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Addiction and treatment experiences among active methamphetamine users recruited from a township community in Cape Town, South Africa: A mixed-methods study

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ABSTRACT

Background: Since 2000, there has been a dramatic increase in methamphetamine use in South Africa, but little is known about the experiences of out-of-treatment users. This mixed-methods study describes the substance use histories, addiction symptoms, and treatment experiences of a community-recruited sample of methamphetamine users in Cape Town.
Methods: Using respondent driven sampling, 360 methamphetamine users (44% female) completed structured clinical interviews to assess substance abuse and treatment history and computerized surveys to assess drug-related risks. A sub-sample of 30 participants completed in-depth interviews to qualitatively explore experiences with methamphetamine use and drug treatment.
Results: Participants had used methamphetamine for an average of 7.06 years (*SD* = 3.64). They reported using methamphetamine on an average of 23.49 of the past 30 days (*SD* = 8.90); 60% used daily. The majority (90%) met ICD-10 criteria for dependence, and many reported severe social, financial, and legal consequences. While only 10% had ever received drug treatment, 90% reported that they wanted treatment. In the qualitative interviews, participants reported multiple barriers to treatment, including beliefs that treatment is ineffective and relapse is inevitable in their social context. They also identified important motivators, including desires to be drug free and improve family functioning.
Conclusion: This study yields valuable information to more effectively respond to emerging methamphetamine epidemics in South Africa and other low- and middle-income countries. Interventions to increase uptake of evidence-based services must actively seek out drug users and build motivation for treatment, and offer continuing care services to prevent relapse. Community education campaigns are also needed.

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1. Introduction

Methamphetamine is a highly addictive amphetamine-type stimulant (ATS) that produces increased energy, alertness, hypersexuality, and euphoria, among other physiological effects (Barr et al., 2006; Darke et al., 2008; Panenka et al., 2013). Globally, ATS is the second most widely used class of drugs, and they are generally more prevalent in high-income countries (United Nations Office on Drugs and Crime, 2014). The prevalence of ATS use remains relatively low in Africa, but notable increases have emerged in the southern and western parts of the continent (Mbwambo et al., 2012). Providing quality treatment for ATS addiction in low- and middle-income countries (LMICs) remains compromised by overstretched health care facilities and the dearth of accessible drug treatments (Coovadia et al., 2009; Mbwambo et al., 2012; Odejide, 2006).

Methamphetamine first emerged in South Africa in the late 1990s, fueled by socio-political changes following the end of apartheid (Peltzer et al., 2010; United Nations Office on Drugs

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and Crime, 2012). The prevalence of methamphetamine use has increased steadily since 2000, with its epicenter in Cape Town (Dada et al., 2014; Parry et al., 2008; Peltzer et al., 2010). Data from drug treatment facilities in the city indicate that the proportion of patients reporting methamphetamine as their primary drug increased from 0.3% in 2002 to 42.3% in 2006, the fastest increase in admissions for a single drug ever noted in South Africa (Pluddemann et al., 2008). In recent years, nearly half of admissions were related to methamphetamine (Dada et al., 2014). Community-based studies provide further evidence of a growing methamphetamine problem in peri-urban ("township") communities that are characterized by high population densities, elevated poverty rates, and limited infrastructure (Meade et al., 2012; Myers et al., 2013; Simbayi et al., 2006; Wechsberg et al., 2010). Methamphetamine use in South Africa is of particular concern because of its association with risky sexual behaviors (Meade et al., 2012; Simbayi et al., 2006; Wechsberg et al., 2010), fueling fears that methamphetamine may accelerate HIV transmission in communities already burdened by high HIV prevalence. With 6.4 million HIV-infected adults (18.8% of persons 15–49 years), South Africa has the largest number of cases of any country in the world (Shisana et al., 2014).

In South Africa, methamphetamine is generally smoked using a glass pipe, and is known as "tik" due to the sound produced when heated (Peltzer et al., 2010). Smoking, like injection, increases drug availability, onset of action, and peak effects, thus increasing risk of dependence (McKetin et al., 2006; Volkow et al., 2004). Studies on amphetamine dependence have originated primarily from North America, Europe, and Australia, with limited information from LMICs (Degenhardt and Hall, 2012). While there are a few studies from China, Thailand, and South Africa (Kelly et al., 2014; Sutcliffe et al., 2009; Watt et al., 2014), none of these examined the drug use histories, symptoms of addiction, and treatment experiences of methamphetamine users in the community. Examining how addiction and drug treatment are perceived by drug users can guide the development of interventions to improve the uptake of services in LMICs that are (or may become) affected by methamphetamine. Our mixed-methods study aimed to fill this gap in the literature by assessing the addiction and treatment experiences of a community-recruited sample of methamphetamine users from a South African township.

2. Methods

2.1. Setting

This study was conducted in Delft, a township located ~24 km from Cape Town's city center that was established in the early 1990s. The majority of Delft's 150,000 residents are Coloured (52%) and Black African (46%) (these terms originate from the Apartheid era and are still used as demographic markers referring to people of mixed versus African ancestry, respectively; City of Cape Town, 2013). The population is relatively uneducated (with only 27% of adults completing high school), largely unemployed (with a 40% unemployment rate), and poor (with 45% of households earning ≤ZAR 600 per month, well below the poverty line; Lehohla, 2012). Like in other similar townships, drug markets are entrenched in the community and controlled by gangs. Drugs, particularly marijuana, methaqualone (Mandrax), and methamphetamine, are sold through drug houses and shebeens (unlicensed drinking venues), as well as through street-based dealers who are gang-affiliated. For many unemployed men, selling drugs is their main source of income. The ready availability of drugs has contributed to a steady rise in drug-related crimes in Delft (Goga, 2014). Within the last few years, a government-funded outpatient drug treatment service became available in this township (Dada et al., 2014).

2.2. Participants and procedures

The sample included active methamphetamine users who met the following eligibility criteria: ≥18 years old, residence in Delft, self-reported smoking of methamphetamine (tik) in the past week, a urine drug screen positive for methamphetamine, no acute intoxication, and intact mental status. As described in detail elsewhere (Kimani et al., 2014), respondent driven sampling was used to recruit participants between May and October 2013. Briefly, eight initial participants ("seeds") were selected from the community based on prior contacts with our study team. After completing the study visit, each participant was given "coupons" to recruit up to two peers who use methamphetamine. Recruits came to the study site, presented their coupons, completed the study assessments if eligible, and then received recruitment coupons. The process continued until 362 participants were enrolled (7 pilot participants, 8 seeds, and 345 recruits). Two participants did not complete the clinical interview, leaving a final sample of 360.

After providing written informed consent, eligible participants completed an audio computer-assisted self-interview (ACASI) and a clinical interview administered by staff with extensive training and ongoing supervision. The visit took ~2 h and was completed in the language of participants' choosing (Afrikaans, Xhosa, or English).

A sub-set of 30 participants, purposely selected for race and gender balance to ensure representation of relevant demographic groups, returned on a separate day to complete individual in-depth interviews (IDIs). The IDIs were audio-recorded, and then transcribed and translated into English.

Participants were compensated with grocery store vouchers worth ZAR 70 (~US$7) each for the survey and IDI. Approval was obtained from the ethical review boards at Duke University Health System and Stellenbosch University.

2.3. Survey measures

2.3.1. Sample characteristics. In the ACASI, participants reported their age, gender, race, sexual orientation, marital status, and indicators of socioeconomic status (e.g., level of education, employment status, housing status, and resources in the home). They also reported if they had ever sold or distributed methamphetamine for money or injected drugs. Finally, participants reported the following sexual behaviors for the past 3 months: number of male and female partners, unprotected intercourse, sex trading (exchanging sex for money or drugs, and vice versa), and having sex while high on methamphetamine.

2.3.2. Addiction Severity Index-Lite (ASI-L). This widely used structured interview assesses substance use and associated impairments (McLellan et al., 1992). Participants reported the number of days in the past 30 days on which they used: ATS, alcohol to intoxication, marijuana, methaqualone, heroin, and other drugs. They also reported how many days they experienced problems related to substance use in the past 30 days, how many years they had regularly used these substances, the most typical route of administration, and whether they had ever been arrested and charged with a drug offense. The ASI-L yields composite scores for alcohol and drugs, ranging from 0 (no problems) to 1 (maximal problems), based on past 30-day frequency of use, associated problems, perceptions of problem severity, and treatment need (McGahan et al., 1986; McLellan et al., 1992).

2.3.3. Composite International Diagnostic Interview (CIDI 3.0). This structured interview, developed for administration by non-clinicians, assesses the prevalence of substance use and other mental disorders. Its reliability and validity have been demonstrated globally, including in South Africa (Seedat et al., 2009; Ustun et al., 1997; van Heerden et al., 2009; Wittchen, 1994). We classified past year ATS use disorders specific to tik, based on the International Classification of Diseases criteria (ICD, 10th revision; Kessler and Üstün, 2004; Robins et al., 1988), using eight items from the CIDI. Each ICD-10 criterion was assessed with one or more items that were coded as present or absent by the interviewer. For example, progressive neglect of alternative pleasures or interests was assessed with two questions, with the first assessing the amount of time spent using tik or recovering from its effects and the second assessing reduction in important activities due to tik use. The total number of criteria present was summed, with a cutoff of ≥3 indicating ICD-10 dependence.

2.3.4. Severity of Dependence Scale (SDS). This 5-item questionnaire assesses severity of dependence, with items specific to tik (Gossop et al., 1995). Total scores were computed, with a cutoff of >4 indicating problematic use (Gossop et al., 1995; Topp and Mattick, 1997a).

2.3.5. Treatment experiences and motivations. Participants reported if and when they had ever received professional treatment for tik. They were then asked: *Do you want to get treatment for your tik use?* Regardless of their response, participants were asked two open-ended follow-up questions: *What are the main reasons that you do want treatment for your tik use?* and *What are the main reasons for not seeking treatment for your tik use?* For these two questions, three authors analyzed responses to identify categorical codes and discussed to reach consensus. Two research assistants then independently coded responses.

2.4. In-depth interviews

For the subset of participants who completed IDIs, staff used a discussion guide to elicit personal narratives of methamphetamine use, including initiation (*Tell me about how you started using tik*), patterns of use (*How has your tik use changed since you started, up until now?*), impacts on various aspects of life (*Do you think your tik use is a problem? Why or why not?*), experiences with drug treatment (*I want to hear your thoughts about getting treatment for tik, or trying to stop tik use*), and motivations for drug cessation (*Do you have any desire to stop using tik now? Why?*). The guide

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