Exploring the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town

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A mini-thesis submitted in partial fulfillment of the requirements for the degree of Master in Public Health at the School of Public Health, University of the Western Cape

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ABSTRACT

Substance abuse has become a significant public health concern in South Africa, more specifically in the Western Cape province. This has become a source of great alarm as South African Police Service (SAPS) statistics show that 80% of the crimes committed in the Western Cape are related to substance abuse. The Western Cape was the province that reported the highest number of persons treated during the 2008-2010 period. During the period January to June 2016, there were 2,976 admissions across all treatment centres in the Western Cape, which was a slight increase compared to the 2,674 admissions during the previous six-month review period. It has also been reported that substance abuse has increased the burden on an already challenged primary health care system in South Africa. The proportion of new treatment admissions amounted to 71% of all admissions during the period 2015-2019.

An issue of great concern is that substance abuse is under-recognised in primary care settings, particularly amongst women, for whom treatment is considered more complicated and difficult. The design of rehabilitation services for women needs to be revisited, and the resources required to reduce the challenges and gaps within these services need to be specified.

This study therefore aimed to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town.

The objectives of this study were: (i) to explore the perceptions of staff regarding the logistical challenges experienced at a rehabilitation centre; (ii) to explore the treatment strategies available for women at a rehabilitation centre; (iii) to identify the specific needs versus resources required within rehabilitative services for women with substance abuse disorder; and (iv) to provide recommendations to rehabilitation centres pertaining to services offered to women.

The study used a qualitative research design. Eight employees were purposefully selected from a substance abuse rehabilitation centre in Cape Town and data was collected using semi-structured interviews. Data was analysed using Atlas.ti, a useful program for analysing large sections of text, visual and audio data. Texts were analysed and interpreted using coding and annotating activities. The data was transcribed, coded, stored in a file, and saved in a drive protected by a password. The information will be discarded after a period of five years.

Guba and Lincoln’s guidelines for ensuring rigour in qualitative studies were followed and the ethical principles of informed consent, nonmaleficence, authenticity of data and anonymity

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were maintained throughout the study. Permission to conduct the study was obtained from the University of the Western Cape's Humanities and Social Sciences Research Ethics Committee, as well as the management at the rehabilitation facility, and representatives from the Department of Health.

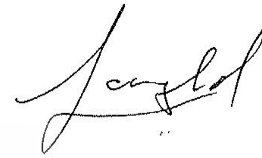
The main findings highlighted gaps pertaining to the entrepreneurial and skills training offered to women clients of the substance abuse centre. This is closely related to aftercare treatment success and reducing the chances of repeating the cycle of domestic abuse, which in turn increases substance abuse. Intense aftercare programmes within treatment programmes to encourage the sustainability of the treatment model were found to be important. Furthermore, a need was identified to develop additional facilities that focus on assisting women who are victims of both gender-based violence (GBV) and those who abuse substances, as these two factors are fundamentally linked. The lack of funding, as well as the manner in which funding was allocated, were highlighted as additional challenges affecting the sustainability of treatment programmes. The study also highlighted the need for treatment facilities to be fully equipped to assist women with mental health issues, as a definite link exists between GBV, substance abuse and mental health. While acknowledging that the relevance of this study is limited to its specific context, the research has highlighted important aspects that could be explored in more depth in future studies.

Keywords: Substance abuse; management; women; treatment; primary health care; social determinants of health; rehabilitation; coping; services; qualitative research

DECLARATION

I declare that the qualitative study, exploring the perceptions of staff regarding the services offered at a rehabilitation centre for women in Cape Town, is my own work, that it has not been submitted for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged by complete references.

Liane Langeveld November 2020



Signature …………………..

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First and foremost, I would like to thank God our Father for carrying me through this process. Lord, you have given me the strength, guidance and support I needed to complete this qualification during a very challenging time in my life.

I can do everything through him who gives me strength. Philippians 4:13

Commit to the Lord whatever you do, and your plans will succeed. Proverbs: 16:3

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To my family and friends, thank you for your continuous prayers and care.

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CHAPTER 1

INTRODUCTION

Substance abuse has become a significant public health concern in South Africa, more specifically in the Western Cape province (Sorsdahl et al., 2012; Strebel et al., 2013). This has become a source of great concern as South African Police Service (SAPS) statistics show that 80% of the crimes committed in the Western Cape are related to substance abuse. Moreover, substance abuse has severe psychological and social consequences, as well as negative impacts on family relationships, occupational functioning, schooling and physical health (Hawkins, Catalano and Miller, 1992).

Globally, substance abuse has had a profound impact on society and public health and safety. The substance abuse problem is complex and addressing it requires a comprehensive approach, with a specific focus on treatment services for women. This chapter introduces the study by setting its context. It also provides insight into the substance abuse problem as a public health concern in South Africa, and relevant implications for treatment.

1.1 Understanding substance abuse and its trajectory

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Over the last decade, there has been a diversification of the substances available on the drug markets, from traditional plant-based substances like cannabis, cocaine and heroin, to synthetic drugs and the non-medical use of prescription medicines. The increase in availability of more potent drugs and the increasing number of substances over time poses a greater risk globally (UNODC, 2018).

The World Drug Report (UNODC, 2018) has indicated that 35 million people worldwide suffer from drug use disorders while only one in seven people receive treatment. Additionally, an estimated 585,000 people died as a result of drug use in 2017. In the same year, the

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prevalence of drug use disorders (0.71%) was higher than previously estimated (0.62% in 2016), corresponding to a change in the estimated number of people suffering from drug use disorders from 30.5 million to 35.0 million. Moreover, the largest quantities of drugs seized globally in 2017 continued to be cannabis, followed by coca and cocaine-related substances, opioids, new psychoactive substances (NPSs) and amphetamine-type substances (ATSs) (mostly methamphetamine).

While the direct cost of substance abuse in South Africa is unknown, international data estimates this to be 6.4% of the Gross Domestic Product (GDP), or approximately R136,380 million annually (Naledi, 2016). The drug abuse surveillance and monitoring system reported that alcohol remained the dominant substance used in the Eastern Cape (EC) and KwaZulu-Natal (KZN) and caused the biggest burden of harm in terms of both communicable and non-communicable diseases. Methamphetamine (MA) remained the most common primary drug reported by patients in the Western Cape (SACENDU, 2018).

Although provincial variations are evident, a higher proportion of persons who admitted suffering from hypertension and mental health problems were found in the Western Cape, accounting for 37% of those reporting dual diagnosis (SACENDU, 2018). Previous reports by the Western Cape government (2015), for the period 2002 to 2004 showed that the province had the second highest twelve-month prevalence rate for substance use disorders in the country. In addition, most dual-diagnosis service users admitted to substance abuse treatment facilities reported mental health problems, with a higher proportion found in the Western Cape (Dada et al., 2014).

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Moreover, prevention and treatment continue to fall far short of needs in many parts of the world, thereby representing a major impediment to achieving the Sustainable Development Goals and fulfilling the international community’s pledge to leave no one behind (UNODC, 2018). On the basis of data from treatment sites across the six regions of South Africa covering the period from July to December 2017, between 29% and 56% of those in treatment had cannabis as the primary drug of concern. Having said this, according to the South African Community Epidemiology Network on Drug Abuse (SACENDU), the Western Cape reported the second highest number of persons treated between January and June 2018. It can also be noted that, although males continue to dominate patient intake, the number of females who abuse substances has increased since 2016 (SACENDU, 2019).

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According to the National Drug Master Plan (NDMP) 2013-2017 (Department of Social Development, 2013), substance abuse has become a significant public health concern in South Africa, more specifically in the Western Cape where 3,182 patients were treated across 35 specialist treatment centres, dominated by male admissions (SACENDU, 2019).

1.2 Substance abuse in the context of economic disenfranchisement

Although South Africa has shown some progress since the first democratic elections in 1994, many of its people continue to be confronted with the challenge of living in a society characterised by economic and social inequality. Apartheid divided South African society on the basis of race and ethnicity, segmenting the nation spatially, politically, and economically (Penedo, 2014). As recognised in previous studies, inequalities of this nature have a negative impact on one's health and behaviour. This impact is experienced through environmental exposures such as extreme poverty and through psychosocial mechanisms such as substance abuse, related to one's social position (Pampel, Kruege andDenney, 2010).

Moreover, the drug economy and the behavioural effects of substance abuse are closely associated with social fragmentation, crime, and conflict. In this case, social fragmentation refers to poverty, low levels of educational attainment and high unemployment rates (Parry et al., 2011). According to Pampel, Kruege and Denney (2010), persons who are economically deprived and living in disadvantaged communities face a variety of chronic stressors in their daily lives. Gangsterism, community violence, gender-based and intimate partner violence are, but a few examples of the threats that face residents residing in lower socio-economic communities (Parry et al., 2011). In addition to battling to make ends meet, individuals who are economically deprivedhave few opportunities to achieve positive goals; thus they experience more negative life events such as unemployment, marital disruption and financial loss, and must deal with discrimination, marginalisation, isolation and powerlessness. These stressors can trigger a host of unhealthy behaviours, such as overeating, drinking and smoking, with women becoming the silent victims (Cormier, Dell and Poole, 2004). Consequently, the effects of poverty that many Western Cape residents continue to face daily has led to the increased prevalence of substance abuse in the province. In the presence of such stressors, substances are often used as a coping strategy (Parry et al., 2011). Additionally, it can be noted that the percentage of GBV cases has increased globally and in South Africa since 2001, impacting negatively on the current public health system (Dunkle et al., 2004).

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Studies have indicated that substance abuse among female populations specifically is likely intertwined with psychological reactions to violence (Lehavot and Simoni, 2011). The fact that women have been found to be at greater risk for experiencing traumas such as intimate partner violence and rape also makes them more vulnerable to misusing substances (Carr and Szymanski, 2011; Hawkins, Catalano and Miller, 1992).

1.3 Substance abuse rehabilitation for women and the perceptions of staff

Whilst limited information is available about the prevalence of the components of substance abuse treatment programming for women, services are also not clearly defined. The services offered may be available to only a limited number of clients because of restricted resources (Center for Behavioral Health Statistics and Quality, 2018). Also, little is known about how employers communicate about or manage these problems (Room, Babor and Rehm, 2005).

There are few comparative studies related to urban contexts. Rural areas often lack options for specialised substance abuse treatment services such as those tailored to women or racial minorities, which may discourage vulnerable, underserved populations to seek treatment (Carr and Szymanski, 2011). Many gaps can easily be overcome by getting information from individuals who not only work closely with these clients but are at the forefront of designing and executing these rehabilitative services. More research is required that looks at improving current rehabilitation services for women, informed by the perceptions of staff regarding challenges and gaps within these services.

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1.4 Problem Statement

Previous research conducted in South Africa shows that there has been an increase in the treatment demand for substance-related problems in large metropolitan areas such as Cape Town. Many of the inpatients in these substance abuse centres come from impoverished community settings characterised by violence, poverty, low education and substance abuse (Parry, Myers and Plüddemann, 2004).

With multifaceted causes of substance abuse, treatment and services become imperative. Treatment is not a cure-all for substance abuse problems; however, the rehabilitation of service users stands to alleviate some of the social challenges associated with substance use. According to Lopes (2013), women are more than likely to be unemployed and consequently

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would not be able to afford treatment at a private treatment centre. They would be more likely to be dependent on state-funded treatment centres, which are limited.

The Prevention of and Treatment for Substance Abuse Act No. 70 of 2008 (South Africa, 2008) promotes accessibility of services, with specific emphasis on vulnerable groups, namely women, children, youth and the disabled. Despite this, the results of historical disenfranchisement are evident in the scarcity of substance abuse treatment services in disadvantaged communities (Parry, Myers and Plüddemann, 2004). The unequal distribution of services continues to affect South Africans, despite the proliferation of policies geared towards redressing these inequalities post 1994. Parry, Myers and Plüddemann (2004), found that black South Africans are under-represented in specialist substance abuse treatment facilities in Cape Town and the Gauteng province.

Having said that, Carr and Szymanski (2011) stipulate that women are also less likely than men to enter any type of treatment facility because of the barriers they confront in their lives. Such barriers include the lack of childcare, fear of stigma, lack of family or financial support, denial, and co-occurring disorders. Additionally, studies have found that women, referred to as hidden users, do not access outpatient treatment due to having to fulfil traditional gender roles and due to stigma associated with women who use drugs (Elbreder, De Humerez, and Laranjeira, 2009; Guerrero et al., 2014; Sorsdahl et al., 2012). Literature strongly suggests that the economic consequences of accessing treatment have a significantly more adverse impact on female users accessing treatment as opposed to males.

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Research has shown that the quality of the relationship between a client and treatment providers influences the likelihood of treatment success (Room, Babor and Rehm, 2005). While it is not possible for a prospective client to know what the dynamic will be like with any given staff member, a professional atmosphere can lay the groundwork for trust, which is a key ingredient of success in treatment. Thus, the therapeutic alliance between the service provider and client could strengthen the patient's engagement and provide benefits to treatment. In a study conducted in a residential treatment programme, Miller (2008) found the therapeutic alliance to be a strong predictor of length of retention. If the client's subjective sense of wellbeing was realised, it was likely that they would remain in treatment.

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The government has introduced strategies such as the National Drug Master Plan (NDMP) (Department of Social Development, 2014) and the City of Cape Town Alcohol and other Drug Harm Minimization and Mitigation Strategy 2011-2014 (City of Cape Town, 2011) to reduce and prevent substance abuse; however, there is limited information about the management of rehabilitative services for women and particularly the perceptions of staff managing rehabilitative services for women (Room, Babor and Rehm, 2005).

Treatment for substance abuse is one aspect of addressing the problem, and it aims to reduce the harm associated with the use of substances. Over the past few years, treatment demand has increased consistently in South Africa and the need for services has been articulated in key legislative and policy documents. Substance abuse is a well-researched field in South Africa (Room, Babor and Rehm, 2005); however, limited research exists that captures the perceptions of service providers who work closely with patients, particularly women who suffer from substance abuse disorder.

More specifically, there is a shortage of literature in South Africa that looks at the design of rehabilitative services offered to women. Previous studies, both locally and internationally, have focused on the implications of substance use in various populations. While Lehavot and Simoni (2011) provide a concise picture of substance abuse and its grave implications for society, they have also suggested ways in which the substance abuse problem, particularly among women, may be understood to a certain extent. However, considering the diversity of social determinants, it is suggested that more research needs to be done on modifications to rehabilitative services. These modifications need to mitigate possible gaps and challenges within the design of services for women, and include resources that reflect the flexibility, relevance and diversity of social determinants and causes of substance abuse amongst women (Lehavot and Simoni, 2011). Additionally, although the substance abuse treatment system has increasingly recognised the need for programmes that address women's specific substance abuse–related problems and barriers to treatment, women's treatment needs were obscured for many years. Little research describing substance abuse treatment programming for women can be identified before the 1980s (Clark et al., 2001). Moreover, while recent strategies such as the NDMP (Department of Social Development, 2014), the City of Cape Town Alcohol and other Drug Harm Minimization and Mitigation Strategy 2011- 2014 (City of Cape Town, 2011), and the Workstream on the Prevention and Treatment of Harmful Alcohol and Drug Use: Modernisation programme (Provincial Government of the Western Cape, 2015) are

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aimed at reducing and preventing substance abuse, very little is known about how staff perceive shortfalls within the design of services and the series of requirements that are absent within these services. In addition, by considering the perceptions of staff, one may be able to understand what the perceived quality of the services offered are, thus allowing the researcher to understand how the treatment setting and experience can impact on the client's recovery process and future outcomes.

Therefore, the study aimed to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town.

1.5 Aims and objectives

The aim of the study is to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town.

The objectives of the study are:

1. To explore the perceptions of staff regarding the logistical challenges experienced at the rehabilitation centre.
2. To explore the treatment strategies available for women at the rehabilitation centre.
3. To identify the specific needs versus resources required within rehabilitative services for women with substance abuse disorder.
4. To provide recommendations to the rehabilitation centre pertaining to services offered to women.

1.6 Thesis outline

The subsequent chapters of this thesis provide detailed information about how this study was executed and, consequently, how the aforementioned aim and objectives were met. In Chapter Two I provide a detailed review of previous research studies that have been conducted in the broad area of substance use and abuse. I also provide a critical appraisal of how these studies are useful in better understanding substance abuse within the context in which this specific research is conducted. This chapter also presents a discussion of the theoretical framework within which this study is situated. In addition, I provide a detailed description of the methods used in the execution of the study, the recruitment of participants, data collection and analysis. In the closing chapters I provide a description and discussion of the research findings.

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CHAPTER 2
LITERATURE REVIEW AND THEORETICAL FRAMEWORK

Introduction

This chapter contextualises substance use in relation to the interpretivist theoretical framework and presents a synopsis of the literature on substance use with an emphasis on women. This section outlines further evidence around the current treatment strategies that are used and presents researchers' concerns regarding emerging limitations that exist within rehabilitation services for women. In this chapter I discuss relevant literature pertaining to substance abuse as a public health concern, gender and substance abuse, as well as social determinants in relation to substance abuse. I also discuss literature related to the management of substance abuse in South Africa, rehabilitation services for women, and the perceptions of staff at treatment facilities.

2.1 Substance abuse as a public health concern

Substance abuse can be defined as the intake of legal or illegal substances in a manner that is socially unacceptable and that could potentially be harmful to the user's social, physical, or psychological health and wellbeing; to that individual's relationships with significant others; or to their education and employment. It could potentially lead to conflict with the law (Moleko and Visser, 2005).

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Globally, about 275 million people, or roughly 5.6% of the global population aged 15–64 years, used drugs at least once during 2016 (UNODC, 2018). The range of substances and combinations available to users has never been wider. Previously, the most commonly abused illicit substances in the world, in order of prevalence, were cannabis, opioids, opiates, cocaine, and ecstasy together with amphetamine-type stimulants (UNODC, 2018).

Moreover, in South Africa, there has been a rapid increase in substance use by persons older than 20 years. From 2005 to 2011 it reached alarming proportions. While between 2008 and 2010 there was a gradual increase in substance use among all age groups, between the second half of 2010 and 2011 there was a sharper increase, the highest being among persons older than 20 years (SACENDU, 2018). During 2019, cannabis was still the most common illicit drug

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used across provinces with 33% of patients attending specialist treatment centres in the Eastern Cape and 50% in the Northern Cape using cannabis as their primary or secondary drug. In the same period, between 3% and 21% of patients in the Western Cape used cannabis/mandrax (methaqualone or 'white-pipe') as their primary or secondary drug. Methamphetamine remained the most common primary drug reported by patients in the Western Cape, where 39% used methamphetamine as their primary drug of choice (UNODC, 2018). Abuse of cocaine remained fairly low in the provinces and it was reported as a secondary drug. Heroin use remains a problem in most provinces, with use in the Western Cape increasing from 7% to 13% during the reporting period. During the same period, patients in all provinces reported the non-medical use of codeine (CAT) (UNODC, 2018).

Although substance abuse cases remain higher amongst males, there has been a slight increase amongst females since 2014 (SACENDU, 2019). Additionally, from 2015 to 2018 it was reported that a third of patients who used alcohol and a quarter of patients who used methamphetamine were female (SACENDU, 2019). Moreover, alcohol has remained the leading substance used in the Eastern Cape, KwaZulu-Natal and the Northern Cape, and it still causes the biggest burden of harm in terms of both communicable and non-communicable diseases (UNODC, 2018).

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A non-communicable disease (NCD) can be defined as a disease that is not transmissible directly from one person to another (Nojilana and Bradshaw, 2016). The burden of NCDs has grown at such an exponential rate that the NCD pandemic is the leading cause of mortality and morbidity globally (Habib and Saha, 2009). According to these authors, an estimated 35 million deaths, equivalent to 60% of all deaths globally, occurred as a result of NCDs in 2005, with the main known risk factors for NCDs including the abuse of alcohol and the inhalation of nicotine.

Malignant neoplasms (liver cancer and stomach cancer) are an important category of NCDs, accounting for about 20% of the overall alcohol-related mortality burden. This is followed by cardiovascular disease (15%) and other non-communicable diseases, mainly alcoholic liver diseases (ALD), such as liver cirrhosis, which cause 13% of all alcohol-attributable deaths. ALD is the most common cause of cirrhosis in the Western world, and currently one of the ten most common causes of death. Liver fibrosis caused by alcohol abuse, and its end stage, cirrhosis, cause enormous worldwide healthcare problems. Patients with cirrhosis and superimposed alcoholic hepatitis have a four-year mortality of more than 60% (Kaplan et al.,

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2014). Interestingly, this meta-analysis of case control studies (not randomised trials) found that women who drank three or more alcoholic beverages per day (or 40 grams of alcohol, with about 13 grams in a standard drink) had a 69% higher risk of getting breast cancer than nondrinkers.

A communicable disease can be defined as an infectious disease that is contagious and that can be transmitted directly or indirectly from one source to another by an infectious agent or its toxins (Parker, Steyn and Levitt, 2012)**.** One major concern is the injecting of substances and sharing of needles, since this is directly associated with the transmission of Hepatitis A and other infectious diseases, specifically HIV/AIDS. Furthermore, studies conducted by the South African Medical Research Council identified a positive relationship between alcohol abuse and HIV infection (Watt et al., 2014). It is further reported that substance use is often associated with impaired judgment and decision-making abilities by the person using or abusing the substance. Watt et al. (2014) found a positive relationship between risky sexual behaviour and substance abuse and postulated that women who used drugs were less likely to insist that their partners use condoms. Disinhibition associated with methamphetamine use is a major public health concern as it increases the risk of contracting sexually transmitted diseases including HIV. Similarly, the practice of sex in exchange for drugs inevitably increases risks of contracting sexually transmitted diseases including HIV (Watt et al., 2014), exacerbating the burden on an already constrained public health system.

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According to the UNODC (2018), patients in all regions had a dual diagnosis at treatment admission, with nearly half of patients (49%) reporting mental health problems at that time. Goodman, Peterson-Badali and Henderson (2011) similarly identified that a significant number of emerging adults develop mental health issues such as depression or anxiety, and that these issues are often accompanied by drug and alcohol abuse and/or dependence. Additionally, Punamaki, Belt and Posa (2013) report that these difficulties are expressed as both hyper- and hypo-arousal; for example, they explain that substance abusers tend to fluctuate between behavioural withdrawal and emotional numbing, and overwhelming and uncontrollable behaviours and feeling states. This dysfunctional processing of emotions underlies depression and anxiety, a propensity towards impulsive and aggressive behaviour, and hostile and angry feeling states. In their research, Sundin et al., (2011) validated previous claims about substance use and suicidal ideation by stating that persons who met all the criteria for a substance use

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disorder diagnosis also had a more than three-fold increase in the odds of having seriously considered suicide.

According to the National Drug Master Plan (2014) of South Africa, it is recognised that mental health problems have serious economic and social costs, which include direct costs related to the provision of health care, and indirect costs, such as reduced productivity at home and work, loss of income and loss of employment. These costs have a direct effect on the mental health care of the user and their family's financial situation. Moreover, the indirect cost of mental disorders is reported to outweigh the cost of direct treatment by two to six times in developed countries, and this may be even higher in developing countries such as South Africa (Room, Babor and Rehm, 2005). The South African government urgently needs to revisit the manner in which funding is allocated to mental health care.

2.2 Gender and substance abuse

While alcohol is still the most commonly used substance in South Africa, other substances such as cannabis and methamphetamine are widely used by women (SACENDU, 2018). Research suggests that gender differences may exist in the use of alcohol and illegal drugs, as well as in the illicit use of prescription drugs (Becker and Hu, 2007). The aforementioned study found that women begin regularly self-administering licit and illicit drugs at lower doses than do males, but that their use escalates to addiction much more quickly. Furthermore, this study also found that, for multiple reasons, women are at greater risk for relapse following the cessation of use.

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A study conducted by the South African Community Epidemiology Network on Drug Use (SACENDU) between 2000 and 2013 analysed a total of 74,368 treatment episodes that were recorded during this period, of which 22% involved women. According to the study, the proportion of women seeking treatment increased from 4% to 11% over time, with the most common primary substance of abuse among this sample being alcohol, followed by methamphetamine (Dada et al., 2018). It further indicated that young, coloured (mixed race) women were almost 18 times more likely than other women to report methamphetamine as their primary substance of abuse, while more than a quarter of women reported poly-substance abuse. On the other hand, women treated for heroin were significantly more likely to be white and younger than 25 years old. The data also portrays an increase in the use of alcohol and

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other substance treatment services by women; particularly for alcohol and methamphetamine use disorders during this time (Dada et al., 2018).

Although males have dominated the statistics pertaining to substance abuse and enrolling in rehabilitative services, the period 2013–2017 saw an increase in the proportion of females who were treated for the use of alcohol (31%), crack/cocaine (35%) and methamphetamine (36%) (SACENDU, 2018). More recent reports have indicated that 68% of female users were coloured, unemployed (30%) and had not completed high school (SACENDU, 2019).

Women are more likely than men to face multiple barriers to accessing substance abuse treatment and are less likely to seek treatment (Jackson and Shannon, 2012). The fact that women have been found to be at a greater risk for experiencing traumas such as intimate partner violence and rape also makes them more vulnerable than men to misusing substances (Carr and Szymanski, 2011; Hawkins, Catalano and Miller, 1992). Studies have indicated that, generally, in comparison with men, more women suffer from co-occurring psychiatric disorders, such as depression, social phobia, post-traumatic stress disorders and eating disorders. These women are usually poor, uneducated, welfare-dependent, and unemployed (Tuchman, 2010).

These studies, however, do not explore the underlying psychological processes the women go through prior to misusing these substances, which may contribute to their tendency to seek care in mental health or primary care settings rather than in specialised treatment programmes.

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Substance-using adults who socialise or live with other substance users also tend to have lower motivation to quit substance use and to seek rehabilitative services (Tuchman, 2010). This is because, although abuse is a significant risk factor for substance use problems, the relationship with the substance is apparently mediated by psychiatric illness, including depression and anxiety disorders. The development of mood and anxiety disorders usually preceded the onset of substance disorders (Douglas et al., 2010).

According to Jackson and Shannon (2012), women generally underutilise the substance abuse treatment system and tend to seek help in non-addiction specialty settings, such as in physicians' offices or mental health facilities, because alcohol abuse and illicit drug use may still carry more stigma for women than for men. This may discourage women from seeking treatment services and may thus hamper detection of substance abuse problems (Jackson and

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Shannon, 2012) or result in a misdiagnosed and untreated addiction. An older Swedish study (Dahlgren and Myrhed, 1977) found that women were more likely than men to enter treatment after serious acute complications of their substance use, such as unconsciousness or suicide attempts.

In addition, it is said that women are more likely to experience economic barriers to treatment, putting family responsibility first and feeling ashamed and embarrassed for seeking treatment (Brady and Ashley, 2005). Some barriers that women have faced in the last 20 years include: pregnancy, fear of losing custody after the baby is born, fear of prosecution, and lack of services for pregnant women. One of the greatest barriers is the lack of childcare, often due to financial constraints. Identifying these barriers can help improve treatment access and services (Greenfield et al., 2013).

Further to this, women also experience additional external challenges that prevent them from seeking treatment. According to Tuchman (2010), most women have challenges accessing transportation to treatment facilities, as well as inadequate health insurance. Simultaneously, many have to deal with an abusive relationship and lack of general support.

While early research suggests that women were discouraged by family members from seeking treatment (Beckman and Amaro, 1986), in South Africa, access to substance abuse treatment and use of services by women is further frustrated by factors such as gender roles, childcare issues and social prejudice associated with substance use (Elbreder, De Humerez and Laranjeira, 2009; Guerrero et al., 2014). Women are subjected to severe stigmatisation and discrimination, and societal expectations of women as the primary caregivers of children and the family may discourage women from having the courage to seek treatment.

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According to Tuchman (2010), studies that investigated the nature of the relationship between substance use and gender have found that gender differences can be observed in all phases of drug abuse, namely, initiation, escalation of use, addiction, and relapse following abstinence. Therefore, the significance of gender in the substance use arena cannot be overlooked (Tuchman, 2010). However, having said that, information about possible differences in how men and women go through these processes is limited. Little is known about how families interact when a family member has substance abuse problems; how the gender of that person influences how families or employers communicate about or manage these

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problems (Room, Babor and Rehm, 2005); or how gender might influence reflection prior to treatment-seeking.

2.3 Social determinants and substance abuse

The social determinants of health are economic and social conditions that influence individual and group differences in health status. (Marmot and Wilkinson, 2005). These circumstances, including factors such as income, food and housing security, and access to services, strongly contribute to health status and the relative level of equity of individuals (Marmot and Bell, 2019). There is also increasing recognition that adverse social conditions detrimentally affect mental health (Fischer and Lyness, 2005). Determinants of health can be explained through various layers such as one's economic, physical, social and behavioural environment (Marmot and Wilkinson, 2005).

Much of one's economic environment can be traced back to economic disfranchisement in the past. Although South Africa has shown relative progress since the first democratic elections in 1994, many of its people continue to be confronted with the challenge of living in a society characterised by economic and social inequality. Apartheid divided South African society on the basis of race and ethnicity, segmenting the nation spatially, politically, and economically (Penedo, 2014). According to Pampel, Kruege and Denney (2010), persons who are economically deprived and living in disadvantaged communities face a variety of chronic stressors in their daily lives. In addition to battling to make ends meet, they have few opportunities to achieve positive goals due to experiencing unemployment and limited income, whilst dealing with discrimination, marginalisation, isolation and powerlessness. Research has shown that many women who abuse substances in the Western Cape reside within lower socio-economic areas, are unemployed, and have low educational attainment (SACENDU, 2019).

Furthermore, research shows that one's socio-economic status will naturally affect one's social environment. Cape Town and the broader Western Cape region have significantly high crime rates, with criminal acts affecting significant numbers of the people who constitute these communities (Parry et al, 2011). Gangsterism, poor education, inadequate health facilities, community violence, and gender-based and intimate partner violence are but a few examples of the threats that face residents of low-income Cape Town communities.

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Many women who live in low socio-economic communities are subjected to traumas such as rape, gang violence and different forms of abuse, whilst already being marginalised due to their gender. The fact that these women have been found to be at a greater risk of experiencing traumas such as intimate partner violence and rape also makes them more vulnerable than men to misusing substances (Carr and Szymanski, 2011; Hawkins, Catalano and Miller, 1992).

Moreover, it has been shown that gender based violencehas been on the increase both globally and within South Africa (Dunkle et al., 2004). According to John et al. (2020), public health measures in a pandemic such as quarantines, school closures and channeling resources towards emergency service provision, expose structural realities of the lives of women and girls globally, as well as point to inequities and weaknesses in our gendered socio-economic and health systems.

Many such women are also at risk for developing post-traumatic stress disorder (PTSD). According to Breslau, Davis and Schultz (2003) exposure to trauma may lead to the development of mental health disorders such as PTSD. The first of these explanations is that PTSD is a risk factor for substance abuse, as substances may be used to help a person cope with distressing symptoms of PTSD, such as intrusive memories of the trauma, and distressing emotions like shame and guilt. Secondly, substance use disorders increase the likelihood of PTSD either by their association with lifestyles that involve an elevated risk of exposure to traumatic events that induce PTSD, or by increasing a person's susceptibility to the PTSD-inducing effects of trauma. Finally, the association of substance use disorders with PTSD might be reflective of shared genetic or environmental factors (Breslau, Davis and Schultz, 2003).

In addition to PTSD, many other mental disorders are activated by traumatic events. According to Punamaki, Belt and Posa (2013), these difficulties in affect are expressed in both hyper- and hypo-arousal; for example, they explain that substance abusers tend to fluctuate between behavioural withdrawal and emotional numbing, to overwhelming and uncontrollable behaviours and feeling states. This dysfunctional processing of emotions underlies depression and anxiety, a propensity towards impulsive and aggressive behaviour, and hostile and angry feeling states. In their research, Sundin et al., (2011) validate previous claims about substance use and suicidal ideation by stating that persons who met all the criteria for a substance use disorder diagnosis also had a more than three-fold increase in the odds of having seriously

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considered suicide. Alcohol is often consumed by both teenagers and adults prior to attempting suicide (Sundin et, al., 2011).

According to Goodman, Peterson-Badali and Henderson (2011), a significant number of individuals develop mental health issues such as depression or anxiety, and these issues are often accompanied by drug and alcohol abuse and/or dependence. Additionally, Goodman, Peterson-Badali and Henderson (2011) explain that substance abuse among female populations specifically is likely intertwined with psychological reactions to violence. In the presence of such stressors, substances are often used as a coping strategy (Parry et al., 2011).

Moreover, behavioural determinants described above have a replicative influence on our physical well-being. It is clear that individuals experience severe consequences as a result of their substance abuse including severe health-related challenges. Whilst the abuse of substances usually results in the development of communicable and non-communicable diseases, an indirect consequence of substance abuse is the growing incidence and prevalence of Fetal Alcohol Spectrum Disorder (FASD) (May et al., 2005) and HIV.

Substance use or abuse is often associated with impaired judgment and decision-making abilities. Wechsberg et al. (2008) found a positive relationship between risky sexual behaviour and substance abuse and postulated that women who use drugs are less likely to use condoms, creating a burden on an already constrained public health system. Often these sexual practices involve coercion and sexual- and gender-based violence. The public health system also has to contend with an increased number of admissions to emergency rooms due to alcohol-related injuries and deaths (Western Cape Government, 2015).

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The relationship between violence, substance abuse and HIV may be shaped by the coexistence of extreme poverty, lack of access to basic healthcare, high prevalence of HIV and commercial sex work, or culturally condoned violence against women (Lehavot and Simoni, 2011). This may be the case in many low-socioeconomic status communities in South Africa.

2.4 Management of substance abuse in South Africa

Treatment for substance abuse is vital in the light of the complex individual-level and structural determinants presented in the previous sections. Treatment is not a cure-all for substance abuse problems; however, the rehabilitation of service users stands to alleviate some

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of the social challenges associated with substance use. At least 15% of South Africans are said to have a drug problem, according to the country's Central Drug Authority, while 8,787 people were admitted for drug treatment in 2016 in South Africa compared to 10,047 in 2017. In the Western Cape, 3,182 patients were treated across all treatment centres for the period January to June 2018, compared to 2,541 in the previous six-month review period (SACENDU, 2019).

The Prevention of and Treatment for Substance Abuse Act (Act 70 of 2008) is the guiding legislative document promulgated to address the substance abuse problem in the South African context. The Act makes provision for the establishment of a Central Drug Authority (CDA) to provide an oversight function in the implementation of the Act, and to take responsibility for the development of a National Drug Master Plan (NDMP) 2013-2017 (Department of Social Development, 2014) to inform a comprehensive approach to addressing the substance abuse problem. In line with the NDMP, most government agencies in the Western Cape broadly divide their services into interventions to reduce both drug supply and drug demand, and interventions to curb underaged drinking, and driving while intoxicated. In addition, the Western Cape Liquor Bill is developed to strengthen the Provincial Government's control of the retail of and access to alcohol (Western Cape Government, 2015). The NDMP 2013–2017 is the current blueprint for the prevention and reduction of substance abuse. Whilst many rehabilitative programmes are based on the aims of the NDMP, greater emphasis is placed on demand and supply reduction strategies rather than on prevention and early intervention strategies in line with international treaties.

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Having said that, a significant challenge identified is that as more non-governmental organisations (NGOs) are established, there seems to be less funding made available by government and the private sector (SACENDU, 2018). Central to the plight of NGOs is accessing funding and managing resources to ensure sustainability (Western Cape Department of Social Development, 2011). It is important that NGOs such as substance abuse organisations are monitored and evaluated as the competition for funding and scarce resources escalates.

Sorsdahl et al. (2015) further recommends that improving clients' perceptions of treatment (and thereby treatment completion rates) would require introducing service quality improvement initiatives into publicly funded treatment services. This would require some shifts in current substance abuse treatment policy (Sorsdahl et al., 2015).

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In addition, it is important to note that factors that influence motivational variables include substance use quantity and frequency; family, peer, and legal involvement; and mental health status. Although these factors seem to play a role regardless of age, the extent of their influence appears to differ across the developmental trajectory. Although these studies effectively illustrate how individual as well as external factors can affect or inform a person's decision to seek treatment, they do not account for the effect the treatment itself can have on the individual. What they also do not explore or hypothesise about are the implications such experiences might have for recovery and potential relapse, factors which are imperative in the future functioning of the individual. By considering the perceptions of staff, one may be able to understand what the perceived pros and cons of the services offered are, thus enabling the researcher to understand how the treatment setting and experience can impact on the client's recovery process and future outcomes.

In spite of the high levels of substance abuse, service utilisation has remained low in Cape Town. Sorsdahl et al. (2015) found that geographic access barriers, awareness of treatment options, and competing financial priorities were some of the predictors of service utilisation. Furthermore, non-structural factors, such as negative beliefs about treatment, and stigma towards persons using drugs, contribute negatively to service utilisation and act as a barrier to treatment, particularly in historically disadvantaged communities (Sorsdahl et al., 2015).

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Additionally, successful substance abuse treatment requires that all life domains be considered to reduce substance use, which would ultimately improve the substance user's overall quality of life (McLellan et al., 2005). Naylor and Lee (2011) support this view, and notes that treatment for substance abuse should consider the overall impact of substance abuse and treatment on the life domains of individuals accessing services. The primary goal of treatment is for the patient to reduce and/or abstain from substance use. However, treatment programmes should consider the individual- and programme-level factors that impact on the experiences of patients, particularly women, and the overall outcome of treatment (Naylor and Lee, 2011).

2.5 Rehabilitation services for women

In apartheid South Africa, substance abuse treatment services were situated in urban areas and reserved for whites. The remnants of separate development are evident in the dearth of substance abuse treatment services in disadvantaged communities (Myers, Fakier and Louw

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(2009); Ramaglan, Peltzer and Matseke, 2010; Watt et al., 2014). The unequal distribution of services continues to affect South Africans, despite the proliferation of redistribution policies geared towards redressing these inequalities post-1994. Myers, Fakier and Louw (2009) found that black South Africans are under-represented in specialist substance abuse treatment facilities in Cape Town and the Gauteng province. The patterns of service utilisation among black South Africans requires further investigation as the statistics may not accurately reflect the need for treatment amongst this population group.

There is an alarming increase in women who abuse substances, and of these many do not seek rehabilitation (John, 2020). Additionally, women remain under-represented in treatment facilities in South Africa (Dada et al., 2018). Access to substance abuse treatment and service utilisation for women is frustrated by factors such as gender roles, childcare issues and social prejudice associated with substance use (Elbreder, De Humerez and Laranjeira, 2009; Guerrero et al. 2014). Research posits that women may be 'hidden' substance users, who do not necessarily present to treatment facilities (Dada et al., 2018). The perception that substance use in terms of gender may be ascribed to socialisation or gender roles could be problematic, as it assumes that women do not engage in substance use. South African legislation is progressive in espousing and protecting women's rights, but it has not addressed the cultural and societal gender roles ascribed to women, which may limit treatment-seeking behaviour (Ramaglan, Peltzer and Matseke, 2010).

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Therefore, according to Sorsdahl et al. (2015), it is recommended that current rehabilitative services undergo certain shifts in policy pertaining to the needs and rights of abused women and the allocation of funding at centres focusing on substance abuse amongst women. Some researchers have proposed that the ideal treatment programme will provide comprehensive, family-centred services. Social-specific support in the treatment process has yielded positive results for service users, ultimately improving the outcomes of treatment (Laudet, Stanick and Sands, 2009; Sorsdahl et al., 2015). Positive social relationships and interactions contribute to abstinence or at least to reduced substance use.

Scholars in the addiction field have shifted from a pathology-focused model, recognising that services should be holistic and include affected others in the treatment process. Family involvement in treatment remains a challenge for service users and providers; for example, an

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outpatient programme in the Western Cape reported a family attendance rate of less than 40% (Strebel et al., 2013). A lack of social support increases the risk of early dropout and relapse.

Greenfield et al. (2013) states that gender differences in the antecedents and consequences of substance abuse require gender-specific treatment, which may provide additional benefits and enhanced treatment outcomes for women. An evaluation of women-only versus mixed-gender addiction groups found that women identified several issues that they would discuss only in women's groups, including guilt regarding being an inadequate mother (Tuchman, 2010). Additionally, several studies have suggested that gender differences in interaction styles and men's traditional societal dominance may negatively affect women in mixed-gender group treatment. As a result, it is generally asserted that substance abuse treatment for women, particularly pregnant women and women with dependent children, must differentially address these complex psychosocial issues. Furthermore, treatment programming designed specifically for women is needed to address not only women's substance abuse related problems, but also their special needs and barriers to treatment (Tuchman, 2010).

According to Punamaki et al (2013), certain studies also argue that inclusion of therapeutic elements and systematic enhancement of optimal mother–infant interaction is imperative for the success of interventions provided to substance-abusing mothers. Interventions of this kind offer mothers positive and rewarding experiences with the baby and boost maternal competence, thus capturing their mind away from drugs (Punamaki, Belt and Posa, 2013). Additionally, Tuchman (2010) states that perhaps the most substantial obstacle for these young women is available, affordable childcare, as few treatment programmes provide on-site childcare or help with making childcare arrangements. Even when women are able to make alternative arrangements, they are likely to face resistance or hostility from family members.

2.6 Perceptions of staff

There is a shortage of treatment interventions designed specifically for women who abuse substances. Although many service providers acknowledge and address gender differences among clients in substance abuse treatment, these differences and the programmes that addresses them have not been adequately studied (Tuchman, 2010). New studies on treatment effectiveness are needed to assess gender differences in response to different treatment strategies. Moreover, it can be noted that service users' perceptions of treatment effectiveness

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could provide useful first-hand information to clarify expectations during the initial phases of treatment and improve retention and ultimately the overall outcomes.

It should be noted that staff at rehabilitation services contribute immensely to the retention of patients. Staff such as counsellors, clinical psychologists and even social workers play the role of a teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behaviour change. The interaction between the staff and the client is realistic and direct but not confrontational or parental. They are trained to conduct treatment sessions and programmes in a way that promotes the patient's self-esteem, dignity, and self-worth There is limited information on the perceptions of staff regarding rehabilitative services that are specific to women (Mark et al., 2002).

2.7 Theoretical Framework

2.7.1 Interpretivism

This study is based on the theory of interpretivism and is similar to phenomenological research. The main aim is to understand reality from an individual's narratives of their experiences and feelings, and to generate in-depth explanations of the phenomenon (Giorgi and Giorgi, 2003). It generally embodies the perception, and the feelings of participants about a phenomenon.

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According to Andrade (2009) an interpretive approach provides a deep insight into the complex world of lived experience from the point of view of those who live it. The key tenet of this approach is that it assumes that reality is socially constructed, and that the researcher becomes the vehicle by which this reality is revealed (Andrade, 2009). This approach is consistent with the construction of the social world, characterised by interaction between the researcher and the participants (Andrade, 2009). Interpretive research assumes that knowledge about reality is gained only through social constructions. Through focusing on the participants' language, consciousness, shared meanings, documents, tools, and other artefacts, the researcher is able to gain insight about the respondent and their subjective reality. The interpretive framework postulates that reality, and the individual who observes it, cannot be separated because individuals' perceptions about the world are inextricably bound to a stream of life experiences.

Furthermore, the lifeworld has both subjective and objective characteristics. The subjective

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characteristics reflect our perceptions about the meaning of the world. The objective characteristics reflect that we constantly negotiate this meaning with others with whom we interact. In other words, it is objective in the sense that it reflects an inter-subjective reality (Andrade, 2009).

2.7.2 History and foundations

Interpretivism was pioneered by Weber (2004) during the late nineteenth century and throughout the twentieth century. It evolved out of hermeneutics and phenomenology and their view of the fundamental differences between the natural and social sciences (Giorgi and Giorgi, 2003). During this time, qualitative and interpretive research methodologies became more widely used (Snape and Spencer, 2003). Weber was mainly concerned with understanding social actions, relationships, and causal relationships. He focused on establishing a valid and objective science of the subjective nature of the social world, and defined sociology as a science which attempts the interpretive understanding of social action, in order to arrive at a causal explanation of its course and effects.

During the first qualitative wave, interpretivism was descriptive and aimed at identifying the realities of the phenomena from the person's perspective. It gradually took an interpretive turn as the role of the researcher became more important (Henning, Van Rensburg and Smit, 2005). During this time, philosophers did not only come to understand that the social sciences required different methods to those of the natural sciences, but social meaning and understanding also became fundamental (Henning, Van Rensburg and Smit, 2005).

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Furthermore, Goldkuhl (2012) explains that in the interpretive tradition, there are no correct and incorrect theories; rather, there are interesting and less interesting ways to view the world. Therefore, interpretive research views knowledge as understanding and its purpose is to be interesting to audiences. People make meaning and construct their own realities, whilst the researcher guides this process. The role of knowledge evolving from this framework is constructed not only in terms of observable phenomena. For Henning, Van Rensburg and Smit (2005), it is also based on descriptions of people's intentions, beliefs, values and reasons, meaning making as well as self-understanding. The social world is understood or interpreted by different people in different contexts in different ways. In addition, interpretive research requires a critical reflection on how meanings are constructed through the interaction between the researcher and the research participants.

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2.7.3 Theoretical Application

According to Andrade (2009), an interpretive approach provides a deep insight into the complex world of lived experience from the point of view of those who live it. The key tenet of this approach is that it assumes that reality is socially constructed, and the researcher becomes the vehicle by which this reality is revealed (Andrade, 2009). This, approach encompasses the perspectives that embrace a view of reality as socially constructed or made meaningful through a participant's (staff) understanding of events (rehabilitative services available to women) (Goldkuhl, 2012). Through focusing on the staff's' language, consciousness, shared meanings, documents, tools, and other artefacts, the researcher is able to gain insight about the respondent and their subjective reality.

Working within an interpretive framework allowed the researcher to identify common features in the experiences of the staff at the rehabilitation centre. The process entails characterisation as a process of interpretation rather than sensory, material apprehension of the external physical world and human behaviour. Therefore, social reality is not some 'thing' that may be interpreted in different ways; it is those interpretations.

The fundamental epistemological principle is that the integrity of the phenomenon should be retained. The logic is based on the everyday processes by which individuals make sense of their own social world (Giddens, 1984). The data of interpretive science are intentional and the intersubjective meanings of actions and situations. Explanations consist of descriptions in terms which are appropriate to the actors' culture. Theory consists of the cultural rules or norms that constitute the meaningfulness of interaction. Validity is based on convention, negotiated agreements between social actors, and the willingness of social actors themselves to find an account of their world acceptable.

The theoretical perspective was applied during the interview process. Participants were told that there were no wrong or right answers to the questions asked, and that the goal of the study was to get their personal understandings and interpretations of their experiences with clients. 'Why' questions were asked in order to elicit information explaining how the participants arrived at certain conclusions. Probes were also used in order to get insight into the belief systems and values that shaped the participants' ideas and how these may have informed their worldviews.

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2.8 Summary

This chapter has provided a review of previous studies conducted in the broad area of substance abuse. It has focused on the various implications of substance use in various populations, both locally and internationally. While these studies provide us with a concise picture of substance abuse and its serious implications for society, they have also suggested ways in which the substance abuse problem, particularly among women, may be addressed. The first section of the chapter focused on substance abuse as a public health concern, while looking at the details of substance abuse determinants, especially amongst women. It has further researched current legislation focusing on the reduction of substances nationally and provincially, and has specified preferred elements that should be focused on and maximised for the improvement of services to women who abuse substances.

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CHAPTER 3
METHODOLOGY

Introduction

This chapter presents the process undertaken in conducting the research study. It incorporates a description of the research approach and design as well as the research setting, sampling procedure and data collection process.

The aim of the study was to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town with the following objectives:

- To explore the perceptions of staff regarding the logistical challenges experienced at the rehabilitation centre.
- To explore the treatment strategies available for women at a rehabilitation centre.
- To identify the specific needs versus resources required within rehabilitative services for women with substance abuse disorder.
- Provide recommendations to rehabilitation centres pertaining to services offered to women.

3.1 Research approach and design

This study was qualitative in nature and according to Malterud (2001), qualitative research methods are founded on an understanding of research as a systematic and reflective process for the development of knowledge. This can be contested and shared whilst implying ambitions of transferability beyond the study setting. A combination of an exploratory and a descriptive design, as proposed by Delport and Fouché (in De Vos, Strydom, Fouché & Delport, 2011), was utilised for the study.

Exploratory research is used when a researcher wants to gain insight and understanding of a social issue (De Vos & Fouche in DeVos et al. 2011). In this case, the researcher wanted to know: What are the challenges experienced by women at the rehabilitation centre and what are the needs and resources required to close these gaps. In taking an exploratory approach in this study, the attempt was to ascertain whether staff view substance abuse treatment as being effective and to offer some insight into how the intervention can be improved. The qualitative

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approach employed provided an opportunity to gain insight into the insider's perspective, but also to describe and understand the phenomenon under investigation.

Descriptive research is used when a researcher wants to provide in-depth descriptions of a social issue, answering "how" and "why" questions (Fouché & De Vos in De Vos et al. 2011). In the current study, the researcher wanted to answer the question pertaining to how rehabilitative services are provided for women who abuse substances and why these services are limited. Therefore, the aim of the study was to address the research objectives through exploring the perceptions of staff working at a rehabilitation centre.

3.2 Research setting

Alcohol and drug abuse are a pervasive problem in Cape Town and within the Cape metropole there are an estimate of 36 specialised substance use rehabilitation centres, providing services to communities who are dealing with this scourge. My interest in the research site was generated due to being previously employed at the Department of Social Development (DSD), thereby having access and knowledge into the funding model for substance abuse treatment centres. My interest was further ignited by having access to the fact that the DSD provided funding to the centre as a substance abuse facility exclusively for women. In my initial investigation, a key finding was that the facility was first and foremost a centre for women victims of GBV where a substance abuse treatment facility was housed for these women. It can also be noted that this finding did not skew the outcomes of this study.

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The research site is situated in a lower socio-economic community where many clients reside. Many lower socio-economic communities in Cape Town are burdened with low educational achievement, poverty, and poor health whilst inequities in health distribution and resource distribution are on the increase. These inequities ultimately contribute to social ills such as gangsterism, rape and other forms of abuse which influence the onset and magnitude of anxiety, depressive disorders and substance abuse.

The substance abuse treatment facility where this particular study was conducted is a one-stop centre for women and children who are survivors of abuse. Their vision is to create a safe and secure society and a human rights culture where women and children are empowered to exercise their full rights. The treatment facility is a Western Cape Provincial DSD-funded substance abuse treatment centre that offers a range of services from a 24-hour emergency shelter and childcare service to offering counselling, job skills training and legal advice.

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Additionally, the facility offers short- and medium-term residential care, counselling for children as well as research on GBV.

This centre provides rehabilitation to a number of females during every treatment cycle whilst accommodating between twenty and forty patients at a time and runs an eight-week in-patient programme for a maximum of 10 women who are substance users. Patients who have successfully completed the treatment and have made satisfactory improvement are discharged after six weeks and start a six-month aftercare programme. There are twenty employees consisting of the director, clinical psychologist, social workers, social auxiliary workers, residential programme managers, night supervisors, lay counsellors, administrative staff and other assistants.

3.3 Sampling procedure

The research participants were staff members at a substance abuse rehabilitation centre located in a low socio-economic community within the Cape Town area. Purposive sampling was used to select the research participants from the population of staff members at a substance abuse treatment centre in the Cape Town. Purposive sampling is a nonprobability sampling technique used to choose a sample of subjects / units from a population (Saunders et al,. 2021). Staff members were particularly recruited to participate in this study in order to explore their perceptions regarding the challenges experienced at the rehabilitation centre and the treatment strategies available for women at a rehabilitation centre. In addition, these participants were recruited to identify the specific needs versus resources required within rehabilitative services for women with substance abuse disorder and to provide recommendations to rehabilitation centres pertaining to services offered to women. The aim and objectives of the study were presented to the participants to ascertain their perception of these services offered to women and to further shortlist a minimum of eight to ten participants to participate. Sampling in the study involved the setting of criteria to ensure that the participants in the study were able to respond to the research questions.

To achieve the goal and objectives of the study, research participants required specific attributes. To this end, criteria for selection was developed and are listed as follows:

- Participants who work closely with patients at the substance abuse treatment centre.

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- Participants who work closely with the development of programmes executed at the centre.
- Participants who work closely with data related to background information, demographics, trends and programme outcomes.

The final sample consisted of a total of eight staff including the director, one residential programme manager, one-night supervisor, and other administrative staff and health professional staff including one psychologist, one social worker, one social auxiliary worker and one relief lay counsellor. All the staff members who participated in the study would have had adequate contact with women clients and would have sufficient knowledge of programmes run at the centre.

The sample size used in qualitative research methods is often smaller than that used in quantitative research methods. This is because qualitative research methods are often concerned with garnering an in-depth understanding of a phenomenon or are focused on *meaning* which are often centered on the *how* and *why* of a particular issue, process, situation, subculture, scene or set of social interactions.

3.4 Data collection instrument

Data was collected through semi-structured, individual interviews through a video conferencing platform using Zoom Connect, due to the Covid-19 National Lockdown. Utilising semi-structured interviews, allows for the researcher to investigate each person's personal perspective for understanding of the personal context within which the research phenomenon is located (Lewis, 2003). These semi-structured interviews (presented in the interview guide in Appendix A) were guided by a set of six to eight pre-determined closed and open-ended questions (including prompts to aid clarification) and allowed for the research participants to actively participate in the interview process. The questions contained in the interview guide were directly related to the phenomenon being investigated and enabled that the researcher gained an adequate understanding of rehabilitation at this specific treatment centre. The use of semi-structured interviews in this study therefore allowed for the necessary flexibility in the exploration of the rehabilitation services provided for women at the centre. Each interview was audio-recorded and transcribed verbatim.

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3.5 Data collection procedure

A formal letter of request (Appendix B) to conduct research at the facility was submitted to the director of the centre. Permission to conduct the research was received in July 2020 once the centre was reopened, in line with the national lockdown regulations imposed due to the Covid19 pandemic. The contact details of those interested were provided to the researcher with their permission. Interviews proceeded from August 2020.

The researcher made telephonic and email contact with prospective participants. After receiving confirmation from participants, information letters (Appendix C) were disseminated to them via email. Informed consent letters (Appendix D) were also obtained from the participants before the interviews were conducted which was managed via a google form. This was generated to allow the participants to indicate consent using an online platform. On receipt of these electronic responses, individual interview sessions were arranged with participants.

3.6 Data analysis

The data analysis phase refers to the method in which raw data is grouped and interpreted by the researcher. Babbie and Mouton (2007) note that the process of analysing data aims to interpret the collected data for the purpose of drawing conclusions that reflect on the interests, ideas, and theories that initiated the inquiry. The study is underpinned by the qualitative paradigm and therefore utilised a qualitative data analysis technique.

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Thematic qualitative data analysis as proposed by Tesch in Creswell (1994) was used to analyse the data collected from participants. Thematic analysis is one of the most common forms of analysis within qualitative research. According to Babbie & Mouton (2007) steps in thematic analysis include:

- Familiarising yourself with your data.
- Assigning preliminary codes to your data in order to describe the content.
- Searching for patterns or themes in your codes across the different interviews.
- Reviewing themes.
- Defining and naming themes.
- Producing your report.

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To enhance the data analysis process, the use of Atlas Ti (Atlas Ti, 2016) which is an electronic data management tool (Babbie & Mouton, 2001) was employed to assist with the qualitative data analysis. With the assistance of Atlas Ti and the process of thematic analysis as proposed by Tesch (Creswell, 1994), the data was coded, and the researcher was able to retrieve codes and excerpts from the participants' narratives in an expedient and convenient manner. Following the meticulous procedure provided in Atlas Ti (2016), the researcher was able to develop themes and sub-themes based on several phases of coding and grouping of these codes. Following Tesch's (Creswell, 1994) steps for analysis, the researcher was able to read the transcripts several times to get a sense of the content and to identify themes. Notes which were written using Atlas Ti, served as memos as suggested by De Vos (2005). In addition, recurring data containing the various meanings were coded, thematically grouped, analysed and wherever relevant, compared with literature that was considered in the literature review.

3.7 Rigour

Credibility according to Morrow (2005) deals with the focus of the research and refers to confidence in how well data and processes of analysis address the intended research question. I conducted brief meetings with the prospective research participants prior to conducting the interviews via Zoom Connect. This helped me establish a rapport with the participants and to inform them about the study as well its aim and objectives and to assess connectivity and availability to Zoom. Further to this, I had regular consultations with my academic supervisors which helped me identify potential flaws during the execution of this process.

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Secondly, transferability refers to the extent to which the research findings can be applicable to other settings or groups (Morrow, 2005). In order to ensure transferability, the results of this study was presented in a way that reflected the context of the participants, the experience and the context in which the fieldwork (interviews) was carried out.

Additionally, dependability according to Shenton (2004) is concerned with the extent to which a study can be replicated by a future researcher where the research design may be viewed as a 'prototype model'. Dependability was ensured by providing a detailed description of the implementation process in terms of the planning and execution of the study.

Triangulation was ensured by asking a critical reader to check the findings against the transcriptions, which allowed for balances - guidelines by Creswell (1998) was used for

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member-checking and the participants were requested to review the transcriptions to check that their responses were accurately captured.

3.8 Ethics

The proposal served before the University of the Western Cape's higher degree Committee for approval. Permission to conduct the study was obtained from the University of the Western Cape's Humanities and Social Sciences Research Ethics Committee (Ethics No: HS20/4/40) (Appendix E) as well as from management at the rehabilitation facility. All participants were notified that participation is on a voluntary basis, with the understanding that they could withdraw from the study at any time without any consequences. An Informed consent, as attached in Appendix D, was obtained from every participant prior to the commencement of their interviews. An information sheet, as attached in Appendix C, was given to all participants with a detailed explanation of the research topic, research objectives and what was expected of them. Anonymity was assured by not using participants' names and the information obtained from the participants was stored securely to ensure that the participants would not be placed at risk of any harm. Participants were assured that debriefing and/or counseling would be made available to them should they have experienced any distress from narrating their perceptions of the rehabilitation services offered to patients. The data was transcribed and coded, stored in a file and saved on a drive protected by a password. The information will be discarded after a period of five years. Participants' data was kept confidential during the data capturing and analysis whilst being captured anonymously; identifiers were attached to each respondent as follows: the first interviewee is participant one indicated as (P01); second interviewee (P02); third interviewee (P03) and so forth and will be presented as such in subsequent chapters.

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CHAPTER 4
FINDINGS

Introduction

This chapter presents the research findings and will be structured around themes that emerged from the semi-structured interviews. Eight semi-structured interviews were conducted with staff at a rehabilitation centre in Cape Town. The chapter comprises two sections. Firstly, the participant profiles will be summarised to reflect the gender, job description and their involvement with women clients at the centre. The second section of this chapter will outline themes and sub-themes derived from coding the raw data as I attempted to address the research objectives guiding this study.

4.1 Participant profile

The following section will provide an overview of the demographic profile of the research participants in relation to gender, job description and the duration of their involvement with the women at the centre, as illustrated in Table 1.

Table 1: Demographic profile of participants

Participant	Gender	Job Title	No. of years worked at the treatment centre	No. of years involved in substance abuse treatment programmes
P01	Female	Shelter Social Worker	2 years	5 years
P02	Female	Social Worker Supervisor	4 years	15 years
P03	Female	Intake Social Worker	5 months	5 years
P04	Female	Director	3 years	3 years
P05	Female	Programme Manager	4 years	6 years
P06	Female	Registered Counsellor	3 years	5 years
P07	Female	Intake Social Worker	1 year	3 year
P08	Female	Nursing Sister	3 years	12 years

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Table 1 provides an overview of the staffing profile at the centre that provide services to female victims of domestic violence and who have a substance abuse problem. All of the staff are female in the research, in line with the centre's staffing criteria.

Related to the tabled information, it is noted that all participants are health professionals who also perform administrative duties at the rehabilitation centre. While six out of eight participants range between the ages of 35–50 years, two of the eight are older 50 years. Although some of the participants have worked at the treatment centre for less than one year, most of the research participants have three or more years of experience in substance abuse related programmes and interventions.

Participants three (P03), seven (P07) and eight (P08) are involved in the admission/intake of women clients that approach the centre while participant one (P01) has worked with women in the substance abuse unit and shelter. Three research participants (P05; P06 and P08) work exclusively with women clients during the duration of the substance abuse residential programme while participant two (P02) and participant four (P04) ensure that substance abuse programmes and services facilitate useful outcomes for women who abuse substances, and these outcomes are strategically aligned to the mission and vision of the centre.

All participants were very passionate about their views on the current services offered and the gaps and limitations that currently exist within those services and programmes at the treatment centre. Moreover, all participants were very objective and impartial about the limitations of services that generally exist for women who abuse substances and shared very interesting opinions on mitigation processes in this regard.

4.2 Key themes

The following section will provide an analysis of the themes that emerged from the qualitative data. Themes and sub-themes have been grouped and respond to the research objectives outlined in the previous chapters as indicated below.

Table 2: Research objectives; themes and sub themes

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Objective	Theme
1. To explore the perceptions of staff regarding the logistical challenges experienced at the rehabilitation centre.	1. Lack of resources *Sub theme:* Complexity of funding
2. To explore the treatment strategies available for women at a rehabilitation centre.	2. Rehabilitation in substance abuse *Sub theme*: Treatment and rehabilitation strategies
3. To identify the specific needs versus resources required within rehabilitative services for women with substance abuse disorder.	3. Context of clients *Sub theme*: Accessing services
4. Provide recommendations to rehabilitation centres pertaining to services offered to women.	4. Exit Strategies

4.2.1 Theme 1: Lack of resources

One of the challenges perceived by staff is a lack of physical (e.g. lack of beds, skilled staff) and external resources (sufficient funding, post-programme services) that affect the staff as well as the women clients. The lack of resources was found to affect the functioning of the centre and its programme implementation. The following Figure generated using Atlas Ti provides an overview of the challenges perceived by the participants where the reliance on sponsors and donors is evident. It also visually displays the challenges and also highlights the needs of the centre.

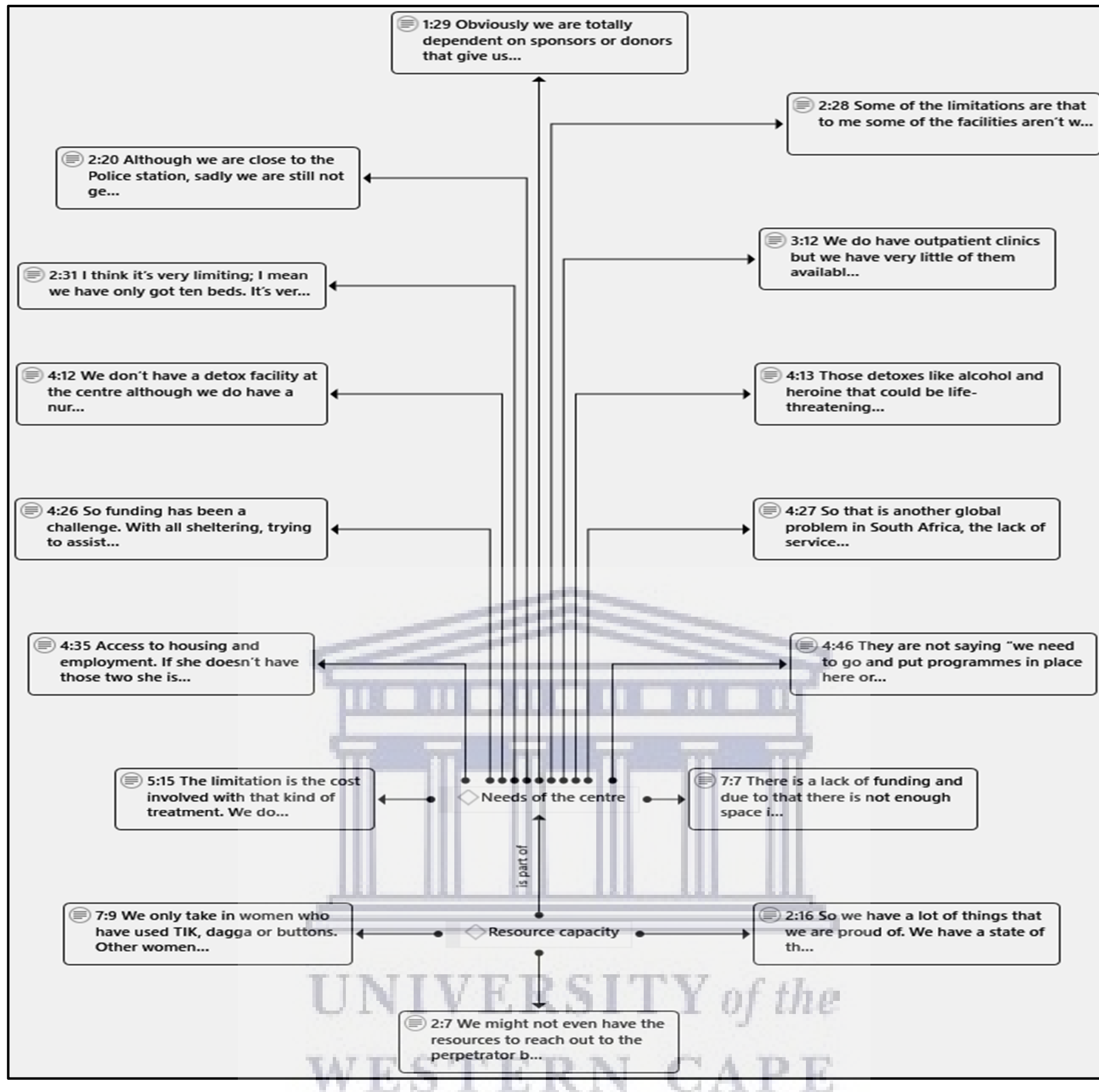

Figure 1: Lack of Resources

The challenges identified by the staff included the dependency of the centre on external funding. Several participants indicated that the lack of funding influences the ability of the centre to provide sufficient bed spaces and the ability to access the appropriate detox treatment for the clients. Furthermore, these challenges are compounded by the lack of support from safety and security forces in the community where the centre is located, as the clients are victims of domestic violence.

The research participants in this study, all being staff at the centre, have had substantial exposure to the immediate and long-term challenges faced at the centre and provided several instances of how the lack of access to resources presented a great challenge. The lack of resources identified ranged from physical resources that affect the daily operations and functioning of the centre to the external supportive services in the community that should be available for the centre to access (safety and security / police). Furthermore, it appears as though some staff members at the centre were also not sufficiently equipped to deal with the extent of the psychological problems that the women presented with and required the necessary support. These were articulated in following extracted statements below:

> **"***We just don't have any more beds and we have to put them on a waiting list. When you phone that women a week later to say that we now have a place for you, you can't reach her" (P01).*

> **"***There are a few other places but the problem with those that are available is that they charge a fee. So, if you want to be enrolled in a programme you have to pay. Whereas with the centre it is absolutely free" (P02).*

> **"***So, we are often faced with a survivor that has personality disorders and we are just completely not trained to deal with someone who is suicidal, paranoid and schizophrenic. Trying to get her into a centre that can assist her is almost a herculean task and, in the meantime, you have got staff members that are ill-equipped to deal with it, you know trying their hand to render a service, it's heart-breaking" (P03).*

> **"***Approximately 80% of the survivors that come into the shelter are substance dependent. We obviously cannot assist women that have dependency on hard substances like alcohol, like heroine, those that would cause major withdrawals because we just don't have the resources to treat them properly. It would require an enormous amount of funding because there is obviously a need" (P06).*

The above statements show evidence that the centre is exposed to short- and long-term challenges affecting the design and execution of programmes and services - this having a direct impact on the staff, clients and centre functioning. Participants 1 (P01) and 2 (P02) explained

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that while the centre is cost effective, the lack of available spaces often results in turning women and children away. This challenge is often followed by the lack of referral opportunities due to the lack of affordability and ultimately losing contact with the victim when availability is possible. Furthermore, participant 3 (P03) and 6 (P06) confirmed that the centre is frequently faced with women who suffer from various psychological disorders as well as being addicted to certain substances that prevent access to the centre.

4.2.1.1 Sub theme: Complexity of funding

Funding opportunities and funding in general, falls under the main theme of lack of resources which causes much of the operational strain at the centre. This is evident in the following extracts.

> *"So, our DSD funding for the substance unit is a very, very small percentage of what we actually need to run the programme properly" (P04)*

> **"***Sometimes funding is a problem. Within the substance unit we are not funded for accredited training, unlike in the shelter section. They don't have adequate funding for training. The shelter people get training but the people in the substance area don't. It's just the way DSD is funding "(P05)*

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Furthermore, the manner in which the centre is funded by the DSD was perceived to be limiting the scope of the centre's initial practice:

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> *DSD doesn't know what to do with us. They didn't know where we fell. We weren't a rehabilitation centre per say, and we weren't a shelter. We were an amalgamation of both of those functions, and we fell within or between two different departments of how they operate. Up until this very quarter, we fell under the substance unit of the Department of Social Development*" (P04)

In addition to this, it was noted that staff were unable to access sufficient funding from government and at the same time struggled with current funding which further lead to a large number of women being turned away. Participants 4 (P04), 5 (P05) and 8 (P08) speak about the inadequacies of the core funding source in relation to running the centre sufficiently as well as the skewed allocation of this funding, leading to the lack of services offered for women in

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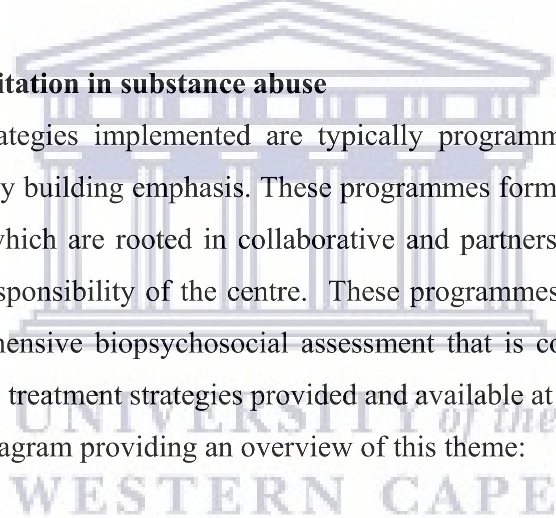
the substance abuse unit. It is stated that the allocation of funding does not offer the same services such as skills training (such as computer skills, first aid, ABET classes) and second phase accommodation, as it does for women in the shelter. It was further confirmed that, the lack of skills training, lack of mental health services and alternative accommodation, are major gaps that have been identified yet the funding has remained the same. These are reflected as follows:

> *"The state doesn't offer any sort of true and effective mental health treatment for survivors" (P04)*

> *"It's quite an expense to run the unit. I think the funding has stayed the same since its inception. There has been no increase. Yet a lot has evolved over the years" (P05)*

4.2.2 Theme 2: Rehabilitation in substance abuse

The rehabilitation strategies implemented are typically programmes with an education development and capacity building emphasis. These programmes form part of the therapeutic process for the clients which are rooted in collaborative and partnership focused strategies, which forms the core responsibility of the centre. These programmes are also developed in response to the comprehensive biopsychosocial assessment that is conducted upon women accessing the centre. The treatment strategies provided and available at the centre is illustrated in Figure 2, a network diagram providing an overview of this theme:



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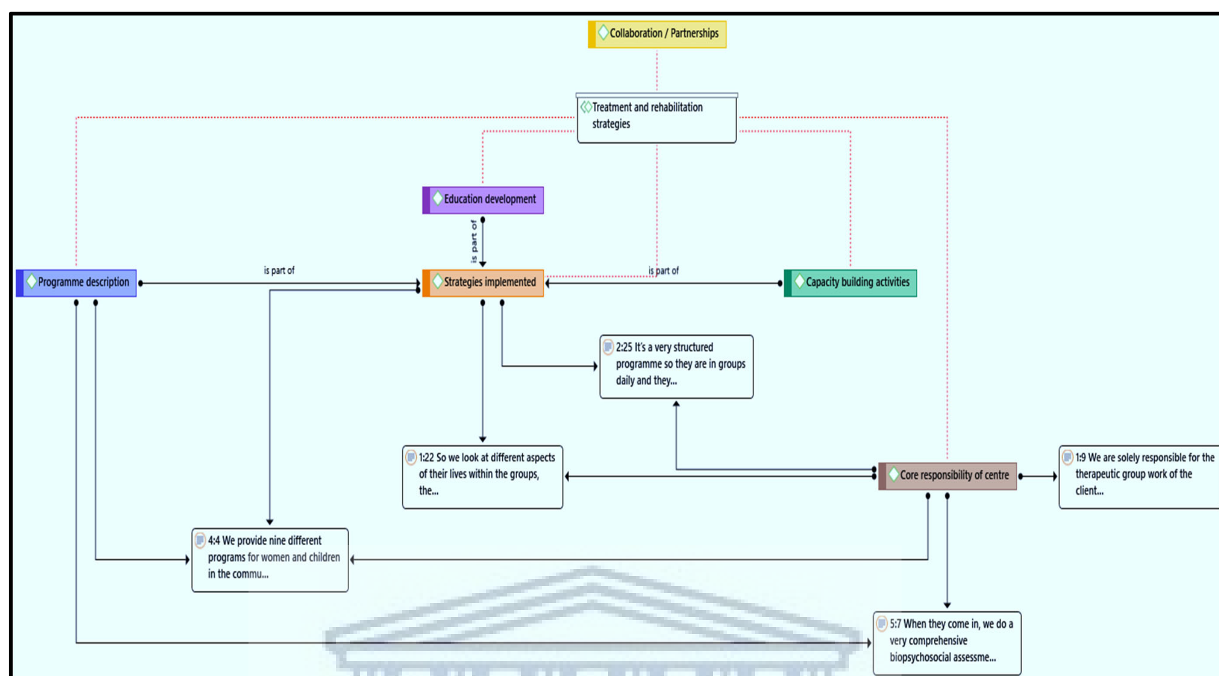

Figure 2: Rehabilitation and Treatment Strategies

It was found that the research participants were administrators and/or facilitators of the 4-month programme which is comprised of various components consisting of an emergency shelter, childcare services, psychosocial support, legal services, and health assessments for clients who are victims of domestic violence and who have a substance abuse health issue. The description of the extent of the services provided by the centre are captured in the following quotations:

> "*The protection order needs to be sorted out. The SASSA needs to be sorted out. A lot of health issues need to be sorted out. All those things need to be sorted out before one can actually start with therapeutic work" (P05)*

> "*We check for HIV and STIs. I take their blood pressure; their pulse and I check for sugar. If they have any physical sickness, I will refer them to the doctor or at a day hospital" (P08)*

> "*So, we work primarily from a twelve step programme point of view and it's an exceedingly hands-on unit. We offer individual therapy; we offer group therapy, and we do workshops with the ladies as well. We also have services from narcotics*

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anonymous that runs group sessions with the ladies and we have got our psycho-social or our psycho-educational groups" (P04)

"*They need to be reconnecting with their family. They often have relationship problems, so you are dealing with that and like skills, communication and dealing with aggression. Those are all the things that they are trained in and deal with" (P03)*

From these statements, participants 5 (P05) and 8 (P08) described the additional services offered to women in the form of grant access and health assessments. These aspects usually have to be sorted out prior to the commencement of the official educational and capacity building programmes. Moreover, participant 4 (P04) further dissected the holistic programme into steps that does not only include individual and group therapy, but incorporates psychoeducation focusing on parenting and all aspects of substance abuse. Participant 3 (P03) further described psychosocial skills training as an important factor to reconnect with the family by enhancing good communication and conflict resolution, strategies that are covered in the programmes.

4.2.2.1. Sub theme: Treatment and rehabilitation strategies

While limitations and challenges have affected the optimal functioning of the centre and the execution of programmes and services, many positive strategies exist that have enabled sufficient operations. Much of the innovative approaches have positively contributed to the efficiency of the centre and has worked to mitigate some of the aforementioned gaps. The following section will explore and highlight the opinions of participants regarding some of the centre's strategies as articulated in the statements below:

"*We have formed a very good partnership with the X hospital and what they have done is they have been assisting with things like Thiamine, the vitamins and minerals that we actually need for the substance dependent women. They need specific things to help with the detoxes" (P03)*

"*There's a lot of other involvement, like they are invited out for prayer meetings, lunches, for some other entertainment; and they are allowed to go. Or organisations come to the centre who will entertain and pamper the ladies*" *(P04)*

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"*We also look at forgiveness and reintegration back into society as well. We look at different aspects of their lives within the groups, the same with your individual sessions, we look at various areas of that too. So, within those four months you need to make a plan as to where you are going forward, after the four months" (P08)*

It is clear from these extracts that the centre relies on its collaborations and partnerships with organisations. Participant 3 (P03) speaks of the centre's partnership with a hospital in close proximity which has provided an innovative way of accessing resources for clients that the centre cannot afford. The centre also incorporates legal services according to participant 7 (P07), which includes the accessing of a protection order and additionally contributes to the success of post treatment strategies for women clients. In addition, participant 4 (P04) describes the incorporation of creative events and services that enhance the programme. Many of these services and activities vary from spiritual meetings with Church organisations and socials ranging from entertainment to pampering sessions. In the extracted quotation earlier, participant 8 (P08) describes how clients are taught how to develop an individual development plan (IDP) that focuses on core measures assisting them with their post treatment success and resilience. These holistic plans include psycho-educational aspects, therapeutic development as well as personal development/constructive plans going forward.

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4.2.3 Theme 3: Context of clients

The following theme explores the perception of participants regarding the needs and resources required. This was important to consider in relation to the context from which the clients accessing the centre originated from. The research participants in this study have confirmed that most women clients come from predominantly disadvantaged communities, where socio-economic conditions are prevalent. These confirmations are presented in the following extracted quotations:

"*I mean still in the Western Cape we have got some of the highest usages in the world. We know that it's so connected to the levels of violence, perpetrators against women and children. It's a systemic problem that needs to be addressed on all walks of life" (P02)*

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"The areas that we service and the reason why the centre was originally formed was that this area had a large need because of high rates of gangsterism, abuse against women and children, poverty, impoverishment, substance abuse, and all the social ills that one would think exists because of a legacy of Apartheid and a failing economy" (P04)

"These women have been abused for years and years and sometimes it starts in their childhood already, so their self-image is absolutely shocking. A lot of them haven't worked in their life" (P05)

Pertaining to the above statements, participants have confirmed that the majority of women clients come from residential areas in close proximity to the centre. Furthermore, participants explained that these structural determinants such as patriarchy, gangsterism and poverty have influenced the onset of all types of abuse, specifically against women and children within these communities. It is further explained that most women have been subjected to physical abuse and rape from a very young age and as a means to cope has turned to abusing substances. The following Figure 3 provides a visual representation of the description of the context of clients accessing the centre.

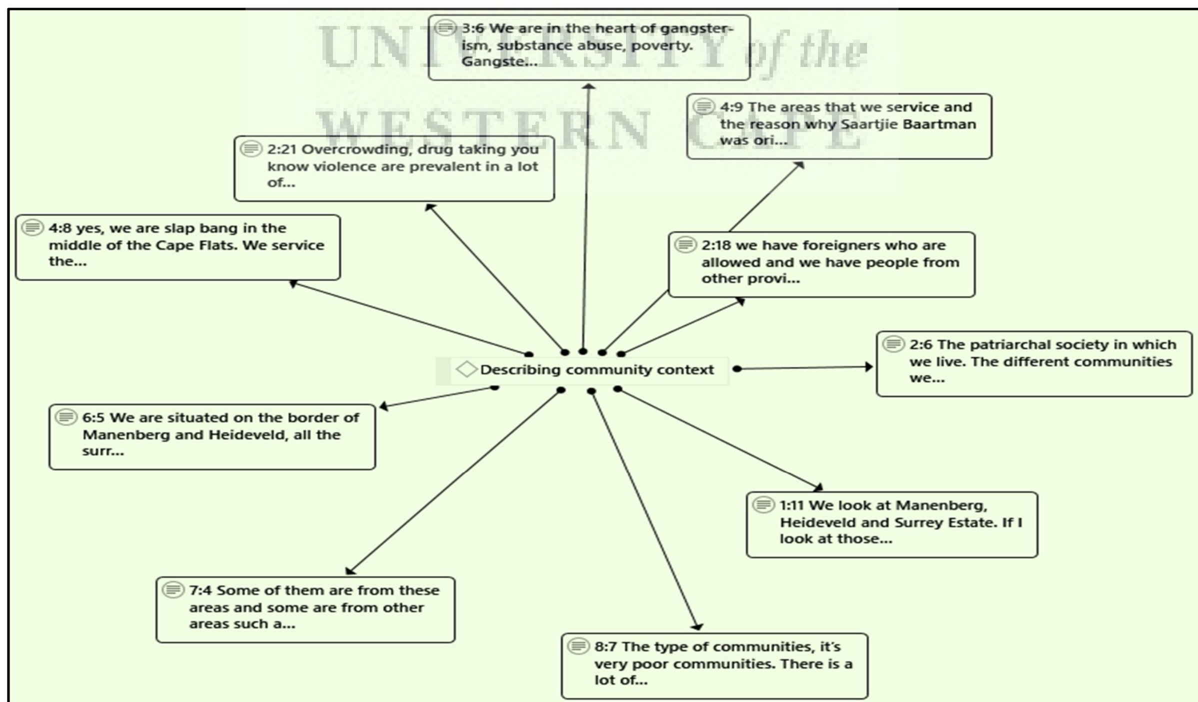

Figure 3: Describing the context of clients

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4.2.3.1 Sub theme: Accessing services at the centre

The research participants in this study have expressed that certain health staff are exposed to abused women with additional challenges that are observed during the entry stages of the treatment centre i.e., during registration or enrollment. This phase is crucial in identifying clients who meet the criteria of the centre, and it is an influential part in the determination and development of programmes and services for these women clients.

The centre is first and foremost an organisation that addresses domestic violence; however, several other criteria are observed during the admission process of potential clients. Research participants identified physical impairments, substance related challenges and childcare needs, as common factors found during registration for all women clients, as articulated in the following statements:

> "*Yes, but remember they must also have evidence of GBV. It is not just a rehabilitation centre for substance abuse, it's for women that have also been physically, mentally, emotionally or verbally abused in her life and as a substance abuser. Often it is linked because part of the abuse by the perpetrator is forcing the women to use the same drugs that they are. Then they become addicted" (P02)*

> "*One of our inclusion criteria is that they must be survivors of domestic violence in addition to their substance dependence. We don't take people who just come where there is no violence, no abuse, and that just wants treatment. The centre is one of few centres, in South Africa, where we take women with children in the rehab centre" (P05)*

> "*We were the first shelter in the world to have a substance abuse unit. And I think the centre took a very bold approach to address that issue where you treat both" (P01)*

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"*Holistic empowerment. So, the idea is that on all levels of a woman's' functioning, whether it is psychological, physical, substance-dependency and parenting. There is such a tight link between domestic violence and substance abuse.?" (P06)*

Related to the above, participants have confirmed that the centre only accepts women into the substance abuse unit if they are victims of both gender-based violence and substance abuse. Furthermore, one participant explained, that not many centres focus on accepting women and their children, making this centre very unique. Many women clients seek help to protect their children due to their fear of losing them to the social welfare system. Whilst the centre is well known for serving as a safe haven for abused women and children, it also recognises the link between the physical or emotional abuse and substance abuse and has further designed their programmes around this connection.

4.2.4 Theme 4: Exit strategies

The exit strategy at the centre has incorporated valuable processes in light of assuring treatment success and continuous resilience for women clients. The following section highlights the opinions of participants regarding aspects pertaining to the exit strategy at the centre as articulated in the statements below:

"*So, we put a safety plan in place and also just make them aware of where they are coming from and should they be back in the same situation what they can do. Also, what they need to put in place for their children as well and the documents they need to have in place should they need to escape again" (P01)*

"*We don't always have the capacity to follow-up. When there are children, in some cases, they are referred to child-welfare or DSD to check up on them" (P02)*

"*We connect them with the support groups outside. So, somebody will come in in their last 6 weeks and negotiating with them, develop a relationship with them and doing sessions with them as well" (P03)*

Pertaining to the aforementioned statements, participant one (PO1) speaks of a safety plan that is designed for the women clients. According to this statement the safety plan includes information on legal processes and steps they can follow should they require emergency

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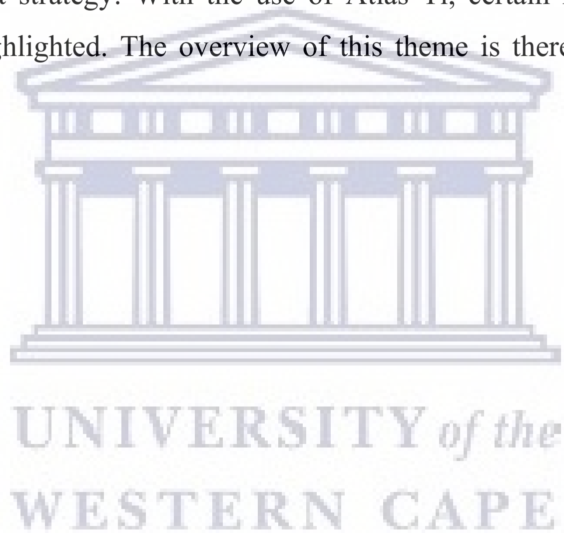
assistance for themselves and their children. In addition, participant two (PO2) confirms that the centre refers specific cases for the monitoring of children when these women return to the community. Adding to the above, participant three (PO3) specifies that different support groups start interacting with women clients during the last six weeks in the aim of creating a continuous relationship when they return to their communities. The exit strategies for clients who have completed the programme needs to include accommodation, support, government support and a safety plan as reflected in the following figure generated using Atlas Ti.

Participants have also identified several recommendations which indicated the need for a formal aftercare service that links to the exit strategy. The centre does not offer a formal aftercare service, but introduces social support and other services during the programme in order to develop an exit strategy. With the use of Atlas Ti, certain recommendations and strategies have been highlighted. The overview of this theme is therefore presented in the following Figure 4.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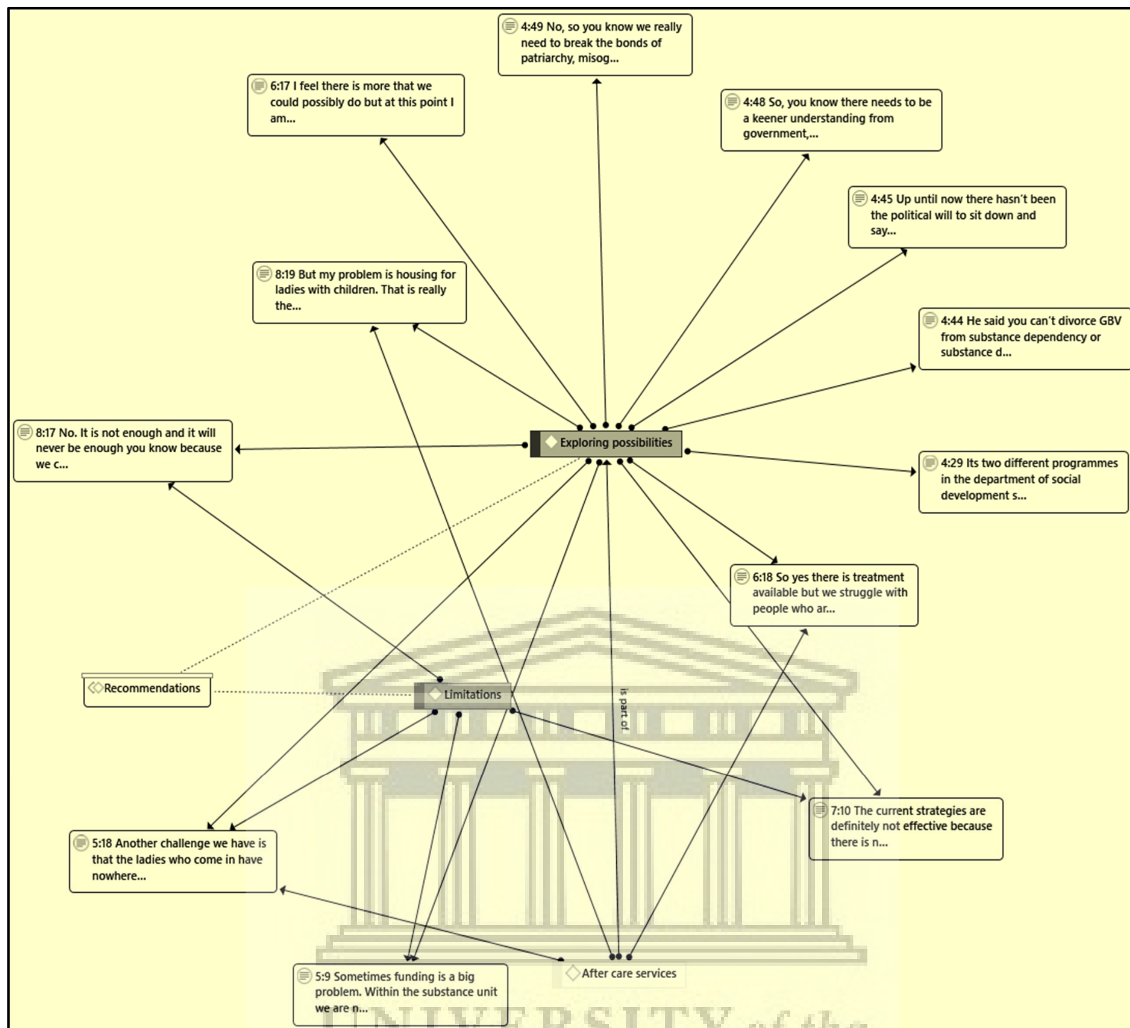

Figure 4: Overview of recommendations

The findings identify several areas where the centre falls short of, including the development of an optimal service and aftercare, that was mentioned several times as illustrated in Figure 4. This chapter presented the results from the data collection process and will be discussed in more detail in the next chapter.

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CHAPTER 5
DISCUSSION

Introduction

This study explored the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town. In the previous chapter, the research findings were presented thematically. This chapter presents a discussion of the research findings with the aim of adding rationality by establishing links between the emerging themes as they relate to the following research objectives that guided the study:

- To explore the perceptions of staff regarding the logistical challenges experienced at the rehabilitation centre;
- To explore the treatment strategies available for women at the rehabilitation centre;
- To identify the specific needs versus resources required within rehabilitative services for women with substance abuse disorder; and
- To provide recommendations to rehabilitation centres pertaining to services offered to women.

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The final section of this chapter will draw conclusions from the findings in relation to existing studies to draw comparisons and identify gaps in the literature.

5.1 Lack of resources

As previously stated, this study has highlighted the need for support to rehabilitation centres, such as the research site, where holistic support for substance abuse programmes and the children of women clients are required. Firstly, many women who approach the centre suffer from extreme psychological disorders such as major depression and PTSD. This is usually due to their circumstances, which have influenced them to abuse substances. Studies have indicated that, generally, more women than men suffer from co-occurring psychiatric disorders, such as depression, social phobia, PTSD and eating disorders. These women are usually poor, uneducated, welfare-dependent and unemployed (Tuchman, 2010). This is further supported

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by Goodman, Peterson-Badali and Henderson (2011), who state that a significant number of individuals develop mental health issues such as depression or anxiety, which are often accompanied by drug and alcohol abuse and/or dependence.

The content of rehabilitation programmes needs to be developed to focus on the reduction of and abstinence from substance abuse, as well as treating psychological disorders. Unfortunately, because staff are not fully equipped to deal with psychological disorders at the centre, many women are referred to privately-owned centres where access is almost impossible due to cost. Moreover, when considering social determinants of health, a link exists between trauma and substance abuse and there is a definite connection between substance abuse and psychological disorders. It is clear that dealing with the two aspects in isolation will not lead to the sustained recovery of women who abuse substances. This is further recognised by the NDMP 2013-2017 (Department of Social Development, 2014), that stipulates that treatment should include both medical and mental health services. However, this is expensive to implement at a centre experiencing financial constraints.

Many women who approach the centre are addicted to substances such as alcohol, cocaine and heroin. According to SACENDU (2018), males have dominated statistics pertaining to substances and enrolling in rehabilitative services. However, the period 2013–2017 saw an increase in the number proportion of females who were treated for the use of alcohol (31%), crack/cocaine (35%) and methamphetamine (36%). Unfortunately, due to the complexity of treating these substances and their side effects, these women are denied access to the centre and referred to specialised institutions where costs are extreme and waiting lists long.

In addition, there has been an increase in negative factors that affect determinants of health. While unemployment and poverty remain problematic, GBV and the abuse of substances have increased substantially amongst women in the Western Cape. Although these statistics have increased, centres such as this specific research site have limited space and resources for women living in lower socio-economic communities.

5.1.1 Complexity of funding

A critical gap in the substance abuse field is the lack of funding for rehabilitation services for abused women who come from lower socio-economic communities. A significant challenge is that, as more non-governmental organisations (NGOs) are established, less funding seems to

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be made available by government and the private sector (SACENDU, 2018). In this study, it was observed that the centre and many similar organisations struggled to access sustainable and adequate funding to run their programmes efficiently. This observation is supported by Bhana, Lopes, and Massawe (2013), who stated that an estimated 60% of social welfare services for women and children were currently being provided by NGOs but that funding covered only part of the costs.

According to the DSD Policy Framework and Strategy (2003), the centre had been fundraising successfully for many years with the institutional budget increasing year on year. However, the organisation began noticing a trend of diminishing resources for shelter provision over time as the funding criteria of the corporate, government and donor sectors shifted to advocacy, research and prevention work, excluding shelters. The lack of sufficient funding has impacted greatly on the operations of organisations such as the centre, in that only a limited number of staff can be employed at entry-level salaries. This has implications for the content of the programme, as specialised professionals who could enhance the programme holistically are unaffordable. Furthermore, while such organisations offer services that go beyond programmatic content, such services are basic and usually non-accredited, and the organisations must rely on volunteers rather than skilled professionals to conduct these services. Basic resources such as food and toiletries for women clients and their children are also limited due to these financial constraints.

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Another major limitation for organisations such as the centre is the allocation of available funding. When funding is accessed and secured, the manner in which it is spent is usually controlled by the funder, who stipulates how spending should be allocated in a Memorandum of Understanding. Having said this, shelter services fall under the broader ambit of the national government's Victim Empowerment Programme (VEP), which is funded by the DSD. The DSD is responsible to provide short-term interventions for women and children in crisis situations (Levendale and Abrahams, 2009). This is a direct reason why most of this funding is allocated to the shelter unit, while the quality of services for women admitted to the substance abuse unit is neglected. Additionally, according to the Western Cape DSD's Annual Report for 2011/12 (Western Cape Department of Social Development, 2011), the VEP sub-programme is focused on designing and implementing integrated programmes and services to support, care for and empower victims of violence. However, the gap pertaining to funding allocation

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becomes clear because some victims are women who abuse substances due to the exposure to trauma and violence and therefore changes to current policies are required.

In this study, it was noted that organisations such as this centre need to operate in innovative ways to sustain their success rates. This is usually accomplished through post-treatment initiatives such as the monitoring of previous patients, referrals to post-treatment organisations, and offering additional support. Post-treatment, by definition, involves the re-integration of clients back into the family, community and workplace following formal treatment (South Africa, 2008). Moreover, aftercare services would contribute greatly to the sustainability of the organisation and are sadly lacking at present. It must also be reiterated that these strategies are limited due to a lack of staff and funding to implement post-treatment support effectively.

5.2 Rehabilitation programmes and strategies

The NDMP 2013–2017 (Department of Social Development, 2014) set out to combat substance abuse by providing holistic and cost-effective strategies, while monitoring the resources and services available to families. Additionally, a range of caring services with a tailored treatment programme and strategic options can be crucial to success, as stipulated in the plan.

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The research participants in this study have confidently described the rehabilitation programme offered at the centre as a holistic process incorporating services in addition to programmes that are specific to substance abuse. Due to the diversity of traumatic experiences as well as gender-related concerns, women who abuse substances require additional services that respond to their different needs. One area that was identified is the aspect of motherhood. According to Tuchman (2010) the most substantial obstacle for young women is available and affordable childcare, yet few treatment programmes provide on-site childcare or assistance in this regard. As the child's main caregiver, the well-being of a patient's child is often the reason a woman enters into treatment, and the reason why she will complete treatment successfully. This is one of only a few centres that takes in patients and their children, and that provides childcare services and resources. Although the incorporation of childcare services enhances success for patients, minimal funding only allows access to a limited number of women and children, with very few options for referral.

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In addition, the physical condition of women patients when they enter the centre is shocking, with most of them never having previously experienced a medical consultation. It is logical that, given their abusive circumstances, all women need to be evaluated to ascertain whether there are underlying illnesses or pregnancies that may prevent them continuing at the centre. According to Naylor and Lee (2011), treatment programmes should consider the individual- and programme-level factors that impact on the experiences of patients, particularly women, and the overall outcome of treatment. Whilst the centre conducts intense medical assessments, medication and further health-related assessments come at a cost and require additional resources, which limits these services.

Furthermore, in this study, the importance of legal assistance for purposes of protecting abused women and children became apparent. Due to the mission of the centre, the perception that all women patients require legal assistance for protection orders and divorce proceedings remains a common thread in this study. According to McLellan et al. (2005), successful substance abuse treatment requires that all life domains be considered. as this would ultimately improve the substance user's overall quality of life. Whilst the centre offers basic legal services and assists patients to access welfare grants, the quality of services is limited due to financial constraints.

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Sorsdahl et al. (2015) recommended that current rehabilitative services undergo certain shifts in policy. Some researchers have proposed that the ideal treatment programme should provide comprehensive, family-centred services incorporating social-specific support in the treatment process to improve the outcomes of treatment (Sorsdahl et al., 2015). Having said this, comprehensive health care requires substantial funding and long-term sustainability. Although the centre provides an intensive 12-step programme with additional services, all the offerings have limitations that deny quality and enhancement due to inadequate funding. In addition, in the 2009 public hearings, the DSD as the centre's main funder stated that it would guarantee that the services provided for in the VEP would be made available to victims with disabilities (PMG, 3 November 2009). This would be done, among other means, through an audit of facilities and their programmes (Parliamentary Monitoring Group, 2009). By the time of writing, this, too, had not yet happened.

In this study, much literature is cited on the importance of developing rehabilitation services that are comprehensive and holistic in nature. Lopes (2013) supports this view and notes that

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treatment should consider the overall impact of substance abuse and treatment on the life domains of individuals accessing services, as the primary goal of treatment is to enable the patient to reduce and/or abstain from substance use.

It is important to note that, due to limited funding, centres such as this require innovative strategies and approaches to create a holistic treatment programme for women patients. The process of enabling access to services pertaining to medical assessments, legal advice and social grant access, has relied on building relationships with supportive organisations that have made resources available at little to no cost. In addition, some service providers who implement psycho-social and family workshops are volunteers or social work interns; sustaining these relationships requires continuous negotiations. Finally, due to financial constraints, centres wanting to offer comprehensive services that sustain post-treatment successes, are forced to rely on existing staff who have other responsibilities at the centre.

Although Sorsdahl et al. (2015) recommend shifts in current substance abuse treatment policy to achieve sustained successful treatment rates, many of the recommendations require continuous creativity and further support from the government in terms of policy change.

5.3 Context of clients

The common trends in the context and background of women clients as identified by the research participants were prominent factors that contributed to the abuse of substances, which is consistent with the literature. Participants stated that most women clients come from lower socio-economic communities that are riddled with poverty. According to Parry et al. (2011), Cape Town and the broader Western Cape region have especially high crime rates, with criminal acts affecting significant numbers of people within these communities. Gangsterism, poor education, inadequate health facilities, community violence, GBV and intimate partner violence are but a few examples of the threats that residents of low-income Cape Town communities face. Furthermore, the participants stated that social ills were the main factors that contributed to the onset of substance abuse amongst women. This observation was supported by recent studies that indicated that 70% of female users were coloured, unemployed (30%) and had not completed high school (SACENDU, 2019). This suggests that there has been a noticeable increase in female substance users and the vulnerable state of women in society. This has been highlighted during the Covid-19 pandemic (John et al., 2020).

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The overlapping cycle of social determinants has been highlighted consistently, suggesting that social ills influencing substance abuse are in turn influenced by deeper factors such as social determinants of health. According to participants' statements, the development and growth of lower socio-economic communities stem from the legacy of apartheid. According to Pampel, Kruege, and Denney (2010), persons who are economically deprived and living in disadvantaged communities face a variety of chronic stressors in their daily lives. In addition to battling to make ends meet, they have few opportunities to achieve positive goals due to unemployment and a lack of education, whilst at the same time dealing with discrimination, marginalisation, isolation, and powerlessness. While Lehavot and Simoni (2011) suggest that socio-economic factors such as extreme poverty, unemployment and lack of sufficient education are the predominant factors that contribute to criminal acts, behavioural determinants such as gangsterism and GBV are causal factors leading people to abuse substances. Inequities within social determinants represent the causes of health inequality: the unequal conditions in which people are born, grow, live, work, and age; and the inequities in power, money, and resources that give rise to them (Marmot and Bell, 2019).

The residential areas serviced by the centre are classified as lower socio-economic status areas and therefore are comprised of determinants that influence the abuse of substances amongst women clients. According to the participants, these structural determinants are related to the disenfranchisement experienced in the past, which has resulted in communities experiencing intense poverty and a lack of education and employment.

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It is evident from the above that the foundation of structural determinants influences the behaviour of individuals living in lower socio-economic communities. The perception of staff has highlighted that women who are affected by issues such as gangsterism, extreme poverty and GBV may use substances to help them cope with trauma. Many women who have suffered from violent acts and various traumas abuse substances to help them 'function' in a society where there is little support and few opportunities.

5.3.1 Accessing services

In this study, trends pertaining to substance abuse amongst women have been linked to the exposure to violence and other forms of trauma. While traumatic events and stressful lifestyles become the norm for most women, rehabilitation may be considered as a last resort when violence and abuse become too overwhelming and life threatening. Therefore, according to

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Lopes (2013), entering treatment is often a means to an end, enabling substance abusers to escape the negative consequences of substance use.

In addition, there is a definite link between GBV and substance abuse. Firstly, the fact that women have been found to be at greater risk of experiencing traumas such as intimate partner violence and rape makes them more vulnerable than men to misusing substances (Carr and Szymanski, 2011; Hawkins, Catalano and Miller, 1992). Having identified this link, it becomes obvious that, when combined with an addiction to drugs or alcohol, forms of abuse can quickly escalate into a dangerous situation that is hard to get away from. For most, the pain of being a victim of abuse and violence can trigger substance abuse. In fact, women who have been abused are 15 times more likely to abuse alcohol and nine times more likely to abuse drugs than those without a history of abuse (Hawkins, Catalano and Miller, 1992). According to Breslau et al. (2003), exposure to trauma may lead to the development of substance use disorders and mental disorders such as PTSD. According to Punamaki, Belt and Posa (2013), these complications in affect are expressed in both hyper- and hypo-arousal; for example, they explain that substance abusers tend to fluctuate between behavioural withdrawal and emotional numbing, and overwhelming and uncontrollable feelings and behaviours. This dysfunctional processing of emotions underlies depression and anxiety, a tendency towards impulsive and aggressive behaviour, and even suicide. Therefore, it is important that programmes and services be developed to simultaneously address the effects of trauma exposure and substance abuse. However, whilst many rehabilitation centres offer specialised trauma psychotherapy in addition to traditional rehabilitation treatments, very few are state-funded and based within lower socio-economic communities where these services are free of charge or affordable. It should also be noted that GBV has been declared as South Africa's second pandemic and is therefore a public health issue (John et al., 2020). Having said this, access to services in the communities where this study was conducted remains an issue, rooted in the availability of resources.

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Moreover, many of the women clients who live in lower socio-economic communities require accommodation in addition to programmes that alleviate substance abuse symptoms. Currently, the centre, is one of very few that treat both the abuse that clients have experienced

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and their substance-related issues. It is therefore an entry requirement of the centre that the client has been a victim of both violence and substance abuse. The centre acts as a hub to offer shelter and services to victims of GBV. It also coordinates programmes for those who have a substance abuse disorder in addition to experiencing trauma. According to McLellan et al. (2005), successful substance abuse treatment requires that all life domains be considered, which should ultimately improve the substance user's overall quality of life. The holistic treatment model that the centre engages in supports this view.

Whilst there has been a substantial increase in crime and GBV statistics in the Western Cape, not many organisations offer both shelter services and substance abuse rehabilitation services to women. The Policy Framework and Strategy for Shelters for Victims report (Department of Social Development, 2003) found that funding constraints limited the ability of shelters to provide comprehensive services to women in the Western Cape. Moreover, the recent Covid-19 pandemic has indicated that critical services, particularly those needed by vulnerable and abused women and girls, often become unavailable or are de-prioritised and deemed non-essential. Moreover, fear of infection, restriction of movement and public unrest, as well as violence and mistreatment, may prevent women from seeking health services during an epidemic (John et al., 2020).

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5.4 Summary

This chapter presented a discussion of the research findings derived from participant narratives and established links between emerging themes and relevant literature. The discussion highlighted gaps pertaining to the lack of entrepreneurial and skills training offered to women clients of the substance abuse centre. This is closely related to aftercare treatment success and reducing the chances of repeating the cycle of domestic abuse that in turn increases substance abuse. Intensive aftercare programmes within treatment programmes that encourage the sustainability of the model were found to be important too.

Furthermore, the need was identified to develop additional facilities that focus on assisting women who are both victims of GBV and who abuse substances, as these two concerns are fundamentally linked.

An additional challenge affecting the services and sustainability of treatment programmes was the lack of funding, as well as the manner in which funding was allocated.

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Finally, there was a need for treatment facilities to be fully equipped to assist women with mental health issues, as a definite link exists between GBV, substance abuse and mental health.

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CHAPTER 6
SUMMARY, RECOMMENDATIONS, CONCLUSION

Introduction

This study explored the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town. Substance abuse has created a burden at all levels of society, particularly affecting individuals, families and communities. In addition, substance abuse has posed challenges to public health and safety and is not limited to those directly affected. This study drew on eight participant interviews, the literature and current policies. It has been highlighted that a holistic approach is needed to reduce and manage alcohol harms amongst women through comprehensive care.

6.1 Summary

An issue of significant concern is that substance abuse is under-recognised in primary care settings, particularly amongst women, for whom treatment is considered more complicated and difficult. The design of rehabilitation services for women needs to be revisited with a clear indication of the resources required to address the challenges and gaps within these services in relation to the primary function of this centre.

This study therefore aimed to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town. The objectives of this study were to explore the perceptions of staff regarding the challenges experienced at a rehabilitation centre; to explore the treatment strategies available for women at a rehabilitation centre; to identify the specific needs versus resources required within rehabilitative services for women with a substance abuse disorder; and to provide recommendations to rehabilitation centres pertaining to services offered to women.

The study used a qualitative research design. Eight employees were purposefully selected from a substance abuse rehabilitation centre in Cape Town and data was collected using semi-structured interviews. Data was also analysed using Atlas.ti which was useful for analysing the large sections of text, visual and audio data. Additionally, it should also be noted that the researcher's understanding of the link between gender-based violence and substance abuse did not influence the data collection process.

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The study identified several areas where the centre fell short. These included the lack of an aftercare service, and the lack of entrepreneurial and skills training for women clients, which is closely related to post-treatment success and reducing the chances of repeating the cycle of abuse. The study recognised a need to develop facilities that focus on assisting women who are both victims of GBV and who also abuse substances. Another finding highlighted the need for treatment facilities to be fully equipped to assist women with mental health issues, as a definite link exists between GBV, substance abuse and mental health.

The issue of funding has been a major theme of this study. The lack of funding has been identified as a major gap, affecting the quality of treatment programmes and services offered to women who abuse substances. Additionally, the way in which funding is allocated by government has been highlighted as an additional challenge affecting the sustainability of treatment programmes.

6.2 Recommendations

A major recommendation arising from this study is to offer more skills and entrepreneurial training to all women clients so that they are better equipped to start their own businesses or to enhance their marketability to obtain employment. This will assist them to become financially independent and substantially reduce their chances of returning to the perpetrator and to the context where they are triggered to engage in substance abuse.

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Secondly, support must be provided to develop facilities that focus on assisting women with mental health issues, as many women clients start abusing substances due to GBV, or become mentally impaired as a result of substance abuse. The link between GBV, substance abuse and mental health needs to be considered when developing programmes.

Thirdly, an intensive aftercare programme needs to be developed to sustain the recovery of clients. Aftercare strategies should include family integration workshops, regular follow-up sessions, post-rehabilitation counselling, emergency plans, referral strategies, and further training and development to ensure that women are holistically supported.

Fourthly, a major finding of the study was that DSD funding is unequally distributed at the centre. As with many NGOs, the funder decides how their funding is allocated. At this centre specifically, most of the DSD funding is allocated to the women in the shelter unit and not

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those in the substance abuse unit. This results in challenges as the women in the substance abuse unit do not get all the services, such as skills training, that the women in the shelter receive. This affects the success rate of the women in the substance abuse unit. Funding needs to be allocated uniformly to ensure the effectiveness of all programmes and the long-term resilience of all women clients.

Next, the eradication of the substance abuse problem cannot be addressed by a single government department. Roles and responsibilities need to be defined in key legislative and policy directives to improve coordination across government departments and enable an holistic response to the substance abuse problem. It is therefore recommended that support and funding for treatment programmes be aligned to existing strategic objectives of different government departments in order to promote the development of holistic programmes and services for women who abuse substances. Departments that have a core responsibility in this regard are the DSD, the Department of Health (DoH), the Department of Community Safety (DoCS), the Department of Education (DoE), and the Department of Economic Development and Tourism (DEDAT). Funding and support from these departments can linked to the following operational and programmatic functions:

Table 3: Relevant functions of government departments

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Department	Operational and programmatic functions
DSD	• Enhancing and implementing of childcare fetal alcohol syndrome (FAS) and early childhood development (ECD) services • Shelter costs • Employment and retention of skilled social workers • Further assistance with accessing welfare grants
DoH	• Psycho-therapeutic programmes • Employment of specialised professionals • Improvement of quality of medical assessments • Incorporation of mental health services
DoCs	• Improvement of emergency services within the aftercare phase
DoE	• Tendering of skills training facilitators • Tendering of adult basic education and training (ABET) facilitators

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DEDAT	• Funding of entrepreneurial skills development programmes

Finally, due to the crippled economy and increasing unemployment in South Africa, it is recommended that reliable funding be provided by government, the private sector and international donors to enable centres to implement the following:

- To employ more staff and skilled practitioners who can offer comprehensive care;
- To improve operations at centres by affording the necessary resources and retaining staff;
- To enhance the quality of existing psycho-therapeutic programmes;
- To offer additional services to assist clients holistically;
- To implement a comprehensive aftercare programme to benefit clients and their children;
- To enable access to the above services at no cost.

While consistent and adequate funding will contribute to making services at such centres more sustainable, it will also contribute to assisting more women clients and reduce the burden of substance abuse amongst women, families and communities.

6.3 Limitations of the study

Some of the limitations pertaining to the study relate to the challenges experienced during the Covid-19 National lockdown, as interviews could only be conducted virtually. This created additional challenges pertaining to a weak signal and access to the internet by participants. It may also have affected the quality of the rapport between me, as researcher, and the participants.

In addition, the fact that only female staff were available to participate could have limited the responses, as some were directly involved with the substance abuse unit and others only partially engaged. From an holistic point of view, it may have been more insightful to have had male participants provide their feedback concerning services available for women who abuse substances.

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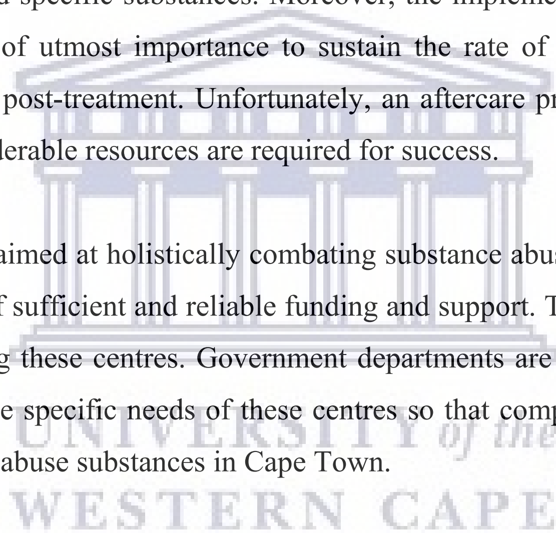
6.4 Conclusion

The themes that have emerged indicate a strong link between social determinants of health and the importance of designing programmes around these concepts. Other than making provision for comprehensive programme costs and childcare services, additional services pertaining to accessing of welfare grants, legal interdicts and intense medical evaluations need to be incorporated to ensure the sustainability of a holistic model.

Most women who enrol in these programmes are poor and uneducated and are likely to have experienced more than one trauma. These traumas have a direct effect on the mental state of women and directly influence their substance abusing behaviours. Additionally, many treatment facilities are not equipped to assist women with various mental health issues, or women who have abused specific substances. Moreover, the implementation of an intensive aftercare programme is of utmost importance to sustain the rate of treatment success and maintain a healthy state post-treatment. Unfortunately, an aftercare programme comes at an exorbitant cost, as considerable resources are required for success.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Current interventions aimed at holistically combating substance abuse amongst women are limited due to the lack of sufficient and reliable funding and support. Therefore, more sectors need to invest in funding these centres. Government departments are required to align their strategic objectives to the specific needs of these centres so that comprehensive care can be provided to women who abuse substances in Cape Town.

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APPENDIX A

INTERVIEW GUIDE

Breakdown of participants: A – Management (Director, Programme Manager, Night Supervisor, administrative staff)

B – Health and Social Professionals (psychologist, social worker, Social auxiliary worker, counsellor)

Question	Objective	Participant
1. What position do you hold at the centre?	*General*	*Category A and B*
2. How long have you worked at the centre?	*General*	*Category A and B*
3. Describe the key responsibilities of your position at the centre.	*General*	*Category A and B*
4. Can you describe the different communities surrounding the centre?	*General*	*Category A and B*
5. Are the women attending the centre from the surrounding communities? (If no, prompt where)	*General*	*Category A and B*

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6. From your experience, what are the general reasons for these women seeking treatment?	*General*	*Category B*
7. Please describe the rehabilitation service that this centre offers to women.	To explore the treatment strategies available for women at the rehabilitation centre.	*Category A*
8. Can you identify limitations / gaps that you experience in the treatment programmes for women at X.	To explore the perceptions of staff regarding challenges experienced at the rehabilitation centre.	*Category A*
9. Can you list some of main needs and resources required by women at the centre?	To identify the specific needs versus resources required within rehabilitation services for women with SAD.	*Category A and B*
10. Are the current strategies effective and efficient to meet the needs of women who abuse substances?	To provide recommendations to rehabilitation centres pertaining to services offered to women.	*Category A and B*

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APPENDIX B

X

Centre X

7764

021-6335287

For Attention: X

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT YOUR CENTRE

Dear Mrs. X

My name is Liane Langeveld and I am a student at the University of the Western Cape completing my Masters in Public Health. The research that I wish to conduct is aimed to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town using a qualitative research design.

The research will be conducted under the supervision of Prof. F. Waggie and Dr. T. Adonis and will serve before the University of the Western Cape's Higher Degree Committee for approval. Permission to conduct the study will be obtained from the University of the Western Cape Faculty of Humanities and social sciences higher degrees and ethics committees.

I hereby seek your consent to interview eight to ten staff members who work closely with the women clients and those who are involved with strategic planning and implementation of the programmes offered at your centre.

I hope to hear from you soon.

Kind Regards,

Liane Langeveld

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APPENDIX C

Information Sheet

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21 959 2809 Fax: 27 21 959 2872
E-mail: soph-comm@uwc.ac.za

INFORMATION SHEET

Project Title: Exploring the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town

What is this study about?

This is a research project being conducted by Liane Langeveld at the University of the Western Cape. We are inviting you to participate in this research project because you are currently working in a rehabilitation centre for women who have abused substances. The purpose of this research project is to explore the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town.

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

You will be asked to share your work experiences at the rehabilitation centre with the researcher. You will also be asked a few questions related to how you think these women started abusing substances, reasons for them seeking rehabilitation as well as the type of rehabilitation services that the centre offers. Additionally, you will be asked to identify any gaps in the treatment programmes and to list some needs that are required by women at the centre. These issues will be discussed in one interview which will be conducted at the rehabilitation centre where you are currently employed. The interview will last about 90 minutes. Here are some of the questions you might be asked:

- Please describe the rehabilitation service that this centre offers to women.
- Can you identify limitations / gaps that you have experienced in the treatment programmes for women at the centre?
- Can you list some of main needs and resources required by women and men at the

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centre?

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality your name will not be used on all documents, this includes the notes sheets that the researcher will use during the interview. All of the information obtained during the interview will be kept in a file that only the researcher will have access to. The data will be transcribed, coded, stored in a file and saved on a drive protected by a password. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities' information that comes to our attention concerning child abuse or neglect or potential harm to you or others.

What are the risks of this research?

There may be some risks from participating in this research study. All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

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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 women and substance abuse and the certain limitations to treatment programmes. We hope that, in the future, other people might benefit from this study through improved understanding of limitations to current treatment programmes for women and proposed amendments and considerations required to make these programmes for efficient and effective for women that abuse substances.

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Describe the anticipated benefits to science or society expected from the research, if any.

The findings of this research will contribute to new knowledge pertaining to the topic. The research findings could contribute to the gap in knowledge and can be built on through additional research in future.

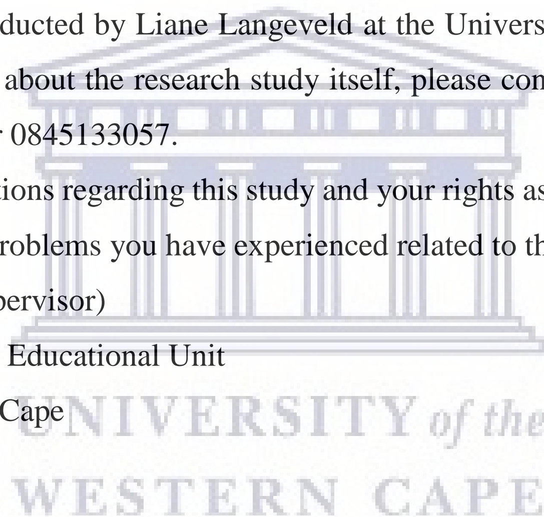
Do I have to be in this research and may I stop participating at any time?

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 penalised or lose any benefits to which you otherwise qualify

What if I have questions?

This research is being conducted by Liane Langeveld at the University of the Western Cape. If you have any questions about the research study itself, please contact Liane Langeveld at: 2115717@myuwc.ac.za or 0845133057.

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: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Prof Firdouza Waggie (supervisor)

Director: Interprofessional Educational Unit

University of the Western Cape

Private Bag X17

Bellville 7535

fwaggie@uwc.ac.za

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APPENDIX D

Informed Consent

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Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2809, Fax: 27 21-959 2872
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CONSENT FORM

Title of Research Project: Exploring the perceptions of staff regarding the services offered at a substance abuse rehabilitation centre for women in Cape Town

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

___ I agree to be **[**audiotaped**]** during my participation in this study.

Participant's name………………………..
Participant's signature……………………………….
Date………………………

The Humanities and Social Sciences Research Ethics Committee
University of the Western Cape

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APPENDIX E

Ethics Approval

UNIVERSITY *of the* WESTERN CAPE

24 June 2020

Ms LC Langeveld
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: HS20/4/40

Project Title: Exploring the perceptions of staff regarding the services offered at a substance abuse rehabilitation center for women in Cape Town.

Approval Period: 23 June 2020 -23 June 2023

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report by 30 November each year for the duration of the project.

The permission to conduct the study must be submitted to HSSREC for record keeping purposes.

The Committee must be informed of any serious adverse event and/or termination of the study.

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

Director: Research Development
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NHREC Registration Number: HSSREC-130416-049

FROM HOPE TO ACTION THROUGH KNOWLEDGE.

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