



Alcohol & Drug Abuse Research Group
Medical Research Council

Report on Audit of Substance
Abuse Treatment Facilities in
Cape Town
(2002)

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EXECUTIVE SUMMARY

A cross-sectional audit of substance abuse treatment facilities was conducted in Cape Town, South Africa. The Treatment Services Audit (TSA) Questionnaire was specially constructed for the purposes of this audit. The TSA collected information from a number of domains including the characteristics of the treatment facility, the types of treatment services offered, the accessibility of services, staffing characteristics, and monitoring and evaluation processes. Information on client characteristics was gathered from the SACENDU database.

This audit found that substance abuse treatment services in Cape Town 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 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 that address the factors underpinning this under-utilization, such as client loads, staff competencies, and facility resources, be conducted.

Substance abuse treatment facilities in Cape Town provide clients with a significantly higher proportion of traditional addiction services than supplementary or support services. Variations in service patterns occur according to treatment modality, ownership and setting. Medical and detoxification services are significantly more accessible in private for-profit and state inpatient facilities than in private non-profit outpatient facilities. For-profit status, differences in client profiles across facilities, and levels of affiliation with larger organisations may account for these differences. Substance abuse treatment facilities should be encouraged to provide supplementary medical and detoxification services in addition to traditional addiction services. Facilities that do not have the financial or human resources to deliver these services should be empowered, through organisational development interventions, to develop affiliations with organisations that do provide supplementary and support services.

When the activities conducted to improve the accessibility of treatment services to under-served groups were considered, it was found that less than half of the treatment services reported conducting outreach activities. Few facilities reported providing services (such as transport, child-care, and reduced fees) aimed at addressing the barriers that prevent clients from accessing available treatment facilities. More private, non-profit facilities reported providing these services than other types of facilities. Private, non-profit outpatient facilities were more likely to provide culturally appropriate assessment and treatment programmes than

other types of facilities. For-profit status, variations in the demographic profile by treatment facility, and the historical under-provision of services to Black clients from the private profit and state sector may account for these findings. A number of recommendations are made to improve the accessibility of treatment services for historically under-served groups.

In terms of monitoring and evaluation activities, this audit found that routine client monitoring systems (post discharge) were not in place at any of the treatment facilities. Similarly, in terms of evaluation activities, only one of the facilities had conducted a formal outcomes-based evaluation of their treatment programme and only one facility had conducted a process evaluation of their treatment programme. These findings point to the need for substance abuse treatment facilities in Cape Town 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 in South Africa, 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.

PART 1: BACKGROUND TO THE MRC AUDIT OF SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

GENERAL BACKGROUND

In recent years, several national, multi-site, longitudinal outcome studies have been conducted in the United States and in the United Kingdom to examine the effectiveness of treatment for substance use disorders (e.g. Gossop et al., 2001; Etheridge et al., 1997). Findings from these studies have been optimistic about the effectiveness of substance abuse treatment across a variety of treatment settings, treatment modalities, and client populations (Paraherakis et al., 2000, Sterling et al., 2001). More specifically, these outcome studies have reported that substance abuse treatment results in clear benefits to the substance abuser, the family and broader society. Treatment has been shown to reduce or eliminate alcohol and other drug (AOD) use, reduce criminal behaviour, result in mental and physical health benefits, and improve employment and welfare status (Best et al., 2002; Gossop et al., 2001; McKay & Weiss, 2001).

Outcome studies have also provided evidence of the cost-effectiveness of substance abuse treatment (Alterman et al., 2001; Langenbucher et al., 2001). For example, post-treatment cost outcomes for the Drug Abuse Treatment Outcome Study (DATOS) revealed that, irrespective of treatment modality, every dollar spent on treatment recouped up to \$3 in savings (Flynn et al., 1997). These savings accrue from a number of sources including reductions in general health care costs, arising from the reduced use of emergency services, fewer AOD-related illnesses, and the reduced use of general hospital and specialised treatment services (Holder, 1998; Humphreys et al., 1997). Crime-related cost savings also accrue from treatment, due to reduced criminal justice activity, lower victim losses, and lower theft losses (Alterman et al., 2001; Mauser & Van Stelle, 1994). To illustrate, the DATOS and National Treatment Outcome Research (NTOR) Study reported crime-related cost reductions of up to 80% (Fletcher et al., 1997; Gossop et al., 2001).

Despite evidence that substance abuse treatment results in clear benefits and cost savings, several socio-political factors have hampered access to substance abuse treatment in South Africa. Prior to 1994, and South Africa's first democratic elections, state-subsidized substance abuse treatment services were in a state of disarray. Although the state historically provided resources for the treatment of people with substance abuse problems through state psychiatric services, welfare agencies (for example, the South African National Council of Alcoholism

and Drug Dependence [SANCA]), and specialized substance abuse treatment centres, funding to these treatment services has generally been inadequate and facilities have been poorly distributed, tending to be concentrated in white, advantaged, urban areas. In addition, due to the apartheid system, major disparities existed in terms of the resources spent on substance abuse treatment and the quality of services for the different race groups (DOH Mental Health Framework, 2001; Parry & Bennetts, 1998).

The historical division of responsibility for the treatment and management of substance-related problems between the Department of Health and the Department of Welfare has also contributed to inequitable service delivery. Relative to other health services, mental health in general and substance abuse in particular was afforded low priority by the National Department of Health (Department of Health, 2001). As both the health and welfare sectors have lacked resources, substance abuse treatment services have not been readily available to all sectors of the population. For example, a situational analysis of substance abuse services in South Africa, conducted in 1995, reported that services in overcrowded townships, informal settlements and in the rural areas of the country were grossly inadequate, especially compared to those in urban areas (White Paper on Social Welfare, 1995).

Since 1994, a number of socio-political changes have also placed substance abuse treatment facilities under increased pressure to provide adequate and effective treatment services. The country's physical and economic isolation, strict monitoring of external borders, and stringent internal controls during the apartheid era restricted access to and availability of most kinds of illicit drugs. Prior to the first democratic elections in 1994, locally cultivated cannabis; Mandrax (methaqualone combined with an anti-histamine) tablets, imported by South Africans with strong familial ties to South Asia; and prescription drugs (e.g. barbiturates, benzodiazepines and opiates) were the only drugs widely available to South Africans. However, improved drug supply- and demand-reduction strategies in Europe and the USA forced traffickers to seek alternative routes and markets. South Africa is, due to its geographical location, a convenient trans-shipment point for illicit drugs from drug-producing countries to drug markets. In addition, the 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 (which are ideal for laundering the proceeds of drug sales and co-ordinating the redistribution of drugs) have made the country an attractive new market for drug cartels. With these changes in global drug markets and local socio-political changes since 1994, South Africans now have access to a broad range of illicit drugs, including cocaine and heroin (Parry et al., 2002a). In

addition, 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 study focuses on substance abuse treatment services in Cape Town. A decision was made to focus on treatment services available in this region as Cape Town has, compared to other sites, the highest proportion of alcohol-related psychiatric discharge diagnoses, the highest proportion of alcohol-positive trauma patients injured through violence and traffic-related accidents, the highest proportion of alcohol-positive non-natural deaths, and the highest proportion of arrestees who reported being intoxicated at the time of the alleged offence (Parry et al., 2002b). Together with Gauteng, Cape Town also has the highest level of drug use and the widest range of drugs used compared to other sites (Parry et al., 2002a). In addition, Cape Town has, compared to other sites, the highest proportion of trauma patients testing positive for cannabis, Mandrax, and cocaine, and the highest proportion of drug-positive arrestees (Parry et al., 2002a).

Substance abuse treatment services in Cape Town

Despite high levels of substance abuse in Cape Town, substance abuse has been given low priority by both the Western Cape Departments of Health and Social Services. For example, in 1996, the Western Cape Department of Social Services ranked substance abuse second to last in its list of priorities. In addition, over time, it has significantly cut its funding to non-government organizations and state-subsided treatment centres. At present, state social services in the Western Cape are overwhelmed by demands placed on them and cannot cope with the additional burden of substance abuse. Similarly, the Western Cape Department of Health has closed a number of treatment services, including a specialised drug unit at a psychiatric hospital in 1995/1996 (Parry, 1997) and a large residential alcohol-only treatment facility in 1998. At present, there is only one state hospital-based inpatient alcohol rehabilitation unit, and only one state AOD inpatient treatment facility in the province. Although there are other state-subsidised substance abuse treatment facilities, over the years state funding to these facilities has decreased in real terms. For these facilities, state funding comprises only a small proportion of their budget*. The number of beds available in general state hospitals for patients with AOD problems has also decreased. Consequently, there are long waiting periods for treatment slots at state-funded facilities. International research has shown that long waiting periods may negatively impact on treatment retention and treatment outcomes, with studies reporting that substance abusers who are placed on waiting lists tend

* For the purposes of this study, state-subsidised facilities will be defined as private non-profit organisations.

to lose their motivation for treatment by the time a treatment slot becomes available (Mejita et al., 1997).

While some steps have been taken to address the availability of substance abuse treatment services at a primary health care level, such as the development and implementation of protocols for the management of AOD intoxication and withdrawal at the regional hospital level by the Provincial Department of Health, implementation has been slow with few substance-related services being offered at the primary health and community levels of care. As in the past, most substance abuse treatment services occur at the tertiary level of care. Given the high levels of substance abuse in this province and the limited number of state facilities, responsibility for the treatment of substance abusers rests heavily on non-government organizations and the private sector. For example, towards the end of 2001, there were 13 private and semi-private treatment centres and 10 SANCA affiliated treatment centres in the Western Cape Province (Western Cape Department of Health, 2002).

While a number of private facilities are available in the province, access to private treatment services is generally limited to individuals with private health insurance or those who can afford to pay out-of-pocket. In South Africa, the private sector has been criticised on a number of access-related issues, including serving mostly white communities; having limited skills for dealing with the cultural, social and language context of historically disadvantaged communities; being located in urban areas and thus being inaccessible to the majority of the population; and for only being accessible to those who can afford to pay for services (Edelstein, Weber, & Pillay, 1997). Given the rising levels of substance abuse in the country, and in the Western Cape in particular (Myers et al., under review; Parry et al., 2002), accessibility to substance abuse treatment services (in either the private or public sector) is an area that needs to be addressed as a matter of urgency.

Although access is generally understood to refer to the ease at which health services are initiated (initial access), access is a multidimensional concept that also refers to the sustainability of health service delivery or retention in treatment services (McCaughrin & Howard, 1996). International treatment outcome studies have reported that treatment retention is a significant predictor of treatment outcome, with longer retention associated with better outcomes (Best et al., 2002; Simpson, 2001). Simpson et al's (2001) generic model of treatment process conceptualises treatment retention as an indicator of engagement in the treatment process. The likelihood of client engagement is predicted by multiple variables, including patient, therapeutic and social environmental factors that are fundamental to effective treatment. In other words, characteristics of the client, the counsellor and the

treatment service environment influence the degree to which clients continue to engage in treatment, and thus access treatment services (Joe et al., 1999; Simpson et al., 2001). In considering the accessibility of substance abuse treatment services, it is thus important to consider the availability and affordability of such services, as well as the extent to which treatment service characteristics impact on client retention, and ultimately treatment outcomes.

Based partly on the need for more detailed information about treatment services, key role players in the province have identified the need for a comprehensive audit of substance abuse treatment services in the Western Cape (PAWC, 2000). To date, only cursory audits have been conducted. These typically consist of a listing of treatment services in a treatment directory. An audit of available treatment services is also necessary as, at present, there is no legislation that regulates and oversees the training, qualification and competencies of addiction treatment service providers. An audit would also be able to reveal gaps in staffing patterns and competencies that need to be addressed in future human resource planning, and thus assist in the planning and delivery of coordinated treatment services. Thirdly, as little is known about what types of services are being offered to clients or about the content of the treatment programmes, a comprehensive audit would begin to make substance abuse treatment services more transparent and ultimately accountable to consumers and the general public. Fourth, as programme characteristics, treatment environment, and accessibility issues impact on treatment retention and ultimately treatment outcomes, an audit that explores access to treatment and treatment environment would provide some understanding of the barriers to equitable and effective service delivery in South Africa. Finally, it is internationally recognized that the collection of substance abuse treatment service information is an important part of treatment service planning, monitoring and evaluation (Grant & Petrie, 2001). Yet in South Africa, substance abuse treatment service information has not been collected. It is hoped that this substance abuse treatment service audit will provide a foundation for the future monitoring and evaluation of treatment facilities in Cape Town. It is also hoped that findings from this study will be used to inform public policy on substance abuse treatment and will aid in the planning and delivery of effective substance abuse treatment services in Cape Town.

Aims

- To gain an understanding of the characteristics of substance abuse treatment facilities in Cape Town
- To gain an understanding of the treatment practices of substance abuse treatment facilities in Cape Town.

- To gain an understanding of the staffing, organisational, and environmental characteristics of substance abuse treatment facilities in Cape Town
- To increase knowledge about the accessibility of substance abuse treatment services in Cape Town.
- To describe the relationship between facility characteristics and accessibility of treatment services
- To use this information to inform substance abuse treatment policy at a provincial and national level.
- To use this information to inform current substance abuse treatment service planning and delivery at a local, provincial and national level.
- To serve as a needs assessment for future evaluative studies of substance abuse treatment services in the region.

Objectives

- To describe the characteristics of substance abuse treatment facilities in Cape Town (e.g. types of care offered, treatment modality, treatment setting, and facility ownership).
- To describe and compare the types of treatment services offered by substance abuse treatment programmes in Cape Town by facility characteristics.
- To compare the structure and content of substance abuse treatment programmes in Cape Town by facility characteristics.
- To describe and compare the client and staffing characteristics of substance abuse treatment programmes by facility characteristics.
- To describe and compare the accessibility of, as well as activities conducted by substance abuse treatment services to improve accessibility and treatment retention by facility characteristics.
- To describe and compare the need for programme evaluation and monitoring activities for substance abuse treatment programmes in Cape Town by facility characteristics.
- To inform interventions to improve the accessibility and quality of substance abuse treatment services in Cape Town.
- To disseminate the information collected, through a variety of mechanisms to local, provincial and national stakeholders.

Methods

Study Design

A cross-sectional audit of substance abuse treatment facilities was conducted in Cape Town, the urban capital of the Western Cape Province of South Africa. This included a cross-sectional survey of the characteristics of clients served by these treatment facilities in the 12 months preceding the audit.

Sample

The sample consists of the total population of specialised substance abuse treatment facilities in Cape Town. According to this study, specialised treatment facilities are defined as delivering one or more specialised substance abuse treatment services to people with AOD problems (Torres, Mattick, Chen & Baillie, 1995). A variety of treatment facilities are covered by this definition, including detoxification and rehabilitation programmes and psychological treatments. Using this definition, sole providers of services (e.g. a psychologist) or facilities that provide substance abuse services in conjunction with other health services (e.g. general hospitals) are not included in the sample. In addition, self-help groups and services that only provide information, education, or crisis intervention are not classified as specialist AOD treatment facilities.

The sample frame was constructed from the list of known treatment facilities made available by the Western Cape Departments of Health and Social Services. Treatment facilities from the South African Community Epidemiology Network on Drug Use Project (SACENDU) database were also added to the frame. At the time of the audit, there were 25 facilities that satisfied the criteria used by this study for the definition of “specialist substance abuse treatment facility”.

Questionnaire

The Treatment Services Audit (TSA) Questionnaire is a 10-page instrument that contains 48 questions, many of which require multiple responses. The principal investigator designed the TSA for the purposes of auditing substance abuse treatment facilities in South Africa. The construction of the 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. TSA questionnaire items were discussed in focus groups comprised of substance abuse treatment experts to ensure applicability to the South African context. The final version of the TSA was then piloted at two treatment facilities and necessary changes were made to problematic items. Following

finalisation of the TSA, all treatment facilities in Cape Town were contacted and asked to participate in the study.

The TSA contains structured questions with forced choice responses, as well as open-ended questions. Information is collected from a number of domains including the characteristics of the treatment facility, the types of treatment services offered, the structure and content of the treatment programme, the accessibility of services, the treatment environment, staffing characteristics, and monitoring and evaluation processes. The TSA is directed at key informants from treatment programmes, such as clinical programme managers or treatment directors.

Procedures

The 25 treatment facilities in the sampling frame were telephonically contacted, informed of the study, and asked to participate. The TSA was delivered to participating facilities in person in August 2002. Completed questionnaires were returned to the investigator in October/November 2002. Non-respondents were followed up on three occasions by telephone and the TSA questionnaire was re-sent to them.

Information on client characteristics for 20 of the 22 facilities was gathered from the SACENDU database. The SACENDU project collects bi-annual data from about 95% of the specialist substance abuse treatment centres in Cape Town. For the purpose of surveillance, a standardised one-page form is completed on each person treated by a given facility during a particular 6-month period. The form elicits responses about the source of referral for treatment, biographical information, type of treatment received (inpatient and/or outpatient), the primary and secondary substances of abuse, the mode(s) of use, and whether the person had received treatment prior to the current episode (Parry et al., 2002a/b).

Data analysis

Statistics for this study were computed using the Statistical Package for the Social Sciences (Norusis/SPSS Inc., 1988). Descriptive statistics were calculated for all treatment service-, client-, staff-, and access-oriented variables. Cross-tabulations were performed on each of these variables by treatment type, ownership, and setting. Cramer's V tests of association for nominal data were performed to determine whether there were any significant differences between treatment modalities on these variables.

Response rates

The response rate for the TSA questionnaire was 88.0%, with 22 out of 25 facilities completing the questionnaire. Facilities that did not complete the questionnaire tended to be smaller, consist of solo practitioners and tended to be unregistered. Of the facilities that did not complete the questionnaire, two are no longer functioning.

PART 2: RESULTS FROM THE MRC AUDIT OF SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

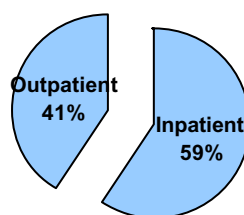
CHARACTERISTICS OF SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

Treatment services research has emphasised that in addition to clinical need, the characteristics of treatment facilities may 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 facility characteristics that have been shown to impact on access to treatment services. These characteristics include: type of care (modality) offered by the treatment service, ownership of the facility, and treatment setting.

Treatment facility profile by type of care

There are two main types of care offered by substance abuse treatment facilities in South Africa, namely inpatient/residential care and outpatient care. Although some treatment facilities provide in- and outpatient levels of care, generally such facilities primarily offer inpatient services and will thus be classified as inpatient facilities. In Cape Town, 13 of the 22 facilities (59.1%) offered primarily inpatient treatment services. In contrast, 9 of the facilities (40.9%) provided outpatient services only.

Figure 1. Proportion of substance abuse treatment services in Cape Town by type of care

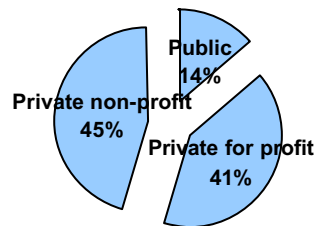


Treatment facility profile by facility ownership

Facility ownership is a variable that has been shown to impact on access to substance abuse treatment services in international treatment services research (Lee et al., 2001). The private sector is classically defined as organisations and individuals working outside the direct control of the state, for either profit or non-profit purposes (Edelstein, Weber, & Pillay, 1997). The former usually have financial gain as their dominant objective, whereas the latter provide health and welfare services for charitable, humanitarian, and a multitude of other reasons. This study makes a distinction between private for-profit and private non-profit substance

abuse treatment facilities, and hypothesises that this distinction impacts on the types of clients served, services offered, and on the accessibility of services. Of the 22 facilities that participated in this study, only 3 (13.6%) were public facilities. In contrast 19 (86.4%) were privately owned facilities. More specifically, of the privately owned facilities, 10 (45.5%) were private non-profit centres and 9 (40.9%) were private for-profit facilities (Figure 2).

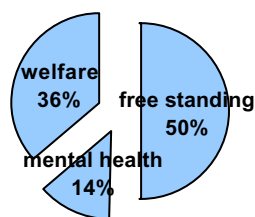
Figure 2. Pie chart of substance abuse treatment facilities in Cape Town by facility ownership



Treatment facility profile by treatment setting

Treatment setting is a facility-level characteristic that also potentially impacts on access to and quality of substance abuse treatment services. In the USA, the most common treatment settings are mental health settings, physical health settings, and stand-alone substance abuse treatment facilities (Lee et al., 2001). This study found that the most common treatment settings were free-standing substance abuse facilities comprising 50.0% of the sample, followed by welfare settings (comprising 36.4% of the sample), and finally mental health settings (e.g. psychiatric hospitals with a specialised substance abuse unit), comprising 13.6% of the sample (Figure 3).

Figure 3. Pie chart of substance abuse treatment facilities by treatment setting

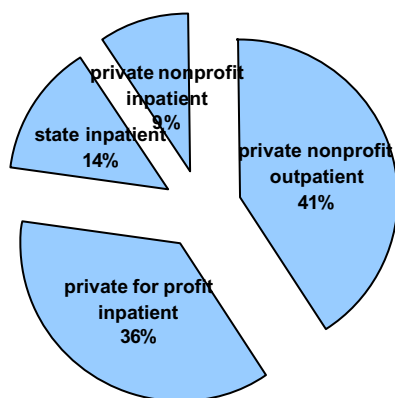


Other treatment facility characteristics by type of care and facility ownership

For the purposes of further analyses, treatment facilities were further classified by both type of care and type of ownership. Of the 22 facilities that participated in the audit, 40.9% (9) were private, non-profit facilities that offered outpatient treatment services, 36.4% (8) were private, for-profit treatment facilities that offered (primarily) inpatient treatment, 13.6% (3)

were state inpatient treatment facilities, and 9.1% (2) were private, non-profit facilities that provided inpatient treatment services. Data for the private, non-profit inpatient facilities will not be further reported on as this category consists of 2 facilities only (Figure 4).

Figure 4. Pie chart of types of substance abuse treatment facilities in Cape Town



Registration of facilities

In terms of registration and licensing, overall 18.1% (4) of the treatment facilities were registered with the Department of Health, 68.1% (15) were registered with the Department of Social Services, and 18.1% (4) were not registered with either licensing body. The proportion of facilities that were not registered consisted entirely of private, for-profit inpatient facilities. These 4 facilities comprised 44.4% of the total number of private inpatient facilities sampled.

Treatment facility profile by capacity

In this study, treatment capacity is understood to refer to the number of beds or treatment slots provided by a facility. Overall, treatment capacity ranged from 9 to 87 clients ($\bar{x} = 40.7$, $SD = 26.7$). Of these facilities, 40.9% (9) had a capacity of 21 to 30 clients, 18.2% (4) had a capacity for more than 30 clients, and 18.2% (4) had a capacity for more than 50 clients. Of the 4 facilities with a capacity for more than 50 clients, all were private non-profit, outpatient treatment services.

Utilisation of treatment capacity was considered by examining the number of clients treated in a typical month by facilities. Overall, the typical number of clients per month ranged from 6 to 64 ($\bar{x} = 24.9$, $SD = 15.2$). This appears considerably lower than the mean number of slots available. A one-sample *t*-test revealed that the mean typical number of clients treated per month was significantly lower than the mean number of treatment spaces available ($t = -4.629$, $df = 21$, $\alpha = 0.000$). More specifically, state facilities served an average of 25 clients;

private non-profit outpatient facilities served an average of 30 clients, and private, for-profit inpatient facilities served an average of 18 clients per month.

Unmet treatment need and access to these treatment slots was explored through examining the number of clients on the waiting list. A large proportion (81.1%) of the facilities had a waiting list. Specifically all the state facilities, 66.7% of the private non-profit facilities and 88.9% of the private for-profit inpatient facilities placed clients on a waiting list when treatment facilities were full. For those facilities that maintained a waiting list, the number of clients on this list at the time of the audit) ranged from 0 to 89 ($\bar{x} = 12.8$, $SD = 24.7$). The majority of the facilities (76.2%) had between 0 and 10 clients currently on the waiting list. However 9.5% of facilities had between 26 and 40 clients on the waiting list and 9.5% had more than 40 clients on their waiting list. All of the facilities with more than 40 clients on their waiting list were state facilities.

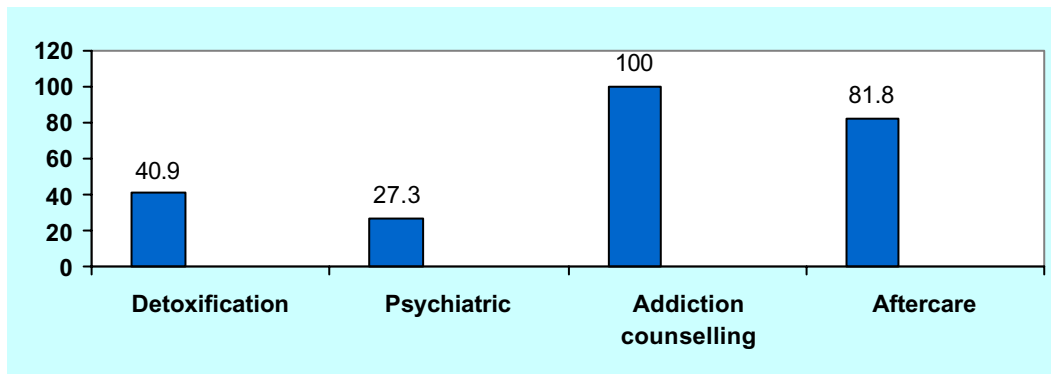
PROFILE OF SERVICES PROVIDED BY SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

This section describes the types of treatment services provided by facilities in Cape Town. This section also examines variations in access to services by facility characteristics such as treatment modality, ownership, and treatment setting. There are two main types of services provided by facilities, namely treatment services proper, and support services. Support services are services directed towards problems that are associated with AOD abuse (e.g. psychological dysfunction). Support services may also be services that retain the substance abuser in treatment, such as transportation services (Lee et al., 2001).

Profile of treatment services offered by substance abuse facilities in Cape Town

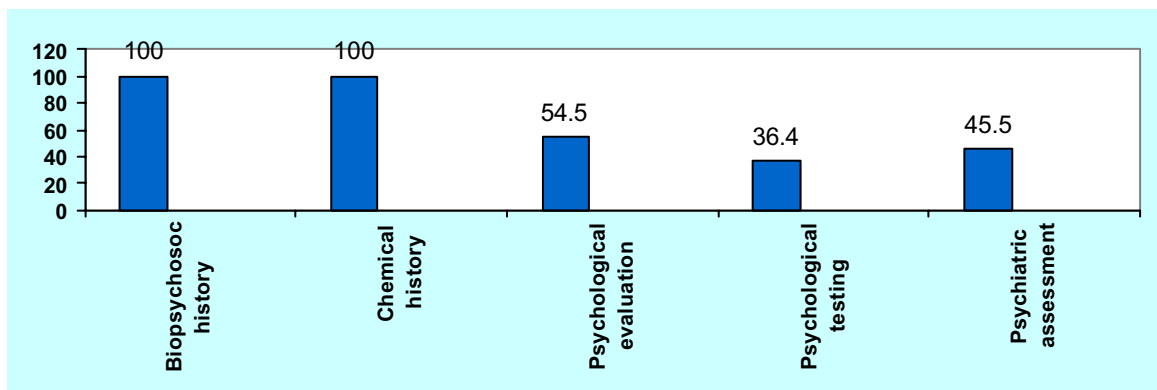
All facilities offered some form of substance abuse counselling and 80% of treatment services offered some type of aftercare service. In contrast, less than half offered medical/detoxification services and less than a third of the facilities offered psychiatric services (Figure 5).

Figure 5. Proportion of facilities offering treatment services to clients (N = 22)



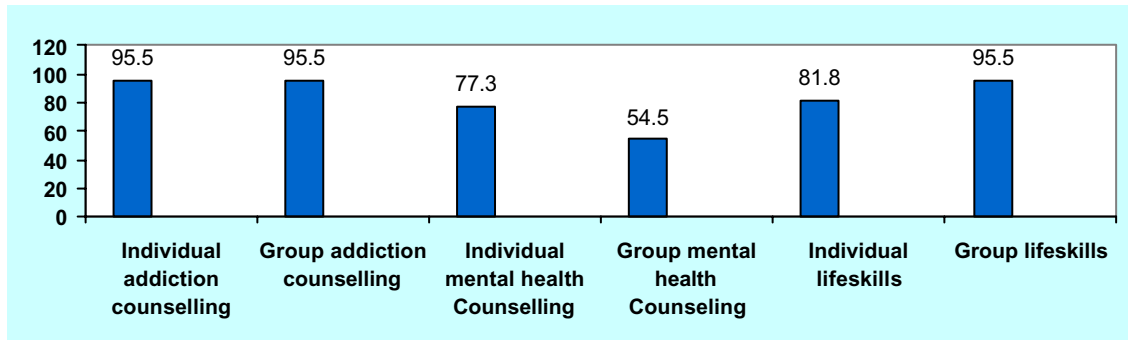
More specifically, in terms of assessment services, all facilities completed a biopsychosocial and chemical history of their clients. In contrast, few facilities conducted psychological evaluations, psychological testing, or psychiatric assessments (Figure 6).

Figure 6. Proportion of facilities providing assessment services to clients (N= 22).



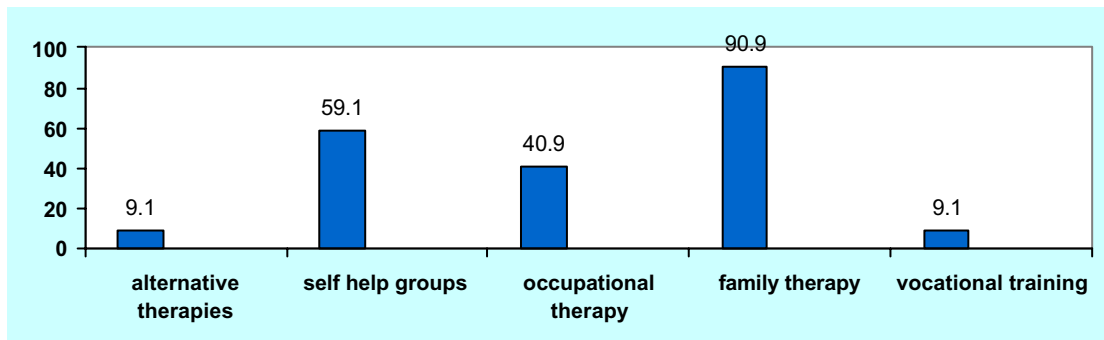
A large proportion of facilities provided individual and group addiction counselling services as well as individual and group life-skills training (Figure 7). In comparison, a smaller proportion of facilities offered individual mental health counselling or group mental health counselling (e.g. bereavement groups).

Figure 7. Proportion of facilities offering counselling services to clients (N = 22)



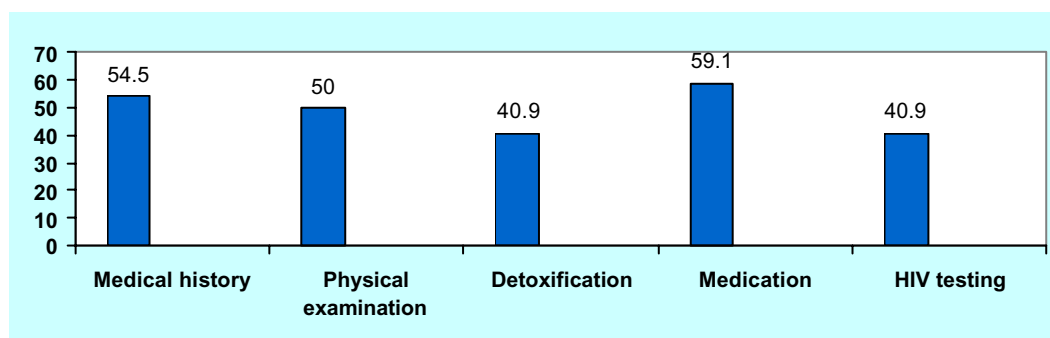
In terms of other therapeutic services offered by facilities, almost all facilities offered family therapy to their clients. In contrast, less than two thirds offered self-help/mutual-help group participation and less than half offered occupational therapy services. A very small proportion of facilities provided alternative healing therapies such as acupuncture or additional services such as vocational training (Figure 8).

Figure 8. Proportion of facilities offering other therapeutic services to clients (N= 22)



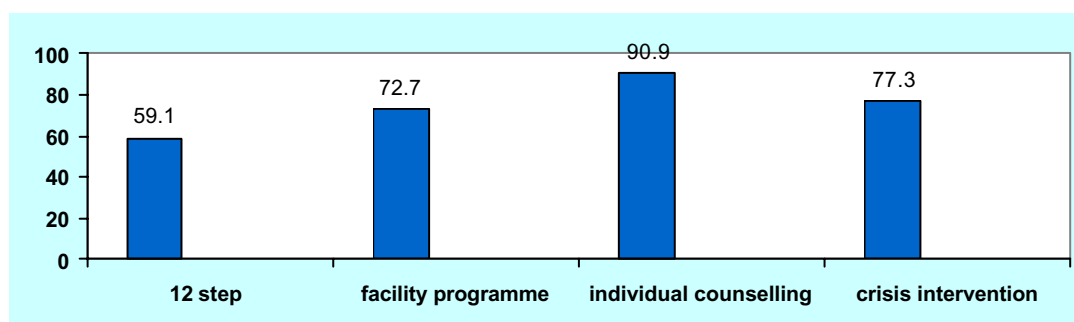
A smaller proportion of facilities provided medically oriented services to their clients, in comparison to counselling services. Specifically, just over half the facilities took a full medical history of their clients, half completed a physical examination of their clients, and less than half provided either detoxification services or HIV testing and counselling services. In contrast, almost 60% of facilities provided clients with medication (Figure 9).

Figure 9. Proportion of facilities offering medical services to clients (N=22)



In terms of aftercare services, a high proportion of facilities reported providing individual aftercare counselling as well as crisis intervention. A smaller proportion reported providing a 12-step aftercare programme (Figure 10).

Figure 10. Proportion of facilities offering aftercare treatment services to clients (N= 22)



Variations in treatment services by facility characteristics

Variations by type of care and facility ownership

As most state and private for-profit facilities offer primarily inpatient care and most private non-profit facilities offer primarily outpatient services, a decision was made to categorise facilities by both facility ownership and type of care. The following table shows variations in access to treatment services by treatment modality and ownership.

Table 1. Variations in access to services by treatment modality and ownership, for substance abuse treatment facilities in Cape Town (N = 21)

	Private inpatient (N = 9)		State inpatient (N = 3)		Private non-profit, outpatient (N= 9)	
	n	%	n	%	n	%
<i>Detoxification services</i>	7	77.8	1	33.3	1	11.1
<i>Psychiatric services</i>	4	44.4	1	33.3	1	11.1
<i>Addiction counselling</i>	9	100.0	3	100.0	9	100.0
<i>After care services</i>	7	77.8	1	33.3	9	100.0

A higher proportion of private, for-profit inpatient treatment facilities provided detoxification services than either state inpatient or private non-profit outpatient facilities. This difference was significant (Cramer's $V = .629$, $p = .016$) Similarly, a higher proportion of private for-profit inpatient treatment facilities provided psychiatric services than either state inpatient or private non-profit outpatient facilities. This difference was however, not significant at the 0.05 level of significance. Aftercare services were provided by most of the private for-profit and private non-profit facilities. Variations in the types of services offered to a typical client by treatment modality and ownership were then examined (Table 2).

In terms of assessment procedures, a higher proportion of private for-profit inpatient treatment facilities conducted psychological evaluations than either state or non-profit outpatient facilities. This difference was significant (Cramer's $V = .730$, $p = .004$). Similarly, a significantly larger proportion of private for-profit inpatient treatment facilities conducted psychological testing than either state or non-profit outpatient facilities (Cramer's $V = .742$, $p = .003$). Psychiatric assessments were conducted by significantly more state or private for-profit inpatient facilities than private non-profit facilities (Cramer's $V = .670$, $p = .009$) (Table 2).

Table 2. Variations in services for a typical client by treatment modality and ownership, for substance abuse treatment facilities in Cape Town (N = 20)

	Private, inpatient (N= 9)		State inpatient (N=2)		Private, non-profit, outpatient (N= 9)	
	n	%	n	%	n	%
<i>Biopsychosocial history</i>	9	100.0	3	100.0	9	100.0
<i>Chemical history</i>	9	100.0	3	100.0	9	100.0
<i>Psychological evaluation</i>	8	88.9	1	33.3	1	11.1
<i>Psychological testing</i>	7	77.8	1	33.3	0	0.0
<i>Psychiatric assessment</i>	6	66.7	3	100.0	1	11.1
<i>Individual substance abuse counselling</i>	9	100.0	2	66.7	9	100.0
<i>Group substance abuse counselling</i>	9	100.0	3	100.0	8	88.9
<i>Individual mental health counselling</i>	8	88.9	3	100.0	5	55.6
<i>Group mental health counselling</i>	7	77.8	3	100.0	1	11.1
<i>Individual life skills</i>	7	77.8	2	66.7	8	88.9
<i>Group life skills</i>	9	100.0	3	100.0	8	88.9
<i>Alternative therapies</i>	1	11.1	0	0.0	1	11.1
<i>Self help groups</i>	9	100.0	2	66.7	1	11.1
<i>Occupational therapy</i>	6	66.7	3	100.0	0	0.0
<i>Family therapy</i>	9	100.0	2	66.7	8	88.9
<i>Medical history</i>	7	77.8	3	100.0	1	11.1
<i>Physical examination</i>	7	77.8	3	100.0	0	0.0
<i>Detoxification services</i>	7	77.8	0	0.0	1	11.1
<i>Provision of medication</i>	8	88.9	3	100.0	1	11.1
<i>HIV testing/counselling</i>	6	66.7	2	66.7	0	0.0
<i>12 step aftercare</i>	9	100.0	1	11.1	2	66.7
<i>Facility's aftercare programme</i>	6	66.7	7	77.8	2	66.7
<i>Individual aftercare counselling</i>	9	100.0	9	10.0	1	33.3
<i>Crisis interventions</i>	8	88.9	8	88.9	1	33.3

Most facilities offered a range of individual and group therapies. However state and private for-profit facilities were more likely to provide group mental health counseling than private non-profit facilities (Cramer's $V = .730$, $p = .004$). Similarly, state and private for-profit facilities were significantly more likely to provide self-help group participation private non-profit facilities (Cramer's $V = .835$, $p = .001$). State and private for-profit inpatient facilities were also significantly more likely to provide occupational therapy than private non-profit outpatient facilities (Cramer's $V = .782$, $p = .002$) (Table 2).

In terms of medical and detoxification services, detoxification was significantly more likely to be provided by private for-profit inpatient facilities than either state inpatient or private, non-profit outpatient facilities (Cramer's $V = .712$, $p = .005$). HIV testing was also significantly more likely to be provided by private for-profit facilities than private, non-profit outpatient facilities (Cramer's $V = .679$, $p = .008$). Medical histories were more likely to be completed at state or private for-profit inpatient facilities than at private non-profit outpatient centers (Cramer's $V = .831$, $p = .006$) and physical examinations were significantly more likely to be conducted at state or private for-profit inpatient facilities than at private non-profit outpatient centers (Cramer's $V = .931$, $p = .001$). Provision of medication was also more likely to occur at state or private for-profit inpatient facilities than at private non-profit outpatient centers (Cramer's $V = .809$, $p = .001$). Facilities also differed significantly in terms of their provision of 12-step aftercare, with private for-profit facilities being most likely to provide this service (Cramer's $V = .835$, $p = .001$). Private for-profit inpatient facilities and private non-profit outpatient facilities were also significantly most likely to provide individual counseling as an aftercare service (Cramer's $V = .795$, $p = .001$).

Variations by treatment setting

The following table shows variations in access to treatment services by treatment setting. For the purposes of this study, specialised substance abuse units in psychiatric hospitals have been classified as mental health settings.

Table 3. Variations in access to services by treatment setting for substance abuse treatment facilities in Cape Town (N = 22)

	Mental health setting (N=3)		Stand alone substance abuse facility (N=11)		Welfare setting (N= 8)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<i>Detoxification services</i>	2	66.7	7	63.6	0	0.0
<i>Psychiatric services</i>	3	100.0	3	27.3	0	0.0
<i>Addiction counselling</i>	3	100.0	11	100.0	8	100.0
<i>After care services</i>	1	33.3	9	81.8	8	100.0

Facilities in welfare settings were significantly less likely to provide detoxification services than stand-alone substance abuse centres or facilities located in mental health settings (Cramer's $V = .629$, $p = .013$). A significantly higher proportion of facilities located in mental health settings provided psychiatric services when compared to either stand-alone facilities or facilities located in welfare settings (Cramer's $V = .707$, $p = .004$). In contrast, stand-alone facilities and facilities located in welfare settings were significantly more likely to provide aftercare services than facilities located in mental health settings (Cramer's $V = .544$, $p = .038$). Variations in the types of services offered to a typical client by treatment setting were then examined.

Table 4. Variations in services for a typical client by treatment setting, for substance abuse treatment facilities in Cape Town (N= 22)

	Mental health setting (N=3)		Stand alone substance abuse facility (N= 11)		Welfare setting (N= 8)	
	n	%	n	%	n	%
<i>Biopsychosocial history</i>	3	100.0	11	100.0	8	100.0
<i>Chemical history</i>	3	100.0	11	100.0	8	100.0
<i>Psychological evaluation</i>	3	100.0	9	81.8	0	0.0
<i>Psychological testing</i>	2	66.7	6	54.5	0	0.0
<i>Psychiatric assessment</i>	3	100.0	7	63.6	0	0.0
<i>Individual substance abuse counselling</i>	2	66.7	11	100.0	8	100.0
<i>Group substance abuse counselling</i>	3	100.0	11	100.0	7	87.5
<i>Individual mental health counselling</i>	3	100.0	10	90.9	4	50.0
<i>Group mental health counselling</i>	3	100.0	9	81.8	0	0.0
<i>Individual life skills</i>	2	66.7	9	81.8	7	87.5
<i>Group life skills</i>	3	100.0	11	100.0	7	87.5
<i>Alternative therapies</i>	1	33.3	1	9.1	0	0.0
<i>Self help groups</i>	2	66.7	11	100.0	0	0.0
<i>Occupational therapy</i>	2	66.7	7	63.6	0	0.0
<i>Family therapy</i>	2	66.7	11	100.0	7	87.5
<i>Medical history</i>	3	100.0	9	81.8	0	0.0
<i>Physical examination</i>	3	100.0	8	72.7	0	0.0
<i>Detoxification services</i>	2	66.7	7	63.6	0	0.0
<i>Provision of medication</i>	3	100.0	10	90.9	0	0.0
<i>HIV testing/counselling</i>	2	66.7	7	63.6	0	0.0
<i>12 step aftercare</i>	2	66.7	11	100.0	0	0.0
<i>Facility's aftercare programme</i>	3	100.0	7	63.6	6	75.0
<i>Individual aftercare counselling</i>	2	66.7	10	90.9	8	100.0
<i>Crisis interventions</i>	2	66.7	8	72.7	7	87.5

A significantly higher proportion of mental health facilities and stand-alone facilities conducted psychological evaluations than facilities in welfare settings (Cramer's $V = .837$, $p = .000$). Similarly, a significantly larger proportion of facilities in mental health settings and stand-alone facilities conducted psychological testing than facilities in welfare settings (Cramer's $V = .577$, $p = .026$). Psychiatric assessments were also conducted by significantly more mental health and stand-alone treatment facilities than welfare facilities (Cramer's $V = .730$, $p = .003$).

Most facilities offered a range of individual and group therapies. However mental health and stand-alone facilities were significantly more likely to provide group mental health counseling than facilities in welfare settings (Cramer's $V = .837$, $p = .000$). Similarly, mental health and stand-alone facilities were significantly more likely to provide self-help group participation than facilities in welfare settings (Cramer's $V = .935$, $p = .000$). Mental health and stand-alone facilities were also significantly more likely to provide occupational therapy than facilities in welfare settings (Cramer's $V = .629$, $p = .013$) (Table 4).

In terms of medical/detoxification services, detoxification services were significantly more likely to be provided by facilities in mental health settings or by stand-alone treatment facilities than those in welfare settings (Cramer's $V = .629$, $p = .013$). HIV testing was also more likely to be provided by facilities in mental health settings or by stand-alone treatment facilities than those in welfare settings (Cramer's $V = .629$, $p = .013$). Medical histories were more likely to be completed at mental health or stand-alone treatment facilities than welfare facilities (Cramer's $V = .924$, $p = .001$) and physical examinations were significantly less likely to be conducted at welfare settings (Cramer's $V = .854$, $p = .003$). Provision of medication was more likely to occur at stand-alone facilities or facilities in mental health settings than at facilities on welfare settings (Cramer's $V = .911$, $p = .000$).

PROFILE OF CLIENTS SERVED BY SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

The following section describes the demographic profile of the clients served, in the 12 months prior to the audit, by substance abuse treatment facilities in Cape Town. More specifically, variations in client profile by treatment modality, facility ownership, and treatment setting are explored.

Demographic and substance abuse profile of clients treated at all substance abuse treatment facilities in Cape Town

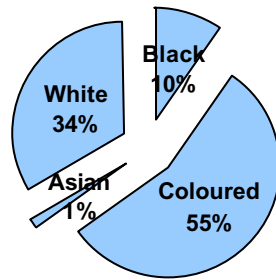
Demographic profile

As mentioned above, the demographic profile of clients seen in the past 12 months by 20 of the 22 treatment facilities is depicted in this section. Overall these facilities treated 3006 clients. Of these clients 81.3% ($n = 2444$) were male and 18.5% ($n = 555$) were female. In terms of age, 22.4% ($n = 670$) of clients receiving substance abuse treatment were less than 20 years old. A further 23.9% ($n = 717$) of the sample was between 20 and 29 years of age. The average age of this sample was 31.7 years ($SD = 12.61$).

The following pie chart illustrates the race profile of the clients served in the past 12 months by substance abuse treatment facilities in Cape Town. For the total sample, 31.3% was White[♦], 51.4% was Coloured, 9.1% was Black, and 1.2% was Asian.

♦ 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. The demographic characteristics of substance users are important as accurate user profiles assist in identifying vulnerable sections of the population and in planning effective prevention and intervention programmes.

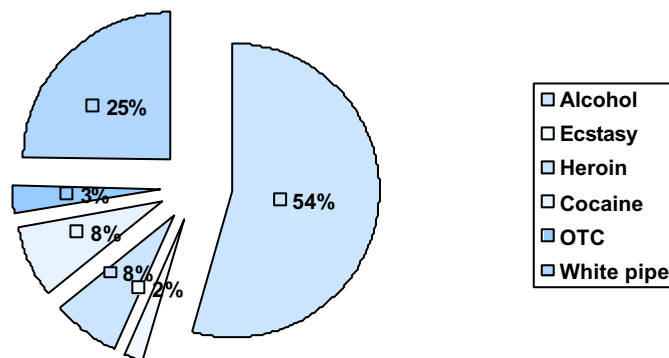
Figure 11. Race of clients served by treatment facilities in Cape Town in 2001-2002.



Substance use profile

For this sample, the most common primary substance of abuse was alcohol, followed by white pipes (cannabis used in combination with Mandrax), cannabis, cocaine and heroin. The following pie chart illustrates the proportion of clients reporting these substances as their primary substance of abuse. Over three quarters of the clients had alcohol, cannabis, or Mandrax as their primary substance of abuse.

Figure 12. Primary substance of abuse of clients attending treatment facilities in Cape Town



Variations in the profile of clients served by substance abuse treatment facilities in Cape Town by facility characteristics

Variations by type of care and facility ownership

The following table describes variations in the profile of clients served by substance abuse treatment facilities by treatment modality and ownership.

Table 5. Demographic profile of clients receiving substance abuse treatment services in Cape Town by treatment modality (2001)

		Private, for profit, inpatient		State inpatient		Private, non-profit, outpatient	
		<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender	<i>Male</i>	923	67.2	439	82.8	1000	84.9
	<i>Female</i>	291	23.9	90	17.0	174	14.8
Age	<i>≤ 19</i>	131	10.8	122	23.2	417	35.5
	<i>20-29</i>	307	25.3	103	19.6	302	25.7
	<i>30-39</i>	315	26.0	130	24.7	298	25.4
	<i>≥40</i>	459	37.9	171	32.5	157	13.4
Race	<i>African/Black</i>	37	3.1	26	5.0	212	21.3
	<i>Coloured</i>	484	40.5	415	79.0	607	61.0
	<i>Asian</i>	13	1.1	4	0.8	20	2.0
	<i>White</i>	662	55.4	80	15.2	156	15.7

A significantly higher proportion of females received treatment services from private for-profit, inpatient facilities than state inpatient and private non-profit outpatient facilities (Cramer's $V = .135$, $p = .000$). In terms of age, a higher proportion of adolescents (62.2%) received services from private, non-profit outpatient facilities than state (18.2%) or private for-profit inpatient facilities (19.6%). In contrast, a significantly larger proportion of clients aged 40 years or older were treated by private for-profit inpatient facilities (54.5%) than private, non-profit outpatient (18.6%) or state inpatient facilities (20.3%) (Cramer's $V = .357$, $p = .000$). The average age of this sample was 31.7 years ($SD = 12.61$). In terms of race, 31.3% of the total sample was White, 51.4% was Coloured, 9.1% was Black, and 1.2% was Asian. Of the Black clients treated by substance abuse facilities, 77.1% were treated by private, non-profit outpatient facilities, compared to 9.5% treated by state and 13.5% treated by private for-profit inpatient facilities (Cramer's $V = .481$, $p = .000$). In contrast, of the White clients treated by substance abuse facilities, 70.4% were treated by private for-profit inpatient facilities, 16.6% were treated by private non-profit outpatient facilities, and 8.5% were treated by state inpatient facilities (Cramer's $V = .481$, $p = .000$).

When the primary substance of abuse reported by clients was compared across treatment modalities and by facility ownership, the most common primary substance of abuse reported by clients at private, for-profit inpatient facilities, was alcohol, followed by white pipes, heroin and cocaine. In contrast, at private, non-profit outpatient facilities, white pipes followed by alcohol and cannabis were the most commonly reported primary substances of abuse. At state inpatient facilities, the most frequently reported primary substance of abuse was alcohol, followed by white pipes and cannabis (Table 6).

Table 6. Primary substance of abuse of clients receiving substance abuse treatment services in Cape Town by treatment modality & facility ownership (2001)

	Private, for profit, inpatient		State inpatient		Private, non-profit, outpatient	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Alcohol	691	56.8	324	61.1	318	27.0
White pipes	156	12.8	108	20.4	375	31.8
Cannabis	46	3.8	77	14.5	241	20.5
Cocaine	109	9.0	6	1.1	94	8.0
Heroin	132	10.9	2	0.4	60	5.1
Ecstasy	16	1.3	2	0.4	21	1.8
Over the counter	54	4.4	2	0.4	22	1.9

Alcohol, cocaine, heroin, and over-the-counter (OTC) medication were more likely to be reported as primary drugs of abuse in private for-profit inpatient facilities than for state or private, non-profit outpatient facilities. In contrast, cannabis, white pipes, and Ecstasy were more likely to be reported as primary drugs of abuse by clients at private non-profit facilities than private for profit inpatient facilities.

Variations by treatment setting

The following table describes variations in the profile of clients served by substance abuse treatment facilities by treatment setting.

Table 7. Demographic profile of clients receiving substance abuse treatment services in Cape Town by treatment setting (2001)

		Mental health setting		Stand alone substance abuse facility		Welfare setting	
		<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Gender	<i>Male</i>	439	70.8	1525	83.8	480	84.7
	<i>Female</i>	181	29.2	290	15.9	84	14.8
Age	<i>≤ 19</i>	75	11.2	399	59.6	196	29.3
	<i>20-29</i>	130	18.1	504	70.3	83	11.6
	<i>30-39</i>	175	22.9	423	55.4	166	21.7
	<i>≥40</i>	237	28.1	488	57.9	118	14.0
Race	<i>African/Black</i>	21	3.5	91	5.6	163	29.4
	<i>Coloured</i>	248	40.9	946	57.8	352	63.4
	<i>Asian</i>	7	1.2	30	1.8	0	0.0
	<i>White</i>	331	54.5	569	34.8	40	7.2

A significantly higher proportion of females received treatment services from facilities in mental health settings than from stand-alone or welfare facilities (Cramer's $V = .145$, $p = .000$). In terms of age, a higher proportion of adolescents (34.8%) received services from welfare facilities than mental health (12.2%) or stand-alone facilities (22.2%). In contrast, a significantly larger proportion of clients aged 40 years or older were treated by mental health facilities (38.4%) than welfare (21.0%) or stand-alone facilities (26.9%) (Cramer's $V = .220$,

$p = .000$). Of the Black clients treated by substance abuse facilities, the majority (59.3%) were treated by welfare facilities, followed by stand-alone facilities (33.1%) and mental health facilities (7.6%). Of the Coloured clients, 61.2% were treated by stand-alone facilities, 22.8% by welfare facilities, and 16.0% by mental health facilities. In contrast, 60.5% of Whites were treated by stand-alone facilities, 35.2% by mental health facilities, and only 4.3% by welfare facilities (Cramer's $V = .426, p = .000$).

Alcohol, followed by heroin, cocaine, white pipes, and over-the-counter (OTC) medication were the most frequently reported primary substances of abuse in mental health settings. In contrast, alcohol, followed by white pipes and cannabis were the most frequently reported primary substances of abuse at both stand-alone treatment facilities and welfare settings. Stand-alone facilities were more likely to have clients reporting problems related to heroin and cocaine use than clients in welfare settings.

Table 8. Primary substance of abuse of clients receiving substance abuse treatment services in Cape Town by treatment setting (2001)

	Mental health setting		Stand alone substance abuse facility		Welfare setting	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Alcohol	404	65.2	700	38.5	309	54.5
White pipes	31	5.0	474	26.1	134	23.6
Cannabis	27	4.4	267	14.7	70	12.3
Cocaine	51	8.2	152	8.4	6	1.1
Heroin	62	10.0	127	7.0	5	0.9
Ecstasy	11	1.8	25	1.4	3	0.5
Over the counter	28	4.5	48	2.6	4	0.7

CHARACTERISTICS OF STAFF AT SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

This section describes the characteristics of the staff employed by substance abuse treatment facilities in Cape Town. Specifically, staff qualifications, staff development activities, and resources for staff are explored. The section also describes variations in staff characteristics by facility characteristics such as treatment modality, facility ownership, and treatment setting.

Characteristics of staff at substance abuse treatment facilities in Cape Town

The total number of full-time staff employed per substance abuse treatment facility ranged from 2 to 56 ($\bar{x} = 14.1, SD = 14.8$). The total number of part time staff ranged from 0 to 14 ($\bar{x} = 3.91, SD = 3.80$). The following table represents the mean number of staff per staffing

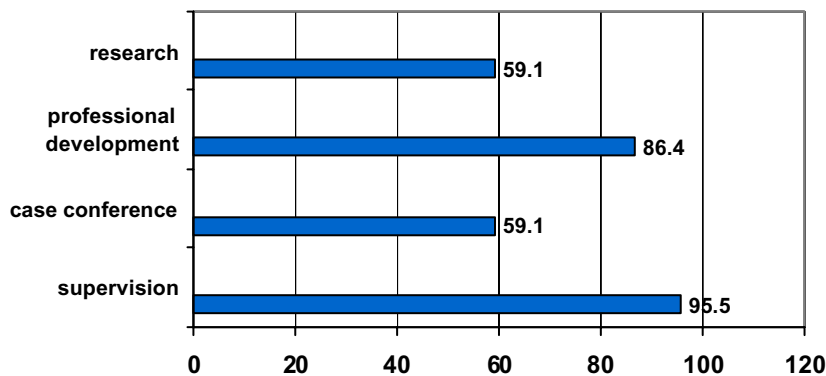
category for treatment facilities in Cape Town. There are a higher mean number of full time support counsellors, followed by social workers and registered nurses than for any other professional staffing category.

Table 9. Mean number of staff per staffing category for substance abuse treatment facilities in Cape Town (N=22).

	All facilities			
	Min	Max	\bar{x}	SD
<i>Full time psychiatrists</i>	0	8	0.5	1.7
<i>Part time psychiatrists</i>	0	1	0.3	0.5
<i>Full time doctors</i>	0	2	0.2	0.5
<i>Part time doctors</i>	0	2	0.5	0.6
<i>Full time psychologists</i>	0	9	0.7	2.0
<i>Part time psychologists</i>	0	1	0.5	0.7
<i>Full time social workers</i>	0	4	1.6	1.5
<i>Full time support counsellors</i>	0	4	2.3	5.7
<i>Part time support counsellors</i>	0	6	0.6	1.7
<i>Full time registered nurses</i>	0	8	1.3	2.3
<i>Part time registered nurses</i>	0	5	0.9	1.7
<i>Full time auxillary nurses</i>	0	6	0.5	1.5

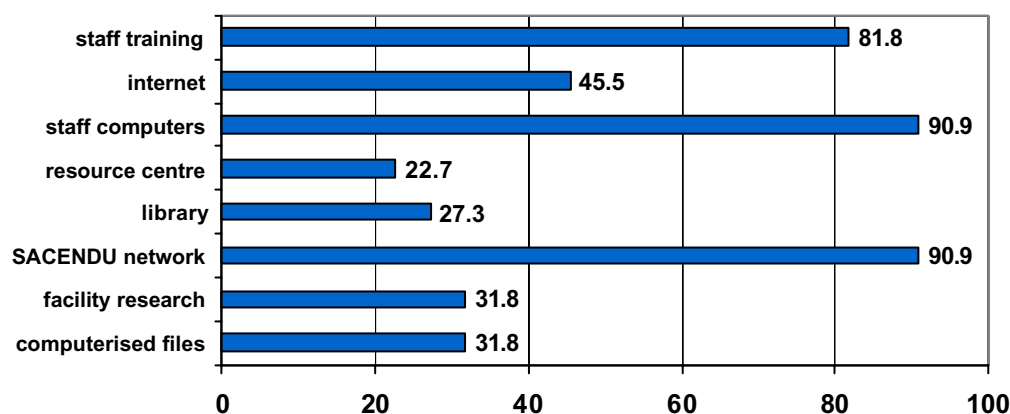
The following graph depicts the proportion of facilities that require their staff to participate in various professional development activities, such as regular supervision.

Figure 13. Proportion of facilities by staff development activities (N=22)



Participation in supervision (95.5%) and professional development activities (86.4%) were the most frequently mentioned staff development activities. Less frequently mentioned activities were involvement in other research (59.1%) or case conferences/ward rounds (59.1%). Facility resources that could be used to support staff and encourage professional development and the provision of quality care were also examined. Findings are depicted in the following graph.

Figure 14. Proportion of facilities with specific resources accessible to staff



Participation in the SACENDU network (90.9%), the provision of staff computers (90.9%), and the provision of training workshops for staff (81.8%) were cited as the most common resources made available by treatment facilities to staff. Proportionally fewer facilities had a library available to staff (27.3%), had a resource centre available for staff (22.7%), had computerised files for clients (management information system) (31.8%) or participated in other research activities (31.8%).

Variations in staff by facility characteristics

Variations in staff by treatment modality and facility ownership

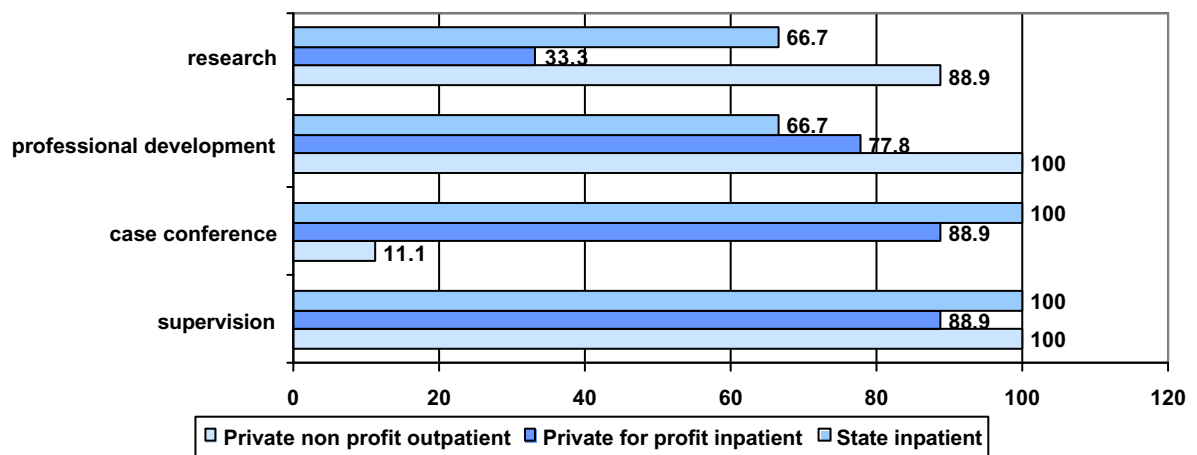
The total number of staff for private, inpatient treatment facilities ranged from 4 to 56 (\bar{x} = 19.8, SD = 15.5). For private, non-profit outpatient facilities, the number of staff ranged from 2 to 10 (\bar{x} = 3.8, SD = 2.5). For state inpatient facilities, the total number of staff employed ranged from 13 to 48 (\bar{x} = 26.3, SD = 18.9). Table 10 reports variations in the descriptive statistics for each staffing category by treatment modality and facility ownership.

Table 10. Descriptive statistics for each staffing category by treatment modality and facility ownership, for substance abuse treatment facilities in Cape Town

	Private, inpatient (N=9)				State inpatient (N=3)				Private, non-profit, outpatient (N =10)			
	Min	Max	\bar{x}	SD	Min	Max	\bar{x}	SD	Min	Max	\bar{x}	SD
<i>Full time psychiatrists</i>	0	8	1.0	2.5	0	0	0.0	0.0	0	0	0.0	0.0
<i>Part time psychiatrists</i>	0	1	0.4	0.5	0	1	0.7	0.6	0	1	0.1	0.3
<i>Full time doctors</i>	0	2	0.4	0.7	0	0	0.0	0.0	0	0	0.0	0.0
<i>Part time doctors</i>	0	2	0.6	0.7	1	1	1.0	0.0	0	1	0.1	0.3
<i>Full time psychologists</i>	0	9	1.6	2.8	0	0	0.0	0.0	0	0	0.0	0.0
<i>Part time psychologists</i>	0	1	0.5	0.5	1	3	1.7	1.1	0	1	0.1	0.3
<i>Full time social workers</i>	0	4	1.1	1.3	0	5	2.0	2.7	1	5	2.1	1.3
<i>Part time social workers</i>	0	1	0.1	0.3	0	0	0.0	0.0	0	0	0.0	0.0
<i>Full time support counsellors</i>	0	4	1.4	1.7	1	26	12.0	12.8	0	1	0.1	0.3
<i>Part time support counsellors</i>	0	6	1.2	2.5	0	0	0.0	0.0	0	1	0.1	0.3
<i>Full time registered nurses</i>	0	8	2.5	3.1	0	2	1.3	1.1	0	0	0.0	0.0
<i>Part time registered nurses</i>	0	5	1.6	2.1	0	4	1.3	2.3	0	0	0.0	0.0
<i>Full time auxillary nurses</i>	0	6	1.0	2.2	0	1	0.3	0.6	0	0	0.0	0.0
<i>Part time auxillary nurses</i>	0	0	0.0	0.0	0	1	0.3	0.6	0	0	0.0	0.0

Private for-profit inpatient treatment facilities have a higher mean number of fulltime psychiatrists, medical doctors, psychologists and registered nurses than either state or private non-profit outpatient facilities (Table 10). In contrast, the state inpatient treatment services seem to rely heavily on social workers and support counsellors for professional addiction services. Similarly, private non-profit outpatient treatment facilities rely on social workers to provide treatment services (Table 10). The following graph depicts variations in the proportion of facilities that required their staff to participate in development activities by treatment modality and facility ownership.

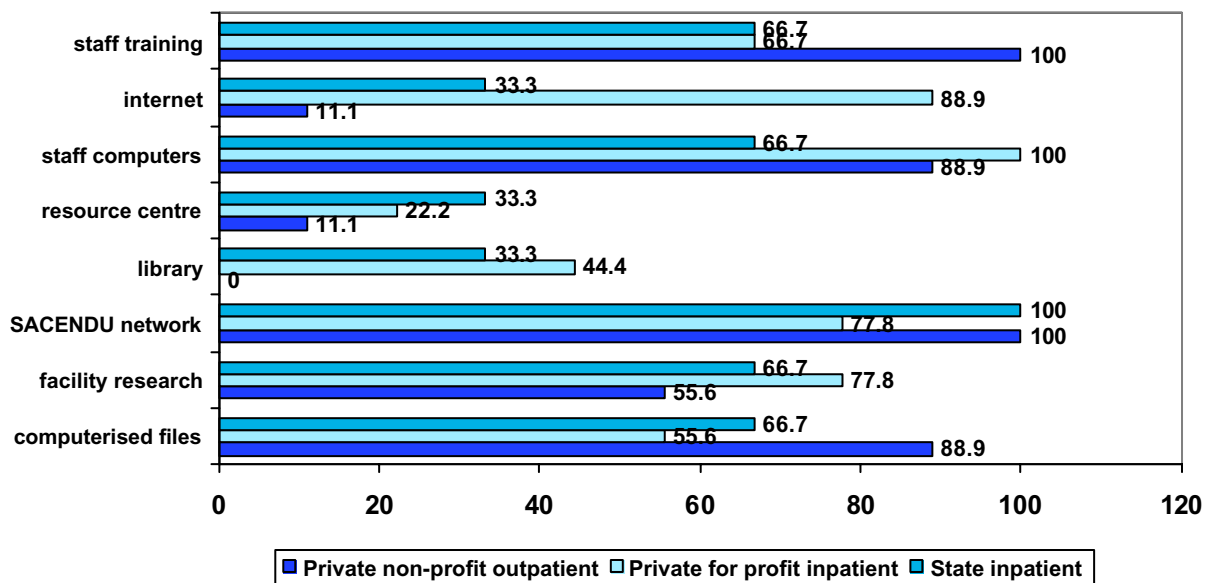
Figure 15. Proportion of facilities encouraging staff development activities by treatment modality and facility ownership



A larger proportion of private, non-profit outpatient facilities required their staff to participate in research, and professional development than either state inpatient or private, for-profit inpatient facilities. These differences were however not significant. In contrast, a significantly higher proportion of state and private for-profit inpatient facilities required staff to attend case conferences than private non-profit outpatient facilities (Cramer's $V = .629, p = .001$). Variations in the facility resources that could be used to support staff and encourage professional development by treatment modality and facility ownership were also examined. Findings are depicted in the following graph.

A larger proportion of private, non-profit outpatient facilities provided staff training workshops and computerised file systems to their staff than either state inpatient or private, for-profit inpatient facilities (Figure 16). These differences were however not significant. In contrast, a higher proportion of private for-profit inpatient facilities provided staff with access to the Internet, computers, a staff library and facility research than state or private non-profit outpatient facilities.

Figure 16. Proportion of facilities with specific resources accessible to staff by treatment modality and facility ownership



Variations in staff by treatment setting

The total number of staff for mental health facilities ranged from 11 to 56 ($\bar{x} = 30.67, SD = 20.03$). For facilities in welfare settings, the number of staff ranged from 2 to 5 ($\bar{x} = 3.0, SD = 1.0$). For stand-alone substance abuse treatment facilities, the total number of staff employed ranged from 4 to 48 ($\bar{x} = 15.1, SD = 13.8$). Table 11 reports variations in the descriptive statistics for each staffing category by treatment modality and facility ownership.

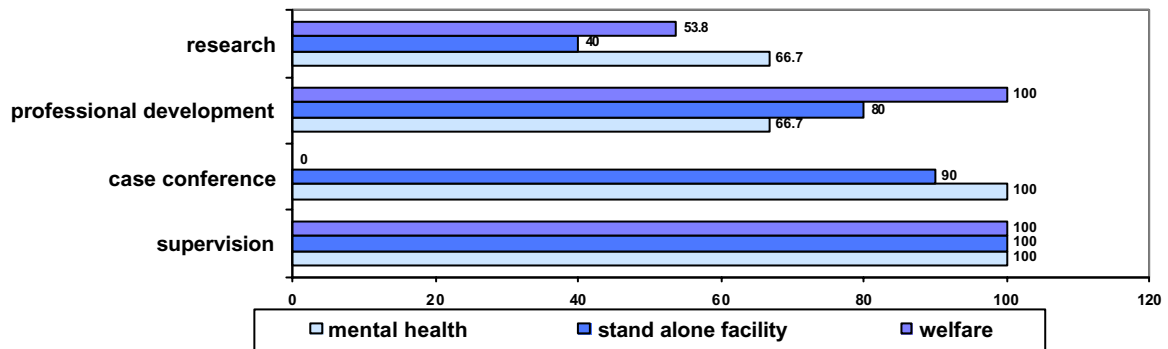
Facilities in mental health settings have a higher mean number of fulltime psychiatrists, medical doctors, psychologists and registered nurses than either stand-alone facilities or facilities in welfare settings (Table 11). In contrast, stand-alone treatment services seem to rely heavily on social workers and support counsellors for professional addiction services and the use of part-time mental health staff. Similarly, facilities in welfare settings rely on social workers and support counsellors to provide treatment services (Table 11).

Table 11. Descriptive statistics for each staffing category by treatment setting for substance abuse treatment facilities in Cape Town

	Mental health (N= 3)				Stand alone substance abuse facilities (N= 10)				Welfare (N=9)			
	Min	Max	\bar{x}	SD	Min	Max	\bar{x}	SD	Min	Max	\bar{x}	SD
<i>Full time psychiatrists</i>	0	8	3.3	4.2	0	0	0.0	0.0	0	0	0.0	0.0
<i>Part time psychiatrists</i>	0	0	0.0	0.0	0	1	0.7	0.5	0	0	0.0	0.0
<i>Full time doctors</i>	0	2	1.0	1.0	0	1	0.1	0.3	0	0	0.0	0.0
<i>Part time doctors</i>	0	1	0.3	0.6	0	2	0.8	0.6	0	0	0.0	0.0
<i>Full time psychologists</i>	0	9	3.3	4.9	0	2	0.3	0.7	0	0	0.0	0.0
<i>Part time psychologists</i>	0	3	1.0	1.7	0	1	0.7	0.5	0	0	0.0	0.0
<i>Full time social workers</i>	0	1	0.3	0.6	0	5	2.0	0.7	1	3	1.8	0.7
<i>Part time social workers</i>	0	0	0.0	0.0	0	1	0.1	0.3	0	0	0.0	0.0
<i>Full time support counsellors</i>	0	4	1.7	2.0	0	26	4.5	8.1	0	1	0.1	0.4
<i>Part time support counsellors</i>	0	0	0.0	0.0	0	6	1.3	2.5	0	0	0.0	0.0
<i>Full time registered nurses</i>	0	8	5.3	4.6	0	2	1.0	1.1	0	0	0.0	0.0
<i>Part time registered nurses</i>	0	5	3.0	2.7	0	4	0.7	1.3	0	0	0.0	0.0
<i>Full time auxillary nurses</i>	0	6	2.0	3.5	0	4	0.5	1.3	0	0	0.0	0.0
<i>Part time auxillary nurses</i>	0	1	0.3	0.6	0	0	0.0	0.0	0	0	0.0	0.0

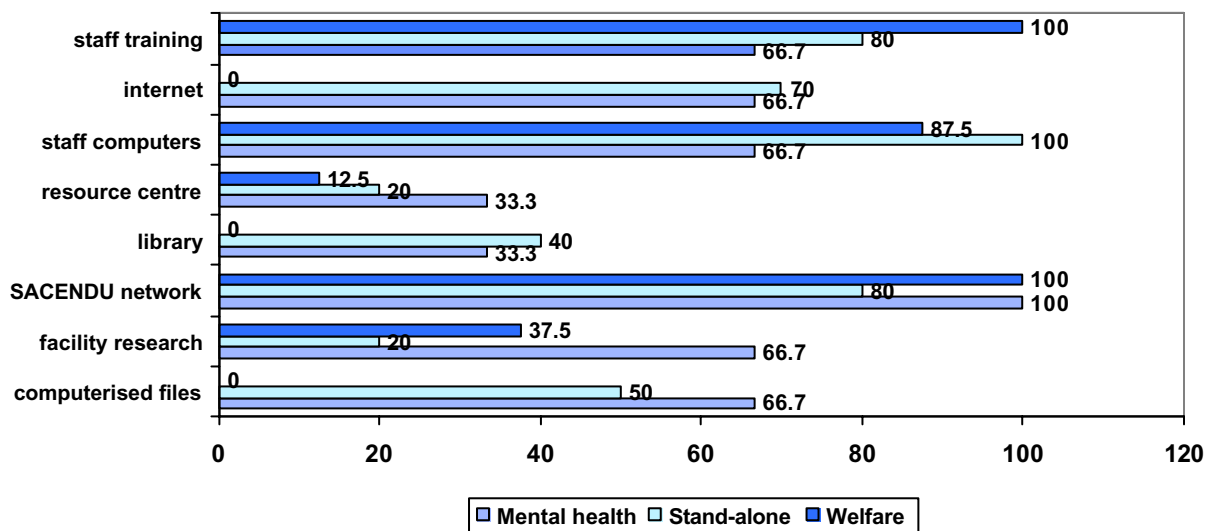
The following graph depicts variations in the proportion of facilities that require their staff to participate in development activities by treatment setting. A larger proportion of mental health facilities required participation in research activities or in case conferences than stand-alone or welfare facilities. For the latter variable, this difference was significant (Cramer's $V = .911, p = .000$). In contrast, a larger proportion of welfare facilities required participation in professional development activities than facilities in mental health or stand-alone settings.

Figure 17. Proportion of facilities encouraging staff development activities by treatment setting



Variations in the facility resources that could be used to support staff and encourage professional development by treatment setting were also examined (Figure 18).

Figure 18. Proportion of facilities with specific resources accessible to staff by treatment setting



A larger proportion of welfare facilities provided staff training workshops to their staff than either mental health or stand-alone facilities. In contrast, a higher proportion of stand-alone facilities provided access to the Internet (Cramer's $V = .702, p = .013$), staff computers and a staff library than either welfare or mental health facilities. A larger proportion of mental health facilities provided staff with a computerised filing system, the opportunity to participate in research and a resource centre than either welfare or stand-alone facilities.

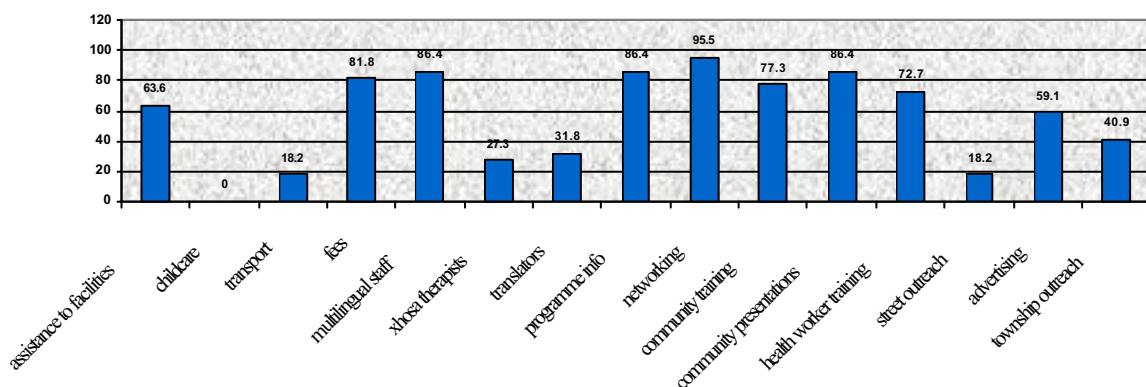
ACCESSIBILITY OF SUBSTANCE ABUSE TREATMENT FACILITIES

This section firstly describes the accessibility of treatment facilities in Cape Town and then describes variations in accessibility by facility characteristics. Practises used by facilities to improve awareness of services, outreach activities to target vulnerable groups, and services designed to improve both initial access to treatment and treatment retention for under-served groups are examined.

Profile of outreach, awareness-building and access-facilitating services provided by substance abuse treatment facilities in Cape Town

The following graph describes outreach activities that are used to target vulnerable groups, improve their awareness of substance abuse treatment and thus improve their access to services provided by substance abuse facilities in Cape Town.

Figure 19. Proportion of treatment facilities with outreach, awareness and access services (N=22)



Few treatment facilities reported performing outreach services among under-served groups. Street outreach activities were only conducted by 18.2% (4) of the treatment facilities and only 40.9% (9) of the facilities offered outreach services in the historically black township areas. Treatment facilities generally reported being involved in a range of awareness-related activities. The most common activities were networking (95.5%), followed by distribution of programme information (86.4%) and community presentations (86.4%).

Few treatment facilities reported performing activities to improve the accessibility of services for under-served groups. None of the facilities offered child-care services. Transport for clients was only provided by 18.2% (4) of the treatment facilities. Only 27.3% (6) of the facilities employed Xhosa-speaking therapists and only 31.8% (7) employed translators. While 86.4% (19) of the facilities employed multilingual staff, further questioning revealed staff, in fact, were bilingual in English and Afrikaans only. Although 81.9% (18) of the

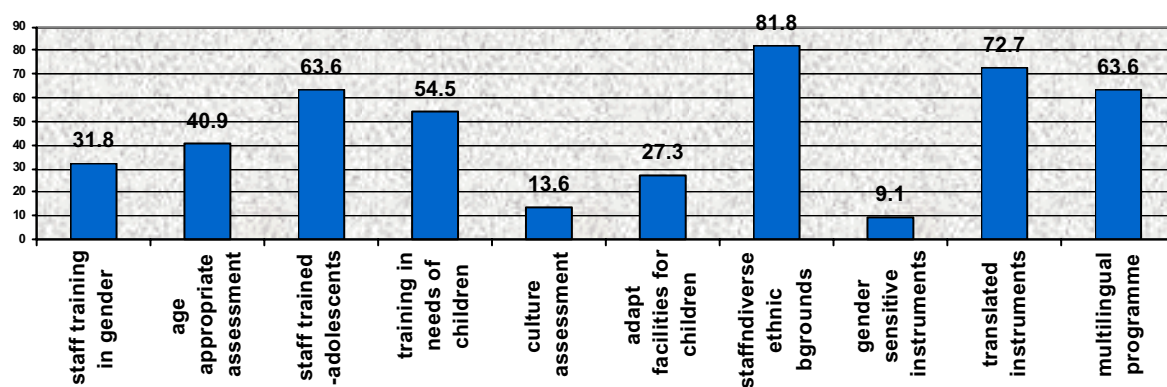
treatment facilities offered reduced fees to clients, the number of indigent beds offered by facilities per year ranged from 0 to 80, with a mean of 21.5.

Profile of activities performed by substance abuse treatment facilities to improve treatment retention for under-served groups

This section describes activities performed by treatment facilities to improve treatment retention by historically under-served groups. As women, adolescents and Black South Africans have been historically under-served in the country, this section will focus particularly on the provision of gender, culture and age-sensitive services.

Treatment facilities generally reported being involved in a range of activities aimed at making the programme more sensitive to cultural issues. Of the 22 facilities, 81.8% (18) employed staff from diverse ethnic backgrounds, 72.7% (16) used translated assessment tools and procedures, and 63.6% (14) offered programme services in a number of languages. However, further questioning revealed that most facilities only offered programme services and translated instruments in English or Afrikaans. Only 13.6% (3) of the facilities made use of culturally appropriate assessment tools and procedures.

Figure 20. Proportion of treatment facilities providing culture, gender and age sensitive services (N=22)



Overall few treatment facilities reported performing activities to improve the gender-appropriateness of treatment services. Only 31.8% (7) of the facilities reported training staff in gender-sensitive interventions. Of the 22 facilities, 63.6% (14) were not involved in activities to improve the gender-appropriateness of treatment services. Treatment facilities reported performing a variety of activities to improve the age appropriateness of treatment services, with 63.6% (14) of facilities employing staff specially trained to work with adolescents and 54.5% (12) of the facilities training staff in the special needs of adolescents. Furthermore, 40.9% (9) of the facilities indicated using age-appropriate assessment

procedures. Only 27.3% (6) of the facilities reported adapting facilities for the safety of children and adolescents.

Variations in the accessibility of substance abuse treatment facilities by facility characteristics

Variations in the accessibility of substance abuse treatment facilities by treatment modality and facility ownership

The following table describes variations in the outreach, awareness-building and access-facilitating services provided by substance abuse treatment facilities by treatment modality and facility ownership.

Table 12. Outreach, awareness activities, and accessibility of services by treatment modality & facility ownership for substance abuse treatment services in Cape Town

	Private, for profit, inpatient (N= 9)		State inpatient (N=3)		Private, non-profit, outpatient (N= 9)	
	n	%	n	%	n	%
<i>Street outreach</i>	2	22.2	0	0.0	2	22.2
<i>Advertising/mass media</i>	5	55.6	1	33.3	6	66.7
<i>Outreach in Townships</i>	1	11.1	1	33.3	6	66.7
<i>Community presentations</i>	7	77.8	2	66.7	9	100.0
<i>Training of allied health workers</i>	5	55.6	2	66.7	8	88.9
<i>Distribution of programme information</i>	8	88.9	2	66.7	8	88.9
<i>Networking</i>	8	88.9	3	100.0	9	100.0
<i>Training services</i>	6	66.7	2	66.7	8	88.9
<i>Providing assistance to other treatment centres</i>	6	66.7	2	66.7	5	55.6
<i>Child care</i>	0	0.0	0	0.0	0	0.0
<i>Transport</i>	3	33.3	0	0.0	1	11.1
<i>Reduced fees</i>	6	66.7	2	66.7	9	100.0
<i>Multilingual Staff</i>	7	77.8	2	66.7	9	100.0
<i>Xhosa-speaking therapists</i>	1	11.1	0	0.0	5	55.6
<i>Translators</i>	1	11.1	2	66.7	4	44.4

For each of the outreach items, more private, non-profit outpatient treatment facilities reported being involved in outreach activities than private for profit, inpatient facilities or state inpatient facilities. State inpatient facilities were the least likely to participate in any form of outreach activity. Of the 8 facilities that reported conducting outreach activities in the township areas, the majority (66.7%) were private, non-profit outpatient treatment facilities. In contrast, of the treatment facilities that reported using advertising and the mass media to perform outreach services, the majority (55.6%) were private, for-profit inpatient facilities. It is questionable whether such an outreach strategy successfully targets under-served groups given both the high rate of illiteracy in South Africa and the facilities' use of predominantly English and Afrikaans media services.

In terms of activities performed to improve the awareness of substance abuse, and substance abuse treatment, both private for-profit, inpatient; private non-profit outpatient and state inpatient facilities generally reported being involved in a range of activities. For each of the items, more private, non-profit outpatient treatment facilities reported being involved in awareness-related activities than private for-profit, inpatient facilities. Specifically, a larger proportion of private non-profit outpatient facilities reported providing community presentations and workshops, providing training to health workers, and providing training services to the general community than either state inpatient or private for-profit inpatient facilities. However, a higher proportion of private, for-profit inpatient facilities reported providing assistance to other treatment centres than private non-profit, outpatient facilities.

With regards to access-facilitating services, a higher proportion of private non-profit, outpatient facilities offered reduced fees to clients, employed multilingual staff, and employed Xhosa-speaking therapists than either state or private for-profit inpatient facilities. In contrast, a higher proportion of state inpatient facilities employed translators than private, non-profit outpatient or private for-profit facilities. A higher proportion of private for-profit facilities offered transport services to clients than state or private non-profit facilities, albeit from a low base. Notably, none of the facilities offered child-care services.

Variations in the accessibility of substance abuse treatment facilities by setting

The following table describes variations in the outreach, awareness-building and access-facilitating services provided by substance abuse treatment facilities by facility setting. For each of the outreach items, more facilities in welfare settings reported being involved in outreach activities than facilities in mental health settings or stand-alone facilities. Mental health facilities were the least likely to participate in any form of outreach activity. Of the facilities that reported conducting outreach activities in the township areas, the majority were facilities in welfare settings (Cramer's $V = .555, p = .034$).

Facilities in all settings generally reported being involved in a range of activities to improve the awareness of substance abuse and substance abuse treatment. A higher proportion of facilities in welfare settings reported being involved in providing community presentations and workshops, providing training services to the general community, and distributing programme information than either mental health or stand-alone substance abuse treatment facilities. In contrast, a higher proportion of mental health facilities provided training to health workers than welfare or stand-alone facilities. A higher proportion of stand-alone facilities provided assistance to other treatment centres.

Table 13. Outreach, awareness activities, and accessibility of services by treatment setting for substance abuse treatment services in Cape Town

	Mental health (N=3)		Stand-alone (N= 11)		Welfare setting (N=8)	
	n	%	n	%	n	%
<i>Street outreach</i>	0	0.0	2	18.2	2	25.0
<i>Advertising/mass media</i>	2	66.7	5	45.5	6	75.0
<i>Outreach in Townships</i>	0	0.0	3	27.3	6	75.0
<i>Community presentations</i>	2	66.7	9	81.8	8	100.0
<i>Training of allied health workers</i>	3	100.0	6	54.5	7	87.5
<i>Distribution of programme information</i>	2	66.7	9	81.8	8	100.0
<i>Networking</i>	3	100.0	10	90.9	8	100.0
<i>Training services</i>	2	66.7	8	72.7	7	87.5
<i>Providing assistance to other treatment centres</i>	2	66.7	8	72.7	4	50.0
<i>Child care</i>	0	0.0	0	0.0	0	0.0
<i>Transport</i>	1	33.3	2	18.2	1	12.5
<i>Reduced fees</i>	3	100.0	7	63.6	8	100.0
<i>Multilingual Staff</i>	2	66.7	9	81.8	8	100.0
<i>Xhosa-speaking therapists</i>	0	0.0	2	18.2	4	50.0
<i>Translators</i>	0	0.0	3	27.3	4	50.0

With regards to access-facilitating services, a higher proportion of facilities in welfare settings employed multilingual staff, Xhosa-speaking therapists, and translators than either stand-alone or mental health facilities. In contrast, a higher proportion of mental health facilities provided transport to clients than either stand-alone or welfare facilities, albeit from a low base. None of the facilities offered child care services.

Variations in activities to improve treatment retention by facility characteristics

Variations in activities to improve treatment retention by treatment modality and ownership

The following table describes variations in activities used to improve treatment retention for historically under-served groups in the country by facility ownership and treatment modality.

For each of the culture-related items, a higher proportion of private, non-profit outpatient treatment facilities and state inpatient facilities reported culturally appropriate practices than for private, for profit, inpatient facilities. For the items “*translated instruments*” and “*programme services offered in number of languages*” significant differences were found between private, non-profit outpatient and private for-profit inpatient facilities (Cramer’s $V = .730, p = .004$ and Cramer’s $V = .742, p = .003$ respectively).

Table 14. Use of culture, age, and gender-appropriate techniques and procedures by treatment modality & facility ownership for substance abuse treatment facilities in Cape Town

	Private, for profit, inpatient (N=9)		State inpatient (N=3)		Private, non-profit, outpatient (N=9)	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
<i>Use of culturally appropriate assessment tools & procedures</i>	0	0.0	0	0.0	3	33.3
<i>Translated instruments</i>	3	33.3	3	100.0	9	100.0
<i>Programme is multilingual</i>	2	22.2	2	66.7	9	100.0
<i>Staff from diverse ethnic backgrounds</i>	6	66.7	3	100.0	8	88.9
<i>Gender appropriate assessment tools</i>	0	0.0	0	0.0	1	11.1
<i>Train staff in gender-sensitive interventions</i>	2	22.2	0	0.0	5	55.6
<i>Age appropriate assessment procedures</i>	2	22.2	2	66.7	5	55.6
<i>Employ staff trained to work with adolescents</i>	5	55.6	3	100.0	6	66.7
<i>Train staff in special needs of children of substance-abusing parents</i>	5	55.6	2	66.7	4	44.4
<i>Adapt facilities for safety of children</i>	2	22.2	2	66.7	2	22.2

Only one of the treatment facilities reported using gender-appropriate assessment tools and procedures. This was a private, non-profit outpatient facility. Of the facilities that trained staff in gender-sensitive interventions, the largest proportion were private non-profit facilities, with the remainder being private for-profit inpatient facilities. For each of the age-related items, a higher proportion of state facilities reported age appropriate practices than either private, non-profit outpatient or private for-profit, inpatient facilities treatment facilities.

Variations in activities to improve treatment retention by treatment setting

The following table describes variations in activities used to improve treatment retention for historically under-served groups in the country by facility setting.

Table 15. Use of culture, age, and gender-appropriate techniques and procedures by treatment setting for substance abuse treatment facilities in Cape Town

	Mental health (N=3)		Stand alone (N=11)		Welfare (N=8)	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
<i>Use of culturally appropriate assessment tools & procedures</i>	0	0.0	0	0.0	3	37.5
<i>Translated instruments</i>	1	33.3	7	63.6	8	100.0
<i>Programme is multilingual</i>	1	33.3	5	45.5	8	100.0
<i>Staff from diverse ethnic backgrounds</i>	3	100.0	8	72.7	7	87.5
<i>Gender appropriate assessment tools</i>	0	0.0	2	18.2	0	0.0
<i>Train staff in gender-sensitive interventions</i>	1	33.3	2	18.2	4	50.0
<i>Age appropriate assessment procedures</i>	1	33.3	4	36.4	4	50.0
<i>Employ staff trained to work with adolescents</i>	3	100.0	6	54.5	5	62.5
<i>Train staff in special needs of children of substance-abusing parents</i>	2	66.7	6	54.5	4	50.0
<i>Adapt facilities for safety of children</i>	1	33.3	3	27.3	2	25.0

A significantly higher proportion of facilities in welfare settings reported culturally appropriate assessment practices (Cramer's $V = .507$, $p = .023$), the use of translated instruments (Cramer's $V = .577$, $p = .026$), and a multilingual programme (Cramer's $V = .633$, $p = .043$) than mental health or stand-alone treatment facilities. However, a higher proportion of mental health facilities employed staff from diverse ethnic backgrounds than welfare or stand-alone substance abuse facilities.

Of the few facilities that reported using gender-appropriate assessment tools and procedures, all were stand-alone substance abuse facilities. Of the facilities that trained staff in gender sensitive interventions, the largest proportion were facilities in welfare settings. For most of the age-related items, a higher proportion of mental health facilities reported age appropriate practices than either welfare or stand-alone facilities.

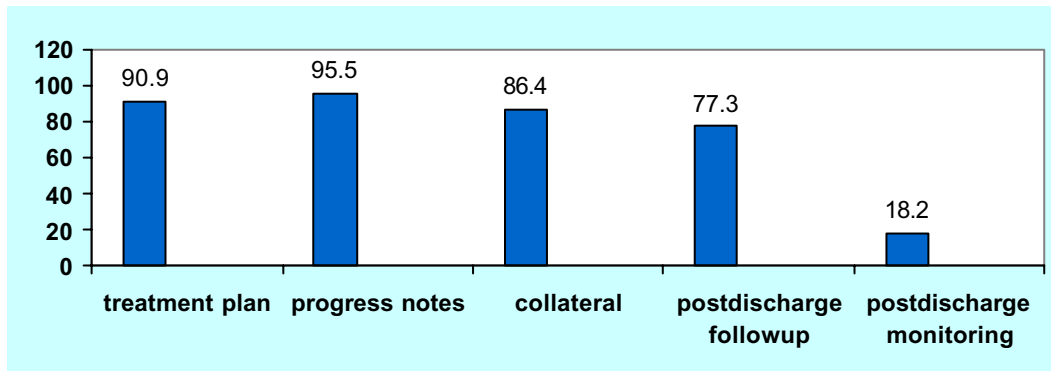
MONITORING AND EVALUATION ACTIVITIES FOR SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

This section describes the monitoring and evaluation (M & E) activities of the substance abuse treatment facilities that participated in this study. More specifically, variations in monitoring and evaluation by treatment modality, facility ownership and facility setting are explored.

Monitoring and evaluation activities conducted by substance abuse treatment facilities in Cape Town

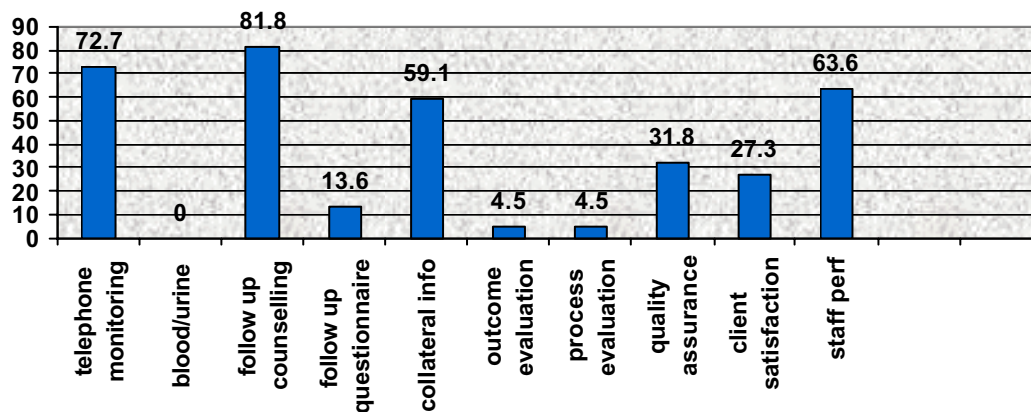
The study also examined activities that should occur during the process of substance abuse treatment to facilitate the monitoring of treatment process and client outcomes. Overall, a large proportion of facilities reported making documented treatment plans for each client, making documented progress notes, making collateral contacts, and for post discharge follow up of clients. However, only a small proportion of facilities, reported the post discharge monitoring of clients (Figure 21).

Figure 21. Proportion of facilities by treatment process monitoring activities (N=22)



The following graph describes the proportion of substance abuse facilities in Cape Town that conduct M & E activities to monitor treatment progress and long-term outcomes of clients.

Figure 22. Proportion of treatment facilities conducting M & E activities (N=22)



In terms of monitoring activities, while a number of facilities reported telephonic, collateral and face-to face follow-up and monitoring procedures, further investigation revealed that this was done on an ad hoc basis. Routine client monitoring systems (post discharge) were not in place at any of the treatment facilities. In terms of evaluative activities, only 1 facility had conducted a formal scientific evaluation of its treatment programme. While a larger proportion of facilities had conducted client satisfaction, staff performance and quality assurance evaluations, these evaluations appeared to be ad hoc, unsystematic, did not result in formal evaluation reports, and the findings were not made public. Furthermore, 24.8% (5) of facilities reported not being involved in any form of evaluative activity, including performance appraisals of staff.

PART 3: DISCUSSION OF KEY FINDINGS FROM THE MRC AUDIT OF SUBSTANCE ABUSE TREATMENT FACILITIES IN CAPE TOWN

DISCUSSION

Availability of treatment services and demand for treatment

While there are a number of substance abuse treatment facilities in Cape Town that offer a range of treatment and support services to clients, this audit has shown that access to various services varies by facility characteristics. In Cape Town, the majority of treatment facilities are privately owned, with the state providing few dedicated substance abuse treatment facilities in the region. More specifically, these treatment facilities consist predominantly of private, non-profit outpatient treatment facilities, with private for-profit, inpatient treatment services comprising just over a third of all facilities. State inpatient treatment services comprise the smallest proportion of the sample. It is thus clear that the responsibility for substance abuse treatment in Cape Town rests heavily on the private sector.

Substance abuse treatment facilities vary in their capacity to treat clients. Over a third of facilities report the capacity to treat 30 clients or more at any given time, with private non-profit facilities having the capacity to treat the greatest number of clients. Although private non-profit outpatient facilities still served the highest mean number of clients per month and private for-profit inpatient facilities served the lowest mean number of clients per month, this audit found that treatment capacity was significantly under-utilised by all types of treatment facilities, despite the demand for substance abuse treatment services. For example, more than 80% of facilities reported that they had clients with an unmet need for treatment at the time of the audit (signified by the presence of a waiting list). Approximately 19% of facilities had more than 25 clients on their waiting list at the time of the audit. State inpatient facilities comprised all the facilities that had more than 40 clients on their waiting list, despite their under-utilised capacity to treat clients.

Provision of supplementary treatment services for clients with substance use disorders

There is accumulating research that supports the relationship between the range and quality of services made accessible to clients during treatment and treatment outcomes (Lee et al., 2001). Despite growing evidence of an association between clients' use of supplementary treatment services (e.g. psychological and medical care) and treatment outcomes, and the fact that international emerging standards for substance abuse treatment have called upon treatment providers to enhance traditional addiction services with services that address

clients' psychosocial and medical needs (Durkin, 2002; Lee et al., 2001), substance abuse treatment programmes in South Africa generally fail to meet this research-based treatment standard. Substance abuse treatment facilities in Cape Town provide clients with a significantly higher proportion of traditional addiction services (which focus on treating the substance abuse problem only) than supplementary or support services (which focus on treating problems associated with and contributing to the substance use problem). For example, in terms of treatment services, all facilities provide comprehensive assessment and diagnosis services. The most accessible counselling services are individual and group addiction counselling, group life-skills, and family therapy, with more than 90% of facilities providing these services. In contrast, the provision of supplementary medical and detoxification services are less accessible to clients. While 59% of facilities provide clients with medication, only 55% complete medical histories for their clients and only 50% conduct physical examinations of their clients. Detoxification services are provided by less than half of all facilities. This is cause for concern given that individuals with chronic substance abuse problems generally show high levels of medical need (such as the need for treatment for respiratory and other chronic health problems associated with substance use) (Durkin, 2002).

Variations in the provision of supplementary medical services by treatment modality & facility ownership

There may be a number of organisational factors that contribute to the availability of medical services in substance abuse treatment facilities. This current study found variations in service patterns according to treatment modality, ownership and setting. Medical and detoxification services are significantly more accessible in private for-profit and state inpatient facilities than in private non-profit outpatient facilities. For example, medical history taking, physical examination of clients, and the provision of medication is significantly more likely to occur at state or private for profit inpatient facilities than at private non-profit outpatient facilities. Detoxification services are most likely to be provided at private for-profit inpatient facilities. Private for-profit inpatient facilities may have more financial strength than private non-profit or state facilities and may thus be able to provide these supplementary services where financially weaker facilities cannot afford to do so. This financial capacity of private for-profit inpatient facilities may also allow these facilities to employ more medically trained staff and enable them to have a lower staff-patient ratio - two factors that have consistently been associated with greater accessibility to medical services (Durkin et al., 2002). Findings from this study tend to confirm this explanation, with private for-profit inpatient facilities having a higher mean number of full-time psychiatrists, doctors and registered nurses than private non-profit facilities. For-profit facilities also have a lower staff-patient ratio than private non-profit facilities.

However, this explanation does not hold for state health facilities whose service delivery is often restricted by tight budgetary constraints (Freeman, 2000). The provision of medical services by state facilities may be enabled through its affiliation with larger organisations such as hospitals, and the broader health and social welfare system. This affiliation may provide access to human and capital resources that are not available to smaller, independent facilities (Durkin, 2002).

Variations in the provision of supplementary medical services by treatment setting

Supplementary medical and detoxification services are also significantly more accessible in mental health and stand-alone facilities than facilities in welfare settings. A likely explanation for this finding may lie in the historic division of responsibility for the treatment and management of substance-related problems between the Department of Health and the Department of Welfare, with the Department of Health responsible for the medical treatment and custodial care of people with substance abuse problems, and the Department of Welfare/Social Services responsible for prevention and community rehabilitation activities (Parry, 1997). Facilities located in welfare settings historically have not provided medically oriented services to their clients. Thus it appears that facility ownership, facility affiliation, and welfare status are variables that impact on the accessibility of medical and detoxification treatment services to clients.

Provision of support services to clients with substance use disorders

In Cape Town, support services (such as psychiatric care, HIV counselling, or transport) are also less accessible than traditional treatment services. For example, less than a third of the facilities offer any form of psychiatric care, with just over half of these facilities conducting psychological evaluations of their clients and less than half conducting psychiatric assessments. Similarly, individual and group mental health counselling are the two counselling-related services that are the least frequently accessible to clients. This is cause for concern given that substance-abusing people often have high levels of co-morbidity (Myers et al., under review) and that individuals with chronic substance use problems often show high levels of psychosocial dysfunction (Durkin, 2002). Other support services, including HIV testing and counselling, occupational therapy, transport, vocational training, and child-care services are offered by less than 50% of facilities. These findings are similar to the findings of the U.S. Alcohol and Drug Services Study (ADSS) conducted in 1996 and the Drug Treatment Systems Survey (DATSS), conducted in 1995, both of which reported that less than 50% of treatment facilities offered support services, with the exception of HIV/AIDS services that were offered at more than 75% of facilities (Lee et al., 2001). The low proportion of facilities that offer HIV testing and counselling is also cause for concern given

South Africa's high rate of HIV infection and the documented association between substance abuse and risky sexual practices (Wechsberg et al., 2002).

Variations in the provision of support services by treatment modality & facility ownership

In contrast to the findings from the ADSS (Lee et al., 2001), this audit found that support services (especially psychiatric support services, HIV testing and transport) are more accessible at private for-profit facilities and less accessible at state or private non-profit facilities. While differences in accessibility to support services may indicate a service deficit in the private non-profit and state sector, it may however also reflect differences between the clientele served by for-profit and not for-profit facilities (where state facilities are also classified as not-for-profit). This audit found significant differences between the clientele served at private for-profit inpatient and private non-profit outpatient or state inpatient facilities. Private for-profit facilities treated a higher proportion of clients over 40 years of age than either state or private non-profit outpatient facilities. In contrast, private non-profit outpatient facilities treated a higher proportion of adolescents than private for-profit inpatient facilities. As a longer history of substance abuse tends to be associated with more severe problems, it is possible that clients in private for-profit inpatient facilities have more severe problems and are thus in need of more support services than clients in private non-profit facilities. The finding that cocaine and heroin are more likely to be the primary drug of abuse among clients in private for-profit treatment facilities than private non-profit outpatient facilities lends further support to this explanation.

It also seems that for support services, for-profit status is a key distinguishing variable that differentiates facilities along ownership lines. Lee et al (2001) also found that ownership-related differences were most evident between private for-profit versus private non-profit and state facilities. As private for-profit facilities are more likely to depend on private funding such as health insurance or client self-pay fees than state or private non-profit facilities, these facilities are more likely to be able to offer support services to clients. This claim seems to be supported by evidence that private for-profit facilities provide their staff with significantly more resources (such as resource centres, libraries, computers, and internet access) than state or private non-profit facilities as well as evidence that private for-profit facilities are more likely to offer a multidisciplinary team approach than either state or private non-profit outpatient facilities. These facilities are thus more equipped not only to provide additional support services to clients, but also to provide staff with opportunities for professional growth and development that ultimately will improve the quality of care provided by the facility.

Variations in the provision of support services by treatment setting

Support services are also more accessible in mental health and stand-alone treatment facilities than in facilities located in welfare settings. In part, this finding may be an artefact of the historical division of services between mental health and welfare, with mental health facilities being responsible for the provision of psychiatric and medical services (Parry, 1997). As substance abuse treatment facilities in mental health settings are more likely to have a higher mean number of full time psychiatrists, medical doctors, psychologists and registered nurses than facilities located in welfare settings, mental health facilities may be more equipped to deliver additional health support services. Furthermore, many mental health facilities are closely affiliated with larger organisations such as hospitals. This affiliation may provide access to support services offered by affiliated organisations that are not available to smaller, independent facilities (Durkin, 2002). In addition, the facility client base of mental health facilities may reflect a need for more support services. Mental health facilities tend to serve a significantly higher proportion of women than facilities located in other settings. As female substance abusers have been shown to have more severe psychiatric problems than their male counterparts (Booth & McLaughlin, 2000) there may be a greater demand for psychiatric services in mental health than in other settings. Similarly, mental health facilities serve a higher proportion of older clients than facilities located in other settings. As a longer history of substance abuse tends to be associated with more severe psychosocial problems, it is possible that clients in mental health facilities are more in need of support services than clients treated in other settings.

In contrast, stand-alone facilities are often private, for-profit facilities that are able to provide access to these support services not only because of their financial resources but also because their staff is more likely to comprise a multidisciplinary team that is more equipped and competent to deliver psychiatric and additional health services than staff working in welfare settings. This explanation seems to be supported by the finding that stand-alone substance abuse treatment facilities were more likely to have a higher mean number of part-time psychiatrists, medical doctors, psychologists and registered nurses than facilities located in welfare settings. Stand-alone treatment facilities are also more likely to provide resources to their staff such as internet access, library access, the use of computers, and computerised filing systems than facilities in welfare settings. These resources may help staff develop skills in the provision of support services and may help them remain up to date with best practice guidelines for the delivery of substance abuse treatment and support services.

Accessibility of substance abuse treatment services to historically under-served groups

When the accessibility of substance abuse treatment services in Cape Town to historically underserved groups was considered, this study found that almost all treatment facilities reported being involved in a range of activities aimed at increasing awareness of the availability and utility of substance abuse treatment. However, less than half of the treatment services reported conducting outreach activities (e.g. street outreach and outreach services in townships) among under-served groups. This despite the finding that outreach activities significantly improve the utilisation of treatment services by under-served groups and treatment outcomes for clients from these groups (Marsh et al., 2000). Similarly, few facilities reported providing services (such as transport, child-care, and reduced fees) aimed at addressing the barriers that prevent clients from accessing available treatment facilities.

Despite the finding that there is an under-representation of Black and an over-representation of White clients in substance abuse treatment facilities in Cape Town, few facilities reported providing services aimed at addressing some of the barriers preventing Black clients from accessing substance abuse treatment. These barriers include difficulties in paying for transport to facilities located in urban centres; the inability to pay for services; linguistic difficulties in participating in English medium programmes, where few programmes employ African-language speaking counsellors or translators; and the questionable cultural appropriateness of programmes developed in Western settings for black South Africans (Myers et al., under review; Parry, 1997). More specifically, less than a third of facilities employed Xhosa-speaking therapists or translators. Although many facilities offered reduced fees to clients, only a small number of treatment slots were available per year for indigent clients. Similarly, while many facilities claimed to provide culturally-appropriate and linguistically diverse assessment and treatment programmes, further investigation revealed that these assessment and treatment services were in fact offered in English and Afrikaans mediums only. Not only do these factors potentially limit the extent to which Black clients can engage in the treatment programme but may also impact on the degree to which Black clients are retained in treatment. It thus appears that treatment facilities in Cape Town have, to a large extent, failed to address the cultural, linguistic and financial barriers that limit both the accessibility of substance abuse treatment services to Black clients, and also limit the degree to which Black clients are retained in treatment. This is cause for concern given that treatment engagement and treatment retention are important treatment process variables that impact on client outcomes (Joe et al., 2000).

Similarly, although substance abuse treatment services are under-utilised by women (Myers et al., under review), few facilities in Cape Town reported providing services aimed at addressing some of the barriers that prevent women from accessing treatment. These barriers include the limited accessibility of services due to a lack of an independent income to pay for treatment, limited resources to arrange for independent childcare (Booth & McLaughlin, 2000), and the lack of women-sensitive treatment programmes with services that focus on the special needs of women such as domestic violence and sexual assault (Booth & McLaughlin, 2000). Significantly, none of the treatment facilities provided access to child-care services for women with dependent children. In addition, approximately two thirds of all facilities were not involved in any activity aimed at improving the gender-appropriateness and sensitivity of assessment and treatment programmes. This may impact on the extent to which women engage with the treatment process (Booth & McLaughlin, 2000). It thus appears that treatment facilities in Cape Town have, to a large extent, failed to address the barriers that limit both the accessibility of substance abuse treatment services to women, and the degree to which women are retained in treatment.

Variations in the accessibility of treatment services to historically under-served groups by treatment modality & facility ownership

The extent to which treatment facilities in Cape Town provide services aimed at addressing the barriers faced by Black clients in accessing and engaging with substance abuse treatment appears to be influenced by organisational factors such as treatment modality, facility ownership, and treatment setting. Not only do significantly more private, non-profit facilities provide outreach services in the township areas than other types of facilities, but a higher proportion of private non-profit outpatient facilities offer reduced fees to clients and employ Xhosa-speaking therapists than other facilities. Furthermore, private, non-profit outpatient facilities were more likely to provide culturally appropriate assessment and treatment programmes than other types of facilities. Given these findings, it is not surprising that private non-profit outpatient facilities are more likely to provide services to Black clients than any other type of facility. For-profit status may be a key variable that accounts for these differences between facilities. As private for-profit facilities are more likely to depend on private funding such as health insurance or client self-pay fees than private non-profit facilities, these facilities are less likely to provide services to indigent clients. 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 clients. Furthermore, as the client base of private for-profit facilities consists mainly of White and Coloured clients who speak either English or Afrikaans, there is not yet a strong demand for these facilities to provide culturally and linguistically appropriate treatment programmes. This explanation,

however does not account for why state facilities are less accessible to Black clients than private non-profit facilities. It is possible that this difference is an artefact from the apartheid system of governance that limited the accessibility of treatment services to Black clients. Whatever the cause, this difference indicates an important service deficit in the state sector that needs to be addressed as a matter of urgency.

Variations in the accessibility of treatment services to historically under-served groups by treatment setting

In addition, substance abuse treatment facilities located in welfare settings are more likely to address the barriers faced by Black clients in accessing and engaging with substance abuse treatment than mental health and stand-alone treatment facilities. In part, this finding may be an artefact of the historical division of services between mental health and welfare, with welfare services being responsible for addressing the social and community-related needs of substance users. As welfare services have historically provided more community-level care than health services, they may be more equipped to provide culturally and linguistically sensitive services. In addition, staff at treatment centres located in welfare settings are predominantly social workers who may have more experience and competency in addressing the social and financial barriers that hinder access to treatment by Black clients than staff at mental health or stand-alone facilities. Furthermore, substance abuse treatment facilities located in welfare settings may be more closely affiliated with other welfare organisations and non-government agencies, enabling them to address more of the barriers facing Black clients than facilities located in other settings.

Monitoring and evaluation activities conducted by substance abuse treatment facilities

This audit also explored the client and treatment process monitoring and evaluation activities that are currently conducted by substance abuse treatment facilities in Cape Town. Research has emphasised the importance of monitoring and evaluating substance abuse treatment programmes, not only because this evaluative process can help identify areas in which treatment programmes and client satisfaction can improve, but also because evidence of the efficacy of existing programmes may help inform policy and decision-making about the rational distribution of human and financial resources to substance abuse treatment services (Cole, 1999). This study found that more than 85% of the facilities made documented treatment plans and progress notes and gathered collateral information for clients- monitoring activities that facilitate the evaluation of these treatment programmes. While more than three quarters of the facilities conducted some form of post-discharge follow-up (generally in the form of a follow-up counselling session), these follow-up activities were informal, unsystematic and undocumented. Significantly, routine client monitoring systems (post

discharge) were not in place at any of the treatment facilities. Of the small proportion of facilities that reported the occasional monitoring of clients, the majority monitored their clients telephonically. None of the facilities monitored their clients through the collection of blood or urine samples and only a small proportion of facilities monitored their clients through the use of questionnaires. Similarly, in terms of evaluation activities, while some facilities had conducted quality assurance, client satisfaction and staff performance evaluations, these evaluations tended to be ad hoc and did not result in formal evaluation reports. Significantly only one of the facilities had conducted a proper outcomes-based evaluation of their treatment programme and a different facility had conducted a process evaluation of their treatment programme. These findings point to both the need for substance abuse treatment facilities in Cape Town to introduce routine, systematic client monitoring systems as well as the need for these substance abuse treatment programmes to be comprehensively evaluated.

RECOMMENDATIONS

Recommendations to improve the availability and utilisation of substance abuse treatment facilities

- As private, non-profit treatment facilities are not only main providers of substance abuse treatment services in Cape Town but also are the largest providers of treatment services to historically under-served groups; it is recommended that funding to these facilities be increased.
- As treatment facilities in Cape Town are under-utilised, it is recommended that interventions that address the factors underpinning this under-utilization such as client loads, staff competencies, and facility resources be conducted.
- In addition to improving the utilisation of treatment facilities, the number of state facilities for substance abuse needs to be increased. The establishment of 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.

Recommendations to improve the accessibility of treatment, supplementary and support services provided by substance abuse treatment facilities

- Substance abuse treatment facilities should be encouraged to provide supplementary medical and detoxification services in addition to traditional addiction services. Facilities that do not have the financial or human resources to deliver these services should be empowered, through organisational development interventions, to develop affiliations with organisations that do provide supplementary services.

- Prior to admission, each client should receive a physical examination from a qualified medical practitioner. The need for supplementary medical services should be assessed during this examination.
- Linkages between the Department of Health and the Department of Social Welfare need to be improved, with a view to improving the capacity of treatment facilities located in welfare settings to address the health problems associated with substance abuse. This would be facilitated through the recognition at both a policy and funding level that substance abuse is a health problem that has social consequences.
- Given that co-morbid psychiatric illness is strongly associated with substance abuse, the accessibility of psychiatric and psychological services for clients with substance abuse problems needs to be improved. Facilities that do not have the financial or human resources to deliver these services should be empowered, through organisational development interventions, to develop affiliations with organisations that do provide these services.
- Given the association between substance use and risky sexual behaviour, HIV-related services that include voluntary counselling and testing as well as interventions aimed at reducing HIV-risk associated with sexual practices and injection drug use should be introduced at all substance abuse treatment facilities.

Recommendations aimed at improving the accessibility of substance abuse treatment facilities to clients from under-served groups

- Staff at substance abuse treatment facilities should be trained in outreach techniques aimed at facilitating treatment entry among under-served population groups.
- The number of beds for indigent clients should be increased at all substance abuse treatment facilities.
- Treatment facilities should be encouraged to employ multilingual staff from diverse ethnic cultures.
- Xhosa and other African language-speaking students of the health and other allied professions should be encouraged to enter the substance abuse field.
- Staff at existing substance abuse treatment facilities need to be trained in culturally and gender-appropriate assessment techniques and substance abuse interventions.
- The capacity of treatment service providers to provide appropriate treatment for clients with special needs could be enhanced through access to a provincial substance abuse resource centre and a national addiction-related clearing house.

Recommendations related to research, monitoring and evaluation

- As part of the monitoring of the quality of substance abuse treatment services in South Africa, 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 the allocation of funding and other resources to existing facilities, based on the extent to which they provide services to historically under-served groups.
- Although national minimum standards for the provision of inpatient substance abuse treatment are currently being developed, national minimum standards for outpatient treatment services should also be developed as a matter of urgency. In addition, a policy framework that supports and outlines the implementation and evaluation of these standards needs to be developed.
- Research is required that evaluates the relative efficacy of treatment programmes that provide traditional addiction and support services and those that provide traditional addiction services only. This research may provide justification for the provision of mental health and HIV-related services in all substance abuse treatment facilities.
- Research is required that evaluates the relative efficacy of treatment facilities that provide traditional addiction and supplementary medical services in comparison to facilities that provide traditional addiction services only.
- Interventions aimed at improving the cultural and gender-sensitivity of treatment programmes need to be designed, implemented, and evaluated.
- Substance abuse treatment facilities should be encouraged to establish routine systems of client monitoring.
- Substance abuse treatment facilities should, as a condition of licensure and funding, conduct comprehensive evaluations of their treatment programmes once every five years. These programme evaluations should be conducted by an external evaluator.

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