

SECTION 2: CAPE TOWN

2a: Specialist Treatment Centres

Ms Pam Cerff

Data were collected from 25 specialist treatment centres on a monthly basis. Some of the data were collected by interview by professional staff and others were collected from patient records by administrative staff.

Table 2.1: Proportion of treatment episodes

	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%							
Beth Rapha	-	-	-	-	-	-	2	1
Crescent	3	2	4	4	5	5	6	<1
CTDCC	17	16	20	19	21	18	18	19
De Novo	7	7	7	6	2	6	7	5
De Novo Youth	2	2	3	4	3	4	3	3
Durbanville	-	-	-	<1	1	2	1	-
Hesketh King	3	3	3	2	3	3	2	2
Horizon	2	2	1	2	1	2	2	2
Kenilworth	6	5	4	5	4	3	5	4
Lifeskills	1	4	1	1	1	<1	1	<1
Orient	3	1	2	2	-	1	3	1
Ramot	10	3	10	8	9	10	9	10
SANCA (7)	18	8	17	17	25	20	16	17
Stepping Stones	7	18	11	8	10	8	9	9
Stikland	10	9	3	10	6	11	10	10
Toevlug	7	10	10	11	9	5	8	12
Tabankulu	-	12	4	-	1	1	1	1
Teen Challenge	-	-	-	-	-	-	-	1
Tijger Clinic	-	-	-	-	-	-	-	3
Total no. in treatment	1695	1696	1571	1561	1608	1552	1724	1659

Overall 1659 patients were treated across all treatment centres for the period July to December 2003, as compared to 1724 for the previous six-month period (Table 2.1).

Table 2.2: First time admissions

	Jan-Jun 1999	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%									
Yes	68	69	68	68	67	67	67	67	67	70
No	32	31	32	32	33	33	33	33	33	30

In Table 2.2 ‘Yes’ indicates a first time admission and ‘No’ indicates a repeat admission. The number of new admissions has increased slightly in the latest reporting period. Of those who had received treatment before, 54% had one prior treatment episode, 27% had two and 9% had three prior to treatment episodes.

Table 2.3: Type of treatment received

	Jul-Dec 1998	Jan-Jun 1999	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%										
Inpatient	59	69	66	66	68	66	65	58	62	67	64
Outpatient	40	27	32	34	32	34	35	42	38	33	36
Both	<1	3	2	<1	<1	-	-	<1	<1	-	-

Table 2.3 indicates that the proportion of patients receiving different types of treatment has remained fairly stable over the last 8 reporting periods, with about two thirds receiving inpatient treatment.

Table 2.4: Referral sources

	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%								
Self/family/friends	40	41	36	38	41	39	38	43	47
Work/employer	16	14	15	13	14	15	14	14	13
Doctor/psychiatrist/nurse	10	13	10	13	14	10	8	10	10
Religious body	3	4	4	4	4	3	4	3	3
Hospital/clinic	3	4	3	3	2	4	4	5	3
Soc services/welfare	17	15	15	16	14	12	14	14	16
Court/correctional	8	7	8	7	6	7	6	6	5
School	2	3	7	4	2	4	6	3	3
Other e.g. radio	1	1	2	2	3	4	4	3	2
Unknown	<1	-	<1	-	-	<1	1	<1	-

Table 2.4 shows that all referral categories have remained fairly stable, with a slight increase in referrals from self/family/friends.

Table 2.5: Population profile

	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%								
GENDER									
Male	83	83	82	80	84	83	80	81	82
Female	17	17	18	20	16	17	20	19	18
ETHNIC GROUP									
Asian	2	1	1	1	3	2	1	3	1
Black	4	7	12	8	11	14	14	10	11
Coloured	61	61	56	53	59	52	52	56	57
White	34	31	32	38	27	32	33	31	31
EMPLOYMENT STATUS									
Working full-time	42	40	39	37	37	39	36	37	36
Working part-time	6	5	4	4	5	5	6	5	7
Not working	35	37	32	36	35	33	34	37	39
Apprentice/ internship	<1	<1	<1	<1	<1	<1	<1	<1	<1
Student/pupil	9	10	19	15	18	17	18	15	14
Disabled: not working	2	2	2	2	1	2	2	2	1
Housewife	1	2	2	2	1	2	1	2	1
Pensioner/ retired	-	2	2	2	2	2	2	2	1
Other	4	<1	1	1	2	<1	2	2	1
MARITAL STATUS									
Married, living with spouse	32	33	27	25	27	27	25	25	24
Married, not living with spouse	5	5	4	4	4	4	4	5	4
Living together	6	6	5	6	6	7	6	7	6
Divorced	12	11	11	10	9	9	11	10	10
Widowed	1	2	2	2	2	2	2	1	2
Never married	45	44	51	52	51	50	52	52	54
Other	<1	<1	<1	<1	<1	<1	1	1	1
EDUCATION									
None/pre - primary	<1	<1*	<1	1	2	1	3	2	1
Primary	19	23*	19	22	23	28	25	21	26
Secondary	71	76*	80	64	65	57	58	63	60
Tertiary	13	-*	11	12	11	14	15	14	12

*Highest school education completed

As can be seen in Table 2.5, males continue to predominate consistently around 80% of patients. Coloured patients, consistent with local demographics, are in the majority. Those working either full- or part-time total 43%. The category 'Other' includes persons suspended from work pending the successful outcome of treatment. More unmarried persons (72%) are in treatment, consistent with previous data. Most patients have secondary level education or more (72%). About 1 in 7 patients treated during July-December 2003 were students/pupils.

Table 2.6: Age distribution

Age in years	Jan-Jun 2000		Jul-Dec 2000		Jan-Jun 2001		Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
10-14	30	2	61	4	41	3	66	4	40	3	60	4	63	4	48	3
15-19	257	15	331	20	222	18	305	20	302	19	303	20	315	18	313	19
20-24	199	12	186	11	213	14	184	12	212	13	209	14	233	14	261	16
25-29	208	12	194	12	187	12	182	12	160	10	179	12	217	13	187	11
30-34	225	13	233	14	196	13	188	12	218	14	187	12	220	13	204	12
35-39	253	15	210	12	201	13	207	13	230	14	198	13	210	12	231	14
40-44	201	12	192	11	180	12	169	11	178	11	154	10	169	10	155	9
45-49	140	8	181	8	116	7	121	8	101	6	106	7	125	7	99	6
50-54	71	4	71	4	79	5	69	4	82	5	75	5	89	5	89	5
55-59	58	4	37	2	36	2	33	2	48	3	44	3	51	3	31	2
60-64	20	1	19	1	20	1	13	1	21	1	19	1	11	<1	14	1
65-69	9	<1	6	<1	5	<1	13	1	6	<1	5	<1	10	<1	7	<1
70-74	4	<1	5	<1	2	<1	1	<1	3	<1	3	<1	2	<1	1	<1
75+	1	<1	2	<1	1	<1	1	<1	-	-	2	<1	2	<1	3	<1

The age range of patients in treatment was from 11 years to 77 years. Table 2.6 shows that there were more patients in treatment in the under 25-year old age group than any other age group during this reporting period. It is of note that 22% of all patients are under 20 years of age, a consistent trend since the 2nd half of 2000.

Table 2.7: Primary substance of abuse

	Jul-Dec 1998	Jan-Jun 1999	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%										
Alcohol	64	56	50	48	51	46	46	48	47	44	39
Dagga/Mandrax	14	20	12	23	19	20	25	21	17	20	24
Dagga	9	9	15	12	13	12	12	13	18	15	15
Crack	5	6	6	5	5	6	4	3	4	6	6
Cocaine	3	2	3	3	2	3	2	3	3	2	3
Heroin	2	3	3	4	5	7	6	7	6	7	7
Ecstasy	<1	<1	<1	2	1	1	1	2	1	<1	1
OCM/PRE	2	2	2	4	3	3	2	2	2	3	2
Other (solvents etc.)	<1	<1	<1	<1	<1	2	2	<1	1	1	<1
Speed/crystal meth	-	-	-	-	-	-	-	-	-	2	2

Table 2.7 indicates that although alcohol remains the most commonly abused substance, it was reported as the primary substance of abuse by 39% of patients in the second half of 2003, the lowest proportion recorded thus far. Proportions for other drugs have remained fairly stable, when compared to the previous period.

Table 2.8: Overall proportion of substances used

	Jan- Jun 2000	Jul- Dec 2000	Jan- Jun 2001	Jul- Dec 2001	Jan- Jun 2002	Jul- Dec 2002	Jan- Jun 2003	Jul- Dec 2003
	%							
Alcohol	64	66	62	62	59	61	60	55
Dagga/Mandrax	36	28	30	35	27	28	34	37
Dagga	28	23	23	24	24	32	29	31
Crack/cocaine	17	15	20	15	14	11	18	22
OCM/PRE	11	9	12	9	5	6	8	6
Ecstasy	5	7	9	9	8	9	10	11
Heroin	5	6	8	7	8	8	8	9
Methamphetamine	-	-	-	-	-	-	5	7

The overall proportion of the primary, secondary and/or tertiary drug of abuse is shown in Table 2.8. Alcohol, dagga in combination with Mandrax, and dagga on its own, are the most common drugs used. Ecstasy and cocaine also seem to be used more commonly as secondary drugs of abuse than as primary drugs, with as many as 22% of patients reporting the use of cocaine. Use of Methamphetamine is also increasing steadily.

Table 2.9: Mode of usage of primary drug

	Jul- Dec 1999	Jan- Jun 2000	Jul- Dec 2000	Jan- Jun 2001	Jul- Dec 2001	Jan- Jun 2002	Jul- Dec 2002	Jan- Jun 2003	Jul- Dec 2003
	%								
Swallowed	52(5)	53(10)	55 (8)	55 (8)	50 (8)	52 (7)	51 (8)	47 (6)	43 (6)
Snorted	2(4)	2 (3)	2 (5)	2 (5)	3 (5)	3 (7)	4 (7)	3 (6)	4 (6)
Injected	<1(1)	2 (3)	2 (4)	2 (4)	2 (3)	2 (4)	2 (4)	3 (5)	3 (5)
Smoked	44 (87)	42 (81)	39 (81)	39 (80)	44 (80)	41 (79)	42 (80)	46 (81)	50 (82)
Other/ Combination	2(3)	2 (3)	2 (3)	2 (3)	2 (4)	2 (3)	1 (2)	2 (3)	1 (2)

Figures in brackets exclude alcohol

In looking at the mode of usage of the primary drug, 43% of patients reported swallowing their substances. When alcohol is excluded about 80% report smoking as their mode of use. This falls in line with the prevalent smoking culture of South Africa. If alcohol is excluded, 5% of patients reported that they injected drugs. (Table 2.9)

Table 2.10: Mean age by primary substance

	Jan-Jun 1999	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
Alcohol	40	40	41	39	39	39	40	39	40	40
Dagga/Mandrax	26	25	26	24	25	26	26	25	25	26
Dagga	22	23	22	19	19	19	19	21	20	21
Crack	30	30	29	28	29	31	30	30	29	30
Cocaine	27	29	28	29	28	28	30	31	30	29
Heroin	21	23	21	23	23	23	24	23	24	24
Ecstasy	24	23	24	19	19	22	22	21	21	22
OCM/PRE	-	-	-	-	39	36	41	38	41	39
Overall mean age	33	33	33	32	31	31	31	31	31	31

The mean age was 31 years for this period. The data continue to show that patients whose primary substance of abuse is alcohol are older, 40 years of age, than those with other primary substances of abuse (see Table 2.10). The mean age for patients with dagga and Ecstasy as primary substance of abuse remains low (21 and 22 years respectively).

Table 2.11: Gender, by primary substance of abuse

	Jul-Dec 1999		Jan-Jun 2000		Jul-Dec 2000		Jan-Jun 2001		Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003	
	%		%		%		%		%		%		%		%		%	
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Alcohol	80	20	80	20	80	20	78	22	79	21	79	21	79	21	77	23	77	23
Dagga/Mandrax	94	6	96	4	94	6	93	7	97	3	95	5	92	8	93	7	95	5
Dagga	89	11	89	11	89	11	84	16	89	11	91	9	87	13	87	13	88	12
Crack	82	18	91	9	81	19	79	21	83	17	84	16	82	18	84	16	82	18
Cocaine	78	22	89	11	79	21	67	33	74	26	74	26	56	44	76	24	78	22
Heroin	67	33	78	22	66	34	73	27	77	23	72	28	70	30	77	23	66	34
Ecstasy			68	32	76	24	60	40	78	22	72	28	59	41	46	54	74	26
OCM/PRE							41	59	55	45	32	68	39	61	39	61	42	58

Dagga and the dagga/Mandrax combination remain mainly male substances of abuse as indicated in Table 2.11. Proportionately more females are treated for the use of cocaine, heroin and Ecstasy than for other drugs. In the second half of 2003 almost 60% of patients treated for abuse of over the counter and prescription medicines were females.

Table 2.12: Race by primary substance of abuse

	African			Coloured			Asian			White		
	%			%			%			%		
	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
Alcohol	14	11	11	49	51	50	<1	1	1	37	37	39
Dagga/ Mandrax	17	16	12	75	73	77	2	4	3	7	6	8
Dagga	22	13	19	57	68	66	1	1	1	20	18	15
Crack/ Cocaine	1	2	7	32	37	46	6	12	3	61	49	45
Ecstasy (n=17)	0	8	0	73	54	78	0	0	0	27	39	22
Heroin	1	0	1	22	32	32	1	6	2	76	62	66

The percentages shown in Table 2.12 total across the rows. The percentage of Asians in treatment remains small. The proportion of Whites in treatment for heroin is still greater than that of any of the other groups, however, the percentage of Coloured heroin patients has increased significantly over time.

Table 2.13: Multiple substance use

	Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003	
	n	%	n	%	n	%	n	%	n	%
Primary substance only	936	60	1102	69	942	61	914	53	854	52
Primary +2 nd substance	334	21	280	17	323	21	433	25	416	25
Primary+2 nd +3 rd substance	177	11	140	9	168	11	204	12	213	13
Primary +2 nd +3 rd +4 th substance	114	7	86	5	119	8	170	10	176	11
Total no. of patients	1561	100	1608	100	1552	100	1721	100	1659	100

Table 2.13 shows that almost 50% of patients report using more than one primary substance of abuse, an increase over previous periods.

Table 2.14: Top eleven ‘suburbs’ for alcohol treatment in the Cape Metropole (Jul-Dec 2003)

Suburb	No in treatment
Mitchell’s Plain	31
Khayelitsha	17
Kraaifontein	16
Strand	14
Parow	13
Kuils River	11
Goodwood	11
Belhar	11
Bellville	10
Gugulethu	10
Eersterivier	10

The suburbs in the table above were the ‘top 11’ suburbs with alcohol patients stating them as their suburb of residence. Outside the Cape Metro, Paarl had 22 patients, Stellenbosch 14, and Worcester had 12 patients in treatment.

Table 2.15: Top twelve suburbs for drug treatment in the Cape Metropole

Suburb	No in treatment
Mitchell’s Plain	92
Khayelitsha	38
Grassy Park	23
Athlone	22
Belhar	20
Bonteheuwel	20
Retreat	19
Gugulethu	19
Kuils River	17
Cape Town	17
Woodstock	16
Durbanville	15

The highest numbers of patients treated for drugs other than alcohol came from Mitchells Plain, Khayelitsha and Grassy Park. Outside the Cape Metro, Paarl had 22 and Stellenbosch 12 patients in treatment.

Table 2.16: Source of payment

	Jul- Dec 1999	Jan- Jun 2000	Jul- Dec 2000	Jan- Jun 2001	Jul- Dec 2001	Jan- Jun 2002	Jul- Dec 2002	Jan- Jun 2003	Jul- Dec 2003
	%								
Self only	14	13	12	16	13	15	15	14	16
Medical Aid only	16	13	15	13	14	16	11	17	16
State	18	14	15	15	14	11	14	16	13
Family/friends only	19	25	26	27	28	26	30	28	34
State & self	8	9	8	6	8	6	7	7	8
Work/employer only	4	4	4	4	4	4	4	4	4
Unknown	4	2	3	2	2	3	2	2	1
Other/combinations	14	15	17	17	17	19	17	12	8

Patients often reported a combination of sources of funding for treatment. The category ‘Family and friends’ remains the most common source of payment for treatment (Table 2.16).

Cape Town – Patients younger than 20 years

Table 2.17: Gender and race profile of patients <20 years

	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
	%	%	%	%	%	%
Gender						
Male	79	86	85	84	84	83
Female	21	14	15	16	16	17
Ethnic Group						
African	14	30	23	27	15	19
Coloured	56	51	57	58	70	68
Asian	2	2	3	1	2	1
White	28	16	17	15	12	13

Table 2.17 above shows that Coloured patients constituted 68% of the patients younger than 20 years during the second half of 2003.

Table 2.18: Primary substance of abuse of patients <20 years

	Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003	
	n	%	n	%	n	%	n	%	n	%
Alcohol	43	12	19	6	28	8	27	7	15	4
Cannabis	145	40	159	46	174	49	172	46	152	42
Cannabis/Mandrax	107	29	111	32	110	31	115	30	118	33
Cocaine	3	1	5	1	2	<1	4	1	6	2
Crack	6	2	6	2	6	2	7	2	11	3
Heroin	33	9	20	6	22	6	18	5	27	7
Ecstasy	8	2	13	4	9	3	7	2	13	4
OTC/PRE	4	1	2	<1	2	<1	2	<1	1	<1
Inhalants	11	3	7	2	2	<1	2	<1	2	1
Other	4	1	-	-	4	1	7	2	1	<1
Speed							15	4	17	5
Total	364	100	342	100	359	100	375	100	363	100

Most young patients are treated for the abuse of cannabis or cannabis/Mandrax although heroin is now the third most common primary substance.

Table 2.19: Primary substance by gender (<20s)

	Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003	
	M	F	M	F	M	F	M	F	M	F
	%		%		%		%		%	
Alcohol	81	19	74	26	75	25	59	41	73	27
Cannabis	87	13	91	9	90	10	85	15	84	16
Cannabis/ Mandrax	95	5	89	11	89	11	94	6	92	8
Cocaine	33	67	80	20	0	100*	33*	67	33	67
Crack	83	17	100	0	50	50	100	0	73	27
Heroin	64	36	35	65	50	50	78	22	70	30
Ecstasy	71	29	69	31	56	44	43	57	77	23
OTC/PRE	100	0	50	50	100*	0	0	100*	100*	0
Inhalants	100	0	86	14	100*	0	100*	0	100*	0

* (n<5)

Most young patients treated for alcohol, cannabis or cannabis/Mandrax abuse are male, whereas a higher proportion of heroin patients are female (30%).

2b: Alcohol abuse and other psychopathology in recently diagnosed HIV patients

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Prevalence of Chronic Alcohol Use in HIV

Studies in the U.S. show that among alcohol-abusing patients the HIV infection rate is significantly higher than the general population (5-10% vs 0.35% infection rate in the general population). Similarly, alcohol use disorders (AUD) are much more common among HIV-infected patients: 29-60% have an AUD at some point in their lives, a rate 3 times higher than the general population. Moreover, the prevalence of a *current* AUD among HIV-infected patients is nearly 12%, about twice the rate of the general population.

Some researchers have questioned these statistics. AUD prevalence rates may be lower. Most epidemiological work was conducted during the early phase of the HIV/AIDS epidemic in the mid-1980s and included mostly samples of gay men, so there may be a sampling bias.

Alcohol and HIV

Nevertheless, many individuals at risk for or infected with HIV are heavy drinkers. Empirical data shows that both HIV infection and heavy alcohol use adversely affect the immune system and CNS function.

Firstly, animal and in-vitro studies suggest that chronic heavy drinking may hasten the progression of the HIV disease process through biological (e.g. immunological) effects. In humans, there is some research to indicate that alcohol consumption greater than 50g/day (4 or 5 drinks) may be a risk factor for disease progression among patients with HIV/HCV co-infection.

Alcohol use and HIV Pharmacotherapy

Secondly, AUDs may interfere with treatment-seeking, treatment adherence, and treatment effectiveness among HIV-infected individuals. For example, excessive alcohol use can modify drug metabolism in the liver and lead to the emergence of a drug-resistant virus. That said, there have been very few studies that have directly addressed the effects of heavy alcohol use on the severity and progression of HIV infection and its progression to AIDS.

STUDY OF PSYCHOPATHOLOGY AND COPING IN HIV

Aim

To measure psychiatric morbidity, coping responses, and disability in male and female outpatients recently diagnosed with HIV Study Population.

Participants

Participants for the study comprised 149 recently diagnosed HIV patients attending an outpatient Infectious Diseases Clinic at Tygerberg Hospital, Cape Town. The hospital is 1 of 2 major tertiary health facilities in the Western Cape. 105 were women and 44 men. Mean time since diagnosis: 5.8 months (SD = 4.1). Inclusion criteria: 18-55 years; HIV diagnosis of <1 year, no diagnosable neurological disorder, and willingness to provide written, informed consent.

Study Procedures

- Diagnostic Interviews : Mini International Neuropsychiatric Interview (M.I.N.I.)
- Demographic and Clinical information (WHO HIV staging, CD4/CD8 counts) obtained
- Patients re-assessed 6 months later (n=65)
- Life Events Scale - is a 42-item clinician-administered checklist that inquires about the number of positive and negative life events during the past 6 months as well as the degree of distress associated with these events (using an impact score of 0 to 2).
- Sheehan Disability Scale - Disability was assessed with the patient-rated 3-item measure for assessing impairment in the domains of work, family, and social life.
- Brief Cope - Coping responses to HIV infection were assessed with the abridged version of the COPE Scale, called the Brief Cope. The Brief Cope is a 12-item scale comprising items on active coping, planning, positive reframing, acceptance, humour etc. For each item, subjects are asked to respond on a 4-point Likert scale ('1' = I did not do this at all to '4' I did this a lot').
- Sexual Risk Behaviour Scale - preceding month and 12 months prior to the study

Overall Findings

- 56% met criteria for at least 1 psychiatric disorder
- Most frequent diagnosis was *major depressive disorder* (34.9%)
- Other SA studies (Bganya, 1999; Els et al., 1999) have found a similar occurrence of major depression (38%) in HIV-positive patients
- Other common diagnoses: dysthymic disorder (21.5%) and posttraumatic stress disorder (14.8%)
- 9% (13/149) met criteria for current alcohol abuse
- 10% (15/149) met criteria for current alcohol dependence
- Only 2% (4/149) met criteria for other drug abuse or dependence
- Men were more likely than women to meet criteria for *alcohol abuse/dependence* and to engage in risky sexual behaviours
 - e.g. heavy alcohol use before sex (in the 12 months before being told of HIV status)

Comparison of Patients with AUDs to those without

- No difference in baseline demographic (e.g. age) and clinical characteristics (e.g. CD4/CD8 counts)
- Patients with AUDs were significantly more likely than those without AUDs to have symptomatic HIV infection (75% vs 47%)
- In terms of psychopathology, patients with AUDs were also more likely than those without AUDs to have:
 - major depressive disorder (63% vs. 32%)
 - dysthymic disorder (56% vs. 17%)

Limitations of Findings

- The study was not designed to measure absolute levels of consumption (alcohol quantity and frequency) nor patterns of change in drinking in the 6 month period of follow-up

- Studies of effects of chronic alcohol abuse on HIV-associated central nervous system (CNS) disease, integrating studies of *immunology, behaviour, neuropsychology, and drug availability* (i.e. potential interactions between HIV medications and alcohol) starting to emerge
- Longitudinal studies which follow groups over extended periods of time will allow for a more powerful assessment of the CNS effects of combined chronic alcohol abuse and CNS disease
- May also provide important information on whether/ how chronic heavy drinking compromises effectiveness of emerging antiretroviral treatment either through:
 - *behavioural effects* on treatment seeking or treatment adherence
 - *biological effects* on metabolism or levels of ARTs.

2c: Trauma and addiction in South African women

Ms Winnie de Roover

Masters thesis Research Psychology, UCT, 2003:
Trauma and Addiction in South African Women: a Qualitative Study

BACKGROUND

Why women

- Connection trauma - addiction better expounded in women
- Women more traumatized- patriarchal society
- Women more verbal, more willing to seek help

Trauma

- Broad concept, to include wide range of experiences:
- In literature sexual abuse receives more attention but more common forms are emotional abuse and neglect
- Definition: Any shocking event to which the subject cannot accord words, that is not in a linear verbal form and therefore remains unprocessed
- acute (rape, accident) or chronic (child abuse and neglect)

Addiction= short-circuit symptom

- People are social/ communicative beings
- Vs. Addict: focus on the own body and products no story to tell, product covers up what's lying underneath
- => addiction serves a special function in trauma- to keep the unmanageable/ uncontrollable/ unprocessed events covered

HYPOTHESES

- Addiction covers up trauma
- During treatment certain trauma traces can be found
- Addicted women have more unprocessed trauma

METHODOLOGY

- Qualitative study: life-stories of addicted women
Narrative approach and Psychoanalysis
- 14 addicted women recruited from 2 inpatient treatment centers
- 1-4 sessions, duration: 45 min to 2 hours
- Session 1: introduction- informed consent- info on procedure- interviewee in control
- “Tell me your life-story”
- gaps- ‘wordlessness’- ‘unspeakable and indescribable’
- tape-recorded, transcribed and field-notes
- Session 2-4: continuation, clarifications, 7 questions

RESULTS

Repression and Denial as linguistic strategies

Repression:

- Motivated forgetting
- Reinterpretation
- Rattling on
- Focus on safe topic
- Screen memory
- Labeling without clarification
- Para-linguistics/ immediate repression
- Blocking-off
- Generalizing

Denial:

- Contradiction & Negation
- Reconstructing the past
- Reversal into opposite
- Nonverbal communication
- Denying impact
- Externalizing
- Minimizing
- Key words

Gaps/ Silencing

Trauma-remnants

- Self-concept
- Guilt
- Shame
- Self-Blame
- No basic trust/ loss of commonality => Ambivalent/problematic relationships
- Compulsive repetitive acts
- Numbing, splitting, substance abuse
- Numerous somatic complaints
- Trauma dynamics: numbing/ dissociation/ escape/ avoidance/reliving/ repetition/ flashbacks/ uncontrollable emotions

CONCLUSION

- Addicted traumatized women: stuck in wordlessness of addiction and trauma
- Trauma as metaphor, first signifier
- Addiction as survival strategy
- Excessive guilt, shame, self-blame, low self-concept, stigma

IMPLICATIONS FOR PRACTISE

Double-edged problem

- Addiction is counter-indication for traumatherapy
 - Addiction covers trauma
 - Addict not to be trusted
 - But - Ignoring addiction and only treating trauma doesn't help either
- Unprocessed trauma inhibits recovery:
 - Exploration => increased need for normal coping strategy => Frequent relapse
- => Treat both problems at the same time

Need for careful diagnosis

- Many times, trauma hidden- numerous vague complaints
- Clinical practice: client only acknowledges one of the problems
- High amount of misdiagnosis
- In treatment issues not explored => endless repetition
- Given high co-morbidity of trauma and addiction in women => necessity to assess both

Individual or Group Treatment

- Group therapy and individual counsellor
- Train addiction counsellors to pick up trauma
- Reinstall group
 - Addiction = solitary
 - Trauma = loss of commonality/ basic trust
 - => reconnecting is difficult
- Group- place of re-enactment
 - Group- retraumatising
 - => team: containment, boundary-setting, exploration

LIMITATIONS

- Small sample size
- Characteristics of sample
- Only women in treatment
- Focus on Narrative Truth
- Snap shot

FURTHER RESEARCH

- Protective factors
- Less accessible groups
- Comparison between men and women

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- Don Foster
- MRC- Alcohol and Drug Abuse Unit
- Stepping Stones
- Crescent Clinic
- SANCA
- Rape Crisis Cape Town

2d: Analysis of requests for expulsion from WCED Schools

Mr Bruce Phillips

LEGISLATION

The **South African Schools Act** (Act 84 of 1996) and the **Western Cape Provincial School Education Act** (Act 12 of 1997) are the guidelines to follow when expulsions are considered.

SERIOUS MISCONDUCT

1. has been convicted by a court of a criminal offence and sentenced to imprisonment without the option of a fine ; or
2. is under the influence of intoxicating liquor or drugs during a school activity or while on the school grounds ; or
3. is guilty of assault, theft or immoral conduct ; or
4. has been repeatedly absent without leave from school and/or classes ; or
5. conducts himself or herself in the opinion of the governing body, in a disgraceful, improper or unbecoming manner.

Reasons for expulsion referrals according to WCED Circular: 2001-2003

Point 1 above – 0%
Point 2 above – 25%
Point 3 above – 36%
Point 4 above – 7%
Point 5 above – 32%

Table 2.20: Gender of expulsion referrals

Gender	2001	2002	2003	2004
Males	166	169	140	475
Females	14	14	22	50

Table 2.21: Grade of expulsion referrals: 2001-2003

	2001	2002	2003
Grade 12	8	12	4
Grade 11	24	21	13
Grade 10	35	36	46
Grade 9	47	49	53
Grade 8	48	55	27
Grade 7	5	7	4
Grade 6	4	2	8
Grade 5	1	1	2
Grade 4	3	0	2
Grade 3	4	0	1
Grade 2	1	0	0
Grade 1	0	0	0
Grade R	0	0	0
El Sen (Snr)	0	0	2
El Sen (Jnr)	0	0	0

Table 2.22: Primary reason for expulsion

	2001	2002	2003
	%	%	%
Absenteeism/truancy	25	9	3
Alcohol related	4	15	8
Arson	0	0	4
Assault/violence	36	33	28
Criminal conviction	0	0	0
Drug-related	41	31	37
Immoral conduct	28	20	15
Improper conduct	27	41	34
Possession of a weapon	5	7	2
Theft	14	27	31

SPECIFIC DRUG- AND ALCOHOL-RELATED EXPULSIONS**SOME INCIDENTS**

- selling “ganja muffins” at Entrepreneurs Day to generate income
- alcohol misuse during school camps
- legal counsel argued that selling dagga at a loss could not be constituted as ‘dealing in drugs’ (introduction of ‘distribution’)

- incidents of dealing/distribution of dagga, Mandrax, ecstasy and Rohypnol at schools

Table 2.23: Expulsion referrals – drug-and alcohol related

	2001	2002	2003
	%	%	%
Drug-related	43	35	46
Alcohol-related	5	16	10

Table 2.24: Gender of expulsion referrals – drug- and alcohol-related

Gender	%
Male	83
Female	17

Table 2.25: Grade of expulsion requests – drug- and alcohol-related

	Grade 6	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12
2001	0	0	10	8	15	13	2
2002	0	0	7	16	12	7	9
2003	4	1	8	9	27	4	3
Total %	3	1	16	21	35	15	9

Table 2.26: WCED Expulsions 2001-2003 – Drug- and Alcohol-related

	%
Drug	94
Alcohol	6

Table 2.27: Drug-related expulsions 2001-2003

	2001	2002	2003
	%	%	%
Drug possession and/or use	18	11	8
Drug dealing and/or distribution	9	5	12

Government Gazette
No. 24172
(dated 13th December 2002)

- “The Ministry differentiates between habitual abuse of drugs and drug dealing, which should be condemned and punished, and experimentation or peer-group led abuse which should be dealt with in the context of restorative justice”.
- Drug misuse (dependency), is a “primary, chronic and progressive health condition”
- “The possession, use or distribution of illegal drugs, and the inappropriate possession, use or distribution of legal drugs, including alcohol and tobacco, is prohibited in South African schools”.
- “All South African schools should become tobacco, alcohol & illicit drug-free zones”.
- “Random drug testing & Random searches of individuals are prohibited”

Too often, the problem presented by a learner who is involved in substance abuse or trafficking is ‘solved’ through expulsion. Rather than solve the problem, this unfortunate course of action merely displaces it and, in certain instances, aggravates it.

Wherever possible, therefore, drugs must be tackled together in the classroom rather than the court room, and schools should have their own internal disciplinary systems and programmes.

EDUCATION WHITE PAPER

- ❖ **ALL children and youth CAN learn**
- ❖ **ALL children and youth NEED support**
- ❖ change attitudes, behaviour, teaching methods, curricula & environment to meet the needs of ALL learners
- ❖ uncover & minimize barriers to learning

BARRIERS TO LEARNING

- ❖ physical ;
 - ❖ mental ;
 - ❖ sensory ;
 - ❖ neurological/developmental impairments ;
 - ❖ psycho-social disturbances ;
 - ❖ differing intellectual ability ;
 - ❖ life experiences ;
 - ❖ socio-economic deprivation
-
- ❖ **Learners who experience mild to moderate disabilities can be adequately accommodated in mainstream education**

Learners requiring :

- ❖ **low-intensive support** ? ordinary schools
- ❖ **moderate support** ? full-service schools
- ❖ **high-intensive support** ? special schools

REFERRAL STRUCTURE

- **District-based Support Team** ⇒ **Education Management & Development Centres** (4 components : Curriculum Service ; Specialised Learner and Educator Support ; Institutional Management and Governance ; Administrative Service)
- **Special Schools / Resource Centres** ⇒ ELSEN schools strengthened to support mainstream & full-service schools & assist learners requiring “**high levels of support**”
- **Full-Service Schools** ⇒ certain ordinary, mainstream schools to be transformed (model inclusive school) / will provide for ALL learners who require “**moderate level support**”
- **Education Support Teams** ⇒ institution-based support team at ALL educational institutions / aid educators to assist learners who experience **barriers to learning**

RESTORATIVE PRINCIPLE

“The approach to learners who have broken school rules and/or the law should focus on **restoring societal harmony** and putting wrongs right, **rather than punishment**. The learner should be held **accountable for his/her actions** and, where possible, **make amends to the affected parties**.”

2e: The nature and extent of heroin use in Cape Town

Mr Andreas Plüddemann

In August 2003 the MRC’s Alcohol & Drug Abuse Research Group commenced a study exploring the nature and extent of heroin use in Cape Town, with funding from the United Nations Office of Drugs & Crime. Phase 1 of the study entails exploring the nature and extent of the problem through interviews with key informants and focus group discussions with heroin users who have been in treatment.

Questions posed to the key informants and topics discussed in the focus groups included the demographic background of heroin users in Cape Town, the extent of use, treatment issues (including availability, relapse, and hospital services), injecting use and HIV, crime issues, and methadone use.

Preliminary findings obtained from two focus group discussions and 15 key informant interviews indicate that heroin use is increasing in Cape Town and it was established that a number of issues are cause for concern relating to the apparent increase in heroin use in Cape Town, including the lack of affordable treatment services for heroin users (see quotes 1 and 2 below from focus groups), problems/issues regarding methadone (see quotes 3 and 4), an increase in heroin use amongst previously disadvantaged communities (see quote 5), and the lack of affordable detoxification services. Findings also suggests that changes are taking place in the profile of users (see quote 6), with increasing use among females, Afrikaans speakers and lower SES populations on the Cape Flats. The time between taking other drugs and experimenting with heroin may be declining. Harm reduction strategies (e.g. needle exchange programmes) may also need to be debated (see quote 7). It also became clear that heroin is available in most suburbs in the Cape metro (see quotes 8-10).

The study will continue in 2004 and move into Phase 2, a quantitative community survey of heroin users aimed at estimating the prevalence of heroin use in Cape Town and gathering further data on associated problems.

Quote 1:

“No. Because of the price the majority of people out there could not afford it. The majority users don’t work as such, majority users steal etc – even if they want to come clean they cannot.”

Quote 2:

“We are very fortunate because a lot of people I know would like to come clean but cannot.”

Quote 3:

“Methadone is the worst thing ... I did a lot of programmes over the years and it was the hardest thing ever to come off – it is just substituting heroin for heroin. It does not have quite the kick but it is the same feeling – that warm thing you know.”

Quote 4:

“Oh it was easy. Give me 150mls of Methadone a day and I could have carried on for the rest of my life. I know in England that was a big thing – people were registered as addicts – if you were registered the doctor would give you 150mls for the rest of your life. It is not a solution I mean in my eyes it is not a solution. “

Quote 5:

“Something I would like to mention – it might not be fact but it is something that I found quite interesting – I was told at one stage that dealers are trying to get into the ‘black market’ – they are selling [for] even less – to the black and very young – baby market – they are trying to sell them less than R50 – like R10 or R15 shots at the station so that they can get them hooked without selling them big quantities or anything like that but they are aiming at selling to babies little bits at a time. Something I heard that is starting to happen because they obviously (the Nigerians) come here and they see that the black people aren’t using, the whites are the target and they have cottoned onto it.”

Quote 6:

“Definitely - every day you start seeing people you never thought would ever, you know. It’s seeping into all sorts of classes you know. Before it was quite a dirty list – the old drug users that was using it – but now it is seeping into the business world everywhere.”

Quote 7:

“You know how many times I have stashed my needles in the dustbin up the road and like 3 o’ clock in the morning you want needles you go to like 3 hospitals they will all turn you away they don’t actually care what you tell them and you end up taking your own needles out of the dustbin after being there for a week and sticking them in So that you can like use them which is crazy. So like preventing you from getting a needle at 4 o’clock in the morning causes more damage than giving them.”

Quote 8:

“Oh it is the easiest thing in the world. You don’t have to leave home it is so easy.”

Quote 9:

“You walk down in the main road in Mowbray and you get offered at least like 10 times from one side to the other.”

Quote 10:

“It is not just Sea Point area it is also Table View and there you find it easy even Durbanville – it is readily available in all areas.”

2f: Access to substance abuse treatment services for clients from historically underserved groups in Cape Town and Gauteng

Ms Bronwyn Myers and Prof Charles Parry

Separate cross-sectional audits of substance abuse treatment facilities were conducted in Cape Town (2002-2003) and Gauteng (2003-2004). Two of the objectives of these audits were (i) to describe the extent to which substance abuse treatment services in the country serve Black South Africans and (ii) to explore the extent to which these services target barriers that limit the extent to which Black South Africans access, engage and are retained in treatment.

The Treatment Services Audit (TSA) Questionnaire and a revised version of the TSA were used in Cape Town and Gauteng respectively, to collect information about the characteristics of treatment facilities such as ownership, affiliations, intensity of care, and organisational resources; the diversity of services provided; the profile of clients served; barriers to treatment entry, engagement and retention; and service delivery. The sample consisted of the total population of specialist substance abuse treatment facilities in Gauteng (N = 36) and Cape Town (N = 25). Amongst these facilities, the response rates were 88% in Cape Town (N = 22) and 86% in Gauteng (N = 31).

Main findings:

A similar pattern emerged among treatment facilities in Cape Town and Gauteng, when the socio-demographic profile of clients served at these facilities was compared to 2001 census data (Statistics South Africa, 2003), with Black clients being underrepresented and clients from other socially defined race groups (particularly White clients), being overrepresented in treatment. The extent to which Black clients are underrepresented probably has less to do with the extent of substance use disorders amongst Black South Africans and more to do with the accessibility of treatment services. In both audits, facility ownership and intensity of care provided are significantly associated with the extent to which facilities are accessible to Black clients, with outpatient facilities being more likely to provide services to Black clients than inpatient facilities and private for-profit facilities being more likely to serve White clients than private non-profit facilities. One reason for this finding could lie in the type of affiliation that private non-profit outpatient facilities have with government. Most private non-profit outpatient facilities are affiliated with the Department of Social Development (DSD). Facilities affiliated with the DSD serve the largest proportion of Black clients than facilities affiliated with the Department of Health (DOH), with dual registration or unregistered facilities. The DSD has historically focused on providing community based services on an outpatient basis and these may be more accessible to Black clients, in terms of geographical location and transport, than DOH-affiliated services that historically have focused on inpatient care and have been located in urban settings.

In terms of activities that target barriers to treatment entry, engagement and retention, relatively few facilities perform outreach activities aimed at improving awareness of treatment options. In addition, while many facilities report providing financial assistance for the direct costs of treatment, few facilities address other logistical barriers to treatment such as the indirect costs associated with

transport. As with logistical barriers, private non-profit outpatient facilities affiliated with the Department of Social Development are more likely to address cultural and linguistic barriers to treatment for underserved groups than facilities with another ownership status, intensity of care, or state affiliation. The organisational goal of profit maximisation, historical factors in the provision of substance abuse treatment services in South Africa and the overlap between race and socio-economic status in South Africa may help account for these findings.

Based on these findings, several recommendations were made. These include the need to increase the capacity of treatment services so that appropriate and accessible services can be provided. This can be achieved through encouraging African language-speaking students to enter the field and through professionalizing the substance abuse treatment field via: forming a single body that registers treatment facilities, introducing ongoing monitoring of facilities as part of registration, introducing a national process for licensing and accreditation of all addiction practitioners- with ongoing professional development, having cultural sensitivity as one of the competencies of addiction practitioners, and developing a Society of Addiction Professionals.

Below are selected tables from the reports:

Table 2.28: Treatment trends (SACENDU): Age <20 years (%)

Area	Jul-Dec 1996	Jan-Jun 1997	Jul-Dec 1997	Jan-Jun 1998	Jul-Dec 1998	Jan-Jun 1999	Jul-Dec 1999	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003
Cape Town	5.5	5.5	6.5	8.5	13	15	16	17	24	21	24	22	24	22	22
Gauteng	-	-	-	-	-	14	14	17	19	19	23	25	25	22	26

Table 2.29: Profile of treatment facilities by ownership and intensity of treatment Cape Town and Gauteng

	Cape Town	Gauteng
	%	%
Private nonprofit outpatient	41	36
Private for profit inpatient	36	26
State inpatient	14	6
Private nonprofit inpatient	9	32

Table 2.30: Comparison of clients in treatment with census data (race) for Cape Town and Gauteng (July-December 2003)

	Cape Town		Gauteng	
	In treatment	Census	In treatment	Census
African/Black	11	32	38	74
White	31	19	51	20
Coloured	57	48	8	4
Asian	1	1	3	2

Table 2.31: Proportion of Black clients by facility affiliation

	Dual	Social Development	Health
Cape Town	6	16	5
Gauteng	10	32	15

Table 2.32: Comparison of race profile of clients by facility ownership and treatment intensity

	Private for Profit		Private non—profit inpatient		Private non—profit outpatient		State inpatient	
	Cape Town	Gauteng	Cape Town	Gauteng	Cape Town	Gauteng	Cape Town	Gauteng
	%	%	%	%	%	%	%	%
Black clients	3	11	2	20	24	51	5	31
Coloured clients	28	3	52	9	65	23	80	9
Asian clients	2	4	0	9	1	12	1	3
White clients	67	82	46	62	12	19	14	57

Table 2.33: Proportion of treatment facilities targeting selected barriers to treatment (African patients): Awareness (1), affordability (2)

	Cape Town	Gauteng
	%	%
Township outreach	41	55
Street outreach	18	26
African language therapists	27	61
Multilingual staff	86	87
Fees	82	81
Free treatment	64	39
Childcare	0	3
Transport	18	29

Table 2.34: Targeting selected barriers to access by facility ownership and treatment intensity

	Private for profit		Private non-profit inpatient		Private non-profit outpatient		State inpatient	
	Cape Town	Gauteng	Cape Town	Gauteng	Cape Town	Gauteng	Cape Town	Gauteng
	%	%	%	%	%	%	%	%
Township outreach	0	13	67	60	67	82	33	50
Street outreach	14	0	33	30	22	46	0	0
African language therapists	14	25	0	100	56	100	0	100
Multilingual staff	71	50	100	70	100	73	67	100
Reduced fees	57	50	100	100	100	100	67	100
Free treatment	38	25	100	70	100	73	100	100

Full report available at <http://www.sahealthinfo.org/admodule/docsauthor.htm>