REFERRING AGENTS' PERCEPTIONS OF ACCESS BARRIERS TO INPATIENT SUBSTANCE ABUSE TREATMENT CENTRES IN THE WESTERN CAPE

DEBORAH LOUISE ISOBELL

Student number: 2636988

A mini-thesis submitted in partial fulfilment for the degree of

Master's of Arts Research Psychology in the

Department of Psychology

University of the Western Cape

Bellville

2013

SUPERVISORS:

Mr. Kamal Kamaloodien

Dr. Shazly Savahl

Keywords: substance abuse, perceptions, treatment, barriers to treatment, PPCT model, access, inpatient treatment, substance abuse treatment centres, referral system, referral agents.

Abstract

High rates of substance use and its associated problems afflict Cape Town, underscoring the need for easily accessible substance abuse treatment. Despite the substantial benefits for both individuals and society at large that substance abuse treatment confers, substance abusers often first have to negotiate considerable challenges in order to access treatment and accumulate these gains. That is, experiencing barriers to accessing treatment, together with the presence of socio-demographic features, rather than "need for treatment", decides who accesses treatment. Referrals are the gateway to inpatient substance abuse treatment in the Western Cape. While several barriers to accessing treatment have been identified by prior studies, none examine these phenomena from the point of view of the agents responsible for referring substance users for treatment. Moreover, access barriers to inpatient substance abuse services are a neglected area in extant literature. To address this gap, this study explored the perceptions of referring agents' of the barriers to accessing state-funded inpatient substance abuse treatment centres in the Western Cape. This enabled the researcher to compare existing access barriers to treatment as identified by prior research, to those elucidated in the study. Bronfenbrenner's Process-Person-Context-Time model was employed as the basis for understanding identified barriers. In accordance with the exploratory qualitative methodological framework of the study, six semi-structured individual in-depth interviews were conducted with referring agents' of differing professional titles who were purposefully selected and expressed a willingness to participate in the study. Interviews were audio-recorded, and transcripts were analysed and interpreted by means of Thematic Analysis. Two broad thematic categories of access barriers were identified: *Person*-related barriers (denial, motivation for treatment, gender considerations, disability, active TB disease, homelessness, psychiatric co-morbidity) and *Context*-related barriers to treatment (cultural and linguistic barriers, stigma, community beliefs about addiction and treatment, awareness of substance abuse treatment, affordability/ financial barriers, geographic locations of treatment facilities, waiting time, lack of collaboration within the treatment system, beliefs of service providers', lack of facilities/ resources within the treatment system, practices at inpatient facilities, referral protocol and uninformed staff). Results suggest that by targeting the aforementioned barriers, access to inpatient and outpatient treatment services can be improved, and recommendations for interventions are offered in this regard. Ethical principles such as obtaining informed consent and ensuring confidentiality were abided by throughout the study and thereafter.

Declaration

I declare that *Referring agents' perceptions of access barriers to inpatient substance abuse treatment centres in the Western Cape* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Deborah Isobell

Acknowledgements

Foremost, I offer all praise and honour to God for allowing me to complete this arduous journey.

Mum and Dad, to whom I am *forever* indebted, may you be blessed beyond measure.

Patrick, my *unending* source of support, optimism and love, thank you for everything.

My earnest thanks to you Ilhaam, for your advice, guidance and humour during my 6 months as a referring agent, and the deep, sincere friendship that developed beyond that.

To my supervisor Mr Kamal Kamaloodien, and co-supervisor Dr Shazly Savahl, thank you for your guidance and critique during this process.

Also, to Sabirah and Cassandra for the continued encouragement, I thank you earnestly.

Lastly, I would also like to acknowledge the assistance of City Health towards recruiting some participants for this research. Opinions articulated, as well as findings and conclusions drawn are those of the author and are not to be attributed to City Health.

UNIVERSITY of the
WESTERN CAPE

Table of Contents

Abstract…...…………………………………………………………………………….……..…ii

Declaration………………………………………………………………………….……..…….iii

Acknowledgements…………………………………………………………...………iv

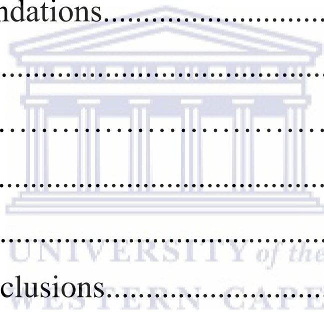
Chapter One: Introduction..1
1.1. Background to the study..1
1.2. Rationale for the study..3
1.3. Significance of the study..4
1.4. Research question..4
1.5. Aim of the study..4
1.5.1. Objectives of the study...4
1.6. Definitions...4
1.7. Conclusion……...6
Chapter Two: Literature Review...7
2.2. The need for accessible substance abuse treatment in South Africa.................................7
2.2.1. Substance use and the burden of harm...7
2.2.2. Crime..8
2.2.3. Health..9
2.3. Treating substance abuse...10
2.3.1. Benefits of substance abuse treatment..12
2.4. Substance abuse treatment system dynamics in South Africa......................................13
2.4.1. Legislation governing the provision of substance abuse treatment in South Africa..13
2.4.2. Referrals as a gateway to accessing inpatient substance abuse treatment..................14
2.5. The substance abuse treatment workforce..16
2.5.1. The impact of the service provider on access to treatment.......................................17
Chapter Three: Theoretical Framework 19

UNIVERSITY of the
WESTERN CAPE

Chapter Four: Method....37
4.1. Research framework....36
4.2. Participants....36
4.3. Data collection procedure....37
4.4. Data analysis....38
4.5. Validity....39
4.6. Ethical considerations....41
4.7. Conclusion....41
Chapter Five: Results....42
5.1. Barriers to treatment....42
5.2. Person- related barriers....43
5.2.1. Denial....43
5.2.2. Motivation for treatment....44
5.2.3. Gender....45
a. Stigma toward women....46
b. Pregnancy....46
c. Childcare considerations....47
d. Lack of treatment centres for females....48
e. Masculinity and gender roles....49
5.2.4. Disability....50
5.2.5. Tuberculosis....51
5.2.6. Psychiatric co-morbidity....52
5.2.7. Homelessness....54
5.3. Context- related barriers....54
5.3.1. Microsystem....55
a. Awareness barriers....55
b. Cultural barriers....56
c. Linguistic barriers....59
5.3.2. Mesosystem....59
a. Stigma....59
b. Beliefs about addiction and treatment....59
c. Community violence....60
5.3.3. Exosystem....61

UNIVERSITY of the
WESTERN CAPE

a. Waiting time...61
b. Lack of collaboration...64
c. Beliefs of service providers..64
d. Lack of facilities/ resources within the treatment system…...65
e. Inpatient treatment facilities' practices as a barrier…..66
f. Referral protocol…...67
g. Social worker reports as a barrier…...71
h. Referral documentation…..70
i. Uninformed staff…...73
j. Helplessness/ frustration...74
5.3.4. Macrosystem...75
a. Geographical access barriers..75
b. Affordability /financial barriers...76
5.3.7. Referring agents' recommendations..81
5.4. Discussion……..83
5.5. Recommendations…………………………………………..……………………….86
5.6. Conclusion…………...87
6.1. Summary of the study...90
6.2. Summary of findings and conclusions..90
6.3. Person-related barriers……………………………………………………………..91
6.4. Context-related barriers…………………………………………………………93
6.5. Limitations of the study..96
References...98
APPENDIX A: Information Sheet...
APPENDIX B: Consent Form...
APPENDIX C: Interview Guide...
APPENDIX D: Ethical Clearance...



Chapter One: Introduction

1.1. Background to the study

This study explored the barriers to entering inpatient substance abuse treatment, as identified by referring agents in the Western Cape.

Given that substance use disorders are the second leading category of lifetime disorders (13, 3%) in South Africa (Herman et al., 2009), substance abuse treatment services are vital (Harker Burnhams, Dada & Myers, 2012). Though alcohol continues to be the primary substance of abuse (van Heerden et al., 2009), the use and trade of amphetamine-type stimulants, heroin and cocaine have noticeably increased in the country (Parry & Pithey, 2006).

In South Africa's Western Cape Province, substance-related problems are especially pervasive (Harker Burnhams, Myers, Fakier, Parry & Carelse, 2011; Myers, Pasche & Adam, 2010b; Plüddemann, Myers, & Parry, 2008), chiefly in Cape Town its capital (Myers, Louw & Fakier, 2007). Great indirect and direct health, social and economic costs are incurred by the use and abuse of substances within the Metro region. Costs related to drugs and alcohol are mirrored in infrastructural damage, legal, medical and emergency services (Parry, 2009 as cited in City of Cape Town Policy Position on Alcohol and Drugs and Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014), broader indirect effects, court cases, imprisonment, and policing (City of Cape Town Policy Position on Alcohol and Drugs and Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011- 2014). This underscores the need for accessible substance abuse treatment services (Myers, Louw & Pasche, 2011; Plüddemann et al., 2008).

UNIVERSITY of the
WESTERN CAPE

Treatment denotes "the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve or maximize personal and social functioning" (United Nations Office on Drugs and Crime, UNODC, 2003, p. 11.2). The treatment of substance abuse confers significant societal and personal benefits (Carr et al., 2008; Fakier & Myers, 2008), and has been shown to combat several substance-related problems (Carr et al., 2008).

Monetary, quality-of-life and social gains are reported at a societal level (Ettner et al., 2006; Koenig et al., 2005 as cited in Carr et al., 2008; McCollister & French, 2003; Zarkin, Dunlap, Hicks, & Mamo, 2005) while psychiatric symptoms, substance use and criminal activity have been found to be reduced as result of treatment, at the level of the individual (cited in Carr et al., 2008). As such, prior studies allude to optimistic outcomes as a result of treatment: enhanced psychological and physical well-being; lessened substance abuse; decreased unlawful activities; advances in social functioning (Fakier & Myers, 2008), reduced health care costs and overall use of health services (National Center for Health Statistics, 2009) and lessened costs of criminality (cost of incarceration, victimisation, and losses due to crime) (McCarty, 2009). Substance dependence necessitates treatment (World Drug Report, 2012), yet substances abusers must first access treatment in order to accumulate these gains, which is often a substantial challenge (Carr et al., 2008). This is evident in South Africa's Western Cape Province, where barriers to entering treatment for substance abuse have been reported.

Myers and Parry (2005) found the accessibility, affordability, and availability of South African substance abuse treatment services to be of concern. Adding to this, Myers et al. (2007) posit that the utilisation of treatment services are dependent not on "need-for-treatment", but on encountering barriers to treatment, in the presence of certain socio-demographic factors which have been associated with affecting treatment utilization (Myers et al., 2007, p.1). Systemic or individual characteristics or events which serve as challenges to receiving substance abuse treatment can be termed 'barriers' (Xu et al., 2007). The current study focuses on the role of systemic and individual influences on the accessibility of inpatient substance abuse treatment.

UNIVERSITY of the
WESTERN CAPE

'Intensity of treatment' makes reference to the level at which, and amount of substance abuse treatment provided. Outpatient, inpatient/ residential care, and a combination thereof are employed in the South African context (Fakier & Myers, 2008). Specialist treatment facilities offer AOD users specialist treatment services (e.g. inpatient treatment services and detoxification) (Shand & Mattick, 2001). The current study limits its focus to these specialised substance abuse treatment facilities as they are unique in their use of a referral system (see Myers et al., 2007).

Those who refer individuals to these treatment facilities have been identified under various categories by the South African Community Epidemiology Network on Drug Use

(SACENDU) Report (2012). Using data from 21 specialist treatment facilities, this report identified that referrals are usually made by: (1) Work/employers; (2) Social services/welfare; (3) Self/ family/ friends; (4) Religious body; (5) Doctor/ psychiatrist/ nurses; (6) Schools; (7) Court/correctional services; (8) other sources (e.g. radio); (9) Hospital/ clinics; (10) Unknown sources.

In contrast to the previous period during which data was aggregated for the report, researchers noted a slight increase in referrals by the substance using individuals themselves, their family or their friends (self/family/friends category). While other sources remained fairly constant, a slight decline occurred in referrals made by the Social Services/ welfare sector (SACENDU, 2012). The current study directs its attention to the perceptions of referrers in the social services/ welfare sector, more specifically, those who refer to state-funded inpatient substance abuse treatment centres. Reports in the Western Cape media call to attention the arduous tasks of Social Workers, one group of referring agents within the *social services/ welfare* category. Social Workers have to bear the burden of substance abuse in the Cape Flats, in addition to the heavy case-loads with which they must contend (West Cape News, 2010).

UNIVERSITY of the
WESTERN CAPE

Myers, Louw and Fakier (2008b, p. 40) observe that in contrast to other treatment service providers, "state-funded early intervention and treatment services are under pressure to improve service coverage, dispersion and availability". It is therefore necessary to examine factors impeding access to state-funded treatment facilities, particularly when considering that 24% of the 2927 patients treated across 21 specialist treatment facilities reported the 'state' as their source of funding, making it the most common source of funding in the Cape Town region (SACENDU, 2012). Examining these factors therefore constitutes one of the objectives of the proposed study.

1.2. Rationale for the study

While several studies have directed attention to the barriers to treatment entry (e.g. Myers & Parry, 2005; Myers, Fakier & Louw, 2009; Perron et al., 2009; Xu et al., 2007), no research has examined this subject matter exclusively amongst those directly involved in the process of enacting referrals to state-funded inpatient treatment services, namely referring agents. Given that the barriers to accessing inpatient treatment facilities remain largely unexplored within the scholarship of treatment access (Wisdom, Cavaleri, Gogel & Nacht, 2011), the

current study presents an opportunity to add to this body of knowledge. Ascertaining the barriers to treatment entry is imperative to improving the utilisation of substance abuse treatment services (e.g. Myers et al., 2007).

1.3. Significance of the study

Against the backdrop of this discussion, this study sought to highlight the barriers to accessing state-funded inpatient treatment from the viewpoint of referring agents. Knowledge of these barriers will permit service providers' and stakeholders to incorporate the insights of these individuals in planning interventions designed to minimize barriers to accessing treatment, making service provision more efficient, assisting referring agents, enabling more individuals to enter into treatment and decreasing the burden of disease. Enabling more individuals to enter treatment will allow them to accrue the benefits of treatment, which extends beyond the substance user (see Carr et al., 2008).

1.4. Research question

What are the barriers faced by those who refer substance abusers for treatment?

1.5. Aim of the study

UNIVERSITY of the WESTERN CAPE

To explore the perceived access barriers to inpatient substance abuse treatment facilities as identified by referring agents in the Western Cape.

1.5.1. Objectives of the study

(1) To identify access barriers to substance abuse treatment, as identified by those responsible for referring individuals to inpatient treatment services.
(2) To compare existing access barriers to treatment as identified by prior research both nationally and internationally, to those elucidated by participants in the current study.
(3) To make recommendations for intervention strategies aimed at facilitating ease of access into inpatient treatment based on emergent themes in the data collected.

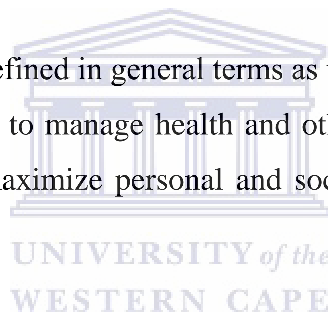
1.6. Definitions

Substance abuse: The World Health Organisation (2000) defines substance abuse as the on-going use of a substance, despite awareness of the serious implications of its use.

Substance dependence: Substance dependence, as specified by the DSM-IV-TR (2000), is a dysfunctional pattern of substance use which results in distress or harm and is clinically significant, transpiring at any time over the period of one year, as indicated by at least three of the following diagnostic criteria: "(1) tolerance; (2) withdrawal; (3) the substance is often taken in larger amounts or over a longer period than was intended; (4) there is a persistent desire or unsuccessful efforts to cut down or control substance use; (5) a great deal of time is spent in activities necessary to obtain the substance; (6) important social, occupational, or recreational activities are given up or reduced; (7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance" (p. 197).

Perception: The means by which incoming, sensory information is made sense of and analysed (Stratton & Hayes, 1993).

Treatment: "Treatment can be defined in general terms as the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve or maximize personal and social functioning" (UNODC, 2003, p.11.2).


UNIVERSITY of the
WESTERN CAPE

Barriers to treatment: "Barriers to treatment are events or characteristics of the individual or system that restrain or serve as obstacles to receiving health care or drug treatment" (cited in Xu et al., 2007, p.1-2).

Process-Person-Context-Time model: A model proposed by Urie Bronfenbrenner which posits that four interrelated components (*Process*, *Person*, *Context*, *Time*) frame our world (Bronfenbrenner & Morris, 2006).

Access: Access to treatment can be understood as either *realised* or *potential.* The latter denotes that resources enabling treatment access are present, while the former makes reference to actual service utilization (Andersen, 1995).

Inpatient treatment: Substance abuse programmes that deliver an array of structured interventions to address substance use disorders (abstinence-oriented interventions are included here), whilst providing accommodation in a drug-free environment (National

Treatment Agency, 2006) on a 24-hour basis (The Prevention of and Treatment for Substance Abuse Bill, 2008).

Substance abuse treatment centres: Substance dependent individuals are provided with rehabilitation and intensive treatment at these public or private facilities (Department of Social Development, Minimum Norms and Standards for Inpatient Treatment Centres, 2005).

Referral system: "A multi-agent system whose member agents are capable of giving and following referrals" (Yu & Singh, 2003, p. 65).

Referral agents: Persons who facilitate the referral process of clients with more severe substance abuse problems to treatment services (Myers, Harker, Fakier, Kader & Mazok, 2008a). In this study the term 'referring agent' was preferred.

1.7. Conclusion

This chapter contextualised the current study, providing a background. The rationale for the study, research question, aims and objectives were emphasised. Chapter Two reviews the relevant literature pertaining to the aims and objectives of the study, together with an overview of the selected theoretical framework. Key findings from the literature are then combined into a summary of the literature. The research methodology is explicated in Chapter Three, where the research design, selection of study participants, data collection method, procedure, validity, reflexivity and ethical considerations are discussed. The analysis, interpretation and discussion of study findings are offered in Chapter 4, where results are also deliberated in relation to prior scholarship. Lastly, a conclusion of the study, detailing its shortcomings and recommendations for interventions are offered in Chapter Five.

UNIVERSITY of the
WESTERN CAPE

Chapter Two: Literature Review

This literature review provides an overview of research relating to accessible substance abuse treatment, using a thematic approach. It discusses the burden of harm attributable to untreated substance use; the use of substances, substance abuse treatment and the potential benefits of treatment in order to illustrate the need for accessible treatment[1]. Furthermore, the manner in which the substance abuse treatment system is operative in the Western Cape is explicated as this situates the integral role of referring agents and the invaluable insights they stand to offer in identifying and overcoming barriers to treatment. The theoretical framework of the study, Bronfenbrenner's Process-Person-Context-Time (PPCT) Model, is then presented as a means of understanding and locating the barriers to treatment identified by earlier research. A brief summary of the reviewed literature then follows.

In order to obtain an understanding of why accessible substance abuse treatment is needed in the Western Cape, this review commences by elucidating statistics pertaining to substance abuse in South Africa and thereafter studies that illustrate the harms that result from substance abuse. Subsequently, literature relating to substance abuse treatment and its benefits are presented.

UNIVERSITY of the
WESTERN CAPE

2.2. The need for accessible substance abuse treatment in South Africa

In light of the social ills associated with the use of substances (see Wisdom et al., 2011), possible resultant dependence, and well-documented benefits of treatment of substance abuse (see Carr et al., 2008), it is imperative to ensure that more individuals are able to access treatment. Several publications from the Medical Research Council of South Africa (Myers, Louw & Pasche, 2011; Myers, Louw & Pasche, 2010a; Myers et al., 2009; Myers et al., 2008) emphasize this need and this constitutes the focus of this part of the literature review.

Among South Africans, substance use disorders are widespread (Pasche & Stein, 2012). Evidence shows rates of substance usage to be comparatively high in the Cape Metro and Western Cape (City of Cape Town Policy Position on Alcohol and Drugs and Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014), in spite of the dearth of comprehensive prevalence statistics (Provincial Government of the Western Cape Blueprint

[1] The first part of this literature review draws on the argument made by Myers et al. (2007), concerning the burden of harm attributable to substance abuse and subsequent need for treatment. It departs from this earlier work in its use of more recent literature and more in-depth focus upon these relevant factors.

2010). Untreated substance use disorders are commonplace in the Western Cape (Myers et al., 2011). Here 15, 8 % of adults report substance use disorders, and alcohol abuse as the most prevalent lifetime disorder (11, 4%). Amongst school-going adolescents excessive alcohol (66%) and tobacco (47%) use has been reported (Medical Research Council of South Africa, MRC, 2013). Recently the SACENDU (2012) project indicated that 2733 patients were treated across 23 specialist treatment centres and programmes during the latter half of 2011. Whilst this suggests high rates of substance use, the project is only able to account for substance users' who have successfully accessed the treatment system (Parry, Plüddemann & Bhana, 2009). These figures are therefore not a true representation of substance use amongst the general, untreated population. Taken together, it is evident that a considerable number of South Africans would benefit from accessible treatment services.

2.2.1. Substance use and the burden of harm

The global burden of disease (Wu, 2011) and more general burden of harm to society are fuelled substantially by substance use disorders, providing one indicator of the need for treatment (Myers et al., 2007). An individual's use of substances affects not only themselves but also their family members and the functioning of society at large. The substance user's accomplishments and health is impacted upon, as is the productivity, financial security, social networks and mental health of their families. Substance users' contact with the healthcare and criminal justice systems thus cause society at large to be affected (Wu, 2011). Studies that illustrate the burden of harm attributable to substance abuse are outlined below.

UNIVERSITY of the WESTERN CAPE

2.2.2. Crime

The drugs-crime nexus (Monaghan, 2012) is one indicator of how society at large is impacted upon. High levels of substance abuse were reported in a qualitative study conducted amongst 2 859 South African arrestees. Amongst the sample, 50 % of [2]coloured participants reported Mandrax use, whilst this was the drug of choice for 39% of Indian participants. Cocaine use was found to be especially prevalent among White arrestees (32%), and even more so amongst White females (65%). Substance use was most likely to occur in those below the age of 20 years (66%) and those with a prior history of arrests tested positive in higher volumes

---

[1]The terms 'coloured' and 'black' were employed as racial categories within the apartheid era to reinforce a segregated society (along with the other racial category, namely Indian), to refer to those who were not afforded the same benefits as whites in this era. These terms are used here merely for descriptive purposes, and does not imply acknowledgement of these terms by the author.

(51%) than those who were incarcerated for the first time (29%) (Leggett, Louw & Parry, 2011). Statistics of the South African Police Service indicate that the highest rates of drug-related crime in South Africa were reported the Western Cape Province during the 2008/2009 financial year. Of the 117 000 cases examined, 52 000 were accounted for in this region (Provincial Government of the Western Cape Blueprint, 2010). As one illustration, alcohol intake was involved in a vast majority (70%) of cases of domestic violence Cape Town (Peden, 2006 cited in Peltzer & Ramlagan, 2009, p. 7).

2.2.3. Health

Substance abuse has been linked to the contraction of HIV (dos Santos, Trautmann & Kools, 2011), tuberculosis (TB) (Deiss, Rodwell, & Garfein, 2009) and Foetal Alcohol Spectrum Disorders (FASD), (Freeman & Parry, 2006) respectively. This is explored in the studies below.

Dos Santos, Trautmann and Kools (2011) explored substance-related transmission of HIV amongst 21 service providers and 63 substance users. Participants were relatively uninformed of the tangible risks to well-being arising from substance use. Besides no longer using substances, their imprecise ideas did not allow for tangible strategies to safe-guard themselves from HIV/ AIDS, and knowledge pertaining to substance-related HIV/AIDS transmission was also found to be poor. Besides the heightened risk of substance-related transmission of HIV, minimal educational attainment and poor living circumstances made treatment less accessible (dos Santos, Trautmann & Kools, 2011). This is paramount as avoiding further social and health harms resulting from sustained substance use is one focus of treatment (reducing the risk for HIV among injecting drug users through harm reduction measures) (Fisher et al., 2007).

UNIVERSITY of the
WESTERN CAPE

Globally, the highest rates of FASD are found in the Western and Northern Cape Provinces of South Africa (Graham, 2012; Chersich et al., 2011; Freeman & Parry, 2006; McKinstry, 2005). Caused by maternal alcohol consumption during pregnancy, FASD is one of the leading causes of avoidable physical and mental retardation among infants (Centers for Disease Control and Prevention, 2001 in McKinstry, 2005). Developmental difficulties, physical dysmorphology and low birthweight are often experienced by infants suffering from the syndrome (McKinstry, 2005). These negative effects for both mother and infant further highlight the importance of accessible substance abuse treatment.

Deiss et al. (2009) ascribe the high prevalence of TB among substance users' to the risk behaviours they engage in, the physiological effects of substance use and environments they frequent. Internationally, HIV-associated TB epidemics have been linked to injecting drug use, and substance users experience heightened vulnerability to TB infection and disease. Substance users' encounter unique barriers to treatment for TB such as limited access to care and poor adherence (Deiss et al., 2009). Substance abuse, homelessness and psychiatric illness are more consistent predictors of non-adherence to TB treatment than are demographic factors of socio-economic status, ethnicity, age, education and gender (Farmer, 2005). Practices that serve as access barriers to substance abuse treatment include necessitating testing for infectious diseases as a prerequisite for access, rendering differential treatment, or unwillingness to admit persons who are otherwise eligible. Nonetheless, treatment seekers suspected to have infectious tuberculosis may be denied access until it has been established medically if treatment is needed prior to being admitted to a substance abuse treatment program, in order to ensure the health and safety of staff and other patients (SAMHSA, 1993). Given that poor adherence or incomplete treatment place communities and infected individuals at serious risk as it leads to remaining infectious for longer periods, resistance to TB treatment, and relapse of the disease or death, the importance of controlling the illness among substance users is underscored (Volmink & Garner, 2009).

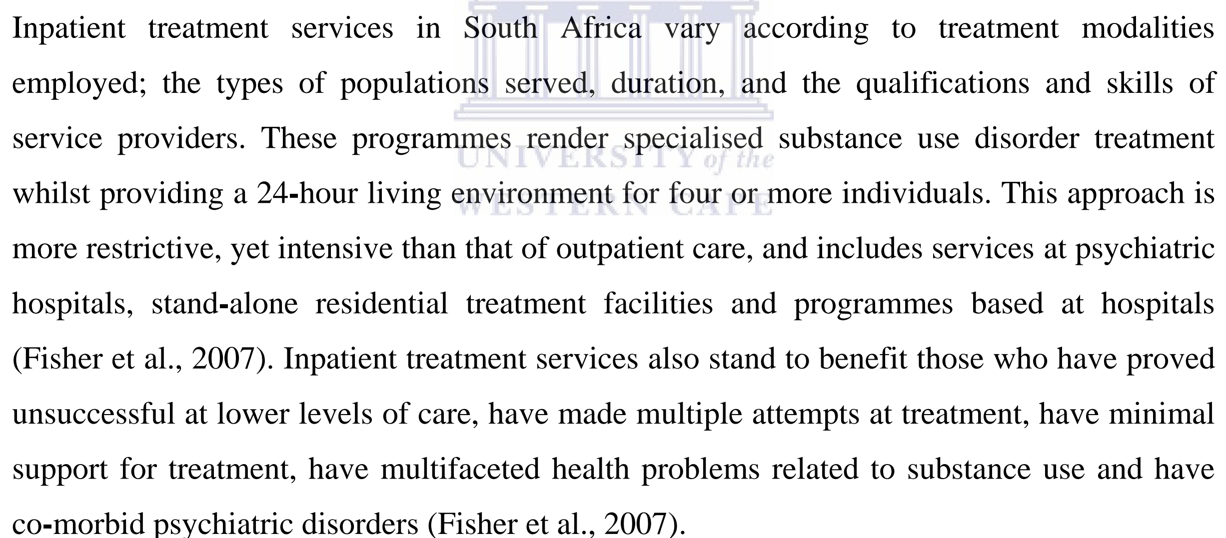
UNIVERSITY of the
WESTERN CAPE

2.3. Treating substance abuse

Treatment addresses the harms of substance abuse (see Jackson & Shannon, 2011), and these services have become more sought after due to the high levels of substance related problems in the Western Cape (Plüddemann et al., 2008). Literature relating to the benefits of substance abuse treatment and the manner in which the treatment system is operative in the Western Cape are presented below.

Substance abuse treatment is regarded as a specialty field in the behavioural sciences and medicine by the World Health Organisation (WHO) (Myers et al., 2008a). Treatment confers specialised social, medical and psychiatric services to individuals, seeking to reverse, minimise or end the adverse social and health consequences linked to substance dependence and abuse (Fisher et al., 2007). Goals of treatment are contingent upon the modality employed and these may include harm reduction or abstinence (Fisher et al., 2007; Myers et al., 2008a). In the Western Cape various treatment services are offered (Myers et al., 2008a).

The WHO (1993) endorses that the degree of severity of substance use determine the treatment intervention strategy. Thus, as use occurs on a continuum (recreational/ occasional use, misuse, abuse, dependence), so too do treatment services. On the one end of the spectrum are primary prevention activities. These aim to ensure that substance use problems and disorders do not occur. Through the provision of treatment, early identification and management of substance use disorders are encompassed under secondary prevention activities, whilst harm reduction activities, treatment and aftercare are contained within tertiary prevention activities, activities that seek to retard or cease the progression of the disorder (Fisher et al., 2007). When treatment systems ensure that recipients access the services suited to their needs, at varying levels of intensity, as required, the 'continuum of care' is ensured (SAMHSA, 2006). The needs of individuals with substance dependence are suited to specialised treatment services which may also be indicated for those with lower levels of problem severity in the event that early interventions were unsuccessful (Fisher et al., 2007).



Inpatient treatment services in South Africa vary according to treatment modalities employed; the types of populations served, duration, and the qualifications and skills of service providers. These programmes render specialised substance use disorder treatment whilst providing a 24-hour living environment for four or more individuals. This approach is more restrictive, yet intensive than that of outpatient care, and includes services at psychiatric hospitals, stand-alone residential treatment facilities and programmes based at hospitals (Fisher et al., 2007). Inpatient treatment services also stand to benefit those who have proved unsuccessful at lower levels of care, have made multiple attempts at treatment, have minimal support for treatment, have multifaceted health problems related to substance use and have co-morbid psychiatric disorders (Fisher et al., 2007).

As an aid to treating substance use disorders, the use of medication is supported by research (Rieckmann, Kovas & Rutkowski, 2010). Efficient substance abuse treatment includes the prescription of medications to deal with psychiatric symptoms; medications to deal with withdrawal; substitution medication for continued periods to substitute for illicit opiates (e.g. heroin) and medications to prevent relapse to alcohol or illicit opiate use (NHS, 2006 as cited in Myers et al., 2008a).

Detoxification is an initial phase of treatment whereby acute withdrawal symptoms of dependent substance use are eased (Gossop, 2006). On its own, detoxification does not constitute treatment, and neither does it result in long-term abstinence when used alone (Lipton & Maranda, 1983 as cited in Gossop, 2006).

The strength of inpatient treatment is that motivation to change and readiness for treatment can be developed during the course of treatment (Fisher et al., 2007), however, state-funded inpatient treatment facilities necessitate a referral from a suitably qualified professional.

2.3.1. Benefits of substance abuse treatment

A considerable body of research shows that treating alcohol and drug disorders lead to substantial benefits (McCarty, 2009). These include the ability to acquire and retain employment, advancements in health, reductions in crime involvement, improvements in the stability of families and financial gains for communities and countries at large. Treatment is therefore regarded as an investment with high social returns. Easing the financial burden to society that arises from problems linked to drug use requires effective and accessible treatment. The costs of treatment are superseded by its benefits (National Center for Health Statistics, 2009).

UNIVERSITY of the
WESTERN CAPE

Ettner et al. (2006) sought to investigate the costs and monetary benefits associated with treating substance abuse. Using the Drug Abuse Treatment Cost Analysis Programme, treatment cost data was collected with a main sample of 2567 clients. Results revealed a greater than 7:1 ratio of benefits to costs, which manifested primarily as increased employment earnings and reduced costs of crime. Added to the more direct benefits of quality of life gains and improved health, a compelling argument is made for why treating substance abuse is a worthy investment.

Parthasarathy et al. (2001) explored healthcare utilisation savings in their Californian study. Treated patients experienced a 26 % reduction in total medical costs, a 39 % reduction in emergency room visits and a 35% decrease in hospital stays, while Jordan et al. (2008) found a substantial decrease in tardiness, missed work, and conflict with co-workers in their intake-to-follow-up evaluation of almost 500 study participants who also underwent treatment.

Previous studies report high rates of substance abuse in the Western Cape which causes a burden of harm to be brought to bear on society. One strategy for addressing this burden of harm is for substance abusers to enter into treatment, which has consistently shown to confer various benefits. Research also consistently shows the cost of treatment to be exceeded by its economic and social benefits. Having established the need for substance abuse treatment services and its benefits, the latter half of this literature review centres upon the process of gaining access.

2.4. Substance abuse treatment system dynamics in South Africa

2.4.1. Legislation governing the provision of substance abuse treatment in South Africa

In South Africa, resource allocations for substance abuse services are regulated by local, provincial and national government (Fakier & Myers, 2008), with the institution of substance dependency treatment and prevention programmes being provided for by the Prevention of and Treatment for Substance Abuse Act, Act 70 of 2008, and The Prevention and Treatment of Drug Dependency Act, Act 20 of 1992 (Department of Social Development, Anti-substance abuse programme of action, 2011-2016).

UNIVERSITY of the
WESTERN CAPE

The Department of Social Development is tasked with advancing strategies and co-ordinating community and government efforts to combat substance use through the co-ordination and development of interventions, and in consultation with the applicable stakeholders and departments (Department of Social Development, Anti-substance abuse programme of action, 2011-2016). The Western Cape provincial Department of Social Development is thus responsible for overseeing and regulating treatment centres within this region.

The Government resource website (www.westerncape.gov.za) list a total of 36 registered treatment centres in the Western Cape. Twelve of these centres employ an out-patient treatment modality; fifteen are identified as being privately owned, registered organisations; three are state-owned; five are subsidised in-patient treatment facilities, and the remaining treatment centres' approach remains unspecified (www.westerncape.gov.za). Relative to the entire African continent, South Africa's substance abuse treatment system is debatably the most advanced (Pasche & Myers, 2012). Prior research however suggests that the demand for treatment exceeds its availability (Myers et al, 2008; Myers, Petersen, Kader & Parry, 2012). Myers et al. (2007) posit that the limited availability of treatment resources in Cape Town is

partially responsible for the limited access to substance abuse treatment as existing resources only enable service providers' to serve a fraction of the population in need of treatment. This is important as lack of treatment slots have been found to serve as a primary access barrier to treatment (Appel et al., 2004).

2.4.2. Referrals as a gateway to accessing inpatient substance abuse treatment

In the Western Cape access to state-funded inpatient substance abuse treatment is facilitated by means of a referral system (see Myers et al., 2007). Aday, Fleming and Andersen (1984, p. 13 as cited in Woodward, 2008) define access as "those dimensions which describe the potential and actual entry of a given population group to the health care delivery system." Aday et al. (1984 as cited in Woodward, 2008) elaborate that characteristics of consumers (their needs, wants and resources) converge with features of the delivery system (its organisation and availability of resources), to impact upon the likelihood of them gaining access to healthcare.

A similar conceptualisation of access was developed by Donabedian (1973, p. 419 as cited in Woodward, 2008) for whom access "comprises those characteristics of the resource that facilitate or obstruct use by potential clients". The former definition has a three-fold focus: features of the health system, individual characteristics and health behaviours. From this perspective the use of health services occurs due to facilitating or impeding factors, a predisposition to use services and the need for care. Donabedian's (1973) understanding of access emphasises the healthcare system (Woodward, 2008). Referrals are appropriate and needed when the special services needed by clients cannot be provided by a particular substance abuse treatment program (Young, 2006).

A referral is any process whereby healthcare providers at lower levels of the health care system, assesses that clients may benefit from accessing different or additional services, seek the aid of providers who are specially trained or better equipped to take over responsibility for a client's condition because they lack the facilities, skills or both to manage it (Al-Mazrou, Al-Shehri & Rao, 1990 as cited in Hensher, Price, & Adomakoh; WHO, n.d.).

Referrals assist clients in accessing the relevant available services to address their psychological, physical and social needs, and are an important tool in ensuring the continuum of care (WHO, n.d.). For the referring agent, referrals signify an act of faith, trust and hope

UNIVERSITY of the
WESTERN CAPE

that the goal of client success is shared in by the agency to which the client is referred. As such referrals are an opportunity for development, change and growth. Referrals present an opportunity to attend to the unmet needs of a client, but also potentially losing the client (Young, 2006). Ascertaining the perceptions of role players within the referral system such as referring agents is important to identify barriers to treatment accessibility as well as more covertly enabling an evaluation of the referral system.

A multi-phase, mixed method study by Myers et al. (2007) found access to substance abuse treatment to be impacted upon by the allocation of resources within the treatment system, as well as the organisation of the substance abuse treatment system itself. Broad political and systemic factors in turn influenced the above-mentioned factors. Multifaceted eligibility criteria, gatekeepers, waiting lists and intricate referral pathways for treatment were found to be organisational access barriers to treatment (Myers et al., 2007).

Multiple steps were found to be involved in the process of accessing state treatment services with access at each step being regulated by the presence of gatekeepers. Therefore, in their attempt to access treatment clients may encounter several obstacles. In particular, a (1) structured referral pathway was found to be absent from the South African substance abuse treatment landscape. Prior to obtaining treatment, individuals reported frequent referrals to numerous organisations as the referral pathway was vague (Myers et al., 2007). (2) The requirement of a referral from a social worker was a further obstacle encountered by those in need of state-funded inpatient treatment. Reports on the financial status, medical status and need for treatment of the client are necessary in order to facilitate this process. The referral process is lengthened considerably when this is considered in light of staff shortages in social work offices and the caseload assigned to social workers. (3) The need for detoxification and/ or mental health services was an additional obstacle faced by those who obtained a referral to inpatient facilities. Should treatment-seekers not be psychiatrically stabilised (where needed) and have completed a (hospital-based) detoxification process, many facilities turn them away (Myers et al., 2007). (4) Access to treatment was also hampered by the presence of eligibility criterion and one group who is denied access by most treatment facilities is court-referred clients. Additionally, individuals encounter a waiting period for their admission date in spite of being accepted into an inpatient facility (Myers et al., 2007).

UNIVERSITY of the
WESTERN CAPE

Individuals frequently abandoning attempts to access treatment services indicate the negative impact that the process of accessing treatment imposes on treatment utilization (Myers et al., 2007). This coincides with other sources that posit that the presence of waiting lists, fees, documentation to be completed and a referral system may further restrict accessibility to treatment services (IDU HIV Prevention, 2002).

2.5. The substance abuse treatment workforce

There is substantial variation in service providers of inpatient treatment in South Africa. The Minimum Norms and Standards for Inpatient Treatment Centres (2005) stipulate that only suitably qualified professionals should be tasked with rendering treatment services. It is thus requisite that all service providers' be registered with a professional body and hold recognised credentials. At minimum, basic counselling skills, training in ethics, the aetiology of substance use disorders and models of substance abuse treatment need be incorporated in these qualifications (Fisher et al., 2007).

Moreover, the Prevention of and Treatment for Substance Abuse Bill (2008) instructs that reports from a social worker must accompany applications towards voluntary admissions to inpatient treatment centres. Psychiatric or medical information, as well as material pertaining to the social circumstances of the applicant must be provided. Preferably, treatment centres receive these reports in advance of the arrival of the treatment-seeker; nonetheless, within a week of the admission of the said individual to the treatment centre, in the event that a social worker was inaccessible at the time of admittance to the centre, reports must reach the centre. Involuntary admittance to treatment centres likewise requires the sworn statement of a community leader, an individual closely affiliated to the potential client or a social worker (Prevention of and Treatment for Substance Abuse Bill, 2008).

UNIVERSITY of the
WESTERN CAPE

Sodano et al. (2010) enlisted 143 professionals considered to be counselling staff from 24 substance abuse treatment centres in five South African provinces, with the aim of describing their job duties, education and demographics. In comparison to Australia and the United Kingdom, counselling staff were 10 times more likely hold the title of social worker (49 %). In relation to their American counterparts, counsellors were also twice as likely to be social workers. Participants were also found to be relatively younger (38 years) than their American colleagues, primarily female (75%) and when employed in an outpatient setting, more likely to hold a graduate degree.

According to Harker Burnhams, Dada and Myers (2012) treatment-seekers from the Western Cape often first approach state social work offices. This is especially true amongst disadvantaged communities. These services are easy to reach for these communities as they are located within every district across the provinces, and are rendered free of charge (Harker Burnhams et al., 2012).

Findings such as these foreground the integral role this category of referring agents occupies in the substance abuse treatment system in South Africa and in the process of accessing inpatient care.

2.5.1. The impact of the service provider on access to treatment

Griffiths and Pearson (1988) found that the care provided by social and health care professionals was directly determined by their attitudes towards substance misusers and substance misuse (as cited in Richmond & Foster, 2003). Gilson, Palmer and Schneider (cited in Pasche et al., 2008) reiterated these findings, adding that this impacts upon the use of services. Richmond and Foster's (2003) study demonstrates this reluctance in providing substance-related care, explaining that professionals may be less eager to render services to these clients for multiple reasons. They suggest that stereotyping and moralistic attitudes in social and health care professionals are often provoked by self-destructive behaviours such as substance abuse. Characterised by mistrust, suspicion and avoidance, the consequence is often punishing, rejecting responses and interactions.

UNIVERSITY of the
WESTERN CAPE

A survey of general practitioners (GPs), (Abed & Neira-Munoz, 1990) found that service providers often considered patients with substance addictions to be especially uncooperative. In South West Sydney, Abouyanni et al. (2000), also utilizing a sample of GPs, found similarly that their sample held the concern that their substance-using patients' would prove demanding, difficult or aggressive. Compared to patients' with alcohol or tobacco dependence, the findings suggest that GPs felt less confident and lacked experience in providing care to those who are dependent on drugs, despite frequently seeing such patients.

A recent South African study which examined the attitudes of health science students towards patients with acute mental illness, intellectual disability and substance abuse found its 548 participants to hold significantly more negative attitudes toward substance using in contrast to their moderate regard for those with acute mental illness. Conversely, students were found to

have a high regard for intellectual disability as a medical condition (Boyle et al., 2010). Pasche, Myers and Louw's (2008) South African study of 126 community-based organisations yielded findings in accordance with prior research. Consistent with Richmond and Foster (2003) and Foster and Onyeukwu (2003), staff attitudes towards substance users were linked closely to substance-related service provision. This is of particular importance in South Africa where increasing prevalence of substance use motivates for effective and accessible treatment (Pasche et al., 2008).

Au (n.d.) emphasises the importance of well-informed, resourced professionals, and posits that the access and treatment of many substance abusers may be delayed due to lack of understanding and awareness of substance abuse among service providers.

These studies exhibit that service providers were not only more likely to view substance abusers and their substance abusing behaviours negatively, but that these negative attitudes play a role in the care provided. Referring agents play an integral role in the process of accessing substance abuse treatment in South Africa, and as such the very presence of these individuals and the attitudes they hold may act as a barrier to the process of accessing treatment. The current study thus directs attention to systemic and individual influences on accessibility to substance abuse treatment, as the above illustrates that they are equally important.

UNIVERSITY of the
WESTERN CAPE

Chapter Three: Theoretical framework

In the current study, access barriers to treatment were understood with Urie Bronfenbrenner's Process-Person-Context-Time (PPCT) model, the "mature form" of his Bio-ecological Systems Theory, (Bronfenbrenner & Morris, 2006; Tudge, Mokrova, Hatfield & Karnik, n.d.). This model emphasises the interaction between an individual's biological disposition and their environment, and is defined by the interrelatedness of its four principle concepts (i.e. process, person, context and time) (Bronfenbrenner & Morris, 2006; Tudge et al., n.d.). As such, it postulates the existence of different levels of interaction. Central to this model is the understanding that influences are bi-directional. As individuals wield influence on their surrounding environments (*context*), so do several influences impact upon individuals (Gabriel, Doiron, Arias de Sanchez, & Wartman, 2010; Paquette & Ryan, 2001). Barriers to treatment occur, and have been documented at different levels of interaction and these may be viewed as structural and non-structural (Myers et al., 2009), or internal and external (Xu et al., 2007). Bronfenbrenner's framework provides a means to understand the factors that impact upon treatment access and to examine these factors at different levels of interaction.

An alternative theoretical basis for understanding the determinants of access to health care is provided for by the Behavioural Model of Health Services Utilization (BHSU) (Andersen, 1995; Myers et al., 2007). While Phillips et al (1998, cited in Myers et al., 2007) assert that an array of contextual, provider-related and individual factors are integrated in this well-established model (Aday & Awe, 1997 cited in Myers et al., 2007), this model also serves to underscore the strengths and suitability of the PPCT model for the current study. While the BHSU looks at the collective impact of three categories of factors on the utilization of health services of individuals (Myers et al., 2010a), the framework provided for by Bronfenbrenner will not only locate the referring agent within a level of interaction, but in so doing allow for the examination of their perceptions of these said influences. The PPCT model is depicted below, visually, followed by an overview of its components as a framework for locating and understanding barriers.

UNIVERSITY of the
WESTERN CAPE

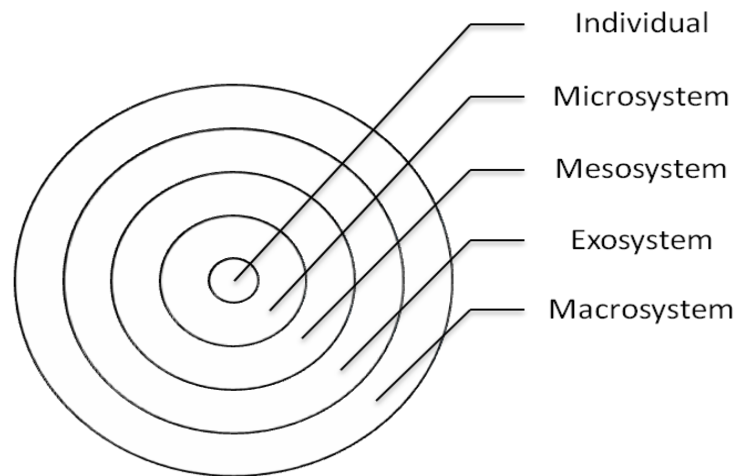


Figure 1: Overview of Bronfenbrenner's PPCT model (Adapted from Ward et al., 2012)

3.7.1. Process

Bronfenbrenner understood *proximal processes* to be enduring forms of interaction and activities between an individual and their immediate external surroundings (Bronfenbrenner & Morris, 2006; Tudge et al., n.d.). The power that these processes exert over the individual varies significantly as a "function of the characteristics of the developing *Person*, of the immediate and more remote environmental *Contexts,* and the *Time* periods in which these proximal processes take place" (Bronfenbrenner & Morris, 2006, p.795). In the current study only *Person, Context and Time* factors are considered.

3.7.2. Person

Bronfenbrenner expressly emphasised the importance of the personal characteristics of individuals which are brought to bear on any social situation. Individual's genetic and biological aspects are acknowledged as significant, but are assigned lesser attention (Tudge et al., n.d.; Bronfenbrenner & Morris, 2006).

Person characteristics are subdivided into *demand* (e.g. physical appearance, gender, age and skin colour), *force* (persistence, motivation and temperament) and *resource* (material and social resources such as access to good housing or nutrition, as well as emotional and mental characteristics in the form of intellect, prior experience and skills) characteristics (Tudge et al., n.d.; Bronfenbrenner & Morris, 2006). For Bronfenbrenner, these characteristics elucidate an individual's role in altering their context, be it actively or passively. Most actively, the degree to which the individual alters the environment is connected, partially to *force*

characteristics or their desire or drive to action this change. *Resource* characteristics, the middle ground between actively and passively effecting change within the context, relate to the ways in which physical, mental or emotional characteristics of individuals' action this process (Tudge et al., n.d.; Bronfenbrenner & Morris, 2006). *Demand* characteristics stand to (passively) modify an individual's environment by means of the mere presence of an individual, or the degree to which their physical appearance, gender, age or skin colour impact on the way in which others react to him or her (Tudge et al., n.d.; Bronfenbrenner & Morris, 2006).

Person characteristics are integral to the current study as they also encompasses internal barriers (phenomena which are subjective in nature; those perceptions and beliefs that arise from within the person; Allen, 1994 as cited in Xu et al., 2007) to accessing substance abuse treatment. Studies related to the *Person* characteristics of motivation for treatment, denial, gender, respectively are discussed below.

a. Motivation for treatment. Motivation is a changing, unfixed state rather than a static attribute and is "purposeful, intentional, and positive-directed towards the best interests of the self" (Miller, 1999, p. 7). Motivation for treatment is multifaceted, comprising extrinsic and intrinsic components (Joe, Simpson & Broome, 1998; Miller, 1999). Extrinsic motivators drive individuals to access and be retained in treatment, yet substantive and enduring change necessitates intrinsic motivation (Miller, 1999). Substance abusers are often regarded to have low motivation, to be resistant and to be in denial. Particularly, failure to access, be retained in and comply with treatment (or change strategies) is linked to low motivation (Miller, 1999).

UNIVERSITY of the
WESTERN CAPE

Common motives for individuals to end their substance use and enter treatment have been identified as "hitting bottom", "family responsibilities and pressures", "tiring of the drug-related hustle" and "fear of being jailed" (Joe, Chastain & Simpson, 1990; Cunningham et al., 1994; Varney et al, 1995 as cited in Joe et al., 1998, p. 1178). Two of the most frequently cited access barriers to treatment are low motivation for treatment and failure to recognise a problem, reinforcing earlier research (cited in Xu et al., 2007) that internal barriers are especially critical disincentives to accessing treatment (cited in Xu et al., 2007).

b. Denial is a common characteristic of addiction (Rinn, Desai, Rosenblatt & Gastfriend, 2001). It is the act whereby the severity of a substance abuse problem is minimised, and constitutes one internal personal barrier that potentially diminishes motivation for treatment or change (Connors, DiClemente, Marden Velasquez & Donovan, 2013).

Wisdom et al. (2011) found 41.38% of substance abuse treatment facility staff in their study to identify denial among youth and parents as a barrier to accessing treatment.

c. Gender. Studies have highlighted the role of gender on the utilization of and access to substance abuse treatment services, revealing that women are less inclined to seek treatment for substance–related problems as they are more likely to encounter multiple barriers to treatment entry than men (Brady & Ashley, 2005; Green, n.d.; Myers et al., 2009). Female substance abusers' are especially impacted by considerations such as the lack of affordable child care, social stigma and increased scrutiny of substance use when pregnant (Brady & Ashley, 2005).

A South African study by Myers et al. (2009) found males with substance use disorders to be more positively perceived than their female counterparts. Congruent with Copeland (1997) who coined the phrase "double deviance" to describe the stereotype that female substance abusers' have poor maternal instincts, are sexually promiscuous and are deficient in social and moral self-control, female substance abuse was linked to a failure to fulfil traditional gender roles, as well as sexual availability (Myers et al., 2009).Women may conceal or refute their substance use for fear of judgmental treatment providers, fear of having children taken away by authorities, fear of labelling or fear of being stigmatised. These considerations hamper treatment seeking for women, serving as a barrier to access (Myers et al., 2009). In contrast, Green (n.d.) found access and retention to treatment to be facilitated when programmes rendered services such as childcare.

Gordon (2007) noted denial of problems, psychological problems, internalization of negative social attitudes, independent attitudes regarding self-reliance and help-seeking, low motivation for treatment and self-definition as a person who does or does not abuse substances as internal barriers to treatment access experienced by women.

UNIVERSITY of the
WESTERN CAPE

Pregnant substance users' in Jackson and Shannon's (2011) study identified availability, acceptability, affordability and accessibility-related factors as barriers they had experienced in accessing treatment. (1) Availability barriers denoted not qualifying for entry to treatment, no space in treatment facilities and/ or placement on a waiting list, barriers linked to referrals/ waiting period or women with children not being accepted by the program. (2) Issues relating to money or medical coverage were included under 'affordability' whilst (3) acceptability entailed self-denial, pregnancy (not wanting to deliver in treatment and/or alone), knowledge that treatment would be challenging, fear of stigma / stigma and features of the treatment environment. Barriers relating to family responsibility, employment, mental health issues, social support, transportation, lack of childcare, legal difficulty, and physical health issues constituted (4) accessibility. Barriers were reported by 81 % of participants with accessibility (49%) and acceptability (51%) barriers being the most salient followed by availability barriers (26%) and affordability barriers (13%) (Jackson & Shannon, 2011). Although these authors adhere to a different conceptualisation of barriers than the current study, all four categories impeded treatment access for women.

While these studies have accentuated the unique barriers faced by female substance abusers', male substance users also encounter unique barriers to accessing treatment services.

UNIVERSITY of the
WESTERN CAPE

Masculine gender-role socialization, the belief that gendered behaviours and attitudes from cultural values, ideologies and norms are learned concerning what it means to be women and men, provides one explanation for differing patterns of entry to treatment for men and women (Addis & Mahalik, 2003). From this vantage point, males receive messages about the importance of emotional control, autonomy and physical strength which are inconsistent with several of the tasks linked to help-seeking from a health professional such as recognizing and labelling an emotional problem, depending on others or acknowledging a need for help (Brannon & David, 1976; Good, Dell, & Mintz, 1989; Levant & Pollack, 1995; Pleck, 1981; Pollack, 1998; Real, 1997 as cited in Addis & Mahalik, 2003). Thus, males who ascribe to this construction of masculinity may be less inclined to recognise the need for treatment, seek out treatment services, and thus access substance abuse treatment services. This is evidenced by numerous studies which illustrate that men seek counselling, psychiatric and psychotherapy less than females (Gove, 1984; Gove & Tudor, 1973; Greenley & Mechanic, 1976; Howard & Orlinsky, 1972; Vessey & Howard, 1993 as cited in Addis & Mahalik, 2003).

d. Disability. Persons with disabilities (PWD) continue to be excluded and stigmatised within society (Substance Abuse and Mental Health Services Administration (SAMHSA), 1998) and, compared to the general population are at heightened risk for substance abuse and dependence (Krahn, Farrell, Gabriel & Deck, 2006; SAMHSA, 1998). Despite this, access to substance abuse treatment services is limited for PWD (Krahn et al., 2006) due to attitudinal, communication and physical barriers which cause treatment experiences to be substandard or restrict treatment options (SAMHSA, 1998).

Four fundamental groups of barriers to treatment for PWD have been identified: *(1) Architectural barriers* encompass the physical characteristics of treatment facilities that impede access (e.g. narrow hallways, the absence of lifts or ramps, poor lighting); (2) *discriminatory policies, procedures or practices* of programmes (e.g. mandatory daily reading) may inadvertently discriminate against PWD, restricting access; (3) *attitudinal barriers* (expectations, beliefs, perceptions or stereotypes) held by service providers may impede their capacity to render care and (4) *barriers to communication* (when a program's communication with others is more accessible than its communication with people with coexisting disabilities), may be present for the hard of hearing or deaf, persons with significant respiratory problems or slow speech (SAMHSA, 1998).

UNIVERSITY of the
WESTERN CAPE

These barriers are especially salient in inpatient programmes, and operate to limit access to treatment services (SAMHSA, 1998). In the South African context, relatively low levels of literacy (Babbie & Mouton, 2010) further problematise the requirement of mandatory daily reading (*discriminatory policies, procedures or practices)* whereas therapeutic actions may be guided by less information as a result of *barriers to communication.* These therapeutic actions are paramount in contexts where referring agents may be based, as a communication with individuals is requisite to complete the reports and administration that are the basis of the referral process (SAMHS, 1998). The mere act of making a telephone call to apply for admission to a treatment programme may be the first barrier experienced for an individual who is deaf. To have access to communication, clients who are deaf and use sign language require sign language interpreters (SAMHSA, 1998).

In the USA Krahn et al. (2006) identified recognition of the need for substance abuse treatment; attributes of PWD; characteristics of treatment services and contextual variables

that enable or impede access to reflect the barriers faced by PWD. These authors recommended policy and practice changes in order to augment access rates for PWD.

The aforementioned studies suggest that access to treatment is not equitable for PWD. Characteristics of PWD, such as the nature of their disability (*Person*-related characteristics) appear to interact with characteristics of the treatment system, such as the architectural features of treatment centres (Exosystem-related influences) to create additional barriers to accessing treatment services for this group. This failure to provide equitable access to treatment facilities for PWD violates one of the principles of effective treatment (WHO, 2008) which stipulates that the dignity and human rights of all should be upheld by treatment services, and that non-discrimination be ensured (WHO, 2008).

***e*. *Psychiatric co-morbidity*.** It is commonplace that individuals with substance use disorders have co-morbid psychiatric disorders (Pasche & Stein, 2012; WHO, 2008). Substance use disorders and mental disorders share a complex association, and as many as 51% of psychiatric patients fit the diagnostic criteria for comorbid substance use disorders (Weich & Pienaar, 2009). Psychiatric co-morbidity, added to the limitations on functioning already imposed by substance abuse and dependence, restrains access to treatment services (Green, n.d.). Moreover, it is disquieting to note that in Cape Town, treatment for mental disorders amongst substance users' is not widely available (Myers et al., 2007), given the probability of psychiatric com-morbidity.

UNIVERSITY of the
WESTERN CAPE

To recapitulate, within Bronfenbrenner's framework, the *demand* characteristics of disability, gender and psychiatric comorbidity, together with the *force* characteristics of motivation and denial function as *person*-related barriers to treatment access.

3.7.3. Context

Four interrelated systems (i.e. the Microsystem, Mesosystem, Exosystem and Macrosystem) constitute the context or environment of Bronfenbrenner's model (Duncan et al, 2007; Tudge et al., n.d.; Visser & Moleko, 2012). *Context* factors incorporate external barriers (sociocultural factors, health care system factors and structural characteristics of a program; Allen, 1994 as cited in Xu et al., 2007) to accessing substance abuse treatment.

a. Microsystem. The *Microsystem* comprises of the most direct environment (psychologically, physically and socially) (Swick & Williams, 2006) of which the individual is part (Duncan et al., 2007). It is any context within which direct personal interaction and immediate experience occurs (Visser, 2007). Bi-directional influences are most powerful at the microsystem level and exert the greatest impact on the individual, yet inner structures can still be impacted by interactions at outer levels, highlighting that a central tenet of this theory is the "interaction of structures within a layer and interactions of structures between layers" (Paquette & Ryan, 2001).

In the following section, homelessness, lack of awareness and culture and language considerations are located and discussed as access barriers to treatment entry within the Microsystem.

Homelessness. Substance abuse results from and leads to homelessness (Zerger, 2002). Homeless individuals are more vulnerable to substance use disorders than those who are housed (Koegel & Buram, 1988; Koegel et al., 1999; Robertson, Zlotnick, & Westerfelt, 1997; Smith, North & Spitznagel 1992 as cited in Wenzel et al., 2001). Substance use disorders can sustain homelessness and aggravate its severity, lending credence to the need for treatment (Robertson, 1991 as cited in Wenzel et al., 2001). The homeless remain under-served by the treatment system nonetheless (Koegel et al., 1999; Robertson, Zlotnick & Westerfelt, 1997; North & Smith, 1993 as cited in Wenzel et al., 2001).

UNIVERSITY of the
WESTERN CAPE

Wenzel et al. (2001) found only 27.5% of the 326 homeless persons in their study with substance use disorders to have accessed inpatient treatment in the previous year. Treatment access was not predicted by contact with other service sectors, and having a partner and Schizophrenia respectively impeded access to treatment. Having an earlier history of treatment for substance problems and having public health insurance were found to improve the likelihood of accessing treatment (Wenzel et al., 2001).

Amongst homeless women the need for treatment is also largely unmet (Tucker et al., 2011). Tucker et al. (2011) found that receiving treatment was less likely amongst women who recently needed mental health treatment, had a more street-based social network, regarded themselves as being homeless, and had a minor child whereas receiving treatment was more

probable among women who had a history of arrest and informational support from their sex partners.

These studies highlight that amongst the homeless, high rates of substance use remain untreated.

Awareness barriers to treatment. Myers et al. (2010a) showed treatment utilisation to be associated with an increased awareness of available treatment facilities. Amongst individuals who had never accessed services there was very little awareness of where to go for substance abuse treatment. Limited awareness may be attributed to the use of primary health clinics and health promotion events at schools-venues not frequented by substance users, as the venues for current substance awareness programmes (Myers et al., 2010a). This coincides with information disseminated elsewhere (Injection Drug Use HIV Prevention factsheet, 2002) which states that individuals may be unaware of the treatment programs available to them, and the nature of services rendered. Myers et al. (2010a) also found that treatment utilisation was strongly influenced by the perceived severity of substance use as it was more likely that treatment would be accessed by those who self-reported extremely serious or considerable substance use-related problems. It is thus important that inadequate awareness of treatment services be attended to (Myers et al., 2010a), considering the pervasive nature of substance abuse in the Western Cape.

UNIVERSITY of the
WESTERN CAPE

Guthmann & Blozis (2001) found awareness of substance abuse to be deficient amongst the deaf and hard of hearing communities. Substance abuse awareness campaigns remain largely inaccessible to these communities as televised material is seldom captioned, school education initiatives have often been insensitive to the culture of deaf and hard of hearing, have failed to accommodate their skills, or communication. Substances other than alcohol were found to elicit the most stigma, and in so doing inhibited the acknowledgment of problematic substance use (Guthmann & Blozis, 2001).

Cultural and linguistic barriers to treatment entry. South Africa is a multicultural society (Rodrigues, 2006). Culture can be understood as "incorporating demographic variables (e.g. age, sex, family), status variables (e.g. socio-economic, educational, vocational, disability), affiliations (formal and informal), and ethnographic variables (e.g. nationality, religion, language, ethnicity)" (SAMHSA, 2000, p. 96), although no single definition of culture enjoys

supremacy (Leitner, 2000). Culture mediates the degree of stigma ascribed to mental illness, decisions to seek professional help, the type of help sought, the coping styles adopted and the social supports available. Furthermore, the meanings that individuals use to inform understandings of their illness are also impacted upon by culture, and this diversity is passed on into the service setting (U.S. Department of Health and Human Services, 2001).

Cultural barriers occur when cultural differences impede cultural exchanges (Leitner, 2000) and Weiss, Kung and Pearson (2003, as cited in Green, n.d.) suggest that cultural barriers such as language problems may be experienced by different ethnic groups when seeking to access treatment services. Whereas most individuals speak one or more of the country's 11 official languages, treatment centre staff speak mostly English and Afrikaans (Myers et al., 2008), as the studies below outline.

In the Limpopo, Free State, North West, Northern Cape and Mpumalanga provinces, Fakier and Myers (2008) exhibited that linguistic barriers to treatment access had not been addressed sufficiently. Only 81, 3 % of facilities employed African language-speaking counsellors, though all facilities reported employing staff from ethnically diverse backgrounds that were multilingual. When compared to facilities that did not employ African language-speaking counsellors, those that did treated a significantly larger proportion of black/African clients (Fakier & Myers, 2008). Researchers could however not determine if treatment facilities actively addressed linguistic barriers to treatment entry and subsequently served a higher proportion of black/ African clients or if it was due to a high proportion of black/ African clientele that African language speakers were employed (Fakier & Myers, 2008).

Myers and Parry (2005) audited specialised treatment facilities in Cape Town and Gauteng and found only a small number of facilities to offer treatment services that addressed linguistic barriers inhibiting treatment access and retention for black clients. With most treatment staff fluent only in English and Afrikaans, African language speaking therapists were employed by less than two-thirds of facilities, with the same proportion of facilities offering multilingual programmes. Additionally, culturally sensitive and suitable assessment and therapeutic approaches were used by less than half of the facilities. This suggests that black clients may be hindered in attempts to seek treatment due to these factors (Myers & Parry, 2005).

The aforementioned findings concur with Myers' (2004) audit of treatment facilities in Gauteng that found only 61, 3% of these facilities to render culturally and linguistically appropriate substance abuse treatment for black/African individuals. Merely a fraction of facilities actively addressed these barriers to treatment access, although earlier literature exhibits that matching counsellors and clients on gender and ethnicity, and rendering treatment services in their home language increases the use of treatment services (Appel et al., 2004; Tucker, Vuchinich, & Rippens, 2004).

Thus these studies highlight that the linguistic and cultural barriers which prohibit access to treatment for certain sectors of South African society are a long-standing problem.

b. Mesosystem. Interrelations among microsystems or contexts in which the person is situated, are termed the *Mesosystem* (Duncan et al., 2007). Relating this to treatment accessibility, community and individual influences such as stigma and negative beliefs about treatment have been found to inform choices to utilise health services (Myers et al., 2009).

Negative attitudes and community stigma. Higher levels of stigma are attached to substance use disorders than other mental and physical disorders (Sorsdahl, Stein & Myers, 2012). Constructions of substance dependence as a "self-acquired disease" foster discrimination and stigma, as it is based on the view that the free will of individuals lead to their first experimentation with illicit substances (WHO, 2008). Stigma constitutes a significant barrier to accessing treatment (Sobell & Sobell, 1998), and has the potential to negatively impact all life domains (Livingston, Milne, Fang & Amari, 2011).

UNIVERSITY of the
WESTERN CAPE

In Cape Town, using a sample of 20 substance abuse treatment system personnel, Myers et al., 2009) reported on two Mesosystemic influences on the use of treatment services: negative beliefs about treatment and stigma. Findings indicated that substance use disorders remained concealed due to stigmatisation of substance using individuals, an access barrier to treatment also acknowledged by IDU HIV Prevention (2002). Unfavourable perceptions of the quality of existing treatment were also found to impede access to substance abuse treatment and already-present stigma to be reinforced/ strengthened by negative images of substance-using individuals in the media (Myers et al., 2009). The negative responses and stigma of others have been found to potentially produce strong unwillingness to search for or participate in services or programs, strong feelings of isolation and suspicion (IDU HIV Prevention, 2002).

c. Exosystem. The *Exosystem* is a system which an individual has no influence over or direct contact with, yet exerts influences over behaviour in microsystems (Duncan et al., 2007). Thus, this level of interaction encompasses factors which inhibit access to substance abuse treatment services although the individual has no direct contact with these factors. Structural barriers to treatment, waiting lists and availability of treatment services are discussed in this regard.

Structural barriers to treatment. In the Cape Town metropole Myers, Louw and Fakier (2008) identified three salient structural barriers to treatment: (1) disjointed service delivery; (2) limited availability of cost-effective services resulting from a restricted distribution of resources to substance abuse treatment, restricted allocation of resources also led to limited the ability of existing services to match the growing demand for services; as well as (3) infrastructural issues (poor intersectoral partnerships, limited conversing with service providers and lack of information) and poor capacity which contribute to problems in constructing and enacting a tactical plan relating to substance abuse problems (Myers et al., 2008b). This study highlighted that Exosystemic factors restrict access to substance abuse treatment services for historically disadvantaged communities.

UNIVERSITY of the
WESTERN CAPE

Waiting lists. Timely access to substance abuse treatment is critical as treatment-seekers may already be ambivalent. Thus, delays in the accessibility and availability of treatment services may result in the loss of potential treatment applicants (NIDA, 1999). Friedmann, Lemon, Stein, & D'Aunno (2003) describe waiting time as “a function both of whether prospective clients can get into the queue and how quickly they get off the queue and into treatment” (p. 891). Both substance abusers and society at large are impacted negatively by waiting for treatment (Carr et al., 2008) and substance users who wait for treatment services are placed at increased risk for exposure to infectious diseases such as HIV and hepatitis, in addition to health difficulties such as overdose, as they often continue to use substances and are less likely to ultimately enter treatment (Chawdhary et al., 2007; Festinger et al., 1995; Hser et al., 1998; Pollini et al., 2006 as cited in Carr et al., 2008). Preventable health care utilisation, the costs of unemployment and welfare social program benefits and the costs of crime are some of the social costs of waiting for treatment (Ettner et al., 2006; Hunkeler et al., 2001; Palepu et al., 2001 as cited in Carr et al., 2008).

In the USA, a survey by Carr et al. (2008) found waiting time for treatment to vary substantially when conceptualised as waiting "pre-assessment" (prior to clinical assessment) and waiting "post-assessment" (subsequent to the assessment but prior to treatment entry). Less desire for change, being court referred and less belief in having a substance abuse problem resulted in lengthier waiting time for assessment. Conversely, a brief waiting time for treatment was predicted by being more ready for treatment, having less severe alcohol problems, having a case manager and having less severe employment problems. Findings suggest that accessibility-enhancing interventions, and system changes that are tailored to the needs of substance abusers at each waiting period, must be enacted (Carr et al., 2008).

In an audit of substance abuse treatment facilities in the Northern Cape, Mpumalanga, Free State, Limpopo and North West provinces of South Africa, seven of the fourteen facilities were found to have waiting lists. With an average waiting period for an available bed or treatment slot of 6 days, 6 clients were found to be waiting at any given time. It is interesting to note however, that in the Northern Cape no facilities reported the use of a waiting list (Fakier & Myers, 2008). In the Western Cape however, a waiting period for admission dates to inpatient treatment *is* encountered, even when the person has been accepted by the receiving facility. By diminishing motivation for treatment and self-efficacy, these extended waiting periods operate as a barrier to treatment utilization (Myers et al., 2007), and thus access.

UNIVERSITY of the
WESTERN CAPE

Availability of substance abuse treatment services. Fakier and Myers (2008) found that partially due to the inadequate availability of treatment services, access to substance abuse treatment facilities was restricted in South Africa's Northern Cape, Free State, Mpumalanga, North West and Limpopo provinces. Researchers found substance abuse to be assigned low priority relative to need, which was evidenced by high levels of prevalence in these provinces. The Mpumalanga and Free State regions were found to house only one state-run substance abuse treatment facility and funding for state-subsidised treatment facilities were problematic. Furthermore, researchers elucidated that lengthy waiting time for state-funded facilities ensued due to the decline in the availability of beds in psychiatric and state-funded general hospitals (Fakier & Myers, 2008).

An earlier study in Gauteng (Myers, 2004) found the availability of treatment services to be impacted upon by the characteristics of 'facility ownership'. Few resources were found to be

offered by the state, and the majority of treatment facilities were privately owned (private non-profit more so than private for-profit facilities), highlighting that the private sector assumed most of the responsibility for substance abuse treatment. In contrast, state-funded treatment facilities were found to be few in number (two facilities), and operating below capacity. Additionally, more state facilities employed waiting lists, and had longer waiting lists when compared to other types of facilities, illustrating that these facilities are not essentially more accessible than private facilities (Myers, 2004).

This is consistent with the contention that inadequate availability of state-funded treatment services in the context of a growing demand for treatment services has given rise to growth in the private treatment sector (Myers & Parry, 2005; Fakier & Myers, 2008).

Moreover, as 80% of South Africans are reliant on the state for healthcare services (including substance abuse treatment) as they are without medical aid (Goosen, Bowley, Degiannis & Plani, 2003; Fakier & Myers, 2008), they are compelled to depend upon the modest number of free treatment services available which results in extensive waiting time for treatment (Myers et al., 2008b).

UNIVERSITY of the
WESTERN CAPE

These aforementioned studies highlight that the treatment system characteristics of waiting lists, as well as the available number of treatment facilities (Exosystem-related factors) limit access treatment services in Cape Town.

d. Macrosystem. Belief systems, ideologies, government decisions and policy are situated in the *Macrosystem* (Duncan et al., 2007).

Socio-political factors. Myers and Parry (2011) argue that South Africa's policy around illicit drugs is outdated, adding that an evidence-based drug policy is to be formulated and affected that sees a departure from the notion of a 'drug-free-society'. The Apartheid system of governance in South Africa, in spite of its abolition, is another access barrier to treatment that is encompassed by Bronfenbrenner's Macrosystem. Myers and Parry (2005) note that substance abuse treatment access in South Africa has been hindered by several socio-political factors, in spite of the need for accessible, effective and inexpensive substance abuse treatment services. Poverty and restricted access to social and health services (e.g. substance

abuse treatment) were exacerbated by geographical apartheid (Harker Burnhams, Dada & Myers, 2012). This adds credence to the earlier work of McLafferty (2003) who posited that "there is growing recognition that geographical barriers to health care intersect with those based on class, race, and ethnicity leading to complex patterns of disadvantage" (p. 28).

Geographic accessibility. Geographic access barriers (particularly extended travelling times to treatment) were found to substantially influence the probability of substance abuse treatment use in a study by Myers et al. (2010a) amongst 989 respondents (434 substance users from disadvantaged communities and 555 persons who had not come into contact with the treatment system). These barriers may intersect with financial barriers due to the potential loss of earnings linked to lengthy and troublesome commutes and high cost of travelling (Myers et al., 2010a).

Under the apartheid regime, health, government and social services were reserved primarily for white South Africans. In black communities, by contrast, few government resources supported health, housing, educational or social services (Peltzer, Ramlagan, Johnson & Phaswana-Mafuya, 2010). In this way the apartheid legacy informed the location of treatment services, impacting upon geographic accessibility.

UNIVERSITY of the
WESTERN CAPE

Affordability/ financial barriers to treatment. Besides the location and operating hours of treatment facilities which may be inconvenient (IDU HIV Prevention, 2002), added to the costs of the counselling session itself, expenses may include time taken to travel as well as transportation costs, considering that both parties must be at a specific geographic location in order to experience face-to-face counselling (Parker, Wills & Wills, 2010). Costs may make this unviable for lower-income groups, where substance abuse is prevalent (cited in Parker et al., 2010).

Myers et al. (2010a) found people from underprivileged communities in Cape Town to experience financial access barriers to substance abuse treatment. The likelihood of treatment utilisation was found to decrease where rival financial priorities and greater apprehension about the affordability of treatment were present. In particular, rival financial priorities associated with the provision of shelter and food was found to impose more of a barrier than concerns about the affordability of treatment (Myers et al., 2010a). Myers et al. (2008b) attribute this lack of concern about treatment affordability to be due to the provision of free

and low cost treatment services in the Cape Town, albeit limited. Indeed Sanders & Chopra (2006) found that the pervasive joblessness and poverty in underprivileged communities profoundly impacted upon access to health and treatment services and that, in order to improve access to treatment services, financial barriers must be addressed as a matter of urgency (McIntyre & Gilson, 2002). Myers et al. (2010a) understood this to mean that impoverished communities regard the need for health services as secondary, in deference to meeting survival needs.

Both geographic and affordability related barriers are situated within the Macrosystem as inequality in income, unevenly distributed access to social services, and poverty are the residuals of apartheid. Contemporary South Africa continues to grapple with the legacy of this segregation after almost two decades of democracy (Statistical Reform in South Africa, n.d.).

e. Time (also referred to as the Chronosystem) is the final defining element of the PPCT model (Bronfenbrenner & Morris, 2006; Paquette & Ryan, 2001). As it pertains to an individual's environment, Bronfenbrenner recognised that processes differ according to the particular historical events that occur (Paquette & Ryan, 2001; Tudge et al., n.d.). The impact of *time* is illustrated by changes within South Africa's political landscape, as policies enacted prior to, as well as after the country's transition to democracy in 1994, all have a bearing on access to health services (inclusive of substance abuse). Access to social resources was determined primarily by race in apartheid South Africa, with socio-political factors and limited service provision for non-white populations, impeding access to substance abuse treatment (Myers et al., 2008a).

Myers et al. (2008a) report that, prior to 1994, poorly distributed facilities and limited state subsidised treatment services; poor intersectoral partnership between the Department of Social Development (DOSD) and the Department of Health (DOH) on AOD issues (locally, provincially and nationally) as well as fragmented service delivery among these departments characterised the government's response to substance-related issues. Post-1994, initiatives to address these challenges to service provision have been implemented by the state social and health welfare sectors: the DOSD now leads substance abuse prevention and treatment initiatives; has prioritised improving access to AOD services for HDCs and has worked diligently to construct comprehensible policies for attending to treatment access. Although

UNIVERSITY of the WESTERN CAPE

concerns about substance abuse treatment accessibility linger, these changes within the substance abuse treatment system draw attention to the impact of *time* on treatment access (Myers et al., 2008a).

The PPCT model, in providing multiple levels of interaction from which to view reality, offers a means of understanding the barriers to treatment accessibility beyond a surface level. Achieving the third objective of the study, outlining recommendations for intervention strategies, is also facilitated by this framework as they are able to be located within various levels of interaction.

3.8. Conclusion

Chapter Two outlined scholarship pertaining to barriers to treatment access within the context of Bronfenbrenner's PPCT Model. It clearly emerged that, despite the need for treatment and documented benefits thereof, several barriers to accessing treatment impede this process.

UNIVERSITY of the
WESTERN CAPE

Chapter Four: Method

This chapter discusses the research design, selection of participants, sampling procedure and method of data collection. It concludes by outlining the method of data analysis and ethical considerations of the current study.

4.1. Research framework

As this study sought to understand the systemic barriers to accessing inpatient substance abuse treatment from the perspective of referring agents, an exploratory qualitative research design was deemed most appropriate to meet its aims and objectives. Qualitative research seeks to offer rich descriptions of the phenomena being studied (Geertz, 1973; Gelo, Braakmann & Benetka, 2008) and strives to understand human action from an emic (insiders') perspective (Babbie & Mouton, 2010), whereas quantitative approaches investigate social and psychological phenomena with the aim of determining causal effects that can be generalised (Gelo et al., 2008). A further rationale for the use of a qualitative methodology in the current study is its sensitivity to influences such as policy, context, time and place, which make it especially suited to examining structural influences on phenomenon (Jones, 2007).

UNIVERSITY of the
WESTERN CAPE

4.2. Participants

Referring agents from outpatient treatment centres, private treatment facilities and the Department of Social Development comprised the population from which participants were selected. Accordingly, the sampling technique employed was that of 'purposive sampling', where sampling "depends not only on availability and willingness to participate but that cases typical of the population are selected" (Terre Blanche, Durrheim & Painter, 2006, p. 139). The motivation for the use of this sampling technique was that it allowed the researcher to include one particular group of employees within the substance abuse treatment system, i.e. referring agents, as the literature identified that no earlier studies had sought to examine referring agents' perceptions of the barriers to accessing inpatient treatment services. Inclusion criteria for participants necessitated that they (1) be actively employed in the substance abuse treatment system; (2) facilitate the referral process to inpatient treatment facilities, (3) hold recognised credentials and be registered with a professional body. A list of outpatient treatment organisations were generated from the local government's resource

website. Contact was made with the head of these respective organisations, and the aim and objectives of the study were articulated. In this way permission was sought to interview three referring agents at differing outpatient treatment centres and specific interview dates were agreed upon with those who expressed a willingness to participate. Concurrently, the Department of Social Development was contacted and the researcher was referred to the City of Cape Town's City Health. A formal application was made in order to garner permission to access referring agents in the employ of this organisation. Upon success of the application, referring agents were contacted at the specific treatment centres where they were based and interviews arranged. Six referring agents with varying professional titles and qualifications (one registered counsellor, one psychologist and four social workers) were interviewed. Of the six participants, five participants were female. These individuals were employed at three subsidised non-profit and three government-run outpatient substance abuse treatment centres.

4.3. Data collection procedure

Referring agents were provided with information about the study and written informed consent was obtained. Perceived barriers to treatment access were explored by means of face-to-face, in-depth individual interviews, conducted in a private setting. Howitt (2010, p. 422) defines the in-depth interview as "a lengthy interview intended to obtain extensive rich and detailed information from an individual". To a greater extent than other qualitative interviews, the objective of in-depth interviews is to allow the inquirer to obtain "the same level of knowledge and understanding as members or research participants" (Johnson, 2002, p. 75). This method of data collection was ideal as the researcher desired to obtain an understanding of the research area equivalent to that of the study participants. Interviews necessitated the development of a semi-structured 'interview guide' (Appendix C) which outlined areas to cover within the interview (Howitt, 2010). The interview guide of the current study centred on themes previously explored by Myers et al. (2008b) and Myers et al. (2007) amongst various service providers (not expressly referring agents') and substance users' respectively: (1) the procedure of gaining entry to inpatient treatment centres; (2) barriers and enabling factors to treatment entry; (3) the substance abuse treatment system in the Western Cape, (particularly as its function and structure relates to inpatient treatment) and (4) insights on the manner in which treatment accessibility can be advanced. Interviews were conducted in English as all participants were fluent in the language. During the gathering of data, audio-recordings were made of each interview, which were later transcribed, verbatim. Six interviews were conducted for the study with the intention that data collection continues

UNIVERSITY of the
WESTERN CAPE

until saturation of the emergent themes was achieved. Saturation is said to occur when conducting more data collection yields no new information or themes (Howitt, 2010; Myers et al., 2007). Similar thematic content emerged from the interviews conducted with coloured referring agents, however the final interview with a [1]black participant, whilst yielding information consistent with that of earlier participants, departed significantly due to the (township) context in which this participant was employed. This is consistent with the inherent nature of qualitative inquiry as an emic, in-depth understanding of the phenomena under consideration, which differed across study participants, was obtained. Each interview lasted between 30-90 minutes.

4.4. Data analysis

Thematic analysis was deemed the best suited analysis technique for the study as it enabled the researcher to analyse and report on the perceived barriers to treatment access as articulated by the participants in an in-depth manner, simultaneously permitting Bronfenbrenner's PPCT model to be integrated with the information yielded.

All transcripts of participant interviews were subject to thematic analysis which allows the researcher to recognise, analyse and report themes within data (Braun & Clarke, 2006). Data analysis occurred in alignment with the six-step model of thematic analysis suggested by Braun and Clarke (2006): (1) becoming familiar with the data; (2) initially generating coding; (3) based on initial coding, search for themes; (4) reviewing identified themes; (5) defining and labelling themes and (6) writing up the report.

To become familiar with, and understand the yielded information, the first step the researcher undertook in the analysis process was to transcribe each interview verbatim. Thereafter transcripts were read and re-read, permitting record to be made of initial ideas.

In accordance with the second step outlined by Braun and Clark (2006), the researcher generated initial codes from each transcript in the data set, systematically noting down key phrases and words that were meaningful in relation to the aims and objectives of the study.
Next, potential themes were constructed by collating the codes. This entailed the grouping of all data relevant to a possible theme (Braun & Clarke, 2006).

UNIVERSITY of the
WESTERN CAPE

During step four the researcher reviewed the themes. In relation to the potential codes and full data set, their efficacy was determined (Braun & Clarke, 2006).

Lastly, as stipulated by Braun and Clark (2006), themes were defined and named. At this stage of the analysis, the researcher refined the particulars of each theme continually and constructed unambiguous definitions and names for each theme.

4.5. Validity

Qualitative research can be deemed 'valid' insofar as it explains, describes or measures what it has sought to explain, describe or measure (Anderson, 2010; Willig, 2008). Qualitative research methods present validity issues to be attended to due to its open-endedness and flexibility (Willig, 2008). Validity remains a contentious issue for qualitative researchers, nonetheless, and accordingly researchers have aligned themselves with various perspectives on validity (Sparkes, 2001). Kvale (1995, 1996) redefined validity in relation to specific forms of qualitative inquiry, advocating that, "any notion of validity is assumed to be socially constructed within specific discourses and communities, at specific historical moments, for specific sets of purposes and interests" (as cited in Sparkes, 2001, p. 542). J. Smith (1989) understood Kvale's reconceptualised validity to imply that social agreement is the foundation of validity or truth for qualitative research. Conditioned by time or place, what is deemed to be valid or true is what we can agree is valid or true, he emphasised (as cited in Sparkes, 2001).

UNIVERSITY of the
WESTERN CAPE

In accordance with this understanding of validity, the need for reflexivity, memos and a clear exposition of methods of data collection and analysis become increasingly important. These techniques, used to ensure 'social agreement' for the current study, are outlined below.

a. Clear exposition of methods of data collection and analysis. A clear account of the data collection and analysis process was provided for the current study. On this basis the reader is able to determine whether the data adequately supports the interpretation of the researcher (Mays & Pope, 2000).

b. Memos. Records of the researcher's insights or thoughts, termed memos (Lasch et al., 2010) were kept throughout all stages of the study.

c. Reflexivity. In the research process, an awareness of the researcher's own presence is termed 'reflexivity' (Barry et al., 1999; Mays & Pope, 2000). This is of particular importance in qualitative research as the researcher is the instrument whereby data is both gathered and analysed (Merriam, 2009). It denotes sensitivity to the prior experiences and assumptions of the researcher and how, together with the research process, these stand to shape the data collection phase (Mays & Pope, 2000).

Likewise with regard to data analysis, Ely et al. (1997, p. 205-6 as cited in Braun & Clark, 2006) note that "if themes 'reside' anywhere, they reside in our heads from our thinking about our data and creating links as we understand them". The researcher must therefore constantly evaluate the impact of their presence on the research process as "the human instrument has shortcomings and biases that might have an impact on the study" (p. 15).

With respect to my own reflexivity within the study, from the outset, I was aware that the chosen area of study stemmed from experiences I had made. Firstly, substance abuse is prevalent not only in the Western Cape region, but is particularly widespread within the community in which I reside. Whilst community members are aware of substance abuse because it is so widespread, many are uninformed or hold the belief that it can be cured.
Secondly, I identified with the responsibility with which the referring agents are tasked. As part of my prior experience of working within the field of substance abuse treatment, I occupied the role of a referring agent; assisting in referring substance using clients into specialised treatment facilities. I experienced many difficulties as a referring agent to inpatient treatment centres first-hand, and found the process to be cumbersome and labour-intensive as it necessitated the completion of reports, medical examinations and financial assessments of clients and their family. An added frustration was the presence of long waiting lists at state-funded treatment centres. Besides these adversities, I came to realise that only once the signature of a Social Worker was present, could a referral report be sent away and the application process be set in motion. It is precisely due to these experiences that I felt compelled to undertake the current study, believing strongly that research was the necessary first step to address the problem. I reminded myself that I needed to remain conscious of these factors, so as not to over-identify with the research subjects. I recognised the importance of being aware of these potential biases from the commencement of the study, and remained mindful of this throughout the research process. This was particularly important during the data collection phase of the study. During the course of data collection

UNIVERSITY of the
WESTERN CAPE

and analysis I had regular debriefing sessions with my supervisor in order to reflect on my experiences, challenges and process.

4.6. Ethical considerations

Ethics were upheld in order to guarantee that the well-being of research subjects were not compromised (Terre Blanche et al., 2006). Ethical clearance was obtained in accordance with the protocol stipulated by the University of the Western Cape (Appendix D). The procedures, purpose and objectives of the study were clearly explained to participants, in addition to their anticipated role within the research endeavour. Participants' were provided with information pertaining to the study verbally, and in written form, assuring them of their right to withdraw from the study, confidentiality, anonymity and voluntary participation. A respondents' information sheet (Appendix A) was given to all subjects in their language of choice (this was limited to English and Afrikaans, as the researcher is bilingual). To ensure that all participants comprehended their role and were able to competently participate in the study, (Terre Blanche et al., 2006) the researcher provided informed consent (Appendix B). Transcripts of interviews were numbered randomly in order to further ensure the anonymity of obtained information. Audio-recordings and transcripts were securely stored in a safe location, able to be accessed only by the researcher and supervisor, as explained to participants. Although the research did not intend to adversely affect or harm its participants, the researcher ensured that counselling sessions were available to those adversely affected by the interviews conducted. Lastly, participants of the study will also be provided with feedback about the study, where they so desired.

UNIVERSITY of the
WESTERN CAPE

4.7. Conclusion

This chapter outlined the methodological considerations of the study, exhibiting that the study design, method of data collection and analysis technique are well-suited to one another. The analysis and interpretation of the study's findings are explicated in the subsequent chapter, as is a discussion thereof.

Chapter Five: Results

This chapter presents and discusses the results of the current study which sought to identify access barriers to state-funded inpatient substance abuse treatment from the vantage point of referral agents. Thematic analysis was utilised to understand and make sense of the vast amount of data obtained through the interview process. In the subsequent sections, support and evidence for the themes are provided by verbatim accounts of study participants. Every theme was examined in relation to the existing literature as delineated in the literature review, and Bronfenbrenner's PPCT model was used to frame the data. The main findings of the study, which aligns itself to two thematic domains, were that referring agents' perceived (i) *Person*-related characteristics (motivation for treatment; denial; gender; disability; active TB disease and psychiatric comorbidity, respectively) and (ii) *Context*-related features (stigma and beliefs about addiction and treatment; community violence; lack of awareness; lack of finances; the geographic location of facilities; waiting time; lack of collaboration; beliefs of service providers; inadequate resources; and referral-related tasks) to serve as access barriers to inpatient treatment facilities. These will now be discussed sequentially.

UNIVERSITY of the
WESTERN CAPE

5.1. Barriers to treatment

All participants expressed that there are barriers that impede access to inpatient facilities. The following statements illustrate the perceptions held by four participants concerning the presence of barriers:

> *"There's always an obstacle in terms of the person getting to the right help, before they get to the treatment that they need... There's lots of barriers... they WANT to access ... and then they cannot just move forward, there's just always first this then that, then that."* (Participant 1)

> *"... there's always a hole, there's always something that pops up"* (Participant 2)

> *"... I find quite a lot of patients want to go, agree to go, and agree they need it, so you get them to that point, but then it sort of gets failed at the level of getting them in."* (Participant 5)

> *"I think that it goes back to like the barriers that we spoke about and the fact that it's not easy for people to go inpatient"* (Participant 6)

The above extracts suggest that referring agents have come to anticipate the presence of barriers and are pessimistic about the process of accessing inpatient treatment facilities. Moreover, two of these extracts exhibit that, even in instances where individuals themselves desired treatment, access barriers to inpatient treatment services abound.

5.2. *Person*-related barriers

This thematic domain addresses the participants' perception of barriers to accessing state-funded inpatient treatment facilities that relate to characteristics of the individual. Themes that arose within this domain are related to psychological features of the individual, gender, physical characteristics, medical status and psychiatric status, respectively.

5.2.1. Denial

Participants mentioned that denial about having a problem with substances had a bearing on the process of accessing inpatient treatment:

"I think with African people, I think they also in denial about substance abuse they believe that substance abuse is a problem for coloured or white communities they do not really see substance abuse as problem for their communities as well. That's one of the things-denial about the problem." Participant 6

UNIVERSITY of the
WESTERN CAPE

"...people are in denial ... I think it's mostly the mindset of people which is maybe one of the barriers for them to go to inpatient centres." Participant 6

"...you are an addict when you come here, especially with the youth, so they would say, I'm not addicted; I don't need to be here… why must I be here?" Participant 1

Referring agents believed that denial hampers access to substance abuse treatment services. Denial, a common characteristic of addiction (Rinn et al., 2001) is expressed as being present amongst young substance abusers' who refute their substance abuse in order to avoid labelling as an "addict". In black/ African communities, substance abuse is believed to be viewed as a problem for coloured or white communities. Accordingly, the '*mindset of individuals'* was believed to act as a barrier to accessing treatment services because a failure to recognise substance abuse as a disease warranting treatment directly prevented individuals from seeking out these services.

5.2.2. Motivation for treatment

Referring agents emphasised the critical, yet complex role of motivation in the process of accessing inpatient treatment. Engaging in sessions at an outpatient treatment centre was regarded as the necessary first step for building motivation. Some participants preferred that clients articulated their desire for inpatient treatment in order to demonstrate their motivation for treatment, whilst for others, a lack of motivation directly prohibited access to inpatient services:

"*...we need to establish that they are ready to change, motivated to change, and to maintain that change. In order to do that they need to belong to the programme ... and that is what we do, we would want them to be part of our programme and then I would want, or it would be best for the person if they elicit a response where they say, I would rather want to go to inpatient."* (Participant 1)

"*...if the person is not really motivated and then does not want to go to an inpatient centre, so I would not be able to send that particular person..."* (Participant 6)

UNIVERSITY of the
WESTERN CAPE

One participant believed that motivation was so critical, that even in the context of an 'ideal' environment for treatment, with easy access to inpatient treatment services, finances and support for treatment, these factors proved irrelevant in its absence. Alternatively, an individual may be motivated for treatment but, faced with several barriers, be unable to access treatment services:

"maybe if they're not motivated, maybe they have all the resources, they have access, their family is able to pay...they have access to NA, they have access to their religion, religious community is able to support them, then that person is not ready for treatment, ok. Maybe the person IS ready for treatment and then they don't have access... they don't have access to the treatment centre and it's too far." (Participant 1)

While admission to treatment centres became increasingly unlikely due to waning motivation, delays in entry to treatment had the potential to end fatally:

"... motivation is the biggest thing, ... motivation is the biggest thing that I find with the client, that happens because for the addict, most probably the most important thing in his life is his addiction, so while his in that space, that's all he focuses on, there's nothing more important for him, but when it comes to that point of change, you know,

there's that small space where that person is wanting space and if you don't take it, wanting change and if you don't take advantage of that, you know, that time he falls back. It's difficult to get him back to that point of wanting help again." (Participant 2)

"*...with substance abuse, you sort of need to motivate that person now and if they say yes, you've got to grab it right there because circumstances change and if you wait too long or wait 6 months the patient's either died or they have lost interest or are in a different space and are not motivated to go anymore...*" (Participant 5)

To counter the negative effects of long waiting periods and to attempt to evade that inpatient treatment–seekers slipped through the cracks, referring agents encouraged individuals to enlist in outpatient treatment facilities where motivation could be fostered:

"...when you start with the outpatient facility, or a treatment programme, motivation needs to be basically fostered there..." (Participant 4)

Though factors related to the treatment system may prohibit clients from following through and entering treatment facilities, fluctuating motivation also had a bearing on the decision to "follow through" with treatment, one referring agent remarked:

"Motivation changes continually, so it's not always the treatment facility's fault that the client didn't follow through. It could be the space where he is at in his motivation."(Participant 2)

UNIVERSITY of the
WESTERN CAPE

In line with referring agents' beliefs, this theme highlighted that in order to have sought out treatment, whether out- or inpatient treatment services, individuals needed to exhibit some degree of motivation. Referring agents acknowledged that, though features of treatment facilities prohibited access to treatment services, the role of the individual's motivation was not to be discounted. Assertions that "*motivation is the biggest thing"* are consistent with Allen's (1994) finding that access to treatment is particularly impacted upon by internal barriers to treatment. Lack of motivation has been frequently cited as a reason for failing to access treatment services (cited in Xu et al., 2007).

5.2.3. Gender

Participants believed that women face added barriers when seeking to access state-funded inpatient treatment services, and that this was evidenced in the number of females utilising these services. The excerpts below elucidate these barriers:

a. Stigma toward women. Female substance abusers are believed to be especially subject to the stigmatising attitudes of others, whereas males were believed to be accessing treatment more freely. The first extract below highlights this stigma, whilst the second reflects a referral agent contemplating why males access services in higher volumes:

"...for women especially, they don't want to come. They don't want to come to a place like this because as a woman, what are you doing in the first place using?" (Participant 1)

"...because of their status, they do not have responsibilities like children, or they don't want to be judged and most females that are entering our programme, they are referrals from social development. Children have been removed out of their care, etcetera etcetera. That's the only type of females that we get here. Other than that it makes you wonder what are the other females doing. Why don't they access our services? Other than that our other females will be referrals from school, like learners" (Participant 4)

Participants believed that the stigma faced by female substance users were a deterrent to accessing treatment services, and often, only when children have been removed from the substance abusing mother by authorities, would she seek care. This is congruent with Brady and Ashley (2005) who noted that females were especially prone to being stigmatised. Likewise Myers et al. (2009) found women may conceal or refute their substance use for fear having children taken away by authorities.

b. Pregnancy was found to be another salient barrier to accessing inpatient treatment facilities. Extracts that lend support to this view are presented below:

"*...if the person is pregnant. There isn't a centre for pregnant women, or whose on heroin, 'cause that's a specialised field. We don't have that, so if the person goes to a normal treatment centre and there are complications, there's already a problem."* (Participant 1)

"*... the ones that's pregnant, it's very difficult, depending on where they are at in their pregnancy and what they are on... a lot of them come here, they WANT to go... and they're 8 months, on heroin, or Tik, and I cannot get them in…They usually drop out because there's no open door, where do you go to? …the detox centre will take them*

UNIVERSITY of the
WESTERN CAPE

but …where do they go to from there? There's no rehab. Now outpatient is not gonna help them (at that stage) to stay clean and also they need to be monitored because of the baby and the dangers to the foetus, because what if she aborts... It's very medically-complicated...It's very difficult for pregnant ladies." (Participant 1)

"... pregnant mothers, we can't do that ...inpatient facilities don't allow that. They don't have the resources. Some of them don't even have you know at base nurses, so it is difficult it's because of the safety of that person… it is policy and procedures as well, because they don't have any facilities for pregnant mothers unless it's a specialised inpatient facility... I've been working in Johannesburg, it's very seldom they'll approve an application where a mother is beyond three months. Sometimes when you get away with murder, when you're still in the first trimester they will allow the person because the application was already approved, but anything thereafter they won't." (Participant 4)

UNIVERSITY of the
WESTERN CAPE

Participants believed that the likelihood of access to treatment for pregnant women was impacted upon by their stage of pregnancy as well as capacity and resource issues at inpatient centres (e.g. whether or not medical staff are employed to attend to the medical complexities that may arise). It was emphasised that no treatment facility in Cape Town renders services that are tailored specifically to the added needs of pregnant substance abusers'. As the treatment system could not accommodate these individuals, women were unable to access treatment services. Congruent with Jackson and Shannon (2011), referring agents' emphasised that treatment was largely inaccessible for pregnant substance users' who did not qualifying for entry.

c. ***Childcare considerations*** were also believed to impede access to inpatient treatment services for women:

"... If the person is a single parent and there's no one looking after their children where do they put the children?" (Participant 1)

"...we often have a problem with is if a mother needs to go and has got kids, and there's no- one to look after the kids then they can't really go, or ... then it becomes an issue of trying to place those kid during that time and then it's a whole nother system of the social workers going to court to try and find a placement for the two month..." (Participant 5)

Referring agents perceived that in the absence of a support network that ensures children are taken care of; women had to forego the opportunity to access inpatient treatment services. Women appear to be required to evaluate what was more important: attaining sobriety, or 'fulfilling' their task as a mother. These beliefs are consistent with Green (n.d.) who found access to treatment to be facilitated when programmes rendered services such as childcare.

d. ***Lack of treatment centres for females.*** Young female substance abusers were also believed to be disadvantaged when seeking inpatient treatment services:

"*the other thing is ages... for youth right, there's only one that's subsidised and then, like* (inpatient treatment centre) *only caters for boys, so the female aspect is a huge thing, whether its youth or adults there isn't enough for females and for pregnant females, and pregnant females that's on heroin that's a huge one..."* (Participant 1)

Only one referring agent remarked that females presented for treatment in higher volumes at the site where they operated:

"I think the adolescent males are more likely to use substances, especially dagga and Tik, and they're more prone to things like Conduct Disorder and those sort of mental disorders which would lead them into those sort of paths, so possibly that's why they are coming through with the adolescent males rather than the females. But the adult side ...I don't know it's possibly just that the males aren't willing to come for help or when the doctor or whoever says "would you like to come to the psychologist?" then they go no thanks or decline it."

UNIVERSITY of the
WESTERN CAPE

This referring agent believes that a disparity exists regarding treatment access amongst males and females, particularly across age groups. It is believed that more adolescent males are present for treatment, due to their predispositions to particular mental disorders that are co-morbid with substance use disorders. With regard to adults however, it is believed that females are more willing to seek therapy, and thus comprise more of the general population of this referring agent (who does not operate from a substance abuse treatment centre, but a community clinic). Thus, unlike referring agents' employed exclusively at substance abuse treatment centres, this participant reports that the majority of clients are female. This is congruent with literature that women are more likely to seek counselling, psychiatric and psychotherapy (Gove, 1984; Gove & Tudor, 1973; Greenley & Mechanic, 1976; Howard & Orlinsky, 1972; Vessey & Howard, 1993 as cited in Addis & Mahalik, 2003).

e. ***Masculinity and gender roles.*** Participants expressed that notions of masculinity impacted upon decisions to engage in substance use, but also upon decisions to seek out (both outpatient and inpatient) treatment facilities. The extracts below illustrate these sentiments:

"*... looking at the issue of gender and maybe what it is to be male and how that's defined, and how that's associated with drug use, I think that's a huge part. I think what I can see now with youth is bullying, ostracising and acceptance by using a drug is becoming more prevalent as well."* (Participant 1

"... like with the youth, they won't look for help because they would want acceptance of the group more than being bullied cause they don't think that the drug is a problem. It's I want… they don't see that as…that's the last thing in their mind that "I have a problem". So why seek out help if that is the issue? I wanna be a male and show my dominance; it's got nothing to do with the drug" (Participant 1)

Substance use is equated with 'belonging' or 'fitting in'. Specifically, it is equated with understandings of what is it to be masculine. For this reason, young male substance users may deny the severity of their problem and not seek out treatment. It appears that masculine gender-role socialization (i.e. that seeking help from professionals is non-masculine) (Addis & Mahalik, 2003) provides one explanation for differing patterns of access to treatment for men and women.

UNIVERSITY of the
WESTERN CAPE

In review, in the current study, participants believed that fewer females were utilising treatment services as women faced additional barriers than their male counterparts when attempting access inpatient treatment services. These included stigma, which was heightened for female substance abusers, and often, only when children have been removed from a substance abusing mother by authorities, would treatment be sought. An inadequate number of gender-specific treatment facilities, together with considerations such as whether or not specialist staff are employed who are able to attend to medically-complex cases; duration of pregnancy and resource considerations served as a barrier to inpatient treatment for pregnant substance abusers'. In instances where women were already parents, childcare responsibilities were believed to cause women to forego the opportunity to access inpatient treatment services. Regarding males, referring agents' suggested that more adolescent males present for treatment, while adult females appear more likely to access referring agents' when located

within clinic settings, than those employed at substance abuse treatment centres. Masculine gender-role socialization appeared to serve as a disincentive for adolescent males to enter into treatment, as substance use fostered acceptance amongst peers. This exhibits the bi-directional relationship between gender (a *demand* characteristic), and other ecological levels such as the treatment system (Exosystem).

5.2.4. Disability

It emerged that access to inpatient treatment services is inequitable for PWD:

> "*Our physically disabled people aren't being serviced at all, because the specifications of accessibility, they just don't cater for that. I mean we struggle just getting a blind person in, then we struggle by getting a paraplegic in. They will consider the application, but I know for a fact they aren't geared to service a disabled person. They don't have the skill and neither do they have the resources."* (Participant 4)
>
> *When you make reference to that, are you referring primarily to the state funded, because you say at the same facility? (*Interviewer)
>
> *"Not private facility, only state (funded). They don't even consider... and most of our paraplegics are dependent on alcohol ...We've never received any disabled client for that, physically disabled though. We only had one client... and it took us forever to get him in and eventually we got him in after a big fight, but ... he didn't make it because... they couldn't ... treat him, he couldn't read the manual, he couldn't participate effectively, the staff felt overwhelmed ..."* (Participant 4)

UNIVERSITY of the
WESTERN CAPE

According to this referring agent, the physical characteristics of treatment centres are not suited to different levels of physical functioning (*They don't ... have the resources")*, and this restricts access to inpatient treatment facilities for PWD. This referring agent also noted that programme requirements such as daily reading necessitated reading skills of a certain standard, and in so doing, disadvantaged the visually impaired or illiterate. Thus, *architectural barriers* (physical characteristics of treatment facilities that impede access) and *discriminatory policies, procedures or practices* of programmes (SAMHSA, 1998) appear to be present.

The specialised care needed to service PWD were also emphasised by one referring agent:

"It's hard, it's a different ball game... there's certain beds that they need, certain care, it's expensive. You can't just ask any health (practitioner) or a nurse just ... to be part of an inpatient facility and there's a physically disabled person. We're talking about bedsores, we're talking about medication ... some of them are diabetic, of which the inpatient facility didn't prepare themselves for that. Now I know when you are an able bodied person and you are a diabetic, they still take you physically to your day hospital or the nearest hospital, you get your medication and they'll bring you back. But it's a different ball game, because the transport that they use aren't accessible for that person, so then they get Dial-a-Ride... And I think it's unfair to make a special facility just for disabled people, because that has nothing to do with them, for what we are fighting for and that is integration."(Participant 4)

Referring agents' noted the lack of appropriately-equipped inpatient facilities, but emphasised the importance of integrating substance abuse treatment services as erecting new facilities exclusive to PWD would only serve to reinforce existing stigma. Findings coincide with the earlier literature stating that access to treatment is limited for PWD (Krahn et al., 2006) as barriers render treatment experiences to be substandard or limited (SAMHSA, 1998). This is important as inequitable access to inpatient treatment facilities for PWD violates one the principles of effective treatment, as non-discrimination was not ensured (WHO, 2008).

5.2.5. Tuberculosis

Active TB disease was expressed as prohibiting access to inpatient treatment services:

Are there any clients you are not able to refer to treatment? (Interviewer)

"Yes, some of my TB patients are a huge problem, because if they've been on treatment for two weeks or longer then it's okay, but if ... they've ... defaulted on TB treatment it's a huge issue because then we don't' know how resistant they are to the medication that they are taking and it's a huge risk to the other patients that are there... then it's about organising the medication so they can't just go in and often those facilities don't have the TB or the ARV treatment. So we need to organise... from our side and make sure the patient either gets ... a lot and the doctor needs to write letters as well. It's not just a simple "I need to go", there's a whole medical part that needs to be addressed as well, so the TB patients and obviously MDR (multidrug-resistant) *and XDR* (extensively

drug-resistant) *are the people we cannot send and a lot of them are the people with alcohol problems ... I can't expect the patient to go there and wear a mask the whole time that they there..."* (Participant 5)

Within this theme it emerged that sufferers of TB are especially problematic to refer to inpatient treatment facilities. The contagious nature of the disease when managed improperly, coupled with the logistical matters of ensuring that adequate medication was available and adhered to throughout inpatient substance abuse treatment, complicated the process of a TB sufferer entering these facilities. The medically-complex nature of certain strains of the disease directly prohibited referral and thus access. The importance of collaboration between various service providers was emphasised as a requirement for the continuum of care to be ensured.

This concurs with prior research (SAMHSA, 1993) that when suspected of having active TB disease treatment seekers may be denied access pending medical confirmation as to whether (TB) treatment is needed prior to being admitted to substance abuse treatment. This helps to ensure the health and safety of staff and other patients (SAMHSA, 1993).

5.2.6. Psychiatric co-morbidity

UNIVERSITY of the WESTERN CAPE

Referring agents articulated that psychiatric co-morbidity impeded access to state-funded inpatient treatment facilities.

"If somebody is psychotic … some inpatient centres even request that if a person has certain mental problems they cannot be admitted to a treatment facility, so when someone is psychotic, or has got a ... mental problem ... often they can't go into a treatment facility because mentally they are not stable and that needs to be dealt with before they can be treated in a treatment facility... Once that has been dealt with they can deal with the addiction ... however our state- funded facilities are not able to manage them both. If the person is mentally unstable, that needs to be dealt with first before they can work on the addiction" (Participant 2)

"a lot of the patients that I see a lot of them have adjustment disorders it's not something as severe as a psychotic disorder for example, if there is a comorbid psychotic and substance abuse disorder I wouldn't send them to somewhere like (state-funded treatment centre)*; they'd first go to* (hospital) *or* (psychiatric hospital) *or* (psychiatric hospital)*, one of those places and once they are lucid and their psychosis*

has subsided then we'd consider sending them to rehab, so it's always deal with the mental health issue first, if it's something like psychosis or something really debilitating and then send them to the rehab afterwards, rather than the other way around, ja" (Participant 5).

"... when you refer, you're always going to get an obstacle, whether it is lack of beds, whether it is you assessing the client and refer for a psychiatric problem where you have to refer first. There's always an obstacle in terms of the person getting to the right help, before they get to the treatment that they need. Even with inpatient like (state-funded inpatient treatment centre)*, once the person is there they get like medical help or psychiatric, maybe they need anti-depressants; they will get it there, but to GET to that point, to be there is very challenging."* (Participant 1)

"...we do screen the clients ... and then we pick up whether, with our psychologists here that you know there is certain mental issues that need to be explored, which we don't diagnose but then we just refer them on to the psychiatric nurse, she will do a psychiatric evaluation. They will then be medicated, if so, and then after when they are actually stabilised, then we allow them in our treatment facility. But even for those patients that are going through psychosis, we can't do an application to an inpatient facility, they would never accept that application." (Participant 4)

UNIVERSITY of the
WESTERN CAPE

Participants believed that treatment seekers with psychiatric co-morbidity were unable to access state-funded treatment facilities, until their condition was stabilised. This was attributed to the inability of these facilities to manage substance abuse disorders and co-occurring mental illness simultaneously. In such instances two referrals must be made; foremost to stabilise the psychiatric disorder and then to address the substance abuse disorder. Previously, Myers et al. (2007) reported that when dealing with persons with co-morbid psychiatric illnesses, facilities often prohibit access until their condition is stable. Though referring agents' expressed confidence in the treatment rendered at inpatient treatment facilities, which included the dispensing of medical and psychiatric treatment, they expressed pessimism about the process of accessing these facilities. Thus substance abusers' with psychiatric co-morbidity appear to be disadvantaged when reliant on state-funded services. This lends support to the earlier findings of Myers et al. (2007), that psychiatric and detoxification services are sparse in Cape Town, whilst highlighting the plight of these treatment-seekers.

5.2.7. Homelessness

Participants expressed that homelessness impeded access to state-funded inpatient treatment facilities, illustrated in the excerpts below:

> *"... if somebody doesn't have a physical address where they go back to, then they cannot be admitted to a treatment facility... they need to have an address that they need to go out to .... often we have to negotiate and try and get the person into a shelter and use the shelter's address as a fixed abode... really taking that step to getting help still while you are on the street is already a big step that you taking and to be shown away because you don't have a place to stay is a concern, but unfortunately that is our system*." (Participant 2)

> *"Very difficult, the only place is* (inpatient treatment centre) *that would take the homeless client, but if they do not have a place when they are discharged chances are that it's very little that they will be accepted to an inpatient treatment."* (Participant 1)

> *"... homelessness because the treatment system won't take the person if they don't have an… address and if they're being discharged, they want that, so that is the difficulty."* (Participant 1)

UNIVERSITY of the
WESTERN CAPE

Referring agents' viewed homelessness as an access barrier to inpatient treatment facilities as a client address of residence was requisite for entry. Only one inpatient facility was believed to accommodate homeless clients. Therefore, in Cape Town, eligibility criterion of treatment facilities impedes access to inpatient treatment facilities for the homeless. This parallels earlier research conducted abroad (see Wenzel et al., 2001), that found the uptake of homeless persons within the substance abuse treatment system to be minimal.

5.3. *Context*-related barriers

This thematic domain attends to barriers to inpatient treatment access situated within Bronfenbrenner's Microsystem, Mesosystem, Macrosystem and Exosystem (*Context*). Referring agents found that general community perceptions were not conducive to the process of accessing inpatient treatment facilities.

5.3.1. Microsystem

a. Awareness barriers. Participants expressed that lack of awareness hindered access to inpatient treatment facilities.

"... people don't know where to go. These facilities are there but... Our community members don't know where to go; the only place they will go to is Social Development. So I think that is the big weakness."(Participant 4)

"... they don't even know they exist. I think the people who... they've been offered to, I think they are more aware, obviously if they have been there, but the average person with an alcohol problem I think they don't know" (Participant 5)

"Well I think in the (community) *community they are quite aware of treatment centres, what is available to them ... In other communities- because I've worked in the* (community) *area as well...- people are not that aware... People are not that aware. People living in the area didn't even know that there was a treatment centre in the area."* (Participant 3)

"There is awareness, but there's too little treatment centres...so for me the concern is, if they gonna raise awareness and there's less resources, they still gonna struggle to get in, cause now they know where to get in but I can't access so why do you tell me... rather look at the resources first and then creating (awareness)." (Participant 1)

UNIVERSITY of the
WESTERN CAPE

Referring agents' believed that community members are unaware of existing facilities and in instances where they are knowledgeable that treatment was available, exhibited uncertainty about how to access these services. Across communities, levels of awareness differed. It was also cautioned *("look at the resources first and then creating awareness")* that addressing awareness barriers must occur concurrently with the provision of more treatment centres, or individuals would remain limited in their ability to access treatment services. As referring agents' require access points for treatment, individuals need to be aware, or need to be made aware of treatment facilities.

Prior research (Myers et al., 2007) has highlighted the prominence of awareness of treatment services as a predictor of access. Likewise, Myers et al. (2010a) found the probability of treatment access to increase with greater awareness of available substance abuse treatment facilities.

b. Cultural barriers. Referring agents' believed that cultural practices and beliefs in black/ African communities impacted upon substance abusers' treatment-seeking:

"...I had a client that ... I was about to refer to an inpatient centre, then the family member said no it's better if we take, like they take the client to Eastern Cape because in Eastern Cape they believe that there isn't like a lot of drugs...and then some family members would believe that ... if maybe they do a ritual for that person, that person would stop using drugs, so there is no need for that particular person to go to an inpatient centre." (Participant 6)

"... education is important ... or maybe like clarifying as to what is being done at an inpatient centre, and then the fact that even if you take a person to Eastern Cape then the person will find drugs there and then clarifying the fact that substance abuse has got nothing to do with rituals, because people believe that okay, this person is misbehaving by using substances because maybe there's a goat that needs to be slaughtered for that particular person, and then people would believe that the person is going to be okay..."(Participant 6)

While these findings parallel earlier research of Myers et al. (2007) who found black/ African communities as having difficulty in recognising when substance abuse treatment was warranted, the present study also deviated from the earlier findings. Unlike Myers et al. (2007, p. 100-101) who held that "rather than seeking treatment in the early stages of the illness, (black/ African) communities tend to seek treatment only once the problem has become severe... as a result, communities tend to demand access to inpatient treatment and are dissatisfied when treatment slots are not immediately available", different practices were operative in the community where this referring agent was employed:

Is this how treatment is viewed generally? (Interviewer)

No, no, no, when it comes to outpatient centres I think it's because a person would come for a session and then ... go back home, so I think that's the difference because they are seeing that the person has come back unlike when they go to an inpatient centre, the person is going to stay there, and then they think that there are guys who are from Pollsmoor , then they are going to get like some information, which is not good information, so when they see a person that goes into an inpatient centre, they only see that the person is going to a place which is the same as going to Pollsmoor

UNIVERSITY of the
WESTERN CAPE

whereby the person is gonna get some information about crime and stuff and then the person would have to come back and then be a worse person that he was before. (Participant 6)

In the current study, a lack of understanding of the treatment activities enacted at inpatient substance abuse treatment centres caused individuals and their families to be less likely to seek out these services, feeling more at ease with the treatment being rendered at outpatient treatment centres as individuals returned home after treatment sessions. Besides this practise, families were more inclined to send the substance abuser to the Eastern Cape, or have a ritual performed on their behalf in the event that they felt opposed to treatment or were unable to recognise its merit.

Cultural practices also impacted other aspects of the treatment process, specifically who was able to administer treatment services, and how the substance abuser was viewed as one service provider expressed:

"Our black clients will only be between... 18 to 27 beyond that they will never stay in the programme because of language barrier, also because of culture, because they are very set in their way. So if you come in here and you are 45 and you look like at Dada, you look like a Dada but you're not actually a grandfather, and you see me, I was told once 'Do you have kids? If you don't have kids I don't need your service'. So culture also plays a big role, especially in (community). *They relate better to a Xhosa therapist as opposed to any other therapist."*(Participant 4)

"Culturally also men, especially black men, they won't have an individual therapy session with a female, they won't; unless you're married. So all of those little things were picked up, and our stats with regards to retention, with regards to black people, very low."(Participant 4)

The most pertinent findings within this theme were that cultural considerations had a profound influence on the likelihood of access to inpatient treatment facilities. Cultural factors influenced (1) the view taken of addiction (deviant behaviour as opposed to being a disease); (2) decisions to seek treatment or not; (3) the type of treatment that was sought and (4) both access to treatment, and retention, as the absence of suitable staff was linked to attrition.

UNIVERSITY of the
WESTERN CAPE

c. Linguistic barriers. Intimately linked to cultural considerations, referring agents identified linguistic barriers (Myers & Parry, 2005) to treatment access.

"..language, especially when it comes to African people, or I would say black guys as well as women because there isn't, like for instance most of the staff members that are working at the inpatient centres, most of them they speak Afrikaans as well as English so there is few of black, Xhosa-speaking or even Zulu or Sotho-speaking people, so, when the guys like want to go to inpatient centres, so one of the problems would be language, like they won't be able to kind of communicate and participate in whatever is being done at the treatment centre..." (Participant 6)

"*... The language barrier is a huge issue because we have people from* (communities) *where for transportation, this* (outpatient treatment centre) *is central BUT for language purposes … it's not conducive for the counselling process. So though we do see people from different languages, it's just… a strain on the counselling process, you don't end up get the information that you want, or you can't counsel in the manner in which you want, it's not as effective as it would have been if the person had or been counselled..." (Interviewer: Accommodated in their mother-tongue)* (Participant 1)

"...maybe if there could be more African social workers or psychologists interested in substance abuse and then be able to work at an inpatient centre, I think that would play an important role as well because when people do go there, at least they will know that there is someone they can relate to in terms of language..." (Participant 6)

Issues that emerged within this theme were that an inadequate number of service providers were fluent in South African indigenous languages. Due to the location of outpatient treatment facilities, black/ African substance abusers' commuted lengthy distances to obtain treatment where treatment centres staff were fluent only in English and Afrikaans. This not only hindered the counselling and referral process which necessitates the completion of relevant documentation at sites where referral agents were operative, but reduced the efficacy of care rendered at inpatient treatment facilities.

Referring agents' beliefs are in line with Myers and Parry (2005) who found the cultural and linguistic barriers to treatment faced by black/ African clients to be addressed by only a small number of substance abuse treatment providers. Equally, study participants concurred that staff are only fluent in English and Afrikaans, factors that impeded access to treatment

(Myers and Parry, 2005). Referral agents highlight that black/ African clients will remain underrepresented in the absence of staff that accommodates African-language speakers in their mother-tongue.

5.3.2. Mesosystem

a. Stigma. Interviewees expressed awareness that stigma exists, and exercises an important influence over individuals' willingness to access care, as illustrated in the following excerpts:

> *"... in family settings people where people say "Oh my God are you going to a rehab. Why are you going to a rehab? Sort your problem out yourself, you don't need to go. That type of stigma, because then people on the outside will know that my child is in a rehab because they have a drug problem.*" (Participant 3)

> "*... there is a stigma, in that you are an addict when you come here, especially with the youth..*" (Participant 1)

> "*...when they come here they are ashamed because I'm not supposed to be here on Tik, uhm and then how will people look at me when I do come here... and if I enter here what will people think?*" (Participant 1)

UNIVERSITY of the
WESTERN CAPE

The preceding statements reflect an awareness of referring agents that stigma towards substance users' exist and that seeking formal treatment publicises their substance abuse ("*people on the outside will know that my child is in a rehab because they have a drug problem*"). It is plausible then that the stigma of which referring agents expressed awareness limits access to both inpatient and outpatient treatment services. This parallels Sobell and Sobell (1998) who found the stigma linked to being labelled to be a primary access barrier to treatment.

b. Beliefs about addiction and treatment. Referring agents perceived that access to state-funded inpatient services was hampered by community beliefs about addiction:

> *"I don't think they think of it as a disease that needs to be treated…They think it's the person's fault; you need to deal with it and to stop it."*(Participant 1)

Referring agents' believed that community members were less empathic toward substance abusers', who (they believed) were to blame for their current substance-related problems.

These sentiments of substance dependence as a “self-acquired disease” contribute to discrimination and stigma, as it is based on the notion that the free will of individuals lead to their first experimentation with illicit substances (WHO, 2008).

It also emerged that community beliefs about inpatient treatment centres and the treatment rendered were faulty.

> “*...the perception people have about the inpatient centres, I think it’s not a good one, because they think of that if a person goes to inpatient centres, he or she will come out ... like a worse person, like using more drugs and stuff. So I think it’s the mindset of people, they do not have more information as to what is happening at an inpatient centre...*” (Participant 6)

> *“I think with African people, I think they also in denial about substance abuse they believe that substance abuse is a problem for coloured or white communities they do not really see substance abuse as problem for their communities as well. That’s one of the things-denial about the problem.*” (Participant 6)

> “*And then the other thing that they believe is that when you go to an inpatient centre, drugs will be drained out of their system and then they believe that maybe you will get some injections, painful injections and stuff like that, and so people do not really have like information as to what exactly is happening because I have never heard of any drugs that have been drained out of the system.”* (Participant 6)

Participants believed that access to inpatient treatment services were limited by community beliefs, and expressed concern that community members had a poor level of awareness about what substance abuse treatment is about. Referring agent’s also expressed that there is a lack of information about addiction (“*people do not really have like information as to what exactly is happening”).* This is also evidenced by the belief that substance abuse is a problem for select communities, as well as the belief that treatment services are not necessary (“*you need to deal with it and to stop it”).*

Community violence. Referring agents believed that the presence of gangsterism and community violence served as a barrier to accessing outpatient treatment centres, as suggested below:

UNIVERSITY of the WESTERN CAPE

"… areas like (community) *and* (community)*, and not so much* (community)*, the gang violence that takes place is also a big barrier for people to access treatment, like in* (community)*, there is apparently these borders and boundaries within the communities so people from the one side can't cross over the border to the other side. So if our treatment centre is now on the other side, then they can't come to use, because they're placing their lives in danger.* (Community) *has some similar set-up because of the gangsters that are there. So the whole gang violence, that whole dynamic is there. So that also is a barrier for people accessing treatment."*

"…it's quite mind-boggling actually, especially in (community)*, for me because I was there for a while, how that whole system works, and how you can't also ask the Police to assist you because then you kind of… the person is going to be seen with the Police van and then that's going to create another dynamic, and it's just a whole rigmarole of things, so ja that's the other thing."* (Participant 3)

The presence of gangs and ensuing violence were expressed as impinging upon access to referring agents, and thus the opportunity to obtain a referral to state-funded inpatient facilities in disadvantaged communities. This corresponds with literature that previously disadvantaged communities continue to be characterised by poverty and high levels of crime and violence (Kalichman et al., 2006).

UNIVERSITY of the
WESTERN CAPE

5.3.3. Exosystem

a. Waiting time. All referring agents' expressed that extensive waiting periods prior to admission to state-funded inpatient treatment facilities were commonplace.

Waiting time prior to admission to inpatient treatment facilities. Extensive waiting time for admission to inpatient treatment services were commonplace amongst referring agents.

"*The other weakness would be moving from an outpatient to an inpatient; the waiting period is just way too long. If you want to refer someone to inpatient, and this I speak from experience, the waiting period is anything from 6 to 9 months…it's a great difficulty for us, because we are even to scared to offer the client inpatient when they come here, because we know what the waiting period is going to be like and it's very difficult to keep people motivated for so long…* (Participant 3)

"Maximum time period for a bed, for admittance would be then three until six months, and that is just one of the barriers. The process alone is tedious, people don't have the patience."(Participant 4)

"*...you know with the addict he uses everything and anything as an excuse. So if he doesn't get in when he wants to get in, eventually it's gonna be...it's because...the treatment facility wasn't able to take me. It's because I had to wait three months and that is why I'm back at using and I didn't stop using so…we just become pulled into that where they use us and they blame us..."*(Participant 2)

Interviewees regarded waiting time as counterproductive to motivation, as it could be used as a rationale for continued use of substances. Waiting periods for admission to inpatient facilities were reported to be so lengthy that one referring agent expressed a fear of even suggesting a referral to inpatient services. Again, the negative impact of waiting time on treatment access is highlighted.

Other participants reported waiting periods at every stage of the inpatient application:

"So barriers is waiting time for that application to be processed, assessed at the inpatient facility. Another barrier would be the waiting period for admission that is too tedious. Another bad area is the fact that if it has to go through statutorial lines it's much more longer..." (Participant 4)

UNIVERSITY of the
WESTERN CAPE

Where detoxification services were needed, waiting lists were also reported, delaying access to inpatient treatment facilities:

"...if you are a heroine user we will apply for inpatient for that person. We already were supposed to have completed that application having a date at hand already before (psychiatric hospital) *will basically admit you. That is more than seven months that you're going to wait honestly..."* (Participant 4)

All study participants mentioned the presence of extensive waiting time, lasting between 3 and 9 months prior to admission to state-funded treatment facilities. All of the steps involved in accessing state-funded centres required waiting: waiting for detoxification services; waiting for applications to be processed and assessed and finally, waiting for bed-space, and thus admission.

Referring agents' concur with Myers et al. (2008b), who found extensive waiting time for affordable treatment slots to result from the inadequate availability of low-cost treatment slots. With regard to detoxification services, study findings correspond with Myers et al. (2007) who found the Western Cape's state detoxification services to be of limited availability. Moreover, access to inpatient treatment was hindered due to the eligibility requirement of detoxification prior to admission.

Besides decreasing the likelihood of clients eventually accessing inpatient treatment facilities through continued use, the progressive nature of the disease led to further profoundly devastating harms while treatment was unavailable, it was elucidated:

Consequences of lengthy waiting time.

> *"...addiction: it's a progressive illness– not only does the client use more but the damages in their life becomes more if they don't have, if they don't access help, and I mean if they don't access help then they continue using and it could mean life or death, it could mean becoming psychotic or not, it could mean landing up in jail or not, you know, even dying. We do say that the end result of using is death, mental institution or jail. So if he doesn't get the help when he really desperately wants it, and we procrastinate and we wait, and we struggle to get him the help, in the meantime we know he can die..."* (Participant 2)

> "*if they say yes, you've got to grab it right there ... if you wait too long or wait 6 months the patient's either died or they have lost interest or are in a different space and are not motivated to go anymore...*" (Participant 5)

UNIVERSITY of the
WESTERN CAPE

Succinctly, participants highlight that the consequences of waiting time for treatment are: (1) death, (2) incarceration, (3) psychosis or (4) a decline in motivation.

Findings of referring agents' concur with earlier research that decreased motivation for treatment results from lengthy waiting periods for low-priced treatment (Myers et al., 2007; Myers et al., 2008b). Waiting periods hampered treatment access and was mainly attributed to a restricted capacity to meet the need for low-cost services (Myers et al., 2007). Findings are also consistent with that of Carlson (2006 as cited in Carr et al., 2008) who asserts that a 'teachable moment', a window of opportunity to reach substance abusers' may be lost due to waiting time.

***b*. Lack of collaboration.** Participants expressed that there is poor networking and collaboration within the substance abuse treatment system. They commented that networking amongst treatment centres and detoxification facilities was not conducive to service delivery, and by the same token, the process of enacting referrals.

"... there needs to be good networking and interaction between different facilities whether it is: inpatient, outpatient, detox facility. Networking needs to improve… and it needs to be more free- flowing whereby it's not just about time or… but that it's a space where things run more smoothly. I think that will help and facilitate the process" (Participant 2)

"So I think everyone work in isolation and they're not working together. So that's a big, that's a big area that we need to look at." (Participant 4)

"I think the collaboration of the treatment centres, I think there isn't that much collaboration amongst treatment centres." (Participant 6)

"…networking is also not that great amongst the different service providers. Everybody seems to be doing their own thing, without kind of getting together and having one kind of structure that they follow."(Participant 3)

UNIVERSITY of the
WESTERN CAPE

Participants believed that poor collaboration and networking amongst service providers impacted upon the process of rendering care, and enacting referrals within the substance abuse treatment system.

Findings depart somewhat from that of Myers et al. (2008b) who reported on lack of 'intersectoral collaboration', the deficient collaboration of government departments on issues relating to alcohol and other drugs and led to fragmented service delivery. Perceptions that ineffective state-led substance abuse interventions were being rendered resulted from fragmented service delivery. Decisions to enter into treatment are impacted upon by such factors (Myers et al., 2008b). These findings highlight that poor collaboration impacts upon service provision, including referral processes, and thus access to inpatient treatment facilities.

***c*. Beliefs of service providers.** One referring agent appeared to hold stereotypical beliefs of individuals based solely on their substance of choice:

"We know that heroin clients aren't motivated, they're not, they just want to go into detox that's it." (Participant 4)

"And to be honest with you, if not, we came up with this new way forward. We know that with heroin users you can medicate them. We don't encourage that, we believe in total abstinence with no medication. As long as we don't make that recommendation. What we do we link the clients and the family up with a physician…of our choice because... he won't just you know, expect the family to pay money because we know these drugs are very expensive, especially Suboxone, it's very expensive." (Participant 4)

This referring agent presupposes that certain clients are less motivated than others, purely on the basis of their substance of choice, and before any collateral information has been collected. Personal beliefs again appear to influence practice when this referring agent mentions that they "*don't encourage"* the use of substitution medication as they *"believe in total abstinence with no medication"*, though it is revealed that this recommendation is not overtly stated to clients.

The beliefs of this referring agent stands in contrast to earlier research (Myers et al., 2008a) that, when combined with behavioural therapies and counselling, for many, medication is an important element of treatment. Moreover, Gilson, Palmer and Schneider (cited in Pasche et al., 2008) caution that the personal beliefs of service providers' stand to impede access to treatment as it plays a role in the quality of care provided.

d. Lack of facilities/ resources within the treatment system. Referring agents' expressed that more resources should be allocated to the substance abuse treatment system in the Western Cape.

"I definitely think ...they (treatment programmes) are effective, but I think the lack of facilities, staff, bed space things like that and the difficulty getting them there is what makes it very frustrating and not that great." (Participant 5)

Participants articulated confidence in state-funded inpatient treatment services, but remarked that resources were inadequate, specifically regarding the capacity of these facilities and the number of staff. Significantly, a lack of treatment facilities was raised as a concern, a sentiment shared in by others:

"... we've got too little treatment centres. We've got too little state-funded treatment centres. That is definitely the first thing."(Participant 3)

"... there is few-especially in other areas-there isn't any other treatment centres, like for instance in areas such as (township), (township), (township)*, there isn't even one treatment centre, so I think those are some of the weaknesses that there is like few, that they still need like, they still need to kind of have more treatment centres in other areas as well."* (Participant 6)

"*... there is few inpatient centres in the Western Cape whereby the person would have to go without having to pay money."* (Participant 6)

Two concerns are raised: the inadequate number of outpatient and inpatient facilities to service the public, as well as the need for more state-funded treatment services. As certain communities had no treatment centre, they had to travel to reach treatment facilities in other geographical locations.

Reference is made to "the masses" that are unable to receive treatment due to the lack of facilities:

"...lack of sites. We're supposed to have eight sites running and we're only sitting at four. We're looking at our site, I service the whole of northern, we're only Tygerberg we'll never be able to service the masses, so I think it's about starting more sites, that's what I think." (Participant 4)

Referring agents' expressed concern about the high levels of treatment need relative to the state's current capacity to provide treatment services. The need for more state-funded treatment facilities, which are evenly dispersed was emphasised as paramount to improving service delivery.

Referring agents' concur that treatment facilities are limited (Myers et al., 2007). This is important, as eighty percent (80%) of South Africa's population rely on the state sector for health services (including substance abuse treatment; Fakier & Myers, 2008) (Goosen, Bowley, Degiannis & Plani, 2003).

***e. Inpatient treatment facilities' practices as a barrier*.** Participants expressed an array of concerns about the practices of state-funded inpatient treatment facilities.

UNIVERSITY of the
WESTERN CAPE

"I also think their administration needs to be reviewed. I think the point of entry to the exit is questionable, because if you're an inpatient facility you still need your outreach workers." (Participant 4)

"Lack of follow up on their part, if a form is incomplete or they need something else then they just-unless you phone them back and ask, and they go and check- you won't hear from them." (Participant 5)

"... we struggle ... getting cannabis users in as well, dependence, we can't get them – what they are saying is that cannabis-that's why I sometimes wonder what type of experts do we have in inpatient facilities-they still say cannabis is not that priority to them." (Participant 4)

"... some of the private rehabilitation centres are para-statal, meaning the state basically… pays for ten beds perhaps... so if they do receive rehab patients... that really can't… afford their services then that's another case. They will make the decision, or they will determine basically who is fit for that and most of our clients can't get in...even though these beds are available, it is still their discretion who they allow and I think it's unfair." (Participant 4)

UNIVERSITY of the
WESTERN CAPE

Practices at state-funded inpatient treatment facilities were viewed as hindering access to these services. Various administrative processes were questioned, as was the failure of these facilities to communicate administrative needs, which impacted upon the success of referrals. Referring agents expressed that inpatient facility staff did not perceive all substances as equally deserving of treatment, and that ultimately, it was at the discretion of these facilities that individuals gained access to treatment. Even in instances where the cost of beds were subsidised, access to these individuals occurred at the discretion of treatment centres.

f. Referral protocol. According to referring agents', access to state-funded inpatient treatment facilities necessitates a referral from a social worker.

"...the social workers in a way, they play an important role in terms of helping the people to access inpatient treatment." (Participant 6)

"With the government funded facilities, they require a referral mostly from either an outpatient facility or it's done by social workers that are in social services at the Department of Social Development. I think the social workers that are at other NGOs

like Crisis Line and (outpatient treatment centre) *and even the social workers that are sitting at the courts.... they ALL can make referrals to the subsidised or the funded inpatient facilities."* (Participant 3)

Referring agents' concur that social worker reports are needed for referrals to state-funded inpatient treatment centres (Myers et al., 2007), emphasising the importance of these professionals as facilitators of access.

g. Social worker reports as a barrier. The requirement of social worker reports itself served as a barrier to accessing inpatient treatment services, as it emerged that certain inpatient treatment facilities would only consider referral applications compiled by a social worker, giving no consideration to other referring agents. This is described in the passage below:

"*...they are not very keen on me making referrals. They want-and I'm speaking specifically about* (state-funded inpatient facility) *that I've had huge issues with... -they want a Social Worker to refer them, and... when I've asked this in the past, you know "why" or "why can't I do it?" they say because they want to refer the patient they have to after discharge refer the person back to the social worker, whoever in the community or whatever...so that's how I understand the actual procedure that we, I pick it up, I need to then refer to whatever other social development or social worker in our clinic, and once they have done an assessment then the social worker writes the referral letter and then sends them off to... or they go on the waiting list and then they phone and they go in hopefully."*

"*...I've said to them I don't understand why I cannot do the referral, I'm more qualified than a social worker and they still would say 'oh but we need a social worker' ... I don't think they really understand-the people on the end of doing the admissions-I don't think they actually understand what my title is and my role and how it differs to a social worker, that we also dealing with these sorts of issues, I don't think they get that and I think they just have on paper that they must have the social worker, so they're stuck in that mindset."* (Participant 5)

These excerpts clearly indicate that the expertise of this psychologist is disregarded in deference to that of a social worker, despite the latter professional holding a different

UNIVERSITY of the
WESTERN CAPE

qualification. In order to ensure that the client still received treatment services, the psychologist made a referral to a social worker who in turn performed an assessment and completed the referral documentation for the client. This time lost during this process is illustrated in the extract that follows:

"I've been trying to refer one patient since December last year, she's still not in, and it's just the typical example that I will phone and say "what's going on?" No we need this form, then they will send the form... then we send it off, then I wait, then a month later I go "what's going on?" "No, you weren't meant to send the form, the social worker was meant to", I said "but... why didn't you phone me and tell me?" so there's ABSOLUTELY no communication-NOTHING! They don't phone to say your form is incomplete or..."actually, you can't send the form" and when they do say they'll phone you back...I'm still waiting for the phone call from two weeks ago." (Participant 5)

Another barrier experienced by this referring agent is the logistical issues arising when working alongside social workers due to differing schedules. This extends the time taken to enact referrals, and thus hampers access to inpatient facilities.

"...usually I incorporate the social worker, get her to do an assessment... and together I try and make-because of me being told that the social worker needs to be involved-then I would do the referral with that... but because the social worker and myself are probably most of the time not here on the same day it creates a huge problem because there's a lack of communication between-just because of logistics between us as well-because she's not here so I can't walk to her office and say "okay, this and this please follow up from the patient", so it's literally, again, passing messages through other people, you know, once I leave that clinic, the next day I'm at another one and it comes with its own issues so I can't-it's so difficult to keep on following up on past stuff at every clinic, I don't have time really... usually just getting the social worker involved and trying to do it together and then the social worker normally has the forms and ... would fill them in...and then fax it off and then it's sort of a waiting game... (Participant 5)

The failure of other referring agents' to be pro-active was an added frustration for this referring agent as it hampered clients' access to the much-needed care of inpatient facilities:

"...every now and again when you see the patient you think "geez it's been two months, what's going on?"... the social workers don't really take an active role to say "you know what? You're still standing here, you're not in rehab, what's going on, let me phone", and now I have to say, and go to them "listen, what's going on here?" or "please can you follow up?" or I will follow up and it's... it's quite an ordeal" (Participant 5)

The requirement of referral reports from social workers appeared to be inconsistently applied, however, as another participant (a Registered Counsellor) reported no difficulty in referring clients:

"How are individuals with your job title or your job description…how are they instrumental in this referral process you've spoken about?" Interviewer

"Okay, so we've got a working relationship with our inpatient facilities, so I would have a relationship with somebody at that inpatient. I'd contact them and tell them look I've got a client...I need to get him in, his not coping in our outpatient facility. That person would obviously tell me fill out the referral form. I'll sit with the client, fill out the referral form and then send it off to the inpatient, and then they'll obviously let me know when they have space available." (Participant 3)

UNIVERSITY of the
WESTERN CAPE

This referring agent reported no difficulty in facilitating access to inpatient facilities, despite being a registered counsellor and not a social worker. This however suggests that practices are not uniform throughout the treatment system, specifically as it relates to enacting referrals.

h. Referral documentation. Besides the aforementioned inconsistencies, participants remarked on the challenging process of completing referral documentation in order to facilitate entry to state-funded treatment centres:

"I must say that the referrals are also not that easy." (Participant 3)

"There is a lot of administration that must be done, because now it becomes not about also the addiction, it becomes a financial aspect, so that in itself is now extra which you have to do, but that's not part of, but that's now because the person is paying, or the person is not paying, and now you have to mention its subsidised, now there's an admin

fee next to it, now you as the counsellor that deals with counselling have to deal with finances as well..." (Participant 1)

Participants perceived the process of completing referral documentation to be challenging. Considerations peripheral to the individual's addiction were perceived as taking centre stage. Financial considerations, for example, were seen as determining which treatment services may be sought.

Participant believed that the completion of referral administrative requirements to be time-consuming and labour-intensive:

"... the paperwork is too long..." (Participant 3)

"For the one inpatient facility the referral form is basically an assessment, so in that you would cover the person's medical history, their...childhood, about their family, their support structures...their psychiatric history...information about their substance use history...any life- changing events that could have maybe contributed to the person actually starting to use... some of the inpatient referral...they not one form, it's like a little pack. It's like doing an assessment of the client and sending that off ..." (Participant 3)

UNIVERSITY of the WESTERN CAPE

"*... the one inpatient facility's referral form... it's so thick that you actually take, you actually take about an hour and a half with your client to fill it out. If you've done your assessment, like we do an assessment here as well, if you've done your assessment you have most of the information that you can fill out, but you have to sit with the client, there's additional stuff that they want and you have to sit and fill it out ..."* (Participant 3)

"So now it's also a lengthy process, and that's gonna determine with ... the admin of the facility, if it's a LOT of paperwork, if they require a lot of things from you, like the salary slip, and an affidavit, and you know, lot of things ..."(Participant 1)

"...to go to inpatient there's all of that legislature and process involved in actually making that happen." (Participant 4)

"So it's just red tape, which really it doesn't make sense because even though the client comes today and I can see the severity of his withdrawal symptoms, application might take three days for me with my psycho-social report. That is sent onto inpatient. When

they phone us it might take four months for the most, three to four months. So it means that that person can't detox. So it doesn't make sense." (Participant 4)

The aforementioned excerpts illustrate that referring agents' find the administrative requirements of referrals to be extensive and time-consuming. These extracts, however, also suggest that referral agents' have a limited understanding of their role.

Participants noted further barriers to treatment directly related to enacting referrals:

"*There's lots of barriers… some of them lose your admin, and you have to do it over again, though you know, and that, when the admin is sort of lost somewhere in transit then you as the referee look unprofessional because the client is depending on you to get things in order to you."* (Participant 1)

In summary, referring agents highlighted that referrals to state-funded inpatient treatment services necessitate a social worker's report. Referring agents who held professional titles other than that of a social worker perceived this requirement as an additional barrier to accessing inpatient treatment as they were obliged to enlist the help of social workers, which lengthened the time taken to complete a referral. Completed referral documentation also did not guarantee that the application process was complete as some facilities were reported to lose paperwork, which had to be compiled again. The referral process was expressed to be time-consuming, labour intensive, and at times 'demoralising'. Referring agents' also exhibited little knowledge of their role. Taken together, the referral system, the very means by which access to inpatient treatment facilities is facilitated, appears to act as a barrier to accessing treatment.

UNIVERSITY of the
WESTERN CAPE

Referral agents' concur with Myers et al. (2007), who found access to services to be hampered by multiple gatekeepers and unclear referral pathways. The procedure for accessing treatment was delayed by the administrative prerequisites for obtaining low-cost or free beds at non-profit treatment facilities. Reports from health professionals and social workers documenting psychiatric history, need for treatment, medical history and levels of motivation, which are time-consuming to compile, are needed in order to access treatment services that are affordable. The unclear referral pathway constitutes another barrier, as delays in treatment result from the referral to numerous non-profit treatment services before help is obtained (Myers et al., 2007).

i. Uninformed staff. Referring agents expressed that uninformed staff within the treatment system impinged upon access to treatment services, evidenced in the extracts below:

"So at the end of the day family's insight ... it's very poor… and the social workers do not give them that information, of which I think they also don't know." (Participant 4)

"The other weakness is the fact that staff, manpower; people aren't educated within the substance abuse field, as experts. I think in this field you do really need to have some form of expertise, not everyone can do substance abuse therapy. No, not everyone." (Participant 4)

"... I don't think they really understand- the people on the end of doing the admissions- I don't think they actually understand what my title is and my role and how it differs to a social worker, that we also dealing with these sorts of issues, I don't think they get that and I think they just have on paper that they must have the social worker, so they're stuck in that mindset." (Participant 5)

*"I think if they train the social workers, and if facilities come to clinics, and just spend ten minutes in one of our meetings and explain how it works, can a doctor refer, can a nurse refer, what do you do?, that would be really helpful because they don't know, they really don't know. Often I'll go to different nurses or different meetings, different clinics to explain my process and substance abuse always comes up, what must we do with these people? They really don't know." (*Participant 5)

UNIVERSITY of the
WESTERN CAPE

"... they don't even know they (treatment facilities) *exist... the average person with an alcohol problem I think they don't know, and from what I've found, the clinic staff also are not that active in-you know some of them, I'm not saying all of them, but some of them will say, you know, have you thought of rehab, or what about getting help for it but often they'll just refer them to me or the social worker they won't think a step further and say "you know what this patient actually might need rehab or benefit", let me just book an appointment with the social worker or phone or suggest or explain what it is, you know, uhm, so often they don't know...very well."* (Participant 5)

Referring agent emphasised that staff within the substance abuse treatment system were largely uninformed. Staff were prohibited from proactively rendering care to clients as they

were uninformed about substance abuse treatment, specifically; suggesting and facilitating the referrals. Poor knowledge within the referral system is therefore a barrier to accessing state-funded inpatient treatment facilities.

j. Helplessness/ frustration. Referring agents expressed a sense of helplessness and frustration, as they are one of several role players within the treatment system:

"...from our side we feel like our hands are cut off because what do we do after the referral? There isn't much that I can do to speed the process along because it's about different agents that's part of it and I am not on that side to move the process along so that it's frustrating for me also, as well" (Participant1)

"... addiction: it's a progressive illness– not only does the client use more but the damages in their life becomes more if they don't have, if they don't access help, and I mean if they don't access help then they continue using and it could mean life or death, it could mean becoming psychotic or not, it could mean landing up in jail or not, you know, even dying... So if he doesn't get the help when he really desperately want it, and we procrastinate and we wait, and we struggle to get him the help, in the meantime we know he can die..." (Participant 2)

UNIVERSITY of the
WESTERN CAPE

"It's very time-consuming... even that paperwork is really time- consuming… it's quite intensive…you really need time out to actually sit and do it, and then obviously the follow-up process; to give them the courtesy call like when do you think you'll have space-you know that type of thing. It's quite a drawn out process and it becomes quite demoralising sometimes, because you just don't even want to go through that." (Participant 3)

"... I've said to them I don't understand why I cannot do the referral, I'm more qualified than a social worker and they still would say oh but we need a social worker ... I don't think they really understand- the people on the end of doing the admissions- I don't think they actually understand what my title is and my role and how it differs to a social worker, that we also dealing with these sorts of issues, I don't think they get that and I think they just have on paper that they must have the social worker, so they're stuck in that mindset." (Participant 5)

Referring agents expressed frustration and helplessness about the process of enacting referrals, but also the inability to speed up the process of admission to treatment after relevant administrative requirements of referrals had been met. The completion of referral documentation was viewed as *demoralising* for one participant, whereas another expressed dissatisfaction about their inability to refer to a particular facility, despite their professional title. Participants appeared especially helpless concerning the (often lengthy) waiting period after a referral has been completed, describing the steady decline of those who progress further in their addiction whilst waiting to be accommodated within the treatment system.

5.3.4. Macrosystem

a. Geographical access barriers (Myers et al., 2010a) were believed to limit access to substance abuse treatment services.

"People can't access our treatment centre because transport is a problem, they don't have money, they can't travel so…that is a big barrier." (Participant 3)

"...they don't have money for transportation, to be honest some of our clients walk from (suburb)*, even from* (suburb)*, that's how committed they are. But you can't expect everyone to have the same level of commitment... transportation is our big, big concern."* (Participant 4)

UNIVERSITY of the
WESTERN CAPE

"Another example I can give you is a client that's travelling from (suburb). (Suburb) *is not far from* (suburb)*, but the taxi doesn't come right down to* (suburb)*, so that person has to get off... they actually have to walk till here and it's not very safe for them to walk... Safety. The transport routes are not always ideal for where the centres are located, so I would say we need more outpatient facilities in the broader community"* (Participant 3)

According to referring agents', the location of the (already limited) outpatient treatment facilities are problematic as they are not centrally located and are not conducive to travelling by public transportation, limiting access to referring agents. Treatment- seekers from various communities were described as undertaking lengthy travelling in order to reach outpatient facilities; walking far distances when no money for transportation is available, and in turn compromised their safety. Participants emphasised not only the dire need for additional treatment facilities, but suggested that these be located en route of public transport services.

Myers et al. (2010a) reported that the probability of substance abuse treatment use was significantly impacted upon by geographic access barriers (particularly extended travel times to treatment), which might be attributed to the susceptibility of individuals from disadvantaged communities to financial barriers. These authors posit that, for disadvantaged South Africans, the likely loss of earnings linked with difficult and lengthy commutes and high costs related to public transport render lengthy travel times as unaffordable.

b. Affordability /financial barriers (Myers et al., 2010a) to treatment were strongly emphasised by several referring agents, illustrated in the extracts below:

"...they struggle with getting here, because a lot of the time we deal with people that… don't have money they find it difficult to travel..." (Participant 2)

"... most of our clients; 99, 9 % of our clients are unemployed. Their families are not able to afford to send them to private or to an inpatient facility" (Participant 3)

"More often than not, with the client that we see in our treatment centre, in their household there'd be no breadwinner. So they would be living off either a (child support) *grant, or the parents will be getting a pension or a disability grant which is so little money... they still have to kind of find means of getting to a treatment centre, they do not have the money to travel... even if they can get to a state- funded outpatient facility like ours they don't always have the money to get to us... so that also becomes a barrier, or that keeps people from seeking treatment. They might come the one day because they managed to get money to come, but how are they going to maintain it for another 6 weeks?"* (Participant 3)

"it's simple things like the patient getting to the facility, some of them literally don't have a cent, so just for them to get from our facility whether they have to go for an outpatient, an interview or whatever it might be, to get there is a barrier..." (Participant 5)

"*... now it becomes not about also the addiction, it becomes a financial aspect.... because the person is paying, or the person is not paying, and now you have to mention its subsidised, now there's an admin fee next to it, now you as the counsellor that deals with counselling have to deal with finances as well. We have to tell the person listen,*

this is an admin fee that you have to pay, are you able to?... they don't have transport they don't... they have to deal with that AS well, to get to the centre..." (Participant 1)

"... all of our clients that come in here ...yes all of our clients come from a more disadvantaged community; they don't have money, their families don't have money so they can't afford a private inpatient but then they have to just wait in line because for state-funded you have to wait in line and see when their turn comes, so that is the problem that we sitting with..." (Participant 3)

"... they want help but "why, that is so much money" and I know my mother is not working and is a pensioner, "why would I put extra burden on them for MY treatment, and I'm already guilty of doing what I did to them. I might as well just go on with what I'm doing now; it's less of a burden for everyone." (Participant 1)

UNIVERSITY of the
WESTERN CAPE

These extracts convey that treatment need is a secondary consideration. The financial standing of treatment-seekers takes centre-stage and influences every step undertaken in the process of accessing inpatient treatment services. Geographic locations of outpatient facilities (or other sites where referring agents are present) stand to limit even initial access to referring agents when no money for transportation is available. Access to referring agents is paramount as they are the gatekeepers of access to state-funded inpatient treatment facilities. Should linkage to referring agents occur, cost considerations again become the determinant of which treatment services are able to be accessed (i.e. private as opposed to state-funded inpatient facilities). An inability to finance treatment at private inpatient facilities compel substance users' to rely on state-funded facilities. The huge demand for state-funded inpatient treatment facilities however, results in extended waiting time for access. Once assured placement at such facilities, treatment seekers again incur the costs of commuting to these facilities. Costs of treatment and the inability to meet these costs becomes an excuse for some substance abusers to continue using. The presence of competing financial considerations are suggested as families are described as sustaining themselves solely on the basis of social welfare grants or pension allowances often due to the absence of a breadwinner. The sum received (*so little money*) has to cover the cost of family expenses, as there is no breadwinner, and treatment costs are viewed as secondary to survival. It is therefore abundantly clear that financial constraints impede access to state-funded inpatient treatment facilities.

Referring agents' concur with Myers et al. (2010a) that the disadvantaged in Cape Town experience financial access barriers to substance abuse treatment, and that treatment use dropped where 'competing financial priorities' existed (e.g. for shelter and food). Indeed earlier research (Sanders & Chopra, 2006; McIntyre & Gilson, 2002) contends that contextual factors such as pervasive joblessness and poverty impacts upon access to health and treatment services for impoverished communities, and that meeting survival needs is assigned first priority (Myers et al., 2010a). This in turn limits access to referring agents', and in so doing, access to inpatient treatment services.

5.3.5. Referring agents' recommendations

Participants' recommendations to improve access to inpatient care are highlighted below.

a. Recommendations for interventions to attend to awareness- related barriers and unfavourable perceptions of treatment. Participants suggested ways in which awareness of existing inpatient substance abuse treatment facilities could be fostered, concurrently counteracting negative community perceptions of these treatment services:

> *"...we really need to educate the communities about inpatient centres or maybe there should be like people from inpatient centres themselves coming out to the community and explaining to the communities what it is exactly that they are doing, what kind of services that they are rendering at an inpatient centre, so maybe that would change the perception of the community members about treatment programmes, especially inpatient centres."* (Participant 6)

> *"I think if they train the social workers, and if facilities come to clinics, and just spend ten minutes in one of our meetings and explain how it works, can a doctor refer, can a nurse refer, what do you do?, that would be really helpful because they don't know, they really don't know... If... someone from the facilities can come around, and explain their role; what they do; about their programme; how long it is; how do I get a patient in there..."* (Participant 5)

Interventions to improve access to substance abuse treatment should centre on clarifying the nature of treatment at inpatient treatment centres for communities and clinic staff members.

UNIVERSITY of the WESTERN CAPE

Awareness programmes should also use inpatient staff members to elucidate the role of inpatient facilities as well as the process of gaining access.

b. Recommendations for interventions to address availability of treatment facilities. Participants suggested ways in which the limited availability of substance abuse treatment facilities could be addressed:

"I just think that there should be …more treatment facilities available." (Participant 2)

"If we have more inpatient facilities, obviously we can access, or more people would be able to access that service provider or that facility." (Participant 3)

"...we definitely need more government- funded inpatient facilities, 'cause we just have too little...we need facilities..." (Participant 3)

"... satellite offices ... they have been really helpful in terms of an in-between point, so if they agree, and I agree the patient would rather benefit from an inpatient facility, rather than just leave the patient on their own for a few months until they go in, send them or refer them to a place like that ... so if they could put up more satellite offices ... or whatever small-scale outpatient facility they have, to hold that patient while, or until they get a place, that would be extremely extremely helpful." (Participant 5)

UNIVERSITY of the
WESTERN CAPE

Participants urged that more outpatient and inpatient state-funded treatment facilities are needed to improve access to treatment services and expand the reach of these services.

c. Recommendations for interventions to address geographic accessibility barriers to access:

As participants emphasised that the geographic location of existing facilities had a bearing on access to care, recommendations were also made in this regard:

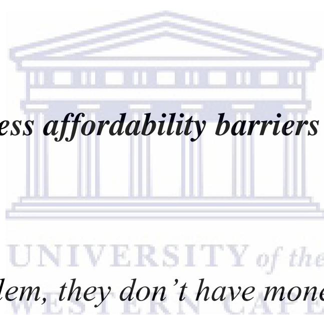
... if we put it (treatment facilities) *in a central area where people in the surrounding areas can access it that would make it a bit easier cause then you can reach those communities as well... treatment centres are also spaced in such a way that they are ... concentrated in certain areas... So therefore you need to ... place them strategically so that people can access them easier and it won't cost them a lot to get there. Ideally it would be in walking*

distance, but we can't get what we ideally would want, but get the next best thing." (Participant 3)

"…we need more outpatient facilities in bigger little…areas. Like have one in (suburb) *maybe, where people from* (suburb) *and* (suburb) *can access them. Have one in* (suburb) *where people from* (suburb), (suburb) *can access it. Where you know, the transport is like on route or they can walk because that is a big barrier... more outpatient facilities in the broader community."* (Participant 3)

"I think resources that's strategically placed where things flow." (Participant 1)

Interventions to target geographic accessibility barriers should direct attention to distributing treatment centres more evenly as they are currently "concentrated in certain areas", as well as locating them more centrally where they are easily accessible to surrounding suburbs.


UNIVERSITY of the
WESTERN CAPE

d. Recommendations to address affordability barriers to substance abuse treatment access.

"...because transport is a problem, they don't have money, they can't travel so…we need more outpatient facilities…where you know, the transport is like on route or they can walk because that is a big barrier...more outpatient facilities in the broader community." (Participant 3)

Establishing new facilities was seen as a counter to the costs incurred through travelling as facilities would be centrally located and within walking distance.

e. Recommendations for interventions that attend to waiting time for treatment

"In terms of the waiting lists, I think there needs to be maybe one or two more inpatient centres that are subsidised by government, whereby a person would have not to pay any money, because the inpatient centres currently like they take a certain number of clients so if they could like be more, I think that would be easier." (Participant 6)

Increasing the number of treatment facilities was also seen as a counter to the lengthy waiting time for treatment.

f. Recommendations for interventions that attend to the referral process.

"Where inpatient is concerned, I think the referral process has to be ironed out a little bit. (Participant 3)

"…the paperwork is too long...The paperwork is very long; the time that they actually get into the facility, obviously the time period is very very long. Also I think if inpatient and outpatient facilitates can work together, build a better partnership, build a better relationship so it doesn't need to be a struggle to actually get them into an inpatient facility (Participant 3)

"... if the admin is NOT a lot for them to get in ..." (Participant 1)

"I don't know if in an ideal world we can have centres where you have a walk-in centre and you stay and you do your treatment and you walk out ..." (Participant 1)

"if either they have a toll-free number they phone, they are referred to a rehab centre, they are able to access the rehab centre, and there is availability in terms of counselling, whether in-or–outpatient" (Participant 1)

UNIVERSITY of the
WESTERN CAPE

"So I think there should be a monitoring system...If you come into the system you will always have a social worker attached to you. You will be seen once a month continuously so there's always progress, always monitoring. So if a referral was sent maybe from the school to social development, or to any organisation... for you to be there to see whether there's actually ... progress taking place..." (Participant 4)

Referring agents' believe that interventions to improve access to substance abuse treatment should focus on refining the referral process and lessening administrative requirements to gain access to inpatient treatment centres. Treatment facilities which were directly accessible to the public were seen as the ideal. The implementation of a computerised system whereby referrals are tracked would also imbue accountability on service providers.

g. Recommendations for interventions that address cultural and linguistic barriers to substance abuse treatment.

"... if there could be more African social workers or psychologists interested in substance abuse and then be able to work at an inpatient centre, I think that would play an important role as well because when people do go there, at least they will know that there is someone they can relate to in terms of language."(Participant 6)

"I think education is important, like awareness campaigns in the community, especially focusing on substance abuse, not maybe focusing on like on prevention, but giving information to family members or community members... and then the fact that even if you take a person to Eastern Cape then the person will find drugs there and then clarifying the fact that substance abuse has got nothing to do with rituals... so I think education is important, then, people getting more information, I think that would break the denial or some of the barriers in terms of accessing treatment or going to treatment." (Participant 6)

Interventions to minimise cultural and linguistic barriers to inpatient substance abuse treatment should focus on employing more black/ African or indigenous language-speaking staff at both outpatient and inpatient treatment centres. Secondly, such interventions should educate families and communities about substance abuse, and how the treatment and recovery process departs from cultural beliefs about appropriate action.

UNIVERSITY of the WESTERN CAPE

h. Recommendations to improve the general functioning and efficacy of the substance abuse treatment system.

"Now if I say we are treatment, we will still have issues 'Oh but that's my court Joe, I can't do awareness raising'. So it's just not about treatment anymore... I just think that people should be more multi-functional... (Participant 4)

Treatment system staff should be encouraged to play multiple roles in order to foster access to, and treatment services for substance abuse.

Features of the substance abuse treatment system (Exosystemic factors), as well as socio-political factors (Macrosystemic factors) are filtered through to interact with Microsystem institutions (Kagee & Delport, 2010) and *Person* characteristics, enacting an important influence on behaviour of substance abusers' as it pertains to accessing inpatient treatment

services. Macrosystemic environmental, political and economic developments shape and influence the Exosystem and Mesosystem in turn (Kagee & Delport, 2010). Specifically, denial, motivation for treatment, disability, active TB disease, psychiatric co-morbidity, homelessness and gender-related issues denoted *Person*-related barriers. *Person*-related barriers were especially salient for women who faced added stigma, were unable to access treatment due to pregnancy, childcare considerations, gender roles and inadequate treatment centres for females, giving credence to participants' general belief that females accessed treatment services in lower volumes than their male counterparts. Notions of masculinity impeded access for adolescents, whilst at a Mesosystemic level of interaction, community perceptions in the form of negative beliefs about addiction and treatment, stigma enacted towards substance abusers and community violence hindered access to treatment services, added to awareness and financial barriers. Macrosystemic influences, in the form of geographical and affordability access barriers were believed to be present. These in turn influenced the Mesosystem and Exosystem. In the current study, numerous Exosystemic treatment system influences were reported by referring agents', inclusive of extended waiting time at every stage of the inpatient application, lack of collaboration amongst service providers, beliefs of service providers, lack of facilities/ resources within the treatment system, uninformed staff, referral protocol and the processes of inpatient treatment facilities as a barrier. These interactions illustrate the bi-directional influences present throughout all levels of interaction. This two-way interaction between the individual and their context operate to hamper or facilitate the process of accessing inpatient treatment services.

UNIVERSITY of the
WESTERN CAPE

5.4. Discussion

The aim of this study was to explore the access barriers to inpatient substance abuse treatment facilities, as perceived by referring agents'. This study reveals that referring agents' find inpatient substance abuse treatment facilities to not be easily accessible as treatment-seekers must overcome innumerable barriers. Specifically, findings indicate that current practices within the substance abuse referral system disadvantage certain subgroups of treatment-seekers.

Due to administrative processes for referrals whereby a residential address is required, the homeless are directly inhibited from being referred to, and thus accessing inpatient treatment services. This is especially problematic given that earlier research has identified substance

abuse as a result of and precursor to homelessness (see Zerger, 2002). Moreover, earlier literature (Wenzel et al., 2001) has established that amongst the homeless substance abuse is widespread, with only a marginal proportion of these individuals accessing the treatment system. In Cape Town, once treatment services are sought, those requiring state-funded inpatient treatment are denied access to these services as they have no fixed residential address. This demonstrates that features of the substance abuse referral system itself preclude access to state-funded inpatient facilities for the homeless, in addition to other barriers they may face.

The subgroup of treatment-seekers with co-morbid psychiatric illnesses (commonplace amongst substance abusers', see Pasche & Stein, 2012) also experience barriers to accessing state-funded treatment services due to constraints of state-funded facilities which require that the psychiatric condition be stabilised prior to entry. This necessitates additional referrals, lending credence to earlier research in Cape Town, that psychiatric services and detoxification services are not widely available to treatment-seekers (Myers et al., 2007).

Pregnant treatment-seekers are another subgroup which referring agents' believe to be disadvantaged by the current substance treatment system. Due to the medical complexities of such pregnancies, together with deficiencies of specialist staff to service these women, pregnant substance abusers' are often denied inpatient treatment services. The larger social consequences are also not to be overlooked, as (in instances where pregnancies result in live births) children, already suffering the consequences of pre-natal exposure to substances will be affected at multiple levels when parented by an (untreated) substance abuser (see Nair, Schuler, Black, Kettinger, & Harrington, 2003).

UNIVERSITY of the
WESTERN CAPE

People with active TB disease, particularly resistant strains thereof, are believed to be another group that is marginalised by the current treatment system. From this study it emerged that no facility is equipped to cater to the needs of these individuals, but also that collaboration between service providers' is lacking. Given the implications of sustained substance abuse on adherence to medication (Farmer, 2005), and risk to others when medication is not complied with (Volmink & Garner, 2009), interventions to address this deficit are needed as a matter of urgency.

Financial/affordability barriers appeared to underpin several other barriers to inpatient services. Treatment-seekers who cannot afford the *"exorbitant fees"* of private facilities are compelled to rely on state-funded treatment facilities (see Myers et al., 2010a). Ultimately, due to the vast number of individuals dependent on these services, lengthy waiting time arises (see Myers et al., 2007; Myers et al., 2010), which in this study was found to exacerbate two features of substance abuse. The fluctuating nature of motivation (Miller, 1999) and progressiveness of substance abuse carries the risk that, should the treatment-seeker continue using substances whilst waiting to enter treatment services (see also Carr et al., 2008), they may succumb to mental illness, be jailed or death. In this way, the harm to individuals and society at large (Wu, 2011) is directly linked to capacity constraints on the part of the substance abuse treatment system (a *context*-related barrier).

This study also found referral system features to preclude access to inpatient treatment services. Referring agents reported that the requirement of social worker reports, (extensive) referral documentation and uninformed staff hinder access to inpatient services. Earlier research by Myers et al. (2007), conducted amongst research and policy makers, local drug action committee members and service providers documented an array of barriers pertaining to referrals within the treatment system. Client eligibility criterion, (i.e. detoxification prior to admission to inpatient facilities, "adequate" motivation and that clients not be court-referred), lengthy waiting time even when having been accepted to inpatient facilities, lack of structure for enacting referrals, the need for social worker reports and the need to detoxification when being referred to inpatient treatment facilities) concluding that these constitute organisational (treatment system) access barriers (Myers et al., 2007).

UNIVERSITY of the
WESTERN CAPE

The multi-faceted nature of barriers identified by referring agents' emphasise the suitability of Bronfenbrenner's PPCT model, the theoretical basis of the study. The PPCT model recognises that various systems of interaction frame our world, and provided a means to locate barriers, ranging from those that pertained to the *person,* to those more distal, *context*-related barriers.

Intrinsic (largely encompassed within *Person*-related) barriers are deemed especially salient in hindering access to treatment (see Xu et al., 2007). In the current study denial and motivation for treatment, gender considerations (i.e. stigma toward women, pregnancy, childcare, lack of treatment centres for females), notions of masculinity, disability, active TB disease, psychiatric co-morbidity and homelessness emerged as *Person*-related factors. These

characteristics together with characteristics of the referral system hindered access to inpatient facilities. As illustration, one study conducted abroad (Wenzel et al., 2001) identified that the homeless are under-served by the substance abuse treatment system. Nonetheless, the current study exhibits that, even in instances where the homeless make contact with the treatment system, should they require a referral to inpatient treatment services, administrative processes (a feature of the treatment system) precludes access as a residential address is required.

The majority of access barriers identified in this study emerged as being *Context*-related. Broadly, this related to the communities within which treatment-seekers reside or sought treatment (e.g. community perceptions, community violence, cultural barriers, linguistic barriers, awareness barriers, finances and competing financial responsibilities, geographical access barriers,), and the treatment system (e.g. waiting time, lack of collaboration, beliefs of service providers, lack of facilities/ resources, inpatient treatment facilities' practices, referral protocol.

UNIVERSITY of the
WESTERN CAPE

Considering the aforementioned barriers related to referrals to inpatient facilities, this study also reveals that the continuum of care, the provision of the most appropriate care in relation to treatment needs, and the ability to access treatment of different levels of intensity, as needed (SAMHSA, 2006) is currently not ensured by the substance abuse treatment system in Cape Town. Clients who enter the substance abuse treatment system at lower levels, and require inpatient treatment services must negotiate several barriers prior to securing access. Together these findings make a cogent argument for a re-evaluation and reform of the current treatment model (and referral system in particular), which appears to have several deficits. This will go a long way to reducing a number of barriers faced by treatment-seekers. This study also demonstrates that initiatives to target access barriers must be instituted at multiple levels (i.e. from targeting communities, to being reflected in policy changes at the Macro-level).

5.5. Recommendations

Grounded on the results of this study, recommendations for interventions that address access barriers to substance abuse treatment are outlined below.

a. **Recommendations for alleviating access barriers relating to the referral system.**

Foremost, interventions to alleviate access barriers related to the referral system should focus upon educating referral agents' as to their role and responsibilities. Secondly, as findings also suggest that the personal beliefs of referring agents' may influence the care rendered, it is critical that initiatives place emphasis on disseminating information about substance use disorders that is evidence based and scientifically-sound, in the form of training for staff. Thirdly, interventions should encompass programme evaluation of the current referral system as a necessary starting point for enacting changes. Finally, consistent with Myers et al. (2007), participants recommend that initiatives should strive to lessen the administrative requirements of referrals to state-funded inpatient treatment facilities.

b. **Recommendations for alleviating awareness-related barriers and negative attitudes.**

As participants expressed that lack of awareness of treatment facilities hindered access to inpatient treatment facilities, initiatives to improve thereupon are imperative. Given that individuals were believed to be unaware of where existing treatment facilities are located, interventions should direct attention to their location, as well as which processes should be followed to gain access. Media advocacy campaigns/ programmes (by way of television advertisements, newspapers and magazine inserts, billboard advertisements, notices and information booklets at libraries, churches and community centres) should be utilised in order to enhance awareness, and also to combat negative attitudes by providing factual information. This mirrors existing recommendations for interventions in Cape Town (Myers et al., 2007) that awareness initiatives should include information on when to seek help for substance use disorders; where help should be sought and how that help can be accessed. Lastly, as it emerged within the current study that black/ African community members were unaware of practices at inpatient centres, providing information in this regard is essential to augment access to these facilities. In particular, participants suggested that inpatient staff members should elucidate the role of inpatient facilities as well as the process of gaining access. Information sessions in this regard should be held at various communal venues.

c. Recommendations for alleviating geographic barriers, affordability barriers and waiting time for access to inpatient treatment facilities. Participants strongly emphasised that initiatives to address barriers to treatment access should focus on the provision of more

outpatient and inpatient state-funded facilities. The establishment of new state-funded facilities will directly address affordability concerns, as treatment will be rendered at no cost, while waiting time for treatment will be reduced due to the treatment system's enhanced capacity. In order to eradicate geographic access barriers, participants suggested that new facilities be located centrally, en route of public transport, and accessible to surrounding suburbs.

d. Recommendations for alleviating cultural and linguistic barriers to inpatient treatment facilities. As findings indicate that cultural and linguistic barriers impede access to inpatient treatment facilities for black/ African communities, recommendations from the referring agent operative in this setting are highlighted. Cultural and linguistic barriers can be attended to through education, and families and communities should be provided with factual information about substance abuse, treatment and recovery principles. Equipped with this information, communities will be better able to engage with the treatment system.

Furthermore, this study participant suggests that more black/ African or indigenous language-speaking staff should be employed at both outpatient and inpatient treatment centres, as imperative to attend to linguistic barriers to treatment. This recommendation concurs with Myers and Parry (2005) who advocate that by employing African language-speaking therapists and rendering multilingual treatment services, cultural and linguistic barriers can be attended to. Likewise Fakier and Myers (2008) reiterate these recommendations, adding that the materials used by treatment programmes should be offered in several languages and ensuring that the treatment/ clinical team comprises of multilingual staff.

e. Recommendations to enhance access to inpatient treatment facilities. Participants in the study recommended that a toll-free helpline be introduced, as a means to facilitate referrals and access to treatment centres, as well as provide another avenue to receive counselling, whether in-or–outpatient in Cape Town. The merits of a telephonic helpline have been recognised in Australia where a 24-hour, seven-day-a-week telephonic substance abuse referral, information and counselling service (DirectLine) is operative. Here community members, substance abusers' or family members of substance abusers' can access support and treatment services while assured of anonymity (Clemens, Cvetkovski & Tyssen, 2005). Such an initiative would therefore also reduced stigma, due to the anonymity it fosters.

UNIVERSITY of the
WESTERN CAPE

5.6. Conclusion

This chapter offered a detailed analysis and interpretation of participants' perceptions of the barriers to accessing inpatient treatment services, offering a discussion thereof. Consistent with earlier scholarship, barriers to accessing substance abuse treatment were found to be pervasive, particularly access barriers to both referring agents and state-funded inpatient treatment services. Barriers identified by participants aligned themselves to two thematic domains: *Person*-related and *Context*-related access barriers, in accord with Bronfenbrenner's PPCT model. Consequently, the participants proposed a number of recommendations for interventions. The subsequent chapter affords a conclusion of the study inclusive of its limitations, and proposed recommendations for interventions to improve access to treatment services.

UNIVERSITY of the
WESTERN CAPE

Chapter Six: Conclusion

This chapter discusses the contributions of the current study. Study limitations and recommendations to enhance access to inpatient treatment services are offered.

6.1. Summary of the study

This study endeavoured to explore the barriers to entering state-funded inpatient substance abuse treatment, from the viewpoint of referring agents in the Western Cape. The impetus for the current study was the absence of South African research on the particular topic, the dearth of knowledge on access barriers to inpatient facilities in extant treatment literature (see Wisdom et al., 2011), together with the researcher's prior experience as a referring agent. The study sought to realise its aim by identifying access barriers to substance abuse treatment, comparing existing access barriers to treatment as identified by prior research and, on the basis of this knowledge, recommend interventions which would enable more individuals to enter into treatment, facilitate referrals to inpatient facilities and render more efficient services. Thus, society at large stands to benefit as more individuals will access treatment and amass its benefits.

Bronfenbrenner's PPCT model was used to understand participants' perceptions. The main premise of this framework, that four interconnected components (*Process*, *Person*, *Context*, *Time*) structure our world, giving emphasis to the interaction between an individual's biological disposition and their environment, and the bi-directional nature of influences, was well-suited to the current study as the participants expressed that barriers to treatment services occurred within and across various settings/ systems (Microsystem, Mesosystem, Exosystem and Macrosystem).

6.2. Summary of findings and conclusions

This study found that state-funded inpatient substance abuse treatment facilities in Cape Town are not easily accessible as treatment-seekers must negotiate multiple barriers. Participants were eager to share their experiences, and the researcher was provided with an in-depth understanding and insight of their perceptions due to the qualitative framework of the study. Using Bronfenbrenner's PPCT Model to frame the data, the two primary findings of the study were that *Person*-related and *Context*-related barriers impede access to inpatient treatment services.

Person-related barriers to treatment services encompassed denial and motivation for treatment, gender (stigma toward women, pregnancy, childcare, lack of treatment centres for females), notions of masculinity, disability, active TB disease, psychiatric co-morbidity and homelessness, respectively. *Context*-related barriers (which include factors within Bronfenbrenner's Microsystem, Mesosystem, Macrosystem and Exosystem) were identified to be community perceptions (stigma, beliefs about addiction and treatment), community violence, cultural barriers, linguistic barriers, awareness barriers, finances and competing financial responsibilities, geographical access barriers, waiting time, lack of collaboration within the treatment system, beliefs of service providers, lack of facilities/ resources within the treatment system, inpatient treatment facilities' practices, referral protocol (social worker reports; referral documentation) and uninformed staff. These barriers are described succinctly in the following sub-sections.

6.3. *Person*-related barriers

a. Denial of the need for treatment services. In the present study, denial and motivation for treatment were found to hamper access to inpatient treatment services. Regarding denial, black/ African communities were reported to view substance abuse as a problem for coloured or white communities, whilst young substance abusers' denied their substance abuse in order to avoid stigma and labelling as an "addict".

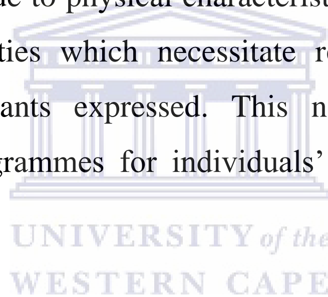
UNIVERSITY of the
WESTERN CAPE

b. Motivation for treatment services. Referring agents' emphasised motivation for treatment as critical to accessing inpatient services, however, as waiting time for treatment increased, motivation decreased, unless intervention occurred. Accordingly referring agents' accentuated the importance of belonging to outpatient treatment programmes. Lack of motivation prohibited referral where referring agents expected clients to verbalise their desire to access inpatient services, as well as in instances where referral agents evaluated that clients required the containment of inpatient services, but clients disagreed.

c. Gender and access to substance abuse treatment. Gender was commonly believed to significantly hamper access to both outpatient and inpatient treatment services, with all but one participant expressing concern about the minimal use of treatment services by women. Female substance abusers often only sought care when children have been removed by authorities, and were believed to be especially subject to stigmatising attitudes. For pregnant substance abusers', resource and capacity considerations at inpatient centres (e.g. the

presence or absence of medical staff to attend to potential medical complexities) as well as current stage of pregnancy was believed to prohibit entry to state-funded inpatient treatment services. Furthermore, childcare considerations were perceived to be a barrier to utilising inpatient services as in the absence of a support network whereby children could be supervised, women had to forego inpatient treatment as this necessitates time away from home. Males generally presented for treatment in higher volumes, participants believed, however, amongst adolescent male substance abusers', notions of masculinity impeded access to treatment services and they were believed to equate substance use with 'fitting in' and belonging.

d. Disability as a barrier to substance abuse treatment. Participants perceived there to be a lack of appropriately-equipped state-funded inpatient facilities which resulted in the failure to provide unbiased access to treatment facilities for PWD. PWD have limited access to inpatient treatment facilities due to physical characteristics of treatment centres as well as the practices at inpatient facilities which necessitate reading skills for engagement in treatment programmes, participants expressed. This not only inhibits access to and engagement with treatment programmes for individuals' with visual constraints, but also potentially for the illiterate.


UNIVERSITY of the
WESTERN CAPE

e. Tuberculosis as a barrier to substance abuse treatment. Active TB disease was believed to prohibit access to inpatient treatment services, and three particular areas of concern in referring TB sufferers were raised: (1) ensuring that medication was available and adhered to; (2) the contagious nature of the disease when managed improperly would place other substance abusers' at these inpatient facilities at risk of contracting TB and (3) that collaboration between various service providers needed to be improved upon to ensure optimal care.

f. Homelessness as a barrier to substance abuse treatment. Although prior research documents that a nominal number of homeless substance abusers' receive substance abuse treatment (see Krahn et al., 2006), eligibility criterion of state-funded inpatient treatment facilities impedes access to inpatient substance abuse treatment in Cape Town, as a residential address is requisite for entry. Furthermore, referring agents' identified only one treatment facility that accommodated homeless substance abusers'.

g. Psychiatric co-morbidity as a barrier to substance abuse treatment. Referring agents' believe that treatment-seekers with psychiatric co-morbidity were unable to be accommodated by state-funded inpatient treatment facilities. Only once stabilised could outpatient treatment facilities accommodate and referring agents' refer to state-funded inpatient treatment facilities.

6.4. *Context*-related barriers

6.4.1. Culture and language as barriers to substance abuse treatment. Study participants believed that too few service providers are fluent in South African indigenous languages, which reduces the efficacy of counselling and referring of black/ African substance abusers'. Cultural considerations were also believed to profoundly influence the likelihood of access to inpatient treatment facilities as these impacted upon (1) decisions to seek treatment; (2) the view taken of addiction (3) the type of treatment that was sought and (4) both access to treatment, and retention, as the absence of suitable staff (to accommodate clients linguistically) was linked to attrition.

6.4.2. Community perceptions as a barrier to substance abuse treatment

UNIVERSITY of the
WESTERN CAPE

a. Stigma. Findings suggest referring agents' awareness that stigma towards substance users' exist. This in turn is believed to serve as a disincentive to accessing treatment services.

b. Beliefs about addiction and treatment. Referring agents' believed that community members have little empathy for substance abusers'. Access to inpatient treatment services were limited by community beliefs and information deficits about inpatient treatment facilities and the care they render. Gangsterism and community violence also impeded access to outpatient treatment centres, and therefore referring agents, as gang territory restricted access to select parts of the community (where treatment services may be located).

c. Awareness of substance abuse treatment. Referring agents' believed that lack of awareness decreased the likelihood of accessing inpatient treatment facilities. Community members exhibited uncertainty about the process of accessing treatment services, and appeared unaware of existing facilities.

6.4.3. Affordability / financial barriers. Findings suggest that every step undertaken in the process of accessing inpatient treatment services is influenced by the financial status treatment-seekers. Foremost, cost considerations determined whether private or state-funded inpatient treatment services were sought. Where clients depended on the State for treatment services, when no money for transportation was available, initial access to referring agents stood to be limited due to the geographic position of sites where they are operative. Extensive waiting time for treatment results from the large number of persons relying on state-funded facilities, and once treatment slots are available, treatment seekers still incur the costs of travelling to these facilities. Financial barriers (Myers et al., 2010a) therefore become the scapegoat for continued use when the cost of treatment cannot be met, participants noted. Additionally, the presence of what Myers et al. (2010a) term *competing financial responsibilities* are suggested as a deterrent to treatment access, giving credence to their assertion that financial constraints impede access to inpatient treatment facilities.

6.4.4. Geographical access barriers (Myers et al., 2010a) were noted by referring agents'. Geographic location of the (already limited) outpatient treatment facilities limited access to referring agents, as they were not conducive to travelling by public transportation or could not be reached in the absence of money for transportation. Treatment-seekers walked far distances (often compromising their safety) or undertook lengthy travelling to reach referring agents'.

UNIVERSITY of the WESTERN CAPE

6.4.5. Waiting lists. Participants reported extensive waiting periods, lasting between 3 and 9 months, to limit access to state-funded treatment facilities. All steps undertaken in the process of reaching state-funded inpatient centres required waiting: access to detoxification services; the processing and assessment of applications and waiting for bed-space to become available.

6.4.6. Lack of collaboration. Participants believed that collaboration and networking amongst service providers were lacking and directly impinged upon enacting referrals, thus hampering access to state-funded inpatient treatment facilities.

6.4.7. Beliefs of service providers. One referring agent appeared to hold stereotypical beliefs of treatment-seekers, based exclusively on the client's substance of choice. This is

concerning as earlier research (see Abed & Neira-Munoz, 1990; Abouyanni et al., 2000; Pasche et al., 2008) has linked the beliefs of service providers to the care they render.

6.4.8. Lack of facilities/ resources within the treatment system. Findings raise concern about the small quantity of outpatient and inpatient facilities, especially state-funded treatment services. Participants mentioned that this lack of treatment facilities exacerbated geographic and financial barriers to treatment as this required travelling to treatment facilities located further away.

6.4.9. Inpatient treatment facilities' practices as a barrier. Participants expressed concern about the practices at state-funded inpatient treatment facilities and suggested that the administrative processes of state-funded inpatient treatment facilities are questionable. Participants reported that inpatient staff did not regard all substances as equally deserving of inpatient treatment. Moreover, it was believed that these facilities failed to communicate administrative needs, which impacted upon the success of referrals, and ultimately determined who gained access to inpatient treatment facilities.

6.4.10. Referral protocol

UNIVERSITY of the
WESTERN CAPE

a. ***Social worker reports as a barrier.*** The requirement of a social worker's report served as a barrier to accessing inpatient treatment services, as certain inpatient treatment facilities gave no consideration to referrals enacted by other referring agents. This requirement appeared to be inconsistently applied within the referral system, however.

b. Referral documentation. The completion of referral administrative requirements was viewed as time-consuming, labour-intensive and 'demoralising'. As some facilities were reported to lose paperwork, completed referral documentation also did not guarantee that the application process was complete. Moreover, findings suggest poor knowledge within the referral system. Referring agents' appear uncertain of their role, which in turn played a role in the care they rendered. Collectively, findings suggest that the referral system, the very means by which access to inpatient treatment facilities is facilitated, acts as a barrier to accessing treatment.

c. Uninformed staff. As uninformed staff were unable to proactively assist clients regarding substance abuse treatment by being able to suggest and facilitate referrals, these individuals also constitute a barrier to accessing state-funded inpatient treatment facilities.

While referring agents' concur with earlier findings, such as the contention that need for treatment is of little consequence to treatment use, as access is determined primarily by the degree to which negative views about treatment are held and barriers to treatment are encountered (Myers et al., 2007), this study is fundamentally different. In exploring access barriers to inpatient facilities from the viewpoint of referring agents', as no earlier research has done, and honing in on inpatient treatment services, the current work has added to extant research, especially as this relates to the South African treatment landscape. Using a qualitative approach allowed comprehensive understanding of participants' perceptions (see (Geertz, 1973; Gelo et al., 2008), aligning itself to the aims and objectives of the current work. Study findings also represent the researcher's interpretations of the information provided by the participants, emphasising the importance of reflexivity. Upon introducing herself to the participants, giving them a brief background of the study and how her interest in the area arose, the researcher needed to be increasingly aware of the manner in which this might influence the course of the interviews. Choosing to disclose this selectively, the researcher found that in all instances where her prior work experience was revealed, the interview process was facilitated, as participants appeared to feel as though she 'understood' the inner dynamics of the treatment system. Thus the questions posed to participants were also more relevant, coming not just from engagement with previous scholarship, but from first-hand experience at ground level. The researcher also reflected on her prior work-related experiences continually, aware that she should not assume that everyone's experience was the same as her experiences; participants were encouraged to lead the session.

UNIVERSITY of the
WESTERN CAPE

6.5. Limitations of the study

It is imperative to consider study findings in light of its limitations. Firstly, it may be argued that qualitative research is limited in terms of the generalizability of its findings. Results of the current study may however be transferable to another context (Anderson, 2010). Secondly, as only one referring agent was operative in a black/ African community setting, the researcher was limited in exploring all the nuances in barriers faced in these settings. Findings of the current study enlighten several stakeholders as to referring agents' perceptions of the barriers to accessing inpatient treatment services. Referring agents'

expressed the need for the institution of various interventions pertaining to the treatment system, referral system and communities at large, accentuating the necessity of multi-level action and collaboration. Importantly, this study also elucidates the need to revisit the continuum of care model, the importance of evaluating the referral system, and enacting reform within the treatment system

UNIVERSITY of the
WESTERN CAPE

References

Abed, R. T., & Neira-Munoz, E. (1990). A survey of general practitioners' opinion and attitude to drug addicts and addiction. *British Journal of Addiction, 85*, 131-136.

Abouyanni, G., Stevens, L. J., Harris, M. F., Wickes, W. A., Ramakrishna, S. S., Ta, E., & Knowlden, S. M. (2000). GP attitudes to managing drug- and alcohol-dependent patients: A reluctant role. *Drug & Alcohol Review, 19* (2), 165-170.

Addis, M.E., Mahalik, J.R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58* (1), 5–14.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders (4th ed., text revision).* Arlington, VA: American Psychiatric Association.

Anderson, C. (2010). Presenting and evaluating Qualitative Research. *American Journal of Pharmaceutical Education, 74* (8), 1-7.

Andersen, R.M. (1995). Revisiting the behavioral model and access to medical care does it matter? *Journal of Health and Social Behavior*, *36*, 1–10.

Appel, P.W., Ellison, A.A., Jansky, H.K. & Oldak, R. (2004). Barriers to enrolment in drug abuse treatment and suggestions for reducing them: Opinions of drug injecting street outreach clients and other system stakeholders. *The American Journal of Drug and Alcohol Abuse, 30*, 129-153.

Au, G. (n.d.). A review of attitude of medical professionals toward substance abuse. Retrieved February 7, 2012 from http://www.nd.gov.hk/en/conference_proceedings/Drugs_proBK_Part2/Drugs_proBK_GraceAu.pdf

Babbie, E. & Mouton, J. (2010). *The practice of social research*. London: Oxford University Press.

Barry, C.A., Britten, N., Barber, N., Bradley, C., & Stevenson, F. (1999). Using reflexivity to optimize teamwork in qualitative research. *Qualitative Health Research 9*, 26.

Boyle, M.J., Williams, B., Brown, T., Molloy, A., McKenna, L., Molloy, E., & Lewis, B. (2010). Attitudes of undergraduate health science students towards patients with intellectual disability, substance abuse, and acute mental illness: A cross-sectional study. *BMC Medical Education*, 10, 71.

Brady, T. M., & Ashley, O. S. (Eds.). (2005). *Women in substance abuse treatment: Results from the Alcohol and Drug Services Study (ADSS)* (DHHS Publication No. SMA 04-3968, Analytic Series A-26). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

UNIVERSITY of the WESTERN CAPE

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3* (2), 77-101.

Bronfenbrenner, U., & Morris, P.A. (2006). The Bio-ecological Model of Human Development. In R.M. Lerner and W. Damon (Ed.), *Theoretical Models of Human Development. Vol. 1 of the Handbook of Child Psychology (5th ed.)* (pp.793- 828). New York: Wiley.

Carr, C. J. A., Xu, J., Redko, C., Lane, D. T., Rapp, R. C., Goris, J., & Carlson, R. G. (2008). Individual and system influences on waiting time for substance abuse treatment. *Journal of Substance Abuse Treatment, 34*(2), 192-201.

Center for Substance Abuse Treatment. Screening for infectious diseases among substance abusers. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). (1993). Treatment Improvement Protocol (TIP) Series, No. 6. Chapter 3- Legal and ethical issues. Retrieved December 28, 2012 from http://www.ncbi.nlm.nih.gov/books/NBK64720/

Center for Substance Abuse Treatment. Substance Use disorder treatment for people with physical and cognitive disabilities. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). (1998). Treatment Improvement Protocol (TIP) Series, No. 29. Chapter 1- Overview of treatment issues. Retrieved November 18, 2012 from http://www.ncbi.nlm.nih.gov/books/NBK64885/

Center for Substance Abuse Treatment. Integrating substance abuse treatment and vocational services. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). (2000). Treatment Improvement Protocol (TIP) Series, No. 38. Chapter 5- Effective referrals and collaborations. Retrieved November 30, 2012 from http://www.ncbi.nlm.nih.gov/books/NBK64299/

Center for Substance Abuse Treatment. Substance Abuse: Clinical Issues in Intensive Outpatient Treatment. Rockville (MD): Substance Abuse and Mental Health Services Administration (US). (2006). Treatment Improvement Protocol (TIP) Series, No. 47. Retrieved March 30, 2013 from http://www.ncbi.nlm.gov/books/NBK64088/

Chersich, M.F., Urban, M., Olivier, L., Davies, L., Chetty, C. & Viljoen, D. (2011). Universal prevention is associated with lower prevalence of Fetal Alcohol Spectrum Disorders in Northern Cape, South Africa: A multicentre before–after study. *Alcohol and Alcoholism, 47* (1), 67–74.

City of Cape Town (South Africa). (2011). Policy Position on Alcohol and Drugs and Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014/ Cape

UNIVERSITY of the WESTERN CAPE

Town: City of Cape Town. Retrieved May 28, 2012 from http://alcoholsouthafrica.files.wordpress.com/2012/04/cape-town-policy-position-on-alcohol-and-drugs-2011-2014.pdf

Clemens, S., Cvetkovski, S., & Tyssen, E. (2005). DirectLine telephone counselling and referral service: What role does it play in the treatment pathway and referral uptake of substance users? Retrieved December 18, 2012 from http://www.health.vic.gov.au/vdapc/archive/directline.pdf

Connors, G.J., DiClemente, C.C., Marden Velasquez, M., & Donovan, D.M. (2013). *Substance abuse treatment and the stages of change: Selecting and planning interventions (2nd ed.)*. New York: The Guilford Press.

Copeland, J. (1997). A qualitative study of barriers to formal treatment among women who self-managed change in addictive behaviors. *Journal of Substance Abuse Treatment, 14* (2), 183-190.

Deiss, R. G., Rodwell, T.C., & Garfein, R.S. (2009). Tuberculosis and illicit drug use: Review and update. *Clinical Infectious Diseases, 48*, 72–82.

dos Santos, M.M.L., Trautmann, F. & Kools, J. (2011). Rapid assessment response (RAR) study: Drug use and health risk – Pretoria. *South Africa Harm Reduction Journal, 8* (14), 1-10.

dos Santos, M.M.L., Rataemane, S.T., Fourie, D., & Trathen, B. (2010). An approach to heroin use disorder intervention within the South African context: A content analysis study. *Substance Abuse Treatment, Prevention, and Policy, 5* (13).

Duncan, N., Bowman, B., Naidoo, A., Pillay, J., Vroos, V. (2007). *Community Psychology*: *Analysis, context and action*. Cape Town: UCT Press.

Ettner, S.L., Huang, D., Evans, E., Ash, D.R., Hardy, M., Jourabchi, M. & Hser, Y. (2006). Benefit– cost in the California Treatment Outcome Project: Does substance abuse treatment “pay for itself”? *Health Services Research*, *41* (1), 192–213.

Fakier, N. & Myers, B. (2008). Audit of substance abuse treatment facilities in Free State, Limpopo, Mpumalanga, North West and Northern Cape (2007- 2008): Technical report. Medical Research Council: Parow.

Farmer, T. (2005). Factors influencing adherence to Tuberculosis Directly Observed Therapy: A review of the literature. Toronto Public Health.

Fisher, S., Myers, B., Parry, P., Weich, L., Morojele, N. & Bhana, A. (2007). Implementation guidelines substance abuse policy. *Substance Misuse: Advocacy, Research and Training*. Retrieved May 20, 2012 from

UNIVERSITY of the WESTERN CAPE

http://d2zmx6mlqh7g3a.cloudfront.net/cdn/farfuture/29B5UwQ9ARt1w0UnY5F51_1_MRFIyK2UrfS4IL2ROUs/mtime:1213013860/files/docs/080603implement.pdf

Foster, J. H., & Onyeukwu, C. (2003). The attitudes of forensic nurses to substance using service users. *Journal of Psychiatric & Mental Health Nursing*, *10* (5), 578.

Freeman, M., & Parry, C. (2006). Alcohol use literature review. Retrieved July 20, 2012 from http://frayintermedia.com/blog/wp-content/uploads/2010/02/Alcohol-Use-Literature-Review.pdf

Friedmann, P.D., Lemon, S.C., Stein, M.D., M, D., & D' Aunno, T. A. (2003). Accessibility of addiction treatment: Results from a national survey of outpatient substance abuse treatment organizations. *Health Services Research, 38* (3), 887- 903.

Gabriel, M., Doiron, R., Arias de Sanchez, G., & Wartman, C. (2010). The research in early child development framework. In R. Doiron & M. Gabriel (Eds.). *Research in early child development in Prince Edward Island: A research monograph* (pp.11-17). Charlottetown, PE: Centre for Education Research, University of Prince Edward Island.

Geertz, C. (1973). Thick description: Toward an interpretive theory of culture. In C. Geertz, *The interpretation of cultures: Selected essays (pp.3- 30)*. New York: Basic Books. Retrieved March 24, 2012 from http://www.alfrehn.com/fahlner/tko/resources/Kultur/Thick-Description.pdf

Gelo, O., Braakmann, D., & Benetka, B. (2008). Quantitative and qualitative research: Beyond the debate. *Integrative Psychological and Behavioral Science, 42*, 266–290.

Gordon, S.M. (2007). *Barriers to treatment for women*. Retrieved December 28, 2011 from http://www.counselormagazine.com/columns-mainmenu-55/27-treatment-strategies-or-protocols/593-barriers-to-treatment-for-women

Goosen, J., Bowley, D.M., Degiannis, E., Plani, F. (2003). Trauma care systems in South Africa. *Injury, International Journal of the Care of the Injured 34*, 704–708.

Gossop, M. (2006). *Treating drug misuse problems: Evidence of effectiveness*. London: National Treatment Agency for Substance Misuse.

Graham, E. (2012). Rising incidence of Fetal Alcohol Syndrome in South Africa. Retrieved October 20, 2012 from www.wsws.org/articles/2012/aug2012/safr-a28.shtml

Green, C.A. (n.d.). Gender and use of substance abuse treatment services. *National Institute on Alcohol Abuse and Alcoholism*. Retrieved March 13, 2012 from http://pubs.niaaa.nih.gov/publications/arh291/55-62.htm

UNIVERSITY of the WESTERN CAPE

Guthmann, D., & Blozis, S.A. (2001). Unique issues faced by deaf individuals entering substance abuse treatment and following discharge. *American Annals of the Deaf, 146* (3), 294 – 303.

Harker Burnhams, N., Dada, S., & Myers, B. (2012). Social services as a point of entry into substance abuse treatment for poor South Africans. *Substance Abuse Treatment Prevention and Policy, 7* (22), 1-10.

Harker Burnhams, N., Myers, B.J., Fakier, N., Parry, C.D.H., & Carelse, J. (2011). Establishing a computerized substance abuse surveillance system for district social workers in the Western Cape Province, South Africa: Methods, successes and challenges. *Drugs-Education Prevention and Policy, 18*(1), 40-46.

Henning, E., Van Rensberg, W., & Smit, B. (2004). *Finding your way in qualitative research*. Pretoria: Van Schaik.

Hensher, M., Price, M., Adomakoh, S. (2006). Referral Hospitals. In D.T. Jamison, J.G. Breman & A.R. Measham et al., (Eds.). *Disease Control Priorities in Developing Countries. (2nd ed.)* (pp. 1229-1243). Washington, DC: World Bank. Retrieved June 20, 2012 from http://www.ncbi.nlm.nih.gov/books/NBK11737/pdf/ch66.pdf

Herman, A.A., Stein, D.J., Seedat, S., Heeringa, S.G., Moomal, H., & Williams, D.R. (2009).The South African Stress and Health (SASH) study: 12-month and lifetime prevalence of common mental disorders. *South African Medical Journal, 99*,339-344.

Howitt, D. (2010). *Introduction to qualitative methods in psychology*. England: Pearson Education Limited.

Injection Drug Users HIV Prevention Factsheet. (2002). Substance abuse treatment for injection drug users: A strategy with many benefits. Retrieved June 18, 2012 from http://www.cdc.gov/idu/facts/TreatmentFin.pdf

Jackson, A., & Shannon, L. (2011). Barriers to receiving substance abuse treatment among rural pregnant women in Kentucky. *Maternal Child Health Journal*. doi: 10.1007/s10995-011-0923-5

Jeewa, A., & Kasiram, M. (2008). Treatment for substance abuse in the 21st century: a South African perspective. *South African Family Practice, 50* (6), 44-44d.

Jessup, M.A., Humphreys, J.C., Brindis, C.D. & Lee, K.A. (2003). Extrinsic barriers to substance abuse treatment among pregnant drug dependent women. *Journal of Drug Issues, 33* (2), 285-304.

Joe, G. W., Simpson, D. D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction, 93,* 117-1190.

UNIVERSITY of the WESTERN CAPE

Johnson, J.M. (2002). In-depth interviewing. In J.F. Gubrium & J.A. Holstein (Eds.), *Handbook of interview research: Context and method*. (pp. 103-120). Thousand Oaks, CA: Sage

Jordan, N., Grissom, G., Alonzo, G., Dietzen, L., Sangsland, S. (2008). Economic benefit of chemical dependency treatment to employers. *Journal of Substance Abuse Treatment*, *34*(3), 311-319.

Jones, R. (2007). Strength of evidence in qualitative research. *Journal of Clinical Epidemiology, 60*, 321- 323.

Lasch, K.E., Marquis, P., Vigneux, M., Abetz, L., Arnould, B., Bayliss, M., Crawford, B., & Rosa, K. (2010). PRO development: Rigorous qualitative research as the crucial foundation. *Quality of Life Research, 19*, 1087–1096.

Leggett, T., Louw, A., & Parry, C. (2011). Drugs and crime in South Africa: A study in three cities. Retrieved June 19, 2012 from http://dspace.cigilibrary.org/jspui/handle/123456789/31468

Leitner, C. (2000). Walking the tightrope. Cultural diversity in the context of European Integration. *Eipascope* 2001/1, 20- 24.

Lincoln, Y.S., & Guba, E.G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage Publications.

Livingston, J.D., Milne, T., Fang, M.L., Amari, E. (2011). The effectiveness of interventions for reducing stigma related to substance use disorders: A systematic review. *Addiction*, *107* (1), 39–50.

Kagee, A., & Delport, T. (2010). Barriers to adherence to antiretroviral treatment. *Journal of Health Psychology, 15* (7), 1001-10011.

Kalichman, S.C., Simbayi, L.C., Kagee, A., Toefy, Y., Jooste, S., Cain, D. & Cherry, C. (2006). Associations of poverty, substance use, and HIV transmission risk behaviors in three South African communities. *Social Science & Medicine*, *62*, 1641-1649.

Krahn, G., Farrell, N., Gabriel, R., & Deck, D. (2006). Access barriers to substance abuse treatment for persons with disabilities: An exploratory study. *Journal of Substance Abuse Treatment, 31* (4), 375-384.

Mays, N., & Pope, C. (2000). Assessing quality in qualitative research. *British Medical Journal, 320*, 50-52.

McCarty, D. (2009).Policy brief on: Substance abuse treatment benefits and costs. Substance Abuse Policy Research Program.

UNIVERSITY of the WESTERN CAPE

McCollister, K.E., & French, M.T. (2003). The relative contribution of outcome domains in the total economic benefit of addiction interventions: A review of first findings. *Addiction*, *98*, 1647–1659.

McIntyre, D., & Gilson, L. (2002). Putting equity in health back on the social policy agenda: Experience from South Africa. *Social Science & Medicine*, *54*, 1637-1656.

McKinstry, J. (2005). Using the Past to Step Forward: Fetal Alcohol Syndrome in the Western Cape Province of South Africa. *American Journal of Public Health, 95* (7), 1097-1099.

McLafferty, S.L. (2003). GIS and health care. *Annual Review of Public Health, 24*, 25–42.

Medical Research Council of South Africa. (2013). Western Cape provincial school survey finds high levels of alcohol and tobacco use, mental health problems, and exposure to violence among learners in grade 8-10 [Press release]. Retrieved from http://www.mrc.ac.za/pressreleases/2013/3press2013.htm

Merriam, S. B. (2009). Qualitative Research: A guide to design and implementation. USA: Wiley & Sons.

Miller, W.R. (1999). Enhancing motivation for change in substance abuse treatment. Treatment Improvement Protocol (TIP) Series 35.

Monaghan, M. (2012). The recent evolution of UK drug strategies: From maintenance to behaviour change? *People, Place & Policy Online, 6* (1), 29-40.

Myers, B. (2004). Technical Report on Audit of Substance Abuse Treatment Facilities in Gauteng (2003-2004). Parow: Medical Research Council.

Myers, B., Fakier, N., Louw J. (2009). Stigma, treatment beliefs, and substance abuse treatment use in historically disadvantaged communities. *African Journal of Psychiatry*, *12*, 218-222.

Myers, B., Harker, N., Fakier, N., Kader, R. & Mazok, C. (2008a). A review of evidence-based interventions for the prevention and treatment of substance use disorders.

Myers, B., Louw, J., & Fakier, N. (2007). *Access to substance abuse treatment in the Cape Town metropole*. Retrieved January 20, 2012 from http://www.sahealthinfo.org/admodule/accessreport.pdf.

Myers, B., Louw, J., & Fakier, N. (2008b). Alcohol and drug abuse: Removing structural barriers to treatment for historically disadvantaged communities in Cape Town. *International Journal of Social Welfare, 17* (2), 156-165.

UNIVERSITY of the
WESTERN CAPE

Myers, B.J., Louw, J., & Pasche, S.C. (2010a). Inequitable access to substance abuse treatment services in Cape Town, South Africa. *Substance Abuse Treatment, Prevention, and Policy, 5*, 28.

Myers, B., Louw, J., & Pasche, S. (2011).Gender differences in barriers to alcohol and other drug treatment in Cape Town, South Africa. *African Journal of Psychiatry, 14* (1), 146-153.

Myers, B. & Parry, C.D.H. (2005). Access to substance abuse treatment services for black South Africans: Findings from audits of specialist treatment facilities in Cape Town and Gauteng. *South African Psychiatry Review, 8,* 15-19.

Myers, B. & Parry, C. (2011). Beyond the rhetoric: Towards a more effective and humane drug policy framework in South Africa. *South African Medical Journal*, *101*,704-706.

Myers, B., Pasche, S., & Adam, M. (2010b).Correlates of substance abuse treatment completion among disadvantaged communities in Cape Town, South Africa. *Substance Abuse Treatment*, *Prevention, and Policy, 5*(1), 3.

Myers, B., Petersen, Z., Kader, R., Parry, C.D.H. (2012). Moving beyond access: Towards a quality-orientated substance abuse treatment system in South Africa. *South African Medical Journal, 102* (8), 667-668.

Naidoo, Y. (2010, October 1). *Social workers burdened by drug abuse*. West Cape News. Retrieved March 10, 2012 from http://westcapenews.com/?p=2270.

Nair, P., Schuler, M.E., Black, M.M., Kettinger, L., & Harrington, B. (2003). Cumulative environmental risk in substance abusing women: Early intervention, parenting stress, child abuse potential and child development. *Child Abuse & Neglect 27*, 997–1017.

National Center for Health Statistics. Health, United States. (2009).

National Treatment Agency for Substance Misuse. (2006). Models of care for treatment of adult drug misusers updated. London: NTA Publications.

National Institute on Drug Abuse (NIDA). (2009). *Principles of drug addiction treatment: A research-based guide (2nd ed.).*National Institute of Health. Washington.

National Institute on Drug Abuse (NIDA). (1999). *Principles of drug addiction treatment: A research-based guide (3rd ed.).* National Institute of Health. Washington. Retrieved June 12, 2012 from http://www.drugabuse.gov/sites/default/files/podat_1.pdf

Paquette, D., & Ryan, J. (2001). *Bronfenbrenner's ecological systems theory.* Retrieved March 10, 2012 from http://pt3.nl.edu/paquetteryanwebquest.pdf#search=%22ecological%20theory%22

UNIVERSITY of the
WESTERN CAPE

Parker, M.B., Wills, J. & Wills, G.B. (2010). Reconstructed Living Lab: Supporting drug users and families through co-operative counselling using mobile phone technology. *South African Family Practice, 52*(3), 245-248.

Parry, C., Plüddemann, A., & Bhana, A. (2009). Monitoring alcohol and drug abuse trends in South Africa (1996- 2006): Reflections on treatment demand trends. *Contemporary Drug Problems, 36,* 685-703.

Parry, C., & Pithey, A. (2006). Risk behaviour and HIV among drug-using populations in South Africa. *African Journal of Drug and Alcohol Studies, 5* (2), 139-156.

Parry, C.D.H., Plüddemann, A., Louw, A., & Leggett, T. (2004).The 3-metros study of drugs and crime in South Africa: Findings and policy implications. *American Journal of Drug and Alcohol Abuse*, *30*(1), 167-185.

Parthasarathy, S., Weisner, C., Hu, T., & Moore, T. (2001). Association of outpatient alcohol and drug treatment with health care utilization and cost: Revisiting the offset hypothesis. *Journal of Studies on Alcohol and Drugs, 62* (1), 89–97.

Pasche, S. & Myers, B. (2012). Substance misuse trends in South Africa. *Human Psychopharmacology: Clinical and Experimental, 27*, 338-341

Pasche, S.C., & Stein, D.J. (2012). Dealing with substance use disorders in general practice. *South African Family Practice, 54*(5), 404-407.

Pasche, S., Myers, B. & Louw, J. (2008). Staff attitudes and services provided by community-based organizations for alcohol and other drug users in Cape Town, South Africa: Implications for training and education. *Drugs: Education, Prevention and Policy, 15* (6), 532–544.

Peltzer, K., & Ramlagan, S. (2009). Alcohol use trends in South Africa. *Journal of Social Science, 18* (1), 1-12.

Peltzer, K., Ramlagan, S., Johnson, B.D., Phaswana-Mafuya, N. (2010). Illicit drug use and treatment in South Africa: A review. Substance Use and Misuse, 45 (13), 2221-43.

Perron, B.E., Mowbray, O.P., Glass, J.E., Delva, J., Vaughn, M.G., & Howard, M.O. (2009). Differences in service utilization and barriers among Blacks, Hispanics, and Whites with drug use disorders. *Substance Abuse Treatment, Prevention, and Policy*, *4* (3) doi: 10.1186/1747-597X-4-3

Plüddemann, A., Myers, B., & Parry, C.D.H. (2008). Surge in methamphetamine use in young people in Cape Town, South Africa: Implications for public health. *Drug and Alcohol Review, 27,* 185-189.

UNIVERSITY of the WESTERN CAPE

Plüddemann, A., Parry, C., Donson, H., & Sukhai, A. (2004). Alcohol use and trauma in Cape Town, Durban, and Port Elizabeth, South Africa: 1999-2001. *Injury Control and Safety Promotion, 11*(4), 265-267.

Provincial Government of the Western Cape. (2010). Blueprint: Workstream on the prevention and treatment of harmful alcohol and other drug use.

Rapp, R.C., Xu, J., Carr, C., Lane, T., Wang, J. & Carlson, R. (2006). Treatment barriers identified by substance abusers assessed at a centralized intake unit. *Journal of Substance Abuse Treat*ment, *30*(3), 227–235.

Richmond, I. C., & Foster, J. H. (2003). Negative attitudes towards people with co-morbid mental health and substance misuse problems: An investigation of mental health professionals. *Journal of Mental Health, 12* (4), 393-403.

Rieckmann, T., Kovas, A.E. & Rutkowski, B. A. (2010). Adoption of medications in substance abuse treatment: Priorities and strategies of single state authorities. *Journal of Psychoactive Drugs, SARC Supplement 6,* 227-238

Rinn, W., Desai, N., Rosenblatt, H., & Gastfriend, D.R. (2002). Addiction denial and cognitive dysfunction: A preliminary investigation. *The Journal of Neuropychiatry and Clinical Neurosciences,14*, 52- 57.

Rodrigues, A. (2006). Serving culturally diverse communities in South African public libraries. *Libri*, *56*, 213-226.

Sandelowski, M., & Barroso, J. (2002). Finding the findings in qualitative studies. *Journal of Nursing Scholarship, 34*(3), 213- 220.

Sanders, D., & Chopra, M. (2006). Key challenges to achieving health for all in an inequitable society: The case of South Africa. *American Journal of Public Health*, 96, 73-78.

Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S., & Ratele, K. (2009).Health in South Africa 5 Violence and injuries in South Africa: Prioritising an agenda for prevention. Retrieved March 10, 2012 from http://www.mrc.ac.za/crime/lancet.pdf

Shand, F.L., & Mattick, R.P. (2001). *Clients of treatment service agencies: May 2001 census findings.* Sydney: Australia.

Sobell, M.B., & Sobell, L.C. (1998). Guiding self-change. Retrieved June 10, 2012 from http://dionysus.psych.wisc.edu/lit/articles/SobellM1998a.pdf

Sodano, R., Watson, D, W., Rataemane, S., Rataemane, L., Ntlhe, N. & Rawson, R. (2010). The substance abuse treatment workforce of South Africa. *International Journal of Mental Health Addiction, 8*, 608–615.

UNIVERSITY of the
WESTERN CAPE

Sorsdahl, K., Stein, D., & Myers, B. (2012). Substance use disorders in South Africa: Variation across substance and by gender. *BMC Psychiatry, 12* (101), 1- 8.

South African Community Epidemiology Network on Drug Use (SACENDU). Monitoring Alcohol and Drug Abuse Treatment Admissions in South Africa. Phase 29, July to December 2010. Cape Town: SACENDU, 2011.

South African Community Epidemiology Network on Drug Use (SACENDU). Monitoring Alcohol and Drug Abuse Treatment Admissions in South Africa. Phase 31, July to December 2011. Cape Town: SACENDU, 2012.

South African National Department of Social Development. (2005). *Minimum norms and standards for inpatient treatment centres*. Pretoria, South Africa.

South African National Department of Social Development. (2006-2011). National Drug Master Plan 2006-2011. Retrieved January 18, 2012 from http://www.dsd.gov.za

South African National Department of Social Development. (2008). Prevention of and Treatment for Substance Abuse bill. Retrieved May 11, 2012 from http://www.dsd.gov.za

South African National Department of Social Development (2011-2014). Anti-substance abuse programme of action. Retrieved May 11, 2012 from http://www.dsd.gov.za

Sparkes, A.C. (2001). Myth 94: Qualitative health researchers will agree about validity. *Qualitative Health Research, 11*, 538-552.

Statistics South Africa. (2009). South Africa: Mid-year population estimates 2009. Retrieved May, 2012 from http://www.statsonline.gov.za/PublicationsHTML/P03022009/html/P03022009.html

Statistical Reform in South Africa. Retrieved June 19, 2012 from http://www.statssa.gov.za/nss/index.asp?link=about.asp

Stratton, P. & Hayes, N. (1993). A student's dictionary of psychology (2nd ed.). New York: Edward Arnold .

Swick, K.J., & Williams, R.D. (2006). An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal, 33*, 371-378.

Terre Blanche, M., Durrheim, K., & Painter, D. (2006). *Research in practice* (2nd ed.). Cape Town: University of Cape Town Press.

Tucker, J.S., Wenzel, S.L., Golinelli, D., Zhou, A., & Green, H.D. (2011). Predictors of substance abuse treatment need and receipt among homeless women. *Substance Abuse Treatment, 40*(3), 287–294.

UNIVERSITY of the WESTERN CAPE

Tucker, J.A., Vuchinich, R.E., & Rippens, P.D. (2004). A factor analytic study of influences on patterns of help-seeking among treated and untreated alcohol dependent persons. *Journal of Substance Abuse Treatment*, *26*, 237–242.

Tudge, J., Mokrova, I., Hatfield, B., & Karnik, R. (n.d.). Uses and misuses of Bronfenbrenner's bioecological theory of human development. Bronfenbrenner's Theory.

United Nations Office on Drugs and Crime (UNODC). (2003). Drug abuse treatment and rehabilitation: A practical planning and implementation guide. Drug Abuse Treatment Toolkit. Retrieved March 20, 2012 from http://www.unodc.org/docs/treatment/Guide_E.pdf

United Nations Office on Drugs and Crime (UNODC), World Drug Report 2011 (United Nations Publication, Sales No. E.11.XI.10). Retrieved February 19, 2012 from http://www.unodc.org/documents/data-and-analysis/WDR2011/World_Drug_ Report_ 2011_ebook.pdf

U.S. Department of Health and Human Services. (2009). Cost Offset of Treatment Services Joint United Nations Programme on HIV/AIDS (UNAIDS) [2010]. UNAIDS Outcome Framework: Business Case 2009–2011.

U.S. Department of Health and Human Services. (2001). Mental health: Culture, race, and ethnicity-A supplement to mental health: A report of the surgeon general. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services.

van Heerden, M.S., Grimsrud, A.T., Seedat, S., Myer, L., Williams, D.R., & Stein, D.J. (2009). Patterns of substance use in South Africa: Results from the South African Stress and Health study. *South African Medical Journal,* 99, 358-366.

Visser, M. (Ed.). (2007). *Contextualising Community Psychology in South Africa*. Van Schaik Publishers.

Volmink, J., & Garner, P. (2006). Directly observed therapy for treating tuberculosis. *Cochrane Database of Systematic Reviews, 4*, 1- 29.

Ward, C.L., Artz, L., Berg, J., Boonzaier, F., Crawford-Browne, S., Dawes, A.,... van der Spuy, E. (2012). Violence, violence prevention, and safety: A research agenda for South Africa. *South African Medical Journal, 102*, 218-224.

Weich, L., & Pienaar, W. (2009). Occurrence of comorbid substance use disorders among acute psychiatric inpatients at Stikland Hospital in the Western Cape, South Africa. *African Journal of Psychiatry, 12*, 213-217.

UNIVERSITY of the
WESTERN CAPE

Wenzel, S. L., Burnham, M.A., Koegel, P., Morton, S.C., Miu, A., Jinnett, K.J., & Greer Sullivan, J. (2001). Access to inpatient or residential substance abuse treatment among homeless adults with alcohol or other drug use disorders. *Medical Care, 39* (11), 1158-1169.

Western Cape government substance abuse treatment centres. (n.d). Retrieved March 17, 2012 from http://www.westerncape.gov.za/eng/directories/facilities/152873

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Wisdom, J.P., Cavaleri, M., Gogel, L., & Nacht, M. (2011). Barriers and facilitators to adolescent drug treatment: Youth, family, and staff reports. *Addiction Research and Theory, 19* (2): 179– 188.

Woodward, A. (2008). Chapter 2: Access to substance abuse treatment and health services: A literature review. Retrieved 20 October 2012 from http://www.samhsa.gov/data/hsr/ch2.htm

World Health Organisation. (1993). National drug and alcohol treatment responses in 23 countries. Results of a key informant survey. Geneva: WHO, Department of Mental Health and Substance Abuse.

World Health Organization (2000). *Primary prevention of substance abuse: A workbook for project operators*. Retrieved February 11, 2012 from http://www.who.int/substance_abuse/activities/global_initiative/en/primary_prevention_guide_17.pdf

World Health Organization (2008). Principles of drug dependence treatment.

Wu, L. (2010). Substance abuse and rehabilitation: Responding to the global burden of diseases attributable to substance abuse. *Substance Abuse Rehabilitation*, *1*, 5–11.

Xu, J., Wang, J., Rapp, R.C., & Carlson, RG. (2007). The Multidimensional Structure of Internal Barriers to Substance Abuse Treatment and Its Invariance Across Gender, Ethnicity, and Age. *Journal of Drug Issues, 37*(2): 321–340.

Young, N.K. (2006). Integrating substance abuse treatment and vocational services. *Treatment Improvement Protocol (TIP) Series,* 38 Retrieved October 19, 2012 from http://www.ncbi.nlm.nih.gov/books/NBK64287/pdf/TOC.pdf

Yu, B., & Singh, M.P. (2003). Searching Social Networks. Proceedings of the second international joint conference on autonomous agents and multi-agent Systems (AAMAS) 03. DOI: 10.1145/860575.860587

UNIVERSITY of the WESTERN CAPE

Zarkin, G.A., Dunlap, L.J., Hicks, K.A., & Mamo, D. (2005). Benefits and costs of methadone treatment: Results from a lifetime simulation model. *Health Economics*, *14*, 1133–1150.

Zerger, S. (2002). Substance abuse treatment: What works for homeless people? A review of the literature.

Department of Psychology

University of the Western Cape
Private Bag X 17
Bellville
7535
Tel: 27 21 959 2283

INFORMATION SHEET

Project Title: Referring agents' perceptions of access barriers to inpatient substance abuse treatment centres in the Western Cape

What is this study about?

This is a research project being conducted by Deborah Isobell at the University of the Western Cape. I am inviting you to participate in this research project because you facilitate the referral process for individuals' who seek access to inpatient treatment for substance abuse. The purpose of this research project is to explore the barriers to entering inpatient substance abuse treatment, as identified by referring agents in the Western Cape.

What will I be asked to do if I agree to participate?

You will be asked to participate in an interview. This interview will ask questions about your perceptions of barriers to accessing inpatient substance abuse treatment services. Interviews will take place at your workplace and will last between 60 – 90 minutes in duration.

Would my participation in this study be kept confidential?

I will do my best to keep your personal information confidential. To help protect your confidentiality, transcripts of interviews will be numbered randomly in order to ensure the anonymity of obtained information. Audio-recordings and transcripts will be securely stored, able to be accessed only by the researcher and supervisor. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

There are no known risks associated with participating in this research project.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about barriers to accessing inpatient substance abuse treatment services from the perspective of referring agents. It is hoped that, in the future, others might benefit from this study through improved understanding of these barriers to substance abuse treatment access.

UNIVERSITY of the
WESTERN CAPE

Findings from the study will inform interventions aimed at improving access to treatment services.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

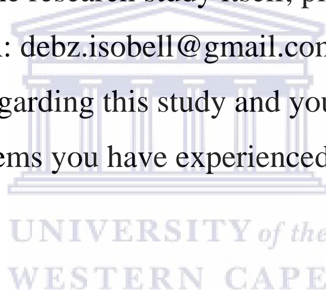
Is any assistance available if I am negatively affected by participating in this study?

In this study every effort has been taken to prevent you from any harm. You will however be provided with information to seek assistance such as counselling should you be affected in any way by the questions asked.

What if I have questions?

This research is being conducted by ***Deborah Isobell*** at the University of the Western Cape. If you have any questions about the research study itself, please contact Deborah Isobell at: 071 855 3762/ 0788872917 Email: debz.isobell@gmail.com .

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:


UNIVERSITY of the
WESTERN CAPE

Head of Department:

Dean of the Faculty of Community and Health Sciences:

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the University of the Western Cape's Senate Research Committee and Ethics Committee.

Department of Psychology

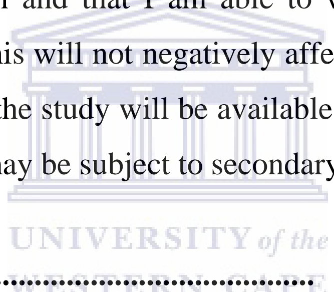
University of the Western Cape
Private Bag X 17
Bellville
7535
Tel: 27 21 959 2283

CONSENT FORM

DEAR PARTICIPANT

Title of Research Project: Referring agents' perceptions of access barriers to inpatient substance abuse treatment centres in the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be made known and that I am able to withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I acknowledge that information obtained during the study will be available to the study supervisor. I am also aware that findings of the study may be subject to secondary analysis or be published.



Participant's name………………………………………………

Participant's signature…………………………………………………

Date………………………

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Miss D. Isobell

Supervisor: Mr. K. Kamaloodien

University of the Western Cape

Private Bag X17, Belville 7535

Telephone: (021) 9592283

Contact number: 0788872917

Email: 2636988@uwc.ac.za

Interview schedule

- **Because you find employment in the substance abuse treatment system, I'd like to know your thoughts on accessing inpatient treatment for substance abuse, and what you perceive to be barriers to entering such treatment. I am interested to hear what your experiences have been, so feel free to include any of these when you answer.**
- **Perhaps you can start by briefly just telling me what your: professional title is, and for (2) how long you've fulfilled this role?**

I'd like to start by speaking about the Substance Abuse Treatment System…..Firstly,

1. How does the substance abuse treatment system operate in the Western Cape? (Inpatient versus outpatient care; private versus state-funded treatment services).
2. In your opinion, what are the **strengths** of this treatment system?
3. What are the **weaknesses** of this treatment system?
4. Within your context, do you consider the substance abuse **treatment system** to be **effective**? Please elaborate

Procedure for gaining entry into residential/ inpatient treatment facilities

WESTERN CAPE

5. If a person were interested in seeking treatment for their substance use disorder, how would they go about doing so? Could you briefly outline this step-by-step process?(**Outpatient and inpatient care**)
6. How are individuals with your job title/ job description instrumental in this process?

Barriers to substance abuse treatment entry

7. In your experience, are there any factors or events that serve as barriers to entering into inpatient substance abuse treatment facilities? (Geographical-accessibility barriers, awareness-related barriers, affordability accessibility barriers, waiting lists, stigma, and gender).
8. Are these factors characteristics inherent of the treatment system or individuals? (Demographic factors/ admission requirements).
9. Are there any individuals you do not refer to treatment? Why is that?
10. Typically, which individuals or subgroups come here in need of help?

Enabling factors to treatment entry

11. Are you able to identify any factors that ease the process of entering into inpatient substance abuse treatment centres? Are these factors related to individuals or the treatment system?
12. Do you perceive that all individuals in need of inpatient substance abuse treatment are ultimately able to access the aid they need? Elaborate
13. What would you suggest be changed or put in place to make accessing inpatient treatment easier?

Service Provider

14. In your opinion/ experience, is substance abuse a treatable illness? Could you briefly elaborate?
15. Is there anything you'd like to add that I may have neglected to ask about accessing inpatient treatment?

UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

27 June 2012

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by: Ms D Isobell (Psychology)

Research Project:	Referring agents' perceptions of access barriers to in-patient substance abuse treatment centres in the Western Cape.
Registration no:	12/4/14

UNIVERSITY of the
WESTERN CAPE

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Private Bag X17, Bellville 7535, South Africa
T: +27 21 959 2988/2948 . F: +27 21 959 3170
E: pjosias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge