City of Cape Town

Policy Position on Alcohol and Drugs

and

Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014

Dated October 2011

City of Cape Town Policy Position on Alcohol and Drugs

The City of Cape Town recognises that the harmful use of alcohol and other drugs has consequences for the well being of users, their families and the broader society. Alcohol and other drug use can result in significant harm to individuals and society. The City of Cape Town is committed to minimizing this harm and mitigating the impact through an approach that **C.A.R.E.S**. (through *Community Awareness, Rehabilitation and Education Services*), but shows 'zero tolerance' to persons manufacturing and selling illegal drugs and/or alcohol through unlicensed premises.

The City of Cape Town acknowledges a problem situation of the high incidence of alcohol and drug use within the Metro region. The situation is characterised by:

- The inadequacy of life-skills development and support services and the absence of appropriate information to enable the youth and other vulnerable persons at risk within the City, to make informed and responsible choices regarding alcohol and licit/illicit drugs and to prevent substance use disorders.
- The disruption and dysfunction of families and communities as a result of harmful alcohol and drug use, whereby certain users become abusive, neglect their family responsibilities and work, engage in inter-personal violence, or pursue crime as a consequence of their substance use.
- A substantial and unfilled demand for treatment services, including demand from persons with substance use disorders that use substances which pose risks to their health and well-being.
- The cost escalation of the heightened demand for social prevention, clinical treatment services, accidents and crime reduction strategies, which negatively impact on the City of Cape Town.

The City of Cape Town intends to contribute towards the reduction of harm to the individual and society through its Alcohol and Other Drug Minimization and Mitigation Strategy. The City of Cape Town seeks to achieve the goals of harm minimization and mitigation through collaboration with Provincial and National Government and through pursuing strategic interventions on three levels:

Firstly, the City of Cape Town will support the mandate of provincial and national government to:

- ensure the availability of and accessibility to registered alcohol and drug and treatment services,
- establish and maintain local alcohol and drug sub-committees as coordinating bodies, and
- restrict the supply of illegal drugs and ensure that liquor is sold through licensed premises in accordance with City of Cape Town By-Laws and Provincial Legislation.

Secondly, the City of Cape Town will undertake strategic proactive and reactive interventions for persons affected by substance use and their families, providing preventative and treatment support where national and provincial services are inadequate and enhancing interventions in key areas to maximize the intended impact of harm minimization and mitigation. The City of Cape Town will collaborate with the private sector, educational and research institutions, non-governmental, community and faith based organisations towards this goal.

Thirdly, the City of Cape Town will mainstream the Alcohol and Other Drug Harm Minimization and Mitigation strategy in all its departments to maximise the impact among both its employees and the people of the Metro region.

City of Cape Town

Policy Position on Alcohol and Drugs
Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014

October 2011

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II. Abbreviations and Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AOD	Alcohol and Other Drug
BAC	Blood Alcohol Concentration
CBO	Community Based Organisation
CTADAC	Cape Town Alcohol and Drug Action Committee
CoCT	City of Cape Town
Department of Health	Provincial Department of Health
DSD	Provincial Department of Social Development
EW	City of Cape Town Employee Wellness Department
ECD Centres	Early Childhood Development Centres
FBO	Faith based organisation
City Health	City of Cape Town Directorate of Health
HIV	Human Immunodeficiency Virus
LDAC	Local Drug Action Committee – as defined in the National Drug Master Plan 2006-2011 and the Prevention of and Treatment for Substance Abuse Act 2008
MoU	Memoranda of Understanding
MI	Motivational Interviewing
NGO	Non-governmental organisation
NDMP	National Drug Master Plan
PGWC	Provincial Government of the Western Cape
SAPS	South African Police Services
SACENDU	South African Community Epidemiology Network on Drug Use
Safety and Security	City of Cape Town Directorate on Safety and Security
CoCT SD	City of Cape Town Department of Social Development(which includes Social Development Facilitation and Arts & Culture)
CoCT SDF	City of Cape Town Social Development Facilitation
SDF	Spatial Development Framework
S&R	City of Cape Town Department of Sport and Recreation
TB	Tuberculosis
WCSAF	Western Cape Substance Abuse Forum
WHO	World Health Organisation

PART A

City of Cape Town Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014

1. Introduction

This document details the City of Cape Town's (CoCT) strategic plan to minimize and mitigate the harm of alcohol and other drug (AOD) use (including tobacco usage). The document comprises two parts.

Part A describes the strategy and operational plan.
Part B provides additional technical information on substance use within the Metro region, definition of key terms, a summary of the legal and institutional framework governing substance use interventions at the local government level, and an analysis of the state of knowledge (available research and documentation) that informs the CoCT's policy position and strategic approach.

The aim of the 2011-2014 strategy is to describe the objectives and outcomes for the implementation of City of Cape Town interventions to minimize and mitigate the harm of alcohol and other drugs (AODs) on individuals. The strategy relates to the period 1 January 2011 to 31 December 2014. The strategy builds upon the 2007 **Draft Operational Alcohol and Drug Strategy 2007-2010**, taking forward the important achievements made during this period with respect to supply and demand reduction. The new strategy thus updates the Draft Strategy as well as details new interventions to enhance the impact and strengthen co-ordination within the CoCT and with other spheres of government and partners. The strategy arose from a thorough process of consultation with councillors, all relevant directorates within the CoCT, key Provincial departments and specialists from research institutions and non-governmental organisations.

The proposed strategy was presented to the Cape Town Alcohol and Drug Action Committee (CTADAC) on the 4th March 2011. At this meeting, specific reformulations to the strategy were requested by members and were incorporated into a draft. All affected directorates were afforded an opportunity to respond to the proposed approach, the proposed objectives and outcomes and supporting evidence. The strategy was presented at the relevant portfolio committees, approved by the Mayoral Committee (MAYCO) on the 18 October 2011 and by the Council of the City of Cape Town on the 26 October 2011.

2. Governmental Mandate

The Prevention of and Treatment for Substance Abuse Act (2008) mandates Local Government to respond to substance abuse through devising and implementing local strategies and co-ordinating actions with Provincial and National government. To fulfil the requirement of the establishment of Local Drug Action Committees (LDAC), the CoCT has established the CTADAC to enable inter-

directorate and inter-governmental co-ordination on alcohol and drug matters and to oversee the implementation of appropriate interventions to minimise substance related harms and reduce the supply of and demand for substances.

The implementation of the Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014 will be managed by the CTADAC and will be included in the Integrated Development Plan (IDP) of 2012/13. The Directorate of Health will hold overall responsibility for co-ordination of the strategy within the CoCT and building collaboration with Provincial Government and other relevant stakeholders.

The strategy implementation process will be co-ordinated by the Directorate of Health under the mandate of the CTADAC.

3. Overriding Principles

In the formulation of the strategy and in its implementation, the following core principles should apply:

People use substances because they seek to experience the neurobiological effects. There is significant variation in the degree to which individuals use substances, which can intensify from mild use, moderate use, and harmful use. Further, in some individuals substance use can result in a dependency condition, an illness which is characterised by the manner in which individuals use substances and the neurobiological effect, rather than any social reason for using substances.

In an ideal society, people should have the knowledge and life skills to make informed and responsible decisions on substance use. Harmful substance use can result in irreversible damage to the user. There are also indirect impacts on society as a consequence of substance induced anti-social behaviour (including violence), and altered physical capabilities resulting in accidents. Government holds the responsibility to discourage the onset of substance use among the youth, whilst preventing users and society from harm (whether intentional or not) through effective management of the problem. The CoCT thus has a role to fulfil in support of and to complement interventions undertaken by Provincial and National Government.

The CoCT will ensure that all CoCT funded, supported and/or driven treatment interventions adhere to evidence based practices. In the AOD context, evidence based practices are those that have undergone measurable scientific trials; have been replicated in other studies with different population groups; have achieved a behavioural change outcome; can address cultural and socio-economic diversities within populations and can be evaluated. In its provision of evidence based prevention and treatment interventions, the CoCT will strive to provide accessible, cost effective, affordable and non-stigmatizing programmes and information resources. The CoCT recognises that no single treatment is appropriate for all individuals. It further recognises that effective treatment must address the multiple needs of the individual and not just focus on substance use. Treatment should be holistic and continue from a structured programme through aftercare with on-going support and counselling.

Universal preventative interventions are essential, but need to be undertaken over a long period, target multiple social layers (the individual, their inter-personal relations, the family and

community) and must comprise a basket of services, including information, life skills development and linkages to treatment interventions.

Targeted interventions should be utilised for reaching individuals who are exhibiting early signs of harmful substance use to limit harms and prevent possible future substance dependency. Prevention programmes should address both licit (for example alcohol, tobacco, over-the-counter, and prescription medication) and illicit substances. Both prevention and treatment services should only be undertaken by suitably qualified, trained and resourced staff in the employment of the Province, the CoCT or appropriate organisations.

As part of its commitment to promote social inclusiveness within the Metro region, the CoCT will specifically focus on marginalised communities and vulnerable persons with inadequate access to non-CoCT treatment and prevention interventions. Treatment and prevention interventions will be tailored to provide age, gender appropriate and culturally suitable messages in the three major language groups within the Metro region.

The responsibility for reduction in the supply of licit and illicit drugs and the illegal sale of alcohol are competencies shared between the three tiers of government. National government has the lead responsibility for regulating and policing the manufacturing and/or distribution of licit and illicit drugs. Provincial government has the lead responsibility for regulating and policing the micro-manufacturing and/or retailing of liquor, with the CoCT afforded authority to determine land use criteria for business activities and trading times. The effectiveness of these three tiers of government in the overall tasks of supply reduction is conditional on collaboration. Similarly, supply reduction requires support and cooperation from the Department of Justice and Constitutional Development in order to prosecute and to secure convictions. The CoCT Safety and Security services (Metro police, Law Enforcement, Traffic and Emergency Services) can best contribute towards the broad objectives of AOD supply reduction through strategic interventions, targeted at specifically reducing AOD harms. These include interventions for established dealers of illicit drugs, drivers under the influence of alcohol in excess of the legal limit and liquor retailers who contravene the CoCT liquor By-Law on Trading Days and Hours. In support of this approach, the CoCT has established specialist units within the Metro Police (Substance Abuse Unit and the Dog Unit) and Law Enforcement (Liquor Enforcement Unit). The CoCT has taken the lead role in enforcing alcohol free zones in commonly and heavily utilised public spaces, including parks, beaches and the area adjacent to sporting, cultural and music events.

The CoCT recognises that supply reduction can be achieved most effectively through securing community support for the aims and objectives of minimizing and mitigating the harms of AOD. The mandate for strong policing should therefore be balanced against the potential harm done to communities through criminalising petty substance users who could, through practical interventions, enhance responsible life choices. The closure of unregulated liquor retail outlets should be tied to economic interventions to provide alternative employment or skills development for these traders. The CoCT recognises the need to provide appropriately zoned land in townships to redress the absence of commercially zoned land on which liquor retail outlets can be established within the framework of the Provincial Law.

4. Externalities

The strategy takes into consideration externalities (and specific conditions) that influence individuals' use, misuse, abuse or dependence on substances and the potential resulting impacts. These externalities include:

- The high burden of infectious and communicable diseases, including tuberculosis and HIV/AIDs, which amplifies the biophysical harm that substance use has on individual users and their social networks.
- The scale and extent of poverty and social marginalisation within the Metro region which enhances the societal consequences of harmful substance use through indirect encouragement and contribution to increased anti-social behaviour and inter-personal conflict and violence.
- The diminished livelihood resilience of families both directly or indirectly affected by substance use through asset depletion strategies and the cost (in money and time) of treatment, as well as those benefiting from the sale and distribution of substances in contravention of the strategy and/or law, including licit substances such as tobacco and alcohol.
- The vulnerability of substance users to crime and violence, arising both from the nature of illicit nature of the supply chains
- Broader activities and cultural trends that may influence substance use – such as new or unforeseen products and user activities and groups.

These externalities influence the social context in which the use of substances occurs, affect access to and availability of prevention and treatment services and impact on the effectiveness of these services as well as the treatment of other diseases.

An important externality in AOD harm concerns the nature of substances themselves and the enterprise dynamics through which these substances are distributed. The main substances of social and health concern, in alphabetical order, are alcohol, cannabis, cocaine, heroin, mandrax, methamphetamine and tobacco. The supply of substances follows trends, with particular substances increasing or falling in demand over time. The overwhelming majority of alcohol sold within the Metro region is legally manufactured, although the illegal micro-manufacturing of alcoholic brews has grown substantially over time. In most townships and informal settlements, the main (by volume) channel for alcohol distribution and sale is through unregulated businesses. Their activities are illegal, but have continued over time as a consequence of the localised demand for alcohol on-and-off- consumption venues within residential areas. The importation and manufacture of illicit drugs has historically been dominated by highly organised, professional crime syndicates and/or gangs who distribute and promote drugs through networks of dealers, street-based pushers and peer to peer mechanisms. The demand for substances is influenced by cultural considerations within some groups embodying substance use within social traditions and celebrations.

5. The Strategy

The strategy has been detailed in the format of a logical framework document and accompanying plan of operations. The logical framework is presented as **Annex 1** of this document. The strategy has been delineated in a hierarchical structure, with the overriding goal at the apex. The logic holds that if all activities are undertaken as planned and in accordance with the planned level of achievement, and if the assumptions are met and the risks to implementation are not realised, then the strategy objective will be achieved, which in turn will achieve the broader strategy goal. The goal is not the ultimately desired state (no substance related harm), but a significant contribution towards the reduction and mitigation of the social impacts of harmful forms of substance use.

A plan of operation has been included in **Annex 2** of this document, outlining the key Directorates and Departments within the CoCT responsible for coordination and conducting the activities. In order to meet each of the objectives the plan of operation clearly sets out the mandated authority, and the role which they must play, alongside other stakeholders within the Metro.

The state of knowledge on the harms of substance use as embodied in secondary literature and official reports is summarised in Part B. This knowledge explicitly informs the strategy, both at the Goal level where the emphasis is on minimizing and mitigating the social impacts of substance use/misuse/abuse and dependence and in the delineation of core objectives where the strategy seeks to confirm to best practices. The main concepts within the strategy are explained in **Part B**, under the definitions.

6. The Overriding Goal

To contribute towards minimizing the harm and mitigating the impact of alcohol and other drugs on individual users, families and society in the Metro through the provision of targeted supply and demand reduction interventions.

7. Strategy Objectives

7.1. Principal Objectives

The strategy has six principal objectives. These are:

I. Safety and security capability within the Metro strengthened and enhanced to reduce alcohol and drug related crime and harms from accidents, on individuals and society.
II. Aspects of safety within the public infrastructure environment improved to reduce AOD crime burden.
III. Access to evidence-based treatment interventions provided and enhanced within the Metro.
IV. Evidence based prevention services provided within the Metro to build coping skills, enhancing knowledge on AOD disorders and risks and providing information about services.
V. Institutional capacity strengthened to enhance inter-departmental action and monitoring of alcohol and drug harm minimization / mitigation initiatives.
VI. Co-ordination of actions on AOD minimization / mitigation strengthened at Metro and local level with other spheres of government, institutions, private sector role-players and NGO/CBO/FBO agencies.

7.2. Activities

Objective 1*: *Safety and security capability within the Metro strengthened and enhanced to reduce alcohol and drug related crime and harms from accidents, on individuals and society.

i) Enforce alcohol free zones in public spaces across the Metro region, targeting law enforcement resources at parks and beaches over the Festive Season.
ii) Increase the use of roadblocks and vehicle check points (VCP) with Blood Alcohol Concentration testing facilities to target drivers under the influence of alcohol.

iii) Institute voluntary/random Blood Alcohol Concentration and drug testing for Metro Police, Law Enforcement and Emergency Services.
iv) Maintain the capacity of specialised units (Substance Abuse Unit and Dog Unit) within the Metro Police to target illicit drug dealers and illicit drug manufacturers.
v) Strengthen and enlarge the capacity of Law Enforcement (Vice Squad and Liquor Enforcement Unit) to strategically target businesses involved in drug sales and/or the unregulated sale of alcohol.
vi) Through co-ordinated operations with SAPS, Metro (Substance Abuse Unit) and Law Enforcement, target illicit drug dealers and wholesalers supplying unregulated liquor venues.
vii) Through co-operation with City Legal Department, Housing Department and National Justice Department, evict illicit drug dealers and unregistered sellers of liquor from Council property.
viii) Establish capacity within the Substance Abuse Unit to obtain, analyse and distribute best available knowledge on supply trends of licit and illicit drugs and alcoholic beverages as well as information on supply crime related impacts.
ix) Support community policing initiatives, including Neighbourhood Watches and Neighbourhood Safety Co-ordinators, to collaborate with SAPS, Metro Police and Law Enforcement to promote 'zero tolerance' of AOD crime.
x) In collaboration with the Liquor Board and SAPS, monitor regulated liquor outlets for adherence to the CoCT By-Law on Trading Days and Hours.
xi) Support initiatives by City, Province and National Government to advance restorative justice, including diversion and alternative sentencing for AOD crimes.

Objective 2: *Aspects of safety within the public infrastructure environment improved to reduce AOD crime burden.*

i) Integrate best practices of planning and design in new housing and public infrastructure developments and the rehabilitation of existing public infrastructure.
ii) Develop integrated community safety plans.
iii) Enhance CoCT sports and recreational facilities.
iv) Investigate planning requirements for the retail liquor sector
v) Enhance the impact of the VPUU programme through piloting interventions targeted at youth and vulnerable groups.

Objective 3*: Access to evidence-based treatment interventions provided and enhanced within the Metro.*

i) Increase the number of Matrix® Sites within CoCT Health Facilities as well as the professional staff needed to meet the demand for service.
ii) Support the skills development of a CoCT Matrix® Key Supervisor to provide key supervision and support for the CoCT Matrix® sites.
iii) Support CoCT Matrix® clients to access in-patient care at treatment centres.
iv) Institute on-going monitoring of treatment outcomes at Matrix® Sites within CoCT Health Clinics.
v) Ensure all patients at Matrix® Sites within the CoCT Health Clinics are screened for mental health and communicable diseases.

vi) In partnership with the Provincial Government and NGOs provide a seamless service model of treatment.
vii) Enhance patient access to AOD treatment at CoCT Health treatment sites through subsidising transport costs and providing access to child care facilities.
viii) Engage with the Provincial Government and private service providers to secure access to detoxification facilities for patients requiring treatment.
ix) Implement simple detoxification at CoCT Matrix® sites.
x) Build the capacity of CoCT Health clinical staff to screen, assess and offer brief interventions and/or referral for patients with evidenced AOD problems.
xi) Implement adolescent-centred alcohol and drug treatment interventions at CoCT Matrix® sites.
xii) Enhance the services of the CoCT Alcohol and Drug Helpline.
xiii) Implement an alcohol and drug treatment programme via the employee wellness department for CoCT employees.

***Objective 4**: Evidence based prevention services provided within the Metro to build coping skills and enhancing knowledge on AOD disorders and risks.*

i) Increase and enhance public awareness of the CoCT Alcohol and Drug Helpline and treatment services.
ii) Enhance professional expertise among CoCT staff providing prevention interventions.
iii) Develop an evidence based AOD prevention programme with universal, selective and indicated interventions.
iv) Where needed, provide parenting skills to preserve the family structure of persons affected by substance use and those with substance use disorders.
v) Ensure the alignment and harmonization of AOD messaging within CoCT and align CoCT initiatives with the Provincial Government.

***Objective 5:** Institutional capacity strengthened to enhance inter-departmental action and monitoring of alcohol and drug harm minimization / mitigation initiatives*.

i) Obtain Council approval of the COCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy.
ii) Secure Mayoral appointment of members of the Cape Town Alcohol and Drug Action Committee.
iii) Strengthen co-ordination through CTADAC.
iv) Promote awareness of the COCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy among councillors through the sub-councils.
v) Strengthen information management system to monitor Departmental progress on implementation of Alcohol and Other Drug Harm Minimization & Mitigation Plan of Operation.
vi) Institute a monitoring system to assess the performance and impact of COCT grant funded interventions (to partners) to maintain harmonization with the strategy.
vii) Monitor trends on AOD burden and treatment within the Metro region through contemporary research.

viii) Conduct annual review of the COCT Alcohol and Other Drug Minimization & Mitigation strategy and institute corrective action.

ix) Influence budget allocations to enhance the strategy during departmental strategic planning.

***Objective 6**: Co-ordination of actions on AOD minimization / mitigation strengthened at Metro and local level with other spheres of government, institutions, private sector role-players and NGO/CBO/FBO Agencies.*

i) Co-ordinate actions and interventions with Provincial and National government and other CoCT partners.

ii) Establish CTADAC sub-committees in each of the 8 CoCT Health Sub-Districts.

iii) Strengthen co-ordination with NGOs/CBOs/FBOs and private service providers to promote awareness of the CoCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy.

iv) Support and strengthen the Provincial Department of Social Development database of prevention and treatment service providers and other relevant agencies within the field of substance abuse.

v) Support and collaborate with local initiatives to establish a professional body for specialists working in AOD prevention and treatment services.

vi) Strengthen co-ordination between the CoCT and the Provincial Government in the registration of private and non-governmental treatment centres.

vii) Engage with National and Provincial government and liquor manufacturers to reduce the negative impact of liquor advertising.

8. Anticipated Outcomes

Within each of the six objectives, the strategy will result in objectively verifiable and measurable outcomes. These are described below:

***Objective 1:** Safety and security capability within the Metro strengthened and enhanced to reduce alcohol and drug related crime and harms from accidents, on individuals and society*
Outcome: AOD supply reduction

- The strategy will result in a reduction in the supply of licit and illicit substances. The impact will be measurable in public spaces where the CoCT Law Enforcement along with Metro Police and SAPS will enforce liquor free zones especially on beaches and parks over the festive season (December to April).
- In order to reduce drink driving, Traffic Services in conjunction with Metro Police will implement up to 800 vehicle check points and/or roadblocks per annum wherein drivers will be tested for their Blood Alcohol Concentration.
- To maintain effective policing services, systematic random alcohol/drug tests will be undertaken for all Substance Abuse Unit members. Voluntary alcohol / drug tests will be undertaken for other safety and security personnel on an annual basis.

- In support of the strategy, current levels of staffing are to be maintained within the Substance Abuse Unit. The personnel requirements will then be reviewed in 2012. At this time, the number of staff within Law Enforcement in the Liquor Unit will be increased to 12 persons.
- The number of coordinated operations (with respect to legal operations targeting known drug dealers and their premises will be increased by 5-10% per annum. By 30 June 2011, up to 150 coordinated inspections of premises serving liquor will be undertaken.
- Where drug dealers are operating from COCT rental properties, considerable efforts will be undertaken to evict these tenants; this action is intended to provide a strong disincentive against drug dealing / illegal liquor retailing.
- To improve knowledge of the supply of drugs and illegally retailed liquor, the Substance Abuse Unit will prepare quarterly reports including charge lists, convictions and follow-ups for the CTADAC. This will enhance monitoring and lead to an improvement in the understanding of supply trends.
- The strategy will bolster the role of community through providing additional support to community policing initiatives, whose number will be increased from seven to fourteen by 2014.

Objective 2: *Improve aspects of safety within the public infrastructure environment to reduce AOD crime burden*
Outcome: Safer public Infrastructure

- The strategy will result in mainstreaming good principles in spatial development planning. As such, by 2012, the Spatial Development Framework 'good principles' for planning and design and New Integrated Zoning Scheme will be approved.
- By 2014, all eight CTADAC sub-committees will have developed community safety plans relevant to their localities with specific interventions to improve aspects of public safety through integrated planning. It is anticipated that these plans will identify strategies to enhance safety and security in areas of high pedestrian traffic and along the walkways that connect people to transport facilities and shops.
- In support to healthy lifestyles, the strategy will result in the rehabilitation of sports and recreational facilities in 18 recreational hubs where AOD burden has been highlighted as great. The rehabilitation of these facilities will adhere to the recommended guidelines in the Spatial Development Framework for the provision and design of recreational space.
- Land use appraisals will be undertaken in up to eight localities within the Metro, with recommendations advanced to create commercial zones for regulated liquor retailing.
- A pilot intervention will be undertaken, whereby synergies between the Departments of Social Development, Sports and Recreation and VPUU (Violence Prevention through Urban Upgrade) will be developed to improve AOD prevention interventions in two sites.

Objective 3*: Access to evidence-based treatment interventions provided and enhanced within the Metro.*
Outcome: Accessible treatment services

- The strategy will enhance current evidence based treatment programmes by increasing the number of Matrix® Sites from four to eight with the necessary professional staff to meet the demand for services. The additional sites will be located within communities of indicative demand for state provision of treatment. In each CoCT Matrix® Site, there will be adolescent-centred alcohol and drug treatment interventions In support of greater

treatment adherence, retention subsidies will be offered for transport for indigent patients, whilst patients will be assisted to access child care facilities if required.

- The strategy will directly benefit CoCT employees. An AOD treatment programme will be offered by the CoCT Employee Wellness Department to CoCT employees in need of treatment
- In order to enhance the effectiveness of the Matrix® programme, the CoCT Matrix® counsellors will be supported by a Matrix® Key Supervisor.
- In order to mainstream diagnostic services of AOD use problems, eight CoCT Health Clinics will provide screening to HIV, TB and ante-natal patients and where necessary offer appropriate brief interventions and referrals. In addition, training will be provided for CoCT clinical staff in AOD screening, brief interventions and referrals; which will be facilitated through the CoCT Health Training Department.
- In order to provide select patients from CoCT Matrix® clinics with in-patient treatment services, the CoCT will develop partnerships with private sector and state facilities to secure access to bed spaces per year at a subsidized rate.
- In order to find a long-term solution to the need for detox facilities, dialogue will be initiated with Provincial Government and the private sector to explore the potential for establishing a private-public detox facility. By 2014, health facilities where Matrix® sites are situated provide simple detoxification treatment to clients accessing treatment.
- Matrix out-patients within CoCT Health Clinics screened for mental health and communicable / infectious diseases (including TB, HIV/AIDS, and HVC). The current outpatient management approach will be bolstered through the introduction of a standardised system of follow ups and reporting.
- The strategy will work towards ensuring that two Matrix® Sites within CoCT Health Clinics will offer a seamless service through the provision of additional staff as well as secondment from the Provincial Government.
- The Alcohol and Drug helpline will be maintained and its service improved. In addition to providing a referral service, the operators will be upskilled to provide lay-counselling where needed.

***Objective 4**: Evidence based prevention services provided within the Metro to build coping skills and enhancing knowledge on AOD disorders and risks.*
Outcome: Universal and targeted prevention services

- To enhance public awareness about the CoCT's prevention interventions, the CoCT website will be updated bi-annually, containing details of the Alcohol and Other Drug Harm Minimization & Mitigation strategy and information on treatment and prevention services.
- Furthermore, the 107 marketing team will promote awareness of the Alcohol and Drug Helpline through targeted marketing drives, reaching vulnerable groups on a quarterly basis.
- To ensure effective and practical prevention interventions, the CoCT will develop and then operationalise a prevention programme with guidelines to ensure all CoCT AOD prevention initiatives comply with best practice principles and the legislative framework. The range of programme interventions will include universal and targeted interventions in collaboration between the Directorate of Health and the Departments of Social Development and Sports, Recreation. It is envisaged that these interventions will include support for eight parenting skills programmes through Early Childhood Development forums. In addition, evidence based messages in alignment with Provincial Government initiatives will be developed and integrated into CoCT Directorate of Health; Social Development; Arts and Culture and Sports and Recreation programmes targeting pre-adolescents, adolescents and youth.

- The CoCT will develop an AOD information pack for distribution through CoCT libraries, clinics, recreational facilities, sub-council offices and partner organisations. This tool will enhance the effectiveness of needs based prevention programmes which will be implemented in all eight health districts. These programmes will address the needs identified in CTADAC sub-committees and include measures to strengthen parenting skills and promote alcohol and drug free lifestyles through sport, recreational activities and art.

Objective 5: *Institutional capacity strengthened to enhance inter-departmental action and monitoring of alcohol and drug harm minimization / mitigation initiatives*
Outcome: Intra-City co-ordination and management

- Upon adoption by Council of the COCT Alcohol and Other Drug Harm Minimization & Mitigation strategy, membership of CTADAC will be confirmed and a schedule of meetings adopted. CTADAC will meet monthly and fulfil the function of ensuring inter-departmental co-ordination and continued support (technical and financial) for the implementation of the strategy in accordance with the plan of operation. Specific monitoring and reporting benchmarks will be developed and operationalised in and between strategy implementing Directorates and included in their Service Delivery Budget Implementation Plan(SDBIP). The key strategy performance objectives will be included within the specific Directorates' Mayoral dashboard.
- In order to mobilise sufficient resources to ensure the goal outcome, CTADAC will endeavour to exert influence towards inter-departmental budget allocations towards the planned activities and enhancing their scale in successive years. Further, to improve efficacy of Ward Grant-in-aid allocations, an information tool will be developed for councillors and distributed through sub-council structures.
- CTADAC will monitor all grants to partner organisations on a quarterly basis to ensure adherence to the principles of cost-effectiveness, best practice and alignment to the COCT Alcohol and Other Drug Minimization & Mitigation strategic objectives.
- To maintain the relevance of the strategy in terms of available knowledge on AOD impacts within the Western Cape / Metro region, the State of Knowledge will be updated annually through an analysis of secondary literature and examination of institutional reports and other documents. This will assist to inform annual reviews of the strategy

Objective 6*: Co-ordination of actions on AOD minimization / mitigation strengthened at Metro and local level with other spheres of government, institutions, private sector role-players and NGO/CBO/FBO Agencies.*
Outcome: Collaboration with partners

- The CTADAC will enhance collaborations with other spheres of government, the private sector and non-governmental organisations. The monthly meeting will provide a vehicle for inter-government / organisation engagement. Furthermore, the CTADAC will maintain its participation within the Western Cape Substance Abuse Forum through attending meetings and responding to Provincial initiatives.
- Within the first year (2011) eight CTADAC sub-committees will be formed and meet on a monthly basis. These sub-committees will provide broad stakeholder representation as stipulated in the legislative framework. Each sub-committee will develop locally appropriate and culturally adaptive local area strategies to address AOD supply and demand reduction and minimize AOD harms. It is envisaged that these strategies will provide guidance on the

local needs for preventative programmes and the development of a safe infrastructural environment.

- The process of building co-operation with NGOs and the private sector will be advanced through the CTADAC sub-committees to share information on the scope and effectiveness of current services and to strengthen working relationships, especially with the aim to harmonise prevention messages. The range of service providers engaged in AOD harm minimization and mitigation activities within the Metro will be held within a 'live' database to enable the CoCT to effectively communicate with these role-players and to monitor the overall scale of service provision. It is envisaged that the data-base will be established in collaboration with the Provincial Government.
- The CTADAC will maintain regular contact through ongoing meetings with those stakeholders driving the professionalization of AOD service provision within the Metro region to ensure that the CoCT treatment and prevention services remain aligned to best practice.
- The CTADAC will provide a forum for assessing applications for the registration of private / NGO treatment facilities and a means for enhancing communication with the Provincial Government in this respect.
- The CTADAC will pursue a process of engagement with other spheres of government, NGOs and the private sector with the objective of reducing the negative impact of liquor advertising, especially on roadside billboards. In this respect it will endeavour to secure a commitment from industry to provide explicit health warning messages on the topics of Fetal Alcohol Spectrum Disorders and under-age drinking.

9. Risks and Assumptions

The strategy is contingent on the affirmation of assumptions and non-occurrence of risk considerations. The ambitious aims of the strategy and its complexity in terms of the reliance on inter-directorate, inter-departmental, inter-governmental cooperation and collaboration with external stakeholders necessitates consideration of broad number of assumptions and identification of risk conditions.

Assumptions

The strategy assumes that:

- Council budget allocation for Health, Social Development and Safety and Security is significantly increased to enable adequate investment in equipment, personnel and systems.
- SAPS remain committed to collaborate with Metro Police and Law Enforcement to target illegal drug dealing and illegal liquor sales.
- Employment alternatives for illegal liquor traders are made available in accordance with the Provincial economic development objectives.
- Community policing initiatives will operate in accordance with the law and regulations governing their role.
- The CoCT By-Law on liquor trading hours will be promulgated.
- Council budget allocation for treatment services enables an expansion to four additional sites (eight in total) and engagement of a Matrix® Key Supervisor.
- Budget allocation within CoCT procurement policy for transport subsidies is sufficient to meet demand from eligible patients.

- The Provincial Government remains committed to the provision of social support and probation services to achieve seamless services in partnership with the CoCT Matrix Sites.
- Treatment outcomes verify the appropriateness and effectiveness of the treatment model.
- Council budget allocation for prevention interventions enables the up-scaling of expertise and service provision.
- There will be consistent prevention messaging between the CoCT and Provincial Government.
- Council remains committed to prioritize AOD harm minimization / mitigation through various specific initiatives.
- The CTADAC meetings will be afforded priority to ensure the active participation of all current and relevant stakeholders in government and civil society.
- Ward councillors ensure harmonisation of grant-in-aid funding with strategy objectives.
- The Regulations of the Prevention of and Treatment for Substance Abuse Act (70 of 2008) will be promulgated.
- The impact of the CoCT strategy will be measurable from year one.
- COCT strategy objectives remain aligned to Provincial and National AOD strategies.
- Communities and other stakeholders are willing and have the capacity to actively participate in CTADAC sub-committees.
- Institutional partners of CTADAC sub-committees have funding opportunities for evidence based local strategies and initiatives in addressing supply, harm and demand reduction.

Risks

The strategy acknowledges the following risk factors:

- The proposed integration of the Metro police into SAPS does not affect the operational capacity of specialised units.
- The closure of venues selling illegal liquor has no unintended impacts on the structure of the liquor supply chain.
- The level of demand for public health services at CoCT Health Facilities does not impact on the availability of specialists to provide ancillary health services to AOD treatment interventions.
- The Provincial Government and private service providers have sufficient detox facilities to meet demand from patients requiring treatment.
- The operational capacity of the Helpline is sufficient to cope with peaks in demand.
- CoCT AOD prevention initiatives are not undermined by non-evidence based interventions undertaken by government, private or non-governmental stakeholders.
- The effectiveness of the CoCT's Helpline will not be affected by mis-use / hoax callers.
- There will be no party political interference in the implementation of the CoCT strategy.
- Gaps and flaws in the state of knowledge do not affect the appropriateness of strategic interventions to reduce illegal drug and non-regulated alcohol supply.
- There is no disruptive external agenda driven interference in the City strategy.
- Other AOD initiatives (Provincial, private, and non-governmental) will continue to provide the lead role in the provision of treatment and prevention services.

PART B

10. Definitions

Blood Alcohol Concentration (BAC)	A measure of the alcohol concentration in the blood stream, reflecting recent consumption. In South Africa the current legal limit for driving a vehicle is a concentration of equal to or greater than 0.05g/100ml.
Cape Town Alcohol and Drug Action Committee(CTADAC)	The Local Drug Action Committee established by the City of Cape Town municipality to give effect to the National Drug Master Plan (Prevention of and Treatment for Substance Abuse Act 2008).
Central Drug Authority	A national and statutory body established by Section 53 of the Prevention of and Treatment for Substance Abuse Act 2008 (Prevention of and Treatment for Substance Abuse Act 2008) to oversee and monitor the implementation of the National Drug Master Plan.
City of Cape Town	The municipal entity of the City of Cape Town established by the City of Cape Town Establishment Notice published in Provincial Notice No. 479 of 2000, and as amended.
Continuing care	Ongoing professional support to a substance user or former user after the initial phase of a formal treatment episode has ended in order to enable him or her to maintain sobriety or abstinence, personal growth and to enhance self reliance and proper social functioning (adapted from Prevention of and Treatment for Substance Abuse Act 2008)
Early intervention	Undertaken upon early detection of problematic substance use to reduce harms associated with risky/problematic substance use or to halt progression for persons who do not have substance abuse or dependence disorders at that point.
Halfway house	A public or private venue established or registered to provide a sober living environment for service users who have completed a formal treatment programme for substance abuse and require a protected living environment in order to prepare them for reintegration into society (both public – government owned – and private) (Prevention of and Treatment for Substance Abuse Act 2008).
Harm Reduction	A practical set of strategies that reduce the negative consequences of substance use/misuse/abuse, incorporating a spectrum of strategies in a continuum from safer use, to managed use to abstinence.
In-patient Treatment	A residential treatment service at a treatment centre (Prevention of and Treatment for Substance Abuse Act 2008). In-patient treatment is indicated for individuals who require hospitalization or who cannot manage in an out-patient setting (WCPG Blueprint for Harmful Alcohol & Drug Use).
Liquor	Any liquid substance containing ethyl alcohol C_2H_5OH. The Liquor Act (59 of 2003), defines liquor as: (a) a liquor product in terms of section 1 of the Liquor Products Act (60 of 1989), (b) beer or traditional African beer, or (c) any other substance or drink declared to be liquor. The definition encompasses the fermentation and distillation of grains, fruits and other agricultural products, whereby the liquid or substance contains more than 1% of alcohol by volume or mass. In both national and (most) provincial legislations, a distinction is drawn between liquor and methyl alcohol spirits; the latter are defined as a denatured spirit and can include medicated spirits.
Local Drug Action Committee	A committee established by a municipality to give effect to the National Drug Master Plan (Prevention of and Treatment for Substance Abuse Act 2008).

Out-patient service	A non residential treatment service provided by an NGO, treatment centre or halfway house to persons requiring treatment for substance abuse (adapted from Prevention of and Treatment for Substance Abuse Act 2008).
Persons affected by substance abuse	Any member of a family or community not abusing or dependent on substances but who requires services as a consequence of substance abuse within their household, peer group or family (Prevention of and Treatment for Substance Abuse Act 2008).
Prevention	With respect to substances; any activity designed to prevent or delay the onset of substance use to reduce its health and social consequences (WHO, 2002). Prevention includes Universal programmes for vulnerable persons (e.g. children and adolescents) who have not yet started use, selective programmes for targeted high risk groups such as school dropouts or street people and/ or indicated programmes for identified individuals who have started using in order to limit harms.
Pre-teen	A child, before the age of 13 years.
Provincial Substance Abuse Forum	The body established in Section 57 of the Prevention and Treatment for Substance Abuse Act 2008 by each Province in order to give effect to the National Drug Master Plan (Prevention of and Treatment for Substance Abuse Act 2008).
Recovery/ Rehabilitation programme	A process by which a person undergoing treatment is enabled to reach and maintain his or her own optimal physical, psychological, intellectual, mental, social or psychiatric functional levels within the context of an abstinence based lifestyle, (adapted from the Prevention of and Treatment for Substance Abuse Act 2008).
Substances	Means chemical, psychoactive substances of mild use, moderate use, harmful use and / or dependence, including tobacco, alcohol, over the counter drugs, prescription drugs and illicit substances defined in the "Drugs and Drug Trafficking Act 1992".
Substance Abuse	Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs. Psychoactive substance use can lead to dependence syndrome - a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state (WHO).
Treatment	The provision of specialised social, psychological and medical services including detoxification to certain persons undergoing treatment and to persons affected by harmful substance use with a view to addressing the social and health consequences associated therewith (Prevention of and Treatment for Substance Abuse Act 2008) and providing the insight and resources to maintain a sustainable recovery programme.
Vulnerable persons	A vulnerable person is one considered to be exposed to the possibility of being harmed and could include women (especially pregnant women); children/youth; people who live and work on the streets, people with physical disabilities and mental health problems or be based on socio-economic conditions or ethnicity.
Youth	The time of life considered to be neither childhood nor adulthood. The United Nations determines youth to be persons "between the ages of 15 and 24 years." The World Bank considers youth "between the ages of 15 to 35." In much of the USA a youth is considered to be between the ages of 14 and 21 years. This can conflict with the legal definition of 'child' or 'dependent'. In this document, a youth is considered to be between the ages of 15 and 24 years.

11. The state of knowledge – alcohol and other drugs in the Western Cape and Cape Town

11.1. The problem environment

Cape Town is a reflection of the broader South African society, with rich and poor, skilled and unskilled living side by side (Cape Town IDP 2008). Within the Metro region the use and misuse of alcohol and drugs brings about high direct and indirect social, economic and health costs. Whilst there is conflicting data reflecting the totality of financial burdens for the Metro and the Province, costs associated with alcohol (a legal, controlled substance) and drugs are reflected in medical, emergency services, legal services and infrastructure damage (Parry, 2009), policing, court cases and incarceration within the criminal justice system, and broader indirect effects. There is a need to reduce these burdens on the CoCT and the Province within a broader requirement for social and economic wellbeing.

11.2. Understanding local substance use and prevalence

Despite an absence of comprehensive data on alcohol and other drug usage prevalence within the Province (Blueprint 2010:17) and the Cape Town Metro region, evidence indicates that use rates are comparatively high. With respect to abuse, in a broader 2009 study of South African Stress and Health (SASH) (Herman *et. al*, 2009), it was found that 13% of the general South African population are reported to undertake harmful substance use. Research indicates that within the Western Cape Province there is widespread use and abuse of substances. For example, the 2008 Youth Risk Behaviour Survey reports that 41% of Western Cape secondary school learners sampled (grades 8-11) had engaged in binge drinking in the month prior to the survey. The survey found that 24.5% of the sample had used cannabis/dagga, of which 16% used regularly, 9% used methamphetamine, 10% used mandrax and 6% used heroin, cocaine or other drugs. The use of each of these substances can be influenced through pricing, societal trends (Meyer 2010) and cultural orientation.

Controlled substances

Alcohol

Alcohol is the most frequently used substance in the Province (Blueprint 2010:6), with its abuse and interpersonal and societal consequences considered a major problem (MRC 2011). The Blueprint (2010:6) reports that prevalence of lifetime alcohol use in the Western Cape ranges from 39% to 64% (though it is unclear whether this is per capita or among a particular age cohort). It is also said that the Province has the highest national rate of risky drinking, falling in the range between 9% and 34%. [The data is drawn from research from Shisana and Simbayi (2002), South African Demographic and Health Survey (2003), and; Shisana *et al*., (2005)]. Despite the knowledge on use and abuse, the state of knowledge reveals high uncertainty regarding the full cost burden of alcohol in terms of disease, service costs and opportunity costs of harms to society. The Blueprint (2010:8) estimates direct Provincial expenditure of R100 million per year on services that address substance abuse directly.

With respect to episodic excessive drinking, Parry (2010) recorded that the Western Cape has the highest national proportions of binge drinkers in high school – 34% in comparison with a national average of 23%. Evidence indicates that the level of binge drinking increases among rural communities (21%) relative to urban communities, although it is higher in informal urban areas (17%) than in formal urban areas (12%) (Harker *et al*, 2008:10). This gradient is a reflection of demographic and poverty factors. In rural communities, Peltzer, K. & Ramlagan, (2009:4) reported that binge drinking among men was highest (nationally) among coloureds (23%), then whites (16%), blacks (13%) and lowest amongst Indian men (7%). The authors further reported that binge drinking among current drinkers, 15 years and above, was the highest in the Western Cape Province comparatively, but had fallen from 33.2% men and 29.6% women of current drinkers in 1998 to 24% men and 9.5% women of current drinkers in 2005. Furthermore, with respect to alcohol abuse, the South African Community Epidemiology Network on Drug Use (SACENDU) has reported a drop in alcohol as a primary substance of abuse from 48% in 2000 to 30% in 2007, although this data reflects only those individuals that have entered treatment programmes.

Although alcohol abuse data indicates a downward trend, there remains a very high rate of Fetal Alcohol Spectrum Disorders (FASD) within the Western Cape Province. The geographical regions where FASD is highest (ranging between 65.2 and 89.2 cases per 1000) are rural areas, especially among communities engaged in agricultural work (Harker *et al*., 2008). This problem has also emerged within the Metro, where, in a study conducted by the MRC's Anxiety and Stress Disorders Research Unit in 2007, found that 20.2% of 332 women attending antenatal classes in Tygerberg admitted to using alcohol while pregnant, and of these, 85% were found to be alcohol dependent. The Blueprint (2010:7) notes that the incidence of FASD within the Metro is one per 282 live births - one of the highest in the world. Further, it is apparent that FASD is a particular threat to offspring of women in their late twenties from poor communities who are expecting their third child; this finding highlights the desperation and vulnerability of young mothers within a poverty context.

Within the Province there is a strong linkage between unnatural deaths (such as motor vehicle accidents) and high Blood Alcohol Concentration (BAC). In this case research by the Department of Transport, quoted in Blueprint (2010:7), it is estimated that 45% of accident fatalities involve pedestrians, of whom approximately 60% had evidence of high BAC at the time of the accident.

In response to the social and economic harm of alcohol, and as a measure to limit access to liquor (and therefore consumption) by the poor populations, the Western Cape Provincial Government recently promulgated and implemented the Western Cape Liquor Act (2008). The Act will come into effect from September 2011. Whilst well intended, the recent Blueprint report (2010) recognises that the problem of illegal liquor retailing is unlikely to disappear as there is a 'lack of economic alternatives for illegal shebeens' and furthermore there is a 'lack of community mobilization against alcohol and its negative impact(s) in communities' (pp. 17).

Over the counter medications

Whilst poorly recorded in the Cape Town setting, there is a wide variety of over the counter medications that are prone to harmful use by residents. These include painkillers, pseudoephedrine, and various sleeping medications. According to Harker *et. al*. (2008) over the last seven years there has a constant proportion of 1-3% of persons admitted to treatment centres with OTC/prescription medication abuse symptoms. It was further reported that more than 70% of these people were female.

Tobacco

Tobacco is a widely used drug within Cape Town and is commonly retailed throughout the formal and informal sectors within the City. Media reporting highlights that tobacco reportedly kills 42,000 South Africans per year, primarily through lung cancer and other respiratory ailments. Flisher *et al.* (2006) reported that amongst a small sample of Grade eight students, 31.5% of males and 18.2% of females had used tobacco in the previous 30 days.

Illicit substances

Cannabis

According to Myers (2007) cannabis is more commonly used within black communities of South Africa than others, though detailed ethnographic research has not been conducted. It is likely that general cannabis usage rates are high - in a small study of Grade eight students by Flisher *et al*. (2006), it was reported that, in the past 30 days, the proportions of males and females respectively who had used cannabis were 17.2 and 5.2%. Furthermore, 26.9% of adolescent Cape Town trauma inpatients tested positive for cannabis (Parry *et al*., 2004).

Cocaine

Shisana *et al* 2005 report that cocaine is a less frequently used drug (population prevalence of less than 1%). Treatment admissions have dropped from 8% in 2000 to 3.9% in the first half of 2007 (SACENDU). As the retail cost of cocaine is substantially greater than other drugs, the main user groups for this illegal substance are found within the affluent communities, although "crack' cocaine has anecdotally infiltrated working class populations.

Heroin

According to Shisana *et al* 2005, Parry *et al* (2004) heroin makes up less than 0.5% of drug use in South Africa. Nevertheless, heroin use appears overrepresented in the Western Cape, which currently has the second highest rate of heroin addicts in South Africa with 11% of dependence linked to heroin usage. This is compared with 3% in the Eastern Cape (SACENDU, 2007). There is a possible growing trend within the Metro region for heroin use, based on treatment admissions whereby Pluddemann *et al* (2008); showed a rise from 2% admissions for heroin dependence (N=2301) in 1998 to 14% of admissions (N= 2660) in 2006, although the proportion of admissions has remained fairly stable from 2007-2010 (MRC 2011). Pluddemann also notes that 93% of 239 heroin users interviewed in the Western Cape come from White or Coloured ethnic groups. A recent rise of "ungah" - a low grade heroin / dagga mix - has been recently recorded in media reports and SACENDU within lower socio-economic areas of Cape Town.

Mandrax

Although drug use trends are dynamic, mandrax has been historically been a drug of choice within coloured communities, although there are growing numbers of black users (Harker *et al* 2010). According to treatment data cannabis and mandrax - more recently consumed together - are currently experiencing decreasing levels of abuse within the Western Cape (Harker *et al* 2010), though these substances are reportedly commonly encountered by the Metro Substance Abuse Unit in their surveillance and operational activities.

Methamphetamine (MA)

Whilst anecdotally the usage of methamphetamine (MA) is common, Pluddemann *et al* (2008); and Harker *et al*. (2010) note that data on MA use in Cape Town is limited. The MRC (2011) highlights that MA is now consistently the most common primary substance of abuse for those admitted for counselling or treatment, and Pluddemann notes that Cape Town has "the highest rate of methamphetamine *addiction* in the world" (*in* Kapp 2008). SACENDU (2007) data shows that 90% of

MA users receiving treatment are coloured, with 57% of people in drug treatment under the age of 20 years stating MA as their primary choice of drug, up from 4% in 2003 (Harker *et al* 2010). This research has further reported linkages between the use of MA and risky sexual activity. Parker (2007) cited in Blueprint (2010:13) found an association between mental health problems and MA use among a sample of patients in a psychiatric hospital in the Western Cape although there is uncertainty whether individual mental wellbeing could be a contributory cause or effect of usage.

11.3. Treatment for substance use disorders

With respect to treatment for substance abuse disorders, SACENDU reports that in the period July to December 2009, 2,642 patients were treated in the Western Cape, a decrease from 3,667 persons in the previous six months. Seventy five percent of those treated were first time admissions, with 42% treated as inpatients; the remainder (58%) as outpatients. In all, 74% of the referrals were male; 26% female. Of these patients, the main substances of utilisation were methamphetamine (46%), alcohol (40%), cannabis / dagga (37%) and dagga and mandrax (18%) (poly-substance use is common). The mean age of the referrals for methamphetamine was 24 years, 38 years for alcohol, 20 years for dagga and 30 years for dagga/mandrax. Although the majority of patients were men, women comprised 27% of methamphetamine users, 33% of alcohol users and 38% of cocaine users. More recent SACENDU research (2010) has shown a decline in the mean age of illicit drug users in treatment in the Western Cape.

Treatment for substance use disorders has varying degrees of success. For inpatient treatment centres there is a reported relapse rate of 60% associated with dependence and an estimated return rate of between two to three visits. The average cost of a six week session of treatment in one of the Provincial Government's in-patient centres is about R25,000 per patient. However, because of the high rate of relapse, the Provincial Government spends up to R100,000 for treatment services on individual cases (Blueprint, 2010:18). There is insufficient monitoring and evaluation data to comment on relapse rates for patients in the CoCT Matrix® outpatient programmes.

11.4. Safety and security

According to SAPS statistics (2009), the Western Province, and the Metro region in particular have the highest rates of drug related crime in the country (almost half of all occurrences - 52,000 from 117,000 cases). In this respect it has been estimated that 70% of domestic violence cases in the Cape Metropole were alcohol related (Peden, 2006; cited in Peltzer, K and S. Ramlagan, 2009:7). In terms of policing, there is currently a backlog of about 30,000 drug related cases within courts in the Western Cape, according to data provided by the Department of Justice and Constitutional Development (Blueprint, 2010:14). There is also a significant backlog on forensic reports to support court cases. For example, the SAPS laboratory has yet to process 19,000 drug samples; and in the National Department of Health Laboratories there are 5,000 blood samples for drunk driving cases and 3,200 blood toxicology samples that still need processing.

With respect to the supply of substances, the true scale of drug distribution is unknown. Liquor has commonly been retailed illegally through unlicensed venues (a consequence of which has been the promulgation of the Western Cape Liquor Act 2008, and City by laws regulating trading times for retailers), whilst the trade and trafficking in drugs is said to be controlled by gangs who exercise power within communities through patronage and employment (Blueprint, 2010:7).

11.5. Recommendations from the literature

The literature offers a range of interventions to deal with the alcohol and drug related situation within the Province and Metro region. These include improvements to legislation and the enforcement of current Acts and City By-Laws, including the Prevention of and Treatment for Substance Abuse Act 2008; Western Cape Liquor Act 2008; and City bylaws pertaining to liquor retailing hours. Other recommendations include;

- A shift towards a more holistic approach involving drug availability, lifeskills training, self-conceptualisation and improving environmental factors (Bateman 2006).
- The limitation of anti-social behaviour through the use of community amenities and facilities (Cape Town IDP 2008).
- The broadening of the scope of liquor regulation to include the majority of formerly established yet unregulated liquor retailers (shebeens), but excluding the least formally constituted of these businesses, under specific conditions to minimize the potential negative impact of noise, alcohol misuse/abuse and anti-social behaviour affecting the broader community (Charman, et al, 2009).
- Programmes of crime prevention, access to alcohol and drug treatment services and law enforcement (Cape Town IDP 2008).
- Improved law enforcement (Cape Town IDP 2008).
- The need for evidence based practices at various stages of harmful substance use (Myers *et al*. 2008).
- The need for further research (Blueprint, 2010).
- The need for treatment interventions to focus on harm reduction - to impact the challenges on which substance abuse is associated such as depression, psychopathology, and risky sex (Harker *et al*., 2008).
- Provision of mobile clinics to combat geographical barriers to services, mapping tools to ensure that resources were allocated in the areas of greatest need and quality assurance mechanisms to improve services (Myers, in Cape Times 2008).
- Acknowledgment of the failure of the war on drugs and the need for facing realities of drug usage and for rational debate on the topic towards a legalisation perspective (de V van Niekerk 2011).

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13.Institutional Framework

International

World Health Organisation

The United Nations Office on Drugs and Crime

South Africa

Government sphere	Dedicated Structures	Guiding documents	
National Government	Central Drug Authority	National Drug Master Plan	
Provincial Government	Western Cape Substance Abuse Forum	Western Cape Provincial Blueprint for Harmful Substance abuse (2010)	Mini Drug Master Plans
City of Cape Town	Cape Town Alcohol and Drug Action Committee (CTADAC) CTADAC sub - Committees (8)	Operational Drug and Alcohol Policy	Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014

14.Relevant legislation

International strategies	
United Nations Guiding Principles on Drug Demand Reduction	
African Union Plan of Action for Drug Control in Africa and Programme of Action for Drugs and Crime in Africa	
Southern African Development Community Drug Control Protocol (SADC Drug Control Programme)	
National legislation and strategies	**Notes:**
Prevention of and Treatment for Substance Abuse Act (2008)	• To provide for a comprehensive national response for the combating of substance abuse; to provide for mechanisms aimed at demand and harm reduction in relation to substance abuse through prevention, early intervention, treatment and re-integration programmes; to provide for the registration and establishment of treatment centres and halfway houses; to provide for the committal of persons to and from treatment centres and for their treatment, rehabilitation and skills development in such treatment centres; to provide for the establishment of the Central Drug Authority; and to provide for matters connected therewith.
Drugs and Drug Trafficking Act (1992)	• The Drugs and Drug Trafficking Act of 1992 is the controlling legislation on street drugs in South Africa. This Act allows charges to be brought under three separate provisions: o Section 3 (manufacture and supply) o Section 4 (use and possession) o Section 5 (dealing)
National Drug Master Plan (2006 – 2011)	• The NDMP is a broad policy and legislative framework for all alcohol and drug strategies; summarises national policies, defines priorities and responsibilities for control efforts pertaining to alcohol and drugs.
Province specific legislation and strategies	
Western Cape Liquor Act (Act 4 of 2008)	• Defines the terms and conditions for issuing of liquor licences to retailers and micro-manufacturers. • Stipulates regulatory conditions and penalties for non-compliance with the Act. • Mandates local government with a role in determining the conditions for granting licences and trading hours and affords communities an opportunity to comment on licence applications via a public participation process • Develops a social fund to contribute towards off-setting the impact of liquor abuse and dependence.
Workstream on the Prevention and Treatment of Harmful Alcohol and Drug Use (Provincial Blueprint)	• A Provincial strategy which informs interventions by and recommends budget expenditure of provincial departments around the prevention and treatment of substance abuse with the Department of the Premiere as the lead driver
City-specific legislation / by laws	
City of Cape Town By-law relating to Liquor Trading Days and Hours (2008)	• Determines liquor trading hours and days for different liquor licence categories.
Zoning regulations	• The CoCT aims to limit liquor trading on land zoned for residential use.
Health and Safety guidelines	• Impact on the provision of residential treatment services
Public nuisance by-laws	• Seeks to limit and prevent anti-social behaviours, directly or indirectly associated with substance use.

Annex 1: Strategy Narrative (Logical framework)

City of Cape Town Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014				
	Details	**Verifiable Indicators**	**Means of Verification**	**Risks and Assumptions**
Goal	To contribute towards minimising the harm and mitigating the impact of alcohol and other drugs on individual users, families and society in the Metro through the provision of targeted supply and demand reduction interventions.	•Decrease in AOD related crime and accidents. •Decrease in the prevalence of alcohol and drug misuse, abuse and dependency.	Annual State of City report. Integrated Development Plan, 2012/13 - 2017/8. Social and epidemiological studies.	•CoCT interventions complement programmes and actions of National and Provincial government. •Communities are willing to partner with the CoCT and fulfil a positive role to reduce the supply of, and demand for, illegal traded alcohol and illicit drugs.
	Objectives	**Verifiable Indicators**	**Means of Verification**	**Risks and Assumptions**
1	**Safety and security capability within the Metro strengthened and enhanced to reduce alcohol and drug related crime and harms from accidents on individuals and society.**			
1.1.	Enforce alcohol free zones in public spaces across the Metro region, targeting law enforcement resources at parks and beaches over the Festive Season.	All CoCT beaches and parks will have visible signage by 2014. Law enforcement will undertake up to 120 co-ordinated interventions at CoCT parks and beaches over the period 1 December to 1 April in 2012.	Annual reports.	•Council budget allocation for safety and security is significantly increased to enable adequate investment in equipment, personnel and systems.
1.2.	Increase the use of roadblocks and vehicle check points (VCP) with Blood Alcohol Concentration testing facilities to target drivers under the influence of alcohol.	Up to 800 VCP conducted per annum.	Annual reports.	•The proposed integration of the Metro police into SAPS does not affect the operational capacity of specialised units.
1.3.	Institute voluntary and random Blood Alcohol Concentration and drug testing for Metro Police, Law Enforcement and emergency services.	Maintain random alcohol/drug tests for all Substance Abuse Unit members. By 2014, introduce random and voluntary alcohol / drug test for other safety and security personnel.	Annual reports. Test results.	•SAPS remain committed to collaborate with Metro Police and Law Enforcement to target illegal drug dealing and illegal liquor sales.
1.4.	Maintain the capacity of specialised units (Substance Abuse Unit and Dog Unit) within the Metro Police to target illicit drug dealers and illicit drug manufacturers.	The number of specialist staff maintained at 35 in 2011/2012 financial year. A review of the capacity requirements of the Specialised Units undertaken and presented to Council by March 2012.	Annual reports. Budget submission.	•The closure of venues selling illegal liquor has no unintended impacts on the structure of the liquor supply chain. Employment alternatives for illegal liquor traders are made available in accordance with the Provincial economic development strategy.
1.5.	Strengthen and enlarge the capacity of law enforcement (Vice Squad and Liquor Enforcement Unit) to strategically target businesses involved in drug sales and/or the unregulated sale of alcohol.	By December 2012, the number of staff increased by 12.	Annual reports.	•Community policing initiatives will operate in accordance with the law and regulations governing their role.
1.6.	Through co-ordinated operations with SAPS, Metro (Substance Abuse Unit) and Law Enforcement, target illicit drug dealers and wholesalers supplying unregulated liquor venues.	The number of co-ordinated operations (with respect to legal operatations targeting known drug dealers and their premises) will be increased.	Annual reports.	•The CoCT By Law on liquor trading hours will be promulgated.
1.7.	Through co-operation with City Legal Department, Housing Department and National Justice Department, evict illicit drug dealers and unregistered sellers of liquor from Council property.	By 2014, evictions from CoCT rental properties will be effected to provide a disincentive against drug dealing / illegal liquor retailing by CoCT tenants.	Annual reports. City Housing Directorate data.	•The informality of illegal drug sales and unregulated liquor sales does not foster an unmanable environment for law enforcement.
1.8.	Establish capacity within the Substance Abuse Unit to obtain, analyse and distribute best available knowledge on supply trends of licit and illicit drugs and alcoholic beverages as well as information on supply crime related impacts.	Quarterly report on illegal alcohol and drug supply situation presented to the CTADAC.	Quarterly report to the CTADAC.	
1.9.	Support community policing initiatives, including Neighbourhood Watches and Neighbourhood Safety Co-ordinators, to collaborate with SAPS, Metro Police and Law Enforcement to promote 'zero tolerance' of AOD crime.	By 2014, number of community policing initiatives increased from seven to fourteen. Annual meeting with CPFs conducted to review progress with respect to AOD crime related law enforcement.	Annual reports.	
1.10.	In collaboration with the Liquor Board and SAPS, monitor regulated liquor outlets for adherence to the CoCT By-Law on Trading Days and Hours.	By 30 June 2011, up to 150 co-ordinated inspections undertaken.	Annual reports.	
1.11.	Support initiatives by CoCT, Province and National Government to advance restorative justice, including diversion and alternative sentencing for AOD crimes .	By December 2012, develop a strategy to work with community courts to help vulnerable people with substance use disorders gain access to registered treatment services, rehabilitation and support alternative sentencing.		
2	**Aspects of safety within the public infrastructure environment improved to reduce AOD crime burden.**			
2.1.	Integrate best practices of planning and design in new housing and public infrastructure developments and the rehabilitation of existing public infrastructure.	By 2012, the SDF 'good principles' for planning and design and New Integrated Zoning Scheme approved.		•The apartheid spatial planning legacy can be undone through low cost interventions.
2.2.	Develop integrated community safety plans.	By 2014, all 8 CTADAC sub-committees develop community safety plans with specific interventions to improve aspects of public safety.		
2.3.	Enhance CoCT sports and recreational facilities.	By 2014, sports and recreational facilities rehabilitated in 18 recreational hubs, targeting youth in areas of high AOD burden.		
2.4.	Investigate planning requirements for the liquor retail sector.	By 2014, recommendations on factors that need to be considered in the granting of liquor licences with respect to zoning made to strengthen spatial planning tools.		
2.5.	Enhance the impact of the YPUU programme through piloting interventions targeted at youth and vulnerable groups.	By 2012, programme synergies with SDF and SRA developed to improve AOD prevention interventions in one site.		
3	**Access to evidence-based treatment interventions provided and enhanced within the Metro.**			
3.1.	Increase the number of Matrix® Sites within CoCT health facilities as well as the professional staff need to meet	By 2014, number of Matrix® sites increased from four to eight with enhanced staff capacity for communities with greatest demand for treatment and linkages established with Provincial Government.	Annual reports.	•Council budget allocation for treatment services enables an expansion to four additional sites (eight in total) and engagement of a Matrix Master trainer.
3.2.	Support the skills development of a CoCT Matrix® Key Supervisor to provide key supervision and support for the CoCT Matrix® sites.	By 2014, two CoCT Matrix® key supervisors engaged to provide training support for all the CoCT Matrix® sites.	MoU with Matrix Master Trainer.	•The level of demand for public health services at CoCT Health Centres does not impact on the availability of specialists to provide ancillary health services to AOD treatment interventions.
3.3.	Support CoCT Matrix® clients to access in-patient care at treatment centres .	By 2014 all patients who require residential treatment are accommodated within provincial and or private in-patient treatment facilities.	MoU with Partners	•The Provincial Government and private service providers have sufficient detox facilities to meet demand from patients requiring treatment.
3.4.	Institute on-going monitoring of treatment outcomes at Matrix® Sites within CoCT health facilities.	By 2012, a standardised system of follow up and reporting to be in operation.	Monitoring reports.	•Budget allocation within CoCT procurement roles for transport subsidies is sufficient to meet demand from eligible patients.
3.5.	Ensure all patients at Matrix® Sites within the CoCT health facilities are screened for mental health and communicable diseases.	By 2012, all patients are screened for mental health and communicable / infectious diseases (including TB, HIV/AIDs).	Annual reports.	•The Provincial Government remains committed to the provision of social support and probation services to achieve seamless services in partnership with the CoCT Matrix Sites.
3.6.	In partnership with the Provincial Government and NGOs, provide a seamless service model of treatment.	By 2014, support two seamless service sites through agreements with Province and NGOs.	Annual reports.	•The operational capacity of the Helpline is sufficient to cope with peaks in demand.
3.7.	Enhance patient access to AOD treatment at CoCT Health treatment sites through subsidising transport costs and providing access to child care facilities.	By 2014, Matrix® sites within CoCT Health Clinics offer subsidised transport to patients unable to afford the costs of transport. By 2014, partnerships created with early childhood development centres at four CoCT Health treatment sites to provide child care for eligible patients attending treatment.	Annual reports.	•Treatment outcomes verify the appropriateness and effectiveness of the Matrix Model approach.

	Objectives	Verifiable Indicators	Means of Verification	Risks and Assumptions
3.8.	Implement simple detoxification at CoCT Matrix® sites.	By 2014, health facilities where Matrix ® sites are situated provide simple detoxification treatment on referral.		
3.9.	Engage with the Provincial Government and private service providers to secure access to detoxification facilities for patients requiring treatment.	By 2012, dialogue initiated with Provincial Government and the private sector on the possibility of establishing a private-public detox facility to provide a detox services.	Annual reports.	
3.10.	Build the capacity of CoCT Health clinical staff to screen, assess and offer brief interventions and/or referral for patients with evidenced AOD problems.	By 2014, an AOD early intervention training programme developed and implemented by the CoCT Health Training Department for clinical staff.	Training programme guidelines.	
3.11.	Implement adolescent-centred alcohol and drug treatment interventions at CoCT Matrix® sites.	By 2014, eight Matrix® sites provide adolescent-centred alcohol and drug treatment interventions.	Annual reports.	
3.12.	Enhance the services of the CoCT Alcohol and Drug Helpline.	By 2013, the capacity of the operators up skilled to provide lay-counselling for callers to the Helpline.	Training report.	
3.13.	Implement an alcohol and drug treatment programme via the employee Wellness Department for CoCT employees.	By 2012, a treatment programme is offered to CoCT employees with AOD abuse and dependency.	Annual reports.	
4	**Evidence based prevention services provided within the Metro to build coping skills and enhancing knowledge on AOD disorders and risks.**			
4.1.	Increase and enhance public awareness of the COCT Alcohol and Drug Helpline and treatment services.	The 107 marketing team to promote awareness of the Helpline through targeted marketing drives to vulnerable groups on a quarterly basis. CoCT website updated bi-annually, containing details of the Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy and information on treatment and prevention services.	Marketing impact assessment report. Web-site updates.	•CoCT AOD prevention initiatives are not undermined by non-evidence based interventions undertaken by other spheres of government and private or non-governmental stakeholders.
4.2.	Enhance professional expertise among CoCT staff providing prevention interventions.	An annual training programme for key staff undertaken.		
4.3.	Develop an evidence based AOD prevention programme with universal, selective and indicated interventions.	By 2014, the CoCT will operationalise a prevention programme and guidelines to ensure all CoCT AOD prevention initiatives comply with best practice principles and the legislative framework.	Programme guidelines.	•The effectiveness of the CoCT's Helpline will not be affected by mis-use / hoax callers.
4.4.	Where needed, provide parenting skills to preserve the family structure of persons affected by substance use and those with use disorders.	Support for eight parenting skills interventions undertaken annually in collaboration with Department of Social Development Facilitation through Early Childhood Development forums.	Training report.	•Prevention programmes will addresses both licit and illicit drugs.
4.5.	Ensure the alignment and harmonization of AOD messaging within the CoCT and align CoCT initiatives with the Provincial Government.	By 2012, harmonised messages integrated into CoCT prevention programmes.	Information Message.	•Prevention programmes will be targeted, sustained and reinforce information provision with life skills development and other social interventions.
5	**Institutional capacity strengthened to enhance inter-departmental action and monitoring of alcohol and drug harm minimization / mitigation initiatives.**			
5.1.	Obtain Council approval of the CoCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy.	By 2011, CoCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy granted Council approval and full operational status.	Council decision.	•Council remains committed to prioritize AOD harm minimization / mitigation.
5.2.	Secure Mayoral appointment of the members of the Cape Town Alcohol and Drug Action Committee.	By 2011, a full CTADAC will be appointed and mandates for specific roles and responsibilities fulfilled.	Monthly minutes of CTADAC meetings.	•The CTADAC meetings will be afforded priority to ensure the active participation of all CoCT stakeholders.
5.3.	Strengthen co-ordination through CTADAC.	By 2011, a co-ordinating forum of the CTADAC established with monthly meetings to enhance collaboration between Health, Safety and Security and Social Development Facilitation.	Monthly minutes of co-ordination forum	•Ward councillors ensure harmonisation of grant-in-aid funding with strategy objectives.
5.4.	Promote awareness of the CoCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy among ward councillors through the sub-councils.	By 2011, a policy and strategy information tool for ward councillors developed and distributed, promoting harmonization to the CoCT policy and strategy.	Information tool.	•There will be no party political interference in the implementation of the CoCT strategy.
5.5.	Strengthen information management system to monitor Departmental progress on implementation of Alcohol and Other Drug Harm Minimization & Mitigation Plan of Operation.	By 2011, monitoring and reporting benchmarks developed and operationalised in and between strategy implementing Directorates. By 2011, key strategy performance objectives included within the Mayoral dashboard.	Monitoring reports.	•The Regulations of the Prevention of and Treatment for Substance Abuse Act (70 of 2008) will be promulgated.
5.6.	Institute a monitoring system to assess the performance and impact of CoCT grant funded interventions (to partners) to maintain harmonization with the strategy.	By 2012, all grants to partner organisations monitored on a quarterly basis to ensure adherence to the principles of cost-effectiveness, best practice and alignment to the CoCT Alcohol and Other Drug Minimization & Mitigation strategic objectives.	Monitoring reports.	•Gaps and flaws in the state of knowledge do not affect the appropriateness of strategic interventions to reduce illegal drug and non-regulated alcohol supply.
5.7.	Monitor trends on AOD burden treatment within the Metro region through contemporary research.	State of Knowledge updated annually through analysis of secondary literature and institutional reports on the burden of alcohol and drug harm within the Metro.	State of Knowledge report.	•The impact of the CoCT strategy will be measurable from year one.
5.8.	Conduct annual review of the CoCT Alcohol and Other Drug Minimization & Mitigation strategy and institute corrective action.	In conjunction with stakeholders from CTADAC, annual review of the strategy conducted and corrective action agreed and implemented.	Annual strategy review.	•The CTADAC meetings will be afforded priority to ensure the active participation of all CoCT stakeholders.
5.9.	Influence budget allocations to enhance the CoCT Alcohol and Other Drug Minimization & Mitigation strategy during departmental strategic planning.	By 2012, in conjunction with stakeholder agencies from within CTADAC, exert influence towards inter-departmental budget allocations towards CTADAC priorities.		

1.10.	In collaboration with the Liquor Board and SAPS, monitor regulated liquor outlets for adherence to the CoCT By-law on Trading Days and Hours.	By 30 June 2011, up to 150 co-ordinated inspections undertaken.	Annual reports.	
1.11.	Support initiatives by CoCT, Province and National Government to advance restorative justice, including diversion and alternative sentencing for AOD crimes .	By December 2012, develop a strategy to work with community courts to help vulnerable people with substance use disorders gain access to registered treatment services, rehabilitation and support alternative sentencing.		
2	**Aspects of safety within the public infrastructure environment improved to reduce AOD crime burden.**			
2.1.	Integrate best practices of planning and design in new housing and public infrastructure developments and the rehabilitation of existing public infrastructure.	By 2012, the SDF 'good principles' for planning and design and New Integrated Zoning Scheme approved.		•The apartheid spatial planning legacy can be undone through low cost interventions.
2.2.	Develop integrated community safety plans.	By 2014, all 8 CTADAC sub-committees develop community safety plans with specific interventions to improve aspects of public safety.		
2.3.	Enhance CoCT sports and recreational facilities.	By 2014, sports and recreational facilities rehabilitated in 18 recreational hubs, targeting youth in areas of high AOD burden.		
2.4.	Investigate planning requirements for the liquor retail sector.	By 2014, recommendations on factors that need to be considered in the granting of liquor licences with respect to zoning made to strengthen spatial planning tools.		
2.5.	Enhance the impact of the VPUU programme through piloting interventions targeted at youth and vulnerable groups.	By 2012, programme synergies with SDF and SRA developed to improve AOD prevention interventions in one site.		
3	**Access to evidence-based treatment interventions provided and enhanced within the Metro.**			
3.1.	Increase the number of Matrix® Sites within CoCT health facilities as well as the professional staff need to meet	By 2014, number of Matrix® sites increased from four to eight with enhanced staff capacity for communities with greatest demand for treatment and linkages established with Provincial Government.	Annual reports.	•Council budget allocation for treatment services enables an expansion to four additional sites (eight in total) and engagement of a Matrix Master trainer.
3.2.	Support the skills development of a CoCT Matrix® Key Supervisor to provide key supervision and support for the CoCT Matrix® sites.	By 2014, two CoCT Matrix® key supervisors engaged to provide training support for all the CoCT Matrix® sites.	MoU with Matrix Master Trainer.	• The level of demand for public health services at CoCT Health Centres does not impact on the availability of specialists to provide ancillary health services to AOD treatment interventions.
3.3.	Support CoCT Matrix® clients to access in-patient care at treatment centres .	By 2014 all patients who require residential treatment are accommodated within provincial and or private in-patient treatment facilities.	MoU with Partners	• The Provincial Government and private service providers have sufficient detox facilities to meet demand from patients requiring treatment.
3.4.	Institute on-going monitoring of treatment outcomes at Matrix® Sites within CoCT health facilities.	By 2012, a standardised system of follow up and reporting to be in operation.	Monitoring reports.	•Budget allocation within CoCT procurement roles for transport subsidies is sufficient to meet demand from eligible patients.
3.5.	Ensure all patients at Matrix® Sites within the CoCT health facilities are screened for mental health and communicable diseases.	By 2012, all patients are screened for mental health and communicable / infectious diseases (including TB, HIV/AIDS).	Annual reports.	• The Provincial Government remains committed to the provision of social support and probation services to achieve seamless services in partnership with the CoCT Matrix Sites.
3.6.	In partnership with the Provincial Government and NGOs, provide a seamless service model of treatment.	By 2014, support two seamless service sites through agreements with Province and NGOs.	Annual reports.	• The operational capacity of the Helpline is sufficient to cope with peaks in demand.
3.7.	Enhance patient access to AOD treatment at CoCT Health treatment sites through subsidising transport costs and providing access to child care facilities.	By 2014, Matrix® sites within CoCT Health Clinics offer subsidised transport to patients unable to afford the costs of transport. By 2014, partnerships created with early childhood development centres at four CoCT Health treatment sites to provide child care for eligible patients attending treatment.	Annual reports.	• Treatment outcomes verify the appropriateness and effectiveness of the Matrix Model approach.
	Objectives	**Verifiable Indicators**	**Means of Verification**	**Risks and Assumptions**
3.8.	Implement simple detoxification at CoCT Matrix® sites.	By 2014, health facilities where Matrix ® sites are situated provide simple detoxification treatment on referral.		
3.9.	Engage with the Provincial Government and private service providers to secure access to detoxification facilities for patients requiring treatment.	By 2012, dialogue initiated with Provincial Government and the private sector on the possibility of establishing a private-public detox facility to provide a detox services.	Annual reports.	
3.10.	Build the capacity of CoCT Health clinical staff to screen, assess and offer brief interventions and/or referral for patients with evidenced AOD problems.	By 2014, an AOD early intervention training programme developed and implemented by the CoCT Health Training Department for clinical staff.	Training programme guidelines.	
3.11.	Implement adolescent-centred alcohol and drug treatment interventions at CoCT Matrix® sites.	By 2014, eight Matrix® sites provide adolescent-centred alcohol and drug treatment interventions.	Annual reports.	
3.12.	Enhance the services of the CoCT Alcohol and Drug Helpline.	By 2013, the capacity of the operators up skilled to provide lay-counselling for callers to the Helpline.	Training report.	
3.13.	Implement an alcohol and drug treatment programme via the employee Wellness Department for CoCT employees.	By 2012, a treatment programme is offered to CoCT employees with AOD abuse and dependency.	Annual reports.	
4	**Evidence based prevention services provided within the Metro to build coping skills and enhancing knowledge on AOD disorders and risks.**			
4.1.	Increase and enhance public awareness of the COCT Alcohol and Drug Helpline and treatment services.	The 107 marketing team to promote awareness of the Helpline through targeted marketing drives to vulnerable groups on a quarterly basis. CoCT website updated bi-annually, containing details of the Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy and information on treatment and prevention services.	Marketing impact assessment report. Web-site updates.	•CoCT AOD prevention initiatives are not undermined by non-evidence based interventions undertaken by other spheres of government and private or non-governmental stakeholders.

Annex 2: Plan of Operations

	City of Cape Town Operational Plan: Alcohol and Other Drug Harm Minimization and Mitigation Strategy, 2011-2014						
Objective	**Activity**	**Timeframe**				**Responsible**	**Assumptions**
		2011	**2012**	**2013**	**2014**		
1	**Safety and security capability within the Metro strengthened and enhanced to reduce alcohol and drug related crime and harms from accidents on individuals and society.**						
1.1.	Enforce alcohol free zones in public spaces across the Metro region, targeting law enforcement resources at parks and beaches over the Festive Season.		X		X	Law Enforcement / Sports, Recreation and Amenities	Coordination with SAPS / Metro Police
1.2.	Increase the use of roadblocks and vehicle check points (VCP) with Blood Alcohol Concentration testing facilities to target drivers under the influence of alcohol.	X	X	X	X	Traffic and Metro Police	Coordination with SAPS
1.3.	Institute voluntary and random Blood Alcohol Concentration and drug testing for Metro Police, Law Enforcement and emergency services.	X	X	X	X	Traffic, Metro Police, Law Enforcement	
1.4.	Maintain the capacity of specialised units (Substance Abuse Unit and Dog Unit) within the Metro Police to target illicit drug dealers and illicit drug manufacturers.	X	X			Metro Police (Specialised Units)	Adequate budget provision.
1.5.	Strengthen and enlarge the capacity of law enforcement (Vice Squad and Liquor Enforcement Unit) to strategically target businesses involved in drug sales and/or the unregulated sale of alcohol.	X	X			Law Enforcement (Vice Squad and Liquor Enforcement Unit)	Adequate budget provision.
1.6.	Through co-ordinated operations with SAPS, Metro (Substance Abuse Unit) and Law Enforcement, target illicit drug dealers and wholesalers supplying unregulated liquor venues.	X	X			Metro Police (Specialised Units)	Adequate support from Justice Department.
1.7.	Through co-operation with City Legal Department, Housing Department and National Justice Department, evict illicit drug dealers and unregistered sellers of liquor from Council property.					Legal Department / Housing Department / Metro Police	Adequate support from Justice Department.
1.8.	Establish capacity within the Substance Abuse Unit to obtain, analyse and distribute best available knowledge on supply trends of licit and illicit drugs and alcoholic beverages as well as information on supply crime related impacts.	X	X			Metro Police (Specialised Units)	AOD crime prevention results are indicated of supply trends.
1.9.	Support community policing initiatives, including Neighbourhood Watches and Neighbourhood Safety Co-ordinators, to collaborate with SAPS, Metro Police and Law Enforcement to promote 'zero tolerance' of AOD crime.	X	X			Metro Police	Community policing initiatives are adequately resourced and supported.
1.10.	In collaboration with the Liquor Board and SAPS, monitor regulated liquor outlets for adherence to the CoCT By-Law on Trading Days and Hours.		X	X	X	Law Enforcement	Coordination with the Liquor Board / SAPS.
1.11.	Support initiatives by CoCT, Province and National Government to advance restorative justice, including diversion and alternative sentencing for AOD crimes .		X			Social Development	Coordination with Province and Department of Justice and Constitutional Development.
2	**Improve aspects of safety within the public infrastructure environment to reduce AOD crime burden.**						
2.1.	Integrate best practices of planning and design in new housing and public infrastructure developments and the rehabilitation of existing public infrastructure.	X	X	X	X	Spatial Planning	Approval of Planning guidelines.
2.2.	Develop integrated community safety plans.		X	X	X	Social Development / Health Directorate	
2.3.	Enhance CoCT sports and recreational facilities.	X	X	X	X	SRA	
2.4.	Investigate planning requirements for the liquor retail sector.	X	X			Spatial Planning	
2.5.	Enhance the impact of the VPUU programme through piloting interventions targeted at youth and vulnerable groups.	X	X	X	X	VPUU	

Objective	Activity	Timeframe				Responsible	Assumptions
		2011	2012	2013	2014		
3	**Access to evidence-based treatment interventions provided and enhanced within the Metro.**						
3.1.	Increase the number of Matrix® Sites within CoCT health facilities as well as the professional staff need to meet the demand for service.	X	X	X	X	Health Directorate	Adequate budget provision.
3.2.	Support the skills development of a CoCT Matrix® Key Supervisor to provide key supervision and support for the CoCT Matrix® sites.				X	Health Directorate	Skill are available and affordable.
3.3.	Support CoCT Matrix® clients to access in-patient care at treatment centres .	X	X	X	X	Health Directorate	Skills training / upgrading provided.
3.4.	Institute on-going monitoring of treatment outcomes at Matrix® Sites within CoCT health facilities.		X	X	X	Health Directorate	Adequate skills availability.
3.5.	Ensure all patients at Matrix® Sites within the CoCT health facilities are screened for mental health and communicable diseases.				X	Health Directorate	Cooperation with Provincial services.
3.6.	In partnership with the Provincial Government and NGOs, provide a seamless service model of treatment.				X	Health Directorate	Adequate skills are available.
3.7.	Enhance patient access to AOD treatment at CoCT Health treatment sites through subsidising transport costs and providing access to child care facilities.				X	Health Directorate	Adequate budget provision.
3.8.	Implement simple detoxification at CoCT Matrix® sites.						
3.9.	Engage with the Provincial Government and private service providers to secure access to detoxification facilities for patients requiring treatment.		X			Health Directorate	Cooperation with Provincial services.
3.10.	Build the capacity of CoCT Health clinical staff to screen, assess and offer brief interventions and/or referral for patients with evidenced AOD problems.				X	Health Directorate	Skills training / upgrading provided.
3.11.	Implement adolescent-centred alcohol and drug treatment interventions at CoCT Matrix® sites.				X	Health Directorate	Skills training / upgrading provided.
3.12.	Enhance the services of the CoCT Alcohol and Drug Helpline.			X		Health Directorate	Adequate budget provision & skills training / upgrading provided.
3.13.	Implement an alcohol and drug treatment programme via the employee Wellness Department for CoCT employees.		X			Health Directorate / Corporate Services	
4	**Evidence based prevention services provided within the Metro to build coping skills and enhancing knowledge on AOD disorders and risks.**						
4.1.	Increase and enhance public awareness of the COCT Alcohol and Drug Helpline and treatment services.	X	X	X	X	Health Directorate	Market approach to target specific groups.
4.2.	Enhance professional expertise among CoCT staff providing prevention interventions.				X	Health Directorate	Short-term expertise utilised.
4.3.	Develop an evidence based AOD prevention programme with universal, selective and indicated interventions.	X	X	X	X	Social Development Facilitation	Adequate budget provision.
4.4.	Where needed, provide parenting skills to preserve the family structure of persons affected by substance use and those with use disorders.			X		Health and Community Services	Short-term expertise utilised.
4.5.	Ensure the alignment and harmonization of AOD messaging within the CoCT and align CoCT initiatives with the Provincial Government.		X			Health and Social Development Facilitation	Skills training / upgrading provided.

Objective	Activity	Time frame				Responsible	Assumptions
		2011	2012	2013	2014		
5	**Institutional capacity strengthened to enhance inter-departmental action and monitoring of alcohol and drug harm minimization / mitigation initiatives.**						
5.1.	Obtain Council approval of the CoCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy.	X				Council	Council approval secured.
5.2.	Secure Mayoral appointment of the members of the Cape Town Alcohol and Drug Action Committee.	X				Council	Council approval secured.
5.3.	Strengthen co-ordination through CTADAC.	X				Health Directorate, Community Services, Safety and Security	Coordination incorporated into Departmental plans.
5.4.	Promote awareness of the CoCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy among ward councillors through the sub-councils.	X				Health Directorate	Sub-Council / Ward Councillor alignment to strategy secured.
5.5.	Strengthen information management system to monitor Departmental progress on implementation of Alcohol and Other Drug Harm Minimization & Mitigation Plan of Operation.	X				Health Directorate, Community Services, Safety and Security, Corporate Services, and Economic Development and Tourism	Skills training / upgrading provided.
5.6.	Institute a monitoring system to assess the performance and impact of CoCT grant funded interventions (to partners) to maintain harmonization with the strategy.		X			Health Directorate	Skills training / upgrading provided.
5.7.	Monitor trends on AOD burden treatment within the Metro region through contemporary research.	X	X	X	X	Health Directorate	New studies address knowledge gaps.
5.8.	Conduct annual review of the CoCT Alcohol and Other Drug Minimization & Mitigation strategy and institute corrective action.	X	X	X	X	Health Directorate and CTADAC members	Strategy impact will be measurable within one year.
5.9.	Influence budget allocations to enhance the strategy during departmental strategic planning.	X	X	X	X	All stakeholders	
6	**Co-ordination of actions on AOD minimization / mitigation strengthened at Metro and local level with other spheres of government, institutions, private sector role-players and NGO/CBO/FBO actors.**						
6.1.	Co-ordinate actions and interventions with Provincial and National government and other COCT partners.	X	X	X	X	Health Directorate	Cooperation with Provincial services and other stakeholders maintained.
6.2.	Establish CTADAC sub-committees in each COCT Health District.	X	X	X	X	Social Development Facilitation	Local stakeholder buy-in.
6.3.	Strengthen co-ordination with NGOs/CBOs/FBOs and private service providers to promote awareness of the COCT Alcohol and Other Drug Harm Minimization & Mitigation policy and strategy.	X	X	X	X	Health Directorate	No political or agenda driven interference in the City strategy.
6.4.	Establish and update a database of prevention and treatment service providers and other relevant agencies to the COCT Alcohol and Other Drug Harm Minimization & Mitigation strategy.	X				Health Directorate	Information is accessible.
6.5.	Support and collaborate with local initiatives to establish a professional body for specialists working in AOD prevention and treatment services.	X	X	X	X	Health Directorate	Cooperation with the City is maintained.
6.6.	Strengthen co-ordination between the COCT and the Provincial Government in the registration of private and non-governmental treatment centres.	X	X	X	X	CTADAC members	Cooperation with Provincial services secured.
6.7.	Engage with National and Provincial government and liquor manufacturers to reduce the negative impact of liquor advertising.		X	X	X	CTADAC members	Supportive legal framework.