng (Chi-square = 4.06; $p = 0.044$).

Figure 23. Proportion (%) of substance abuse treatment facilities offering culturally and linguistically appropriate services



Independent samples t-tests revealed that the mean number of Black/African clients treated is significantly greater at facilities with staff from diverse ethnic backgrounds than at facilities without these workers ($t = 2.86$; $p = 0.006$). Similarly, the mean number of Black/African clients treated is significantly greater at facilities providing culturally appropriate counselling than at facilities where this does not occur ($t = 4.30$; $p < 0.000$). The mean number of Black/African clients treated is also significantly greater at facilities offering treatment services in multiple languages than at facilities without this service ($t = 2.32$; $p = 0.025$).

Provision of culturally and linguistically appropriate services by treatment intensity and facility ownership

We examined variations in the proportion of facilities providing cultural and linguistically appropriate services by ownership status. Compared to for-profit facilities, a significantly higher proportion of private non-profit and state non-profit facilities provide multilingual treatment services (Chi-square = 7.81; $p = 0.005$), culturally appropriate counselling (Chi-square = 4.82; $p = 0.028$) and employ staff from diverse ethnic backgrounds (Chi-square = 6.35; $p = 0.012$). No significant differences emerged when we examined variations in the proportion of facilities providing these services by intensity of care. We also examined variations in the proportion of facilities conducting activities to improve the cultural and linguistic appropriateness of services by treatment intensity and facility ownership (Table 20).

Table 20. *Proportion (%) of facilities that address cultural and linguistic appropriateness of services by treatment intensity and ownership*

Activities to improve cultural and linguistic appropriateness of treatment	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Culturally appropriate assessment tools	0	0.0	4	36.4	0	0.0	5	38.5	1	25.0	0	0.0
Translated materials	0	0.0	2	18.2	0	0.0	7	53.8	1	25.0	0	0.0
Culturally appropriate therapy	2	40.0	4	36.4	0	0.0	13	100.0	3	75.0	1	50.0
Programmes: multiple languages	0	0.0	4	36.4	0	0.0	7	53.8	2	50.0	2	100.0
Staff: diverse ethnic backgrounds	3	60.0	8	72.7	0	0.0	12	92.3	4	100.0	1	50.0

None of the private for-profit outpatient facilities reported attempting to improve the cultural sensitivity and appropriateness of their programmes (Table 20). A significantly higher proportion of state inpatient and private non-profit outpatient facilities employ staff from diverse ethnic backgrounds, compared to the other types of facilities (Chi-square = 13.36; $p = 0.048$). Similarly, compared to the other types of facilities, a significantly greater proportion of state inpatient and private non-profit outpatient facilities reported using culturally appropriate and sensitive counselling techniques (Chi-

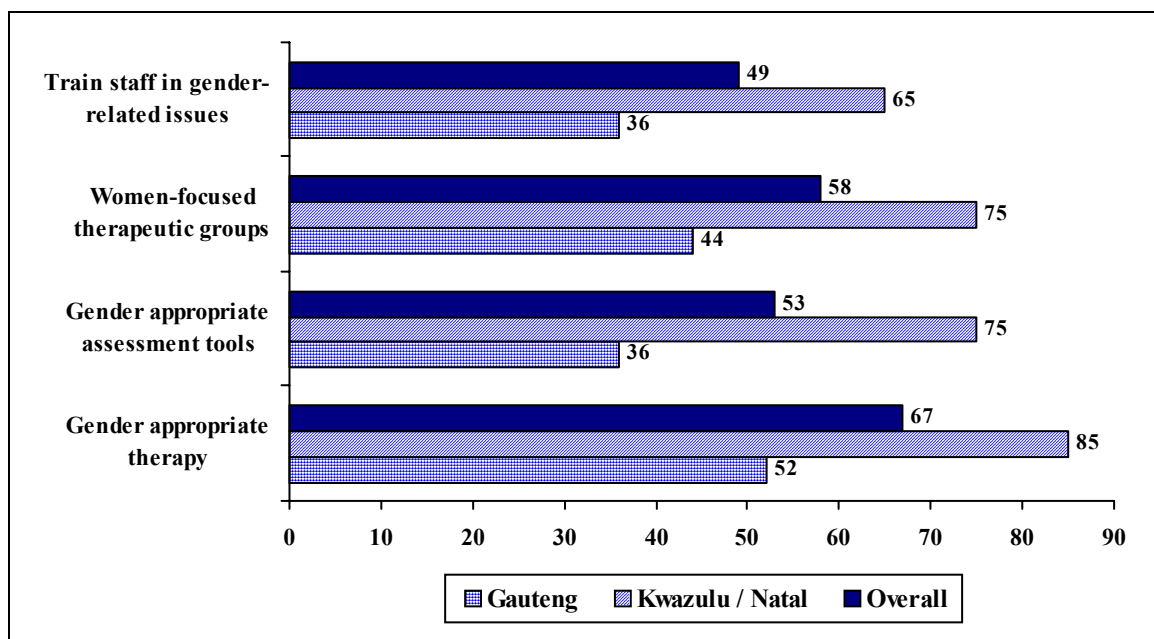
square = 21.98; $p = 0.038$). Overall, state inpatient and non-profit outpatient facilities were the most likely to provide culturally sensitive treatment services.

3.8.2. Gender sensitivity and appropriateness of treatment

Two-thirds of facilities provide gender-appropriate and sensitive counselling services (Figure 24), with 58% of facilities providing gender-specific services, such as women-only treatment groups. A significantly greater proportion of facilities in KZN providing gender-specific services than facilities in Gauteng (Chi-square = 3.95; $p = 0.047$).

In addition, 53% of facilities use gender appropriate assessment tools, with a significantly greater proportion of facilities in KZN reporting the use of these tools than facilities in Gauteng (Chi-square = 6.65; $p = 0.036$). Despite this, only half of the facilities provide staff with special training in gender-related issues that may be pertinent to treatment (such as domestic violence).

Figure 24. *Proportion (%) of substance abuse treatment facilities offering gender appropriate services*



Provision of gender appropriate services by treatment intensity and facility ownership

We examined variations in the proportion of facilities conducting activities to improve the gender appropriateness of services by treatment intensity and facility ownership (Table 21).

Table 21. Proportion (%) of facilities that address the gender appropriateness of services by treatment intensity and ownership

Activities to improve gender appropriateness of treatment	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Gender appropriate assessment	2	40.0	5	45.5	0	0.0	8	61.5	2	50.0	1	50.0
Gender appropriate therapy	4	80.0	6	54.5	1	50.0	8	61.5	3	75.0	1	50.0
Women-specific counselling	5	100.0	5	45.5	0	0.0	7	53.8	3	75.0	2	100.0
Training: gender-related issues	4	80.0	4	36.4	0	0.0	8	61.5	2	50.0	0	0.0

Compared to other types of facilities, a higher proportion of private non-profit outpatient facilities use gender appropriate assessment tools (Table 21). In contrast, relative to other sites, a higher proportion of private for-profit inpatient and state inpatient facilities use gender appropriate counselling techniques. A higher proportion of private for-profit inpatient and state outpatient treatment facilities and offer gender-specific services (e.g. women-focused therapeutic groups) relative to other facilities. None of these differences were however statistically significant. Overall, for-profit inpatient facilities appear the most likely to provide gender appropriate services.

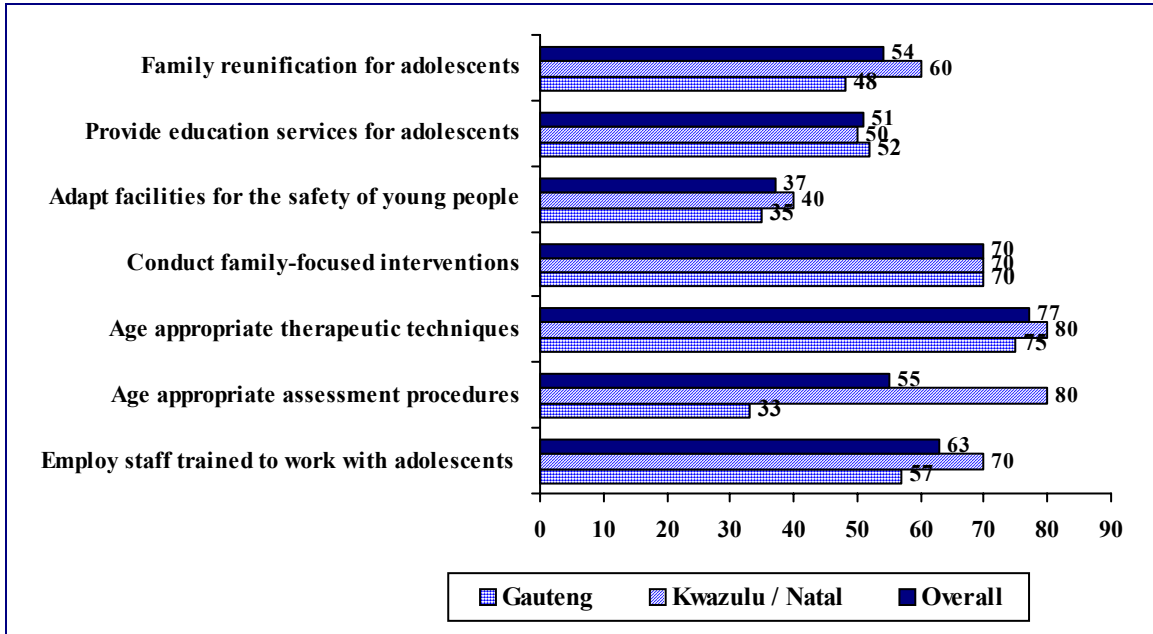
3.8.3. Age appropriateness of treatment services

Just over half the facilities report using age appropriate assessment tools and more than three quarters of the facilities report providing counselling services that are age and developmentally appropriate (Figure 25). In addition, 70% of facilities provide family-focused intervention services. Despite this, only 60% of facilities employ staff trained to work with adolescents and young people. A smaller proportion of facilities provide family reunification services (54%), education services for young people (51%), and adapt the facility environment to ensure the safety of young people (37%) (Figure 25).

Independent samples t-tests revealed that the mean number of clients under 20 years of age is significantly greater at facilities providing family-focused interventions than at facilities without these services ($t= 2.19$; $p = 0.034$) Similarly, the mean number of clients under 20 years of age is significantly greater at facilities that have adapted their facilities

to make them suitable for young people than at facilities where this has not occurred ($t=2.11$; $p = 0.042$).

Figure 25. *Proportion (%) of substance abuse treatment facilities offering age appropriate services*



Although a greater proportion of treatment facilities in KZN report the provision of age and adolescent appropriate services, these differences were only significant for the use of age appropriate assessment tools. For this variable, a significantly greater proportion of facilities in KZN reported the use of these tools compared with facilities in Gauteng (Chi-square = 3.95; $p = 0.047$).

Provision of age appropriate services by treatment intensity and facility ownership

We also examined variations in the proportion of facilities conducting activities to improve the age appropriateness of services by treatment intensity and facility ownership (Table 22).

A higher proportion of state outpatient and private non-profit inpatient facilities employ staff trained to work with adolescents and children than other types of facilities. In addition, a higher proportion of state (both inpatient and outpatient) facilities use age-appropriate therapeutic techniques. A higher proportion of private for-profit outpatient, state outpatient and private non-profit outpatient facilities conduct family-focused

interventions than inpatient facilities. However, none of these differences were statistically significant.

Table 22. Proportion (%) of facilities that address age appropriateness of services by treatment intensity and ownership

Activities provided to improve age appropriateness of treatment	for-profit inpatient (N = 5)		non-profit inpatient (N = 11)		for-profit outpatient (N = 2)		non-profit outpatient (N = 13)		State inpatient (N = 4)		State outpatient (N = 2)	
	N	%	N	%	N	%	N	%	N	%	N	%
Age appropriate assessment	2	40.0	8	72.7	2	100.0	5	38.5	2	50.0	1	50.0
Age appropriate counselling	4	80.0	7	63.6	0	0.0	9	69.2	4	100.0	2	100.0
Family-focused interventions	3	60.0	6 ^a	60.0	2	100.0	11	84.6	3	75.0	2	100.0
Staff trained to work with adolescents	3	60.0	8 ^b	80.0	1	50.0	8	61.5	2	50.0	2	100.0
Adapt facilities for the safety of young people	0	0.0	4 ^c	40.0	1	50.0	7	53.8	1	25.0	1	50.0
Education services	2	40.0	6 ^d	60.0	2	100.0	8	61.5	1	25.0	1	50.0
Family reunification services	1	20.0	8 ^e	80.0	1	50.0	6	46.2	2	50.0	2	100.0

Note. ^{a, b, c, d, e}Missing information N = 1.

3.9. MONITORING AND EVALUATION ACTIVITIES FOR SUBSTANCE ABUSE TREATMENT FACILITIES

This section describes the extent to which substance abuse treatment facilities in Gauteng and KZN conduct monitoring and evaluation (M & E) activities. More specifically, variations in monitoring and evaluation by treatment intensity and facility ownership are explored.

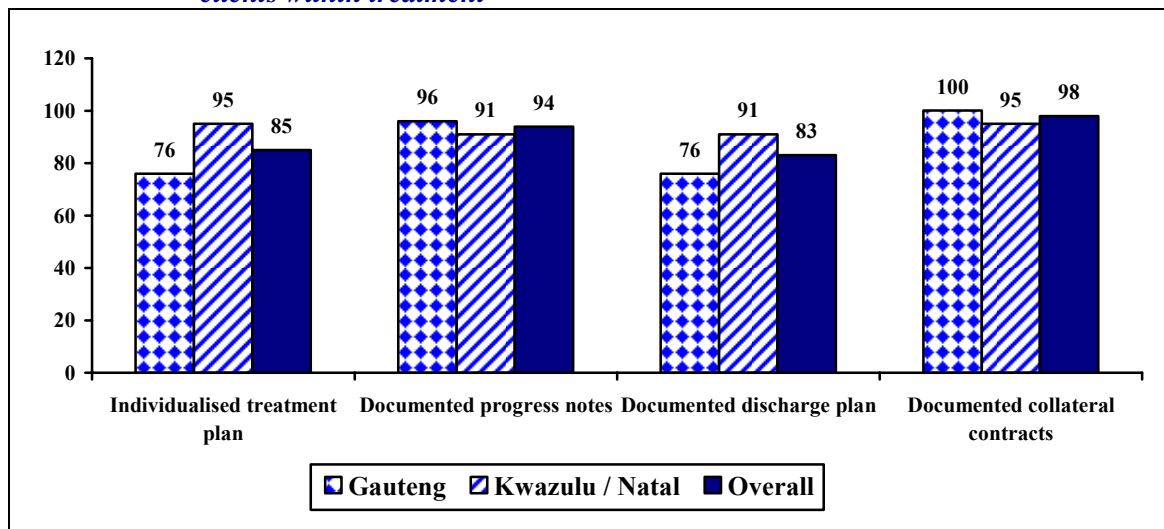
Core findings:

- Most facilities have structures that allow for the within-treatment monitoring of clients
- Only half of the facilities report post-discharge monitoring of clients.
- Facilities in KZN were significantly more likely to conduct post-discharge monitoring than facilities in Gauteng
- Less than a third of facilities had conducted an outcome evaluation and only 37% had conducted a process evaluation of their treatment programme
- State and private non-profit facilities were the least likely to have conducted any form of programme evaluation

3.9.1. Monitoring of clients' progress during the course of treatment

Administrative and procedural structures and activities that facilitate the monitoring of client progress during the course of treatment were explored. These structures and activities are important as they help facilitate the monitoring of client outcomes post-treatment. Overall, most facilities report developing individualised treatment plans for each client (85%), keeping documented notes of clients' progress during treatment (94%), and obtaining collateral information from clients' family members (98%). A slightly smaller percentage of facilities have formal discharge plans for each client (83%) (Figure 26). We found no significant differences between facilities in KZN and facilities in Gauteng on any of these variables.

Figure 26. *Proportion (%) of substance abuse treatment facilities reporting monitoring of clients within treatment*



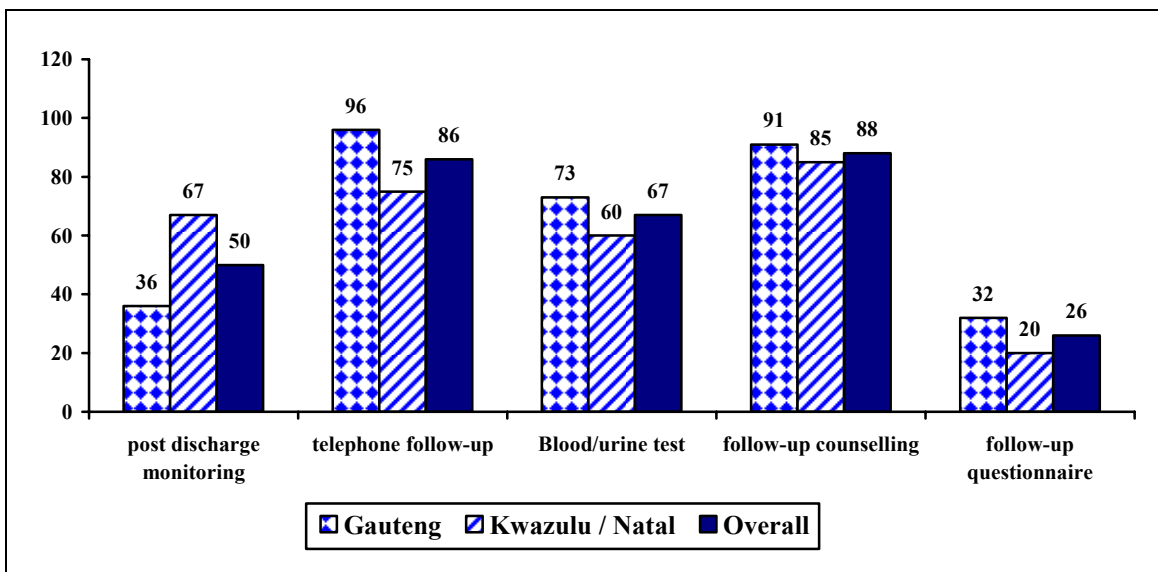
3.9.2. Monitoring of clients' progress post-treatment

We also examined the extent to which facilities monitored client progress post-treatment. When facilities were asked about post-discharge monitoring of clients, only 50% of facilities reported routinely tracking client progress once they had completed treatment (Figure 27). A significantly greater proportion of facilities in KZN reported post-discharge monitoring compared to facilities in Gauteng (Chi-square = 4.29; $p = 0.038$).

However, when asked about specific post-treatment monitoring activities, a relatively large proportion of facilities reported monitoring clients' progress telephonically (86%) and monitoring clients' progress during aftercare counselling sessions (88%). In addition

66.7% of facilities reported the use of blood tests and or urinalysis to monitor clients' substance use (Figure 27). The apparent discrepancy between these findings and the low proportion of facilities reporting post-discharge monitoring may lie in the fact that telephonic monitoring and monitoring during aftercare counselling are relatively informal and unstructured ways of tracking clients' progress; whereas post-discharge monitoring refers to a more formalised system of monitoring where self-report questionnaires and/or blood and urine tests are used to establish the extent to which clients have achieved and maintained treatment goals. This explanation seems to be supported by the finding that only 26% of facilities use structured follow-up questionnaires to track clients' progress post-treatment.

Figure 27. *Proportion (%) of substance abuse treatment facilities reporting monitoring of clients post-treatment*

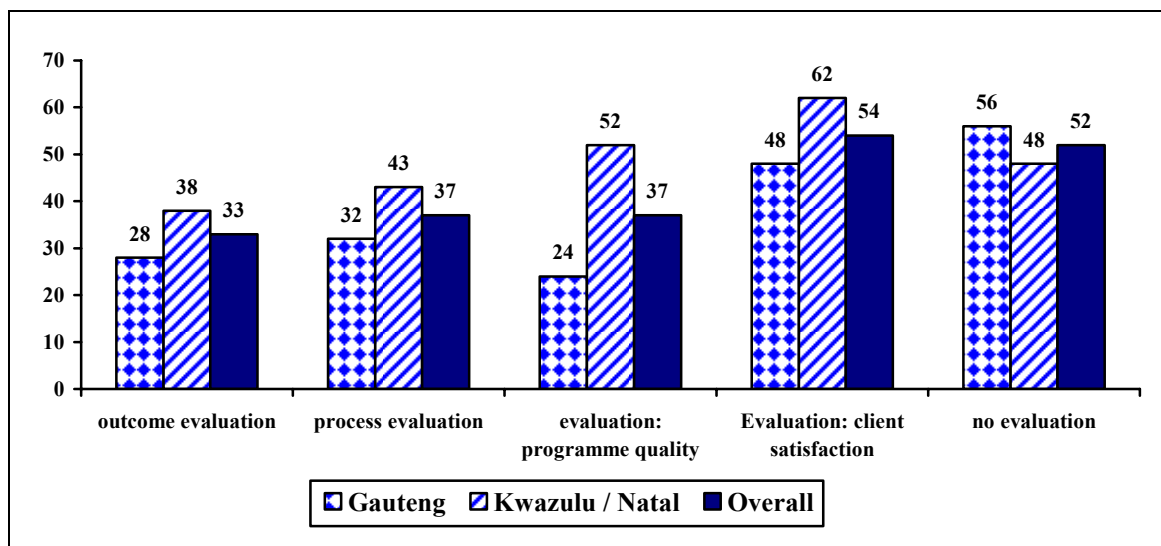


In addition, further questioning revealed that most blood and urine screening is conducted within the course of treatment rather than post-treatment. Most post-treatment blood and urine screening appears to be conducted on an ad hoc basis, either due to a request by family members or as a partial requirement for a court or work-related referral. Facilities do not conduct routine blood and urine screens for the purpose of monitoring client progress and treatment outcomes.

3.9.3. Formal treatment programme evaluation

The proportion of substance abuse treatment facilities that had conducted formal evaluations of their treatment programmes and the types of evaluations conducted was also examined (Figure 28). Overall, more than half of the facilities surveyed had not conducted any form of treatment programme evaluation. More specifically, less than a third of facilities reported having conducted a treatment outcomes evaluation of their programme. Similarly, only 37% of facilities had conducted a process evaluation of their treatment programme/s. Only 37% of facilities had evaluated the quality of their treatment programmes; with a significantly larger proportion of facilities in KZN relative to facilities in Gauteng having conducted such an evaluation (Chi-square = 3.95; $p = 0.047$). A slightly larger proportion of facilities had examined client satisfaction with treatment services provided (54%) (Figure 28).

Figure 28. *Proportion (%) of substance abuse treatment facilities conducting formal evaluations of their treatment programmes*



It should be noted that all of the state outpatient, 76.9% of the private non-profit outpatient, 70% of the private non-profit inpatient, 50% of the state inpatient facilities, 14.3% of the private for-profit inpatient facilities, and 0% of the private for-profit outpatient facilities reported never having conducted any form of programme evaluation. These differences between the facilities were significant (Chi-square = 14.09; $p = 0.029$).

PART 4: DISCUSSION OF KEY FINDINGS

While substance abuse treatment facilities in Gauteng and KZN offer a range of services to clients, this audit shows that access to services varies extensively among facilities. This variation is associated with several organisational factors including facility ownership, intensity of services provided, and resources. The following sections describe the availability of substance abuse treatment, the range of services provided, and the extent to which barriers to entering, engaging and being retained in treatment for clients from historically underserved groups are addressed by treatment facilities. Variations in these components of access are discussed in the light of facility characteristics, including staffing resources and the organisational environment; as well as in the light of minimum norms and standards for treatment facilities. Finally, recommendations are made for improving the accessibility and quality of treatment services.

4.1. AVAILABILITY OF SUBSTANCE ABUSE TREATMENT SERVICES

This study examined the availability of substance abuse treatment services (in terms of treatment capacity), the extent to which available treatment slots are utilised (in terms of treatment occupancy rates), the demand for treatment services (in terms of waiting lists), and the extent to which available treatment slots are effectively used (in terms of client retention rates). Availability of services is an important variable to examine as low availability may act as a barrier to accessing services; even when there are high levels of perceived need (Appel et al., 2004).

4.1.1. Availability of treatment services

The availability of substance abuse treatment services appears to be greater in KZN than Gauteng, with findings suggesting that facilities in KZN have significantly more treatment slots available and treat significantly greater numbers of clients than facilities in Gauteng. The intensity of care provided by facilities is also associated with treatment capacity and the number of clients served, with outpatient facilities having significantly greater treatment capacity and serving significantly greater numbers of clients than inpatient services. However, this does not account for the inter-provincial difference in the availability of services, as the proportion of outpatient facilities does not differ significantly between the provinces. Although we examined whether staffing resources

may have impacted on treatment capacity, the number of treatment staff employed and staff case loads does not differ between treatment facilities in KZN and Gauteng. Nonetheless, a significantly greater proportion of facilities in KZN report recent increases in the size of their treatment team. This may help account for the observed difference in treatment capacity.

4.1.2. Utilisation of and demand for available treatment slots

We also examined the extent to which available treatment slots are utilized. For the overall sample, approximately three-quarters of the available treatment slots are occupied on an annual basis. This treatment occupancy rate does not differ significantly between the provinces. Although this occupancy rate is relatively high, it is still cause for concern given the high demand for substance abuse treatment services in both provinces. This demand for treatment services is reflected in the finding that almost 6 in 10 facilities have waiting lists, with an average of 6 clients waiting for an available treatment slot. It should be noted that facilities in KZN are significantly more likely to have waiting lists than facilities in Gauteng.

Findings suggest that state inpatient facilities have the lowest treatment occupancy rates, with these facilities operating on average at 65% of their capacity. This does not reflect limited demand for state inpatient services as findings show that 1 in 2 state inpatient facilities have waiting lists, with an average of 24 persons waiting for an available treatment slot. Given the findings that state inpatient facilities are significantly more likely to provide indigent clients with free treatment services and reduced fees, this potentially impacts on the availability of affordable substance abuse treatment services for vulnerable persons.

The length of these waiting lists is also cause for concern as long waiting lists have been identified as a barrier to substance abuse treatment (Grant, 1997; Hser et al., 1998; Tucker et al., 2004), particularly for low-income and uninsured substance abusers who rely on state and private no-profit services (Friedmann et al., 2003). Timely access is important for facilitating treatment entry as many substance abusers are ambivalent about seeking treatment and may have little tolerance for waiting for the next available treatment slot (Kaplan & Johri, 2000).

4.1.3. Effective use of available treatment slots

In this study, the effective use of available treatment slots is indicated by the degree to which clients are retained in treatment. Client retention rates differ broadly across facilities, with some facilities reporting retention rates as low as 15%. On average, facilities retain about 75% of their clients in treatment. Rates of client retention do not differ significantly between the provinces. However, rates of client retention do differ by the intensity of services provided, with outpatient services reporting significantly lower rates of client retention than inpatient facilities. This is not surprising, given that inpatient facilities have a captive client population and do not have to ensure that clients keep returning to the facility after each counselling session. However, given that client retention in treatment is a key indicator of treatment outcomes (McKay & Weiss, 2001), this finding raises serious questions about the extent to which outpatient services are effective. As findings show that outpatient facilities treat significantly larger numbers of clients than inpatient facilities, this is cause for concern and needs to be addressed as a matter of urgency.

4.2. RANGE AND DIVERSITY OF SERVICES PROVIDED

Despite growing evidence of an association between the availability of ancillary treatment services (e.g. psychological and medical care) and treatment outcomes, and evidence-based practice guidelines that emphasise the need to integrate ancillary medical and mental health services with core addiction services (Durkin, 2002; Lee et al., 2001), findings suggest that substance abuse treatment facilities in South Africa generally fail to meet this standard. In both Gauteng and KZN, clients are provided with ancillary medical and mental health-oriented services much less frequently than core addiction services. This is similar to findings from previous audits of specialist substance abuse treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004).

4.2.1. Provision of ancillary mental health services

In both provinces, substance abuse treatment facilities focus primarily on treating the core substance abuse problem and rarely provide ancillary psychiatric services that target psychiatric disorders and other mental health problems that are associated with, an outcome of, and or contributed to the development of the substance use disorder. More specifically, less than a quarter of facilities provide ancillary psychiatric services.

In addition, less than 60% of facilities assess clients for psychiatric disorders. Facilities in Gauteng are significantly less likely to assess their clients for psychiatric disorders than facilities in KZN, with only 40% of facilities in Gauteng routinely assessing whether clients have co-occurring psychiatric disorders. While this is similar to findings from a previous audit of treatment facilities in Gauteng (Myers, 2004), it remains a cause for concern; especially as international research points to the high prevalence of co-occurring psychiatric disorders among individuals with substance use disorders, which if left undetected negatively impact on treatment outcomes (Teesson, Havard, Fairbairn, Ross, Lynskey, & Darke, 2005).

Findings from previous research also suggest that individuals with co-occurring disorders have more complex treatment needs than persons with substance use disorders only (Durkin, 2002; Teesson et al, 2005). These findings suggest that in order to increase the chance of positive treatment outcomes for individuals with co-occurring disorders, psychiatric disorders need to be detected and managed during the course of treatment (Teesson et al., 2005). Despite this, findings from this study show that a significantly smaller proportion of facilities offer counselling focused on mental health problems, relative to counselling focused on substance abuse and/or family issues. In addition, just over half the facilities provide clients with psychiatric medication to manage their co-occurring mood and/or anxiety disorders.

Variations in the provision of mental health services by organisational factors

Findings show that facility ownership and treatment intensity are strongly associated with the provision of ancillary mental health services. These services seem to be more accessible at inpatient facilities compared to outpatient treatment facilities, with a significantly greater proportion of inpatient facilities conducting psychiatric assessments and providing both psychiatric medication and mental health counselling services to clients than outpatient facilities.

To some extent, ownership status appears to interact with the intensity of care provided to influence the provision of ancillary mental health services, with a significantly greater proportion of private for-profit inpatient facilities conducting psychiatric assessments

than state or private non-profit inpatient facilities. In addition, compared to other types of facilities, private non-profit and state outpatient treatment facilities are the least likely to conduct psychiatric assessments and psychological evaluations and are the least likely to provide mental health counselling and psychiatric medication to clients. In keeping with findings from previous audits of substance abuse treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004), these findings suggest that ancillary mental health services are more likely to be provided at treatment facilities characterised by an inpatient level of care and are least likely to be provided at treatment facilities characterised by an outpatient level of care and a (public or private) non-profit ownership status.

Intensity of care, however, appears to be more strongly associated with the provision of mental health services than ownership status. This explanation appears to be supported by the finding that ownership status (considered alone) was not *significantly* associated with the provision of specific mental health services and the finding that intensity of care (considered both separately and together with ownership status) significantly distinguished between facilities on mental health service variables. This requires further investigation especially as the current study did not specifically examine the relationships between these independent variables.

The association between inpatient treatment and the provision of ancillary mental health services corresponds with findings from international research that suggest outpatient facilities provide less direct access to ancillary mental health services than inpatient facilities (Friedman et al, 2003; McLellan et al., 1999). While the relative scarcity of mental health services in substance abuse outpatient facilities can be interpreted as a service deficit and/or a consequence of cost-cutting initiatives, it could also be a reasonable response to a client population with fewer mental health needs (Friedman et al., 1999). Research suggests that clients requiring inpatient treatment often have greater mental health needs than clients requiring outpatient treatment (McLellan et al., 1999). The finding that private for-profit inpatient and private non-profit inpatient facilities are more likely to serve clients from older age cohorts and women than either private for-profit outpatient or private non-profit outpatient facilities lends some support to this claim- especially given evidence suggesting that clients with these gender and age

profiles have more mental health-related treatment needs than clients with other demographic profiles (Booth & McLaughlin, 2000).

Nevertheless, as many individuals for whom inpatient treatment is indicated may only be able to afford outpatient care, outpatient facilities may still have clients who require ancillary mental health services. For these clients, the limited availability of mental health services may negatively impact on their treatment outcomes. There is thus a need for further research that explicitly examines the mental health-related needs of clients entering (inpatient and outpatient) substance abuse treatment as well as the extent to which these needs are met during the course of treatment.

The availability of speciality staffing resources may also help account for the greater likelihood of mental health services being provided at inpatient facilities than at outpatient facilities. Prior research suggests that the availability of mental health services is strongly associated with the proportion of staff (employed by facilities) trained to deliver these speciality services (Durkin et al., 2002; Friedman et al., 1999). Findings from this study tend to confirm this explanation, with mental health services being more likely to be provided at facilities employing psychiatrists and psychologists than at facilities without these speciality staff. For instance, a greater proportion of facilities employing psychiatrists and psychologists conduct psychiatric assessments and provide mental health counselling services than facilities without these speciality staff. In addition, as findings reflect that a larger proportion of inpatient facilities employ psychiatrists and psychologists than outpatient facilities, it is not surprising that these outpatient facilities are relatively less likely to provide mental health services.

A possible reason for the association between inpatient level of care and access to psychiatrically-trained staff may lie in the fact that historically most mental health services in South Africa have been provided at an inpatient, tertiary level of care and served as training sites for mental health professionals. As inpatient facilities continue to serve as training sites for psychiatrists and psychologists, these facilities are possibly more able to afford having a contingent of psychiatrists and psychologists than non-profit outpatient facilities.

In summary, this study suggests that the organisational features of facilities (such as ownership status, intensity of care provided, and staffing resources) together with the needs of clients served may influence whether ancillary mental health services are provided to clients. This is in keeping with findings from treatment services research conducted in the USA (Durkin et al., 2002; Friedman et al., 1999; Friedman et al., 2003) as well as findings from previous audits of substance abuse treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004).

4.2.2. Provision of ancillary health services

In comparison to the proportion of facilities providing core addiction and aftercare services, a significantly smaller proportion of facilities provide ancillary medical and health services. In both provinces, the overall proportion of substance abuse treatment facilities providing these services is less than 60%. Although this is in keeping with findings from previous audits of substance abuse treatment facilities (Myers, 2004; Myers & Parry, 2003), these findings are cause for concern as many substance-abusing individuals experience substance-related health concerns. The provision of ancillary health services (of both a palliative and preventative nature) is thus an important aspect of quality substance abuse treatment (Friedman et al., 1999).

Similar to findings from previous studies, facilities in both provinces are more likely to conduct medical assessments than provide clients with substitution medication and/or detoxification services. More specifically, only two-thirds of facilities provide clients with access to substitution medication- this despite the fact that substitution medication is internationally acknowledged to be a useful tool for limiting the harms of substance abuse and for retaining clients in treatment. The provision of substitution medication is also internationally recognised as one of the key principles of effective substance abuse treatment (NIDA, 2006). Similarly, only 64% of facilities report providing clients with on-site detoxification services. The limited availability of these services within treatment facilities is cause for concern, especially as treatment facilities that do not provide detoxification services often require clients to have completed a hospital-based detoxification prior to entering treatment. This acts as a barrier to treatment entry due to the scarcity of hospital-based detoxification services (Myers, 2007).

Findings also show that only a small proportion of facilities conduct interventions to reduce the health risks associated with continued substance use. For example, in both provinces less than half of the facilities test for and conduct interventions to reduce the risks of substance-related infectious disease (such as hepatitis), and less than half the facilities test for and conduct interventions to reduce the risk of HIV. Finally, less than a third of facilities conduct interventions to reduce the health risks associated with injection drug use. While the latter may be due to the fact that only a small proportion of South African drug users are injection drug users (Dewing et al., 2006), injection drug users still face many health risks that can be ameliorated through timely interventions. Of greater concern is the small proportion of facilities that conduct HIV harm reduction interventions especially given the strong association between substance abuse and risky sexual practices (Wechsberg et al., 1998) and South Africa's high HIV prevalence rate.

Variations in the provision of health services by organisational factors

Findings show that the intensity of treatment provided by facilities is strongly associated with the extent to which facilities provide ancillary health services. These services seem to be more available at inpatient facilities than at outpatient treatment facilities. Findings, for example, show that compared to outpatient facilities, a significantly greater proportion of inpatient facilities provide detoxification services, conduct physical examinations of clients, and conduct interventions to reduce the risks for infectious disease and HIV among clients. In contrast, findings show that ownership status is not significantly associated with the provision of ancillary health services.

These findings suggest that medically-oriented services are more accessible at treatment facilities characterised by an inpatient level of care. This association between inpatient treatment and the provision of ancillary health services is in keeping with findings from international research that suggest outpatient facilities provide less direct on-site access to ancillary health services than inpatient facilities (Friedman et al., 2003; McLellan et al., 1999). While the relative scarcity of ancillary health services in substance abuse outpatient facilities can be interpreted as a service deficit, it could also be a reasonable response to a client population with fewer health needs (Friedman et al., 1999). For instance, clients for whom inpatient treatment is indicated generally have greater substance abuse problem severity and may have greater health-related needs than clients

for whom outpatient treatment is indicated. It is therefore plausible that clients attending inpatient facilities may have a greater need for ancillary health services than clients attending outpatient facilities. Even though problem severity should be one of the key factors that influence the intensity and range of treatment services received; in South Africa, the availability and affordability of services often overrides ideal patient-placement criteria. Many South Africans with substance use disorders may only be able to afford and/or access outpatient treatment services, even though inpatient services are better suited to their level of problem severity. For these clients, the limited availability of ancillary health services at outpatient facilities may negatively impact on both their treatment outcomes and their physical well-being.

The availability of speciality staffing resources may also help account for the greater likelihood of ancillary health services being provided at inpatient rather than at outpatient facilities. Prior research has shown that the availability of medical services is strongly associated with the proportion of medically-trained staff employed by facilities (Durkin et al., 2002; Friedman et al., 1999). Findings from this study tend to confirm this, with ancillary health services significantly more likely to be provided at facilities employing doctors and nurses than at facilities without these speciality staff. For example, compared to facilities without medically-trained staff, a significantly greater proportion of facilities with medically-trained staff complete clients' medical histories, conduct physical examinations of clients, provide detoxification services, and conduct HIV harm reduction interventions. In addition, as findings reflect that inpatient facilities employ a greater contingent of medically-trained staff (e.g. doctors and nurses) than outpatient facilities, it is not surprising that these inpatient facilities are more likely to provide health-oriented services than outpatient facilities.

A possible reason for the association between inpatient level of care and access to medically-trained staff can be found in the fact that state and non-profit inpatient facilities serve as training and placement sites for health professionals. Moreover, as medical internship and training posts are paid for by the state, the overall costs of employing speciality staff are reduced for these (public and private) non-profit facilities. This may free up financial resources and allow for (i) additional professional staff to be employed and (ii) resources to be allocated to support, train and develop clinical staff. As

a result, these facilities may have more staff qualified to provide medical assessments, detoxification services and harm reduction interventions than outpatient facilities. The finding that state inpatient facilities have significantly higher proportions of full-time professional staff than any other type of facility provides partial support for this explanation.

In summary, this study suggests that the organisational features of facilities (such as the intensity of care provided and staffing resources) may influence whether ancillary health services are provided to clients. This is in keeping with findings from treatment services research conducted in the USA (Durkin et al., 2002; Friedman et al., 1999; Friedman et al., 2003) as well as findings from previous audits of substance abuse treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004).

4.3. TARGETING BARRIERS TO TREATMENT ENTRY, ENGAGEMENT AND RETENTION FOR CLIENTS FROM UNDERSERVED GROUPS

International principles of effective treatment for substance use disorders (NIDA, 2006) and South African norms and standards for inpatient and outpatient treatment emphasise that substance abuse treatment services should be (i) accessible to individuals who need and want services and (ii) appropriate for different cultural, age and gender groups.

Despite these standards and widespread concern about the accessibility and appropriateness of existing treatment services for clients from historically underserved groups (Myers et al., 2005), South African substance abuse treatment facilities generally fail to meet these standards. The following sections describe the accessibility and appropriateness of substance abuse treatment services with particular reference to historically underserved population group; namely Black/African substance users and women.

4.3.1. The extent to which services are accessible to underserved groups

Findings show that in both provinces, Black/African clients continue to be under-represented in substance abuse treatment facilities. Although Black/African persons comprise about 74% of the general population of Gauteng (Statistics South Africa, 2005), they comprise only 28% of the client population at substance abuse treatment facilities. Similarly, while Black/African persons comprise about 85% of the general population in

KZN (Statistics South Africa, 2005), they comprise about 41% of the client population at substance abuse treatment facilities in this province. In contrast, White South Africans continue to be over-represented in substance abuse treatment facilities, relative to the demographic profile of the general population. These findings are in keeping with findings from previous audits of treatment facilities in Gauteng (Myers, 2004) and Cape Town (Myers & Parry, 2003).

As substance abuse treatment need has not been properly investigated in South Africa, it is unclear whether there are disparities in the need for substance abuse treatment services among the racially-defined social groups. Despite this gap, emerging evidence suggests that poor Black/African communities may be especially vulnerable to substance use disorders, due to the psychological stress associated with rapid urbanization, poverty, neighbourhood social dysfunction, and a lack of basic infrastructure (Flisher & Charlton, 2001; Kalichman et al., 2006) – factors that often characterise these communities.

Anecdotal reports of increasing levels of substance use among Black/African communities also suggest that this pattern of service utilization reflects the limited extent to which Black/African South Africans have access to substance abuse treatment rather than lower levels of substance use by these racially-defined social groups (Myers et al., 2004; Myers & Parry, 2005).

In terms of gender, findings show that women are also under-represented in substance abuse treatment facilities. Although women comprise at least half of the general population (Statistics South Africa, 2005), on average only 25% of the recipients of substance abuse treatment services in South Africa are women. This finding is in keeping with findings from previous audits of substance abuse treatment facilities in Cape Town and Gauteng (Myers, 2004; Myers & Parry, 2003) as well as international research which points to the under-representation of women in treatment (Schober & Annis, 1996). However, this pattern of treatment service utilization by women probably reflects the limited extent to which women have access to substance abuse treatment rather than lower levels of substance use by women; especially given research which suggests that similar proportions of men and women drink at risky levels in South Africa (Parry et al., 2005) and that points to high levels of substance use among women in Cape Town (Sawyer, Wechsberg & Myers, 2006)..

Variations in the proportion of underserved groups served by organisational factors

Findings show that facility ownership and treatment intensity are strongly associated with the provision of services to Black/African clients and women. More specifically, private non-profit and state outpatient facilities are significantly more likely to have a client population comprised of a large proportion of Black/African clients relative to the other treatment facilities. In contrast, compared to the other types of facilities private for-profit facilities (both inpatient and outpatient) are significantly more likely to have low proportions of Black/African clients in their client population. These findings are in keeping with findings from previous audits conducted in Gauteng and Cape Town (Myers, 2004; Myers & Parry, 2003). Given that socio-economic disadvantage remains associated with race in South Africa - despite a growing black middle class (Goosen et al., 2003; Statistics South Africa, 2005), it is not surprising that Black/African substance users are more likely to seek treatment at state and private non-profit outpatient facilities which have lower treatment costs than for-profit facilities and are more likely to be geographically accessible than non-profit inpatient facilities (Myers & Parry, 2005).

In terms of gender, private for-profit facilities (whether inpatient or outpatient) are significantly more likely to have a large proportion of women comprising their client population than state or non-profit facilities. While these findings are in keeping with findings from previous audits conducted in Gauteng and Cape Town (Myers, 2004; Myers & Parry, 2003), the reason for these findings is unclear. One possibility is that there is an interaction between race, gender and treatment-seeking behaviour. As private for-profit facilities mostly serve White communities (who either have health insurance or have wealthier social networks that can be drawn upon to co-fund treatment) (Myers & Parry, 2005), it is plausible that the women accessing these treatment services are predominantly White. If this is true, it would seem that Black/African women experience more barriers to accessing treatment (such as stigma, costs, and competing priorities) than either White women or Black/African men. Further research is needed to examine the possible between gender, race and access to treatment services, so that potential differences in access between race and gender groups can be identified and interventions developed that target these differences.

4.3.2. Access to treatment: Targeting barriers to treatment entry

Several studies have identified barriers that hinder access to treatment for clients from underserved groups. In South Africa, these barriers include awareness of treatment services; logistic barriers including access to transport; affordability barriers relating to the costs of services; and linguistic barriers, relating to the language in which services are provided (Myers, 2007). These barriers, if unaddressed, may negatively impact on treatment-seeking behaviour (Beardley et al., 2003; Joe et al., 1999). This study examined the extent to which substance abuse treatment facilities address these key barriers to treatment entry for clients from historically underserved groups.

Awareness-related barriers to treatment entry

Limited knowledge and awareness about where to seek help for substance use disorders and how to access help appears to inhibit entry into substance abuse treatment (Hser et al., 1998), particularly for poor Black/African substance users (Myers, 2007). A large proportion of facilities attempt to address this barrier by conducting awareness campaigns that provide information about substance abuse treatment options. Similarly, more than two-thirds of facilities conduct outreach among vulnerable groups, conduct outreach in disadvantaged areas, and distribute information and materials pertaining to substance abuse and available treatment options.

Although the proportion of facilities conducting outreach is a significant improvement on the proportion of facilities conducting outreach in previous audits of treatment facilities in Gauteng (Myers, 2004), there is still room for improvement. Outreach in inner city areas remains relatively neglected, with only 40% of facilities targeting these high-risk areas. Of greater concern is that only half of the facilities employ dedicated outreach workers to conduct outreach and awareness campaigns. The frequency with which the other 50% of facilities conduct outreach is thus questionable, especially given the high caseloads of treatment staff.

The important role that outreach can play in addressing awareness-related barriers among under-served Black/African communities (and in facilitating treatment entry) is reflected in findings that facilities which conduct outreach activities in disadvantaged areas and

employ dedicated outreach workers treat significantly more Black/African clients than facilities without these services.

Logistic and affordability barriers to treatment entry

Affordability and other logistic barriers (such as access to transport) also hamper entry into treatment for South African substance abusing populations (Myers, 2007). For example, several studies report that “lack of transportation” is a barrier to substance abuse treatment entry (Hser et al., 1998), especially for low-income groups who have less access to private transportation and who may not be able to afford public transport (Allard, Tolman, & Rosen, 2003). Although research indicates that providing clients with transport increases substance abusers’ use of treatment services (Booth et al., 2003; Friedmann et al., 2000; Hser et al., 1998), only 40% of facilities participating in this study provided clients with transport to their treatment facility. In addition, less than 10% of facilities provided clients’ families with transport to their facilities. This lack of transportation may limit the extent to which poorer families are able to participate in the treatment process. This is cause for concern as family participation in treatment is an essential ingredient of effective treatment, particularly for adolescent clients (NIDA, 2006) and because a lack of participation may limit their knowledge of how to provide a supportive social environment to their family member – a key ingredient for positive treatment outcomes (Joe et al., 1999).

Affordability factors have also been identified as significant obstacles to substance abuse treatment entry (Hser et al., 1998; Myers, 2007; Tucker et al., 2004). These factors include the direct costs of treatment as well as indirect costs associated with transport to treatment facilities, replacement of wages, and child care (Myers, 2007; Tucker et al., 2004). Cost barriers seem highest for substance users without health insurance (Sturm & Sherbourne, 2001), which in South Africa consists largely of Black/African persons (Goosen, et al., 2003). Findings from this study show that few treatment facilities address the cost barriers that restrict poorer clients from entering treatment. Although a very large proportion of facilities report offering indigent clients reduced fees, often these reduced fees are still unaffordable to indigent clients. Despite this, only half of the facilities have free treatment slots available for clients who cannot afford to pay for treatment. In terms of the indirect costs of entering treatment, less than 10% of facilities

have child care services available to clients participating in their treatment programmes. As affordability considerations are one of the most important predictors of treatment entry among South African substance abusers (Myers, 2007), it is vital that facilities consider innovative ways in which the costs associated with treatment can be reduced for clients from underserved groups; particularly as addressing these barriers appears to significantly improve entry into substance abuse treatment (Friedman et al., 2001). Findings from this study support this claim, with facilities that offer free treatment services treating significantly more Black/African clients than facilities without free treatment slots.

Cultural and linguistic barriers to treatment entry

Historically, one of the major barriers to entering substance abuse treatment for Black/African persons has been the lack of cultural and linguistically appropriate services, with most treatment services being provided in English or Afrikaans and by White or Coloured treatment staff (Myers, 2004; Myers et al., 2005). Although research indicates that providing clients with treatment services in their home language and matching clients and counsellors on ethnicity and gender dimensions increases substance abusers' use of treatment services (Appel et al., 2004; Tucker et al., 2004), only a small proportion of facilities actively address these cultural and linguistic barriers to treatment entry for Black/African clients.

Although a high proportion of facilities report employing multilingual staff and staff from ethnically diverse backgrounds, further questioning revealed that for the most part, staff are fluent in English and Afrikaans only, and are White, Coloured or Asian/Indian. This is confirmed by the finding that only 60% of facilities employ African language-speaking counsellors. In addition, less than 10% of facilities employ professional translators.

These factors potentially inhibit Black/African persons from seeking treatment, with Black clients being more likely to seek treatment at facilities which actively address the cultural/linguistic barriers they experience. For example, facilities which employ African language speaking counsellors treat a significantly greater proportion of Black/African clients, than facilities without these counsellors. Although treatment facilities may serve a higher proportion of Black clients because they actively target linguistic barriers to treatment entry, it is also possible that certain facilities employ African language-

speaking counsellors because a high proportion of their clientele are Black/African. To fully understand these findings, further investigation into the relationships among demographic profile, treatment needs, and factors facilitating treatment entry for recipients of substance abuse treatment is required.

In summary, it seems that treatment facilities in Gauteng and KZN have not addressed key affordability, logistical and linguistic barriers to treatment entry for substance abusers from under-served communities. These findings mirror those found in previous audits of treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004). If inequities in treatment service utilization are to be addressed, these barriers need to be targeted as a matter of urgency.

Variations in activities to target barriers to treatment entry by organisational factors

Findings show that facility ownership and treatment intensity are strongly associated with whether substance abuse treatment facilities in Gauteng and KZN target barriers to treatment entry for underserved population groups in general and Black/African substance abusers in particular. More specifically, inpatient treatment facilities are more likely to address logistical and affordability barriers to treatment than outpatient facilities, with a greater proportion of these facilities providing transport to treatment for both clients and their families than outpatient facilities. In addition, a greater proportion of inpatient facilities offer free treatment slots to indigent clients than outpatient facilities. However, these findings should be interpreted with caution given that only a small proportion of facilities report providing treatment services and free treatment slots.

Ownership status is also linked to whether treatment facilities in Gauteng and KZN target barriers to entry, with a greater proportion of non-profit facilities (both private non-profit and state owned) targeting awareness-related barriers to treatment entry than private for-profit facilities. For example, significantly greater proportions of private non-profit and state facilities conduct substance abuse awareness campaigns, conduct outreach among vulnerable groups, conduct outreach in disadvantaged areas and employ dedicated outreach workers than private for-profit facilities. Similarly, private non-profit facilities and state facilities are significantly more likely to address cultural and linguistic barriers to treatment entry than private for-profit facilities. For example, a significantly higher

proportion of these facilities employ African-language-speaking counsellors than private for-profit facilities. Compared to facilities with private non-profit or state ownership status, private for-profit facilities are the least likely to address barriers to treatment entry for Black clients. This pattern of findings mirrors that found among previous audits of treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004).

Considered together, these two organisational factors appear to interact to influence whether substance abuse treatment facilities address barriers to treatment entry for underserved communities. In terms of awareness barriers, more state outpatient and private non-profit outpatient treatment facilities conduct outreach activities than private for-profit, private non-profit inpatient or state inpatient facilities. More specifically, compared to the other types of treatment facilities, a significantly greater proportion of private non-profit and state outpatient facilities conduct outreach among vulnerable groups and disadvantaged communities. State outpatient and private non-profit outpatient treatment facilities are also the most likely to have dedicated outreach workers. In contrast, private for-profit outpatient facilities are the least likely to conduct any form of outreach. In terms of logistic and affordability barriers, state inpatient and private non-profit inpatient facilities are the most likely to provide transport services to the client's family and free treatment slots to indigent clients. In contrast, compared to other treatment facilities, private for-profit outpatient facilities are significantly less likely to offer reduced fees or free treatment slots to indigent clients. With regards to cultural and linguistic barriers, private for-profit outpatient and inpatient facilities are, compared to other types of facilities, the least likely to target these barriers to treatment entry; with a smaller proportion of these facilities employing African language-speaking therapists and multilingual staff than state and private non-profit facilities.

These findings suggest that facilities characterised by an outpatient level of care and private for-profit ownership are less likely to target barriers to treatment entry for underserved communities in general and Black/African substance abusers in particular than facilities characterised by a non-profit status. Ownership status seems to be the key variable accounting for differences between facilities; with intensity of care only weakly associated with barriers to treatment entry. This explanation is supported by findings that intensity of care (considered alone) is not significantly associated with any of the

awareness and cultural/linguistic barriers to treatment entry. Furthermore, the finding that ownership status (considered both separately and together with intensity of care) differentiates between facilities on most barriers to treatment entry lends support to this explanation.

Differences in the organizational goals of for-profit and non-profit facilities may help account for these findings. Private for-profit facilities are likely to place more emphasis on the goal of profit-maximisation than other types of facilities. This goal could lead to organizations limiting their involvement in nonessential activities (such as outreach) in order to reduce overhead costs (Friedman et al., 1999). In addition, as private for-profit facilities are more likely to depend on private funding (such as health insurance or client self-pay fees) and less likely to receive state subsidies for treatment than private non-profit facilities, it is not within the financial interests of these organisations to target clients that cannot afford the costs of treatment. As socio-economic status and race are still closely associated in South Africa, it is not surprising that private for-profit facilities are more likely to serve White than Black/African clients. Furthermore, with a treatment population dominated by White and Coloured clients (for whom English or Afrikaans is the language of choice) the relative lack of activities targeting cultural and linguistic barriers for Black/African substance users may not necessarily reflect a service deficit; but may be a realistic response to the socio-demographic profile of their client base and target population.

In summary, this study suggests that the organizational features of treatment facilities (such as ownership status and intensity of care) as well as the demographic profile of persons seeking treatment may influence whether facilities target barriers to treatment entry for under-served population groups in general and Black/African substance abusers in particular. This is in keeping with findings from previous audits of substance abuse treatment facilities (Myers & Parry, 2003; Myers, 2004).

4.3.3. Targeting barriers to treatment retention: the appropriateness of services

In South Africa few facilities provide age, gender and culturally-sensitive treatment programmes (Myers & Parry, 2002; Myers, 2004). This is a concern as the absence of appropriate services for groups such as women and cultural minorities and concerns

about the cultural and gender appropriateness of services have been identified as barriers to substance abuse treatment utilization in previous research (Appel et al., 2004; Tucker et al., 2004). The following sections describe the extent to which treatment facilities provide culturally, gender and age-sensitive treatment services.

Cultural and linguistic appropriateness of services

Concerns about the cultural and linguistic appropriateness of South African treatment services have also been an obstacle to treatment retention for clients from underserved groups, particularly Black/African substance abusers. This study found that although a large proportion of facilities report employing staff from diverse ethnic backgrounds, a much smaller proportion of facilities provide treatment programmes in multiple languages, provide counselling that is culturally-appropriate, use culturally appropriate assessment tools, and translate programme materials into multiple languages.

These factors potentially inhibit Black/African persons from being retained in treatment, with Black clients being more likely to remain in facilities which provide cultural and linguistically appropriate services. For example, facilities which employ staff from diverse ethnic backgrounds; provide culturally appropriate counselling services; and offer treatment services in multiple languages treat a significantly greater proportion of Black/African clients, than facilities without these services. Although treatment facilities may serve a higher proportion of Black clients because they attempt to ensure that their services are culturally and linguistically appropriate, it is also possible that certain facilities examine the appropriateness of their services because a high proportion of their clientele are Black/African. To fully understand these findings, further investigation into the relationships among demographic profile, treatment needs, and factors facilitating treatment retention for recipients of substance abuse treatment is required.

In addition, findings show that facility ownership is strongly associated with whether substance abuse treatment facilities in Gauteng and KZN target cultural and linguistic barriers to treatment retention for underserved population groups in general and Black/African substance abusers in particular. Findings show that a greater proportion of non-profit facilities (both private non-profit and state owned) target these barriers than private for-profit facilities. For example, significantly greater proportions of private non-

profit and state non-profit facilities provide multilingual treatment services, culturally appropriate counselling, and employ staff from diverse ethnic backgrounds than private for-profit facilities. This pattern of findings mirrors that found among previous audits of treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004).

While no significant association was found between treatment intensity and the provision of culturally appropriate services; when intensity of care and ownership status were considered together, these two organisational factors seem to interact to influence the extent to which facilities provide culturally appropriate services. Private for-profit outpatient are, compared to other types of facilities, the least likely to provide culturally appropriate services; with a significantly smaller proportion of these facilities employing African language-speaking therapists, employing multilingual staff, employing staff from diverse ethnic backgrounds, and using culturally appropriate and sensitive counselling techniques than state and private non-profit outpatient facilities. Overall, state inpatient and non-profit outpatient facilities were the most likely to provide culturally sensitive and appropriate treatment services.

These findings suggest that facilities characterised by an outpatient level of care and private for-profit ownership are less likely to provide culturally appropriate services than facilities characterised by a non-profit status. These findings can be partially accounted for in terms of the target populations at for-profit and non-profit facilities. As private for-profit facilities depend heavily on private funding (such as health insurance or client self-pay fees) for financial sustainability (and are less likely to receive state subsidies for treatment than private non-profit facilities), it is not within the financial interests of these organisations to target clients that cannot afford the costs of treatment. In South Africa, Black/African clients are the least likely to be able to afford the costs of private for-profit facilities, particularly because of their limited access to health insurance (Goosen et al., 2003). Therefore, it is not surprising that private for-profit facilities are more likely to serve White than Black/African clients. With a treatment population dominated by White and Coloured clients (for whom English or Afrikaans is the language of choice) the relative failure to provide culturally and linguistically appropriate services for Black/African clients may not necessarily reflect a service deficit; but may represent a

realistic response to the socio-demographic profile of their client base and target population.

In summary, this study suggests that the organizational features of treatment facilities (such as ownership status) as well as the demographic profile of persons seeking treatment may influence whether facilities provide culturally and linguistically appropriate services for Black/African substance abusers. This is in keeping with findings from previous audits of substance abuse treatment facilities (Myers & Parry, 2003; Myers, 2004).

Gender appropriateness of services

Although substance abuse treatment services are under-utilised by women (Myers et al., 2005), few facilities in Gauteng and KZN provide services aimed at addressing some of the barriers that prevent women from engaging and being retained in treatment. These barriers include limited resources to arrange for independent childcare (Booth & McLaughlin, 2000), and the lack of women-sensitive treatment programmes that focus on the special needs of women (such as domestic violence and sexual assault) (Booth & McLaughlin, 2000).

This study found that although two-thirds of facilities report providing gender-appropriate and sensitive counselling services, a smaller proportion of facilities provide gender-specific services (such as women-only treatment groups) and use gender appropriate assessment tools. Although facilities in KZN are much more likely to provide gender-specific treatment services and use gender appropriate assessment tools than facilities in Gauteng, facilities in KZN do not treat significantly greater proportions of women than facilities in Gauteng. A possible reason for this finding may lie in the fact that only half of the facilities provide staff with special training in gender-related issues that may be pertinent to treatment (such as domestic violence). Even though facilities may report the provision of women-sensitive services, this lack of training in gender-related issues may affect the extent to which these services effectively address gender-specific issues, and ultimately the retention of female substance abusers in treatment.

While these findings represent an improvement on findings from previous audits of substance abuse treatment facilities in Gauteng (Myers, 2004), they are still cause for concern as previous research has identified treatment facilities' failure to have a gender-sensitive treatment approach as a factor that limits female clients engagement and retention in treatment (Booth & McLaughlin, 2000). In addition, these findings highlight the need to provide treatment staff with training on topics such as domestic violence, victimisation, and trauma that may be pertinent to female substance abusers as well as the need to provide staff with training on gender-sensitive treatment approaches.

In addition, findings show that for-profit inpatient facilities are the most likely to provide gender appropriate services. This is not surprising as these types of facilities treat a significantly greater proportion of female substance abusers than other types of facilities. Although these treatment facilities may serve a higher proportion of female clients because they actively target gender-related barriers to treatment retention, it is also possible that certain facilities provide these services because a high proportion of their clients are female. Further investigation into the relationships amongst demographic profile, treatment needs, and barriers to retention for female substance abusers in South Africa is thus required.

Age appropriate services

Access to age and developmentally appropriate services is a key ingredient of effective treatment for young people (NIDA, 2006). Findings show that a relatively large proportion of facilities report using age appropriate assessment tools, providing counselling services that are age and developmentally appropriate, and providing family-focused interventions. Despite this, a much smaller proportion of facilities employ staff trained to work with adolescents and young people, provide family reunification services for adolescents, provide education services for young people, and adapt their facility environment to ensure the safety of young people. The lack of staff trained to work with adolescents and young people is a particular concern as this lack of staff capacity may affect the extent to which treatment services are appropriate for young people, and ultimately adolescents' treatment outcomes.

In addition, these factors potentially inhibit young people from being retained in treatment, with young clients being more likely to remain in facilities which provide age appropriate services. For example, facilities which provide family-focused interventions and which adapt facility environments to make them suitable for young people treat a significantly greater proportion of clients younger than 20 years of age than facilities without these services. Although treatment facilities may serve a higher proportion of adolescent clients because they provide age appropriate services, it is also possible that certain facilities examine the appropriateness of their services because a high proportion of their clients are adolescents. To fully understand these findings, further investigation into the relationships among demographic profile, treatment needs, and factors facilitating treatment retention for recipients of substance abuse treatment is needed.

4.4. MONITORING AND EVALUATION IN SUBSTANCE ABUSE TREATMENT FACILITIES

Research has emphasised the importance of monitoring and evaluating (M & E) the process and outcomes of substance abuse treatment, not only because M & E helps identify areas in which treatment programmes and service delivery can be improved, but also because evidence of treatment effectiveness can be used to inform decision-making about the rational distribution of human and financial resources to substance abuse treatment services (Cole, 1999). This study examined M & E activities that facilitate (i) the monitoring of clients' progress during the course of treatment, (ii) the monitoring of clients progress post-treatment, and (iii) the evaluation of substance abuse treatment programmes.

This study examined administrative and procedural structures and activities that facilitate the monitoring of client progress during the course of treatment. Findings show that although most treatment facilities report having good administrative systems and structures that facilitate the monitoring of clients within-treatment, a significantly smaller proportion of facilities report monitoring clients post-treatment. While most facilities develop individualised treatment plans for each client; keep notes of clients' progress during treatment; obtain collateral information from clients' family members; and record case conferences, only 50% of facilities routinely tracking clients' progress once they

complete treatment. These findings are in keeping with findings from previous audits of treatment facilities in Gauteng (Myers, 2004) and Cape Town (Myers & Parry, 2003).

Findings suggest a discrepancy between the proportion of facilities that systematically monitor clients' progress post-treatment and the (large) proportion of facilities that report monitoring clients' progress post-treatment via telephone and during aftercare counselling sessions. A possible explanation for this apparent discrepancy may lie in the fact that telephonic monitoring and monitoring during aftercare counselling are relatively informal and unstructured ways of tracking clients' progress; whereas post-discharge monitoring refers to a more formalised system of monitoring where self-report questionnaires and/or blood and urine tests are used to establish the extent to which clients have achieved and maintained treatment goals. This explanation seems to be supported by the finding that only a quarter of facilities use structured follow-up questionnaires to track clients' progress post-treatment. Although a high proportion of facilities report using blood and urine screens to monitor clients, these screens are mostly used within treatment and are rarely used for monitoring client progress post-treatment (for outcome evaluation purposes). These findings mirror findings from audits of substance abuse treatment facilities in Cape Town (Myers & Parry, 2003) and Gauteng (Myers, 2004). It should be noted that we did not ask about the proportion of clients that are monitored post-treatment. It is thus difficult to gauge the degree to which post-treatment monitoring routinely occurs at substance abuse treatment facilities in KZN and Gauteng.

In terms of activities relating to programme evaluation, findings show that few facilities in Gauteng and KZN have conducted formal evaluations of their treatment programmes; with more than half of the facilities not having conducted any form of programme evaluation. More specifically, just over a third of facilities had conducted a process evaluation of their programme/s; with a similar proportion having evaluated the quality of their treatment services. In addition, less than a third of facilities have conducted an outcome evaluation of their programme. Despite this, many treatment facilities make statements about their treatment "success rate." This is cause for concern as it is impossible to make accurate claims about treatment "success rates" without having conducted an outcome evaluation.

Findings also indicate that facilities characterised by private for-profit ownership are most likely to have conducted some form of programme evaluation than facilities characterised by a non-profit status. These findings can be partially accounted for in terms of the costs associated with conducting evaluations as well as the resources available to staff. More specifically, non-profit and state facilities are significantly less likely to maintain computerised client files and management information systems that help facilitate the formal monitoring of clients post-discharge and outcome evaluations. In addition, the costs of conducting formal programme evaluations are often high, and facilities that rely on public funding for financial sustainability may not have financial resources available for research and evaluation. Nonetheless, as findings from programme evaluations can be used to both improve service quality (and client outcomes) and to motivate funding agencies for additional treatment resources, it is vital that non-profit facilities afford greater priority to programme evaluation activities.

Finally, many facilities displayed poor understandings of the terms “monitoring” and “evaluation.” This reflects a need for substance abuse practitioners to be trained in i) the importance of monitoring and evaluation for programme planning and service improvement, ii) basic principles of monitoring and evaluation (such as the identification of suitable indicators for monitoring and evaluating substance abuse treatment programmes), and iii) systems for the routine monitoring of clients within and post-treatment.

4.5. RECOMMENDATIONS

To improve the availability and utilisation of substance abuse treatment facilities

Availability of treatment services

- In general, the availability of affordable treatment options needs to be increased. A cost-effective way of achieving this would be to increase the number of state-funded outpatient facilities.
- As private, non-profit treatment facilities are the largest providers of treatment services to historically under-served groups, funding to these facilities should be increased.

- The number of state facilities for substance abuse treatment needs to be increased. The establishment of more state-funded outpatient facilities may be a means of providing cost-effective substance abuse treatment services that are accessible to all sectors of the population. This should be considered for KZN especially, given that there are no state outpatient facilities in this province.
- The occupancy rates of available treatment facilities needs to be maximised. Research which identifies the factors underpinning the under-utilisation of substance abuse treatment facilities (such as client loads, staff competencies, and facility resources) needs to be conducted. Based on the findings of this research, interventions that target the factors underpinning this under-utilization should be designed, implemented and evaluated.

Waiting list interventions

- The length of waiting lists for available treatment slots needs to be reduced, especially at non-profit and state facilities and for facilities in KZN. This is important as shorter waiting periods would mean that more clients could be served. Shorter waiting periods have also been associated with better treatment outcomes.
- The feasibility and effectiveness of interventions aimed at (i) shortening the waiting list (e.g. by making the treatment programme of shorter duration) or (ii) maintaining motivation for treatment among individuals on waiting lists should be explored.

Improving treatment capacity

- Treatment capacity needs to be increased at all existing facilities, but particularly for facilities in Gauteng.
- One way of improving capacity would be to increase the number of professional staff at treatment facilities. Additional funding needs to be earmarked for this purpose

To improve the diversity of services and range of services provided through increasing access to ancillary health and mental health services

- A comprehensive, integrated range of services that includes access to ancillary medical and mental health treatment services should be accessible at all treatment facilities

Unmet mental health needs

- All clients should be assessed for co-occurring mental health disorders and ancillary health problems
- All clients who require detoxification services should have access to these services- either directly or indirectly through referral to state hospital detoxification programmes
- To ensure that clients have access to detoxification services, the availability of detoxification services within the public health services sector needs to be prioritized. This is important as access to detoxification is a major barrier to treatment entry.
- Facilities should be encouraged to incorporate health risk-reduction interventions into their treatment programmes. These interventions should focus on HIV prevention (i.e. reducing substance use-related sexual risks) and harm reduction interventions for injection drug users.

Unmet medical needs

- All clients should be assessed for co-occurring health disorders and health-related risks, such as risk for HIV and other infectious disease
- Research which examines the extent to which clients at outpatient facilities have unmet mental health needs should occur as a matter of urgency. If there are unmet mental health needs at these facilities, interventions should focus on improving access to ancillary mental health services at outpatient facilities.

Case management

- While it is not always financially feasible to provide on-site access to ancillary mental health treatment services, facilities should be encouraged to provide either

direct on-site access or indirect access via referral to agencies specializing in mental health-related problems.

- Where facilities do not directly provide access to ancillary services, a case management approach should ensure that clients receive the ancillary services as planned. The role of the case manager should be to ensure that clients are linked to external service providers and that they are able to access these services.
- Another way of ensuring (indirect) access to ancillary services is through pre-contracting external service providers to ensure that they are available to provide ancillary services when these services are required.

To address barriers to treatment entry for under-served groups

- Awareness should be raised among treatment providers about the importance of addressing barriers to treatment entry for clients from historically underserved groups. Treatment providers require training in suitable methods of targeting these barriers.

Logistic and affordability barriers

- Logistical barriers to treatment can be addressed through increasing the number of beds available for impoverished clients and also through addressing the indirect costs associated with treatment (e.g. transport and childcare). These indirect costs may prevent poorer clients from seeking treatment.
- Although it is not feasible to provide transport services to all poor clients, transport-related barriers can be ameliorated by ensuring that new services are geographically accessible to poor communities. One way of meeting this standard is through the introduction of mobile outpatient services that travel from community to community rather than being purely facility-based.

Awareness barriers

- Awareness-related barriers should continue to be addressed among vulnerable and disadvantaged communities

- To facilitate this, facilities should be encouraged to employ dedicated outreach workers who can focus on raising awareness of services and distributing information and materials among at-risk communities
- Although headway has been made in improving awareness of substance abuse, facilities need to give increased attention to outreach in inner city areas.

Cultural and linguistic barriers

- Cultural and linguistic barriers to treatment entry, engagement and retention among Black/African clients should be addressed as a matter of urgency.
- The number of facilities employing African language-speaking counsellors needs to be increased.
- In order to achieve this goal, a long-term view needs to be adopted that includes (i) training more African language-speaking health and social work professionals at tertiary institutions, (ii) attracting African language speaking health and social work professionals into the substance abuse field, and (iii) providing health and social work professionals with adequate financial remuneration in order to retain them in the substance abuse treatment field.

Improving the cultural, gender and age appropriateness of services

Cultural and linguistic appropriateness of services

- The cultural and linguistic appropriateness of services needs to be improved
- Linguistic factors can be addressed through offering treatment services in a number of languages (when the clients served speak a number of languages), employing multilingual staff as members of the clinical/treatment team, employing African language speaking therapists, and ensuring that treatment programme materials are available in a number of languages.
- Training programmes should also be developed that increase the cultural sensitivity of existing treatment programmes and materials. For example, these training

programmes can explore the cultural meanings and understandings associated with alcohol and drug use and substance use disorders.

Gender appropriateness of services

- The proportion of women treated at existing treatment facilities needs to be improved, especially in private non-profit and state facilities
- The extent to which existing services are sensitive to the needs of female substance abusers needs to be improved
- This can be addressed through offering treatment services for women-only and through the provision of counselling services that are sensitive to the multiple needs of female substance users, including need for interventions relating to sexual abuse histories, domestic violence and PTSD.
- Training programmes should also be developed that increase the gender sensitivity of existing treatment programmes and materials. For example, these training programmes can explore the multiple needs of substance using women, key barriers to their treatment process, and effective treatment strategies for women.

Age appropriateness of services

- The extent to which existing services are age and developmentally appropriate for adolescents and young people needs to be examined
- The age appropriateness of services can be improved through adapting programmes directed for adults to the developmental needs of young people as well as through introducing evidence-based treatment models that target adolescents specifically, such as multisystemic family therapy (NIDA, 2006).
- In order to ensure the appropriateness of services for young people, facilities should also be encouraged to include family members in the treatment process. This can be done by providing family reunification services as well as by providing family-focused counselling services.

- The proportion of facilities that employ staff with special training to work with adolescents, young people and families needs to be increased. This is important not only for treatment outcomes, but also because of the complex ethical considerations that come into play when working with young people.

To improve treatment service planning and delivery through research and monitoring and evaluation activities

National audit

- As part of the monitoring of the quality of substance abuse treatment services, and to ensure that facilities endorsed by the state deliver adequate and appropriate services, a national treatment audit should be conducted on a regular basis (at least once every 2 years).
- Findings from this national audit should be used to inform decision-making about (i) the allocation of funding and other resources to existing facilities and (ii) the development of new services. This decision-making should be informed by the extent to which facilities provide services to historically under-served groups.

National prevalence study of substance use disorders and unmet treatment need

- To prevent duplication of services and enable maximisation of scarce resources, a national survey examining the prevalence of substance use disorders and the prevalence of unmet need for substance abuse treatment services should be conducted on a regular basis (at least once every two years). Findings from this survey will help identify under-served communities where there is the greatest need for services and will thus facilitate the rational allocation of new treatment resources.

Monitoring and evaluation

- Substance abuse treatment facilities should, as a condition of registration and funding, conduct comprehensive evaluations of their treatment programmes once every five years. These programme evaluations should be conducted by an external evaluator.
- To cover the costs of these evaluations, 10-15% of all grant monies and public funding allocated to substance abuse treatment facilities should be ring-fenced for programme evaluation purposes. This should be a condition of public funding.

- Capacity to conduct client monitoring and programme evaluations within substance abuse treatment facilities needs to be developed as a matter of urgency. The state should consider providing publicly-funded treatment facilities with introductory courses to client monitoring and programme evaluation that include the provision of basic tools to facilitate these activities. The World Health Organisation has developed a framework for programme evaluation within substance abuse treatment services that may serve as a useful starting point.
- Research which evaluates the relative efficacy of treatment programmes that provide comprehensive services (that is, core addiction treatment services and ancillary mental health and medical treatment services) and programmes that provide core addiction services only is required. Findings from this research may provide justification for the provision of a more comprehensive range of services at substance abuse treatment facilities.
- Research which evaluates the relative efficacy of treatment programmes that provide outpatient services and programmes that provide inpatient services is required; especially given findings that outpatient facilities have lower rates of client retention than inpatient facilities.

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