

## SECTION 2: PORT ELIZABETH/ EAST LONDON

### 2a: PE Specialist treatment centres

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**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	Jan-Jun 2004
	%	%	%	%	%	%	%	%	%
SANCA PE	84	87	90	89	87	92	83	83	87
Welbedacht	16	13	10	11	13	8	11	8	9
Shepherd's Field	-	-	-	-	-	-	7	9	4
<b>Total no of persons treated</b>	<b>N=352</b>	<b>N=312</b>	<b>N=414</b>	<b>N=409</b>	<b>N=440</b>	<b>N=384</b>	<b>N=515</b>	<b>N=450</b>	<b>N=505</b>

A total of 505 patients were treated at the three Port Elizabeth treatment centres.

**Table 2.2: First time admissions**

	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%	%	%	%	%
<b>Yes</b>	74	79	74	81	87	81	74	67	76
<b>No</b>	26	21	26	19	13	19	26	33	24

76% of patients reported that it was their first admission.

**Table 2.3: Types of treatment received**

	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%	%	%	%
<b>Inpatient</b>	12	14	11	2	1	18	18	15
<b>Outpatient</b>	88	84	86	97	99	82	82	85
<b>Both</b>	-	2	3	1	-	-	-	-

**Table 2.4: Referral sources**

	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%	%	%	%	%
Self/family/friends	39	38	39	45	38	47	39	42	45
Work/employer	22	21	24	15	20	19	17	18	16
Doctor/psychiatrist/nurse (health professional)	21	20	15	12	11	7	11	14	12
Religious body	3	3	<1	2	2	1	2	2	1
Hospital/clinic	5	4	4	4	7	8	10	7	9
Social services/welfare	6	8	6	5	5	4	8	6	4
Court/correctional services/police/lawyer	1	4	2	7	7	4	2	4	5
School	2	1	7	9	9	7	8	6	4
Other e.g. radio, Children's home, adverts	1	0	<1	-	<1	3	4	1	4

45% of all referrals are self/family/friends referrals. Referrals from employers are at 16%.

**Table 2.5: Population Profile**

	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%	%	%	%
<b>GENDER</b>								
Male	81	82	83	82	83	79	82	85
Female	19	18	17	18	17	21	18	15
<b>ETHNIC GROUP</b>								
African	20	18	24	25	26	27	29	28
White	30	22	21	22	18	24	26	27
Coloured	48	51	51	51	51	46	42	41
Asian	2	9	4	2	5	3	3	3
<b>MARITAL STATUS</b>								
Single	43	49	52	56	53	55	53	46
Married	45	35	28	27	34	25	30	29
Widowed	2	2	2	2	1	1	2	2
Divorced/ Separated	10	8	10	8	6	9	9	8
Living Together	-	6	8	7	5	6	6	8
<b>EMPLOYMENT STATUS</b>								
Employed	57	42	37	39	35	35	34	39
Unemployed	34	34	31	32	37	33	40	33
School/Student	7	15	24	22	20	22	15	14
Pension/Retired	2	4	4	1	1	2	2	2
Housewife	-	2	1	1	<1	2	1	1
Part-time	-	3	3	4	3	3	5	5
Disabled/ medically boarded	-	-	-	-	2	2	1	2
Other	-	-	-	-	-	-	2	0
Apprentice	-	-	-	-	-	-	-	<1

Table 2.5 shows the population profile of persons attending treatment centres in PE. Gender profiles remain stable. “Other” as indicated under employment status refers to those individuals who have dropped out of school.

**Table 2.6: Age distribution**

	Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%
10-14	11	3	11	3	14	3	14	4	11	2
15-19	105	27	71	20	99	22	61	14	76	15
20-24	39	10	41	12	68	15	67	15	86	17
25-29	62	16	53	15	66	14	66	15	68	13
30-34	53	14	45	13	48	10	45	11	70	14
35-39	41	11	42	12	45	10	54	13	64	13
40-44	28	7	37	10	50	11	44	10	59	12
45-49	18	4	33	9	26	6	31	7	43	8
50-54	11	2	12	3	23	5	17	4	13	3
55-59	7	1	3	1	11	2	9	2	15*	4
60-64	4	1	1	<1	5	1	1	<1		
65-69	-	-	1	<1	-	-	-	-		
70-80	1	<1	1	<1	-	-	-	-		
Age unknown	2	<1	2	<1	4	1	-	-		

\*age category changed to 55-65

The majority of persons seeking treatment fall into the 15-29 years age group. 17% of all patients receiving treatment were in the age category under 20 years.

**Table 2.7: Primary substance of abuse**

	Jan-Jun 2000	Jul-Dec 2000	Jan-Jun 2001	Jul-Dec 2001	Jan-Jun 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%	%	%	%	%
Alcohol	52	65	45	56	45	55	46	51	48
Dagga/Mandrax	34	26	42	35	29	25	32	26	24
Dagga	-	-	-	-	19	13	16	12	15
OTC/PRE	7	4	3	3	4	4	5	5	3
Nicotine	1	<1	2	1	2	-	-	<1	-
Cocaine/Crack	<1	<1	3	1	1	<1	2	2	6
Polysubstance	2	3	2	2	-	-	-	-	-
Ecstasy	<1	<1	1	1	<1	1	<1	2	3
Heroin	-	-	-	-	-	<1	-	-	2
Ephedrine	-	-	-	-	-	-	-	1	-
Inhalants	-	-	-	-	-	-	-	1	-
Other	1	<1	2	1	<1	-	<1	-	-

Alcohol remains the primary drug of abuse. No significant change is noted in this category, trends for drugs like whitepipe (dagga-Mandrax) remain stable. For the first time 2% of patients reported heroin as their primary drug.

**Table 2.8: Frequency of use of primary substance of abuse**

	Jan-June 2004
	%
Daily	52
2-6 times a week	37
Once a week	8
Not used in past month	2

**Table 2.9: Age at which primary substance of abuse first used or experimented with**

Years	Jan-Jun 2004
	%
10-19	67
20-29	25
30-39	5
40-49	2
50-60	<1

**Table 2.10: Gender by primary substance of abuse**

	Jan-Jul 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	M	F	M	F	M	F	M	F	M	F
	%	%	%	%	%	%	%	%	%	%
Alcohol	77	23	80	20	78	22	79	21	84	16
Crack/Cocaine	25	75	0	100	57	43	78	22	-	-
Cocaine	-	-	-	-	-	-	-	-	85	15
Crack	-	-	-	-	-	-	-	-	86	14
Ecstasy	100	0	100	0	100	-	50	50	69	31
OTC/PRE	6	94	36	64	25	75	17	83	-	-
OTC	-	-	-	-	-	-	-	-	50	50
PRE	-	-	-	-	-	-	-	-	31	69
Dagga/Mandrax	93	7	96	4	91	9	94	6	94	6
Dagga	91	9	87	13	95	5	95	5	88	12
Heroin	-	-	50	50	-	-	-	-	73	27
Inhalants	-	-	-	-	-	-	100	-	-	-
Ephedrine	-	-	-	-	-	-	-	100	-	-

Most dagga and Mandrax patients are male, whereas a high proportion of patients abusing over-the-counter or prescription medicines are female.

**Table 2.11: Race by primary substance of abuse**

	African			Coloured			Asian			White		
	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%	%	%	%	%	%	%	%
Alcohol	34	34	37	52	43	38	2	<1	<1	12	22	25
Dagga/ Mandrax	24	27	22	64	57	60	5	5	5	6	11	13
Dagga	41	35	35	46	35	32	3	2	4	10	28	28
Crack/ Cocaine	14	-	-	-	-	-	-	11	-	86	89	-
Cocaine	-	-	8	-	-	15	-	-	15	-	-	62
Crack	-	-	-	-	-	21	-	-	14	-	-	64
Ecstasy	-	-	-	-	50	50	-	-	-	100	50	50
OTC/PRE	-	8	-	73	67	-	9	13	-	18	13	-
OTC	-	-	-	-	-	-	-	-	-	-	-	100
PRE	-	-	8	-	-	54	-	-	8	-	-	31
Heroin	-	-	18	-	-	-	-	-	-	-	-	82
Inhalants	-	86	-	-	14	-	-	-	-	-	-	-
Ephedrine	-	-	-	-	-	-	-	-	-	-	100	-

From Table 2.11 it can be seen that the majority of patients admitted for alcohol and dagga/Mandrax abuse are Coloured while most cocaine patients are White.

**Table 2.12: Average/Mean age by Primary Substance**

	Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	Number of Patients	Mean age of Patients	Number of Patients	Mean age of Patients	Number of Patients	Mean age of Patients	Number of Patients	Mean age of Patients
Alcohol	181	36	187	36	202	37	240	37
Dagga/ Mandrax	90	27	104	25	115	24	120	25
Dagga	45	21	61	20	43	20	74	21
Ecstasy	-	-	-	-	2	23	16	21
Cocaine/ Crack	-	-	6	27	9	29	-	-
Cocaine	-	-	-	-	-	-	13	28
Crack	-	-	-	-	-	-	14	31
OTC/PRE	14	35	8	40	24	38	-	-
OTC	-	-	-	-	-	-	4	39
PRE	-	-	-	-	-	-	13	40
Heroin	-	-	-	-	-	-	11	25
Inhalants	-	-	-	-	7	14	-	-
Ephedrine	-	-	-	-	5	17	-	-

The average age for whitepipe and alcohol abuse is 25 years and 37 years respectively. The average age for most substances has remained stable over the last 3 review periods.

**Table 2.13: Secondary substance of abuse**

	Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%
<b>Alcohol</b>	67	17	53	15	47	15	48	23	53	35
<b>Dagga/Mandrax</b>	10	3	5	1	26	8	12	6	21	14
<b>Dagga</b>	11	3	21	6	-	-	-	-	29	19
<b>Cocaine/Crack</b>	7	2	2	1	10	3	10	5	-	-
<b>Cocaine</b>	-	-	-	-	-	-	-	-	10	7
<b>Crack</b>	-	-	-	-	-	-	-	-	10	7
<b>Ecstasy/LSD</b>	1	<1	7	2	20	6	-	-	-	-
<b>Ecstasy</b>	-	-	-	-	-	-	13	6	17	11
<b>LSD</b>	-	-	-	-	-	-	-	1	2	1
<b>Nicotine</b>	181	47	148	42	193	62	94	44	-	-
<b>OTC/PRE</b>	4	1	2	<1	13	5	11	5	-	-
<b>OTC</b>	-	-	-	-	-	-	-	-	3	2
<b>PRE</b>									4	3
<b>Ephedrine/Acid/Speed</b>	-	-	-	-	-	-	2	<1	-	-
<b>Heroin</b>	-	-	-	-	-	-	1	<1	1	4
<b>Inhalants</b>	-	-	-	-	-	-	3	1	-	-

**Table 2.14: Frequency of use of secondary substance of abuse**

	Jan-June 2004
	%
Daily	23
2-6 times a week	35
Once a week	31
Not used in past month	11

**Table 2.15: Tertiary substance of abuse**

	Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%
<b>Alcohol</b>	24	6	20	6	15	34	7	16	10	22
<b>Dagga/ Mandrax</b>	2	<1	3	1	2	4	1	2	6	16
<b>Dagga</b>	2	<1	4	1	1	2	-	-	4	9
<b>Cocaine</b>	2	<1	1	<1	3	7	5	11	6	13
<b>Crack</b>									8	18
<b>Heroin</b>	1	<1	-	-	-	-	1	2	1	2
<b>Ecstasy</b>	1	<1	3	1	6	13	10	23	6	13
<b>Ecstasy/ Cocaine</b>	1	<1	-	-	-	-	-	-	-	-
<b>Nicotine</b>	21	5	23	7	18	40	15	34	-	-
<b>Ephedrine/ Acid/Speed</b>	-	-	-	-	-	-	3	6		-
<b>OTC/PRE</b>	-	-	-	-	-	-	2	4	2	4
<b>LSD</b>	-	-	-	-	-	-	-	-	2	4

**Table 2.16: Frequency of use of tertiary substance of abuse**

	Jan-June 2004
	%
Daily	9
2-6 times a week	22
Once a week	36
Not used in past month	33

**Table 2.17: Mode of use for primary drug**

	Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%
<b>Swallowed</b>	167	44	197	56	258	50	233	57	276	55
<b>Snorted</b>	2	<1	1	<1	3	1	4	1	9	2
<b>Injected</b>	1	<1	1	<1	-	-	1	<1	5	1
<b>Smoked</b>	210	55	146	41	227	44	164	40	215	43
<b>Sniffed/inhaled</b>	1	<1	-	-	1	<1	7	2	-	-
<b>Other/ Combination</b>	1	<1	8	2	26	5	-	-	-	-

The primary mode of usage is swallowing (55%) followed by smoking (43%).

**Table 2.18: Treatment population – suburb of residence**

	<b>Jan-Jun 2002</b>	<b>Jul-Dec 2002</b>	<b>Jan-Jun 2003</b>	<b>Jul-Dec 2003</b>	<b>Jan-Jun 2004</b>
	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
<b>METRO SUBSTRUCTURE</b>					
Bethelsdorp, Gelvandale, Korsten, Malabar, Bloemendal	47	42	35	37	30
Roadhouse, New Brighton, Swartkops, Motherwell, Zwide	19	19	17	23	19
Uitenhage, Despatch	13	16	16	14	16
North End, Mount Road, Township (Central)	8	8	10	12	11
Walmer, Kabega Park, Westering, Summerstrand	13	14	14	11	20
<b>OTHER PARTS OF THE PROVINCE</b>					
Port Alfred, Hankey, Tsitsikamma, Plettenberg Bay, Cradock, Mosselbay, Kirkwood, Queenstown, Umtata, Jeffreys Bay, East London, Addo, Alexandria	<1	3	6	2	6

**Table 2.19: Drug types and cost**

<b>Type of drug</b>	<b>Cost/Quantity</b>
Heroin	R120-180 per gram
Cannabis	R20 per bank bag
Mandrax	R40 per tablet
Ecstasy	R20 per tablet
Cocaine	R200-300 per gram (depending on the quality)
Crack	R40-80 per rock (depending on quality and rock size)
Stillpayne	80c per tablet
LSD	R40-60 per trip
Magic Mushrooms	R80-100 per bank bag

**Table 2.20: Source of payment**

	<b>Jan-Jun 2002</b>	<b>Jul-Dec 2002</b>	<b>Jan-Jun 2003</b>	<b>Jul-Dec 2003</b>	<b>Jan-Jun 2004</b>
	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>	<b>%</b>
<b>Self</b>	32	35	28	34	40
<b>Medical Aid</b>	19	24	18	10	21
<b>Family</b>	32	30	31	35	27
<b>Friends</b>	1	1	1	<1	<1
<b>Employer</b>	3	2	4	5	4
<b>Church Minister</b>	<1	-	-	-	-
<b>Unknown</b>	12	8	11	14	5
<b>Other</b>	<1	<1	6	-	4
<b>State</b>	-	-	-	<1	<1

Family and 'self' are the most common sources of payment.

## SUBSTANCE ABUSE FOR PERSONS UNDER 20 YEARS

Table 2.21: Primary substance of abuse of patients younger than 20 years

	Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%
<b>Alcohol</b>	10	9	15	18	17	16	12	16	9	10
<b>Dagga/Mandrax</b>	39	34	21	26	33	31	29	39	32	37
<b>Dagga</b>	58	50	33	40	41	38	21	28	37	42
<b>Ecstasy</b>	1	<1	2	2	1	1	-	-	5	6
<b>Inhalants</b>	1	<1	-	-	1	1	7	9	-	-
<b>Nicotine</b>	7	6	11	13	8	7	1	1	-	-
<b>Poppers</b>	-	-	-	-	1	1	-	-	-	-
<b>Polysubstance</b>	-	-	-	-	6	5	-	-	-	-
<b>Cocaine</b>	-	-	-	-	-	-	-	-	1	1
<b>Heroin</b>	-	-	-	-	-	-	-	-	1	1
<b>Crack</b>	-	-	-	-	-	-	-	-	1	1
<b>PRE</b>	-	-	-	-	-	-	-	-	1	1
<b>Ephedrine</b>	-	-	-	-	-	-	5	7	-	-
<b>Total</b>	<b>116</b>	<b>100</b>	<b>82</b>	<b>100</b>	<b>108</b>	<b>100</b>	<b>75</b>	<b>100</b>	<b>87</b>	<b>100</b>

Most young patients report dagga, 'whitepipe' or alcohol as their primary substance of abuse.

Table 2.22: Gender of patients abusing substances younger than 20 years

	Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%
<b>Male</b>	71	87	86	80	66	88	73	84
<b>Female</b>	11	13	22	20	9	12	14	16

Table 2.23: Race of patients younger than 20 years

	Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%
<b>African</b>	22	27	38	35	37	49	28	32
<b>Asian</b>	4	5	2	2	-	-	2	2
<b>Coloured</b>	32	39	62	57	22	29	35	40
<b>White</b>	24	29	6	6	16	21	22	25

**Table 2.24: Gender, by primary substance of abuse for patients younger than 20 years**

	Jul-Dec 2003		Jan-Jun 2004	
	%	%	%	%
	Male	Female	Male	Female
Alcohol	50	50	78	22
Dagga	95	5	86	14
Ephedrine	100	-	-	-
Inhalants	100	-	-	-
Dagga/Mandrax	93	7	94	6
Cocaine	-	-	0	100
Crack			100	0
Ecstasy	-	-	40	60
Nicotine	100	-	-	-
Heroin	-	-	0	100
PRE			100	0
Total	75	100		

Trends show that females under 20 tend to abuse alcohol and dagga more than any other drugs.

**Table 2.25: Race, by primary substance of abuse for patients younger than 20 years**

	African		Coloured		Asian		White	
	Jul-Dec 2003	Jan-Jun 2004	Jul-Dec 2003	Jan-Jun 2004	Jul-Dec 2003	Jan-Jun 2004	Jul-Dec 2003	Jan-Jun 2004
	%		%		%		%	
Alcohol	33	33	58	44	-	-	8	22
Dagga/Mandrax	58	44	21	34	-	3	21	19
Dagga	43	30	38	43	-	3	19	24
Ephedrine	-	-	-	-	-	-	100	-
Inhalants	86	-	14	-	-	-	-	-
Nicotine	100	-	-	-	-	-	-	-

# 2b: Alcohol drinking problems in three Urban High Schools at Umtata

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## Introduction

Alcohol is still the most important substance of abuse in South Africa and it's associated with violence, crime and traffic-related trauma (*The SACENDU Project*<sup>1</sup>).

Research conducted by the National Institute on Alcohol Abuse and Alcoholism Task Force (E.U.) on College Drinking found that college drinking is more extended than it was before and even responsible for a large number of death among youngsters between 18-24 year of age (*NIAAA Study Finds Extensive Damage From College Drinking*<sup>2</sup>).

The SACENDU Project mentioned that about one in four Grade 7, 10 and 11 learners in a Pretoria school survey undertaken by UNISA reported getting drunk occasionally during the course of a typical month. Also there is a report from the same research group, on increasing use of cannabis, Mandrax and other harder drugs among young people in South Africa<sup>3</sup>.

The first step in a successful intervention is to determine how extensive the damage is and to target risk groups.

Hence the primary aim of the present study is to assess the use of alcohol and other drugs of abuse in some urban High Schools at Umtata.

## Objectives

- Primary objective: To determine the number of students affected by alcohol use at three Urban High Schools in Umtata.
- Secondary objective: To determine the number of students affected by other drug use, and to assess Socio-demographic characteristics of students affected by use of alcohol and other drugs of abuse.

## Method

The Alcohol Use Disorders Identification Test (AUDIT) is a widely used instrument to recognize persons whose alcohol consumption has become hazardous or harmful to their health (AUDIT Guidelines for use in Primary Health Care<sup>4, 5, 6</sup>). AUDIT has been recommended to be used in adolescent populations at risk<sup>7</sup>. The authors of the present study selected AUDIT as screening tool to assess hazardous or harmful alcohol use among the whole population of students who were present and accepted to cooperate at the moment of the interview, (N=1424) at three urban High Schools at Umtata. A group of 6th and 4th year medical students were trained to participate in the study as interviewers. Participation of younger people could facilitate communication with adolescents and at the same time contributes to a better understanding for them of alcohol related disorders.

The objectives and methodology of the present study as well as the use of AUDIT as screening tool were explained to the group of students designated to participate. AUDIT was embedded in a broader questionnaire that includes questions for general identification, questions to determine other substance use and two questions on physical and sexual abuse. The questionnaire was applied at the same time at the whole school, each group in their own classroom.

Data collection was completed in March 2003.

### **Ethical Issues**

In previous contacts with school Principals and schoolteachers' boards consent from educational authorities was obtained. The purposes of the study were explained to students before giving them the questionnaire and voluntary participation was stimulated, therefore individual consent was granted.

### **Results**

The total sample size was 1424 students. Of these, 786 (55.2%) were female and 638 (44.8%) male.

**Table 2.26: Distribution according to gender**

<b>Gender</b>	<b>No</b>
Females	786
Males	638

Of these 1424 students, 168 (11.8%) were between 12 and 14 years of age; 766 (53.8%) were between 15 to 17 years of age and 490 (34.4%) were older than 18.

**Table 2.27: Distribution according to Age**

<b>Age range</b>	<b>No</b>
12 to 14	168
15 to 17	766
> 18	490

120 (8.3%) were in Standard 6, 110 (7.72%) were in Standard 7, 378 (26.5%) were in Standard 8, 467 (32.8%) were in Standard 9 and 349 (24.5%) were in Standard 10.

**Table 2.28: Distribution according to Standards**

<b>Standard</b>	<b>No</b>	<b>%</b>
Standard 6	120	8.3
Standard 7	110	7.72
Standard 8	378	26.5
Standard 9	467	32.8
Standard 10	349	24.5

**Table 2.29: Correlation between AUDIT positive and sex**

	<b>Females</b>	<b>Males</b>
Audit+	4.42	14.26
Audit-	50.77	30.55

266 (18.68 %) of students tested AUDIT positive (cut off point  $\geq 8$ ), of which 63 (4.42%) were females and 203 (14.26%) males. 10.18% of them were between 15 to 17 years of age. When looking at symptoms related with alcohol dependence, 209 (14.67%) reported they were unable to stop drinking once they had started, 166 (11.66%) reported having failed to do what was normally expected from them because of drinking and 169 (11.87%) students confirmed they had needed a first drink in the morning to get themselves going after a heavy drinking session. 73 students (5.13%) reported having been injured themselves or somebody else during the last year as a result of their drinking.

351 students (24.65%) reported drug related problems in their families. 225 (15.8%) students admitted using dagga sometimes. 69 (4.85%) used Mandrax and 64 (4.49%) admitted using cocaine at some time in their lives. 149 (10.46%) students were victims of physical abuse and 91 (6.69%) of sexual abuse. Sexual or physical abuse was not significantly correlated with AUDIT positive rate.

**Table 2.30: Symptoms related with hazardous drinking**

	<b>How often you drink alcohol</b>		<b>How often you have more than 6 drinks</b>	
	<b>F</b>	<b>%</b>	<b>F</b>	<b>%</b>
<b>Never</b>	984	69.1	1115	73.3
<b>Less than monthly</b>	217	15.24	113	7.94
<b>Monthly</b>	121	8.5	102	7.16
<b>Weekly</b>	52	3.68	64	4.49
<b>Almost Daily</b>	45	3.16	28	1.97
<b>No answer</b>	5	0.35	2	0.14

**Table 2.31: Hazardous drinking: drinks per day**

<b>How many drinks you have on a typical day</b>	<b>N</b>
1 or 2	177
2 or 4	103
5 or 6	65
7 to 9	29
> 10	67
None	979

**Table 2.32: Dependence related symptoms**

	Unable to stop		Failed to do what was expected		“Eyeopener” first drink in the morning	
	F	%	F	%	F	%
<b>Never</b>	1209	84.9	1255	88.13	1253	87.99
<b>Less than monthly</b>	66	4.63	64	4.49	58	4.07
<b>Monthly</b>	62	4.35	39	2.74	35	2.46
<b>Weekly</b>	43	3.02	28	1.97	38	2.67
<b>Daily</b>	38	2.67	35	2.46	38	2.67
<b>No Answer</b>	6	0.42	3	0.21	2	0.14

**Table 2.33: Symptoms related with harmful drinking:**

	How often do you have a guilty feeling after drinking		How often have you been unable to remember what happened (blackouts)	
	F	%	F	%
<b>Never</b>	1196	83.9	1255	88.1
<b>Less than monthly</b>	91	6.4	67	4.7
<b>Monthly</b>	42	2.9	36	2.5
<b>Weekly</b>	42	2.9	33	2.3
<b>Almost Daily</b>	50	3.5	31	2.2
<b>No Answer</b>	3	0.21	2	0.14

**Table 2.34: Symptoms related with harmful drinking**

	Have you or someone been injured as a result of your drinking?		Has a relative, a friend or a doctor suggested to cut down your drinking?	
	F	%	F	%
<b>No</b>	1241	87.2	1278	89.7
<b>Yes (but not in last year)</b>	105	7.4	70	5
<b>Yes, during last year</b>	73	5.1	71	5
<b>No answer</b>	5	0.3	5	0.3

**Table 2.35: Relatives with substance related problems**

	Frequency	%
Nobody	1064	74.72
Parents	55	3.86
Siblings	72	5.06
Other	224	15.73
Parents + siblings + others	4	0.28
No answer	5	0.35

**Table 2.36: Other drugs used**

	Dagga		Mandrax		Cocaine	
	F	%	F	%	F	%
<b>No</b>	1195	83.92	1352	94.94	1357	95.29
<b>Yes</b>	225	15.8	69	4.85	64	4.49
<b>No answer</b>	4	0.28	3	0.21	3	0.21

**Table 2.37: Correlation between physical abuse and alcohol related problems**

	AUDIT-	AUDIT+	Total
No physical abuse	74.3	15.24	89.54
Physical abuse	7.02	3.44	10.46
Total	81.32	18.68	100

**Table 2.38: Correlation between sexual abuse and alcohol related problems**

	AUDIT-	AUDIT+	Total
No sexual abuse	77.32	16.29	93.61
Sexual abuse	4	2.39	6.39
Total	81.32	18.68	100

## Discussion

Audit is a useful tool to detect alcohol related problems in PHC. In this group of students there is a clear high rate of students with some kind of alcohol related problem. Important symptoms of alcohol dependence were found in a relatively high group of students, which should be understood as an indicator of the severity of the alcohol problem in this group of students even though no diagnostic conclusions could be extracted from the above data. Relationship of alcohol use and accidents is highlighted by the number of students that reported having injured themselves or others during last year as a result of the way they were drinking. An issue of concern is the number of students admitting use of cocaine at some time. This data needs to be confirmed because cocaine is expensive and a small town like Umtata doesn't seem to be the logical market for this kind of drug, nevertheless use of cocaine among adolescents in large cities like Johannesburg and Cape Town have been reported by Parry et al (Trends in adolescent alcohol and other drug use<sup>8</sup>) as "emerging problem drugs of abuse". Use of Methaqualone was also reported but in slightly less amount than Marijuana also coincident with other studies in South Africa. There are numerous reports in

literature about relationship between sexual and physical abuse and substance related disorders<sup>9, 10, 11, 12</sup>, in this group of students a high number of them confirmed physical or sexual abuse but no statistical significance with substance related disorders could be found.

### **Conclusions**

Alcohol was the most common drug abused in the screened group, followed by dagga, Mandrax and cocaine; this is coincident with similar studies in the country<sup>1, 3, 8</sup>. A health education programme and more specific interventions will be designed based on the present research findings.

### **Acknowledgements**

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## 2c: SANCA - East London

Ms Carol Johnson

Table 2.39: Demographics

	Jan-Jun 2004	
	n	%
<b><i>GENDER</i></b>		
Males	122	82
Females	26	18
<b>TOTAL</b>	<b>148</b>	<b>100</b>
<b><i>POPULATION GROUP</i></b>		
Black	96	65
White	33	22
Coloured	17	12
Asian	1	1
<b>TOTAL</b>	<b>147</b>	<b>100</b>
<b><i>EMPLOYMENT STATUS</i></b>		
Working full time	53	36
Working part time	12	8
Not working	36	25
Student/learner	42	29
Disabled/medically boarded	1	<1
Pensioner	1	<1
Other	1	<1
<b>TOTAL</b>	<b>146</b>	<b>100</b>
<b><i>MARITAL STATUS</i></b>		
Married, living with spouse	27	18
Married not living with spouse	2	1
Living in intimate relationship	16	11
Divorced	9	6
Widowed	1	1
Never married	92	63
<b>TOTAL</b>	<b>147</b>	<b>100</b>
<b><i>EDUCATION</i></b>		
None	1	<1
Grade 1-6	21	14
Grade 7	13	9
Grade 8-11	70	47
Grade 12	30	20
Tertiary	129	9
<b>TOTAL</b>	<b>148</b>	<b>100</b>

**Table 2.40: Referral source**

	<b>Jan-Jun 2004</b>	
	<b>n</b>	<b>%</b>
Self	26	18
Family or friends	60	41
Employers	35	24
Health Profession	4	3
Religious groups	1	<1
Hospital/clinic	2	1
Social Services	7	5
Courts/correctional services	5	3
School	8	5

**Table 2.41: Age group**

<b>Age group</b>	<b>n</b>	<b>%</b>
11-14	3	2
15-19	32	22
20-24	33	22
25-29	15	10
30-34	11	7
35-39	18	12
40-44	13	9
45-49	7	5
50-54	8	5
55+	8	5
<b>TOTAL</b>	<b>148</b>	<b>100</b>

Almost a quarter of patients are under 20 years of age.

**Table 2.42: Inpatient versus outpatient**

	<b>n</b>	<b>%</b>
Inpatient	6	4
Outpatient	142	96
<b>TOTAL</b>	<b>148</b>	<b>100</b>

**Table 2.43: First time admissions**

	<b>n</b>	<b>%</b>
Yes	124	84
No	23	16
<b>TOTAL</b>	<b>148</b>	<b>100</b>

Most patients are admitted for the first time.

**Table 2.44: Number of previous treatments**

	<b>n</b>	<b>%</b>
One	13	88
Two	2	1
Three	3	2
<b>TOTAL</b>	<b>148</b>	<b>100</b>

**Table 2.45: Source of payment**

	<b>n</b>	<b>%</b>
State	3	2
State/self	1	1
Medical aid	4	3
Medical aid/employer/self	1	1
Medical aid/self	1	1
Family	64	43
Family/friend/self	1	1
Family/self	1	1
Friends	3	2
Employer	18	12
Employer/self	1	1
Self	31	21
Unknown	11	7
Other	6	4
<b>TOTAL</b>	<b>148</b>	<b>100</b>

**Table 2.46: Primary substance of abuse**

	<b>n</b>	<b>%</b>
Alcohol	82	55
Cocaine	4	3
Crack	2	1
Dagga	30	20
Heroin	1	<1
PRE/MED	1	<1
OTC	1	<1
Mandrax	27	18
<b>TOTAL</b>	<b>148</b>	<b>100</b>

Alcohol is the most common primary drug, followed by cannabis (dagga) and Mandrax.

**Table 2.47: Mode of usage**

	<b>n</b>	<b>%</b>
Swallow	83	56
Smoke	56	38
Snort/Sniff	9	6
<b>TOTAL</b>	<b>148</b>	<b>100</b>

**Table 2.48: Primary substance of abuse by Gender**

	Male		Female	
	n	%	n	%
<b>Alcohol</b>	66	80	16	20
<b>Cocaine</b>	2	50	2	50
<b>Crack</b>	2	100	0	-
<b>Dagga</b>	28	93	2	7
<b>Heroin</b>	-	-	1	100
<b>PRE/MED</b>	-	-	1	100
<b>OTC</b>	-	-	1	100
<b>White Pipe</b>	24	89	3	11
<b>TOTAL</b>	<b>122</b>	<b>82</b>	<b>26</b>	<b>18</b>

**Table 2.49: Primary substance of abuse by race**

	January – June 2004			
	African	Coloured	Asian	White
	%	%	%	%
<b>Alcohol</b>	69	12	-	18
<b>Cocaine</b>	-	-	-	100
<b>Crack</b>	-	-	-	100
<b>Dagga</b>	67	7	3	23
<b>Heroin</b>	100	-	-	-
<b>PRE/MED</b>	-	-	-	100
<b>OTC</b>	-	-	-	100
<b>White Pipe</b>	70	19	-	11
<b>TOTAL</b>	65	12	<1	22

**Table 2.50: Primary substance of abuse by frequency**

	Daily		2-6 days per week		Once a week or less often		Not used in past month	
	n	%	n	%	n	%	n	%
<b>Alcohol</b>	22	30	30	40	14	19	8	11
<b>Cocaine</b>	1	25	2	50	1	25	0	0
<b>Crack</b>	0	0	0	0	2	100	0	0
<b>Dagga</b>	15	57	7	27	2	8	2	8
<b>Heroin</b>	1	100	0	0	0	0	0	0
<b>PRE/MED</b>	1	100	0	0	0	0	0	0
<b>White Pipe</b>	15	60	4	16	3	12	3	12
<b>TOTAL</b>	<b>55</b>	<b>41</b>	<b>43</b>	<b>32</b>	<b>22</b>	<b>16</b>	<b>13</b>	<b>10</b>

**Table 2.51: Secondary substance of abuse**

	<b>n</b>	<b>%</b>
Alcohol	17	12
Cocaine	4	3
Dagga	14	10
Ecstasy	3	2
Whitepipe		4
Sleeping tablets	1	1
<b>TOTAL</b>	<b>148</b>	<b>100</b>

**Table 2.52: Tertiary substance of abuse**

	<b>n</b>	<b>%</b>
Alcohol	2	1
Crack	2	1
Dagga	1	<1
Ecstasy	3	2
Glue	1	<1
<b>TOTAL</b>	<b>148</b>	<b>100</b>

The average age of all patients was 30.4 years.

The average age of alcohol patients was 37.3 years.

The average age of all dagga patients was 18.9 years.

The average age of all Mandrax patients was 22.5 years

### **Conclusion**

- Alcohol remains the main primary substance of abuse, followed by dagga and the white pipe.
- The first half of 2004 saw a 7% increase in females seeking assistance (18%) when compared to 2003 (11%)
- Although we treated only one heroin patient in the 1st half 2004, we have noted a significant increase in this area in the 2nd half of the year
- The 2nd half of 2004 has also been marked by a significant increase in patients seeking assistance for cocaine and crack abuse.

# 2d: Social norms related to substance abuse at UPE

Ms D de la Harpe

Unit for Student Counselling  
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## SOCIAL NORMS

### *Norms*

- The term norm, as it is used here, is an umbrella term for all behaviour that is expected, accepted, or supported by the group, explicitly or in other more subtle ways.
- A norm therefore refers to a behavioural standard within a particular context.
- These social standards of behaviour may or may not be consistent with individual or cultural values.

### *Perceptions*

"We simply assume that the way we see things is the way they really are or the way they should be. And our attitudes and behaviours grow out of these assumptions." *Stephen Covey*

At an individual level our perceptions of what those norms are have a very real influence on our attitudes and behaviours.

### **What is social norms theory?**

Perceptions of what is 'normal' or 'typical' greatly influences people's behaviour. (Allen, 1998)  
Perceptions – Norms – behaviour

When people come together over time, they bring with them, or create, certain expectations regarding one another's behaviour (or social norms).

### **Origins of the Social Norms approach**

- Perkins and Berkowitz (1986)
  - survey on student drinking behaviour
    - students' tended to overestimate the extent to which their peers engaged in permissive drinking behaviours
    - this tendency predicted how much individuals drank
      - i.e. people's perception, whether accurate or distorted, will greatly influence behaviour

## **SOCIAL NORMS MARKETING**

Mass behaviour change strategy aimed at reducing high-risk behaviours within a community. The process used to disseminate accurate information about campus norms.

## Why do social norms marketing?

- Embraces a **positive approach**
  - A ‘wellness’ way of dealing with high-risk behaviours, vs. traditional use of scare tactics
  - “After years of wars on drugs, kids, teens, and S.T.D.’s, the time is right for messages that are affirming and positive” (Michael Haines, quoted by Frauenfelder, 2001).
- Have been **used to address a wide range of issues** e.g.
  - Drinking, driving under the influence, seatbelt use, smoking, rape proclivity in men, substance abuse, sexual assault, homophobia, eating disorders, etc.
- Many of these campaigns have gathered **data** to support the continued use of the social norms approach
- **Encouraging results** have been found to date (e.g., DeJong, 2002; Berkowitz, 2004)

## Background to Social Norms Marketing at UPE

- Emphasis on wellness
- The social norms approach has been implemented since 2000 (Van Lingen, Watson & De Jager, 2000)
- 7-step Montana Model
- Developed by the USA Department of Health and Human Development at Montana State University in order to extend the components of SNM to a broader range of issues than just high risk drinking behaviour (Linkenbach, 1999)

## The Montana model

The Montana model includes a seven-step process for applying the social norms concept to a variety of health issues ...

### *Our target population*

- Universal level of prevention - 2000 to 2004
- Targeted interventions - 2004
- Individual - Not attempted

## Step 3: Message Development

- Disparity between perceived norms and actual behaviours drives the SNM process
- Majority statements

Chi-square = to check for significant relationships/differences between subgroup means per item (gender, faculty, language, place of residence, institution i.e. UPE vs PE Technikon), and across years.

## DRINKING

**Table 2.53: Drinking**

<i>Teetotallers</i>	
2003	Almost half of UPE students <i>never drink</i>
2004	A third (32.35%) of students <i>never drink</i>
<i>Times per week</i>	
2003	81% of UPE students drink 2 or less times per week
2004	Over 70% of UPE students drink 2 or less times per week
<i>Drinks per session</i>	
2003	The majority (61%) of UPE students drink 2 or <i>less drinks</i> per session
2004	The majority (59.62%) of UPE students drink 2 or less drinks per session

Example:

<b>You estimated that:</b>	<b>Truth is...</b>
<ul style="list-style-type: none"> <li>▪ Less than 1% (0.85%) never drink</li> <li>▪ The majority / nearly half (47%) drink 1-2 times per week</li> <li>▪ Nearly a third (26%) drink 3-4 times per week</li> </ul>	<ul style="list-style-type: none"> <li>▪ The majority / nearly half (48.71%) never drink.</li> <li>▪ Only a third (31.62%) drink 1 to 2 times per week</li> <li>▪ Less than 3% (2.56) drink 3-4 times per week</li> </ul>
<b>Almost 20% (19.66%) drink more than 4 times per week</b>	<b>This response category was not marked even once by any of you</b>

## SMOKING

**Table 2.54: Smoking**

2003	Over 70% of UPE students do not smoke
2004	Almost 80% of UPE students do not smoke

### **You estimated that:**

- The majority of ... students are smokers,
- with very nearly half (49.57%) of ... students smoking 1-5 cigarettes per day,

- and just over a third (32.48%) smoking 6 to 10 cigarettes per day.

**Truth is:**

- Over 80% (83%) of students *do not smoke!!*
- **less than 3 % (2.57%) reported smoking 6-10 cigarettes per day**

**DRUGS**

**Table 2.55: Drugs**

2003	Almost 80% of UPE students don't do drugs
2004	80% of UPE students never do drugs

**WHAT HAVE WE LEARNED?**

- Students are more likely to drink, smoke, etc. more heavily if they think that other students drink etc. a lot, and that they approve of heavy drinking, smoking, and drug use.
- Students don't drink, or smoke, or do drugs as much as is thought.
- Most students who do drink or smoke are more responsible than we give them credit for.
- Students are making healthier choices than we realize, whether or not they choose to drink, or smoke, or do drugs.

**Levels of intervention**

- Universal
  - directed at all members of the student population
- Targeted
  - focus on members of a particular group, such as first-year students, athletes etc.
- Individual
  - Targeting high-risk individuals, such as drinkers and abusers, as part of individual counselling interventions.

(Berkowitz, 1997 & 2004).

## 2e: Psychiatric treatment in PE

Ms Nadine Harker

Comparative statistics on alcohol and drug related admissions for the Elizabeth Donkin Psychiatric facility.

**Table 2.56: Comparative Statistics: Psychiatric facility**

	Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%	n	%
<b><i>GENDER</i></b>												
Male	58	82	64	80	45	76	41	80	54	86	42	81
Female	13	18	16	20	14	24	10	20	9	14	10	19
<b>Total</b>	<b>71</b>	<b>100</b>	<b>80</b>	<b>100</b>	<b>59</b>	<b>100</b>	<b>51</b>	<b>100</b>	<b>63</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b><i>RACE</i></b>												
African	31	44	38	48	26	44	22	43	23	37	31	60
White	7	10	11	14	9	15	9	18	7	11	1-	21
Asian									-	-	-	-
Coloured	33	46	31	38	24	41	20	39	33	52	11	19
<b>Total</b>	<b>71</b>	<b>100</b>	<b>80</b>	<b>100</b>	<b>59</b>	<b>100</b>	<b>51</b>	<b>100</b>	<b>63</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b><i>MARITAL STATUS</i></b>												
Single	58	82	63	79	45	76	40	78	50	79	42	81
Married	8	11	13	16	8	14	5	10	8	13	5	10
Widowed	1	1	0	0	1	2	1	2	1	2	2	4
Divorced/Separated	4	6	4	5	5	8	5	10	4	6	3	6
<b>Total</b>	<b>71</b>	<b>100</b>	<b>80</b>	<b>100</b>	<b>59</b>	<b>100</b>	<b>51</b>	<b>100</b>	<b>63</b>	<b>100</b>	<b>52</b>	<b>100</b>
<b><i>EMPLOYMENT STATUS</i></b>												
Employed	11	15	11	14	9	15	9	18	6	10	13	25
Unemployed	54	76	62	78	48	81	40	78	52	83	39	75
Student	1	1	2	3	2	4	1	2	2	3	-	-
Pensioner	5	7	0	0	0	0	0	0	-	-	-	-
Casual Employment	0	0	3	4	0	0	1	2	3	5	-	-
Housewife	0	0	1	1	0	0	0	0	-	-	-	-
Other	0	0	1	1	0	0	0	0	-	-	-	-
<b>Total</b>	<b>71</b>	<b>100</b>	<b>80</b>	<b>100</b>	<b>59</b>	<b>100</b>	<b>51</b>	<b>100</b>	<b>63</b>	<b>100</b>	<b>52</b>	<b>100</b>

The unemployed, single African male now dominates the profile of the patient admitted to the Elizabeth Donkin Hospital.

**Table 2.57: Primary diagnoses: Elizabeth Donkin Hospital (PE)**

Primary diagnosis	Jan-Jun 2001		Jul-Dec 2001		Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Alcohol	12	27	17	24	28	35	22	37	15	31	14	22	10	19
Dagga	19	42	45	63	45	57	33	56	33	65	23	37	32	62
Dagga/ Mandrax	-	-	-	-	-	-	-	-	-	-	6	10	3	6
Poly Drugs	14	31	6	8	5	6	3	5	2	4	7	11	5	10
PRE/OTC	-	-	3	5	2	3	1	2	-	-	3	5	1	2
Unknown	-	-	-	-	-	-	-	-	-	-	10	16	1	-
<b>Total</b>	<b>45</b>	<b>100</b>	<b>71</b>	<b>100</b>	<b>80</b>	<b>100</b>	<b>59</b>	<b>100</b>	<b>51</b>	<b>100</b>	<b>63</b>	<b>100</b>	<b>52</b>	<b>100</b>

The primary drug of abuse of patients admitted to the Elizabeth Donkin Hospital is Dagga at 62%, followed by alcohol at 19%.

**Table 2.58: Psychiatric discharge diagnoses: Elizabeth Donkin Hospital (PE)**

	Jan-Jun 2002		Jul-Dec 2002		Jan-Jun 2003		Jul-Dec 2003		Jan-Jun 2004	
	n	%	n	%	n	%	n	%	n	%
Alcohol-related diagnosis only	19	4	12	3	11	2	10	2	6	2
Alcohol-related diagnosis + other diagnosis	14	3	9	2	5	1	4	1	4	1
Drug-related diagnosis only	33	8	26	6	18	4	36	8	20	5
Drug-related diagnosis + other diagnosis	14	3	10	2	17	4	13	3	22	6
Non-substance abuse related diagnosis	349	81	384	87	407	89	397	86	320	86
<b>TOTAL</b>	<b>429</b>	<b>100</b>	<b>441</b>	<b>100</b>	<b>458</b>	<b>100</b>	<b>460</b>	<b>100</b>	<b>372</b>	<b>100</b>
Alcohol as % of total	33	8	21	5	16	3	14	3	10	3
All substance related %	47	11	36	8	35	8	63	17	42	11

In this period 372 patients were admitted to EDH. Of the 372 patients, 26 patients had alcohol or drug abuse as their primary diagnosis. Secondary diagnosis of alcohol and drugs at 26 patients.

# 2f: Methamphetamine (“Tik”) use in Cape Town

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## **What is methamphetamine?**

It is a powerfully addictive stimulant that affects many areas of the central nervous system. It is a white, odourless, bitter-tasting crystalline powder that readily dissolves in water or alcohol. The drug can easily be made in clandestine laboratories from relatively inexpensive over-the-counter ingredients and can be purchased at a relatively low cost (about R60/‘straw’).

## **Modes of administration**

It can be smoked, snorted, orally ingested or injected intravenously. In South Africa it is typically smoked by placing the powder/crystal in a light bulb, from which the metal threading has been removed. A lighter is used to heat the bulb and the fumes are smoked.

## **Typical patterns of use**

- Methamphetamine use by addicts typically in range of 250-500 mg/day and can escalate to a several grams over a 3-4 day “run/binge”
- Effects can last 4 to 24 hours, depending on methods of use (rapid onset of effects)
- Typical “binge and crash” pattern of use

## **Consequences of methamphetamine use**

### ***Acute intoxication and/or overdose***

Methamphetamine triggers release of epinephrine, norepinephrine and dopamine in the sympathetic nervous system. Common effects of intoxication are euphoria, increased energy and self-confidence, insomnia, restlessness, irritability, heightened sense of sexuality, and tremors. Respiratory effects include increased respirations, pulmonary edema, pulmonary hypertension and decreased lung capacity. Cardiovascular effects include increased heart rate and blood pressure, tachycardia (abnormally rapid heart beat) and/or arrhythmias. Users run the risk of overdose characterised by dehydration, hyperthermia, convulsions, renal failure, stroke and myocardial infarction.

### ***Long-term/chronic use***

Prolonged use can result in severe weight loss/anorexia, severe dermatological problems, higher risk of seizures and uncontrollable rage/violent behaviour. Chronic mental health effects include confusion, impaired concentration and memory, hallucinations, insomnia, depressive reactions, psychotic reactions, paranoid reactions, and panic disorders. Long term use also increases the risk of contracting HIV and Hepatitis C due to injection drug use and sexual risk behaviour.

## **Increased risk of infectious disease**

- ◆ Methamphetamine users report that methamphetamine increases their sex drive, enhances their sexual performance & pleasure

- ◆ At risk for infection/transmission of infectious disease due to IDU and sexual risk behaviours
  - ◆ In USA, meth users are 2-5 times more likely to be HIV +ve than non-meth users
  - ◆ Some evidence that the HIV virus replicates and mutates faster in an environment where meth is present
  - ◆ A large proportion of meth users report failing to engage in protected sex, having a large number of sexual partners

#### Methamphetamine use and violence

- About 50% of MA users report engaging in violence
- A quarter to two-thirds attributed this violence to MA use

**Table 2.59: Treatment demand trends: Methamphetamine (%) as primary drug and secondary of abuse (Cape Town)**

	Jan-June 2002	Jul-Dec 2002	Jan-Jun 2003	Jul-Dec 2003	Jan-Jun 2004
	%	%	%	%	%
<b>Primary</b>	0.3	0.8	2.3	2.3	10.7
<b>Secondary</b>	0.4	1.2	2.6	5	8.3
<b>Overall</b>	0.7	2.1	4.8	7.3	19

**Table 2.60: Data on patients coming to treatment in Cape Town for problems related to methamphetamine use: January – June 2004**

	%
<b>Where treated</b>	
Private (non-profit)	76.8
Private (for profit)	20.8
State	2.5
<b>Type of treatment</b>	
Outpatients	61
Inpatients	39
<b>First time Admissions</b>	
Yes	84.5
No	15.5
<b>Gender</b>	
Male	73
Female	27
<b>Race</b>	
Coloured	81
White	15
Asian	3
Black	4
<b>Marital status</b>	
Never married	90

- ◆ Average age: 20 years (see age distribution)

**Table 2.61: Age distribution of patients with MA as primary substance of abuse versus non-MA patients: January – June 2004**

Age	Meth	Non-MA	Alcohol	Dagga	Mandrax	Cocaine	Heroin
	%	%	%	%	%	%	%
10-14	5.4	2.9	0.5	14	3.4	0	0
15-19	53.5	18.5	2.9	55.7	31.7	9.6	23.6
20-24	28.6	15.3	4.5	13.7	24.9	18.8	44.2
25-29	7.1	11.6	7.3	5.5	18.3	19.7	18.1
30-34	3.7	12.3	15.2	3.7	7.9	21.1	8.5
35-39	0.8	12.7	18.6	3.3	6.3	20.6	3
40-44	0.4	10.7	19.5	1.5	4.5	6.4	2.5
45-49	0	6.5	12.3	1.1	2.4	2.8	0
50-54	0.4	4.3	8.7	0.7	0.5	0	0
55-59	0	2.9	5.9	0	0	0.9	0
60-64	0	1.5	2.8	0.7	0	0	0
65-69	0	0.7	0.6	0	0	0	0
70-74	0	0	0.8	0	0	0	0
75+	0	0	0.5	0	0	0	0

**Table 2.62: Data on patients coming to treatment in Cape Town for problems related to methamphetamine use: January – June 2004**

	%
Grade 1-6	0.8
Grade 7	7.1
Grade 8-11	59.3
Grade 12	26.6
Tertiary	6.2
Student	40.8
Working – FT or PT	25.4
Not working	33.3
Other	0.4

**Table 2.63: Referral Sources and Sources of payment: January – June 2004**

	%
Self	10.8
Family/friends	57.1
Employer	4.6
Health Professional	8.8
Religious-body	1.7
Hospital/ Clinic	1.7
Medical Aid	0
Social services/ Welfare	7.9
Courts	0.8
School	6.3
State	0
Other	0.4

**Table 2.64: Data on patients coming to treatment in Cape Town for problems related to methamphetamine use: January – June 2004 – methamphetamine as 1<sup>st</sup> drug of abuse**

<b>Mode of use</b>	<b>%</b>
Swallow	2.5
Smoke	90
Snort	6.3
Smoke-snort	0.8
Inject	0.4
<b>Frequency</b>	<b>%</b>
Daily	40.9
2-6 days/week	34.7
Once a week or less	15.6
Not used in past month	8.9

**Table 2.65: Average number of years between first use and first time in treatment**

	<b>Years</b>
Methamphetamine	1.6
Heroin	3
Cocaine/crack	5
Dagga	4.8
Mandrax	7.6

**Table 2.66: Age of first use**

<b>Age</b>	<b>%</b>
<14	20.7
15-19	53.9
20-24	18.5
>25	6.9

**Table 2.67: Other drugs used by methamphetamine patients**

	<b>%</b>
Dagga	34.4
Ecstasy	27.8
Mandrax	19.9
Cocaine	14.5
Alcohol	12
Heroin	5.8

## **Rising to the challenge**

### **Treatment strategies**

- ▶ Ensure that there is adequate access to affordable and effective treatment.
- ▶ Establish methamphetamine treatment protocols in public hospitals and specialized care facilities.
- ▶ Equip primary health care providers/ER personnel to provide brief screening and interventions.
- ▶ Train health and social service providers, especially those in emergency room settings, to identify, assess and manage methamphetamine-induced psychosis, anxiety, withdrawal and overdose.
- ▶ Introduce science-based models of substance abuse treatment into community settings, especially cognitive-behavioural approaches which are particularly effective in treating methamphetamine abuse.
- ▶ Develop a systemic criminal justice approach with substance abusing offenders, using screening, assessment, monitoring and treatment.

### **Prevention strategies**

- ▶ Raise awareness and provide accurate information to the public and policy makers on methamphetamine.
- ▶ Introduce specific, science-based prevention programmes that target individual, family and community risk and protective factors for substance use.
- ▶ Actively promote the development of broad-based school-based drug policies.

### **Interdiction strategies**

- ▶ Introduce laws governing the sale of precursor chemicals (e.g. pseudoephedrine, ephedrine, anhydrous ammonia and red phosphorous) used in the manufacture of methamphetamine.
- ▶ Investigate companies that distribute chemicals or equipment used in clandestine methamphetamine laboratories and seek harsher penalties for such crimes.
- ▶ Expand community policing strategies to engage the public in methamphetamine issues.
- ▶ Continue to put pressure on drug-related organised crime (especially focusing on certain related crimes such as perlemoen smuggling as well as on high intensity drug dealing/trafficking areas).

