Attitudes and Perceptions towards Organizational Functioning in Substance Abuse Treatment Facilities across South Africa

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COMPULSORY DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

Signature: Signed by candidate Date: 19 January 2009

ABSTRACT

This study examined the attitudes and perceptions of directors and treatment staff towards organizational functioning within substance abuse treatment facilities across South Africa. In South Africa a history of socio-political factors have hindered substance abuse treatment. Large disparities existed between racially defined population groups and the quality and allocation of resources to substance abuse treatment services across South Africa have not been equitable. Understanding organizational functioning within substance abuse treatment facilities is essential to identifying and prioritizing treatment facility issues that both directors and staff believe need attention. The identification and examination of these issues facilitate the development of appropriate strategies to promote treatment facility improvements and the adoption of evidence-based treatment practices. Cross-sectional surveys of substance abuse treatment facilities were conducted in the Western Cape (2005) and in the Eastern Cape, Gauteng, and Kwa-Zulu Natal (2006). Forty-four treatment facilities participated in this study from a population of 89 facilities. The Texas Christian University survey of Organizational Functioning (TCU ORC) was used to assess directors' and staff's attitudes and perceptions towards organizational functioning within their treatment facilities. One-way analysis of variance tests were used to examine whether certain contextual and demographic variables influenced directors' and staff's attitudes and perceptions. Results indicated that directors and staff displayed favorable attitudes and perceptions towards the TCU ORC domains organizational climate and staff attributes, and indecisive attitudes and perceptions towards the motivation for change domain. Demographic variables including: ethnicity, levels of education, amount of work experience, and provincial location were found to influence directors' and staff's attitudes and perceptions towards organizational functioning.

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Chapter 1: Introduction

General background – the need for effective substance abuse treatment in South Africa

In 1993 Parry and Yach described the South African public healthcare system to be in a state of crisis. South Africa was in an epidemiological snare in which high rates of infectious diseases amongst the poor, a largely impoverished population, and social instability all contributed to a rise in sexually transmitted diseases especially HIV/AIDS, substance abuse, as well as violence and crime (Parry & Yach, 1993). The combination of these factors placed a heavy burden on the South African healthcare system.

Prior to 1994, South Africa's physical and economic isolation from the rest of the world, as well as its rigorous and severe internal controls, restricted access to and the availability of a majority of illicit drugs (Myers, 2004). The period post 1994 saw a reduction in internal and external border controls, an increase in foreign trade and an escalation in land and air travel. Together with these socio-political changes and inadequately resourced law enforcement agencies the majority of the population now had access to a broader range of illicit drugs (Myers, 2004; Parry *et al.*, 2002). This expansion of the domestic drug market led to increased pressures on substance abuse treatment facilities in South Africa to provide effective and accessible treatment services.

In 1995 Yach, Parry and Harrison identified substance abuse as an important issue to be dealt with for improving healthcare in South Africa. Substance abuse was identified as a major impediment to both the healthcare system and the economy. Abuse of substances such as alcohol, tobacco, cannabis, crystal methamphetamine, cocaine and heroin causes immense physical, mental and social damage and costs the country vast amounts of money each year. Cost estimates attributed to losses in productivity as well as more direct costs of hospitals and outpatient treatment for substance abuse reported annual amounts of approximately R8.5 billion nationwide (Yach, Parry & Harrison, 1995).

Between 1997 and 2001 a number of changes in substance abuse treatment were observed. A review of self-reports by treatment facility patients showed that alcohol

accounted for more than 60% of the treatment demand for overall substance abuse. Although alcohol remained the most common primary abused substance, there was also a trend showing significant increases in the demand for the treatment of substances other than alcohol. From 1997 to 2001 the proportion of patients reporting cannabis, crystal methamphetamine, cocaine, and heroin as their primary substance of abuse had increased significantly. Additionally, there was an increase in the demand for treatment services by patients who were less than 20 years old for heroin related problems (Myers, Parry & Pluddemann, 2004). By 2003 the demand for treatment of alcohol-related problems had substantially declined. In Cape Town the proportion of patients with alcohol as their primary abused substance decreased from 81% in 1996 to 39% in 2003 (Parry, 2005a). Research findings further pointed to rising demand for substance abuse treatment in Gauteng due to high levels of substance abuse as well as substance-related problems. Gauteng presented a high proportion of arrestees that reported the need for treatment for problems related to not only alcohol, but also cannabis and Mandrax (methaqualone combined with an anti-histamine) (Parry *et al.*, 2002). Although alcohol has remained a constant substance of abuse across South Africa there has been an increasing demand for substance abuse treatment services to include substances other than alcohol.

The socio-political context of substance abuse treatment services in South Africa

International research provides evidence of the benefits of substance abuse treatment to the population, state and economy of a country. Benefits include reductions in alcohol and drug use, reductions in criminal behavior, improvements in employment and welfare status, as well as improvements in general healthcare and crime-related costs avoided (Alterman, Langenbucher & Morrison, 2001; McKay & Weiss, 2001). Despite the need for substance abuse treatment and the evidence of treatment benefits, the availability and accessibility of substance abuse treatment services in South Africa remain limited (Myers, 2004).

According to Parry and Yach (1993), South Africa's socio-political history had created a national healthcare system that was highly fragmented, inefficient and wasteful of deployed resources. This severely fragmented system was further weakened by conflicts between different categories of health workers as well as between management and organized labor (Parry & Yach, 1993). Funding to state-

subsidized treatment services in South Africa has historically been inadequate. Under the apartheid system the available treatment facilities were unevenly distributed geographically, with the majority of treatment services concentrated in urban areas that were historically reserved for the White population (Myers, 2004). Substantial imbalances also existed between the racially defined population groups of the country in terms of the distribution of resources to and the quality of substance abuse treatment services. Therefore treatment services were not readily available to all sectors of the population (Myers & Parry, 2005).

Despite efforts by both the government and social services since South Africa's transition to democracy in 1994, treatment services have remained insufficient to meet the population demands and are still fragmented and poorly geographically distributed. Meanwhile, there has been a dramatic increase in the establishment of private treatment services and numerous state treatment centers focusing on people with alcohol-related problems have been discontinued (Parry, 2005a). Substance abuse treatment services in South Africa are now predominantly provided by private, for-profit facilities that are not widely accessible to the poor. There are further concerns about the limited number of affordable facilities, given that there are few dedicated state-funded treatment facilities in the country and that the number of beds available in state hospitals for substance abuse cases continues to be reduced (Myers & Parry, 2005).

South Africa's increased demand for substance abuse treatment in conjunction with the limited availability of state services has also contributed to a growing private, for-profit treatment sector. While a number of these private facilities are available in South Africa, access to these private treatment services is generally limited to individuals with private health insurance or those who can afford to pay upfront (Myers, 2004; Myers & Parry, 2005). Overtime funding to state-subsidized treatment facilities continues to decrease, thus limiting their treatment capacity and their ability to expand treatment services to historically underserved areas. Ironically these funding reductions have been part of an attempt to increase service accessibility to historically underserved communities by reducing the provision of tertiary level services and integrating these services into existing primary healthcare networks. However, these implementations have been slow with few substance-related services

being offered at the primary level (Myers & Parry, 2005; Parry, 2005b). Despite the documented high levels of substance abuse in South Africa, substance abuse has been given a low priority by the provincial departments of social services. In addition, these departments have focused their resources on prevention, early intervention and statutory activities rather than the provision of treatment services (Myers, 2004). These education and persuasion strategies such as substance abuse education in schools and public information campaigns have not been empirically shown to be effective (Parry, 2005c).

Furthermore while the private, for-profit treatment facilities fill an important gap in addressing South Africa's substance abuse crisis these facilities have been severely criticized. Criticisms of the these treatment facilities include treating mostly White communities, possessing limited skills for dealing with the socio-cultural and language contexts of historically disadvantaged communities, being predominantly located in urban areas inaccessible to the majority of people, and for being largely unaffordable without private healthcare insurance (Myers & Parry, 2005). Previous research data from specialist treatment facilities has shown that the race profile of patients has not reflected the demographics of the general population. There has been an under-representation of Black South African patients and an over-representation of White patients (Myers *et al.*, 2004). These findings reflect the limited availability of treatment services in historically disadvantaged areas, the limited accessibility of treatment facilities for historically disadvantaged race groups due to facilities being located in urban centers, the inability to pay for services, and the linguistic difficulties in participating in English- and Afrikaans-medium programs. In addition, few treatment facilities provide services that target the cultural and linguistic barriers that prevent Black clients' access to and retention in substance abuse treatment and few facilities employ African-language speaking counselors and translators. The majority of staff throughout treatment facilities are only fluent in English and Afrikaans, only a small minority of facilities offer multilingual programs and few facilities use culturally sensitive and appropriate assessment approaches. These factors not only inhibit Black South Africans from seeking treatment, but may also impact the extent to which Black patients engage in treatment (Myers *et al.*, 2004; Myers & Parry, 2005).

In South Africa, provincial and local governments control the allocation of resources for non-private substance abuse services. Several key resources are necessary for these governments to plan and deliver substance abuse treatment services that ensure adequate provision of services to the community and high-risk population groups including: access to quality information about local treatment needs, existing treatment services, patterns of service utilization and performances (Myers, 2004; Myers et al., 2004). This argues for the need for an effective monitoring system for substance abuse treatment services in South Africa. International research further justifies this need by stating that the collection of substance abuse treatment service information plays an important part in treatment service planning, monitoring and evaluation (Grant & Petrie, 2001). Despite this awareness, the planning and delivery of alcohol and other drug treatment services in South Africa has been hindered by a lack of accurate information on treatment needs and service utilization (Myers *et al.*, 2004).

In 1996 the South African Community Epidemiology Network on Drug Use (SACENDU) project was established. The SACENDU project is a network of researchers, practitioners and policy makers from all areas of South Africa that provides community-level public health surveillance of alcohol and other drug use trends. The project operates in nine provinces across South Africa and provides further descriptive information on emerging trends, risk factors associated with alcohol and other drug use, the characteristics of vulnerable population groups, as well as the consequences of substance use in South Africa (SA Health Info, 2007). Whilst the SACENDU project provides essential information that should be collected as part of a national monitoring system, it does not collect information on the type or quality of treatment services provided. Information provided by the SACENDU project generally consists of a brief description of the types of clients served and the treatment services provided. South African state departments require more detailed information for a treatment facility to be registered. Required information includes descriptions of the structural and organizational features of a treatment facility as well as descriptions of their service delivery plans. However, state departments do not require the routine monitoring of service delivery for the purpose of continued registration (Myers, 2004; Myers *et al.*, 2004; Myers & Parry, 2005).

These gaps in current policy and legislation, as well as a lack of minimum standards for substance abuse treatment services, have allowed the South African substance abuse treatment industry to become and remain unregulated. More importantly very few treatment facilities, whether licensed or unlicensed, have conducted systematic and comprehensive evaluations of their treatment services. As a result, any claims about the effectiveness and efficacy of existing treatment facilities in South Africa remain unsubstantiated. These gaps further demonstrate the need for regular, national audits of existing treatment facilities and make a strong argument for treatment service providers, researchers and policy-makers to collaborate their efforts to address the treatment service inequities in South Africa (Myer & Parry, 2005; Myers *et al.*, 2004).

Conceptualizing the substance abuse treatment process

The substance abuse treatment process has many properties that are essential to understanding how treatment operates. In recent years treatment retention has primarily served as an overall indicator for the amount of treatment that a patient receives. This has proven to be a strong and consistent predictor of post-treatment outcomes, but further research has shown that retention alone is limited as a treatment process indicator (Joe, Simpson, Dansereau & Rowan-Szal, 2001). Research further suggests that less attention should be paid towards outcome evaluations and there should be greater focus on the treatment process itself. According to Prendergast, Podus, Chang, and Urada (2002) evidence is conclusive that substance abuse treatment can be effective in a variety of programs and that a significant proportion of drug users exhibit substantial improvement within these programs, but there are still performance variations between various treatment programs and the clients in the programs.

Substance abuse treatment is comprised of several variables: the client's motivation for seeking treatment and client's background, attributes of the counseling session, the relationship between counselor and client, outcomes during treatment, treatment retention and post-treatment outcomes, and the client's social relations outside of treatment (Joe *et al.*, 2001). Thus an important issue of the substance abuse treatment process is not only that client changes occur during treatment, but also the degree of change that can be attributed to the treatment process (Simpson, 2004). A treatment

facility's institutional knowledge of the characteristics of treatment counseling and knowledge of the client's perceived quality of the treatment process can lead to the strategic improvement on these properties as well as better treatment outcomes (Joe *et al.*, 2001). Thus it is essential not only to be aware of these therapeutic properties, but also to integrate them efficiently into a conceptual scheme that can help guide treatment applications and lead to further treatment facility improvements (Simpson, 2004).

A conceptual model for the drug treatment process developed by Simpson (2004) and colleagues at the Texas Christian University (TCU) Institute of Behavioral Research (see Figure 1) can be used for identifying indicators for predicting client performance during treatment as well as client retention and post-treatment outcomes.

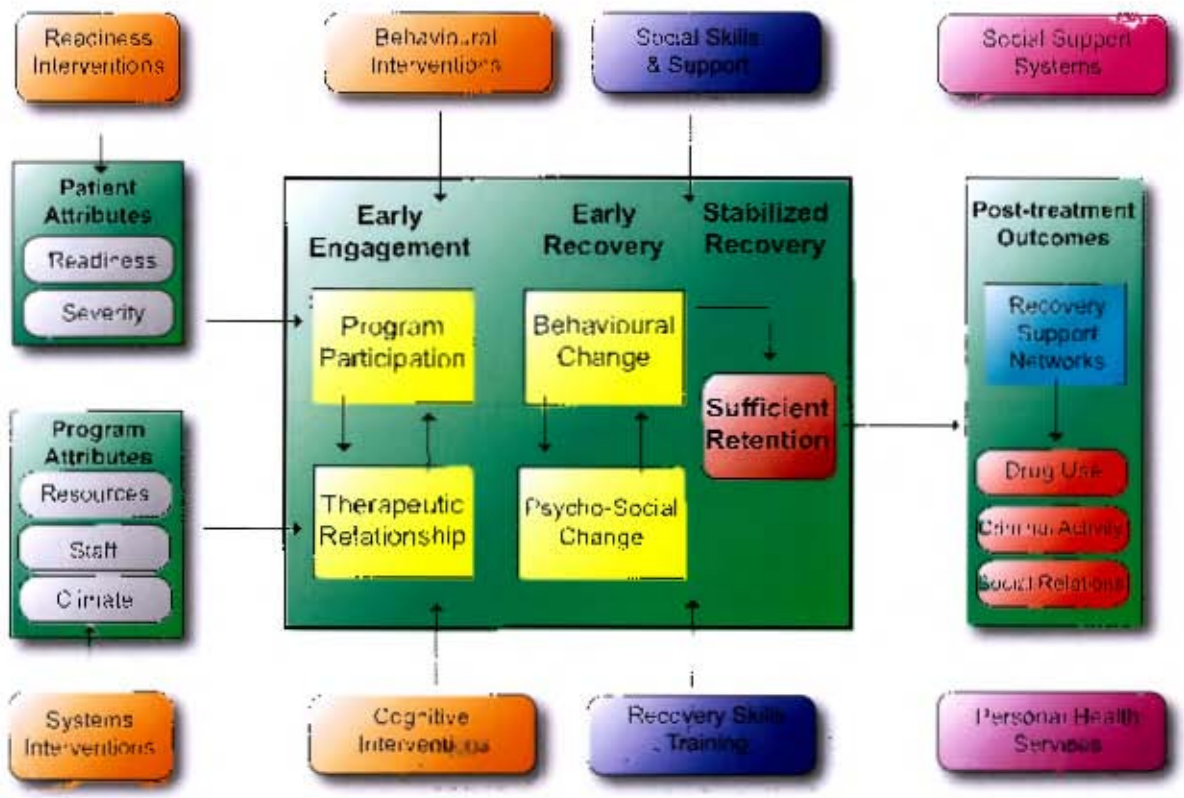


Figure 1. Overview of TCU Treatment Model, representing sequential influences of patient and program attributes, stages of treatment, and evidence-based interventions on post-treatment outcomes (Simpson, 2004).

The TCU Treatment Model identifies key factors associated with an effective treatment process and effective treatment outcomes. The model focuses attention on sequential phases of the treatment process and how therapeutic interventions link

together over time to help sustain client engagement and retention, thus improving the client's functioning during and after treatment (Simpson, 2004).

Although the treatment process is portrayed as an integrated whole by the TCU Treatment Model, a number of different service providers or multiple episodes of treatment (e.g., detoxification, inpatient and outpatient treatments) are likely to be operating simultaneously and may even be linked together in practice (Joe *et al.*, 2001). The significance of client and program attributes operating simultaneously for the treatment process will be examined and each sequential facet of the TCU Treatment Model will be described in more detail.

Client and program attributes at treatment intake (first left margin of Figure 1, p. 11)

- Client attributes

Contextual influences on the treatment process, such as the client's background and the treatment facility's organizational functioning, can have significant influence on treatment outcomes. Three important client attributes include their motivation for change, their readiness for treatment, and their addiction severity at intake. Four program attributes that are important to treatment effectiveness include: facility resources, staff skills, organizational climate, and the information systems in place for clinical and program management (Simpson, 2004).

Client pre-treatment characteristics such as addiction severity, criminal history, social resources, and psychological dysfunction all influence the client's treatment engagement and retention. Two pre-treatment characteristics of particular importance are client motivation for treatment and their readiness for change (Simpson & Joe, 1993). Motivation for treatment is an important factor for the rehabilitation of clients with addiction problems. It is important to distinguish between clients' personal motivation to change and their recognition of a need for treatment to assist them with personal change (i.e. the clients' readiness for treatment). Different treatment outcomes can be expected between these two motivational concepts (Joe, Broome, Grace, Rowan-Szal & Simpson, 2002). Additionally, it is important to differentiate between external and internal client motivation. Clients voluntarily entering inpatient and outpatient treatment programs demonstrate a greater motivation for change and readiness for treatment than compared to clients mandated or coerced into treatment

or dug education programs, particularly criminal justice population referrals (Joe *et al.*, 2002; Simpson, 2004). The higher the clients' motivation and readiness for treatment, the higher their therapeutic engagement and treatment retention are likely to be. The greater the client therapeutic engagement and treatment retention, the more likely positive and sustainable post-treatment outcomes are to occur.

Internal client motivation emphasizes problem recognition, desire for help, and treatment readiness. Problem recognition is primarily relevant at the beginning of the treatment process because a client denying or over-looking addiction problems may prevent commitment to treatment and decrease therapeutic engagement and retention. Once addiction problems are acknowledged, the next step is for clients to want help in dealing with their problems. Substance abusers who express a desire for help are more likely to participate in treatment counseling, engage in therapeutic engagement, and display greater retention (Joe *et al.*, 2002). Although the internal motivation to actively change through the participation of a treatment program is important, substance abusers that are motivated to end their addiction and acknowledge the need for treatment to assist them with this change may still be uncommitted to treatment programs and interventions because of certain external factors. Certain external factors may be related to family, legal, or health problems. Access to treatment programs in addition to their availability, affordability, accommodation, and service diversity are additional external factors that may hinder a client's commitment to a treatment program (McCaughrin & Howard, 1996). Treatment program locations have also been correlated with treatment participation. Studies have found that as client travel barriers have increased, the degree of client participation in treatment counseling has decreased. It is important to note that the distance needed to travel to and from treatment programs imposes costs on clients in the form of both increased time commitment and economic expenses (Beardsley, Wish, Bonanno Fitzelle, O'Grady & Arria, 2003).

Research further shows that clients with increased levels of addiction severity require more intensive and longer treatment programs (Grella, Joshi, & Hser, 2003). Problem severity is broadly defined by the clients' psychological and social functioning, their legal status, and drug use history. In some instances, clients with more severe drug use histories and higher dependence levels, especially amongst injection drug users,

may require medical detoxification before the client is ready for treatment. Higher levels of addiction severity are typically associated with poorer post-treatment outcomes and treatment programs that engage in higher severity cases often face more difficult treatment challenges. Thus, higher pre-treatment drug use and addiction severity can be a significant barrier to favorable treatment engagement and post-treatment outcomes (Simpson, 2004). From this literature it is evident that client motivation and addiction severity are dynamic factors that need to be taken into account for successful and sustainable therapeutic engagement, treatment retention, and post-treatment outcomes.

- *Program attributes*

Diagnostic and assessment strategies, treatment resources, and requirements for treatment program admissions are highly diverse between facilities, thus not all treatment programs operate alike or are equally effective. The TCU Treatment Model lists four program attributes that are important to treatment effectiveness: facility resources, staff skills, organizational climate, and information systems in place for clinical and program management (Simpson, 2004). Programs that are strong in the attributes listed above are organizationally more effective and efficient, thus enabling counselors to develop stronger rapport with their clients.

The rapport between the treatment counselor and client is often considered to be at the core of the therapeutic relationship. This rapport is required for a therapeutic bond to develop between the counselor and client as treatment progresses. This rapport is also related to treatment retention, client engagement and satisfaction, and positive post-treatment outcomes (Joe *et al.*, 2001). However, it is a modest expectation that treatment services within each facility should be tailored to acute individual client needs. This application of client-to-treatment matching requires a level of sophistication in assessment services and an availability of comprehensive services that are uncommon in real world environments. Thus, treatment programs need to consider their resources, organizational climate and staff infrastructure when planning intervention strategies and institutional functioning (Simpson, 2004).

It is fairly common for staff in a treatment facility to experience various occupational and workplace stressors. These stressors can produce an adverse organizational

climate, low staff morale, poor job performance and high staff turnover, which overall can significantly erode the quality of treatment provided by a treatment facility (Schaefer & Moos, 1993a). Schaefer and Moos (1993b) define three major domains for work stressors in the healthcare work environment: relationship, task, and system stressors. Relationship stressors arise from interactions with co-workers, supervisors and other facility staff. These stressors include communication problems, lack of support, conflicts with co-workers, and disagreements about treatment interventions. Task stressors originate from the responsibilities that staff confront in their job and how well prepared they are to cope with them. Key task stressors are working with uncooperative clients, and a lack of occupational knowledge and competence. System stressors refer to the overall management of the treatment facility and the resources available to staff. Heavy caseloads and understaffing are prominent system stressors. Additional system stressors include: scheduling problems, lack of needed equipment and supplies, and inadequacies in the physical work environment (Schaefer & Moos, 1993b).

Work stressors experienced by treatment staff can further be related to their demographic characteristics (e.g. race, age, and gender), role within the facility, work experience, and overall work climate. Research based in the U.S.A. has shown that staff from minority racial groups, such as Black and Latin American, may find the workplace more stressful and differences in cultural factors may contribute to job dissatisfaction. Treatment staff that regularly experience work stressors and have greater job dissatisfaction have less intention to remain, therefore leading to high staff turnover. A lack of organizational support from the treatment facility can further contribute to job dissatisfaction, poor job performance, and staff turnover (Schaefer & Moos, 1993a, 1993b).

High staff turnover and instability not only decrease counselor and client rapport, but also threaten the ability of a treatment facility to meet the requirements associated with organizational survival (Knudsen, Johnson, & Roman, 2003). Both the financial and non-financial consequences of high turnover, represents a threat to the effectiveness of a majority of organizations and not only substance abuse treatment centers (Vandenberg & Nelson, 1999). Treatment facility financial costs associated with high turnover include recruiting, hiring, and training new counseling staff. Non-

financial costs include inconsistency and discontinuity in service delivery. These inconsistencies serve as a barrier to providing high quality treatment. Research indicates that inconsistent levels of treatment delivery lead to poor client rapport, decreased therapeutic engagement and treatment retention, as well as high financial costs associated with early treatment dropout (Joe *et al.*, 2001; Knudsen *et al.*, 2003; Simpson, 2004).

Good management practices can sharply reduce or eliminate staff turnover. Numerous dimensions of the organizational environment can be affected by management practices and these practices can positively impact organizational commitment, job satisfaction and staff turnover (Knudsen *et al.*, 2003). Treatment facility variables such as inconvenient work areas or inadequate resources, counselor roles and job characteristics, levels of job autonomy, and organizational support for staff can all be affected by management practices. Research shows that if management is able to provide satisfying work environments, sufficient opportunities for staff to influence their work environment and the autonomy of participative decision making, there are significant increases in job satisfaction, organizational commitment, improved morale, and staff performance (Schaefer & Moos, 1993a, 1993b; Knudsen *et al.*, 2003). These improvements essentially lead to greater counseling rapport between staff and clients, which results in greater therapeutic engagement, treatment retention, and post-treatment outcomes (Joe *et al.*, 2001). Thus, a treatment facility's available resources, organizational climate, staff infrastructure, and management practices all need to be considered when planning client intervention strategies and altering institutional functioning.

Early engagement (second margin of Figure 1, p. 11)

Early engagement is the first phase of the treatment process and is focused towards client recovery. Early engagement refers to the extent to which clients attend and actively engage in their roles as a patient. This is measured primarily by program participation and the formation of therapeutic relationships between counselors and clients in the initial weeks of treatment (Simpson, 2004). Research supports that highly motivated clients at treatment intake are twice as likely to attend sessions and participate in treatment programs during the initial stages. Furthermore, clients that achieve higher participation are also more likely to develop more positive therapeutic

relationships with their counselors, which are related to more favorable post-treatment outcomes (Joe *et al.*, 2001; Simpson & Joe, 2004).

Program participation involves treatment session attendance. Higher individual and group session exposure in treatment programs is related to greater rapport and stronger bonding with counselors. As a result of this, higher session attendance is a good predictor for greater treatment retention and better post-treatment outcomes (Simpson, 2004). Insufficient counselor and client rapport as well as weak therapeutic relationships are related to poor session attendance and low treatment retention (Joe *et al.*, 2001). However, it is important to note that treatment attendance can be affected by various client attributes such as family and social responsibilities, travel barriers, and economic expenses (Beardsley *et al.*, 2003; Knudsen *et al.*, 2003).

The other component of early engagement is the therapeutic relationship. This counselor and client relationship is commonly considered to be the core of effective substance abuse treatment. The success of a treatment program is consistently related to the quality of this relationship and is highly associated with client participation in treatment sessions. Although client satisfaction with treatment services (e.g. access, accommodation, availability, and confidence in effectiveness) is related to drug treatment outcomes, this appears to be secondary to the influence of the therapeutic relationship, which primarily involves counselor and client rapport (McCaughrin & Howard, 1996; Joe *et al.*, 2001; Simpson, 2004). This rapport reflects the extent to which the counselor and client are on the same wavelength and concerned for each other's well being. Establishing a positive therapeutic relationship requires increasing emphasis on counselor skills, intervention strategies, and the organizational context. Research indicates that counselors with more flexible and eclectic approaches help contribute to better treatment outcomes. In addition, treatment effectiveness is not rigorously aligned to any particular treatment orientation or setting. Nevertheless, treatment facilities that are well organized, systematic, and have easy access to clinical records that are user-friendly and relevant to treatment needs, do provide more enhanced and beneficial treatment (Humphreys, Noke, & Moos, 1996; Joe *et al.*, 2001; Simpson, 2004).

Early recovery (third margin of Figure 1, p. 11)

The second stage of the treatment process is early recovery and reflects on the client's psychosocial and behavioral changes. This early stage of recovery is signified by changes in the client's thinking and acting. Changes in thinking and acting build on successes from the previous engagement stage and help sustain retention in treatment sufficient to witness evidence of enduring change in drug use and drug related problem behaviors (Simpson, 2004). Evidence indicates that clients who share favorable therapeutic relationships with counselors are more likely to achieve positive changes in psychosocial functioning (e.g. self-esteem, depression, anxiety, and decision making). In turn, these psychosocial changes substantially increase the likelihood of behavioral changes occurring (i.e. decreased drug use). Finally these positive behavioral changes are further associated with greater treatment retention (Joe *et al.*, 2001; Joe *et al.*, 2002; Simpson, 2004). The purpose of the early recovery stage is to establish new patterns of thinking and acting that can be stabilized and sustained over time. The more positively the client has engaged in the stage of early engagement (involving program participation and the therapeutic relationship) the more favorable the influence on the deployment of relapse prevention strategies (Simpson, 2004).

During the early recovery stage of the treatment program it is important to focus on family and social support networks as well. Families and social networks can either be part of the solution or problem. These networks may either give effective support to the recovery of the client, or may themselves need help and assistance to deal with the client's substance abuse problems (Miller, 2003; Simpson, 2004). Various additional treatment components have been found to positively influence treatment retention and reduced drug use behaviors. These components include childcare services for mothers in treatment, educational sessions on healthcare and social skills, access to mental healthcare services, and the use of more multi-service combinations of treatment (Ashley, Marsden, & Brady, 2003).

Stabilized recovery (fourth margin of Figure 1, p. 11)

The third stage of the treatment process focuses on the client's treatment retention and transition out of treatment. The stabilized recovery phase helps stabilize the recovery of the client by building on the progress of the two previous stages. This phase

focuses on the need for retaining clients beyond the minimal effectiveness threshold and allowing for a successful transition out of recovery (Simpson, 2004). Treatment outcomes, depending on problem severity at intake, tend to improve in a linear manner as treatment retention increases. Clients with higher problem severity at intake require longer and more intensive treatment. If client treatment retention fails to meet the minimal effectiveness threshold period they will have a substantially low probability of showing improved treatment outcomes. As time in the treatment program increases beyond this threshold, therapeutic benefits will begin to accumulate. These thresholds are defined statistically and clients who remain in treatment for these periods and longer display sustained improvements in drug treatment and social functioning in both the first year following treatment and in long-term follow up evaluations (Simpson, Joe, & Broome, 2002; Simpson, 2004).

The stabilized recovery stage of a treatment program is intended to sustain client change over time and integrate these changes into the client's lifestyle so that the new behaviors acquired during substance abuse treatment will become preferred habitual behaviors. Thus according to the TCU Treatment Model, this phase reflects the assumption that clients will remain in treatment long enough to stabilize their recovery behaviors and support networks before treatment discharge and social re-entry (Simpson, 2004).

Post-treatment outcomes (fifth margin of Figure 1, p. 11)

Achieving sustainable post-treatment outcomes and successful client transitions back into their social networks require a variety of health and social support services to address any continuing social deficiencies (Moos, Finney, & Moos, 2000). This final stage of post-treatment outcomes involves two important components. The first component is an extended care system that clients may require during and after the treatment process and is referred to as wrap-around services. These services address continual deficiencies involving medical, psychiatric, family, and employment problems. The second component, commonly referred to as transitional or aftercare services, involves a less intense continuum-of-care drug treatment programs or less formal social support networks (Simpson, 2004). These transitional care services following primary treatment programs can be challenging, but are crucial for a comprehensive treatment system. The importance of these transitional services is

particularly evident in criminal-justice referrals and correctional populations. However, because these transitional services require strategic coordination and responsibility, they often tend to be neglected or ignored due to costs and complexities (Griffith, Hiller, Knight, & Simpson, 1999; Simpson, 2004).

The role of organizational functioning

According the TCU Treatment Model, the substance abuse treatment process consists of five distinct stages and has numerous different properties. The TCU Treatment Model further illustrates that for effective substance treatment to occur both client attributes and program characteristics need to be integrated. It is evident that both client attributes and program characteristics substantially influence the degree to which clients become engaged in the treatment process and how long they remain in treatment. Client attributes inevitably change and for treatment facilities to remain durable, effective, and efficient in dealing with these changes, they need to have the appropriate characteristics. Sufficient organizational factors need to be in place for treatment facilities to adopt and implement the appropriate services to meet the evolving demands of their clients (Simpson, 2002). Thus, while it might not be possible for treatment facilities to determine or preempt changes in client attributes, having good management practices and appropriate organizational characteristics in place can positively assist treatment facilities with adapting and dealing with these changes.

Until recently, however, there has been limited attention on the differences between engagement levels among treatment facilities and how organizational factors might contribute to clients' subjective experiences. Treatment facilities are organizations. The way in which treatment programs are structured and managed, as well as the social norms that develop within facilities, have an impact on both the clients and the staff (Broome, Flynn, Knight, & Simpson, 2007). A professional organizational community is an environment in which staff interaction is frequent, continuous and in-depth, and in which staff share organizational goals and values. In a substance abuse treatment context three practices are required for a proficient organizational community: staff collaboration in which counselors engage in their actual and shared work, a setting in which counselors can observe and learn from each other's approach, and reflective communication among staff about therapeutic techniques and client

changes. These practices help support a shared staff focus on client outcomes and a sense of collective responsibility for program operations and improvement. In addition, certain organizational features such as service delivery, program size, staff skills, and staff views on organizational climate also influence client engagement. A treatment program that is smaller in size, focuses on maintaining quality of service delivery, has more skilled and confident counselors, and provides sufficient opportunities for staff to collaborate and interact yields greater success at engaging clients, increasing retention, and producing positive post-treatment outcomes (Broome *et al.*, 2007).

In the context of substance abuse treatment change at both the client and organizational level is constant and universal. Therefore, a comprehensive assessment of a treatment facility's organizational functioning and its readiness for change is vital for not only sustaining, but also improving substance treatment. This type of assessment can further assist with identifying functional barriers in the treatment process and help with transferring new technologies into practice (Simpson, 2002).

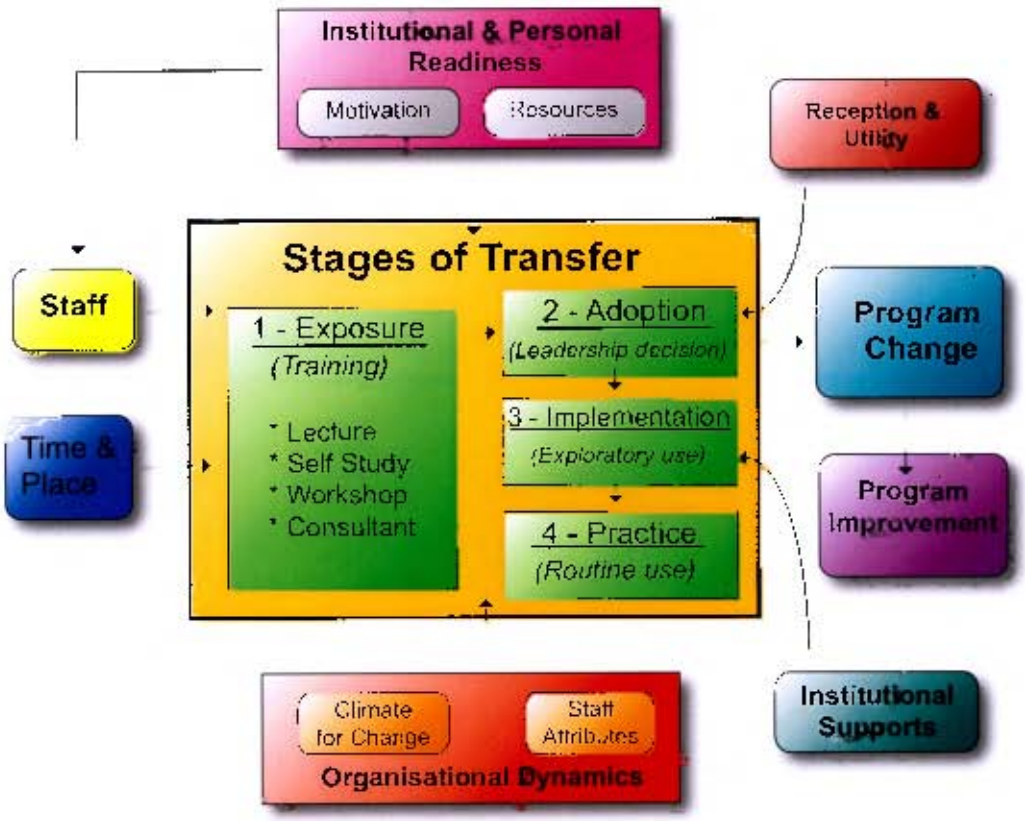


Figure 2. Overview of the TCU Program Change Model for transferring research into practice (Simpson, 2002).

Organizational functioning and readiness for change

The adaptation and implementation of treatment innovation is a process, not an isolated event. Simpson (2002) presents a process model of program change within substance abuse treatment facilities (see Figure 2, p. 21). This process includes exposure to new technologies, adoption of these technologies, and the implementation, practice and routine use of these technologies (Lehman, Greener, & Simpson, 2002).

If thoroughly achieved, this transfer process can lead to both program change and improvement. However, each of these stages of transfer can be impacted by organizational attributes. Institutional readiness for change (e.g., the motivation and resources for change), and the organizational dynamics (e.g., climate for change and staff attributes) are two particular important attributes that impact this process. Institutional readiness for change can have a facilitating effect on the organization during a period of change and sufficient motivation by program management can lead staff to be more open and less resistant to change. However, even if adequate motivation for change is present and treatment facilities have the necessary resources to allow for change, the organizational dynamics of a facility can still hinder or suppress the change process. The implementation or use of new treatment interventions is neither plausible nor feasible if the organizational climate is not change-oriented. Furthermore, if the staff do not possess necessary attributes for change (e.g., adaptability and growth-orientation) then the implementation of new treatment interventions is even less likely to occur (Lehman *et al.*, 2002). Studies show that greater job autonomy within treatment facilities relates to greater organizational commitment by treatment staff, and a supportive and goal-directed organizational climate improves client participation, their satisfaction with treatment, and post-treatment outcomes (Moos & Moos, 1998; Knudsen *et al.*, 2003).

The long-term survival of treatment facilities requires the organizational capacities to respond to both the external and internal pressures for change. Although treatment facilities need to be able to adapt to these pressures as well as constant changing environments, poorly implemented changes may not necessarily lead to more effective treatment outcomes (Lehman *et al.*, 2002). To initiate and sustain the use of both effective and new treatment interventions the following components are

required: staff that can implement and maintain the treatment program, continuous staff training, staff supervision and performance feedback, management and administrative support, and comprehensive evaluations of facility functioning. Treatment facilities that neglect one or more of the above components will struggle to effectively use or implement new treatment technologies. Thus, it is important to assess a facility's organizational functioning and its readiness for change prior to new technology implementation, and to maintain effective and efficient substance abuse treatment services (Lehman *et al.*, 2002; Knudsen *et al.*, 2003; Fuller *et al.*, 2007).

Organizational functioning in treatment facilities is important because of its linkage between program health and client engagement (Courtney, Joe, Rowan-Szal, & Simpson, 2007). Organizational factors measured by the TCU Organizational Readiness for Change (ORC) assessment are strongly related to client engagement, counselor rapport, client treatment satisfaction, and treatment retention. These four measures are important for the therapeutic relationship. The therapeutic relationship between clients and counselors is generally seen as a critical component in the treatment process and treatment outcomes can be substantially improved by addressing this relationship (Greener *et al.*, 2007). The ORC is a promising assessment tool for analyzing organizational functioning, and for identifying barriers that may prevent a treatment facility from successfully implementing change. The assessment includes measures of organizational factors, staff characteristics, and the work environment, with a primary focus on how the organizational climate and staff attributes relate to the treatment domain and to implementing new intervention technologies (Lehman *et al.*, 2002).

Findings from previous research based in the U.S.A. indicate that counselor rapport and treatment satisfaction is higher among clients treated in healthier organizational settings that score more positively on the ORC assessment (Greener *et al.*, 2007; Saldana, Chapman, Henggeler, & Rowland, 2007; Simpson, Joe, & Rowan-Szal, 2007). Treatment programs that showed higher ORC scores were related to more favorable staff ratings, staff post-training satisfaction, and the use of new intervention technologies. Well-functioning treatment programs defined by high ORC scores further demonstrate organizational coherence regarding program mission, staff cohesion and communication, and a greater adaptability to successfully meet

pressures of change (Simpson *et al.*, 2007). ORC results can also help identify deficiencies in organizational functioning, which if corrected, can lead to improved treatment outcomes. Low ORC scores identify specific areas that treatment facilities can intentionally target to improve the overall level of organizational functioning. The identification of these problematic areas is necessary to develop and implement appropriate intervention strategies (Greener *et al.*, 2007). Courtney *et al.* (2007) show that when treatment programs are provided with evidence of their organizational deficits, via results from the ORC assessment, they are more likely to respond with appropriate and positive strategic plans for implementing the needed corrective actions. In addition, the ORC scale demonstrates the ability to distinguish between treatment staff and program directors on factors that are consistent with their respective positions (Saldana *et al.*, 2007). Program directors and staff have different levels of responsibility in the functioning of treatment programs and thus have varied perspectives. Differences in the ORC responses between program directors and counselors appear to be consistent with their respective roles and responsibilities. Directors generally perceive greater immediate needs for training, greater access to resources, more openness to communication between staff, and a greater organizational willingness to change. Counselors generally perceive treatment resources (e.g., offices, staffing, training, and computer access) to be lower. These differences in how directors and treatment staff characterize their facility are an important factor needed to assess the overall functioning of a program (Lehman *et al.*, 2002; Fuller *et al.*, 2007).

Client engagement is a key requirement for an effective therapeutic process and client performance is interrelated with program performance (Lehman *et al.*, 2002; Simpson, 2004). Research shows that measures of client rapport, satisfaction with treatment services, and participation in treatment are all positively correlated with counselor perceptions of program resources, staff attributes, and the organizational climate (Greener *et al.*, 2007). Additional studies indicate that healthy organizational structure and functioning of treatment facilities are important when it comes to positive client engagement and treatment retention (Broome *et al.*, 2007). Joe *et al.* (2001) found that positive client engagement and greater lengths of treatment retention generally result in more positive and sustainable post-treatment outcomes.

Research question

Literature regarding the substance abuse context of South Africa clearly illustrates the need for diverse, effective, and efficient treatment services within the country. However, in South Africa, very few treatment facilities have conducted systematic and comprehensive evaluations of the treatment services they provide. As a result any claims about the effectiveness and efficacy of existing treatment facilities in South Africa remain unsubstantiated (Myer & Parry, 2005; Myers *et al.*, 2004). In the realm of substance abuse treatment, there is an important link between the relationship of organizational functioning and treatment effectiveness. This relationship is understood better within the conceptual framework described by Simpson (2004), and the TCU Treatment Model provides further explanation where organizational functioning fits within the overall treatment process. Using Simpson's (2004) conceptual framework and the TCU Treatment Model as a guide, this study examines the attitudes and perceptions of directors and treatment staff towards organizational functioning within substance abuse treatment facilities across South Africa. This study further analyzes whether certain contextual and demographic variables pertaining to South Africa influence these attitudes and perceptions.

Chapter 2: Method

Study design

Separate cross-sectional surveys of substance abuse treatment facilities were conducted in the Western Cape (June to September 2005), and in Gauteng, Kwa-Zulu Natal, and the Eastern Cape (August to November 2006).

Sample

The sample consisted of the total population of specialized substance abuse treatment facilities in the Western Cape, Gauteng, Kwa-Zulu Natal, and the Eastern Cape. This study defined specialized treatment facilities as a treatment facility that provides one or more specialized substance abuse treatment services to individuals with substance use disorders (Torres, Mattick, Chen, & Baillie, 1995). By using this definition, all facilities that provide information and education, self-help groups, and crisis intervention and prevention programs were not classified as specialized substance abuse treatment facilities. In addition, solo practitioners and facilities that provide general health and social services, including substance abuse related services (e.g., general hospitals, psychologists, and social workers) were not included in the sample (Myers, 2004). The four, of nine, South African provinces selected for this study were chosen based on local literature and on their demographic statistics. In these four provinces resides 65% of South Africa's population (21% in Kwa-Zulu Natal, 20% in Gauteng, 14% in the Eastern Cape, and 10% in the Western Cape). In addition, these four provinces comprise 72% of the country's employed population (Statistics South Africa, 2007).

As a result of being able to identify the total population of specialized substance abuse treatment facilities across the four provinces, it was decided to survey all the identified treatment facilities instead of using non-random, purposive sampling. The targeted population consisted of all facilities in the Western Cape (N=25), Gauteng (N=36), Kwa-Zulu Natal (N=15), and the Eastern Cape (N=13), comprising a total of 89 treatment facilities across all four provinces. In the Western Cape the response rate was 92.0% (N=23), 22.2% (N=8) in Gauteng, 33.3% (N=5) in Kwa-Zulu Natal, and 61.5% (N=8) in the Eastern Cape. Overall, the return rate for the provinces combined was 49.3%. This return percentage is slightly lower than the return ranges of 53% to 58% achieved in similar studies across the United States (Greener *et al.*, 2007;

Simpson *et al.*, 2007). Comprehensive and detailed summaries of the above, and following, demographics are provided in Appendix A.

The majority of treatment facilities (64%) operated independently, and 36% were affiliated with other treatment programs. More than half the treatment facilities represented were residential (57% inpatient programs, 7% therapeutic communities) and 34% were outpatient program types. Fifty nine percent of participating treatment facilities operated in primary urban areas, 32% in peri-urban (local townships), and 9% in rural areas. English was the primary language used for providing treatment services in 59% of treatment facilities, and other South African languages (e.g., Afrikaans, Zulu, Xhosa, etc.) were used in the remaining 41%. Approximately 66% of treatment facilities had a total of 40 or fewer clients, roughly 18% were treating client ranges greater than 40 and fewer than 160, and 16% had a total of 160 clients or more.

Both the program directors and counselors from the substance abuse treatment facilities recruited for this study completed and returned surveys. A total of 44 program directors participated in the study. Approximately half (52%) the program directors were female, 75% were White, 7% were Black, and 12% were of other ethnic descent. About 79% had a bachelor's degree or higher, and 59% had at least five years of work experience. Forty eight percent (48%) were in their present job for over five years, 45% were in it for 1 to 4 years, and 7% held their position for 11 months or less.

Surveys from 102 treatment counselors were received. More than two thirds (76%) of the treatment counselors were female, 55% were White, 13% were Black, and 32% were of other ethnic descent. The majority of treatment counselors (72%) had a bachelor's degree or higher, 3% did not have a high school diploma, and 25% had various other levels of education (e.g. technikon diploma, registered nurse etc.). Roughly one third (34%) of treatment staff in participating facilities were employed as addiction counselors, 38% occupied the position of social worker, and 43% had at least five years of work experience. Just over half (51%) of the counselors were in their present job between one and four years, 32% were in it for at least five years, and 17% held their position for 11 months or fewer. Only 32% of counselors had a

client caseload of fewer than ten clients, whereas 26% had a caseload of more than 40 clients.

Materials

Organizational Readiness for Change assessment (ORC)

The ORC assessment was used as the primary tool for measuring program functioning in this study. The rationale, scale descriptions, favorable psychometric properties, and use of the ORC to assess organizational needs and functioning are reported in detail by Lehman *et al.*, (2002). The ORC assessment's broad applicability is demonstrated by the more than 4000 ORC surveys that have been administered in over 650 organizations during the past five years (Simpson & Flynn, 2007; Greener *et al.*, 2007; Saldana *et al.*, 2007; Simpson *et al.*, 2007). The ORC includes four major domains for measuring staff perceptions including: the adequacy of program resources, counselor attributes, organizational climate, and the motivation or pressures for program changes. These four domains consist of 18 scales and each scale contains an average of six items. The 18 scales comprise of 129 five-point Likert scale items using response categories ranging from *strongly disagree* to *strongly agree*, and requires approximately 25 minutes to complete (Greener *et al.*, 2007; Simpson & Flynn, 2007). A brief description of the four domains and the 18 scales in the ORC is given in Table 1 (p. 29).

The ORC scoring guide explains the procedures for computing the scores of the 18 scales, as reversed-scoring is required for certain items with reverse wording. ORC scores are obtained by computing the mean of the item responses (e.g., the Likert values between one and five) for each scale and multiplying it by ten. This yields scores that range from ten to 50, with a midpoint of 30. Thus, 30 represents a neutral score and reflects neither overall agreement nor disagreement with the set of items from any given scale. Scores above 30 indicate stronger levels of agreement, and similarly scores below 30 indicate stronger levels of disagreement.

Two versions of the ORC are available. One version (ORC-D) is designed for treatment facility program directors (Appendix B), and another version (ORC-S) is designed for treatment facility staff (Appendix C). Program directors and treatment staff have different levels of responsibilities within the treatment facility and thus

have varied perspectives. The differences, and consistencies, between these perspectives are an important factor in how the ORC assesses treatment programs (Lehman *et al.*, 2002).

Table 1
Brief description and overview of the scales in the ORC survey (adapted from Greener *et al.*, 2007, p. 142)

A. Motivation for change
1. *Program needs for improvement* reflect evaluations made by treatment staff about the programs strengths/weaknesses and areas that need attention. These areas include assessing client needs, program performance, and treatment services provided. Sample item: Your program needs additional guidance in assessing client needs.
2. *Training needs* assess perceptions of training in knowledge-based and technical areas that may be needed by treatment personnel. Sample item: You need more training in assessing client problems and needs.
3. *Pressures for change* perceived to come from internal (i.e., clients, staff or leadership) or external (i.e., regulatory or funding agencies) sources. Sample item: Current pressures for change come from clients in the program.

B. Adequacy of resources
1. *Offices* refers to the adequacy of office equipment and the physical work environment (e.g., space available, office lighting etc.) Sample item: Your offices and equipment are adequate.
2. *Staffing* focuses on the overall adequacy of the treatment staff. Sample item: There are enough counselors here to meet current client needs.
3. *Training* addresses resources and scheduling for staff training and education. Sample item: Staff training and continuing education are priorities at this facility.
4. *Equipment* deals with the adequacy and use of computerized system and equipment. Sample item: Client assessments are usually conducted using a computer.
5. *Internet* assesses staff access and use of the Internet for professional communications, networking, and obtaining work-related information. Sample item: You have easy access for using the Internet at work.

C. Staff attributes
1. *Growth* reflects the extent to which treatment personnel value and use the opportunities provided for their own professional growth. Sample item: You do a good job of regularly updating and improving your skills.
2. *Efficacy* measures staff confidence in their own occupational skills and performance. Sample item: You have the skills needed to conduct effective group counseling.
3. *Influence* addresses staff interactions, support, and the extent that others seek their advice. Sample item: Other staff often ask your advice about program procedures.
4. *Adaptability* focuses on the ability of staff to effectively adapt to new ideas and change. Sample item: Learning and using new procedures are easy for you.

D. Organizational climate
1. *Mission* assesses staff awareness about program mission and the clarity of its goals. Sample item: Your duties are clearly related to the goals of this program.
2. *Cohesion* reflects on workgroup trust and cooperation. Sample item: Staff at this program all get along very well.
3. *Autonomy* measures the freedom and latitude treatment personnel have in performing their jobs. Sample item: Counselors are given broad authority in treating their own clients.
4. *Communication* addresses the adequacy of information networks to keep staff informed and the bidirectional interactions with management. Sample item: Program staff are always kept well informed.
5. *Stress* measures perceived occupational strain, stress, and role overload. Sample item: You are under too much pressure to do your job effectively.
6. *Change* reflects staff attitudes about program openness and efforts towards keeping up with changes that are needed. Sample item: You are encouraged here to try new and different techniques.

The ORC scales are useful indicators of a treatment program's strengths and weaknesses, and useful for identifying potential areas for the treatment program to consider. Each ORC domain has also demonstrated satisfactory reliability and internal consistency at the director, staff, and program levels of evaluation (Lehman *et al.*, 2002; Saldana *et al.*, 2007; Simpson *et al.*, 2007). The actual Cronbach's alpha values for the scale and this study appear under the results section.

In order to use the ORC in the South African context, several minor adjustments were made to the original version. Additional demographic questions were added at the start of the survey to obtain contextual information relating to treatment facilities within South Africa. In order to minimize non-response and increase interest from participants, the South African Medical Research Council and the University of Cape Town letterheads were placed on the front page of the survey. All items comprising the 18 scales of the ORC remained unaltered and no language alterations were necessary. Although the ORC was presented in English, the questions were phrased in an uncomplicated manner that the comprehension of English as a second language was sufficient to successfully complete the survey.

Data collection procedures

Data for this study were collected between June and September 2005 (Western Cape), and August and November 2006 (all other sample provinces). The target population consisted of program directors and counseling staff from 89 identified specialized substance abuse treatment facilities across South Africa. These treatment facilities were identified through the South African Central Drug Authority (CDA) resource directory. In 2000, the CDA was established in South Africa to oversee the implementation of a National Drug Master Plan. This plan mandates government departments to formulate local drug plans and to establish provincial drug forums and local drug action committees (Parry, 2005b). The CDA resource directory listed 110 registered substance abuse treatment facilities in South Africa, 89 of those facilities were operating in the four provinces selected for this study. The CDA resource directory also contains the names and contact details of all registered treatment facilities in South Africa that provide alcohol and drug related treatment services.

Treatment program directors of all the treatment facilities in the target population were initially contacted telephonically by a member from the South African Medical Research Council's Alcohol and Drug Abuse Research Unit (ADARU), informed about the study and its purpose, and asked to participate. Program directors were assured that any identifying information on treatment facilities would not be included in the final reporting of the data. Following this, data collection packets containing both ORC-D and ORC-S assessments, a cover letter explaining the purpose of the study (appendix D), a contract of informed consent (appendix E), and an ADARU-addressed (and stamped) return envelope were sent via mail and/or fax to identified informants at participating treatment facilities. Due to low treatment staff numbers in South Africa, and demographic information provided by ADARU and SACENDU, each collection packet contained one ORC-D assessment and three ORC-S assessments per treatment facility. During the data collection phase, the researcher was available via telephone and email to answer treatment facilities' questions about the study.

Each participating treatment program was asked to administer the package of forms to their treatment facility for completion by the program director and three treatment staff members. It is important to note that certain participating treatment facilities had fewer than three treatment staff members. Once completed, the facilities were asked to return both the ORC-D and ORC-S assessments in the ADARU-addressed (and stamped) envelopes. Participation in the study was voluntary and a passive consent procedure was also accepted. This means that completed assessments returned to ADARU in the attached envelope, without completed consent documents, were still accepted with an implied consent to participate.

The data collection period ran from June to September 2005 for the Western Cape, and August to November 2006 for Gauteng, Kwa-Zulu Natal, and the Eastern Cape. Four weeks after the initial mailing, reminder emails were sent to all facilities and reminder telephone calls were made. Eight weeks after the initial mailing, further reminder telephone calls were made to non-responding facilities. At this point all treatment facilities that acknowledged having lost their data collection packets were sent a second mailing. Approximately four weeks after the second mailing and reminder calls, all non-respondent treatment facilities received a third reminder

telephone call and a second reminder email. Finally, all remaining treatment facilities that had not responded within two weeks after their third reminder were contacted again via telephone and sent a final mailing. All non-respondent treatment facilities were followed up telephonically on at least four occasions.

The provincial return rate for the Western Cape (92.0%) was higher than the return rates for the three other provinces. Both the researcher and ADARU are situated in the Western Cape, and within the final stage of the Western Cape data collection period the remaining non-respondent treatment facilities were contacted telephonically to arrange a suitable date for the collection of their data packets in person. The researcher and ADARU personnel then collected the remaining outstanding data collection packets in person. The provincial return rates for Gauteng (22.2%), Kwa-Zulu Natal (33.3%), and the Eastern Cape (61.5%) were lower in comparison to the Western Cape. Between September and October 2006 of the data collection period for Gauteng, Kwa-Zulu Natal, and the Eastern Cape, certain parts of these provinces experienced substantial flooding which obstructed the majority of civil services, and large quantities of mail were lost during this period. It is possible that these extraneous variables may have had influences on the provincial return rates of this study. The overall return rate at the end of both data collection periods was 49.3% and was slightly lower than the return rates (ranging between 53% and 58%) of similar studies carried out across the United States (Greener *et al.*, 2007; Simpson *et al.*, 2007).

Data analysis

Inter-item reliability for each of the 18 ORC scales was computed with Cronbach's alpha for both the ORC-D and ORC-S, and then compared to alpha values obtained by Lehman *et al.* (2002). Descriptive statistics were calculated on the mean scores obtained from the 18 ORC scales for both the program directors and treatment staff. The scale scores were then averaged across all director and staff respondents respectively in order to formulate a program functioning profile for treatment facilities in South Africa. One-way Analysis of Variance tests were performed to further test if certain South African contextual factors had any effect on the four domains of the ORC for both program directors and treatment staff. Categorical factors that were tested for directors included: provincial location, primary service

area, ethnicity, level of education, and their amount of work experience. Categorical factors that were tested for treatment staff included provincial location, ethnicity, level of education, client caseloads, and their amount of work experience.

Chapter 3: Results

Reliability

The ORC assessment was developed, tested, and verified in 111 different substance abuse treatment facilities across the United States (Lehman *et al.*, 2002). Using this assessment in a South African context, reliability for each of the 18 ORC scales was computed for both program directors and treatment staff with Cronbach's Alpha. The alpha values obtained from the South African sample were then compared to the alpha values reported by Lehman *et al.* (2002) used to establish favorable psychometric properties for the ORC assessment. Results for the South African director sample and its comparison are presented in Table 3.1.

Table 3.1
South African and U.S. director inter-item reliability comparison

		Alpha	
ORC-D scales	Items	S.A. Directors ($N = 44$)	U.S. Directors ($N = 135$)
Motivation for change			
Program needs	8	.80	.80
Training needs	8	.90	.84
Pressures for change	7	.60	.75
Adequacy of resources			
Offices	4	.59	.74
Staffing	6	.74	.60
Training	4	.48	.63
Equipment	7	.62	.72
Internet	4	.88	.79
Staff attributes			
Growth	5	.71	.74
Efficacy	5	.65	.66
Influence	6	.80	.75
Adaptability	4	.39	.51
Organizational climate			
Mission	5	.67	.62
Cohesion	6	.62	.83
Autonomy	5	.29	.52
Communication	5	.62	.67
Stress	4	.64	.82
Change	5	.80	.49

Overall, seven of the director scales had reliabilities above .70 and a further seven scales scored above .60. Four scales (Offices, Training, Adaptability, and Autonomy) had reliabilities below .60. The two lowest scales were Adaptability and Autonomy (alpha values below .40). Lehman's *et al.* (2002) results indicated 10 of the 18 scales in the U.S. sample had reliabilities above .70, and five scales had reliabilities above

.60. Three scales (Adaptability, Autonomy, and Change) had alpha values of .60. In Lehman's *et al.* (2002) study, both Adaptability and Autonomy scored substantially low as well with respective reliabilities of .51 and .52. One distinct difference between the South African and U.S. director reliabilities was the Change scale (.80 compared to .49 in the U.S.).

Results for the South African treatment staff sample and its comparison are presented in Table 3.2.

Table 3.2
South African and U.S. treatment staff inter-item reliability comparison

		Alpha	
ORC-S scales	Items	S.A. Staff (N = 102)	U.S. Staff (N = 458)
Motivation for change			
Program needs	8	.91	.87
Training needs	8	.89	.84
Pressures for change	7	.70	.70
Adequacy of resources			
Offices	4	.65	.62
Staffing	6	.53	.70
Training	4	.65	.57
Equipment	7	.75	.60
Internet	4	.77	.69
Staff attributes			
Growth	5	.65	.62
Efficacy	5	.65	.71
Influence	6	.74	.79
Adaptability	4	.58	.66
Organizational climate			
Mission	5	.54	.70
Cohesion	6	.84	.84
Autonomy	5	.43	.57
Communication	5	.72	.80
Stress	4	.73	.79
Change	5	.65	.73

At the staff level, nine of the 18 ORC scales had reliabilities of .70 or higher, and five scales had scales had reliabilities above .60. Four scales (Staffing, Adaptability, Mission, and Autonomy) had alpha values below .60. Staffing and Autonomy had the lowest reliabilities of .53 and .43. According to Lehman *et al.* (2002), 11 of the 18 ORC scales had reliabilities of .70 or higher in their U.S. sample. Five scales had reliabilities higher than .60, and two scales (Training and Autonomy) had alpha

values below .60. The Autonomy scale had the lowest reliability in both the South African and U.S. samples with respective alpha values of .43 and .57.

Descriptive statistics

Means and standard deviations of the ORC-D scales for directors are shown in Table 3.3. Scores ranged from ten to 50, with a midpoint of 30. A score of 30 is neutral and higher scores on each scale represent more agreement with the attribute being represented. Similarly, lower scores below 30 represent less agreement with the attribute being represented.

Table 3.3
Organizational functioning and readiness for change – Director means and standard deviations

	Directors ($N = 44$)	
ORC-D scales	Mean	*SD*
Motivation for change		
Program needs	31.36	7.17
Training needs	30.79	8.83
Pressures for change	27.95	5.98
Adequacy of resources		
Offices	38.12	7.43
Staffing	35.11	7.45
Training	32.27	7.73
Equipment	30.22	6.49
Internet	36.19	11.12
Staff attributes		
Growth	35.50	6.94
Efficacy	39.82	4.22
Influence	39.82	4.99
Adaptability	38.23	4.33
Organizational climate		
Mission	39.18	5.46
Cohesion	38.14	7.20
Autonomy	39.13	4.23
Communication	38.64	5.12
Stress	30.05	6.89
Change	37.45	6.19

Means and standard deviations of the ORC-S scales for treatment staff are shown in Table 3.4.

Table 3.4
Organizational functioning and readiness for change –Treatment staff means and standard deviations

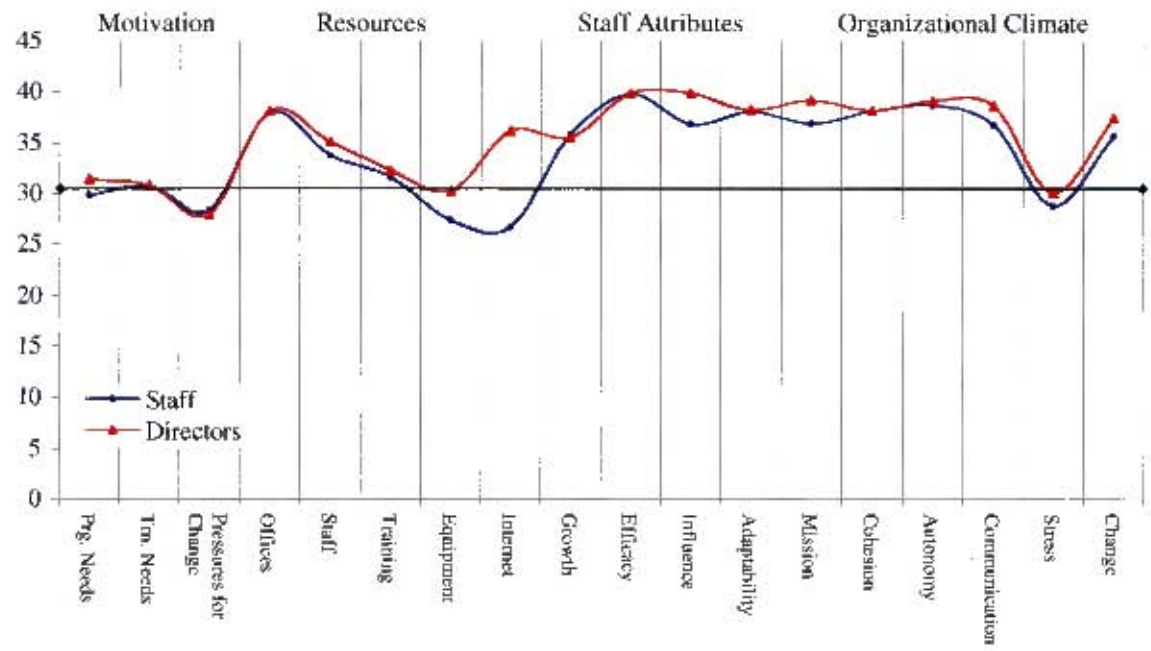
	Staff (N = 102)	
ORC-D scales	Mean	*SD*
Motivation for change		
Program needs	29.82	9.27
Training needs	30.71	8.35
Pressures for change	28.38	6.35
Adequacy of resources		
Offices	37.89	6.98
Staffing	33.74	5.35
Training	31.59	8.07
Equipment	27.36	7.39
Internet	26.79	10.17
Staff attributes		
Growth	35.80	5.91
Efficacy	39.80	4.39
Influence	36.83	5.37
Adaptability	38.03	4.74
Organizational climate		
Mission	36.90	3.64
Cohesion	38.12	6.97
Autonomy	38.70	4.04
Communication	36.76	5.55
Stress	28.82	7.36
Change	35.68	5.22

The means and standard deviations for the four domains (motivation for change, adequacy of resources, staff attributes, and organizational climate) for directors and staff in South Africa are shown in Table 3.5.

Table 3.5
Means and standard deviations for the four ORC domains – Directors and staff

	Directors (N = 44)		Staff (N = 102)	
ORC domain	Mean	*SD*	Mean	*SD*
Motivation for change	30.03	6.18	29.63	6.69
Adequacy of resources	34.38	5.07	31.47	5.15
Staff attributes	34.38	4.13	37.62	3.80
Organizational climate	37.10	3.66	35.83	2.77

The means of the ORC scales for directors and staff were plotted graphically in a line chart to create an *organizational functioning and readiness for change* profile on treatment facilities in South Africa. Figure 3.1 presents the calculated mean ORC scores from the 44 treatment facilities that participated in the study.



Organizational Functioning and Readiness for Change ORC Scores

Figure 3.1 Means of the ORC-D and ORC-S scores obtained from treatment facilities across South Africa.

According to this profile and the calculated mean ORC scores, it is evident that directors and staff in treatment facilities across South Africa share similar cognitive appraisals regarding the four ORC domains of organizational functioning and readiness for change. This profile further indicates that directors and staff are in agreement with majority of the ORC scales. In addition to mean ORC scale scores, standard deviations for each ORC scale and ORC domain were calculated as indicators of director and staff consensus. Lower standard deviation values reflect stronger agreement on the ORC scales among directors and staff from different treatment facilities.

The mean scores for directors ($M = 30.03$) and staff ($M = 29.63$) on the motivation for change domain are extremely close the neutral midpoint of 30, and the standard deviation values for directors ($SD = 6.18$) and staff ($SD = 6.69$) are high. This ORC domain reflects on programs' strengths and weaknesses, the training needs of staff, and whether the programs' pressures for change come from internal (e.g., staff or client) or external (e.g., regulatory or funding agencies) sources. The close to neutral mean values indicate that directors and staff are not certain of exact facility strengths or weaknesses, and are not sure if staff need specialized training, or if internal or

external sources are exerting pressures on the facility to change. Large standard deviations show high disagreement amongst directors and staff.

Both directors (M = 34.38) and staff (M = 31.47) have mean scores of above 30 for the adequacy of resources domain. This domain assesses the adequacy of the physical work environment and offices, quality of staff, training resources available, and usage of computers and the Internet. It is interesting to note that directors scored slightly higher on all the resource scales (except the Internet scale), showing that directors tend to have a more positive view on the adequacy of the facility resources. There is a large difference between the director (M = 36.19) and staff (M = 26.79) mean scores for the Internet scale. This indicates more convenient access and greater use of the Internet for directors, at certain treatment facilities, in comparison to staff. Large standard deviations represent little agreement between directors (SD = 5.07), and staff (SD = 5.15), on the adequacy of resources domain.

The staff attributes domain assesses the extent to which staff perceive opportunities for professional growth, confidence in their own counseling skills, ability to influence coworkers, and their ability to adapt to changing environments. Directors (M = 34.38) and staff (M = 37.62) are in strong agreement with the attributes in this domain. Low standard deviations also reflect strong agreement amongst directors (SD = 4.13), and staff (SD = 3.80). According to these mean scores, staff have a slightly higher perception of their attributes in comparison to directors.

Directors (M = 37.10) and staff (M = 35.83) organizational climate mean scores indicate high staff awareness on facility goals and mission, positive workgroup cooperation and trust, and sufficient latitude to work with their own clients. These scores further show positive bidirectional communication with management, and positive efforts from management in keeping up with change. The staff (M = 28.82) mean score for the stress scale of this domain shows that staff do not perceive strain, stress, and role overload to be common, and does not hinder facility effectiveness. The director (30.05) mean score indicates directors are uncertain and neither agree nor disagree that stress hinders facility effectiveness. Standard deviations are the lowest for this domain, directors (SD = 3.66) and staff (SD = 2.77), and represents strong agreement amongst staff, and directors.

One-way Analysis of Variance (ANOVA) tests on South African contextual factors

Due to the socio-political history and context of South Africa, certain contextual factors may impact a substance abuse treatment facility's organizational functioning and readiness for change. A continual history of highly fragmented healthcare systems, inadequate state funding, historical educational inequalities, substantial imbalances between the racially defined population groups, poor geographical distribution of treatment facilities, and the majority of treatment services being historically reserved for the White population, have all had a significant impact on the availability and quality of substance abuse treatment facilities that operate in South Africa (Parry & Yach, 1993; Myers & Parry, 2005).

Assumption of homogeneity and normality

Due to the uneven distribution of treatment facilities across the provinces of South Africa, the low and uneven number of counselors employed by each facility, and the varied responses from the different provinces, the assumptions of homogeneity and normality were tested to validate the results of the one-way ANOVA analyses. A Levene's Test was used to test for the assumption of homogeneity and Normal P-Plots were used to test for the assumption of normality. Neither assumption was violated for all of the following analyses.

One-way ANOVA results for directors

Based on South African and drug treatment literature, one-way ANOVA tests were used to see if the demographic factors (independent variables) provincial location, primary service area, ethnicity, level of education, and amount of work experience, had any effect on the four ORC-D domains (motivation for change, adequacy of resources, staff attributes, and organizational climate).

- *Motivation for change*

There were no significant differences among motivation for change and three of the demographic factors tested for, provincial location ($F(3, 40) = .616$, $p = .608$), primary service area $F(2, 41) = 1.616$, $p = .210$), and work experience ($F(3, 40) = 2.106$, $p = .114$). Effects were found between motivation for change and ethnicity ($F(3, 40) = 6.513$, $p = .001$) (see Table 3.6), and level of education ($F(5, 38) = 4.437$, $p = .002$) (see Table 3.7).

Table 3.6
One-way ANOVA between director ethnicity and motivation for change

Effect	SS	*df*	MS	F	*p*
Ethnicity	539.12	3	179.71	6.513	.001
Error	1103.62	40	27.59		

A Tukey HSD post-hoc test indicated that White directors (M = 28.0), compared to Black directors (M = 37.4), Colored directors(M = 36.3), and directors of other ethnicity(M = 36.3) showed less agreement with the attributes represented by motivation for change (see Figure 3.2).

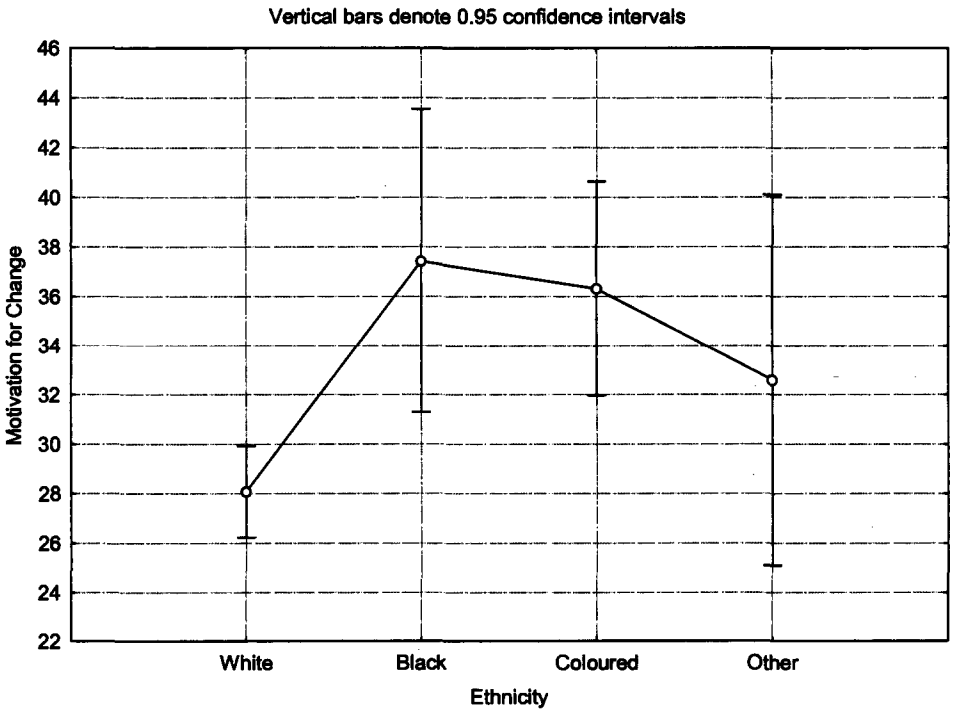


Figure 3.2 Director *motivation for change* mean scores according to ethnicity.

Table 3.7
One-way ANOVA between director level of education and motivation for change

Effect	SS	*df*	MS	F	*p*
Education	605.60	5	121.12	4.437	.002
Error	1037.14	38	27.29		

A Tukey HSD post-hoc test showed that directors with Bachelor's degrees (M = 32.5) and technikon diplomas (M = 33.5) were more in agreement with the attributes represented by motivation for change when compared to directors with Master's degrees (M = 26.0), doctoral degrees (M = 25.8), and other forms of education (M =

24.5) (e.g. registered nurse). The test further showed that directors with no high school diploma (M = 21.4) were in strong disagreement with these attributes (see Figure 3.3).

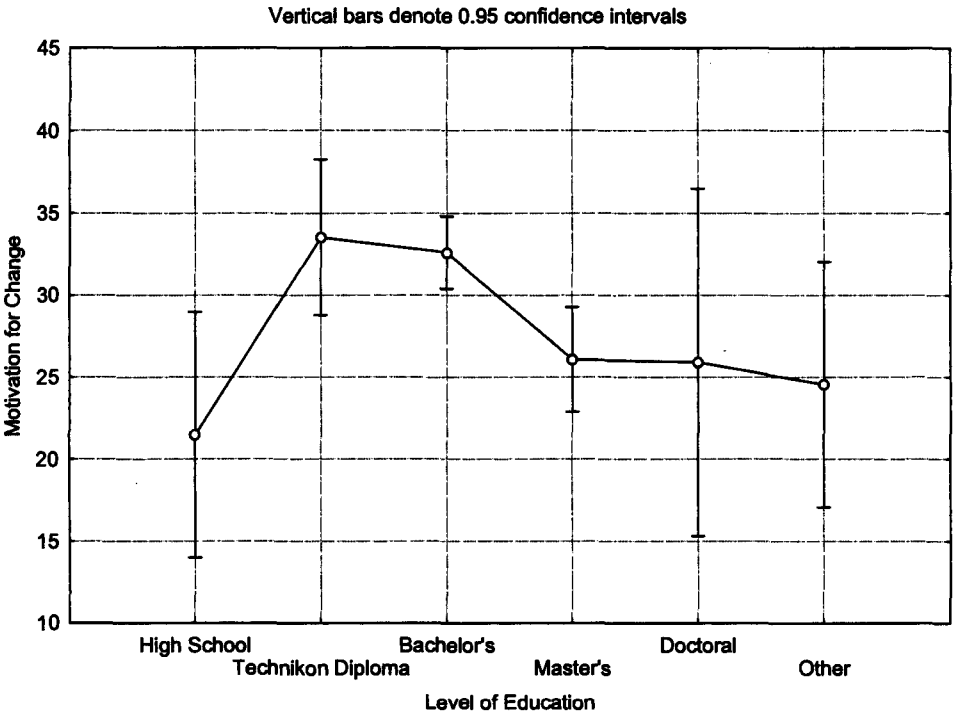


Figure 3.3 Director *motivation for change* mean scores according to their level of education.

- Adequacy of resources

Differences could be found between the adequacy of resources domain and the categorical demographic factors ethnicity ($F(3, 40) = 3.480$, $p = .024$) (see Table 3.8), and work experience ($F(3, 40) = 3.263$, $p = .031$) (see Table 3.9). There were no significant differences between the adequacy of resources domain and level of education ($F(5, 38) = 1.329$, $p = .272$), provincial location ($F(3, 40) = .382$, $p = .765$), or primary service area ($F(2, 41) = 2.235$, $p = .119$).

Table 3.8
One-way ANOVA between director ethnicity and adequacy of resources

Effect	SS	*df*	MS	F	*p*
Ethnicity	229.17	3	76.39	3.480	.024
Error	877.98	40	21.95		

A Tukey HSD post-hoc test found that Black directors (M = 28.5) were in disagreement with the attributes represented in this domain, and White directors (M =

35.6), Colored directors (M = 31.0), and directors of other ethnicity (M = 32.3) were in agreement with the adequacy of resources domain factors (see Figure 3.4).

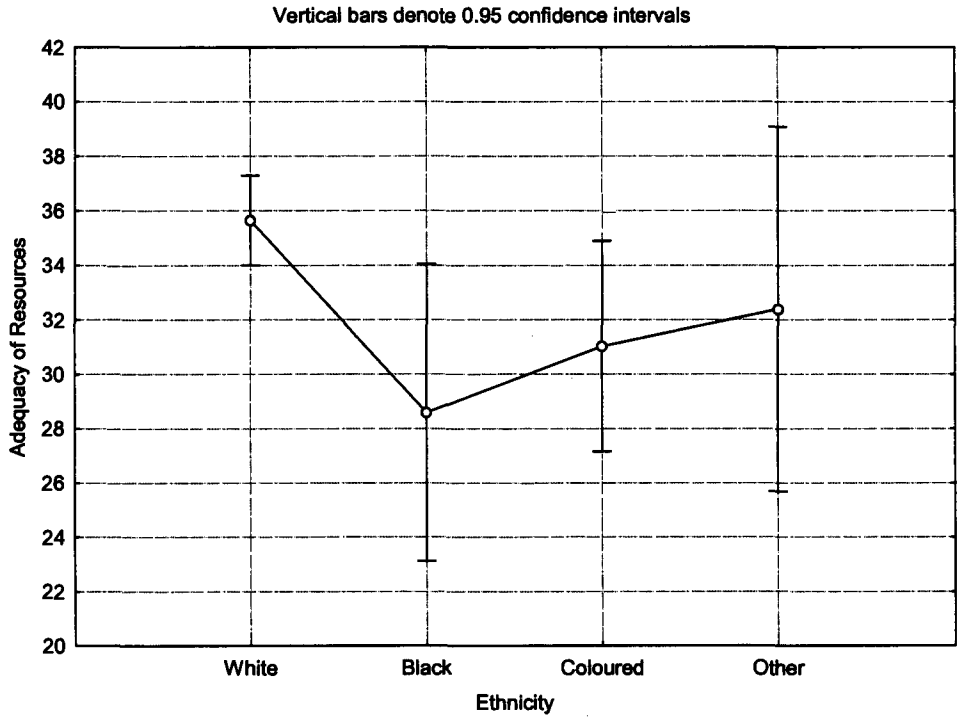


Figure 3.4 Director *adequacy of resources* mean scores according to their ethnicity.

Table 3.9
One-way ANOVA between director work experience and adequacy of resources

Effect	SS	*df*	MS	F	*p*
Experience	217.70	3	72.57	3.264	.031
Error	889.44	40	22.24		

A Tukey HSD post-hoc test indicated that directors with less than one year experience (M = 34.3), three to five years experience (M = 33.1), and more than five years experience (M = 35.8) were in agreement with the adequacy of resources domain and its attributes. Directors who had between one and two years experience (M = 28.9) disagreed with the attributes represented in adequacy of resources domain (see Figure 3.5).

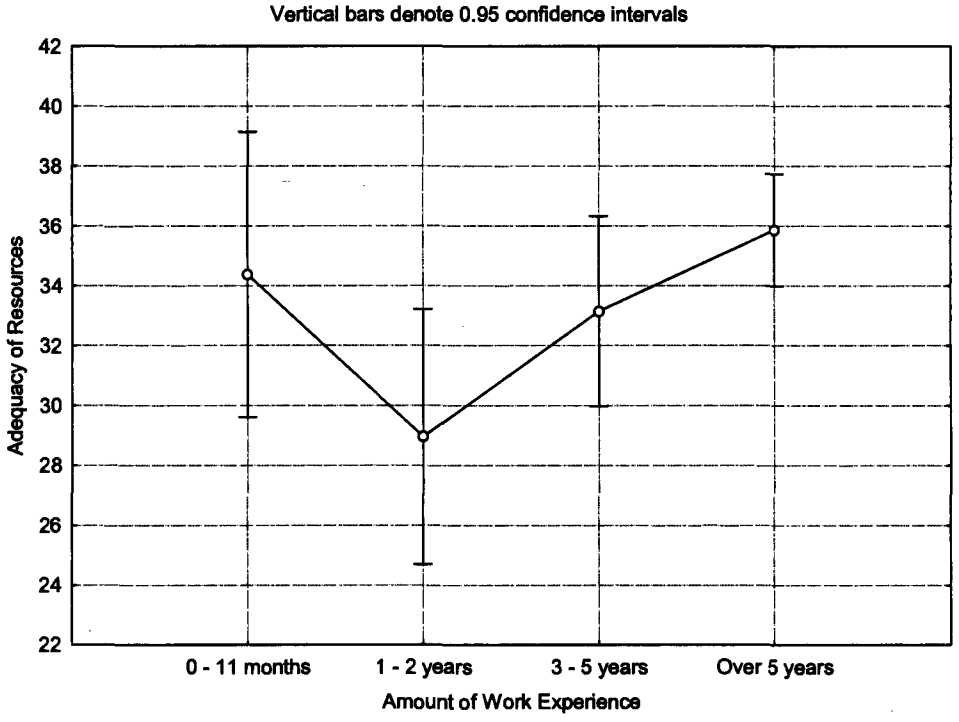


Figure 3.5 Director *adequacy of resources* mean scores according to their work experience.

- *Staff attributes*

Only one significant difference was found between staff attributes and director work experience (F(3, 40) = 3.148, p = .035) (see Table 3.10). No differences were found between staff attributes and director provincial location (F(3, 40) = .291, p = .831), primary service area (F(2, 41) = 2.652, p = .082), ethnicity(F(3, 40) = 2.242, p = .098), or level of education (F(5, 38) = 1.566, p = .192).

Table 3.10
One-way ANOVA between director work experience and staff attributes

Effect	SS	*df*	MS	F	*p*
Experience	140.76	3	46.92	3.148	.035
Error	596.16	40	14.90		

A Tukey HSD post-hoc test revealed that directors who had three to five years (*M* = 39.6), and five or more years (*M* = 39.0) were in greater agreement about their staff attributes. Directors with less experience, less than one year (*M* = 36.6) and between one and two years (*M* = 33.8), were in less agreement with these attributes (see Figure 3.6)

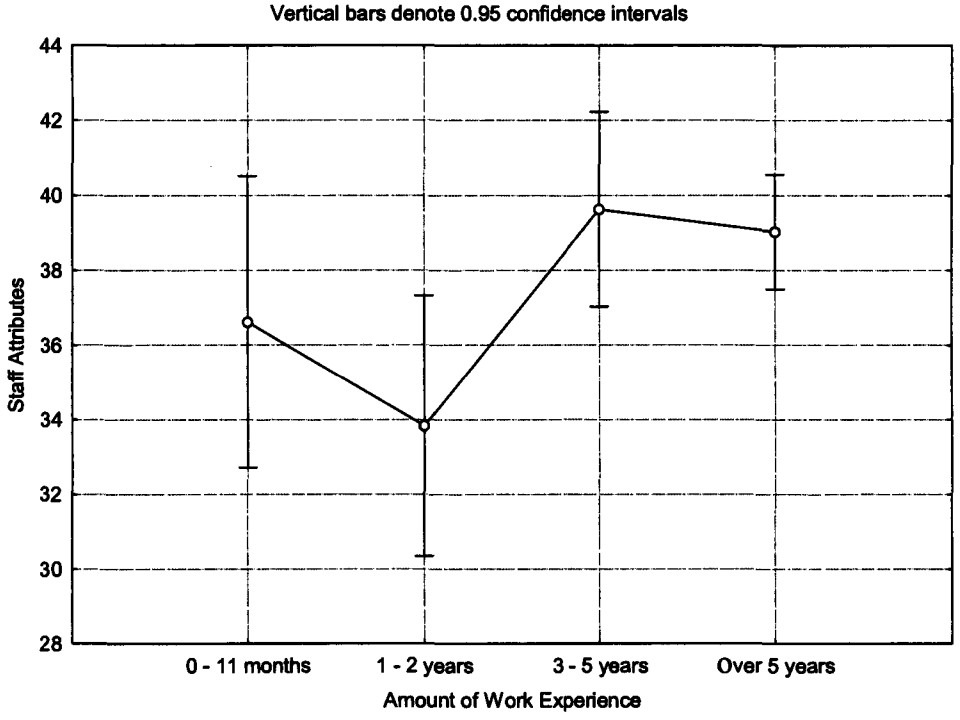


Figure 3.6 Director *staff attributes* mean scores according to their work experience.

- *Organizational climate*

Significant differences were found between the organizational climate domain and the categorical demographic factor primary service area ($F(2, 41) = 9.117$, $p = .000$) (see Table 3.11), and the directors' amount of work experience ($F(3, 40) = 5.468$, $p = .003$) (see Table 3.12). No differences were seen between the organizational climate domain and provincial location ($F(3, 40) = .658$, $p = .582$), director ethnicity ($F(3, 40) = 1.318$, $p = .281$), or director level of education ($F(5, 38) = .354$, $p = .875$).

Table 3.11
One-way ANOVA between director primary service area and organizational climate

Effect	SS	*df*	MS	F	*p*
Service area	178.09	2	89.04	9.118	.0005
Error	400.41	41	9.77		

Results from a Tukey HSD post-hoc test show that directors from treatment facilities that primarily served in urban ($M = 38.4$) and rural ($M = 38.4$) areas were in greater, and similar, agreement about the organizational climate attributes. Directors from facilities primarily operating in peri-urban (e.g., local townships and informal settlements) were in less agreement ($M = 34.1$) (see Figure 3.7).

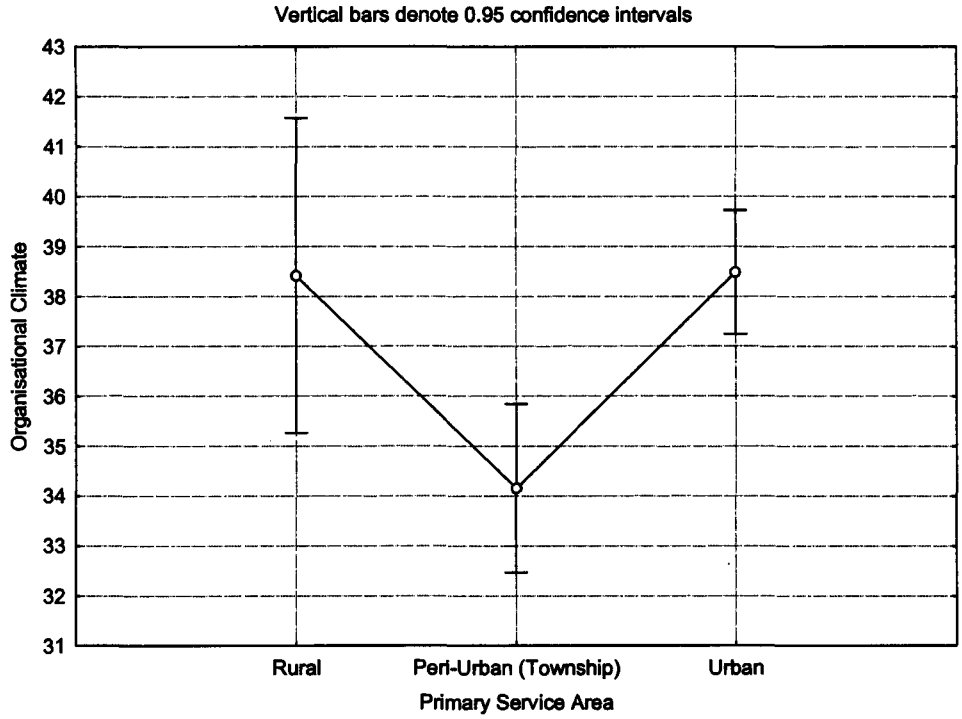


Figure 3.7 Director *organizational climate* mean scores according to their primary service area.

Table 3.12
One-way ANOVA between director work experience and organizational climate

Effect	SS	*df*	MS	F	*p*
Experience	168.26	3	56.09	5.469	.003
Error	410.24	40	10.26		

A Tukey HSD post-hoc test revealed that directors with three to five years work experience (M = 38.7), and with at least five years work experience (M = 37.6) were in strong agreement about the attributes represented by organizational climate. Directors who had less than one year of work experience (M = 36.0) were in slightly less agreement, and directors with between one and two years work experience (M = 31.9) expressed the least amount of agreement (see Figure 3.8).

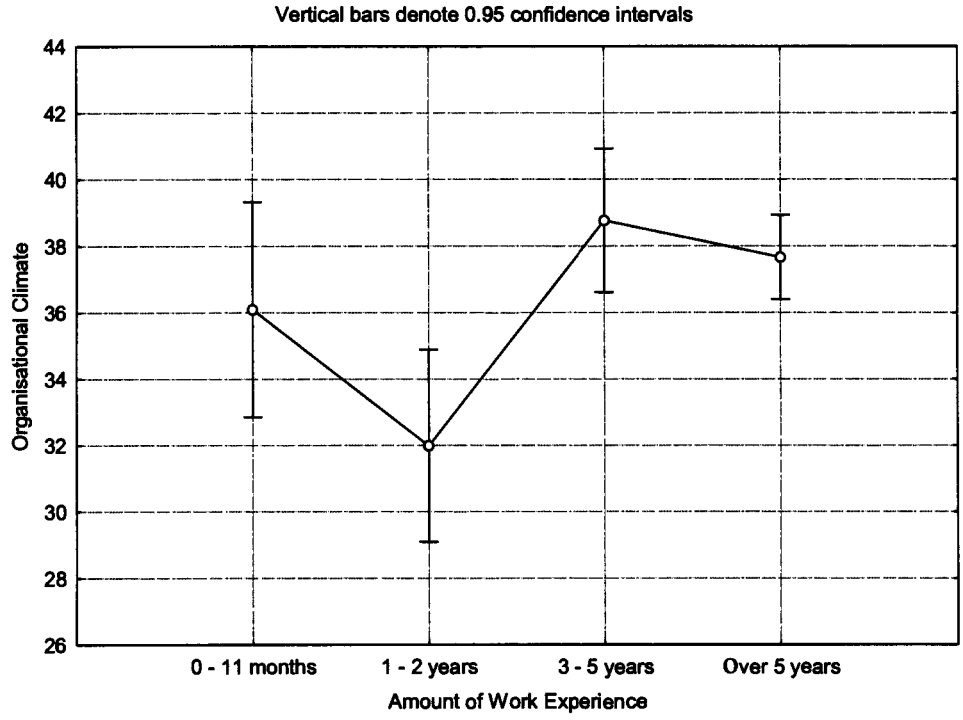


Figure 3.8 Director *organizational climate* mean scores according to their work experience

One-way ANOVA results for treatment staff

Based on South African and drug treatment literature, one-way ANOVA tests were used to see if the demographic factors (independent variables) provincial location, ethnicity, level of education, client caseload, and amount of work experience had any effect on the four ORC-S domains (motivation for change, adequacy of resources, staff attributes, and organizational climate).

- *Motivation for change*

There were no significant differences among the motivation for change domain and four of the demographic categorical factors tested for: provincial location ($F(3, 98) = 2.083$, $p = .107$), staff ethnicity ($F(3, 98) = 2.340$, $p = .078$), client caseloads ($F(4, 97) = 1.049$, $p = .385$), and staff amount of work experience ($F(3, 98) = .287$, $p = .834$). A significant difference was found between motivation for change and the staff level of education ($F(6, 95) = 2.690$, $p = .018$) (see Table 3.13).

Table 3.13
One-way ANOVA between staff level of education and motivation for change

Effect	SS	*df*	MS	F	*p*
Education	657.03	6	109.50	2.690	.018
Error	3867.21	95	40.71		

A Tukey HSD post-hoc analysis revealed that staff with doctoral degrees (M = 21.2), Master's degrees (M = 25.1), Bachelor's degrees (M = 29.3), and no high school diploma (M = 28.8) were in disagreement to the attributes represented by the motivation for change domain. Staff with high school diplomas (M = 30.8) were in neither agreement nor disagreement. Staff with technikon diplomas (M = 31.3), and other levels of education (e.g., registered nurse) (M = 36.9) were in agreement with these attributes (see Figure 3.9).

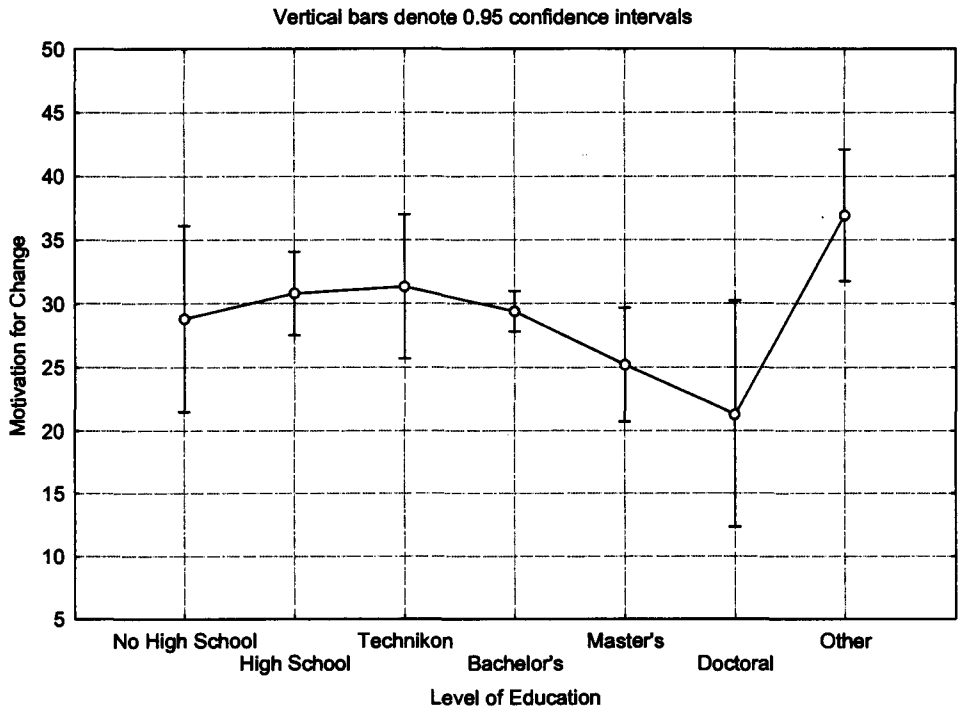


Figure 3.9 Staff *motivation for change* mean scores according to their level of education

- *Adequacy of resources*

Significant differences were found between the adequacy of resources domain and the categorical factors staff ethnicity (F(3, 98) = 3.831, p = .012) (see Table 3.14), and provincial location (F(3, 98) = 6.431, p = .000) (see Table 3.15). No significant differences were found for the demographics of staff level of education (F(6, 95) =

1.226, p = .299), client caseloads (F(4, 97) = .452, p = .770), and amount of staff work experience (F(3, 98) = 1.623, p = .188).

Table 3.14
One-way ANOVA between staff ethnicity and adequacy of resources

Effect	SS	*df*	MS	F	*p*
Ethnicity	281.64	3	93.88	3.831	.012
Error	2401.44	98	24.50		

A Tukey HSD post-hoc test showed that White (M = 32.4) and Black (M = 33.2) treatment staff were in agreement with the attributes of this domain. Colored (M = 28.5) treatment staff were in disagreement with the attributes represented by motivation for change, and treatment staff of other ethnicity (M = 30.0) were undecided on these attributes (see Figure 3.10).

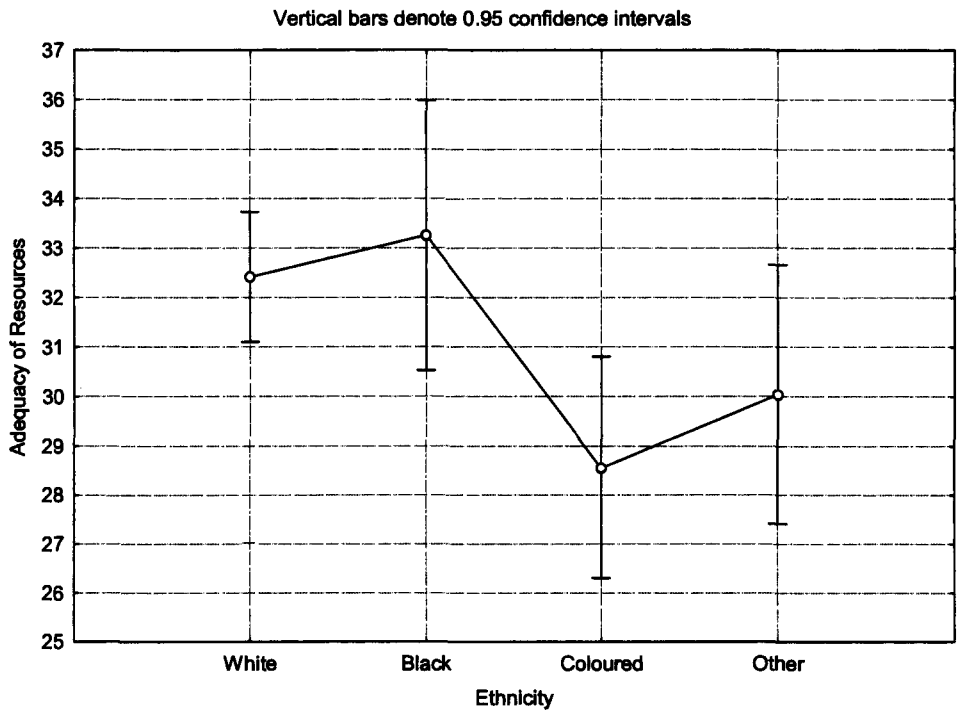


Figure 3.10 Staff *adequacy of resources* mean scores according their ethnicity

Table 3.15
One-way ANOVA between staff provincial location and adequacy of resources

Effect	SS	*df*	MS	F	*p*
Province	441.37	3	147.12	6.432	.0005
Error	2241.71	98	22.87		

The results from a Tukey HSD post-hoc analysis showed that treatment staff from the Eastern Cape (M = 35.0), Gauteng (M = 33.7), and Kwa-Zulu Natal (M = 31.1) were in agreement with the adequacy of resources domain and its attributes. The results also indicated that treatment staff from the Western Cape (M = 29.7) were in disagreement about the attributes of this domain (see Figure 3.11).

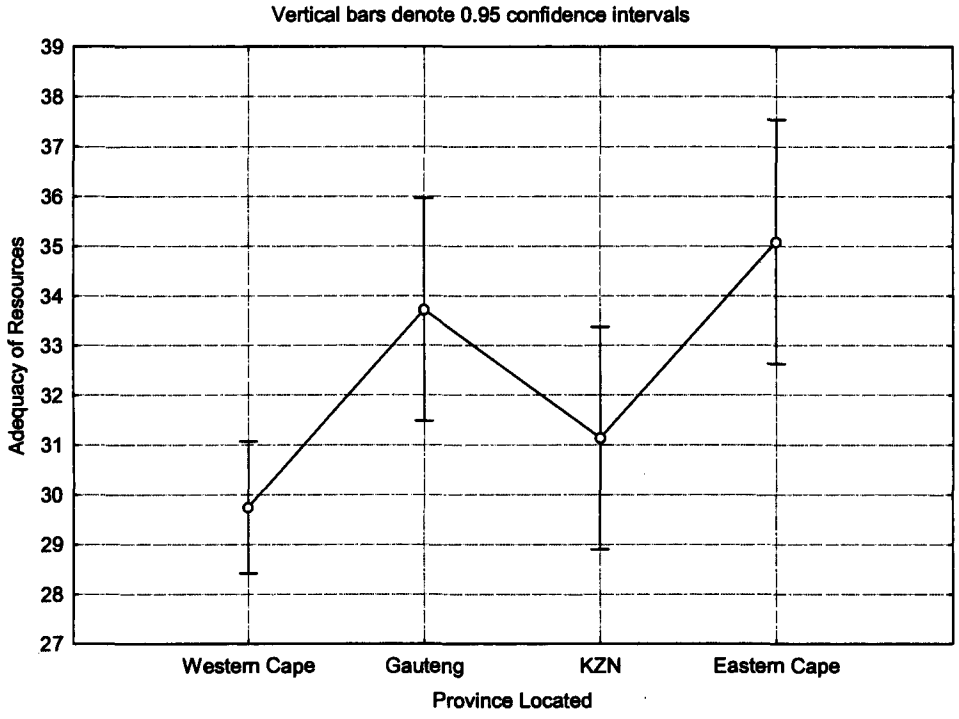


Figure 3.11 Staff *adequacy of resources* mean scores according their provincial location

- *Staff attributes*

No significant differences were found between the staff attributes domain and any of the five categorical demographic factors tested for: provincial location ($F(3, 98) = .308$, $p = .818$), staff ethnicity ($F(3, 98) = .365$, $p = .777$), staff level of education ($F(6, 95) = .137$, $p = .990$), client caseloads ($F(4, 97) = .230$, $p = .920$), and staff amount of work experience ($F(3, 98) = .437$, $p = .727$).

- *Organizational climate*

No significant differences were found between the organizational climate domain and any of the five categorical demographic factors tested for: provincial location ($F(3, 98) = .078$, $p = .971$), staff ethnicity ($F(3, 98) = .747$, $p = .526$), staff level of education ($F(6, 95) = .503$, $p = .804$), client caseloads ($F(4, 97) = .194$, $p = .940$), or staff amount of work experience ($F(3, 98) = .687$, $p = .562$).

Chapter 4: Discussion

This study began with the expectations that the ORC scores obtained from facility directors in South Africa would differ from the ORC scores obtained from treatment staff, and that certain contextual and demographic variables would influence both directors and treatment staff perceptions towards organizational functioning within their substance abuse treatment facilities. According to the results these expectations were moderately supported.

Significance of the results and study

Lehman *et al.* (2002) states that directors and treatment staff can have important and different perspectives on the organizational functioning of a treatment facility. Directors and staff have different levels of responsibility in the functioning of a treatment facility and thus each has varied perceptions. These differences warrant the need for separate versions of the ORC for program directors and treatment staff.

In the South African treatment facilities both directors and staff tended to converge in their perceptions towards organizational functioning more often than they diverged. The results indicated that both the directors and treatment staff ORC scores converged on the majority of the 18 ORC scales, with two important differences to note.

Although both directors and treatment staff had favorable perceptions of the domains adequacy of resources, staff attributes, and organizational climate, the first divergence is that directors had more favorable perceptions of these domains in comparison to staff perceptions. According to Lehman *et al.* (2002) the directors' more favorable perceptions could be a result of viewing particular domains as a reflection of their managerial effectiveness, and therefore rating these areas in a more positive view.

The second divergence is that although South African directors have favorable perceptions towards the facility equipment and Internet ORC scales, South African treatment staff have negative perceptions towards these two scales. However, it is not surprising that directors report better computer access and the use of electronic communications. In environments where resources are limited, computer access and Internet usage are more likely to be made available to facility management first before being offered to treatment staff (Lehman *et al.*, 2002).

In South Africa evidence points to a great need for substance abuse intervention services. In the past decade there has been the establishment of ADARU at the Medical Research Council and the Foundation for Alcohol-Related Research at the University of Cape Town. However, while these organizations signal progress, there have also been significant reductions in funding to non-governmental organizations and state-subsidized treatment facilities, limiting their treatment capacity and their ability to expand services to historically underserved areas. Valuable resources have further diminished with cuts in funding to numerous specialist substance abuse treatment facilities resulting in closures and decreases in the number of beds in general state hospitals for patients with substance abuse problems (Myers *et al.*, 2004; Parry, 2005a). It is evident that available resources for substance abuse treatment facilities in South Africa are scarce and the results from this study appear to be in support of Lehman's *et al.* (2002) findings that accessible resources are made available to program directors first before being made available to treatment staff. These results further support that program management may perceive treatment circumstances to be slightly more favorable in relation to their managerial effectiveness, than the perceptions of treatment staff that may be formulated closer to their occupational circumstances.

The ORC domain motivation for change focuses on motivational forces for change within treatment facilities. This domain includes perceptions about the facility status in regards to clinical and organizational functioning. Director and staff perceptions formulated from this domain incorporate areas such as a treatment program's need for improvement, staff training needs, and whether pressures for facility changes are internal (e.g. management or staff) or external (e.g. regulatory or funding) (Lehman *et al.*, 2002). Perceptions from both directors and treatment staff in South Africa were neutral and uncertain regarding this domain. This may be the result of a lack of minimum standards guiding the provision of substance abuse treatment services. There is a further lack of substance abuse treatment policy and legislation, which has allowed the treatment industry to remain unregulated and many treatment facilities are not operating according to evidence-based treatment models. Few facilities have conducted systematic and comprehensive evaluations of their services and as a result any claims about their effectiveness and efficacy remain unsubstantiated (Myers *et*

al., 2004, Parry 2005b). According to these findings both directors and treatment staff hold neither favorable nor negative perceptions towards whether program or training needs are required, and whether the pressures for program changes are internal or external. However, according to Simpson *et al.* (2007) higher ORC scores on program needs and training needs have been found to be predictive of staff responsiveness to workshop training and the use of innovative materials. For example, better workshop experiences for staff tend to result in a greater likelihood for adoption of innovative materials and improved treatment counseling (Simpson *et al.* 2007). The neutral and uncertain responses from South African directors and staff on the ORC domain motivation for change indicates that certain gaps regarding substance abuse treatment policy and practice in South Africa need to be addressed, and there is a strong need for the monitoring and evaluation of existing services.

South African program directors and treatment staff both held similar and favorable perceptions towards the ORC domains organizational climate, staff attributes, and adequacy of resources. These three domains primarily revolve around perceptions towards a treatment facility's mission and goals, personnel group cohesion, personnel stress levels, and the physical office environment (Lehman *et al.*, 2002). In environments where program directors are close to the daily operations of the treatment facility it is expected that they perceive similar levels of the above organizational characteristics as the treatment staff. It is also expected for a treatment facility to function efficiently and effectively that management and staff agree on the climate of the organization, its mission, personnel cohesion, and the stress levels experienced within the facility (Lehman *et al.*, 2002). Both of these expectations were supported by the results of this study. Although program directors held slightly more favorable perceptions towards these domains than treatment staff, it is evident that both director and staff perceptions towards organizational functioning in treatment facilities in South Africa are consistent with each other. This can be graphically seen in Figure 3.1 p. 38.

According to Greener *et al.* (2007) counselor rapport and client treatment satisfaction are higher in treatment facilities with healthier organizational settings, and facilities' organizational settings have a strong relationship with the ORC indicators of organizational functioning. Likewise, facilities with favorable ratings on the

organizational climate domain, and adequacy of resources domain, have higher ratings on client rapport and satisfaction scales. Research further shows that favorable ORC scores on the organizational climate domain are related to more favorable staff ratings on post-training satisfaction and the trial use of new innovative treatment practices. Clients that are treated at facilities with higher staff ratings on innovation adoption tend to show higher rapport with counselors and greater participation in treatment (Simpson *et al.* 2007). Another importance of the organizational climate domain is its potential link to work stress. According to Schaefer & Moos (1993b) staff that perceive a lack of clarity in the mission of the treatment facility, poor communication, and low cohesiveness, tend to develop job ambiguity and increased workload. Higher ORC scores on the organizational climate domain indicate clarity of mission, strong staff autonomy and work efficacy. These factors may help buffer the stress effects experienced within the treatment facility as they reflect adaptability and a better understanding of occupational stressors (Joe, Broome, Simpson, & Rowan-Szal, 2007). The results from this study show that mission clarity, staff autonomy, cohesion, and communication appear to be healthy amongst directors and treatment staff within treatment facilities in South Africa.

The results of this study indicate that South African directors and treatment staff held favorable perceptions towards the ORC domains organizational climate and staff attributes. Perceptions were less favorable towards the domain concerning institutional resources, and perceptions of uncertainty and ambiguity were related to the domain motivation for change. According to Greener *et al.* (2007) these results identify the deficiencies in organizational functioning, and if corrected, can contribute to improved client outcomes in the substance abuse treatment process. Treatment facilities that focus on the lower scoring ORC domains and seek out strategies to improve functioning in these specific areas are more likely to develop the appropriate interventions. In South Africa, provincial and local governments control the allocation of resources for substance abuse treatment services. In order for local governments to sufficiently plan and deliver adequate substance abuse treatment services that will address both current and projected treatment needs, accurate trend data on treatment demand and treatment services provided are required. Despite this awareness, the planning of treatment services in South Africa has been hampered by a lack of accurate information on treatment service utilization (Myers *et al.*, 2004). In addition,

many treatment facilities do not operate according to evidence-based treatment models and the lack of standards guiding the provision of treatment services have allowed the industry to remain unregulated (Parry, 2005b).

Saldana *et al.* (2007) states that results from the ORC domains enable treatment facilities by helping them to identify and examine the circumstantial realties or barriers that occur in their occupational realm. The identification and examination of these barriers facilitates the development of appropriate strategies to promote the successful adoption of evidence-based treatment practices. The organizational readiness of a treatment facility to adopt new practices is a key factor in the successful implementation of evidence-based treatment models. Some facilities are more compliant to adopting new evidence-based treatment models than others, and the identification of these compliant domains can facilitate the dissemination efforts by treatment developers and treatment service funders. According to research studies the ORC scales comprising of the four ORC domains are a promising measure of the key constructs required to evaluate a treatment facility's readiness to adopt new treatment technologies and help bridge the evidence-based treatment practice gap (Simpson, 2002; Simpson, 2007; Saldana *et al.*, 2007).

However, in South Africa a history of socio-political factors have hindered treatment for substance abuse. Under the apartheid system of governance treatment facilities were poorly distributed geographically, funding to state-subsidized treatment facilities has been inadequate, and a majority of treatment services were historically reserved for the White population. Moreover, large disparities existed between racially defined population groups and the quality and allocation of resources to substance abuse treatment services across South Africa were not equitable (Myers, 2004; Myers & Parry, 2005). These inequalities need to be taken into consideration when assessing director and staff perceptions towards organizational functioning of treatment facilities in South Africa.

Results from this study indicate that certain racial and demographic factors have an influence on both director and staff perceptions towards the organizational functioning of treatment facilities within South Africa. Directors' ethnicity and level of education were found to influence their perceptions towards the motivation for

change domain. Results further show that the level of education for treatment staff influenced their perceptions towards the same domain. White directors expressed negative perceptions towards the motivation for change domain and director perceptions towards this domain fluctuated according to various levels of education. Treatment staff with higher levels of education, such as Bachelors and Masters degrees, expressed negative perceptions towards the motivation for change domain. According to these results the notable uncertainty towards this domain for both directors and treatment staff is influenced by their ethnicity and education.

Directors' ethnicity and their amount of work experience also influenced their perceptions towards the adequacy of resources domain, while staff ethnicity and provincial location influenced their perceptions towards this domain. Directors who had over five years of work experience, as well as White directors, both expressed strong favorable perceptions towards the adequacy of resources domain. Treatment staff perceptions towards the adequacy of resources domain fluctuated according to their various provincial locations. Staff that operated in treatment facilities in the Western Cape and Kwa-Zulu Natal expressed less favorable perceptions towards this domain. White treatment staff expressed favorable perceptions towards this domain, while Colored staff expressed negative perceptions towards the adequacy of resources domain.

Directors' perceptions towards the organizational climate domain were influenced by the primary service area of the substance abuse treatment facility and by the amount of executive level work experience they had. Directors from treatment facilities that were primarily operating in either urban or rural areas expressed stronger positive perceptions towards this domain. However, directors from treatment facilities that were primarily operating in peri-urban environments (commonly known as townships in South Africa) expressed less favorable perceptions towards the organizational climate domain. Directors with five years of experience or more also expressed more favorable perceptions towards this domain than in comparison to directors with less experience.

These results appear to be in agreement with the history of socio-political factors that have hindered substance abuse treatment in South Africa. Since the country's

transition to democracy in 1994, the health and social service sector has worked hard to improve substance treatment to historically underserved groups, however certain concerns still remain. According to Myers and Parry (2005) the majority of substance treatment services in South Africa were historically reserved for the White population and research shows that the race profile of clients at specialist treatment facilities does not reflect the demographics of the general population. Apart from the four primary organizational functioning domains measured by the ORC, South African treatment facilities may need to take certain cultural barriers into account. In specialist treatment facilities in South Africa it is possible that cultural barriers may prevent Black clients from being retained in substance abuse treatment. As a result of this, facilities may need to employ more African-language speaking therapists and offer more multilingual programs. The infrequent use of culturally sensitive and appropriate therapeutic approaches in South African treatment facilities is another area of concern. All these factors may impact the extent to which Black clients in South Africa engage in treatment and Myers and Parry (2005) recommend that regular national audits need to be conducted to monitor the attempts by treatment facilities to address the cultural barriers regarding Black clients. Myers and Parry (2005) further state that the potential harm that untreated substance abuse holds for both the individual client and society, together with evidence of causal relationships between client engagement, retention and outcome, provides a strong need for treatment service providers, researchers and policy-makers to address the inequities in substance abuse in South Africa.

In substance abuse treatment there is no universal treatment policy to ideally fit all situations. Substance abuse problems have multiple causes, arise in different situations, and affect diverse populations. This leads to the premise that a variety of treatment policies and services are required instead of an all encompassing treatment policy or solution intended for numerous contexts and circumstances (Yach *et al.*, 1995). According to Fuller *et al.* (2007) the long-term survival of a substance abuse treatment facility requires the understanding and comprehension of its organizational capacities to respond to external and internal pressures for change. The TCU ORC focuses on organizational traits that predict programmatic change and is used for identifying and prioritizing treatment issues that the facility directors and staff believe need attention (Simpson, 2004). In South Africa it is evident that the realm of

substance abuse treatment is faced with a plethora of external and internal pressures for change and that the successful transfer of evidence-based innovations to real-world applications to meet these pressures for change will require careful planning, implementation, and on-going evaluation. Greener *et al.* (2007) states that the TCU ORC scales serve as an effective measure to assess both treatment facilities' organizational readiness for change and their level of organizational functioning. Research further indicates that organizational functioning is predictive of treatment engagement and outcomes, and by addressing organizational functioning issues can result in the identification of specific client needs and changes in treatment services to improve client functioning (Broome *et al.*, 2007; Courtney *et al.*, 2007; Fuller *et al.*, 2007; Greener *et al.*, 2007). Thus further use of the TCU ORC in South Africa can be beneficial as substance abuse treatment service planning needs to develop contextual and culturally appropriate interventions that ensure racially diverse clients engage and remain in existing and future treatment services.

Limitations of the findings and study

The results of this study must be interpreted within the context of certain limitations. The sample was intended to be nationally representative, and although it was large and geographically diverse the overall return rate was 49.3% for the sample population. Additionally, the small staff size at certain treatment facilities, combined with lower response rates from the Gauteng and Kwa-Zulu Natal provinces may limit the generalizations of the findings. In addition, the data collection procedure relied on anonymous voluntary participation at the treatment facility level and thus the sample may predominantly consist of responses from facilities that have a positive view of their level of organizational functioning and display an initiative and desire to improve. Due to the collaboration of ADARU treatment facilities that viewed their level of organizational functioning negatively may have been more reluctant to participate in the study. The responses from understaffed and inundated treatment facilities were also likely to be lower than those from treatment facilities with sufficient resources.

Majority of treatment facilities were unwilling to provide any information on client treatment records and their levels of retention. Demographic questions were included in the survey asking both directors and staff to indicate the percentage of their clients

that remained in treatment for the entire duration of the program and the percentage of clients who dropped out of the program before completion. However, from the 44 treatment facilities that responded, all 44 facilities reported a client completion rate of 100% and a client dropout rate of 0%. The combination of these skewed percentages and the lack of client documentation prevented this study from making any comparisons between the level of organizational functioning within treatment facilities across South Africa and their rates of client retention.

Recommendations

These limitations suggest that certain improvements should be made for future research efforts. As was outlined in the data collection procedure, although the researcher went to great lengths to increase the return rate, future research could include an improved strategy for obtaining higher response rates. According the CDA resource directory the sample population of substance abuse treatment facilities in South Africa consists of 110 treatment facilities. Given the geographical size of South Africa, a lengthier data collection period and the assistance of additional research associates it is possible to survey the entire sample population. Future research efforts should rely less on using the mail system for survey returns and establish survey collection dates with each treatment facility. This method was partially used in the Western Cape for this study and yielded a 92% return rate. This percentage was substantially higher in comparison to the return rates of the provinces where surveys were returned solely via mail.

Additional client surveys should also be administered to clients at each treatment facility. These surveys should report on the client's level of satisfaction with the services they have received, inquire how many times they have attended substance abuse treatment, and allow them to report on their level of participation and engagement with the program and treatment staff. The addition of this information with obtained ORC scores can allow for meaningful comparisons to be made between the level organizational functioning within treatment facilities in South Africa and their levels of client engagement and retention.

The use of workshops to provide directors and treatment staff with the results of ORC scores and additional feedback can be beneficial. The process of organizational

change in treatment facilities is not an easy process, but is necessary for facilities to remain successful. The use of the TCU ORC can help with the identification of treatment facilities that are likely to be responsive to organizational change, as well as identify existing issues that the facility directors and staff believe need attention.

Finally, in South Africa many treatment facilities are not operating according to evidence-based treatment models (Parry, 2005b) and the shortcomings in the country's policy and legislation have allowed the substance abuse treatment industry to remain unregulated (Myers *et al.*, 2004). Further use of the TCU ORC in South Africa is important because according to Broome *et al.* (2007) organizational functioning in substance abuse treatment facility not only links the treatment facility's health to its client's engagement and retention in the treatment process, it is also an important factor that deserves consideration by all facilities wanting to implement new treatment innovations. Parry (2005a) states that although government responses to substance abuse treatment in South Africa are more likely to be based on evidence-based practices it is important to first understand a treatment facility's functional dynamics in order to implement and transfer new treatment interventions and techniques more effectively.

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APPENDIX A - Treatment Facilities, Directors, and Counselors Demographic Information

Provincial breakdown of participating treatment facilities

Province	N	Percentage
Kwa-Zulu Natal	5	12 %
Gauteng	8	18 %
Eastern Cape	8	18 %
Western Cape	23	52 %

Treatment Facility Affiliation

Facility affiliation	N	Percentage
Operate independently	28	64 %
Affiliated with other programs	16	36 %

Treatment facility program types

Program type	N	Percentage
Outpatient services	15	34 %
Therapeutic community	3	7 %
Inpatient services	25	57 %
Other	1	2 %

Primary service area of treatment facilities

Primary service area	N	Percentage
Rural	4	9 %
Peri-Urban (Local townships)	14	32 %
Urban	26	59 %

Primary language of use in treatment facilities

Language	N	Percentage
English	30	69 %
Afrikaans	6	13 %
Xhosa	3	7 %
Zulu	4	9 %
Other	1	2 %

Number of clients being treated by treatment facility

Number of clients	N	Percentage
1 – 20 clients	15	34 %
21 – 40 clients	14	32 %
41 – 80 clients	2	5 %
81 – 160 clients	6	13 %
More than 160 clients	7	16 %

Gender of directors

Gender	N	Percentage
Male	21	48 %
Female	23	52 %

Ethnicity of directors

Ethnicity	N	Percentage
White	33	75 %
Black	3	7 %
Colored	6	13 %
Other	2	5 %

Director level of education

Education	N	Percentage
High school	2	5 %
Technikon diploma	5	11 %
Registered nurse / other	2	5 %
Bachelors degree	23	52 %
Masters degree	11	25 %
Doctoral	1	2 %

Director work experience

Years of experience	N	Percentage
0 – 11 months	4	9 %
1 – 2 years	5	11 %
3 – 4 years	9	21 %
Over 5 years	26	59 %

Director length at present job

Current service length	N	Percentage
0 – 11 months	3	7 %
1 – 2 years	11	25 %
3 – 4 years	9	20 %
Over 5 years	21	48 %

Provincial breakdown of treatment counselors

Province	N	Percentage
Kwa-Zulu Natal	18	18 %
Gauteng	18	18 %
Eastern Cape	15	14 %
Western Cape	51	50 %

Gender of counselors

Gender	N	Percentage
Male	24	24 %
Female	78	76 %

Ethnicity of counselors

Ethnicity	N	Percentage
White	56	55 %
Black	13	13 %
Colored	19	18 %
Other	14	14 %

Counselor level of education

Education	N	Percentage
No high school	3	3 %
High school	15	14 %
Technikon diploma	5	5 %
Registered nurse / other	6	6 %
Bachelors degree	63	62 %
Masters degree	8	8 %
Doctoral	2	2 %

Counselor profession

Profession	N	Percentage
Addictions counselor	3	34 %
Educational counselor	1	1 %
Other counselor	6	6 %
Social worker	39	38 %
Psychologist	5	5 %
General practitioner	1	1 %
Registered nurse	9	9 %
Administration	1	1 %
Occupational therapist	4	4 %
Other	1	1 %

Counselor work experience

Years of experience	N	Percentage
0 – 11 months	12	12 %
1 – 2 years	30	29 %
3 – 4 years	16	16 %
Over 5 years	44	43 %

Counselor length at present job

Current service length	N	Percentage
0 – 11 months	17	17 %
1 – 2 years	37	36 %
3 – 4 years	15	15 %
Over 5 years	33	32 %

Number of clients being treated by counselor

Number of clients	N	Percentage
1 – 10 clients	33	32 %
11 – 20 clients	28	27 %
21 – 30 clients	9	9 %
31 – 40 clients	6	6 %
More than 40 clients	26	26 %

Survey of Organisational Functioning (Treatment Programme Director Version)

Instructions:

This survey asks questions about you view yourself as a treatment programme director and how you view your current programme. No personal information is required, as all information obtained will be used solely for descriptive purposes. To complete the questionnaire, please mark your answers by circling the appropriate number.

Demographic Information

Today's Date: |__||__ |__||__||__|__| **Are You:** Male |__ Female |__

Province located in: |__| Gauteng |__| Kwazulu Natal |__| Eastern Cape

Are you: |__| White |__| Black |__| Coloured Other: __ ___ ___ ___

Highest Level of Education:
|__| No high school diploma or equivalent
|__| High school diploma or equivalent
|__| Technikon diploma
|__| Bachelor's degree
|__| Master's degree
|__| Doctoral degree or equivalent
|__| Other

Discipline/Profession:

|__| Addictions Counselling	|__| Social Work/Human Services	|__| Nurse
|__| Other Counselling	|__| Psychologist	|__| Administration
|__| Education	|__| Medicine: GP/Family practice	|__ None, Student
|__| Criminal Justice	|__| Medicine: Psychiatry	|__ OT

Other: ___ _____

How many years of experience do you have in substance abuse counselling?

|__| 0 – 11 months |__| 1 – 2 years |__| 3 -5 years |__| over 5 years

How long have you been in your present job?

|__| 0 – 11 months |__| 1 – 2 years |__| 3 -5 years |__| over 5 years

How many clients are currently being treated in your programme?

|__| 1 – 20 |__| 21 – 40 |__| 41 – 80 |__| 81 – 160 |__| > 160

What is the average number of clients enrolled at any given time during the past 12 months?

|__| 1 – 20 |__| 21 – 40 |__| 41 – 80 |__| 81 – 160 |__| > 160

What are the most frequently used languages in your programme?

|__| English |__| Afrikaans |__| Xhosa |__| Other _____

What proportion of your clients fit into the following racially defined social groups?

Black / African	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
Coloured	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
Asian / Indian	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
White	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%

What proportion of your clients belong to the following gender groups?

Male	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
Female	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%

What proportion of your clients belongs to the following age groups?

Less than 20 years	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
20 – 29 years of age	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
30 – 39 years of age	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
40 – 49 years of age	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
50 years or older	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%

Drug Treatment Programme Information

Is your drug treatment facility –

|__| For-Profit
|__| Non-Profit

Is your drug treatment programme –

|__| Independent (not part of a parent organisation)
|__| One of several units under a parent organisation

Which one best describes this treatment programme?

|__| Outpatient services
|__| Therapeutic community
|__| Inpatient
|__| Halfway house/work release
|__| Other (*please specify*) _____

Primary service area for treatment unit?

|__| Rural |__| peri-urban (township) |__| Urban

Type of substance abuse problems treated?

|__| Alcohol problems only |__| Drug problems only |__| Both alcohol/drug problems

Does your treatment unit primarily serve –

Adults	|__| No	|__| Yes
Adolescents	|__| No	|__| Yes
Criminal justice referrals	|__| No	|__| Yes
Women only	|__| No	|__| Yes
Pregnant women	|__| No	|__| Yes
Women with children	|__| No	|__| Yes
Dual diagnosis clients *(Mental health and substance abuse)*	|__| No	|__| Yes
Non-English speaking clients	|__| No	|__| Yes

APPENDIX B: ORC-D

What is the number of slots / beds available for clients –

| | 1 – 20 | | 21 – 40 | | 41 80 | | 81 – 160 | | > 160

The average proportion of beds that are occupied at any given point in time –

| | 0 25% | | 26 – 50% | | 51 – 75% | | 76 – 100%

What is the average length of stay / participation for clients –

| | 0 - 3 weeks | | 4 - 8 weeks | | 9 - 12 weeks | | 13 - 18 weeks

What is the estimated proportion of clients that drop-out the program –

| | 0 – 25% | | 26 – 50% | | 51 – 75% | | 76 100%

What is the estimated proportion of clients that complete the facility's treatment programme –

| | 0 – 25% | | 26 – 50% | | 51 – 75% | | 76 – 100%

Survey of Organisational Functioning- (Program Director Version). Please circle one of the following responses

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

Your program <u>needs additional guidance</u> in –

1. documenting service needs of clients for making treatment placements 1	2	3	4	5
2. tracking and evaluating performance of clients over time 1	2	3	4	5
3. obtaining information that can document program effectiveness 1	2	3	4	5
4. automating client records for billing and financial applications 1	2	3	4	5
5. evaluating staff performance and organizational functioning 1	2	3	4	5

APPENDIX B: ORC-D

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
6. selecting new treatment interventions and strategies for which staff need training	1	2	3	4	5
7. improving the recording and retrieval of financial information	1	2	3	4	5
8. generating timely "management" reports on clinical, financial, and outcome data	1	2	3	4	5
Your counselling staff needs more training for –					
9. assessing client problems and needs	1	2	3	4	5
10. increasing client participation in treatment	1	2	3	4	5
11. monitoring client progress.	1	2	3	4	5
12. improving relations with clients	1	2	3	4	5
13. improving client thinking and problem solving skills	1	2	3	4	5
14. improving behavioural management of clients.....	1	2	3	4	5
15. improving cognitive focus of clients during group counselling	1	2	3	4	5
16. using computerized client assessments	1	2	3	4	5
Current pressures to make program changes come from-					
17. clients in the programme	1	2	3	4	5
18. programme staff members	1	2	3	4	5
19. programme supervisors or managers	1	2	3	4	5
20. board members.....	1	2	3	4	5
21. community action groups	1	2	3	4	5
22. funding agencies	1	2	3	4	5

APPENDIX B: ORC-D

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
23. accreditation or licensing authorities ..... (State/Professional organisations/BHF)	1	2	3	4	5

How strongly do you agree or disagree with each of the following statements?

24. your staff prefers training content that is based on principles of best practice	1	2	3	4	5
25. your offices and equipment are adequate	1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

26. you have the skills to conduct effective staff meetings	1	2	3	4	5
27. some staff get confused about the main goals for this programme	1	2	3	4	5
28. staff here get along very well	1	2	3	4	5
29. Psychodynamic theory is commonly used in counselling here	1	2	3	4	5
30. your staff often has trouble implementing concepts they learn at workshops	1	2	3	4	5
31. programme staff understand how this programme fits as part of the treatment system in your community	1	2	3	4	5
32. decisions about treatment for clients here often have to be corrected by a counsellor supervisor	1	2	3	4	5
33. staff training and continuing education are priorities at this programme	1	2	3	4	5
34. we have facilities for conducting group counselling	1	2	3	4	5
35. you frequently discuss new counselling ideas with staff	1	2	3	4	5

APPENDIX B: ORC-D

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

36. you were satisfied with outside training opportunities available to your staff last year 1 2 3 4 5

37. you used the internet to communicate with other treatment professionals (e.g. list serves and forums) in the past month 1 2 3 4 5

38. you trust the professional judgement of staff who work with clients here..... 1 2 3 4 5

How strongly do you agree or disagree with each of the following statements? (cont.)

39. pharmacotherapy and medications are important parts of this programme 1 2 3 4 5

40. there is too much friction among staff members 1 2 3 4 5

41. some staff members here resist any type of change 1 2 3 4 5

42. you always listen to ideas and suggestions from staff 1 2 3 4 5

43. staff generally regard you as a valuable source of information 1 2 3 4 5

44. you have easy access for using the internet at work 1 2 3 4 5

45. the staff here always work together as a team 1 2 3 4 5

46. client assessments here are usually conducted using a computer 1 2 3 4 5

47. your duties are clearly related to the goals of this programme 1 2 3 4 5

48. you learned new management skills or techniques at a professional conference or workshop in the past year 1 2 3 4 5

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
49. you consistently plan ahead and carry out your plans	1	2	3	4	5
50. you are under too many pressures to do your job effectively	1	2	3	4	5
51. counsellors here are given sufficient authority in treating their own clients	1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

52. this programme encourages and supports professional growth	1	2	3	4	5
53. behaviour reinforcement is used with many clients here	1	2	3	4	5
54. you read about new techniques and treatment information each month	1	2	3	4	5
55. staff here are always quick to help one another when needed	1	2	3	4	5
56. computer problems are usually repaired promptly at this programme	1	2	3	4	5
57. novel treatment ideas by staff are discouraged	1	2	3	4	5
58. there are enough counsellors here to meet current client needs	1	2	3	4	5
59. the budget here allows staff to attend training opportunities each year	1	2	3	4	5
60. you have enough opportunities to keep your management skills up-to-date	1	2	3	4	5
61. trust and cooperation amongst staff in this programme are strong	1	2	3	4	5
62. most client records here are computerised.	1	2	3	4	5
63. you are willing to try new ideas even if some staff members are reluctant	1	2	3	4	5

APPENDIX B: ORC-D

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
64. learning and using new procedures are easy for you	1	2	3	4	5
65. this programme operates with clear goals and objectives	1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

66. staff members often show signs of stress and strain	1	2	3	4	5
67. you have staff meetings weekly	1	2	3	4	5
68. you achieve programme goals majority of the time	1	2	3	4	5
69. you can change procedures here quickly to meet new conditions	1	2	3	4	5
70. counsellors here often try out different techniques to improve their effectiveness	1	2	3	4	5
71. you used the internet to access drug treatment information in the past month	1	2	3	4	5
72. the formal and informal communication channels here work very well	1	2	3	4	5
73. you have programme policies that limit staff access to the internet and use of email	1	2	3	4	5
74. offices here allow the privacy needed for individual counselling	1	2	3	4	5
75. you are sometimes too cautious or reluctant to make changes	1	2	3	4	5
76. staff members think they have too many rules here	1	2	3	4	5
77. you feel a lot of stress here	1	2	3	4	5

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
78. 12-step theory (AA/NA) is followed by many counsellors here	1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

79. programme staff are always kept well informed	1	2	3	4	5
80. the heavy workload here reduces programme effectiveness	1	2	3	4	5
81. you regularly read professional journal articles or books on drugs abuse treatment	1	2	3	4	5
82. communications with other programmes that have similar interests would help	1	2	3	4	5
83. staff readily implement your ideas for changing programme procedures	1	2	3	4	5
84. more open discussions about programme issues are needed here	1	2	3	4	5
85. this programme holds regular in-service training.....	1	2	3	4	5
86. you learned new management skills or techniques from manuals orc other self-education materials in the past year.....	1	2	3	4	5
87. you frequently hear good staff ideas for improving treatment	1	2	3	4	5
88. staff seek your opinions about counselling and treatment issues	1	2	3	4	5
89. you are effective and confident in doing your job.....	1	2	3	4	5
90. you have a computer to use in your personal office space at work.....	1	2	3	4	5
91. some staff here do not do their fair share of work	1	2	3	4	5

APPENDIX B: ORC-D

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

92. a larger support staff is needed to help meet program needs	1	2	3	4	5
93. the general attitude here is to use new and changing technology.....	1	2	3	4	5
94. you do a good job of regularly updating and improving your skills.....	1	2	3	4	5
95. staff members always feel free to ask questions and express concerns in this programme.....	1	2	3	4	5
96. you are highly effective in working with community leaders and board members ...	1	2	3	4	5
97. staff frustration is common here.....	1	2	3	4	5
98. direct access to counselling resources on the internet is needed by staff here.....	1	2	3	4	5
99. you have a clear plan for leading this programme.....	1	2	3	4	5
100. your staff readily follows your leadership.....	1	2	3	4	5
101. you have easy access to specialised medical or psychiatric advice for clients when needed	1	2	3	4	5
102. you have convenient access to email at work	1	2	3	4	5
103. you encourage counsellors to try new and different techniques.....	1	2	3	4	5
104. you are able to adapt quickly when you have to shift focus.....	1	2	3	4	5

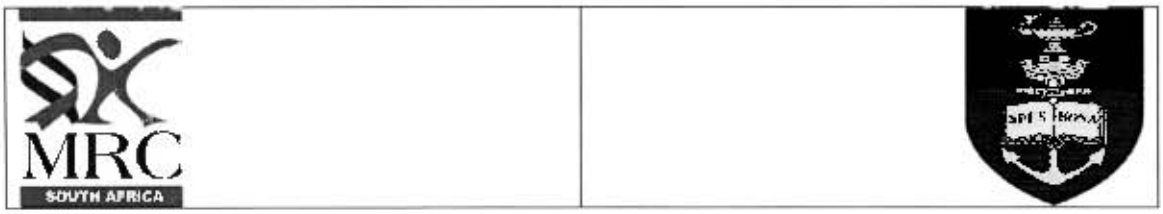
APPENDIX B: ORC-D

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

105.	cognitive theory (RE, RBT, Relapse prevention) guides much of the counselling here	1	2	3	4	5
106.	you are viewed as a strong leader by the staff here	1	2	3	4	5
107.	computer equipment at this programme is mostly old and out dated	1	2	3	4	5
108.	this programme provides a comfortable reception/waiting area for clients.....	1	2	3	4	5
109.	staff here feel comfortable using computers..	1	2	3	4	5
110.	frequent staff turnover is a problem for this programme.....	1	2	3	4	5
111.	counsellors here are able to spend enough time with clients.....	1	2	3	4	5
112.	support staff here have the skills they need to do their jobs.....	1	2	3	4	5
113.	clinical staff here are well trained.....	1	2	3	4	5
114.	the workload and pressures at your programme keep motivation for new training low. ...	1	2	3	4	5
115.	more computers are needed in this programme for staff use.....	1	2	3	4	5

Thank you for participating in this study. Your responses will be collated with responses from other facilities in order to better understand the needs of substance abuse treatment providers across South Africa.



Survey of Organisational Functioning (Programme Staff Version)

Instructions:

This survey asks questions about you view yourself as a counsellor and how you view your current treatment programme. No personal information is required, as all information obtained will be used solely for descriptive purposes. To complete the questionnaire, please mark your answers by circling the appropriate number. The example below shows how to answer to a question

For Example –

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

1, I like chocolate ice cream..... 1 (2) 3 4 5

The person DOES NOT LIKE chocolate ice cream

Demographic Information

Today's Date: |__||__| |__|__|__|__| **Are You:** Male |__| Female |__|

Are you: __| White __| Black |__| Coloured Other: _____

Province located in: |__| Gauteng __| Kwazulu Natal __| Eastern Cape

APPENDIX C: ORC-S

Highest Level of Education:
|__| No high school diploma or equivalent
|__| High school diploma or equivalent
|__| Technikon diploma
|__| Bachelor's degree
|__| Master's degree
|__| Doctoral degree or equivalent
|__| Other (*medical assistant, RN, post-doctorate*)

Discipline/Profession:

|__| Addictions Counselling	|__| Social Work/Human Services	|__| Nurse
|__| Other Counselling	|__| Psychologist	|__| Administration
|__| Education	|__| Medicine: GP/Family practice	|__| None, Student
|__| Criminal Justice	|__| Medicine: Psychiatry	|__| OT

Other: _____

How many years of experience do you have in substance abuse counselling?

|__| 0 – 11 months |__| 1 – 2 years |__| 3 -5 years |__| over 5 years

How long have you been in your present job?

|__| 0 – 11 months |__| 1 – 2 years |__| 3 -5 years |__| over 5 years

How many clients are you currently treating (*your current caseload*)?

|__| 1 – 10 |__| 11 – 20 |__| 21 – 30 |__| 31 – 40 |__| > 40

What is the average number of clients enrolled at any given time during the past 12 months –

|__| 1 – 20 |__| 21 – 40 |__| 41 – 80 |__| 81 – 160 |__| > 160

What proportion of your clients fit into the following racially defined social groups –

Black / African	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
Coloured	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
Asian / Indian	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
White	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%

What proportion of your clients belong to the following gender groups –

Male	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
Female	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%

What proportion of your clients belong to the following age groups –

Less than 20 years	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
20 – 29 years of age	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
30 – 39 years of age	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
40 – 49 years of age	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%
50 years or older	|__| 0 – 25%	|__| 26 – 50%	|__| 51 – 75%	|__| 76 – 100%

Drug Treatment Programme Information

Is your drug treatment facility –

|__| For-profit
|__| Non-profit

Which one best describes this treatment programme?

|__| Outpatient services
|__| Therapeutic community
|__| Inpatient
|__| Halfway house/work release
|__| Other (*please specify*) _____

Primary service area for treatment programme?

|__| Rural |__| Peri-urban (township) |__| Urban

Type of substance abuse problems treated?

|__| Alcohol problems only |__| Drug problems only |__| Both alcohol/drug problems

Does your treatment programme primarily serve –

Adults	|__| No	|__| Yes
Adolescents	|__| No	|__| Yes
Criminal justice referrals	|__| No	|__| Yes
Women only	|__| No	|__| Yes
Pregnant women	|__| No	|__| Yes
Women with children	|__| No	|__| Yes
Dual diagnosis clients *(Mental health and substance abuse)*	|__| No	|__| Yes
Non-English speaking clients	|__| No	|__| Yes

What is the number of slots / beds available for clients –

|__| 1 – 20 |__| 21 – 40 |__| 41 – 80 |__| 81 – 160 |__| > 160

The average proportion of beds that are occupied at any given point in time –

|__| 0 – 25% |__| 26 – 50% |__| 51 – 75% |__| 76 – 100%

What is the average length of stay / participation for clients –

|__| 0 - 3 weeks |__| 4 - 8 weeks |__| 9 - 12 weeks |__| 13 - 18 weeks

The estimated proportion of clients that drop-out of this facility's treatment programme –

|__| 0 – 25% |__| 26 – 50% |__| 51 – 75% |__| 76 – 100%

The estimated proportion of clients that complete this facility's treatment programme –

|__| 0 – 25% |__| 26 – 50% |__| 51 – 75% |__| 76 – 100%

Survey of Organisational Functioning- (Programme Staff Version)
Please circle the appropriate response

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

Your programme <u>needs additional guidance</u> in-

1. assessing client needs	1	2	3	4	5
2. matching needs with services	1	2	3	4	5
3. increasing programme participation by clients	1	2	3	4	5
4. measuring client performance	1	2	3	4	5
5. developing more effective group sessions	1	2	3	4	5

APPENDIX C: ORC-S

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
6. raising overall quality of counselling.....	1	2	3	4	5
7. using client assessments to guide clinical and program decisions	1	2	3	4	5
8. using client assessments to document programme effectiveness	1	2	3	4	5
<u>You</u> need more training for-					
9. assessing client problems and needs	1	2	3	4	5
10. increasing client participation in treatment	1	2	3	4	5
11. monitoring client progress.....	1	2	3	4	5
12. improving relations with clients	1	2	3	4	5
13. improving client thinking and problem solving skills	1	2	3	4	5
14. improving behavioural management of clients	1	2	3	4	5
15. improving cognitive focus of clients during group counselling	1	2	3	4	5
16. using computerized client assessments	1	2	3	4	5
Current <u>pressures</u> to make programme changes come from –					
17. clients in the programme	1	2	3	4	5
18. programme staff members	1	2	3	4	5
19. programme supervisors or managers	1	2	3	4	5
20. board members.....	1	2	3	4	5
21. community action groups	1	2	3	4	5
22. funding agencies	1	2	3	4	5

	Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
	1	2	3	4	5
23. accreditation or licensing authorities ..... (State/Professional organisations/BHF)	1	2	3	4	5

How strongly do you agree or disagree with each of the following statements?

24. you prefer training content that is based on principles of best practice	1	2	3	4	5
25. your offices and equipment are adequate	1	2	3	4	5
26. you have the skills to conduct effective group counselling	1	2	3	4	5
27. some staff get confused about the main goals for this programme	1	2	3	4	5
28. staff here get along very well	1	2	3	4	5
29. Psychodynamic theory is commonly used in counselling here	1	2	3	4	5
30. you often have trouble implementing concepts learned at workshops	1	2	3	4	5
31. programme staff understand how this programme fits as part of the treatment system in your community	1	2	3	4	5
32. decisions about treatment for clients here often have to be corrected by a counsellor supervisor	1	2	3	4	5
33. staff training and continuing education are priorities at this programme	1	2	3	4	5
34. we have facilities for conducting group counselling	1	2	3	4	5
35. you frequently discuss new counselling ideas with other staff	1	2	3	4	5
36. you were satisfied with the training offered at workshops available to you last year	1	2	3	4	5

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

37. you used the internet to communicate with other treatment professionals (e.g. list serves and forums) in the past month	1	2	3	4	5
38. management here fully trusts your professional judgement	1	2	3	4	5
39. pharmacotherapy and medications are important parts of this programme	1	2	3	4	5
40. there is too much friction among staff members	1	2	3	4	5
41. some staff members here resist any type of change	1	2	3	4	5
42. ideas and suggestions from staff get fair consideration by programme management	1	2	3	4	5
43. staff generally regard you as a valuable source of information	1	2	3	4	5
44. you have easy access for using the internet at work	1	2	3	4	5
45. the staff here always work together as a team	1	2	3	4	5
46. client assessments here are usually conducted using a computer	1	2	3	4	5
47. your duties are clearly related to the goals of this programme	1	2	3	4	5
48. you learned new management skills or techniques at a professional conference or workshop in the past year	1	2	3	4	5
49. you consistently plan ahead and carry out your plans	1	2	3	4	5

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

50. you are under too many pressures to do your job effectively.....	1	2	3	4	5
51. counsellors here are given sufficient authority in treating their own clients	1	2	3	4	5
52. this programme encourages and supports professional growth.....	1	2	3	4	5
53. behaviour reinforcement is used with many clients here.....	1	2	3	4	5
54. you read about new techniques and treatment information each month	1	2	3	4	5
55. staff here are always quick to help one another when needed	1	2	3	4	5
56. computer problems are usually repaired promptly at this programme	1	2	3	4	5
57. novel treatment ideas by staff are discouraged	1	2	3	4	5
58. there are enough counsellors here to meet current client needs	1	2	3	4	5
59. the budget here allows staff to attend training opportunities each year	1	2	3	4	5
60. you have enough opportunities to keep your counselling skills up-to-date	1	2	3	4	5
61. trust and cooperation amongst staff in this programme are strong	1	2	3	4	5
62. most client records here are computerised.	1	2	3	4	5
63. you are willing to try new ideas even if some staff members are reluctant	1	2	3	4	5

APPENDIX C: ORC-S

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

64. learning and using new procedures are easy for you.....	1	2	3	4	5
65. this programme operates with clear goals and objectives	1	2	3	4	5
66. staff members often show signs of stress and strain.....	1	2	3	4	5
67. you have staff meetings weekly.....	1	2	3	4	5
68. you achieve programme goals majority of the time	1	2	3	4	5
69. it is easy to change procedures here quickly to meet new conditions	1	2	3	4	5
70. counsellors here often try out different techniques to improve their effectiveness	1	2	3	4	5
71. you used the internet to access drug treatment information in the past month.....	1	2	3	4	5
72. the formal and informal communication channels here work very well.....	1	2	3	4	5
73. programme policies here limit staff access to the internet and use of email	1	2	3	4	5
74. offices here allow the privacy needed for individual counselling.....	1	2	3	4	5
75. you are sometimes too cautious or reluctant to make changes.....	1	2	3	4	5
76. staff members here are given too many rules	1	2	3	4	5
77. you feel a lot of stress here	1	2	3	4	5

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

78. 12-step theory (AA/NA) is followed by many counsellors here	1	2	3	4	5
79. programme staff are always kept well informed	1	2	3	4	5
80. the heavy workload here reduces programme effectiveness	1	2	3	4	5
81. you regularly read professional journal articles or books on drugs abuse treatment	1	2	3	4	5
82. communications with other programmes that have similar interests would help	1	2	3	4	5
83. other staff often ask your advice about programme procedures	1	2	3	4	5
84. more open discussions about programme issues are needed here	1	2	3	4	5
85. this programme holds regular in-service training.....	1	2	3	4	5
86. you learned new management skills or techniques from manuals ore other self-education materials in the past year.....	1	2	3	4	5
87. you frequently hear good staff ideas for improving treatment	1	2	3	4	5
88. other staff often ask for your opinions about counselling and treatment issues	1	2	3	4	5
89. you are effective and confident in doing your job.....	1	2	3	4	5
90. you have a computer to use in your personal office space at work.....	1	2	3	4	5

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

91. some staff here do not do their fair share of work	1	2	3	4	5
92. a larger support staff is needed to help meet program needs	1	2	3	4	5
93. the general attitude here is to use new and changing technology.....	1	2	3	4	5
94. you do a good job of regularly updating and improving your skills.....	1	2	3	4	5
95. staff members always feel free to ask questions and express concerns in this programme.....	1	2	3	4	5
96. you have the skills needed to conduct effective individual counselling	1	2	3	4	5
97. staff frustration is common here.....	1	2	3	4	5
98. you need direct access to while at work to counselling resources on the internet ...	1	2	3	4	5
99. management has a clear plan for this programme.....	1	2	3	4	5
100. you often influence the decisions of other staff here	1	2	3	4	5
101. you have easy access to specialised medical or psychiatric advice for clients when needed	1	2	3	4	5
102. you have convenient access to email at work	1	2	3	4	5
103. you encourage counsellors to try new and different techniques.....	1	2	3	4	5

APPENDIX C: ORC-S

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

104. you are able to adapt quickly when you have to shift focus.....	1	2	3	4	5
105. cognitive theory (RE, RBT, Relapse prevention) guides much of the counselling here	1	2	3	4	5
106. you are viewed as a leader by other staff here	1	2	3	4	5
107. computer equipment at this programme is mostly old and out dated	1	2	3	4	5
108. this programme provides a comfortable reception/waiting area for clients.....	1	2	3	4	5
109. staff here feel comfortable using computers..	1	2	3	4	5
110. frequent staff turnover is a problem for this programme.....	1	2	3	4	5
111. counsellors here are able to spend enough time with clients.....	1	2	3	4	5
112. support staff here have the skills they need to do their jobs.....	1	2	3	4	5
113. clinical staff here are well trained.....	1	2	3	4	5
114. the workload and pressures at your programme keep motivation for new training low. ...	1	2	3	4	5
115. more computers are needed in this programme for staff use.....	1	2	3	4	5
116. you were satisfied with the training opportunities available to you last year ...	1	2	3	4	5

Disagree Strongly	Disagree	Uncertain	Agree	Agree Strongly
1	2	3	4	5

How strongly do you agree or disagree with each of the following statements? (cont.)

117. the instruction methods you prefer for learning new counselling strategies or materials are:

a.	Lectures	1	2	3	4	5
b.	self- study	1	2	3	4	5
c.	workshops	1	2	3	4	5
d.	consultants	1	2	3	4	5
e.	in-services	1	2	3	4	5
f.	supervision/feedback	1	2	3	4	5

Please answer the following questions to the best of your ability. Circle the number that best fits your answer

	0	1	2	3	4+
118. In the last year, how often did you attend training workshops held within 80km of your agency?	0	1	2	3	4+
119. In the last year, how often do you attend training workshops held more than 80km from your agency?	0	1	2	3	4+
120. How many workshops do you expect to attend in the next 12 months?	0	1	2	3	4+
121. In the last year, how many times did outside trainers come to your agency to give workshops?	0	1	2	3	4+
122. In the last year, how many times did your agency offer special in-house training?	0	1	2	3	4+

How often does the following occur. Please tick the appropriate box

	Never	*Rarely*	*Sometimes*	*A lot*	*Almost Always*
123. When you attend workshops, how often do you try out the new interventions or techniques learned?	☐	☐	☐	☐	☐
124. Are your clients interested or responsive to new ideas or counselling materials when you try them?	☐	☐	☐	☐	☐
125. In recent years, how often have you adopted (for regular use) new counselling interventions or techniques from a workshop?	☐	☐	☐	☐	☐
126. When you have adopted new ideas into your counselling, how often have you encouraged other staff to try to use them?	☐	☐	☐	☐	☐
127. How often do new interventions or techniques that the staff from your programme learn at workshops get adopted for general use?	☐	☐	☐	☐	☐
128. How often do new ideas learned from workshops get discussed or presented at your staff meetings?	☐	☐	☐	☐	☐
129. How often does the management at your program recommend or support new ideas or techniques for use by all counsellors?	☐	☐	☐	☐	☐

Thank you for completing this survey. Your responses will be collated with responses from other facilities in order to better understand the needs of substance abuse treatment providers across South Africa.

APPENDIX D: Cover letter

Alcohol & Drug Abuse Research Group
Medical Research Council (Cape Town)

Francie van Zijl Drive, Parow Phone: +27-21-938-0350
Fax: +27-21-938-0342 E-mail: bmyers@mrc.ac.za
PO Box 19070 Tygerberg 7505, South Africa
URL: http://www.mrc.ac.za/adarg/adarg.htm

January 22, 2009

Name
Title
Name of Treatment Centre
Address of centre

Dear *insert name*

SURVEY OF SUBSTANCE ABUSE TREATMENT SERVICES

The Psychology Department of the University of Cape Town and the Alcohol and Drug Abuse Research Unit of the Medical Research Council recognise the importance of identifying the challenges that substance abuse treatment programmes face when delivering treatment services. Through understanding these challenges, we may be able to design interventions to improve service delivery. Following a study of treatment service providers in Cape Town in 2005, we have decided to conduct a survey of substance abuse treatment facilities across South Africa that focuses on factors that enable and/or restrict the delivery of effective services.

We have enclosed a questionnaire that takes approximately thirty minutes to complete. We would greatly appreciate it if you or the treatment programme manager of your facility could complete this questionnaire, in full, and return it to us within the next two weeks. A self-addressed stamped envelope is enclosed for this purpose. The information will not be analysed at an individual clinic/treatment service provider level but information from each participating facility will be grouped together. All information that you provide to us will be treated confidentially and will not be used to make judgements about the nature of services you provide. Once again, thank you for your co-operation. Should you have any queries regarding completion of the questionnaire, please do not hesitate to contact either Steven Bowles on 082 870 0504 or Bronwyn Myers on 021 938 0350.

Yours sincerely

Steven Bowles
Psychology Department
University of Cape Town

Bronwyn Myers
Alcohol & Drug Abuse Research Unit
Medical Research Council

APPENDIX E: Informed consent

Informed Consent Document

PARTICPANT INFORMATION AND INFORMED CONSENT

All information collected from this questionnaire will be kept confidential. The recorded information will solely be used for statistical analyses and will not be made available to anyone other than the researcher. Precautions will be taken to protect the identity of the participants when reporting the results of the study. No personal identifying information will be entered into the results or the analysis of the report.

The primary risk associated with this study is the inappropriate disclosure of a participant's information. The risk of inappropriate disclosure is minimal since all questionnaires will be kept in a locked file. Informed consent forms that have the participant's full name will be kept in the same locked files as with the questionnaires with restricted access to the researcher only.

INFORMED CONSENT

I hereby confirm that I have been informed about the nature, conduct, and risks of the study. I have also received, read and understood the above written information regarding the study.

I may at any stage, without prejudice or explanation, withdraw my consent and participation in the study. I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the following study.

Participant's name (please print) _____

Participant's signature (or parent/guardian) _____

Date _____

Witness's name (please print) * _____

* Consent procedure should be witnessed whenever possible

Witness's signature _____

Date _____