

# Indicators of substance abuse treatment demand in Cape Town, South Africa (1997-2001)

B Myers, M.Soc.Sci Medical Research Council  
CDH Parry, Ph.D., Medical Research Council  
A Plüddemann, M.A., Medical Research Council

## Abstract

Few studies have investigated the demand for substance abuse treatment in South Africa. This article uses data collected from specialist substance abuse treatment centres to describe substance abuse treatment demand and patterns of service utilisation in Cape Town for the period January 1997 to December 2001. Findings suggest that although treatment demand for alcohol-related problems remains high, treatment demand for substances other than alcohol has increased over time. Patterns of treatment service utilisation suggest that women and black South Africans remain underserved. The need for comprehensive and accessible substance abuse treatment services in Cape Town is highlighted and recommendations are made for improving access to treatment services, and undertaking comprehensive evaluations of existing treatment facilities.

## Opsomming

Min studies het al die aanvraag vir middelmisbruik behandeling in Suid-Afrika ondersoek. Hierdie studie gebruik data wat van spesialis middelmisbruik-behandelingsentrums gekollekteer is om die middelmisbruik behandeling aanvraag en patrone van diensgebruik in Kaapstad vir die periode Januarie 1997 tot Desember 2001 te ondersoek. Bevindings toon dat alhoewel aanvraag vir behandeling van alkohol-verwante probleme hoog bly, aanvraag vir behandeling van middels, behalwe alkohol, oor tyd toegeneem het. Patrone van diensgebruik van handelingsentrums dui daarop dat dienste vir vrouens en swart Suid-Afrikaners steeds onvoldoende is. Die nodigheid vir omvattende en toeganklike middelmisbruik handelingsdienste in Kaapstad word uitgelig en aanbevelings vir verbeterings ten opsigte van toegang tot handelingsdienste en onderneming van omvattende evaluasies van bestaande handelingsfasiliteite, word gemaak.

## Introduction

South Africa, like many developing countries, is experiencing high levels of alcohol-related problems (Parry, Bhana, Myers, Plüddemann, Flisher, Peden & Morojele, 2002a p.434). A pattern of drinking until intoxication has become common in the country, with the National Demographic and Health Survey of 1998 reporting that almost a third of male and a third of female drinkers consume alcohol at risky levels over weekends<sup>1</sup> (Parry, 2001 p.441). Although the use of alcohol has featured prominently in South Africa's socio-political history (see Parry & Bennetts, 1998 pp. 3-23 for a review), the country's physical and economic isolation, strict monitoring of external borders, and stringent internal controls during the apartheid era restricted access

to and availability of most kinds of illicit drugs. However, with the changes in global and local drug markets since the first democratic elections in 1994, South Africans now have access to a broad range of illicit drugs, including cocaine and heroin (Parry, Bhana, Plüddemann, Myers, Siegfried, Morojele, Flisher & Kozel, 2002b pp.974-975).

In South Africa, provincial and local governments control the allocation of resources for substance abuse services. Cape Town, a large port city, is one local area that has been identified as having high levels of substance abuse and substance-related problems (Parry et al., 2002a p.434; Parry et al., 2002b p.974). Cape Town is the capital city of the Western Cape Province and the legislative capital of South Africa. It has a population of approximately 2.7 million people, of which about 51% are Coloured<sup>2</sup>, 26% are Black,

<sup>1</sup> Risky drinking was defined as five or more drinks for males on one occasion, and three or more drinks for females

<sup>2</sup> The terms "White, Black, Asian/Indian, and Coloured" refer to demographic markers and do not signify inherent characteristics. These markers were chosen for their historical significance. The demographic characteristics of substance users are important as accurate user profiles assist in identifying vulnerable sections of the population and in planning effective prevention and intervention programmes.

22% are White, and 1% are Asian (Statistics South Africa, 1998 pp.3-4). For local governments to plan and deliver alcohol and other drug (AOD) treatment services that address current and projected treatment needs, target high-risk groups, and are ac-

cessible to all sectors of the population, accurate trend data on AOD treatment demand and patterns of treatment service utilisation are required. Despite this awareness, the planning of AOD treatment services in Cape Town, as in the rest of the country, has been hampered by a lack of accurate information on treatment needs and service utilisation.

The purpose of this article is to (i) provide descriptive, epidemiological information about trends in AOD treatment demand in Cape Town, for the period January 1997 to December 2001; (ii) describe patterns of specialist AOD treatment service utilisation in Cape Town for the same period; and (iii) to outline the implications of these findings for policies and practices relating to substance abuse intervention in the region.

## Method

Treatment data are collected bi-annually from 23 specialist substance abuse treatment centres in Cape Town. Together these facilities serve over 3000 clients per year. This represents at least 95% of the specialist treatment centres in Cape Town. Treatment centres include public and private institutions. In order to be admitted to a specialist AOD treatment centre, patients are required to meet the DSM-IV criteria for substance abuse or substance dependence. For the purpose of surveillance, a standardised one-page form is completed on each person treated by a given centre during a particular 6-month period. The form elicits forced-choice responses about the source of referral for treatment, biographical information, type of treatment received (inpatient and/or outpatient), the primary and secondary substances of abuse<sup>3</sup>, the mode(s) of use, and whether the person had received treatment prior to the current episode. Regular training in data collection procedures is given to treatment centre staff. To ensure data quality, completed

**Table 1. Proportion (%) of patients in treatment in Cape Town by primary substance of abuse (1997-2001)**

Period	Alcohol	Cannabis	Mandrax	Cocaine	Heroin	Ecstasy	N
1997a**	82	5	7	4	1	<1	2103
1997b***	78	6	9	4	1	1	2160
1998a	74	5	10	6	2	<1	2301
1998b	64	9	14	8	2	<1	1361
1999a	56	9	20	8	4	1	1527
1999b	50	15	12	9	3	<1	1550
2000a	48	12	23	8	4	2	1695
2000b	51	13	19	7	5	1	1696
2001a	46	12	20	9	7	2	1571
2001b	46	12	25	6	6	1	1561

\* White pipe

\*\* January to June 1997 \*\*\*July to December 1997

forms are checked for missing information and possible miscodes.

## Results

Since January 1997, a number of changes in substance abuse treatment demand have been observed in Cape Town. Although alcohol remains the most common primary substance of abuse, the proportion of patients citing alcohol as their primary substance of abuse, relative to other drugs, decreased significantly from 1997a (January to June 1997) to 2001b (July to December 2001), from 82% to 46% ( $Z = -35.52$ ;  $p < 0.001$ ;  $N = 17529$ ) (Table 1).

Cannabis or cannabis smoked with Mandrax (termed a "white pipe") is the most common primary drug of abuse in Cape Town. From January 1997 to December 2001, treatment demand for cannabis abuse increased from 5% to 12% of the total demand for AOD treatment ( $Z = 12.83$ ;  $p < 0.0001$ ;  $N = 17525$ ) (Table 1). For the same period, treatment demand for white-pipe abuse, as a proportion of the total demand for AOD treatment, increased significantly from 7% to 25% ( $Z = 14.78$ ;  $p < 0.0001$ ;  $N = 17525$ ) (Table 1). Treatment demand for cocaine-related problems, as a proportion of the total demand for substance abuse treatment, also increased significantly, from 4% to 6% ( $Z = 6.26$ ;  $p < 0.0001$ ;  $N = 17525$ ) from January 1997 to December 2001 (Table 1). In addition, the proportion of patients treated for heroin-related problems, relative to other substances, increased significantly, from 1% to 6% ( $Z = 14.15$ ;  $p < 0.0001$ ;  $N = 17525$ ). Similarly, treatment demand for Ecstasy-related problems increased significantly, albeit from a low base, from 0.5% to 1% of the total demand for AOD treatment ( $Z = 2.74$ ;  $p = 0.006$ ;  $N = 17529$ ) (Table 1).

Over time, a large proportion of patients in specialist AOD treatment facilities report abusing more than one substance. For example, 42% and 40% of the total proportion of pa-

<sup>3</sup> Responses to these two items are not forced-choice

**Table 2. Proportion (%) of patients in treatment in Cape Town by primary and secondary substance of abuse (1997-2001)**

Primary and secondary substance	2000a	2000b	2001a	2001b
Alcohol	64	66	62	62
Cannabis/Mandrax	36	28	30	35
Cannabis	28	23	23	24
Crack/ cocaine	17	15	20	15
Heroin	5	6	8	7
Ecstasy	5	7	9	9

tients in specialist centres in 2001a and 2001b respectively, reported poly-substance abuse, such as the abuse of alcohol and cocaine, or alcohol, cannabis and Mandrax. When the overall proportion of patients reporting a specific substance as a primary or secondary substance of abuse is considered, alcohol is the most common substance of abuse. The most common illicit drugs of abuse, in order of importance are white pipes, cannabis, cocaine, Ecstasy, and heroin (Table 2). Treatment centre data also reflects the high relapse rate among patients. Since the start of surveillance in 1997, between 30% and 33% of patients have reported receiving AOD treatment prior to the current treatment episode.

From January 1997 to December 2001, the proportion of

patients who were less than 20 years old increased significantly from 6% to 24% of the total proportion of patients receiving specialist substance abuse treatment services (Table 3). Of concern is the increase in treatment demand among adolescents in Cape Town for heroin-related problems, from 2% (1997a) to 8% (2001b) of the total adolescent substance abuse treatment demand. Since the start of surveillance in 1997, over 80% of patients receiving specialist substance abuse treatment services have been male (Table 3). Over time, the proportion of Black patients receiving treatment for substance abuse has ranged between 4% and 13% of the total proportion of patients receiving specialist substance abuse services (Table 3).

## Discussion

Although findings from specialist substance abuse treatment services suggest that treatment demand for alcohol as a primary substance of abuse has decreased over time, when the overall proportion of substance use (reported by patients in these facilities) is considered, alcohol accounts

for more than 60% of the treatment demand (Table 2). Trauma, mortality and psychiatric indicators cited in other studies also point to the high need for alcohol-related treatment services in the general population (Peden, Van der Spuy, Smith, & Bautz, 2000 p.254; Parry et al., 2002a p.434).

Findings from specialist substance abuse treatment facilities also point to the increase in treatment demand for substances other than alcohol. More specifically, since the start of surveillance in 1997, the proportion of patients reporting cannabis, white pipes, cocaine and heroin as their primary substances of abuse has increased significantly. Although these increases in demand for drug-related treatment may be due to factors other than an in-

**Table 3. Demographic profile of patients in substance abuse treatment programmes in Cape Town for 1997-2001 (% positive)**

	1997a	1997b	1998a	1998b	1999a	1999b	2000a	2000b	2001a	2001b
<b>Gender Male</b>	82	83	82	81	80	83	84	82	80	84
<b>Female</b>	18	17	18	19	20	17	17	18	20	16
<b>Race African</b>	11	13	12	7	5	4	7	12	8	11
<b>Coloured</b>	64	63	63	56	53	61	61	56	53	59
<b>Asian</b>	1	1	1	<1	1	2	1	1	1	3
<b>White</b>	24	23	25	37	41	34	31	32	38	27
<b>Age ≤20</b>	6	7	9	13	15	16	17	24	21	24
<b>20-24</b>	5	7	7	8	10	12	12	11	14	12
<b>25-29</b>	9	10	11	12	14	13	12	12	12	12
<b>30-34</b>	14	15	15	16	17	13	13	14	13	12
<b>35-39</b>	20	16	17	17	15	16	15	12	13	13
<b>≥ 40</b>	66	45	41	36	30	31	30	27	28	28
<b>N</b>	2105	2162	2301	1361	1527	1550	1695	1696	1571	1561

crease in the need for treatment (such as improved public awareness of the availability of substance abuse treatment services), indicators from other studies seem to confirm that the need for drug-related treatment is increasing in Cape Town, with this region having a high rate of psychiatric patients with drug-related disorders, a high rate of drug-positive trauma patients (Peden et al., 2000 p.254; Parry et al., 2002b p.973), a high proportion of drug-positive mortality cases (Lourens, 2001 pp.60-61) and a high proportion of arrestees who test positive for at least one drug (Parry et al., 2002b p.973). Despite this finding, many of the region's AOD treatment centres provide services primarily aimed at alcohol-related problems and the abuse of so called "softer" drugs, such as cannabis. The significant increase in demand for the treatment of cannabis, white pipe, cocaine, and heroin-related problems from 1997 to 2001 however, points to the (urgent) need for AOD treatment centres to expand their treatment programmes from a primary focus on alcohol to include services aimed at cocaine, heroin, and poly-substance abuse.

Although evidence points to the great need for substance abuse intervention services in Cape Town, the local Department of Social Services has significantly cut its funding to non-government organisations and state-subsided treatment facilities. In recent years, the Western Cape Department of Health has closed a number of specialist substance abuse treatment centers. At present only two state specialist substance abuse treatment facilities are available to the population of the Western Cape. The number of beds in general state hospitals for patients with substance abuse problems has also been decreased. Given the high levels of substance abuse in this province, and the limited number of state facilities, responsibility for the treatment of substance abusers rests heavily on non-government organizations and the private sector (Western Cape Department of Health, 2002 p.5). Yet, the lack of minimum standards of care guiding the provision of substance abuse treatment services and gaps in current policy and legislation have allowed the substance abuse treatment industry to remain unregulated. Importantly, few treatment facilities, whether licensed or unlicensed, have conducted systematic, comprehensive evaluations of their treatment services. As a result, claims about the effectiveness and efficacy of existing treatment facilities in Cape Town remain unsubstantiated.

To ensure that substance abuse services are accessible to clients from all sectors of the population, treatment services planning should be informed by patterns of AOD treatment service utilisation. Data from specialist treatment facilities show that since the start of surveillance, the race profile of patients has not reflected the demographics of the general population in Cape Town (Statistics South Africa, 1998 pp.3-4). In general, there has been an under-representation of Black and an over-representation of White South Africans. Instead of reflecting lower levels of substance abuse by Black South Africans, this pattern of treatment service utilization probably reflects the limited availability of treatment services in historically disadvantaged areas; the limited accessibility of treatment facilities for historically disadvantaged race groups due to difficulties in paying for transport to facilities located in urban centres

and the inability to pay for services; linguistic difficulties in participating in English- or Afrikaans-medium programmes, where few programmes employ African-language speaking counsellors or translators; and the questionable cultural appropriateness of programmes developed in Western settings for Black South Africans.

Over time, significantly more male than female patients have utilised substance abuse treatment facilities in the Western Cape. Given that equal proportions of male and female current drinkers reported drinking at risky levels in the South African demographic health survey of 1998 (Parry, 2001 p.441), the high prevalence of foetal alcohol syndrome in the Western Cape, and the high proportion of women who report drinking at risky levels during pregnancy (London, 2000 pp.202-203; May, Brooke, Gossage, Croxford, Adnams, Jones, Robinson & Viljoen, 2000 pp.1909-1910), it is likely that women's utilization of treatment services is reflective of gender differences in accessibility to treatment rather than gender differences in AOD abuse. Women's utilization of treatment services may be hampered by the greater stigma associated with AOD-help seeking behaviour among women (Mphi, 1994 p.945), the limited accessibility of services due to a lack of an independent income to pay for treatment, limited resources to arrange for independent childcare, and the lack of women-sensitive treatment programmes with services that focus on the special needs of women such as domestic violence and sexual assault (Booth & McLaughlin, 2000 p.1272).

The steady increase in the proportion of adolescents utilising AOD treatment services in Cape Town since 1997 points to the need for substance abuse treatment services in Cape Town to ensure that they are able to provide age-appropriate treatment services that cater for the special developmental needs of young substance abusers. These are important points to consider in the planning of treatment programmes as they can impact on the treatment outcomes of adolescents (Weinberg, Rahdert, Collier & Glantz, 1998 p. 258).

Based on the above findings, a number of health and other policy recommendations can be made to help improve substance abuse treatment service delivery and utilisation, and ultimately address the high level of treatment demand for AOD-related problems in Cape Town. Firstly, an increase in affordable, accessible and effective substance abuse treatment services in the Western Cape is needed. Secondly, policy and legislation to regulate treatment facilities and the training and qualification of treatment service providers needs to be developed as a matter of urgency. A comprehensive audit of available services, service delivery, and competencies of staff delivering these services would also help identify the gaps in current treatment services. It is also essential that existing treatment services are comprehensively evaluated so that the extent to which they effectively meet AOD treatment needs in the region can be established, to improve the outcomes of existing treatment facilities, and to develop models of best practice for AOD treatment in the South African context. Finally, access to treatment services by underserved groups such as women, Black patients and young people needs to be improved through targeted interventions that address the barriers that prevent clients from these groups from accessing treat-

ment.

## Conclusion

Over time, indicators of substance abuse treatment demand for Cape Town have pointed to the need for comprehensive and accessible substance abuse treatment services in the region. Findings from specialist treatment facilities reflect the need for treatment services to cater not only for alcohol-related problems, but also for problems related to the use of a broad range of substances. Analysis of patterns of treatment service utilisation point to the increased use of treatment services by adolescents, while women and black South Africans remain under-represented in treatment facilities. Future treatment service planning needs to develop age-, gender- and culturally-sensitive interventions that ensure that clients from these special population groups do not slip through the gaps of existing services.

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