

DRUGS AND CRIME IN SOUTH AFRICA

A STUDY IN THREE CITIES

edited by Ted Leggett

ACKNOWLEDGEMENTS

AUTHORS

EXECUTIVE SUMMARY

LIST OF TABLES AND FIGURES

CHAPTER 1

Introduction

Ted Leggett

CHAPTER 2

Background and methodology of the 3-metrol arrestee study

*Andreas Plüddemann, Charles Parry, Antoinette Louw
and Patrick Burton*

CHAPTER 3

Perspectives on demand: results of the 3-metros arrestee study

*Andreas Plüddemann, Charles Parry, Antoinette Louw,
and Patrick Burton*

CHAPTER 4

Perspectives on supply: the drug trade in Johannesburg, Durban and Cape Town

Ted Leggett

CHAPTER 5

Implications for drugs policy

Ted Leggett, Antoinette Louw and Charles Parry

CHAPTER 6

Conclusion

Ted Leggett

NOTES

APPENDIX: DATA TABLES

ACKNOWLEDGEMENTS

The authors would like to acknowledge the support of the Innovation Fund of the Department of Arts, Culture, Science, and Technology, whose support made this research possible, and the other members of the consortium who participated in related research—the Human Sciences Research Council and the Centre for Scientific and Industrial Research. They would also like to thank, for their help, the Crime Information Analysis Centre of the South African Police Service in particular Dr Chris de Kock, Louis Watermeyer, Dalene Locke, and Herman van Rensburg—and the station commissioners and staff at the following police stations: Hillbrow, Mitchell's Plain, CR Swart, Pinetown, Phoenix, Jabulani, Bellville, Khayelitsha, Sea Point, and Kempton Park. The staff of DRA Development especially Patrick Burton, Aki Stavrou, and Kerry Vermaak—also deserve thanks for their help in managing the surveys and analysing the data.

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EXECUTIVE SUMMARY

This monograph is based on interviews and urinalysis of nearly 3 000 arrestees sampled in three phases over 14 months in Johannesburg, Cape Town, and Durban. It follows closely the methodology used by the Arrestee Drug Abuse Monitoring (ADAM) project in the United States and related projects worldwide. By comparing arrestee demographics, self-reported data, and the drug testing results, and drawing on qualitative work done in the past, the following findings were made and policy conclusions reached:

Finding	Policy implications

<p>About 46% of 2 859 arrestees given urine tests for drugs were found to be positive for one of six controlled substance types</p>	<p>The high association between using drugs and being arrested needs further research to determine the extent and nature of causation. Police members need to be trained in handling suspects under the influence of drugs.</p>
<p>Certain ethnic groups were found to be more likely to test positive for certain substances.</p>	<p>The drug markets of South Africa are ethnically segmented, and interventions need to be tailored to each user group.</p>
<p>Coloured (50%) and Indian (39%) arrestees were more likely to test positive for Mandrax, especially coloureds in Mitchell's Plain (56%)</p>	<p>Special interventions are needed to address Mandrax use in these communities and the associated gang culture.</p>
<p>Whites (32%), particularly white women (65%) were more likely to test positive for cocaine. Whites arrested in Hillbrow (63%) were especially affected.</p>	<p>Special interventions are needed to address cocaine use in this community, especially among sex workers.</p>
<p>Arrestees under the age of 20 were most likely to test positive for some substance (66%).</p>	<p>Special interventions are needed for youth, such as school based education programmes, especially in communities at risk.</p>
<p>Those testing positive for a substance (51%) were more likely than those who tested negative (29%) to have been arrested before.</p>	<p>Diversion to treatment needs to be explored as a crime prevention technique. Attention needs to be paid to the availability of drugs in correctional facilities, and rehabilitation services provided for prisoners.</p>
<p>Few arrestees tested positive for amphetamine type substances.</p>	<p>Users of club drugs do not presently represent a major criminal justice problem. Policy of escalating arrests in this area needs to be reviewed.</p>
<p>A small group of amphetamine positive Indian males in the Durban suburb of Phoenix was found.</p>	<p>Further research is needed in this area.</p>

LIST OF TABLES AND FIGURES

TABLE 1: Arrestee consent

TABLE 2: Crime categories

TABLE 3: Profile of those testing positive for any drug

Table 4: Ethnic drug market segmentation

FIGURE 1: Male and female sample by age

FIGURE 2: Male and female sample by ethnicity

FIGURE 3: Educational background, total sample

FIGURE 4: Employment profile, total sample

FIGURE 5: Nationality of the non-South African sample

FIGURE 6: Categories of arrests

FIGURE 7: Offence categories by sites

FIGURE 8: Offence by gender and age

FIGURE 9: Offence by gender and ethnicity

FIGURE 10: Offence by monthly income level

FIGURE 11: Reported use in the last 30 days

FIGURE 12: Weekday and weekend alcohol consumption of arrestees who reported drinking in the past 12 months

FIGURE 13: Percentage 'in need' or under the influence

FIGURE 14: Percentage of arrestees testing positive by site

FIGURE 15: Positive for any drug by offence type

CHAPTER 1

Introduction

Ted Leggett

Given the formidable array of obstacles facing the emerging South Africa, why should the country worry about drugs? In the progressive moral climate characterising the democratic era, one might infer the

right to consume mind-altering substances alongside the rights to abortion and consensual sodomy. The common premise is that people have sovereignty over their own bodies and the state should not second-guess the choices adults make concerning their own physical and spiritual health. Looking at the expensive and largely futile attempts of the developed world to stop drug use, pragmatism would seem to echo principle in advocating a 'hands off' approach to chemical experimentation.

Furthermore, compared to many legal substances, illegal drugs produce relatively few deaths. Mortality studies in South Africa find a far closer correlation between alcohol and unnatural death than any other substance,¹ and this is a country where less than half of the population drinks.² Deaths attributed to chronic use or acute overdose of illegal drugs pale next to the number of tobacco smokers who die from their habit annually.³ And while the death of a young person poisoned at a dance party attracts major headlines, it is not even a drop in the ocean of the thousands of equally preventable deaths due to HIV or the more than 20 000 murders the country suffers each year. Indeed, in a nation torn by crime and AIDS, the state might well deem other priorities more important than the recreational use of chemicals. But this would be very short sighted, because certain drugs have been found to be pivotal in promoting both crime and HIV in other countries around the world. Until now, little formal research has been done into the drugs-crime link in South Africa. This monograph is the first step in addressing this gap in the research.

Drugs and crime

There are at least three ways drugs can effect crime:

- People on drugs, just like people on alcohol, act out in ways they would not ordinarily behave. Some drugs distort perceptions, some impact mood, and most 'disinhibit' in some sense of the word. While much is made of those freak incidents in which murder is committed by people too deep in hallucinations to appreciate the nature of their acts, this is hardly the norm. Far more common is the violence that comes from that little push a chemical can give towards acting on impulses that would otherwise be ignored. Alcohol has been used for years to provide both the excuse and the recklessness to perform acts most people in their right minds wouldn't do, like robbing a liquor store. Drugs can be used in very much the same way, if one prefers to smoke, snort, or inject one's Dutch courage.
- Being illegal, the retail price of drugs far exceeds their production costs. Prohibition creates a very lucrative market for those willing to chance incarceration. This group generally includes those who are otherwise criminally inclined, including violent offenders. Even well established, mainstream markets have their frictions, and legal commerce relies heavily on the dispute resolution mechanisms of the state's courts. These, of course, are not available when peddling drugs, and violence is often required to sort out business disagreements.
- Some drugs are highly associated with drug dependency or addiction. This means that some users become quite convinced that they cannot live without them. Feeding this acquired imperative requires money, and being dependent on drugs can make finding the time to hold down a job quite difficult. The fact that they are illegal aggravates this dilemma, as it pushes up the price and ensures that drugs can only be purchased from criminals. The need for large amounts of instant cash without having to work a regular job tends to lead women into prostitution and fraud, while it tends to lead men into more direct forms of acquisitive crime. As the urgency of addiction increases, these crimes can often become violent.

From the above discussion, it should be clear that the fact that drugs are illegal is responsible for much of the illegality surrounding them. But even without this factor, drugs do disinhibit and they do form the

fixation point for costly and debilitating dependencies. Countries with liberal drug policies have found that providing support for addicts is an expensive process, both in terms of social services and in terms of lost productivity. Common sense would dictate that where a national drug habit can be curbed, it should be. An ounce of prevention is worth a pound of cure.

Alcohol and cigarettes have had many generations to achieve market penetration, and uprooting these dependencies is a slow and painful process of public education and increasingly unfriendly regulation. But is it possible to prevent the abuse of currently illegal substances in South Africa? To answer this question, we need to look at how far our national drug epidemic has advanced.

South Africa and drugs

The nature and extent of drug abuse in South Africa has been in a state of flux over the last several decades. The introduction of Mandrax (methaqualone) in the 1970s, and the creation of the 'white pipe' means of smoking the drug shortly thereafter, changed forever the way many South Africans chose to get high. But while members of all the country's ethnic groups became involved with the drug, it became especially entrenched in coloured and Indian communities.⁴ This 'ethnic segmentation' of the country's drug cultures was reinforced by apartheid segregation, and similar associations are found with other substances.

As it became clear that the years of repression were coming to an end, things began to change further. In the early 1990s, white youths introduced the international rave culture to the country, and with it, an increase in the use of the so-called 'club drugs', principally ecstasy and LSD. After 1994, the country experienced an influx of chemicals that international isolation during the apartheid years had kept out. Chief among these were cocaine and heroin, both of which have shown dramatic increases in popularity since the first democratic elections. Crack has thus far outpaced heroin in popularity, but both are expanding beyond the communities in which they found their initial consumer base.

Certain drugs seem not to have yet found their market niche in South Africa. Several forms of 'speed' are consumed by white ravers, but this is usually in combination with ecstasy. Direct amphetamine and methamphetamine use is not common, with certain forms of ingestion being virtually unknown. While the prescription painkiller Wellconal was popular some years ago, the black market for prescription drugs is not well developed, perhaps due to the fact that prescription access is relatively easy. The extent of this problem is difficult to track, since it often occurs within the boundaries of the law. Similarly, the lack of popularity of hashish may be due to very inexpensive and readily available cannabis. Injection as a method of ingestion is still uncommon and, where it does exist, highly regionalised. But even given these minor anomalies, South Africa can be said to have fully globalised in the range of drugs consumed, and there are few popular substances that cannot be bought in the urban centres of the country.

There is a paucity of data on the extent of drug use among the general population in South Africa. As will be discussed below, this makes the interpretation of the present study more difficult, because it is hard to gauge how the subject population (arrestees) differs from the citizenship at large. Presently, no regular series of national surveys aimed at assessing the situation is in place, and much of the survey data that does exist is either limited in its focus or very dated.

Probably the best source of trend information is the South African Community Epidemiology Network on Drug Use (SACENDU), a project coordinated by the Medical Research Council of South Africa. Since 1996, this project has drawn on figures and qualitative data provided by a range of actors, including treatment centres, the South African Police Service, specialist researchers, and hospitals and mortuaries. SACENDU has shown a steady growth in drug use of all kinds, and a sharp rise in indicators relating to cocaine, club drugs, and, in some areas, heroin.

The situation described above has drawn a rather uneven response from law enforcement, with no clear priorities being shown in arrest figures. For example, arrests for possession of cannabis showed a steady decline to less than a quarter of what they had been between 1990 and 1996, but then doubled between 1996 and 2000. Last year, police arrested 40% more people for possession and sales of ecstasy than they did for cocaine. The present study is designed in part to gauge whether such a strategy is likely to bear fruit in terms of crime reduction, and to guide future efforts at creating effective approaches to the drug issue.

This monograph describes the methodology ([Chapter 2](#)) and the findings ([Chapter 3](#)) of this study. This is followed by a discussion of the findings in light of what is presently known about drug markets ([Chapter 4](#)) and an exploration of the policy ramifications of this study ([Chapter 5](#)). After a concluding statement ([Chapter 6](#)) are attached data tables for each of the three metros ([Appendix](#)).

CHAPTER 2

Background and methodology of the 3-metrol arrestee study

*Andreas Plüddemann, Charles Parry, Antoinette Louw
and Patrick Burton*

Rising crime and drug use throughout South Africa over the past decades has led to an increased focus on the relationship between crime and the abuse of various substances. Such linkages have been explored in a number of countries through a range of studies. In 1987, the United States National Institute of Justice established a Drug Use Forecasting programme, which attempted not only to forecast trends in drug use, but to provide statistically accurate information that would inform policy impacting on both crime and the control of drugs and drug abuse prevention programmes. Due to the success of the programme, in 1997 it was expanded and redesigned with an increased focus on the methodology and statistical validity of the forecasts produced.

The programme was renamed the Arrestee Drug Abuse Monitoring Programme (ADAM). The revisions in the sampling procedure allowed for the ability to directly compare and contrast the various participating sites. In 1998, similar programmes were established in a variety of different countries. To date, England, Chile, Australia, and Scotland have all successfully established the programme, together forming the International ADAM, or I-ADAM programme.

In 1996, a small feasibility study was conducted in the Hillbrow police station in Johannesburg by the South African Police Service's Crime Information Analysis Centre (CIAC) and the Human Sciences Research Council (HSRC). Based on a sample of 90 arrestees interviewed at the police station, a 92% response rate was reported for the face-to-face interview, and a 83% compliance rate for the urine specimen request, both of which are well within an acceptable range for statistical analysis. Urine testing was, however, not actually undertaken in this feasibility study.

This study inspired the establishment of a South African Arrestee Drug Abuse Monitoring Project (SA-ADAM). The project was an initiative funded by the Department of Arts, Culture, Science, and Technology. A research consortium was formed, comprised of the Council for Scientific and Industrial Research (CSIR), Human Sciences Research Council (HSRC), Medical Research Council (MRC) and the Institute for Security Studies (ISS) and supported by the SAPS Crime Information Analysis Centre (CIAC). The SA-ADAM project consisted of three components:

- A national cross-sectional study at 146 police stations country wide, by the HSRC, to assess drug use amongst arrestees

- The 3-Metros Arrestee Study on drug use amongst arrestees, which focused on selected police stations in three metropolitan sites (Durban, Johannesburg and Cape Town), and was conducted in three phases over a fourteen-month period. This study was conducted by the MRC and ISS
- The drug recognition programme conducted by the CSIR, which looked at the identification of drug users through an examination by a trained 'interviewer' coupled with confirmatory drug testing.

The data derived from the SA-ADAM programme serves a number of purposes. It allows for statistically valid linkages between crime and drugs to be established, contributes to the depth of existing knowledge on drug usage and habits within the country, provides an effective policy tool, and allows for the design and implementation of more effective interventions. Further, it provides the basis for more informed handling of drug-affected arrestees on the part of the police.

Aims and methods

The aims of the 3-Metros Arrestee Study were to:

- Gain a greater understanding of the relationship between alcohol/drug use and crime
- Increase knowledge of the prevalence of HIV in a high-risk population
- Inform health policy and the provision of health service to prisoners
- Inform crime and drug prevention policy at a local, provincial and national level
- Assess the feasibility of implementing and sustaining an ADAM project in South Africa.

The 3-Metros study was undertaken over two years, with three data collection periods at six-month intervals, namely August/September 1999, February/March 2000 and August/September 2000. Four sites were selected in Cape Town (Bellville⁵, Khayelitsha, Mitchells Plain, Sea Point), three sites in Johannesburg (Hillbrow, Jabulani, Kempton Park), and two sites in Durban (CR Swart and Phoenix).⁶ Each site was selected based on arrestee flow data for the previous twelve months, which was collected prior to the study by the CIAC. A timeframe for fieldwork was established, and tended to depend on the individual station routines. A random sample was drawn from the cell register. Data on the arrestee flow during the study period at each station were collected by the field teams. These data were later used to weight the survey data to ensure a valid representation of the arrestees that were detained during the course of the fieldwork. The data were weighted by police station and major offence category (i.e., violent crime, property crime, drug/alcohol-related crime or 'other' crime). Weighted and unweighted percentages typically varied very little (<1%). A total of 2 859 respondents agreed to be interviewed. The sample size at each station is listed in the [Appendix](#).

Participation in the study was voluntary, and anonymity assured. A consent form was signed by each respondent. The option of providing a urine sample was presented to each respondent, which, assuming consent, was collected following the interview and sent to laboratories for testing. Two specimens were collected from each respondent giving consent: the first was tested for a range of drugs (Cannabis, Mandrax, Cocaine, Amphetamines, Benzodiazepines, and Opiates)⁷; the second was tested separately for HIV. Table 1 presents a summary of those arrestees who were approached and those who gave consent for the two urinalysis tests. Arrestees who were under the age of 18 as well as those who were deemed unfit due to extreme intoxication from the use of alcohol, drugs or medications and persons who were considered at the time of the interview to be so mentally ill or violent as to put the interviewers' safety at risk were excluded from the study.

Fieldworkers were trained in the administration of the questionnaire and urine sample collection.

Security for interviewers was provided by police officers that remained in the vicinity, but out of hearing, of the interview. A secure interview facility was arranged with the individual station commanders.

The 3-Metros Arrestee Study questionnaire was based on US/UK questionnaires and was modified for local conditions. There were 11 sections:

- administrative information (completed prior to interview)
- demographic information
- source of income
- arrest history
- current arrest information
- profile of substance use
- purchasing of drugs
- other drugs experienced
- information about new drugs on the streets
- firearms and perceptions of crime
- HIV/AIDS and sexual health.

A more detailed set of questions relating to the purchasing of drugs was administered to arrestees in the Durban sample during Phase 1 of the project. This section was however modified for Phase 2, with all three sites using the same questionnaire, as the extra questions asked of arrestees in Durban during Phase 1 did not prove to be particularly valuable. During Phase 3 the questionnaire did not change from Phase 2.

Following each phase of interviewing, feedback was provided to the individual police stations, as well as provincial police management, in the form of oral presentations and written reports.

Table 1: Arrestee consent

Phase	Johannesburg			Cape Town			Durban		
	1	2	3	1	2	3	1	2	3
Approached	*	377	364	361	357	339	274	360	355
Consented to questionnaire	365	365	360	339	350	339	266	350	351
Consented to provide urine sample for drug test	319	324	321	308	334	336	251	324	342
Consented to provide urine sample for HIV test	318	289	*	304	337	*	251	306	*
* Not available									

The following chapter lays out the basic data on the arrestee population studied, their self-reported drug use, and the results of the urinalyses. It also includes self-reported details of their drug use and alcohol consumption. Data from the three phases of the study were combined into one data set, as there were no major differences between phases. Figures given refer to this combined data set, but are weighted on the basis of police station and arrest category to reflect the actual flow of arrestees through the cells during the days data was collected at each police station.

Demographics

As reflected in Figures 1 and 2, the following demographic trends were noted:

- Men accounted for over four fifths (81%) of the sample.
- Almost half of those arrested fell between the ages of 18 and 25, with over a fifth being less than 20 years old.

- The ethnic composition of the sample reflected the population served by the various sites, as well as police operations that coincided with the study. For example, while over a tenth of the male sample was Indian, these respondents were found largely in the Durban region. The high numbers of foreigners and white female respondents are explained by the mass of illegal immigrants and commercial sex workers that were arrested during the time of the study, particularly at Hillbrow.

Figure 1: Male and female sample by age

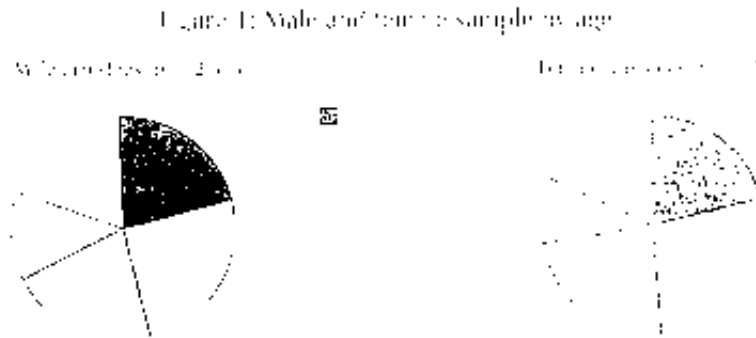
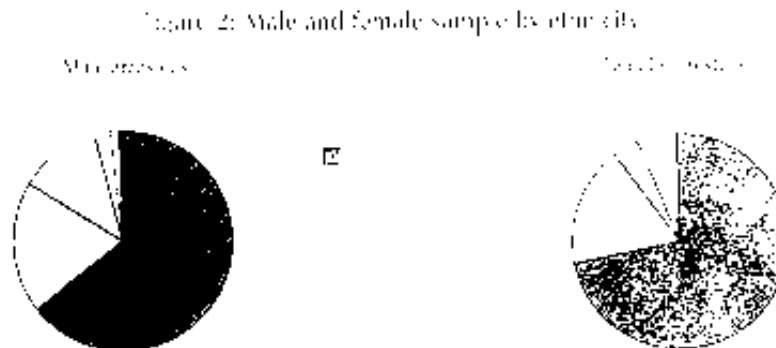


Figure 2: Male and female sample by ethnicity



As reflected in part in Figures 3 and 4, the respondents showed the following background particulars:

- The majority of respondents had completed at least some basic education. Only 16% of the total sample had a grade six level of education or less, with a third having completed between grade seven and grade nine, another third either grade ten or eleven, and a fifth of all respondents completing matric or grade twelve.
- Links between crime and unemployment are not shown in the employment profile of the sample. Over a quarter of respondents had full-time, formal, permanent employment. Another fifth considered themselves self-employed, and a further 20% were dependent on others for their income. This support generally included remittances or support from family or partners.
- Almost half of the sample (45%) lived in a formal brick and mortar house, while a further quarter (26%) lived in a flat or apartment. Slightly over a tenth (13%) lived in a shack or an informal structure.
- Over two thirds of the sample (67%) were single and had never been married, while less than one fifth (19%) were married. Only 4% were separated or divorced, while under a tenth (8%) were

unmarried but living with their partner.

Figure 3: Educational background, total sample

Figure 3: Educational background, total sample

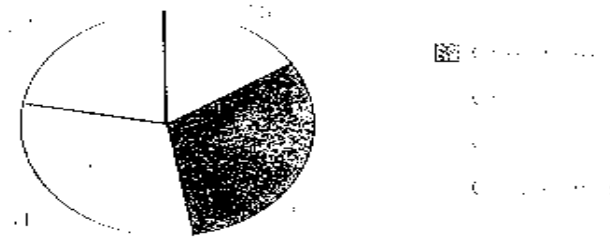


Figure 4: Employment profile, total sample

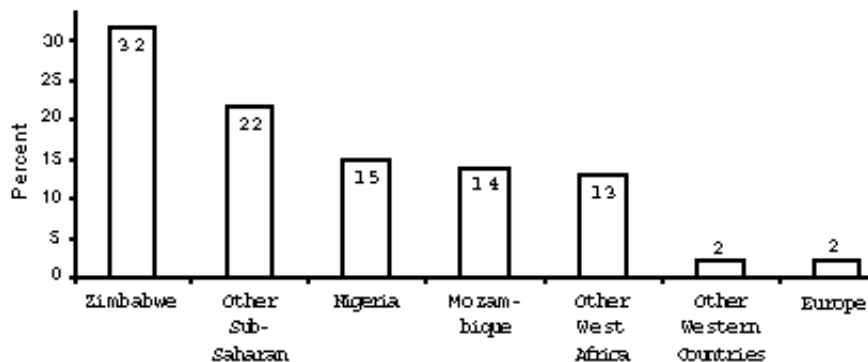
Figure 4: Employment profile, total sample



A total of 14% of the sample interviewed were not South African citizens and just over one tenth of the sample was arrested for being in South Africa illegally (Figure 5). This shows that most of the foreign nationals arrested were arrested for immigration matters only. Of these illegal immigrants, almost three-quarters (73%) were interviewed in Johannesburg, predominantly at the Hillbrow and Kempton Park police stations. There are two reasons for this:

- Since Kempton Park is the station closest to Johannesburg International Airport, any person trying to enter illegally by air is likely to be removed to that police station to await deportation.
- Johannesburg generally and Hillbrow in particular are home to many illegal immigrants.

Figure 5: Nationality of the non-South African sample



Crime profile of arrestees

The offences for which the subjects were arrested were broken down into the categories of violent crime, property crime, drug-related crime, and 'other' (Table 2). 'Other' crimes constituted the single largest arrest category, with 40% of the arrestees falling under this heading.

Table 2: Crime categories

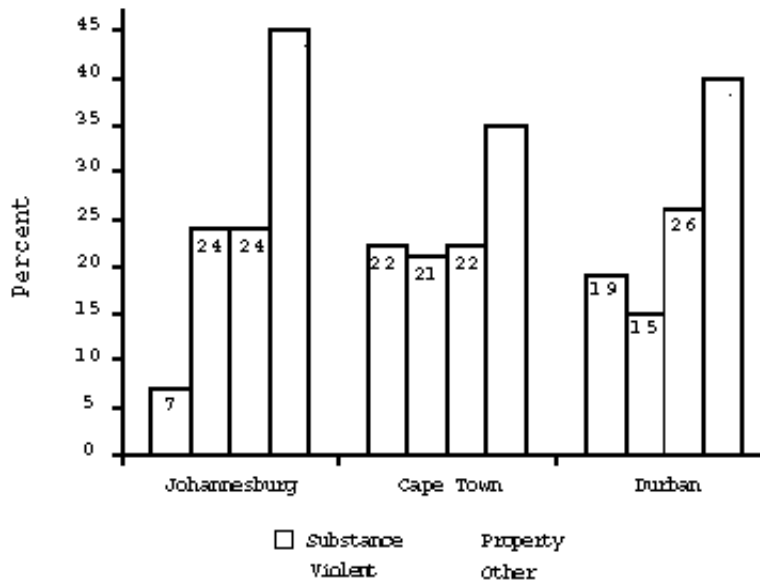
Violent offences	Murder (including attempted murder; assault (including grievous bodily harm, stabbing, indecent assault), weapons (including firing and pointing a firearm, theft of, possession of unlicensed firearm or ammunition), rape (including attempted), robbery (including attempted and armed), other violent crimes (including kidnapping, child abuse and bomb threat)
Property offences	Shoplifting, theft of motor vehicle, other thefts (including out of vehicles), housebreaking, other property offences (including trespassing, vandalism possession of stolen goods, forgery, arson)
Substance-related	Drug dealing or possession, alcohol offences
Other offences	Miscellaneous offences including illegal immigrants, deportation, fraud, possession of false documentation), illegal strikes, child care act, crimen injuria, warrant of arrest, other sexual offences, gambling, traffic violations, economic crimes, crimes against the government other family cases

Property crimes accounted for almost a quarter of those arrested, followed by violent crimes at 20%, with substance-related crimes accounting for only 16% of the crimes for which arrestees were held (Figures 6 and 7).

Figure 6: Categories of arrests



Figure 7: Offence categories by sites



So, who are these 'other' offenders? Illegal immigrants constituted the largest proportion of this category, accounting for almost a fifth (18%) of those interviewed in the first phase, declining to around a tenth in phases two and three (9% and 10% respectively). Aside from this group, the rest of the 'other' subjects were accused of a range of crimes, both serious and minor. Almost 5% of the respondents were arrested for fraud, and 3% for traffic offences.

This distribution does not necessarily reflect the real crime profile of each area—it is more likely to reflect the station-level priorities of the police, which can vary from week to week. For example, during one phase of the study, the Hillbrow police station in Johannesburg prioritised illegal immigrants and sex workers, which resulted in a particularly high number of both being detained over a particular weekend. Similarly, arrests for substance-related offences were lower in Johannesburg than in Durban and Cape Town, implying that police in Johannesburg are not prioritising these crimes to the same extent as the other metros (see Figure 7).

Those accused of committing violent crimes come from all generations—between one fifth and a quarter of those arrested within each age category were detained for violent crimes (Figure 8). Women arrested for violent crimes were generally accused of assault resulting in grievous bodily harm and common assault—very few were charged with murder. Those arrested for substance-related offences were older than might be expected: nearly a quarter were above the age of 36 within the male sample.

Figure 8a: Offence by gender and age (Male)

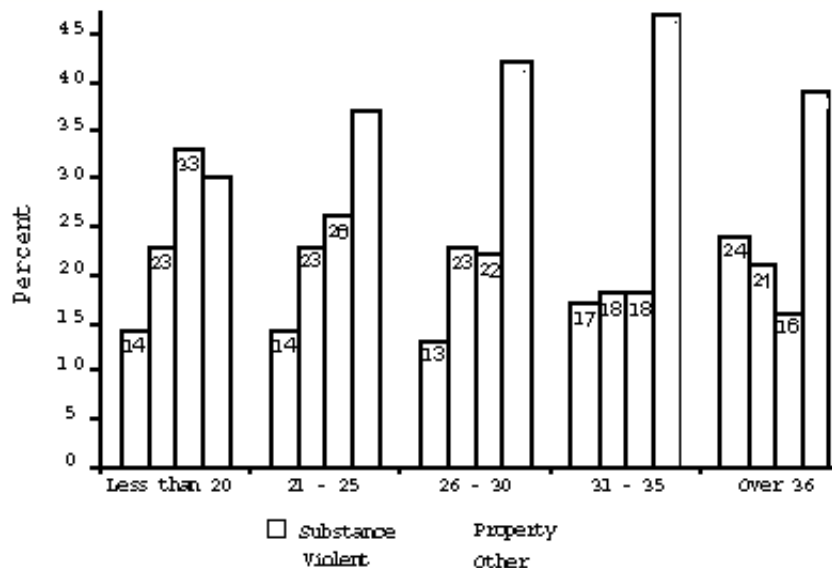
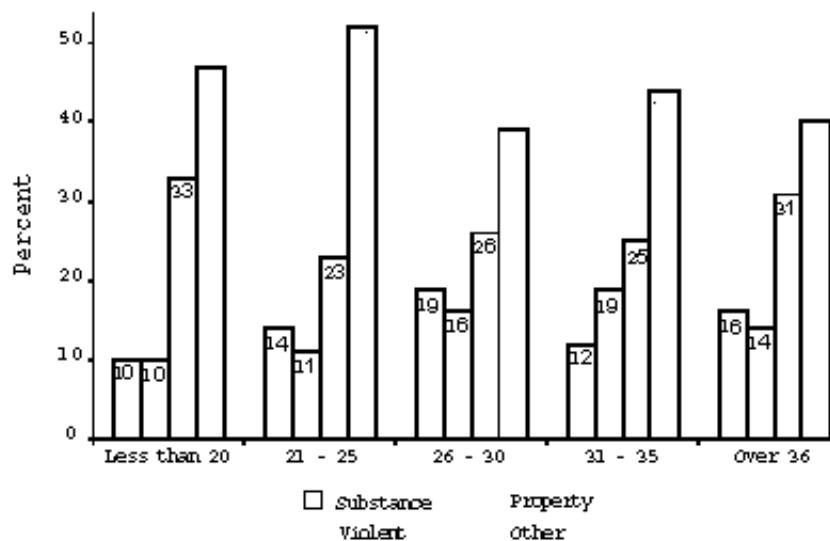


Figure 8b: Offence by gender and age (Female)



As detailed in Figure 9, white and Indian men were most likely to be arrested for substance-related crime, while African men were most likely to be arrested for violent and other crime (including illegal immigration). Women were generally more likely to be arrested in the 'other' category, which includes offences such as violations of the child care act and prostitution. Coloured females also show a high rate of substance-related arrests, which may be due to the fact that the majority were arrested in drug infested areas of the Cape.

Figure 9a: Offence by gender and ethnicity (Male)

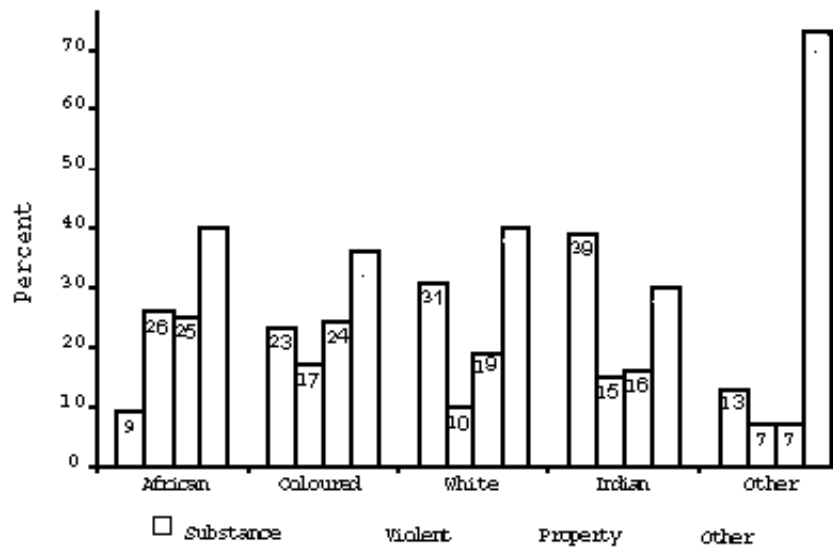
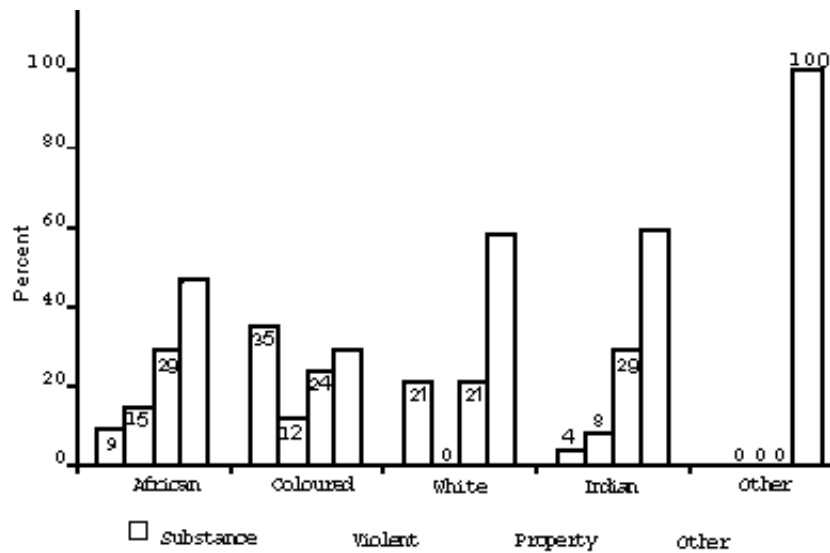
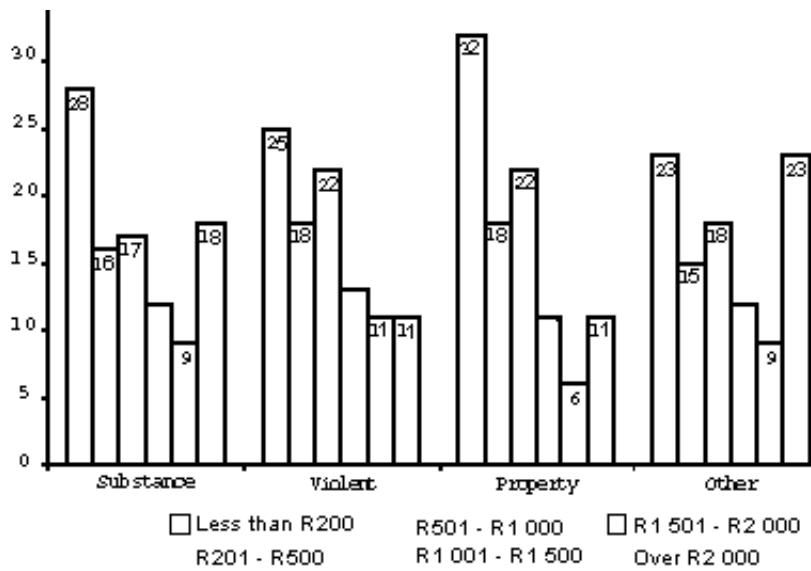


Figure 9b: Offence by gender and thnicity (Female)



Given the links between poverty and crime and the tendency to under-report monthly income in studies of this nature, it is not surprising that the majority of those interviewed claimed to fall into the lowest income bracket (Figure 10). Over a quarter of those arrested received a monthly income of less than R200, but 17% of the sample received over R2 000 monthly. While those arrested for property crimes were more likely to fall into the lowest income category, those arrested for substance-related offences followed the broader trend.

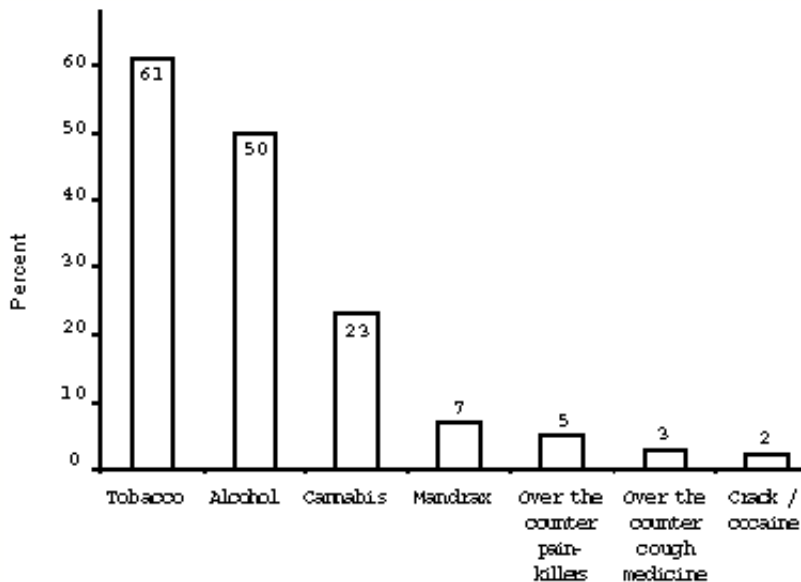
Figure 10: Offence by monthly income level



Self-reported substance use

Respondents were asked whether they had ever tried a range of drugs, and whether they had used these within the past 12 months, 30 days, seven days, and three days. While self-reported use of tobacco and alcohol was high, reported use of harder drugs in the preceding thirty days was comparatively low (Figure 11).

Figure 11: Reported use in the last 30 days



Dagga (cannabis) is the drug that arrestees were most likely to say that they had used: 839 respondents admitted to using it in the past twelve months, of whom 738 (88%) reported using it within the past 30 days. This probably indicates both the high levels of usage in the arrestee population as well as a willingness to admit to using a drug that has some degree of popular acceptance.

After cannabis, those interviewed were most likely to admit having, at least once, used over-the-counter drugs to achieve effects other than what they are medically prescribed for. Ten percent reported such use, while 8% claimed to have done so with prescription drugs. Assuming they understood the question, this high rate of reporting could reflect an under-explored pattern of drug use, or it could be due to the fact

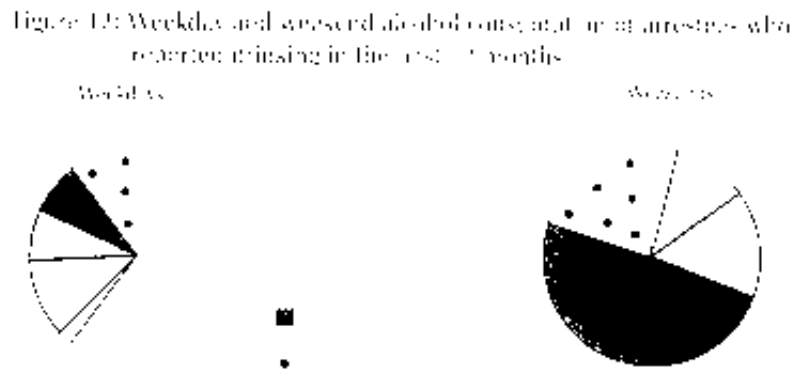
that this behaviour is not necessarily illegal.

Mandrax (9%) and crack (3%) were the drugs the arrestees were next most likely to admit having tried at least once, and in both instances were used by almost 80% of the users in the past month. The use of amphetamines, steroids, heroin, PCP, LSD, cocaine, relaxants and designer drugs were all reported, albeit by relatively few arrestees.

Those who admitted usage were questioned further about their behaviour, including the amount of money they spend monthly on drugs. Here cocaine users distinguished themselves, with over half admitting to spending more than 40% of their income getting high. This is especially impressive given that cocaine users were far more likely to fall into the higher income brackets. Mandrax, despite its lower cost, also took a good chunk of the income of its generally poorer user base—one third said they spent more than half of their income on this addictive substance. But one third of all self-confessed drug users were more casual in their consumption patterns, estimating that they spent less than 1% of their income on drugs.

Self-reporting showed many more arrestees willing to admit alcohol than drug use. Unfortunately, given unavoidable administrative delays, it was not possible to chemically test alcohol levels. In the third phase of the study, questions were added to assess weekly drinking patterns of arrestees who reported drinking in the past 12 months. Despite a large percentage being unemployed, alcohol consumption was largely limited to weekend binges, during which nearly half drank more than five drinks a day.

Figure 12: Weekday and weekend alcohol consumption of arrestees who reported drinking in the past 12 months



Use of drugs and alcohol when committing crime

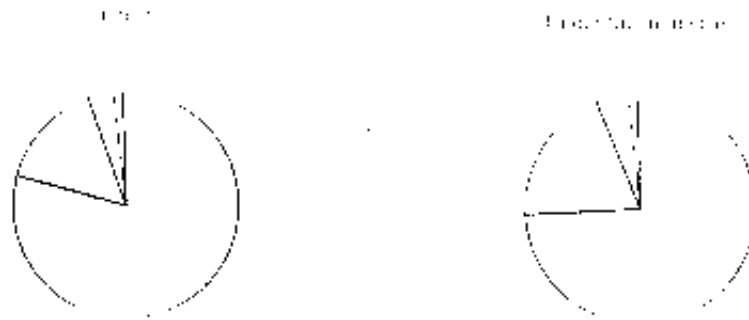
In order to probe the causal relationship between drug use and crime, arrestees were asked two sets of questions:

- Were you in need of drugs (or alcohol) at the time of the alleged offence?
- Were you under the influence of drugs (or alcohol) at the time of the alleged offence?

The former question was aimed at probing the relationship between substance dependency and crime, and the latter the relationship between disinhibition and crime. Less than 5% admitted to being either under the influence or in need of drugs at the time of the offence, and half of those who denied drug use at this stage later tested positive for drugs (Figure 13).

Figure 13: Percentage 'in need' or under the influence

Figure 14: Percentage in need of or under the influence



Still, nearly 20% said they were under the influence of alcohol at the time of the alleged offence, and 16% said they were in need of a drink. This result must also be treated with some caution, however, as arrestees may have felt compelled to explain away their anti-social behaviour with intoxication. This was illustrated in the drug urinalysis results that follow, where of the 98 respondents that self-reported the use of drugs to commit crime, only 74% tested positive. While some of these may have committed the crime for which they were arrested some time ago, most police arrests occur at the time of the offence.

Urinalysis

Almost half (46%) of those arrestees that consented to interviews tested positive for one or more of the six drug types for which tests were done. The most prevalent drug found was cannabis, with almost 40% of those consenting testing positive for this drug. This was followed by Mandrax (21%), cocaine (4%), opiates (2%), benzodiazepines (2%) and amphetamines (1%). Drug usage seems to be more prevalent among young people and men, with 65% of males below the age of 20 testing positive for drugs. Women using drugs tended to be older than male users (Table 3).

Table 3a: Percentage testing positive for any drug (age)

Drug	Gender	Age				
		< = 20	21 - 25	26 - 30	31 - 35	> = 36
Any drug	Male	65.4	55.8	39.2	42.4	45.3
	Female	33.3	22.0	36.4	21.2	24.4
Cannabis	Male	60.2	48.7	35.7	38.1	40.1
	Female	22.8	12.0	12.0	13.2	12.8
Mandrax	Male	33.7	27.7	16.0	16.5	19.7
	Female	14.9	10.7	10.4	13.2	6.3
Cocaine	Male	3.0	3.2	3.5	1.3	1.1
	Female	14.0	12.7	10.4	9.6	3.2
Opiates	Male	1.8	2.7	1.9	2.6	1.3
	Female	1.8	2.0	5.6	0.0	8.4
Amphetamines	Male	0.4	0.9	0.8	1.3	0.9
	Female	0.0	1.3	1.6	0.0	0.0
Benzodiazepine	Male	3.8	3.6	1.7	2.6	2.4
	Female	0.0	0.0	0.8	0.0	3.2

Table 3b: Percentage testing positive for any drug (race)

Drug	Gender	Age				
		African	Coloured	White	Indian	Other
Any drug	Male	44.3	66.5	43.3	57.5	15.4
	Female	16.2	50.9	72.2	40.0	10.0
Cannabis	Male	41.2	57.1	31.7	50.9	0.0

	Female	9.7	31.1	29.4	10.0	10.0
Mandrax	Male	10.9	54.1	9.8	38.6	0.0
	Female	3.1	33.0	10.0	30.0	10.0
Cocaine	Male	1.6	3.7	23.3	1.1	0.0
	Female	4.2	23.6	64.7	15.0	10.0
Opiates	Male	1.7	2.8	9.8	1.1	0.0
	Female	3.1	3.8	11.8	5.3	0.0
Amphetamines	Male	0.2	0.0	0.0	4.9	15.4
	Female	0.5	0.0	11.1	0.0	0.0
Benzodiazepine	Male	1.7	6.9	0.0	2.8	0.0
	Female	0.3	2.8	0.0	0.0	0.0

Perhaps due to site selection, coloured arrestees were more likely to test positive than other ethnic groups (64%), with Indians (56%), whites (50%), and Africans (39%) following. Mandrax was the most prevalent drug in the coloured sample (50%), while cocaine was found more among whites (32% tested positive for cocaine). Adding in gender, this difference becomes even more extreme: Mandrax was far more likely to be detected in coloured men (54%), while cocaine was found in more white women (65%).

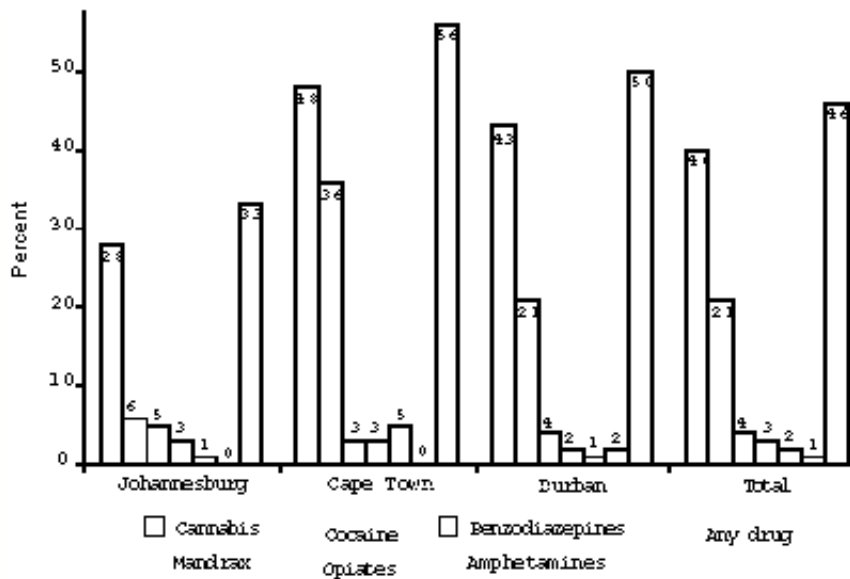
Drugs seem to be associated with repeat offending. Half of those that tested positive for drug use had been arrested previously, whereas just over a quarter of those who tested drug negative had been arrested previously. Over 60% of those testing positive for Mandrax reported prior arrests. These previous arrests had not necessarily led to prison sentences, however, and jailtime was served in only 40% of these cases. A tenth of those currently arrested for substance-related crimes had previously been arrested on the same charge.

The links between drugs, alcohol and crime

In an attempt to probe the relationship between offending and victimisation, respondents were asked whether they themselves had been victims of crime in the past five years. A quarter of the accused said they had, and 57% of those who had been victims of crime tested drug positive, compared to 46% in the overall sample. This suggests a slightly greater tendency of drug using criminal suspects to become victims. A high proportion of arrestees who had been victims of crime tested positive for Mandrax (31%, compared to a prevalence of 21% in the overall sample), which could be attributed to the fact that a disproportionate number of Mandrax users came from high crime areas such as Mitchell's Plain in Cape Town. It may also have to do with the fact that the initial stages of Mandrax intoxication leave the user highly vulnerable.

While much of the difference can be explained by site selection and local arrest priorities, stark differences can be seen in the number of arrestees testing positive between regions. While more than half of those tested for drugs in Cape Town were positive (56%), half in Durban were positive, and only a third of those tested in Johannesburg were positive.

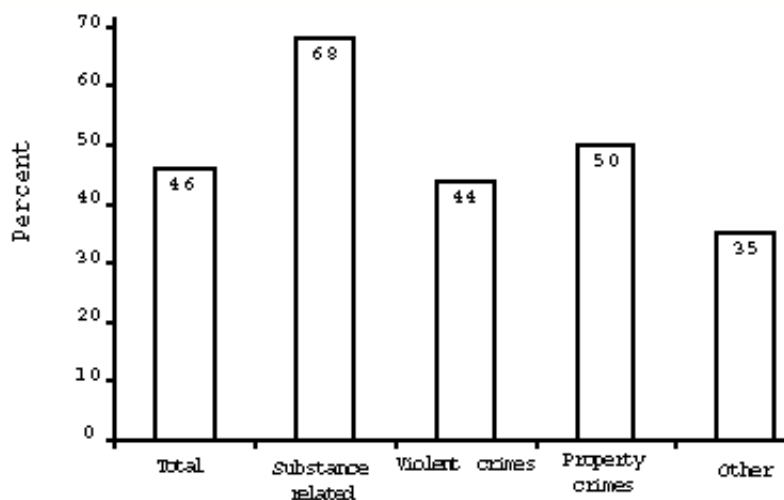
Figure 14: Percentage of arrestees testing positive by site



But Cape Town also had the highest number of drug related arrests, while the Johannesburg sample included a large number of illegal immigrants, very few of whom tested positive, and Africans, who were the local ethnic group least likely to show drug use. Cape Town showed higher levels of both cannabis and Mandrax consumption (likely due to the white pipe combination), while Johannesburg arrestees were slightly more likely to test positive for cocaine, due in part to the sex workers arrested there.

There are no baseline figures on drug consumption levels among the general population, but unless nearly half the public is continually high, offenders across crime categories are more likely than average to test positive. As might be expected, those accused of substance offences are the most likely to show drugs in their systems (68%), followed by those accused of property crimes (50%), violent crimes (44%) and other crimes (35%) (Figure 15).

Figure 15: Positive for any drug by offence type



Looking more carefully at specific crimes and substances, we find remarkably high levels of Mandrax among those accused of housebreaking (35%). Higher than average levels of cocaine were found among those accused of 'other' crimes (largely prostitution), and motor vehicle theft (7%). High levels of drugs generally were found among those who were accused of house breaking (66%), vehicular theft (59%) and 'other' thefts (56%).⁸ This evidence supports the idea that certain acquisitive crimes may be motivated by drugs.

Are drugs causing crime?

It is very difficult to demonstrate a causal link between drugs and crime with a study of this sort. Half of those who denied ever having used drugs nonetheless tested positive, indicating recent use. These statements were made despite assurance of confidentiality, and despite the fact that the suspects knew they would be submitting to urine testing later. This level of mendacity makes any information based on self-reporting highly suspect.

The issue is further complicated by the lack of information around substance use in the general public. To know for certain whether suspected offenders are more or less likely to use drugs than the general public, some sort of baseline figures would be required. Still, with nearly half the offenders showing the presence of illegal drug metabolites in their urine, it is not unreasonable to suspect that these levels are unusually high.

But the fact that those accused of crime are more likely to also use drugs does not mean that drug use promotes criminal activity. It may be that drugs are more readily available and accepted in the social circles in which criminals circulate. People at risk for arrest for other forms of criminal activity may feel less deterred by the fact that these substances are illegal, and may thus consume them as others would cigarettes or alcohol.

Clearly, more qualitative research is needed to understand the ways in which drug use and crime interact, but the data shows some interesting patterns from which law enforcement can learn, and these are detailed in the next chapter.

CHAPTER 4

Perspectives on supply: the drug trade in Johannesburg, Durban and Cape Town

Ted Leggett

The following chapter interprets the findings of the 3-Metros study in light of the qualitative research the author has done in the area of drug markets. Illicit drugs are market commodities, and drug dealing is similar in many ways to other forms of business. Prices go up and down based on the same laws of supply and demand in both contexts. Drugs may be 'branded' and graded just like other sorts of products. There is competition for drug customers, and both volume and customer-loyalty discounts are offered in some cases. Elaborate market chains develop to bring illicit drugs to the consumer, sometimes involving credit, commission sales, exclusive supply 'contracts' and other mainstream concepts.

But drug markets are unique in many ways. Being illegal, the state is not available to settle disputes, and violence is often the alternative mechanism by which conflicts are resolved. Quality control is reliant on market mechanisms, which, due to their underground nature, can be slow to act even when the product turns deadly. The fact that some users are addicted impacts upon their ability to negotiate terms, as well as upon what they are willing to do make sure they have the product.

Those with an interest in reducing the harm drugs cause would be well advised to understand the way drug markets work. State action can have unintended side effects as the market moves to compensate for any imposed change. For example, in some cases, traditional supply reduction can be effective in reducing harm if applied at the weak point in the market chain. In other cases, however, reducing supply can make the situation much worse:

- by forcing addicts into more serious forms of crime to afford the now 'scarce' (and thus more

expensive) product;

- by forcing suppliers to adulterate their product to maintain volume in sales;
- by increasing violence among suppliers competing for limited markets; and
- by diverting users into still more dangerous alternative drugs.

Before looking at the subject of drug markets in South Africa, it is important to keep in mind the limitations of the present study. Testing for drugs among arrestees does not provide information about drug users in South Africa as a whole, because many people who use and deal in drugs are not involved in other forms of crime. These people are unlikely to get arrested, especially if they have the resources to avoid sales and consumption in public places. Indeed, it is likely that many addicts in South Africa get their drugs entirely legally, by prescription. Therefore, while this study deals with a good cross section of those who have been arrested in the stations where the testing was conducted, it only involves a very specific segment of the drug-using public—those drug users who also engage in other forms of crime or who were foolish enough to get arrested for specific drug-related offences.

Just as the study cannot purport to discuss all drug users, it also cannot be said to canvass all drugs. It was not possible in this study to test for alcohol use, nor for the use of other common drugs, such as inhalants and steroids. Many prescription and designer drugs were also beyond the scope of the study.

Eleven percent of the total sample in this study was arrested primarily for drug-related crimes (excluding alcohol), but 46% of the arrestees tested positive for some substance. While there is no public baseline with which to compare this figure, it seems likely that there is a significant overlap between those who use drugs and those who commit crimes other than substance offences. Part of this may be explained by the fact that people who break the law are more likely to engage in a range of deviant and illegal behaviours, including drug use. They are also probably more likely than the average person to smoke, drive too fast, fail to wear their seatbelt, and engage in other sorts of risky behaviour. But there is also good reason to believe that a causal connection exists between some forms of crime and drug use.

Some drugs may be seen to lower inhibitions or otherwise contribute to the mental state in which crime is committed, but it is difficult to evaluate the importance of this effect in the present study. Only 6% of the arrestees said they were under the influence of drugs at the time the offence was committed, but over 20% said they were under the influence of alcohol. Self-reporting of drug use was found to be highly unreliable in this study, however, so it is not clear how accurate this information is. The need to 'justify' bad behaviour, even to a neutral interviewer, must be taken into account.

Rather than further exploring this psychological effect, this chapter focuses on the nature of drug markets in South Africa, and the ways in which crime and drug use are linked in these markets. There are at least two ways drug markets generate additional crime: addicts may commit crime in order to gain money to support their habits (3% admitted to being 'in need' of drugs at the time of the offence), and dealers may use violence in order to impose order on an otherwise unregulated market. Both forms of drug-related crime are in evidence in South Africa, but, as we will see, they vary in both type and intensity based on the drug being dealt, the point in the market chain concerned, and the area where the transaction takes place.

Drug markets generally

Due to the segregation imposed during the apartheid regime, drug markets in South Africa are highly segmented along ethnic, class, and regional lines. Certain drugs are used primarily by specific ethnic and

class groupings, and each segment of the market chain is likewise divided. While this is rapidly changing as people become more integrated, the ethnic generalisations captured in Table 4 still hold true in most areas. Drug use patterns also vary sharply by region, with the Western Cape in particular showing different market conditions. This means that South Africa has not one drug problem, but several distinct drug problems, each of which must be discussed and dealt with separately.

Table 4: Ethnic drug market segmentation

	Production/importation	Wholesale	Retail	Consumption
Dagga	Black	Black	All groups	All groups
Mandrax	Indian/Coloured	Indian/Coloured	Indian/Coloured	Indian/Coloured
Cocaine/Heroin	Nigerian/Other	Nigerian	Nigerian/Coloured/East African (heroin)	White sex workers/sex workers/White youth/Whites/Coloured
Club Drugs	White	White	White	White/Coloured/Indian

That this segmentation persists to this day, at least as far as consumption is concerned, is supported by the data in the present study. Thirty-nine percent of Indian arrestees and over half of all coloured arrestees tested positive for Mandrax, as compared to 9% of black and 13% of white arrestees. Thirty-two percent of whites, however, tested positive for cocaine, while only 7% of coloureds, and 2% of Indians and blacks tested positive. Thus, coloureds are five times more likely to test positive for Mandrax than blacks, and whites are sixteen times more likely to test positive for cocaine than Indians. In general, though, arrestees of all race groups use drugs, with coloureds being more likely than average to test positive (64%) and blacks being less likely (39%).

The testing data also shows how regionalised drug markets are. Thus, 31% of blacks in Kempton Park tested positive for dagga, compared to 53% in Phoenix, in the province where much of the drug is produced. Similarly, a third of the whites in Sea Point and central Durban, and 63% in Hillbrow, tested positive for cocaine, while, in many other areas, no arrestees tested positive for this substance. Fifty-six percent of coloureds arrested in Mitchell's Plain and 42% of those arrested in Sea Point were positive for Mandrax, while only one coloured person arrested in Hillbrow was positive.

But while race and class categories may provide convenient shorthand for South Africa's drug problems, a more accurate description is possible. South Africa has several distinct drug 'cultures', each of which has a market mechanism built around it. Individual markets for dagga, Mandrax, cocaine, and the other drugs will be discussed in turn.

Dagga entrepreneurs

Cannabis is a crop with a long history in South Africa. It is accepted by many as a plant with medicinal uses, and it is commonly grown with minimal effort in the rural areas of the Eastern Cape and KwaZulu-Natal. The extent of cannabis production in South Africa is almost impossible to estimate, but the quantity must be truly vast because no seizure or crop eradication programme has ever been able to budge the price. It has remained consistently cheap throughout the years, priced barely high enough to justify the efforts of cultivation, packaging, and sales. It is cheaper to get stoned on dagga in South Africa than it is to get drunk on beer. In addition, the South African taste for the drug is sophisticated enough to support massive importation of premium product from Swaziland and Malawi. Despite the high quality of local product, these imported varieties are preferred by many, in much the same way that some prefer imported cigarettes.

Dagga is consumed by people of all ethnic groups throughout the country, and 40% of those arrestees agreeing to be tested were positive for cannabis. The city showing the highest level was Durban, which is near some of the primary production areas, where 43% tested positive for the drug.

The producers are an army of small farmers, mostly poor and black, who supplement their subsistence agriculture with a patch of the easy to grow cash crop. These rural people are not part of some massive drug conspiracy—they are simply responding to market demand and are not generally organised beyond a local level. Collecting their product in 50 kg mealie bags or other large sacks and buckets several times a year, money can be earned for school fees, transportation costs, or other activities where cash is required. Despite the large amounts of product produced, few of these farmers get rich off the business, as the wholesalers who transport the product to urban areas pay them a tiny fraction of the street value.

The wholesalers are mostly black men with connections to both the rural and urban worlds, who gather the large bags in a wide range of transport vehicles, including minibus taxis. They break the bags into smaller, but still sizeable, units, generally called 'arms'. These are distributed to retailers at out of the way locations, typically men's hostels. The retailer, who could be anyone with the connection, then repackages the dagga into still smaller units, typically paper wraps, plastic bank change bags, paper envelopes, or matchboxes. These are then sold in a variety of settings, from houses designated for the purpose, to street corners, petrol stations, and night-clubs. The actual street vendor may be an employee of the retailer, working for packets of dagga that he can then re-sell.

In this market chain, the wholesaler makes the most money. Although his mark up is less than that of the retailer, the quantities in which he deals are much larger. Most poorly paid are the producer and the street dealer, who work for subsistence-level income. At no point in the domestic market chain is much money made, however, as the markets is too diffuse and the unit cost too small. The real money is in export.

South Africa is believed to be one of the largest producers of dagga in the world, and international demand is very high. Since cannabis varies so much in terms of quality and is usually sold by volume, not weight, it is difficult to make direct price comparisons. The various estimates that do exist, however, suggest a mark up of hundreds of times the farm price. The real expenses are incurred in covertly transporting what is a bulky and distinctive smelling plant product overseas and in the human resource costs of distribution.

South Africa has become the single largest supplier of cannabis to the United Kingdom. Twice as many UK seizures of dagga had a South African origin in 1999 than the previous British supply leader, Jamaica.⁹ This drug trade with the British is not one-sided—while we export dagga to the UK, we import club drugs from it. These club drugs, such as ecstasy, are priced very low by international standards in South Africa. Their prices, like those of many other under-priced drugs, do not seem to vary with exchange rate fluctuations. All this suggests that some sort of barter is going on, with international syndicates trading our dagga for other drugs overseas. If so, cannabis may be more than a harmless local herb—it may be the lynchpin on which the whole drug economy is based.

Aside from this possibility, though, very little additional crime is associated with domestic dagga markets. The supply and the demand are both immense, and the stakes are not high enough to merit much violence. Costs are low so even habitual users are not compelled to engage in crime to get their drugs, and it is generally agreed that cannabis is not physically addictive.

One twist on this story is that cannabis use is associated with violent behaviour in the minds of some local African people. In a way similar to alcohol, the disinhibitory effect of dagga is seen as promoting violent behaviour in otherwise peaceful individuals. This perception is contrary to the standard western view of cannabis, which sees it as a relaxant, but studies on the cross cultural effects of alcohol suggest that the social impact of drug use may be largely socially determined. In some countries alcohol use is culturally associated with violent or sexual behaviour, while in others it is not, and the extent of the

national alcohol problem is strongly influenced by these expectations.¹⁰ While alcohol surely has the same physiological effect in each context, cultural interpretations of this effect vary. Thus, whether being 'under the influence' provides an excuse for anti-social behaviour depends on the setting in which the alcohol is consumed and the cultural background of the user.

The cultural belief that cannabis leads to violence is not borne out in the present study, however. The offence profile of those who tested positive for cannabis is about the same as those who did not, except cannabis users were more likely to have been arrested for drug related offences. Cannabis users were not more likely to be arrested for violent crimes, but, like all drug users, were more likely to report a prior arrest history.

About 4% of dagga users admitted to selling the drug themselves at some point in the past. About 30% had purchased dagga themselves in the last 24 hours, and about 80% paid cash the last time they bought the drug. Most bought it from a regular source in their own neighbourhood either by visiting a known house or flat (50%) or on the street (34%).

White pipe and gangsterism

White pipe is a form of drug usage found only in South Africa. Mandrax (methaqualone and diaphenhydramine or diazepam) is crushed and smoked with a mixture of tobacco and 'magat' (low grade cannabis, often dried with a volatile solvent), usually in a broken bottleneck. Most dagga smokers who had tried a combination of drugs had tried white pipe, and many of those testing positive for dagga probably used it in smoking Mandrax. Mandrax usage is highly regionalised, with nearly half the arrestees in Mitchell's Plain, 35% in Phoenix, 30% in Bellville, and 29% in Sea Point testing positive, compared to 10% or less in all other areas. This broadly correlates with the ethnic profile of each of these areas—the Mitchell's Plain sample was 82% coloured, the Phoenix sample was 66% Indian, and the Bellville sample was 60% coloured. Sea Point was more mixed, but is a notorious drug area in a province known for Mandrax. Only 4% of Johannesburg arrestees tested positive for Mandrax, as compared to 36% of the Cape Town and 17% of the Durban samples.

White pipe is a South African innovation, and it is seated in the culture of certain South African populations, especially the coloured gangs of the Western Cape. Only one of those testing positive for Mandrax was not a South African citizen. The drug was previously pharmaceutically manufactured in South Africa, and production was later taken up by Project Coast as part of the apartheid government's chemical warfare programme.¹¹ The Indian population most likely became involved with the drug when India was the primary supplier of illicit Mandrax to South Africa. Today, Mandrax is still manufactured in India, but supplies also originate in the Middle-East, perhaps in China, and other parts of Southern Africa. Underground domestic manufacture makes up about half the supply, and while precursors are monitored, the drug is quite easy to synthesise once the components are available.

One unusual requirement of the market is that Mandrax can only be sold in tablet form, despite the fact that it is crushed back into a powder before consumption in any case. Making tablets out of powder is the most difficult and dangerous part of the manufacturing process, because it requires a pill press—an expensive one ton piece of machinery that requires a skilled operator to use. The sources of pill presses are closely monitored in South Africa, but the market demand for tablets is so strong that this risk cannot be avoided.

The tablets are branded as a way of telling one manufacturer's product from another, although the most popular brands have been re-used to the point that these markings have meaning only in a given locality at a given time. Some of the more common brands are marked with a swastika (the so-called 'German mark'), stars (including stars of David), 'golf-clubs' (sometimes resembling the Volkswagen logo), and

other symbols combining the letters 'M' and 'X'. Most are purple/blue/grey in colouring, but examples have been found in a range of colours.

Despite the fact that Mandrax is not difficult to manufacture, good sources are difficult to come by, and producers guard trade secrets jealously. Most of the big domestic manufacturing operations have been found in Johannesburg, despite the fact that the biggest consumer community is in the Western Cape. Major seizures have seriously limited supply and affected price at various times, and the production/importation segment of the chain is particularly vulnerable to law enforcement efforts.

Further down the chain, the target hardens. In some of the biggest consumer communities, Mandrax is controlled by gangs. Many of these gangs have existed as criminal organisations long before Mandrax appeared on the scene, with many street gangs tracing their pedigree back to the Second World War and some of the prison gangs claiming roots in the 19th Century.¹² Thus the drug, while presently an important source of income, is not at the root of gangsterism, nor is it the source of the crime and violence in which gangsters participate.

Indeed, criminality is not just instrumental in gang culture; it is an end in itself. Young gangsters generate their identity in opposition to the law, and assert their masculinity through violence. They are fuelled on, rather than deterred, by police action aimed at putting them behind bars. They consume and sell the drug as part of their larger counterculture, but that counterculture is not dependent on the drug.

That having been said, wars for territory and customers are a major source of violence, especially in the Cape Flats and in the coloured suburbs of Johannesburg, such as Eldorado Park and Westbury. Mandrax is a dependence producing substance, which also means users may feel compelled to engage in criminal behaviour in order to secure the drug. For example, Mandrax was the drug of choice among many sex workers prior to 1994, when crack cocaine began to supplant it.

Despite the strong empirical connections between Mandrax and other forms of crime, those who tested positive for Mandrax in this study were not arrested for a particularly distinctive set of crimes. Over one quarter of those testing positive for Mandrax were arrested for drug-related crimes. Otherwise, their offence profile does not differ from that of the other arrestees. More than half were under the age of 25. About 17% said they were under the influence of drugs or drugs and alcohol at the time the offence was committed. Only 7% admitted selling the drug at some point in the past. 32% admitted to procuring Mandrax in the last month, with 83% paying cash for the drug. Most bought it in a house or on the street, with just over half buying in their own neighbourhoods. Surprisingly, 65% of coloured arrestees in Mitchell's Plain bought outside their neighbourhood, despite the availability of the drug in this area. This may be due to the fact that many of the arrestees were gangsters, and that they bought drugs for personal use at a wholesaler outside, rather than paying local retail prices.

Crack and bad buildings

Prior to the democratic elections in 1994, cocaine and crack cocaine were not commonly available in South Africa. The first arrest for crack cocaine occurred in 1995, a full decade after crack's peak in the United States. This phenomenon is not due to international cocaine barons observing sanctions, nor is it due to impenetrable borders—both the state and the opposition smuggled on a large scale throughout the later apartheid era. Rather, it was due to a lack of a community of pushers resident in South Africa, people with the international connections to procure the drug and the experience to know how to best market it.

This market vacuum was filled when Nigerian nationals arrived in central Johannesburg just as democracy was dawning. They settled in the residential hotels of Hillbrow, where they found themselves

next door to sex workers, who were largely addicted to Mandrax at the time. This connection became the basis for a crack market that would grow exponentially in the coming years. Nigerian dealers have proliferated to every corner of the country. In this sample alone, Nigerians were arrested in Hillbrow, Mitchells Plain, Khayelitsha, and Sea Point.

Nigerian nationals had long been involved in the transnational trade in cocaine and heroin, and crack is a drug that almost appears to have been designed for sex work. Addicted sex workers would much rather smoke drugs with their clients than have sex with them, and so have a strong incentive to spread the drug. Soon crack could be found in every fair sized city in South Africa.

Nigerian dealers succeeded where others failed because they do not consume their own drugs, although they do enjoy local cannabis. None of the 57 Nigerians in this sample tested positive for cocaine, although 26% of those who consented to testing showed positive for cannabis. They treat crack as a business, and, unlike gangsters, do not have any special point to prove about their masculinity. They are generally not as violent as the local people and try to keep a fairly low profile while they reap their profits. Nigerian nationals are also involved in legal forms of trade, including retail and wholesale operations, as well as street trade. They are also involved in other forms of crime, such as fraud and dealing in stolen property. None of the Nigerians in this sample were arrested for violent crime, with theft, drug offences, fraud, and illegal alien status being the most common offences.

Nigerian syndicates are not organised along 'gang' lines or even in immutable syndicates. While individual loyalties exist between wholesalers and retailers, most Nigerian dealers operate as free agents, ultimately responsible only to themselves. They are, however, protected in a general way by the entire local Nigerian community. Their activities are organised and regulated in the residential hotels they occupy by democratically elected 'building committees', with a president, vice-president, secretary, treasurer, and a 'task force' to enforce the decisions of the body. The committee manages a 'legal fund' to provide bribes or legal fees for any participating Nigerian arrested. The decisions of the committee are binding only on Nigerians, but are enforced by fines and stronger measures. While this level of authority and organisation might be taken to imply a syndicate that could be dismantled by traditional law enforcement, the truth is that these structures are extremely malleable, and the removal of any particular individual or group will have little effect on the functioning of the institutions themselves.

On the demand side, crack is a drug of unlimited potential. Unlike other addictive drugs, like heroin and Mandrax, crack has no natural saturation point. A heroin addict is happy with a maintenance dose of his drug, and excess Mandrax use simply renders the user unconscious. Crack users have no ceiling on their use, and tend to consume the drug until there are no more resources left with which to purchase it. One respondent in the present study claimed to have spent R3 000 on crack in the last seven days.

As the Nigerians' best customers, sex workers represent the core of the demand and are also a pivotal part of the distribution process. While only one segment of sex workers is involved in promoting cocaine (urban, largely white, addicts), they provide a point of linkage between their patrons, who come from all backgrounds and neighbourhoods, and the dealers. A crack addicted sex worker has two choices when she manages to secure a client—she can have sex with him and use that money to buy her drug, or she can sell him crack as an 'aphrodisiac'. Since the client is already 'taking a walk on the wild side' by picking up a hooker, he may be persuaded to take his deviant behaviour a little further. The sex worker, as a preferred client, gets the biggest rocks from her dealer, and, after procuring the drug, may cut the client's rock in half with a razor blade and keep half for herself. The client, who is unconnected, still receives a rock as big as the one he would have acquired if he had bought on his own on the street, and the sex worker receives a little bonus.

In addition, it is good crack etiquette to supply your female companion with rocks. Often, the client will

forget all about sex and focus on the drug. If he remains interested in sex, he may not be able to perform, because crack use causes impotency in many men. If he does manage to perform, the sex worker is in trouble, because crack also retards orgasm, meaning sex on crack tends to be prolonged. It is a gamble many sex workers are willing to take. Once the client is hooked on the drug, he will probably seek out the sex worker in future to procure more drugs. She does the buying, supplies a safe place to smoke, and provides company for the new addict.

Sex workers rely on the residential hotel system because they find it very difficult to find more permanent accommodation. They work on a cash basis, where every pink R50 note equals a rock of crack or a night indoors. Many addicts price their services in terms of these commodities—R100 for vaginal sex, R50 for oral sex. It is a rare crack-addicted sex worker who can find the will to save up for deposit on a flat, and a rarer one still who can convince a landlord that they are a good risk. They need to be located in the inner city close to the areas clients know to frequent. And the residential hotels suit the Nigerians as well, as they are able to move frequently, remain anonymous, and house and evict their stable of sex workers at will. The high association between cocaine use and sex work is shown in this study by the fact that only one of the ten women arrested for 'other sexual offences' during Phase 2 of the project tested negative for cocaine.

For a person to test positive for cocaine after arrest indicates either coincidence or high rates of usage. Cocaine remains in the system in testable amounts for three days at most. Thus, most of the cocaine positive individuals are likely to be cases of chronic use. Half of those who admitted to using cocaine in the past 30 days said that they used it every day.

More whites tested positive for cocaine than any other group (32%), with coloureds coming second (7%). White females tested highest of all, with 65% testing positive. Based on the locations of their arrests, most of the women were probably sex workers, whether this was the crime for which they were detained or not. In areas populated mainly by coloureds, gangsters sell both Mandrax and crack, as well as controlling local prostitution. Hillbrow, CR Swart, Sea Point, and Mitchells Plain contained the vast majority of cocaine positive cases, all station areas associated with prostitution or gang activity.

Crack is often part of a pattern of poly-drug use, with 65% of those testing positive for cocaine also testing positive for cannabis, and 48% testing positive for Mandrax. Dagga and Mandrax, either separately or in combination, are often used by sex workers as a way of coming down off a crack binge. Dual use is also common among gangsters. All the Mitchells Plain cocaine users also tested positive for Mandrax.

Other drugs

Fairly low levels of other drugs were detected. Combining all three phases, 71 people tested positive for benzodiazepines (2.5%), 23 people tested positive for amphetamines (.8%), and 68 people tested positive for opiates (2.4%). This is not surprising. The only benzodiazepine that is commonly sold on the streets in South Africa is Rohypnol. It is primarily used by white youth, particularly those in the dance scene, but may be expanding outside this market. South Africa has also never had much of a speed problem, with the exception of the above mentioned ravers, who consume vast quantities of amphetamine-type substances. But these young people are generally fairly well off, and are not likely to be arrested for non-drug related offences.

Heroin is only now budding into a problem in South Africa, again among white youth and urban (mainly white) sex workers. Wellconal, a synthetic opiate that was used intravenously during the apartheid era, largely by whites and sex workers, is in decline. This is due to the fact that most long-term users are dead.

It is true, however, that a number of over the counter and prescription drugs will cause positive results in these drug categories using the EMIT enzyme immunoassay. Benzodiazepines are commonly prescribed throughout the world, including South Africa. A range of legal over the counter cold remedies, asthma medication, and diet pills will produce urine positive for amphetamine. Poppy seeds, codeine, many cough syrups, and most prescription pain medicine can lead to positive tests for opiates.

Thus, the positive tests in this area must be scrutinised carefully in light of what we know about current consumption patterns. Positives that show a random distribution are probably false positives. Where patterns are shown, however, new consumption patterns may be revealed. These areas call out for further research.

For example, over half of those testing positive for benzodiazepines were coloured, and about 6% of coloureds, or 37 people, tested positive for benzodiazepines. Over 90% of these cases were in Cape Town, and 92% also tested positive for Mandrax. Since Cape gangsters are not known for popping Valium, this anomaly requires some explanation. These positives are probably due to the presence of diazepam in Mandrax, which is occasionally used as an alternative to diaphenhydramine as a synergist with methaqualone. The remaining 12% may be due to differences in metabolism rates between methaqualone and diazepam. On a national level, 78% of the positive benzodiazepine cases were also positive for methaqualone. The remainder are either false positives, or either licit or illicit use of benzodiazepines. There are only 16 cases that fall in this category (representing about half a percent error) in any event.

The majority of the amphetamine users—14 out of 23—were Indian males from Phoenix. Recent research in Durban has indicated that there is indeed a growing use of club drugs among Indian youth in the area, largely due to one particular club frequented by all races near the Durban station. Club drug dealers line the approach to this popular dance spot, and Indian youth in particular are drawn to what had previously been a white cultural preserve—the rave scene. This is one unfortunate consequence of integration in the post-apartheid era.

But there is one serious problem with this explanation. The median age of these respondents was 32. While five were arrested for drug related offences, the rest were involved in a range of crimes, including several violent crimes. Half were married, and most were either unemployed or had very low incomes relative to their responsibilities. This is not the typical profile of a club drugs user.

It is entirely possible that amphetamine and methamphetamine have found their way into South African markets at last. Both drugs are easy to synthesise once the precursors are available, and it is the Indian community, via their connections to the subcontinent, that led the way in importing the leading South African synthetic—Mandrax. But while these men admitted to using a range of substances (ten out of 14 admitted Mandrax use and three had tried crack), all denied using amphetamines or designer drugs. Further research is clearly needed in this area.

The data around opiates are even more puzzling, if one assumes that the opiate positives were indeed heroin and not codeine or morphine. While the number testing positive for opiates as a percentage of the general population within that ethnic group show that whites (10%) are more likely to test positive than blacks (2%), it is remarkable that any blacks tested positive at all. Thirty-eight out of 68 testing positive for opiates were black (56%), but this is less than the blacks share of the overall arrestee population (65%). If an across the board false positive rate of 1% to 3% were, in fact, the case, then only the white positives require an explanation.

Of all the arrestees to test positive for opiates, only six admitted having tried heroin—all were white.

Indeed, only two opiate-positive whites denied use, and they may also have been false positives. All of those who admitted using heroin and tested positive for opiates fit the profile of a user. Three were white youth in their 20s from Pretoria who were arrested in Hillbrow, two males with full-time jobs and one female with a long history of multi-substance use. The others were older people with long drug histories who admitted to being under the influence and in need of drugs at the time of the offence.

Conclusion

The results of the urinalysis strongly support the qualitative data on drug markets gathered in previous studies. While the markets remain highly segmented, crossover effects—such as that possibly seen with Indian male amphetamine positives—may be starting to occur. This is bad news, because it creates new markets for drug merchants and increases competition between distribution chains, which can lead to violence.

A good example of a crossover is the sale of ecstasy by Nigerians. In Durban, for example, the central white 'bouncer mafia' dominated the ecstasy trade for many years. Traditionally, bouncers and other white security people control the club drugs trade because they control the clubs—they decide which drugs and which dealers to allow on the dance floor. Thirteen members of this syndicate (which included former policemen, prominent businessmen, and well-known athletes) were arrested in 1998. While this did not interrupt the flow of drugs, it did open a window for users to seek other sources. The Nigerians had been supplying ecstasy to their white female associates for some time, and were able to offer the drug in Durban at a substantial discount off the club price. Soon, clubbers had the cell phone number of Nigerian suppliers and procured their drugs before entering the club.

The white dealers in Durban soon found it more convenient to co-operate with the Nigerians and avoid the heat themselves. The unfortunate side effect of this is that the Nigerians also deal much harder drugs, like crack and heroin, and there has been a notable rise in the use of these drugs among white youth. The white dealers were part of the rave culture and found their social network in the clubs. This provided a sense of trust and accountability that is lacking with the business-minded Nigerians.

Thus, the drug markets are becoming more complex and soon will defy large-scale solutions. As problems become more localised, they will become increasingly difficult for centralised government to resolve.

In all cases, the correct form of state intervention depends on the nature of the drug market concerned. Many interventions make no sense because they are focused at the wrong point in the market chain. Hitting the market where it is strongest wastes resources and aggravates the problem. Instead, efforts should be aimed at the points where the market is vulnerable and where the real damage is being done.

For example, attacking the dagga supply is like spitting in the ocean. The amount of expense and effort that would be required to prevent cannabis from being grown in South Africa is prohibitive. Crop eradication and other source-oriented measures only serve to perpetuate poverty, robbing a household of a source of income while failing to make any significant impact on the problem. Rather, enforcement efforts should focus on preventing dagga from leaving the country. While exports may, at first glance, appear to be 'somebody else's problem', the funds raised by overseas sales are used to purchase hard drugs for import into the country. By targeting exporters, we will be hitting the real criminals—people making masses of money by poisoning this country.

The same reasoning holds for Mandrax. Getting tossed in jail is a rite of passage for button-dealing gangsters. Jailing those who retail the product only provides temporary incapacitation of that particular dealer (and there are thousands like him out there), while not providing any significant deterrent. But

Mandrax is a drug where supply is vulnerable, where the price of the drug has varied in the past after a major seizure. Thus, Mandrax should be attacked at the top, among the producers and importers, and precursor monitoring is especially important for this drug.

In contrast, trying to take out the 'top man' in a Nigerian syndicate is an exercise in futility. A Nigerian 'syndicate' is, in fact, an organic network where new vacuums are easily filled. The fact that Nigerian nationals and residential hotels are still at the core of the crack epidemic does allow several options, however. The Nigerian dealers are easy to identify, and most are here illegally. The hotels, which provide the essential link between the dealers and the sex workers, are mostly in rates arrears and in stark violation of health and building codes. These buildings could be closed administratively or seized under the Prevention of Organised Crime Act. Once acquired, these buildings could be converted into social housing by selling the units to local people in exchange for their housing grants. Funds raised in this way can be used to improve and keep up the buildings, and the new residents will fight to keep their property crime free.

Another way of removing the power of the drug lords is to decriminalise sex work. Due to the illegal nature of their work, prostitutes are defined as criminals from the outset, and have little incentive to acknowledge drug laws. Driven underground, they are difficult to access for needed social services. Investors are hesitant to put money into this industry, keeping the indoor industry small and forcing more women to work outdoors. Outdoor sex workers are far more likely to be involved in drugs, and are exposed to much harsher conditions, than indoor sex workers. By taking sex work off the street and out of the residential hotels, serious damage could be done to a key mechanism for the distribution of crack cocaine in this country.

While many questions remain, this study reinforces qualitative work that argues for a more nuanced approach to the drug problem. South Africa is still very early in its struggle against the primary chemicals that have confounded the best in Western law enforcement. Targeted intervention at this stage could save the country a fortune in future law enforcement costs, health and social services expenses, and lost lives.

CHAPTER 5

Implications for drugs policy

Ted Leggett, Antoinette Louw and Charles Parry

The greatest danger with a study of this sort is to exaggerate the significance of the findings. The fact that 46% of all arrestees in the study tested positive for some drug might lead some to conclude that drugs are a major driver of crime in this country. While this may be true, this conclusion cannot be made on the basis of this research alone.

While some drugs are only detectable with the EMIT test within a short period after use, some linger in the system for some time. Chronic users of cannabis can excrete detectable metabolites a month or more after last use. Even methaqualone is detectable up to two weeks after being consumed. Thus, for most drugs, it is impossible to say that users were under the influence at the time of the arrest (which is generally close to the time of the offence). One notable exception to this rule is cocaine, which is often undetectable 48 hours after use. The fact that 65% of white women tested positive for this drug suggests a significant portion of this group were high at the time of committing the crime, and the implications of this fact are discussed in more detail below.

What this study does show is that drug use is common among people arrested for committing a wide range of crimes. While it cannot be concluded that drugs caused the criminal activity, it can be said with

some certainty that nearly half the people arrested for crime in the areas studied paid a visit to their local dealer some time in the last month. While we cannot say that most drug users are criminals, we can say that many criminals use drugs. This convergence suggests that the drug markets are central to the lives of many involved in the criminal underworld, and that dealing with the drug markets is likely to have a strong effect on those who engage in all sorts of criminal activity.

While many of those testing positive might not fit the profile of the typical addiction driven criminal, much drug-related criminal activity is likely to evade a study of this sort if the criminals were not themselves users of the drug. The prime example of this would be Nigerian cocaine dealers, who, while not themselves users of the drug, might be compelled to commit (or, more likely, contract out) violent attacks in order to protect their markets and resolve business disputes. The short metabolic life of cocaine and the fact that crack use occurs in binges also suggests that the impact of this drug in particular could easily be underestimated.

A significant finding of this study is the high association of drugs with ethnicity, gender, and geography. Just like the white female cocaine users, the coloured male white pipe smokers of the Western Cape form a distinct group of people involved in crime.

This fact highlights the need for interventions that target the specific needs and concerns of these drug-using groups. These interventions would necessarily be locally based, and the need for local action is an important tenet of South Africa's core document of substance policy, the National Drug Master Plan (NDMP).

The National Drug Master Plan (NDMP)

The NDMP was approved by the South African Cabinet in 1999. It has the following vision: 'to build a drug free society together and to make a contribution to the global problem of substance abuse'. Various priorities identified in the Plan include: crime, youth, community health and welfare, research and information dissemination, international involvement, and communication.

The NDMP is not the first document issued by the state on the subject—it is the culmination of a series of national efforts to come to grips with the drug problem:

- In 1980, the 'National Plan to Prevent and Combat Alcohol Abuse and Alcoholism' was launched. The main problem with this initiative was that it had a relatively narrow focus. It did not include drugs and it did not provide a feasible implementation plan.
- This was followed in 1988 by the 'National Plan to Prevent and Combat Alcohol Abuse and Drug Abuse in South Africa', which was formulated by the National Advisory Board on Rehabilitation Matters (NABOR) in collaboration with experts in the private and public sectors. This was an improved version of the 1980 Plan, and in November 1992 the Minister of National Health and Population Development convened a colloquium to facilitate implementation of a revised 1988 Plan. While this colloquium included role players from health, welfare, justice and the business community, it did not involve community-based groupings or major political parties, such as the African National Congress (ANC), and few resources were allocated to support the implementation of this strategy.
- In terms of the Prevention and Treatment of Drug Dependency Act of 1992, the Drug Advisory Board (DAB) was established in November 1993 to replace NABOR. It was also intended to advise the Minister of Welfare on matters pertaining to alcohol and drug abuse, and specifically to plan, co-ordinate and promote measures relating to the prevention and combating of drug abuse

and the treatment of drug dependent persons. The first DAB revised and accepted the National Strategy; convened two conferences (one on preventing substance abuse among youth and another on Mandrax); compiled a manual of treatment and prevention programmes; and undertook a review of international legislation in areas such as money laundering and confiscation of assets of drug dealers. While the first DAB achieved a fair amount given its meagre resources and advisory status, the failure to successfully implement a coherent strategy at national and other levels has resulted in fragmentation of effort and a failure to secure sufficient resources to combat substance abuse.

- A new DAB was formed in 1995. During the three-year term of this board (November 1996 to November 1999) a number of activities were undertaken, including the development and launching of the 'SA Guide to Drugs and Drug Abuse', the formulation of the NDMP, and the motivation for a pilot juvenile treatment programme for first time offenders.
- The motivation for the NDMP came largely as a result of internal pressure to develop an implementable strategy. An external pressure came from the United Nations, which, in 1995, issued a highly influential document titled 'Format and Guidelines for the Preparation of National Drug Control Master Plans'. This document gave practical guidelines on how to proceed in a systematic fashion to formulate such Plans.

Finalised after an extensive consultative process, the South African NDMP recommends the establishment of several executive bodies:

- A national Central Drug Authority to oversee and monitor the implementation of the Plan
- A Secretariat to oversee the Plan's administration
- Action Committees in the 382 magisterial districts to ensure implementation of the Plan and the uniform spread of information and policies in every part of the country
- Provincial Substance Abuse Fora to strengthen member organisations in carrying out their existing functions and to keep substance abuse high on the public and political agenda.

Crime was identified as one of six priorities in the NDMP and five goals were identified under this heading:

- ensure that the law is effectively enforced, especially against those involved in the supply and trafficking of illegal drugs
- to reduce the incidence of drug-related crime
- to reduce the harmful consequences of drug-related crime
- to reduce the level of drug misuse in prisons
- to reduce the level of substance abuse among road users.

While the NDMP represents considerable progress in the nation's attempt to deal with drugs, it is still a document with some serious flaws. At its core, the goal of creating a 'drug free society' is unrealistic, and reflects the failure of the drafters to come to terms with some of the most important community inputs. While it mentions harm reduction and the possibility of decriminalisation, it does not take a position on

either issue, and one gets the sense that these policy approaches were tagged on at the last moment. On the other extreme, the drafting Committee failed to enlist the full participation of the Department of Safety and Security.

The NDMP is mainly a 'plan to make plans', with no clear strategies of its own and no articulated action steps. Perhaps most significantly, NDMP does not come with a budget, and is therefore very limited in the kinds of activity it can undertake. It is hoped that funds can be raised from within government to allow the CDA to undertake its work.

On the up side, the Central Drug Authority does include a greater civil society component than previous similar bodies. The CDA is required to report annually to Parliament and is to be aided by a dedicated Secretariat. Unfortunately, the Secretariat had not yet been appointed by the beginning of 2002, although a two million rand budget has been presented to the Department of Social Development. The empowerment of this Secretariat is essential, as the CDA members themselves are busy professionals with many other responsibilities.

It is too early to judge whether the CDA will emerge as a major player in national drug policy, or whether the lack of funding, clout, and dedicated capacity will ultimately result in the NDMP becoming just another hollow declaration of intent. Early meetings have resulted in the creation of an executive committee, five working groups, and the identification of a set of 20 priorities. The working groups have begun to discuss some intriguing matters, including a national media campaign, research into cannabis policy, and a review of alcohol advertising.

The present study reinforces the focus the NDMP places on the creation of local drug action teams and provincial substance abuse fora. Strategies for dealing with these issues clearly need to be based in a sophisticated understanding of local dynamics. The CDA needs to ensure that national policies do not conflict with local initiatives, and needs to dedicate a substantial amount of its energy to getting local bodies active in areas of high levels of substance abuse. Given that the most problematic drug markets are concentrated in a few limited areas, the ambitious goals of the NDMP are best served by concentrating on these problem spots.

The study also highlighted the importance of the NDMP focus on youth, since 66% of those arrestees under the age of 20 tested positive for drugs. The present facilities for diversion of addicted youthful offenders are extremely limited, and considerable attention needs to be paid that we are not jailing children who are simply in need of medical attention.

The association between drug use and previous arrest emphasises the role drugs can play in recidivism. Over half of those who tested positive had an arrest history, while only 27% of those who tested negative did. Whether drugs caused the initial descent into crime or not, drugs do reinforce a marginal lifestyle and can make it harder for those with a record to reintegrate into society. The correctional facility is intended to rehabilitate offenders, and one of the best places to start is with the issue of substance abuse. Unfortunately, much qualitative research indicates that drugs are even more readily available in prison than on the streets, and that the boredom of prison life may make substance use more attractive than it otherwise would be. This may ultimately explain the fact that a history of past arrest is a good predictor for substance use in this study. Urgent attention to this issue is needed.

Given that substance abusers of all ages need special attention, the idea of specialised drug courts has been mooted. While more expensive and subject to 'dumping' of case loads from other courts (with corresponding delays in the justice process), these courts could be staffed by those with the training and experience to evaluate the substance issues of arrestees and to make decisions based on the range of treatment options available. Of course, specialist drug courts cannot reach those accused of non-

substance-related crimes where drugs are not clearly implicated.

CHAPTER 6

Conclusion

Ted Leggett

This study has given an intriguing glance into a world in need of urgent attention: the world of the drug-motivated criminal. It has shown that this is not one world, but many worlds: sex workers trading their attentions for rocks, Cape gangsters warring over a prime retail street corner, wife beaters gearing up on booze or other drugs, white kids from the suburbs peddling stolen cell phones for a fix in the inner city. But this research has barely scratched the surface of this complicated and often contradictory underground.

The central limitation of a study of this sort is that the causal links between drugs and crime cannot be adequately probed. The interview component was conducted by non-specialists in an accusatory environment, resulting in startling levels of prevarication among the subjects of the research. This leaves high levels of certainty about the presence of drugs, but little guidance about what can be made of this fact.

There was much confirmation of what had been learned in qualitative research:

- South Africa's drug problems are still very much segmented along ethnic, gender, and geographic lines. Blacks are least likely to use drugs, whites are most likely to use cocaine, and coloureds and Indians are most likely to use Mandrax. The Cape Flats represent a major problem area for Mandrax use and associated crime. White sex workers have a crack problem
- Drugs use is more common among youthful offenders
- People who have done time in prison are more likely to do drugs.

But the central questions are left unanswered:

- Does drug use lead to crime?
- If so, how and what kind of crime does it lead to?
- Which comes first—the drugs or the crime?
- How much violent crime is associated with drug markets?
- How much interpersonal violence is due to intoxication?
- How common is substance addiction among those who commit crime?

To answer these questions, more qualitative research is needed. This work needs to be conducted by those who are able to display a good knowledge of drugs in order to win the trust of the subjects, possibly by peers. It needs to take place under conditions that are non-threatening, such as circumstances where drug use is common or easily admitted (such as in rehabilitation centres, prisons, or on-site where drugs are consumed). The parallel processes of the criminal career and the personal drug history need to be traced, and their interstices mapped. Sophistication is needed in the interpretation of this data, as even the user-criminals themselves may lack insight into the relationship between these two phenomena.

It is nice to have numbers, but these numbers are rarely so clear-cut as to justify the sound bytes that are often made of them. Proper interpretation of this data requires as much qualification as any focus group or key informant interview. The veneer of science laid by test tubes and metabolites should not gloss

over the central limitations of the research.

That having been said, the 3-Metros Arrestee Study does show, using internationally accepted methodology, that parts of South Africa's arrestee population have levels of drug use that stand up to those of any other part of the world where similar research has been done. This is an issue that demands the attention of a country where crime is consistently rated by all sectors of society as the number one problem facing the nation. If the drug use is indeed driving crime in South Africa, every effort must be made to diminish its input.

This should be done, as suggested by the findings of the study, by addressing the motivations of the many distinct actors in the drug markets, from the importers/manufacturers/cultivators to the consumers. To prevent people from using or selling drugs, it must be understood why they got involved in the first place.

NOTES

1. M Peden, Final Report: The sentinel surveillance of substance abuse and trauma, Department of Arts, Culture, Science, and Technology Innovation Fund, 2001.
2. C D H Parry, Alcohol and other drug use, in A Ntuli, N Crisp, E Clarke & P Barron (eds) 2000 South African Health Review, Health Systems Trust, Durban, 2001.
3. While figures are not available for South Africa, the American Drug Abuse Warning Network (DAWN) tracks drug related deaths through 139 Medical Examiner's offices in 40 urban areas in the US. In 1999, 11 570 deaths were tied to drug abuse. In 23% of those cases for which a cause was known, the death was due to intentional suicide. While most of these deaths were due to acute incidents and may not include those for whom drug use was a contributing factor in a decline in general health, it cannot compare to the estimated 400 000 who die annually in the US due to cigarette smoking.
4. 'White', 'Black', 'Indian', and 'Coloured' refer to demographic markers and are not meant to signify inherent characteristics. The demographic characteristics of substance users are important to include in drug-related research as accurate user profiles can assist in identifying vulnerable sections of the population and in the planning and implementation of effective prevention and intervention programmes.
5. Bellville was left out of the third phase of data collection due to renovations being undertaken.
6. Pinetown police station was included during Phase 2 as a back-up, but was excluded in Phase 3 due to low numbers of arrestees in that station.
7. LSD was tested for during Phase 1, but as no arrestees tested positive, it was excluded for Phases 2 and 3.
8. These figures are based on Phase 3 data only.
9. British Customs and Excise, personal communication.
10. C McAndrew & R Edgerton, Drunken comportment: A social explanation, Aldine, Chicago, 1969.

11. Truth and Reconciliation Commission, Final Report, Part 4, sections 20-24, 1998.

12. N Haysom, Towards an understanding of prison gangs, Institute of Criminology, Cape Town, 1981.

APPENDIX: DATA TABLES

Johannesburg

Sample size

Gender	n	Age					Race				
		20 or less	21 - 25	26 - 30	31 - 35	36 or more	African	Coloured	White	Indian	Other
Male	889	17.1	26.0	28.3	15.5	13.0	90.7	2.6	3.0	2.9	0.8
Female	196	17.3	30.1	33.2	8.2	11.2	86.8	0.5	4.1	3.6	5.1

Percent positive for drugs

Drug	Gender	Age					Race				
		20 or less	21 - 25	26 - 30	31 - 35	36+	African	Coloured	White	Indian	Other
Any drug	Male	51.7	42.8	29.1	25.9	37.1	36.8	36.8	42.9	13.0	0.0
	Female	24.2	12.5	13.6	20.0	14.3	13.0	0.0	75.0	40.0	0.0
Cannabis	Male	49.3	37.1	26.9	24.1	27.9	34.5	26.3	28.6	13.0	0.0
	Female	11.8	3.6	8.5	12.5	9.5	7.4	0.0	25.0	16.7	0.0
Mandrax	Male	13.4	9.3	5.3	2.6	1.9	7.3	5.3	0.0	4.3	0.0
	Female	0.0	1.8	0.0	6.7	0.0	0.6	0.0	12.5	0.0	0.0
Cocaine	Male	4.9	3.6	3.5	0.0	2.9	2.7	15.8	28.6	0.0	0.0
	Female	17.6	9.1	6.7	6.7	9.5	6.8	0.0	75.0	20.0	0.0
Opiates	Male	2.8	5.7	0.0	0.9	1.9	2.0	15.8	14.3	0.0	0.0
	Female	6.1	3.6	5.0	0.0	4.5	2.5	0.0	28.6	20.0	0.0
Amphetamines	Male	0.0	1.5	0.0	0.0	0.0	0.4	0.0	0.0	0.0	0.0
	Female	0.0	0.0	1.7	0.0	0.0	0.6	0.0	0.0	0.0	0.0
Benzodiazepines	Male	0.7	2.6	0.4	0.0	1.0	1.1	0.0	0.0	4.3	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0

Percent positive for drugs, by offence category

Testing positive for ...	Gender	Substance-related	Violent crimes	Property crimes	Other
Any drug	Male	36.5	41.8	46.9	26.3
	Female	15.4	20.7	11.1	17.2
Cannabis	Male	28.8	38.8	41.0	25.5
	Female	0.0	7.1	4.4	11.1
Mandrax	Male	2.0	9.6	8.7	4.9
	Female	0.0	0.0	0.0	2.0
Cocaine	Male	15.4	3.3	4.1	1.5
	Female	8.3	3.4	4.4	14.1
Opiates	Male	7.7	1.9	3.6	1.2
	Female	8.3	10.3	4.4	2.0
Amphetamines	Male	0.0	0.0	2.2	0.0
	Female	0.0	0.0	2.2	0.0
Benzodiazepines	Male	0.0	1.9	1.5	1.1
	Female	0.0	0.0	0.0	0.0

Cape Town

Sample size

Gender	n	Age					Race				
		20 or less	21 - 25	26 - 30	31 - 35	36 or more	African	Coloured	White	Indian	Other
Male	860	20.7	25.5	15.7	13.0	25.0	39.8	55.4	2.5	1.5	0.8
Female	171	19.9	25.1	19.9	9.9	25.1	40.6	55.1	1.8	0.0	0.6

Percent positive for drugs

Drug	Gender	Age					Race				
		20 or less	21 - 25	26 - 30	31 - 35	36+	African	Coloured	White	Indian	Other
Any drug	Male	78.6	65.0	54.5	52.8	46.1	49.5	68.0	31.6	71.4	28.6
	Female	54.8	20.0	44.1	26.7	30.8	17.2	45.7	100.0	0.0	100.0
Cannabis	Male	73.4	56.5	48.8	47.7	37.1	46.7	58.5	22.2	71.4	0.0
	Female	45.2	17.1	17.6	14.3	12.8	7.8	29.3	50.0	0.0	0.0
Mandrax	Male	55.7	46.4	31.7	28.3	28.8	17.1	56.9	5.6	28.6	0.0
	Female	29.0	17.5	26.5	26.7	10.3	6.3	27.2	100.0	0.0	0.0
Cocaine	Male	2.3	3.9	3.3	1.9	0.0	0.6	2.8	16.7	0.0	0.0
	Female	13.3	7.3	17.6	14.3	2.5	0.0	13.0	100.0	20.0	100.0
Opiates	Male	2.3	0.5	4.1	1.9	1.5	1.0	2.4	0.0	0.0	0.0
	Female	0.0	2.4	5.9	0.0	15.4	7.8	4.3	0.0	0.0	0.0
Amphetamines	Male	0.0	0.0	1.6	0.0	0.0	0.0	0.0	0.0	0.0	28.6
	Female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Benzodiazepines	Male	8.1	4.8	5.7	5.6	4.9	4.1	7.4	0.0	0.0	0.0
	Female	0.0	0.0	2.9	0.0	7.7	1.6	3.3	0.0	0.0	0.0

Percent positive for drugs, by offence category

Testing positive for ...	Gender	Substance-related	Violent crimes	Property crimes	Other
Any drug	Male	80.5	50.3	73.2	46.3
	Female	53.1	9.4	31.1	39.4
Cannabis	Male	67.7	44.3	69.1	40.2
	Female	27.1	6.1	24.4	24.2
Mandrax	Male	49.4	28.8	55.6	30.4
	Female	26.5	6.3	22.2	21.2
Cocaine	Male	3.0	0.0	3.9	1.7
	Female	16.7	0.0	9.1	8.8
Opiates	Male	0.6	2.3	1.7	2.4
	Female	10.2	3.1	2.2	6.1
Amphetamines	Male	1.2	0.0	0.0	0.0
	Female	0.0	0.0	0.0	0.0
Benzodiazepines	Male	5.5	5.1	10.7	3.4
	Female	2.0	3.1	0.0	6.1

Durban

Sample size

Gender	n	Age					Race				
		20 or less	21 - 25	26 - 30	31 - 35	36 or more	African	Coloured	White	Indian	Other
Male	756	25.4	22.5	18.8	11.8	21.6	60.8	1.8	3.0	34.2	0.1

Female	211	25.5	26.9	17.0	12.3	18.4	81.5	6.2	3.8	8.5	0.0
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Percent positive for drugs

Drug	Gender	Age					Race				
		20 or less	21 - 25	26 - 30	31 - 35	36+	African	Coloured	White	Indian	Other
Any drug	Male	63.6	59.5	42.4	52.3	55.0	52.4	57.1	57.1	60.6	0.0
	Female	28.0	32.1	31.3	18.2	23.5	18.6	92.3	62.5	42.9	0.0
Cannabis	Male	56.5	52.5	38.6	45.5	52.6	48.4	53.3	42.9	53.2	0.0
	Female	18.0	16.7	12.5	9.1	14.7	12.7	46.2	25.0	13.3	0.0
Mandrax	Male	28.8	25.9	20.3	19.3	19.9	12.5	28.6	19.0	42.2	0.0
	Female	16.0	14.8	12.9	9.1	5.9	4.5	69.2	25.0	40.0	0.0
Cocaine	Male	1.6	1.9	3.8	1.1	0.7	0.9	20.0	23.8	1.2	0.0
	Female	12.0	20.4	9.7	9.1	2.9	3.8	92.3	37.5	14.3	0.0
Opiates	Male	0.5	1.9	3.0	5.7	1.3	1.9	0.0	14.3	1.2	0.0
	Female	0.0	1.9	6.3	0.0	2.9	2.5	0.0	0.0	0.0	0.0
Amphetamines	Male	1.1	1.3	1.5	4.5	2.6	0.0	0.0	0.0	5.6	0.0
	Female	0.0	3.7	6.3	0.0	0.0	1.3	0.0	25.0	0.0	0.0
Benzodiazepines	Male	2.2	3.1	0.8	2.3	0.0	1.2	0.0	0.0	2.8	0.0
	Female	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Percent positive for drugs, by offence category

Testing positive for ...	Gender	Substance-related	Violent crimes	Property crimes	Other
Any drug	Male	78.3	50.4	56.4	43.1
	Female	41.2	50.0	18.3	28.6
Cannabis	Male	71.3	45.0	50.6	38.7
	Female	17.6	12.5	13.1	16.2
Mandrax	Male	39.9	22.5	21.8	14.5
	Female	23.5	12.5	1.7	16.0
Cocaine	Male	1.9	0.8	3.9	0.8
	Female	22.2	37.5	0.0	15.2
Opiates	Male	0.0	3.1	1.1	3.2
	Female	0.0	0.0	6.6	0.0
Amphetamines	Male	3.8	0.8	0.6	2.4
	Female	0.0	0.0	0.0	2.9
Benzodiazepines	Male	1.9	1.6	1.7	2.0
	Female	0.0	0.0	0.0	0.0