HHS Public Access

Author manuscript

Int J Drug Policy. Author manuscript; available in PMC 2021 January 01.

Published in final edited form as:

Int J Drug Policy. 2020 January ; 75: 102628. doi:10.1016/j.drugpo.2019.102628.

Service providers' perceptions of barriers to the implementation of trauma-focused substance use services for women in Cape Town, South Africa

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Abstract

Background—A substantial number of South African women with substance use disorders also report psychological trauma related to experiences of physical and sexual abuse. Trauma-focused substance use programmes may support recovery from co-occurring substance use disorders and psychological trauma, yet integrated programmes are not widely available in South Africa. As part of the process of developing a trauma-focused substance use programme for South African women, we explored service providers' views of the feasibility of implementing trauma-focused substance use interventions within usual care settings in Cape Town, including potential barriers that need to be considered when planning for implementation.

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Conflict of Interest

The authors report no conflicts of interest pertaining to this work.

Methods—We conducted 16 in-depth interviews with key informants responsible for planning or delivering substance use, psychological trauma or gender-based violence services to women in Cape Town. Guided by Extended Normalisation Process Theory, interviews explored participants' perceptions of the potential value of trauma-focused substance use programmes, the feasibility of their implementation, and factors that may facilitate or hinder the implementation of trauma-focused substance use programmes. Qualitative data were analysed using the framework approach.

Results—Three themes emerged: (1) Potential for the implementation of trauma-focused substance use programmes, describing participants' views of the acceptability of these programmes; (2) Capacity for intersectoral collaboration, which participants considered necessary for limiting barriers to implementation; and (3) Co-operation with community structures to enhance capability for implementation.

Conclusion—Findings show potential for implementing trauma-focused substance use interventions in South Africa, however context-specific capacity and capability barriers need to be considered and addressed for implementation to be successful.

Keywords

women; low-and-middle income country; South Africa; substance use; trauma; Extended Normalisation Process Theory; implementation

Introduction

Exposure to psychological trauma, in the form of physical and sexual abuse, is highly prevalent among South African women (Atwoli et al., 2013; Kaminer, Grimsrud, Myer, Stein, & Williams, 2008). Several intersecting factors contribute to the high prevalence of abuse in this context including poverty, high rates of unemployment and income inequality; socio-cultural norms that promote hegemonic masculinity; witnessing abuse and violence; and excessive alcohol use (Hatcher, Gibbs, McBride, Rebombo, Khumalo, & Christofides, 2019; Makanga, Schuurman, & Randall, 2017; Minnis et al., 2015; van Niekerk, Tonsing, Seedat, Jacobs, Ratele, & McLure, 2015).

Evidence suggests that psychological trauma is a risk factor for substance use (Hobkirk, Watt, Myers, Skinner, & Meade, 2016). Women with histories of psychological trauma may use substances for pleasure (Valentine & Fraser, 2008) and to avoid or mitigate the pain associated with these experiences (Berg, Hobkirk, Joska, & Meade, 2017; Ullman, Relyea, Peter-Hagene, & Vasquez, 2013). Depending on the meaning attached to substance use and the function it serves (Pienaar, Moore, Fraser, Kokanovic, Treloar, & Dilkes-Frayne, 2017), some women may choose to continue using substances despite experiencing adverse effects, while others may seek treatment.

For women who seek treatment, trauma-focused substance use interventions, that treat psychological trauma and substance use disorders concurrently, may hold benefits. These interventions emerged in response to evidence that patients with these co-occurring difficulties had poorer responses to substance use treatment programmes than women without psychological trauma (Flanagan, Korte, Killeen, & Back, 2016; Myers, Kline, Doherty, Carney, & Wechsberg, 2014; Reed, Myers, Novak, Browne, & Wechsberg, 2015).

In the past decade, several trauma-focused substance use interventions have been developed, tested and implemented in high-income country (HIC) settings (Najavits & Hein, 2013; Simpson, Lehavot, & Petrakis, 2017; Tripp, Jones, Back, & Norman, 2019). Common elements of these interventions include psychoeducation about the interrelationship between trauma and substance use; integrated cognitive-behavioural treatment for identifying and managing trauma and substance use triggers through emotional regulation, adaptive coping and problem-solving; and sometimes exposure therapy (Schäfer et al., 2019; Tripp et al., 2019). Systematic reviews provide evidence in support of the effectiveness of these integrated approaches for reducing substance use and trauma symptoms (Lenz, Henesy, & Callender, 2016; Roberts, Jones, & Bisson, 2015; Torchalla, Nosen, Rostam, & Allen, 2012), with these positive effects seemingly maintained over time (Jones, Jarnecke, & Back, 2018).

Despite growing evidence suggestive of the effectiveness of these interventions, they are not widely available in low-and middle-income countries (LMICs), such as South Africa (Chen, Olin, Stirman, & Kaysen, 2016; Myers, Carney, Browne, & Wechsberg, 2018). To address this gap, we developed a trauma-focused substance use intervention for South African women. This intervention was developed to complement other structural and policy interventions that the South African government has embarked upon to reduce the prevalence of physical and sexual abuse (van Niekerk et al., 2015). While most trauma-focused substance use interventions developed in HICs focus on the individual psyche with little recognition being given to the socio-economic and structural context that informs individual behaviour, our intervention is grounded in feminist empowerment theory and includes a focus on gender roles and power dynamics within interpersonal relationships (Myers et al., 2018; Myers, Carney, Browne, & Wechsberg, 2019). Further, to ensure that this intervention is responsive to the needs of trauma-exposed women who use substances and sensitive to the South African context, it was codeveloped with the inputs of potential service users, service providers and other key stakeholders (Myers et al., 2018).

Despite the promise of this intervention, there are probably barriers to delivering trauma-focused substance use interventions in Cape Town that need to be considered before asking service providers to implement this programme. A handful of studies from HICs have identified barriers to the delivery of trauma-focused care that are located within the clinical context, such as provider attitudes and organisational resources (Gielen, Krumeich, Havermas, Smeets, & Jansen, 2014; Killeen, Back, & Brady, 2011; Naas, Van Rens, & Dijkstra, 2019). Here context is defined as a complex adaptive system that creates the environment within which implementation occurs (May et al., 2018). While offering insights, these studies have focused narrowly on the micro-level organisational context within which implementation occurs without considering the meso-level (community) and macro-level (socio-economic and policy) context within which these organisations are situated (Chen et al., 2016).

For a more comprehensive understanding, we used Extended Normalisation Process Theory (ENPT) to explore the likelihood of implementing trauma-focused substance use interventions in this context. More specifically, this paper aims to explore substance use and trauma providers' views of the feasibility of implementing trauma-focused substance use

interventions within usual care settings in Cape Town, including potential barriers that need to be considered when planning for implementation.

Theoretical framework

ENPT is a variant of Normalisation Process Theory (NPT), a theory of implementation initially developed by May (2006), that explains the work that needs to happen to embed complex interventions into routine practice. A recent systematic review of NPT (May et al., 2018) identified 108 unique studies examining a wide range of health topics in diverse settings, including LMICs such as India, Pakistan, Mozambique, Nigeria (Khowaja et al., 2016) and South Africa (Atkins, Lewin, Ringsberg, Thorson, 2011; Leon, Lewin, & Mathews, 2013). ENPT, the most recent iteration of NPT, includes a greater focus on the role of context in facilitating implementation. We chose ENPT as a conceptual framework as it has been widely used to plan for and understand the delivery of substance use and mental health interventions (Brooks, Sanders, Lovell, Fraser, & Rogers, 2015; Burau, Carstensen, Fredens, & Kousgaard, 2018; Coupe, Anderson, Gask, Sykes, Richards, & Chew-Graham, 2014; O'Donnell & Kaner, 2017; Segrott et al., 2017).

According to ENPT, the feasibility of implementing a complex intervention can be explained through four constructs (May, Johnson, & Finch, 2016; May et al., 2018). *Capacity* refers to participants' agency and capacity to work together to deliver an intervention. *Potential* refers to participants' commitment to delivering the intervention, based on the degree to which they value the intervention and consider it feasible. *Capability* refers to ability to deliver the intervention within the specific implementation setting and actions required to facilitate implementation. These three constructs address elements that are needed to mobilise support for implementation. In contrast, *Contribution* refers to the ways in which participants make sense of their role in the actual implementation of a programme (May et al., 2018). As this study used ENPT as a tool to understand factors that need to be considered when planning for the implementation of a trauma-focused substance use programme, this paper only focuses on the first three constructs of ENPT.

Methods

We used an instrumental collective case study design, guided by a critical realist perspective that recognises the role of context in shaping programme implementation (Lacouture, Breton, Guichard, & Riddle, 2015). We chose this design as it provided a structure for exploring the feasibility of and barriers to implementing trauma-focused substance use programmes across the diverse range of trauma and substance use services available in Cape Town (Stake, 1995). This enabled us to identify shared barriers that require consideration before introducing these integrated programmes into usual care services in Cape Town.

Participants and procedures

Between July and August 2015, we conducted 16 in-depth interviews (IDIs) with providers of trauma counselling and substance use services. In South Africa, most individuals access trauma counselling and substance use services through state facilities or publicly-funded non-profit organisations that include both residential and outpatient services. Trauma and

substance use services are provided through separate systems of care, largely because mental health service delivery is a legislative responsibility of the Department of Health whereas substance use services are the responsibility of the Department of Social Development (Myers & Fakier, 2009). As such, none of the organisations represented in this study provided trauma-focused substance use interventions.

We generated a list of publicly-funded substance use and trauma services in Cape Town and purposefully selected key informants (KIs) from these organisations to interview. This selection was guided by a Community Advisory Board (CAB) established to facilitate community consultation and participation in research focused on improving health service access for women who use substances. This CAB meets twice a year and includes representation from nongovernmental organisations, community-based organisations, government agencies, and communities (Wechsberg et al., 2008; Wechsberg et al., 2013).

To be eligible for inclusion, KIs had to be responsible for planning or delivering substance use, psychological trauma or gender-based violence services to women from impoverished communities. Research staff contacted potential KIs, described the study, and invited them for an interview; none of the individuals who were approached refused to participate. The final sample comprised nine providers from trauma support services and seven from substance use treatment services. Thirteen of the 16 KIs were female (82%). They included clinical managers (n=6), social workers (n=4), psychologists (n=3), and substance use (n=2) or trauma counsellors (n=1). Most KIs had been working in their respective field for more than 10 years.

The first author conducted interviews in English, with the third author assisting with note-taking. Both interviewers are women with postgraduate training in psychological research and experience in conducting IDIs. A semi-structured interview guide with opening questions and prompts was used to elicit KIs' perceptions of the potential value of trauma-focused substance use programmes, the feasibility of their implementation, and factors that may facilitate or hinder programme implementation. Interviews were about 60 minutes in duration and were digitally audio-recorded before being transcribed verbatim. Data saturation was reached after 12 IDIs. Participants were provided with a gift voucher for their participation.

Ethical considerations

The South African Medical Research Council's Research Ethics Committee and Research Triangle Institute International's Institutional Review Board approved this study. Written informed consent was obtained from KIs prior to the start of the interviews, after they had received full information about the project and had an opportunity to ask questions. In the analysis and reporting of the data, steps were taken to conceal KIs' identity so that findings could not be linked back to them or their organisation.

Analysis

We used the framework method (Ritchie & Spencer, 1994) to analyse the data. This method is aligned with thematic and content analysis. It involves seven stages: (1) transcribing the interviews; (2) familiarisation with the transcripts; (3) coding each transcript; (4) developing

a working analytical framework; (5) applying this analytical framework through indexing the remaining transcripts; (6) charting the data in a framework matrix that summarises the data for each coding category;, and (7) data interpretation (Gale, Health, Cameron, Rashid, & Redwood, 2013). For this study, two researchers read each transcript, identified emerging themes, and developed a coding framework. They used NVivo version 11, a qualitative software programme, for coding, meeting regularly to compare notes and resolve coding differences. A third person was not needed to break coding ties. Inter-coder reliability was good, with a Kappa score of 0.86. Although all transcripts were analysed, no new codes emerged after coding 12 transcripts. Inductive coding was used to identify initial themes in the data, before using ENPT to help organise these themes (see Table 1). During data analysis, the researchers remained aware of their assumptions about trauma-focused substance use services which they reflected on during their meetings. The main themes were discussed at a CAB meeting where members corroborated the themes from the analysis and provided recommendations for addressing the implementation barriers.

Results

Three intersecting themes emerged from the data that reflect KIs' views of the feasibility and potential barriers to implementing trauma-focused substance use interventions in usual care settings in Cape Town. Themes include: (1) Potential for the implementation of trauma-focused substance use programmes, which describes KIs' views of the acceptability of these programmes; (2) Capacity for intersectoral collaboration, which KIs considered necessary for limiting barriers to implementation; and (3) Co-operation with community structures to enhance capability for implementation (see Table 1). These themes are described below and illustrated with quotes from participants.

Potential for the introduction of trauma-focused substance use programmes

Both substance use and trauma providers expressed enthusiasm for the introduction of trauma-focused substance use interventions, largely because they thought that such interventions would address unmet needs among women who used their services. Substance use providers (SUP) mentioned high rates of trauma exposure among women using substances and trauma providers (TP) noted high rates of substance use among their female clients.

> "Many patients who come here would disclose they have been raped, that they have been molested." [SUP 1]

> "It comes up a lot as an issue, a lot present with some form of substance use." [TP 4]

Their understanding of psychological trauma and substance use problems as intersecting issues seemed to enhance the value they attached to the provision of integrated care. While acknowledging that substance use sometimes preceded physical or sexual trauma, providers recounted how women often used substances to cope with the emotional distress arising from experiences of trauma, even if they had not used substances prior to the traumatic event. One KI reflected how women use substances to suppress these feelings:

> "She drinks when she is feeling her anger and it's going to spill out of her and she feels she is going to hurt someone or break something." [TP 9]

Given the lack of trauma-focused substance use interventions, many providers raised concerns about the effectiveness of their services:

> "If you do the part that addresses drug addiction, but you don't do the part that addresses life and the person's social environment, then you're setting that woman up for failure." [TP 7]

These providers described individual efforts to meet women's trauma and substance use service needs through referring women to external agencies for additional interventions. However, they perceived this practice as ineffectual as women "often lack the means to get to different places to receive further interventions" [SUP 4]. Others indicated that the stigma associated with both substance use and trauma made it difficult for women to disclose their experiences to multiple providers which impacted on their uptake of these referrals. These providers thought that having the "same caseworker who deals with both concerns" [TP 2] through the introduction of integrated trauma-focused substance use programmes would help them work more effectively with trauma-exposed women who use substances.

Capacity for intersectoral collaboration

Despite their support for the implementation of trauma-focused substance use services, almost all KIs raised concerns about whether the health and social service sectors would work together to support the provision of trauma-focused substance use services. They considered this intersectoral collaboration necessary for ensuring that organisations had staff with the necessary competencies to deliver these interventions. Several KIs described how trauma and substance use services were regulated by different government departments, each with their own set of legislative requirements and funding mechanisms. KIs explained how publicly-funded organisations were funded to provide either substance use or trauma counselling services, with no funding mechanism available for the provision of integrated care. They noted that the lack of a funding mechanism for intersectoral service delivery would adversely impact on their capability for providing trauma-focused substance use interventions as they would need financial support to build capacity among their staff for trauma or substance-related work. Alternatively, organisations would need to employ additional providers with these competencies:

> "We need training to provide trauma services … if someone tells you today like I was raped, how do you debrief in a way that is positive and not necessarily negative. I don't think all the staff have the skills to be able to do that." [SUP 2]

> "Without having a multidisciplinary team, it is very difficult for us to help people with substance abuse." [TP 8]

Most KIs doubted whether the South African government would shift from funding the provision of vertically organised substance use and mental health services towards a more integrated approach. They questioned the degree to which policy makers and service planners understood the complexity of these issues and the extent to which the provision of services for psychological trauma and substance use were prioritised:

> "There is a lack of intersectoral collaboration and what appears to be a lack of commitment or appreciation for how intertwined the issues are." [SUP 7]

> "They just don't see the importance of the whole thing or the possibility of us having a concerted kind of service rendering … nobody sits down and thinks deeply about this." [TP 1]

Co-operation with community structures to enhance capability for implementation

KIs also raised concerns about the extent to which women would utilise these services, noting that poor service uptake would lower the value that organisations attach to these interventions and their willingness to continue with programme implementation. They reflected on several factors within local communities that could affect the uptake of trauma-focused substance use services, including stigma towards women who use substances:

> "We have heard from women that sometimes if they have had experience of violence, they do not want to come forward and talk about it because they are blamed … especially if there is sexual violence." [TP 2]

KIs also thought that social institutions (such as the police, family, and faith-based organisations) often responded in unhelpful and inappropriate ways to women who did seek assistance. They provided examples of how the police and justice system discriminated against women who use substances, with their complaints of violence and abuse not being taken seriously or properly investigated:

> "When you walk into the police station and you mention that you are using substances and then that you are being abused, people will first say 'why don't you clean up your act? Maybe if you weren't using substances maybe you wouldn't have been abused?' It's those kinds of attitudes that push people away." [TP 6]

KIs also described how families sometimes discouraged women from disclosing experiences of abuse due to concerns about stigma and fears that disclosure will bring shame on the family. One KI reflected how this lack of family support kept women trapped in a cycle of abuse and substance use:

> "She was raped at a young age and the family didn't want to come out and say the uncle was abusing her. The family knew but they said she mustn't say anything about it. She grew up having that pain with no-one to share it with … and then abusing liquor to let it out." [TP 4]

KIs further described how faith-based organisations sometimes discouraged women from leaving violent relationships due to traditional beliefs about women needing to be submissive and beliefs about the sanctity of marriage and family:

> "It's the church, the police - getting resistance from these resources where you think you should be getting help from, where people who are supposed to be encouraging or educating people are doing the opposite. It's these kinds of things that act as barriers to seeking and staying in care." [TP 7]

KIs also identified limited income-generation opportunities for women and widespread unemployment and poverty within communities as potential contextual influences on

women's use of trauma-focused substance use programmes. Many KIs remarked how women with limited financial resources struggled to engage in therapeutic programmes due to other competing priorities. As one provider remarked:

> "The need for social assistance is so great, and it actually overpowers the psychological responses … so they need a shelter, or they need food today - they are just too poor to also come for services." [TP 4]

> "If a person is hungry, they are not going to think about their recovery. If there is no money in the house and there is no food and her kids are hungry, she may just go sell herself to make some money and along with that comes substance use." [SUP 4]

KIs emphasised the importance of addressing these barriers to service uptake to ensure that trauma-focused substance use interventions were feasible for organisations to implement. They noted that implementation of trauma-focused substance use interventions should be accompanied by efforts to build support for these services among community institutions and other key stakeholders as well as a culture of co-operation around the implementation of these integrated programmes.

> "If those people are on board you will get a successful programme because they are very influential in that community …. if you can tap into those people and if those people are also enthusiastic then you would have successful programmes." [TP 6]

KIs also suggested that co-operative activities with community stakeholders focus on establishing community support networks and income generation opportunities for women. KIs highlighted the importance of providing women with skills development and income generation opportunities to facilitate their independence.

> "Many have limited skills hence the dependence on the partner to sustain them … getting them to become independent is very important – they need skills that can help them look after themselves and look after their children [SUP 3]

Whilst considered beyond the scope of the services they could provide, KIs reflected that organisations could help women access these services through working together with other agencies and community structures. In addition, KIs perceived community support groups as playing an important role in providing ongoing emotional and practical support for women in their recovery journeys.

> "The support group happened outside the centre - they were meeting on their own, they were sharing with each other job opportunities and they were supporting each other. We found that women in this group coped better than those where the networking process wasn't happening. I think our clients really benefit from being able to locate themselves in their communities." [TP 1]

Discussion

This study applied Extended Normalisation Process Theory (May et al., 2018) to explore service providers' perceptions about the feasibility of implementing trauma-focused substance use interventions within usual substance use and trauma care services in Cape

Town and potential barriers that need to be considered when planning for implementation. Findings indicate that providers view the introduction of trauma-focused substance use programmes as acceptable and potentially feasible to implement provided that organisational capability for implementing these programmes is enhanced through optimising intersectoral collaboration around resourcing and co-operating with community structures to ensure support for these services.

More specifically, service providers were acutely aware of the high levels of unmet need among the women they served and thought they were ill-equipped to respond effectively within the current substance use and mental health service system. Their perceptions that separate systems of care for trauma counselling and substance use increased women's barriers to care is aligned with findings from other countries where mental health and substance use services are similarly organised (Otiashvili et al., 2013; Sarang, Rhodes, & Sheon, 2013; Sterling, Chi, & Hinman, 2011). With this backdrop in mind, providers seemed to support plans for introducing integrated, trauma-focused substance use services into the local setting. Much like providers from HICs (Killeen et al., 2011; Naas et al., 2019; Tripp et al., 2019), they hoped that the introduction of these integrated services would reduce women's barriers to care and lead to better treatment outcomes.

Although these providers perceived trauma-focused substance use programmes to be acceptable and generally feasible, they expressed reservations about their organisation's capability for implementing these integrated programmes within the context of South Africa's current health and social service systems. They reflected how funding regulations and resource constraints in the macro context affected their ability to provide an appropriately trained workforce to deliver these additional services. Resource limitations are commonly cited as impediments to the implementation of health innovations in South Africa and other LMICs (Brooke-Sumner, Petersen-Williams, Kruger, Mahomed, & Myers, 2019). In South Africa, mental health and substance use services are chronically under-funded with this likely to continue due to the country's fragile economy (Docrat, Besada, Cleary, Daviaud, & Lund, 2019). However, these barriers are not insurmountable. Local evidence from health system strengthening efforts highlight the potential to implement health innovations within resource constrained settings through the reconfiguration of existing programmes and resources, with minimal additional investments (Brooke-Sumner et al., 2019). Workforce costs can also be contained through task-shifting the delivery of these interventions from specialist providers (psychologists and social workers) to non-specialist providers, including community health workers and social auxiliary workers. Growing evidence from South Africa and other LMICs of the feasibility, acceptability and effectiveness of task-shifted treatment for psychological trauma and substance use (Myers et al., 2019; Rossouw, Yadin, Alexander, Mbanga, Jacobs, & Seedat, 2016; Singla et al., 2017) provides a strong rationale for expanding the mental health and substance use workforce to include non-specialist providers.

Yet, providers were still concerned about the lack of a global budget for the provision of integrated trauma and substance use services, which could have long-term effects on the provision of integrated care. The lack of intersectoral collaboration between the primary funders of these services, namely the Departments of Health and Social Development has

been well-documented (Myers, Carney, & Wechsberg, 2016) and has resulted in financial and regulatory silos that has made it difficult for these departments to finance integrated services. Similar difficulties have been experienced by other countries who have been trying to fund integrated care across multiple service sectors (Kroening-Roche, Hall, Cameron, Rowland, & Cohen, 2017). Regulatory and policy reforms that allow for the financing of integrated care in these countries have been tabled. While South Africa's National Drug Master Plan (2013–2017) does emphasise the importance of intersectoral co-operation for limiting drug-related harms, it does not lay out a framework for funding and regulating these intersectoral activities (Howell & Couzyn, 2015). Leadership on these issues has been noticeably lacking, with seemingly little appetite to change the status quo. The fact that the country is currently operating in a policy vacuum, with the 4th National Drug Master Plan (2018–2022) still not finalised, reflects the apathy for legislative and regulatory reform. The voices of people who use drugs, mental health service users and other drug policy advocacy groups could play an influential role in nudging the government to make the necessary reforms to support integrated care provision.

Findings also suggest that building providers' capacity to work collaboratively with community structures could support the successful implementation of trauma-focused substance use programmes within the local context. Through building collaborative relationships with key stakeholders in local communities, service providers could help create an enabling social context within which to embed their programmes. For instance, with appropriate support and training from service providers, stakeholders could help identify women who might benefit from services and develop referral pathways that minimise women's barriers to care. Also, providers could encourage community institutions to facilitate the emergence of peer support groups and income generation projects that may benefit long-term recovery (Haskell, Graham, Bernards, Flynn, & Wells, 2016). Given our findings, along with those of others (Magidson et al., 2019; Myers, Carney, & Wechsberg, 2016) of pervasive stigma among family members and community institutions towards women with substance use and trauma concerns, significant investment in community education, stigma-reduction, and community mobilisation initiatives will be required to make these provider-community partnerships successful. Nevertheless, structural interventions such as these are needed to create an environment that encourages women to seek help and supports their efforts to recover from substance use and trauma. If these interventions are not implemented and the uptake of trauma-focused substance use services is poor, organisations may question whether to continue implementing the programme.

Limitations

This study has limitations that require consideration. First, the sample was small and limited to providers in Cape Town who may not have been representative of all trauma and substance use providers in South Africa, particularly those located in rural regions. Second, this sample did not include the perspectives of a broad range of community stakeholders (such as traditional healers, religious leaders and other community structures). Including the perspectives of community stakeholders may have identified additional factors to consider before embedding a trauma-focused substance use programme into local communities. Third, this study was limited to providers' views of trauma-focused substance use

programmes for women; factors that could influence the implementation of these services for men were not explored. Future research is needed to address this gap, particularly given high rates of trauma among South African men (Atwoli et al., 2013; Gibbs et al., 2018) which is associated with violence perpetration (Gibbs, Jewkes, Willan, & Washington, 2019). Ensuring that all South Africans can access trauma-focused substance use programmes (if desired) is key to ensuring an equitable treatment system.

Conclusion

Findings indicate that service providers generally thought it feasible to implement trauma-focused substance use programmes in usual care settings in Cape Town provided that context-specific factors that limit organisations' ability to implement such programmes are addressed. Key recommendations to address these barriers include building relationships with community stakeholders to facilitate the development of referral pathways, providing communities with training to reduce stigma towards women who use substances, and assisting communities to develop resources for recovery support and income generation. Findings further suggest that policy and regulatory barriers to the financing and provision of integrated care need to be addressed before implementation can proceed. While apathy around policy reform is a stumbling block, South Africa has a long history of successfully mobilising communities to press for policy reforms, with community mobilisation around access to antiretroviral therapy for HIV treatment as a prime example. Practitioners and advocacy groups could build on these experiences when calling for drug policy reform.

In addition, findings add to the nascent literature on the provision of trauma-focused treatments in LMICs (Chen et al., 2016), through using ENPT to examine the ways in which the local delivery context may influence implementation of these interventions. While context-specific barriers to the implementation of health services have been explored by earlier applications of ENPT, these studies have focused on barriers within the micro context and how these impact on providers' agency for implementation without fully considering how these organisational contexts are shaped by broader socio-political factors (May et al., 2018). This study addresses this gap by demonstrating how factors within the meso- and macro-level context can either constrain or enhance organisations' capability for implementing trauma-focused substance use programmes in Cape Town. These findings underscore the importance of a whole systems approach when using ENPT to explore the feasibility of implementing new substance use services.

Acknowledgements

Research reported in this publication was supported by the *Eunice Kennedy Shriver* National Institute of Child Health and Human Development of the National Institutes of Health under Award Number R21HD082866 and by the South African Medical Research Council and National Research Foundation. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

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Table 1.

Mapping of overarching themes and subthemes to Extended Normalisation Process Theory (ENPT) framework

ENPT construct	Theme	Sub-theme
Potential	Potential for the introduction of trauma-focused substance use programmes	• Unmet needs related to psychological trauma among women who use substances • Understanding of psychological trauma and substance use as intersecting issues • Limitations to the sequential provision of substance use and trauma counselling services • Perceived benefits of integrated programmes for women's recovery
Capacity	Capacity for intersectoral collaboration	• Separate funding and regulatory systems for mental health and substance use care results in lack of intersectoral collaboration • Separate policy and regulatory environment impacts on availability of financial and human resources that organisations require for integrated care provision • Apathy in policy environment for health and social service reform
Capability	Co-operation with community structures to enhance capability for implementation	• Poor service uptake could affect how organisations view the intervention • Community stigma and discrimination as a barrier to women engaging in services • Poverty and competing priorities as a barrier to women engaging in services • Community engagement and partnerships to overcome contextual barriers